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ALASKA HEALTH CARE COMMISSION

FRIDAY, JUNE 21, 2013

8:00 A.M.

FRONTIER BUILDING, ROOM 896

3601 "C" STREET

ANCHORAGE, ALASKA

VOLUME 2 OF 2

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1 established under the Governor's administrative order.

2 The statute that created the Commission is substantially
3 similar to the administrative order, but it's not exactly the
4 same. So what we were -- what we did here, just as a reminder
5 from last time, is we went through and revised all of the
6 wording about the duties and responsibilities of the
7 Commission so it matches exactly the wording in our statute.

8 So I'll give you a minute. I had provided last time in
9 your notebooks, a copy of our statute. I did not do that
10 again today, so -- for comparison purposes. Yes, Allen.

11 COMMISSIONER HIPPLER: Thank you, Deborah. So are you
12 saying we must adopt these changes as presented?

13 MS. ERICKSON: I will say that it was something that the
14 legislative auditors pointed out as an issue. I don't know
15 what that means, honestly.

16 COMMISSIONER HIPPLER: Well, I don't like some of the
17 changes.

18 MS. ERICKSON: So the duties and responsibilities matched
19 exactly the wording in the Governor's administrative order
20 when the initial Commission was created and now, we're just
21 revising them to match exactly what's in the statute. So
22 whether we must do it or not, it was a disparity that was
23 pointed out to us by our auditors. I don't know what real
24 problem it causes if we don't. Dave, go ahead.

25 COMMISSIONER MORGAN: Do you have something more to say?

1 COMMISSIONER HIPPLER: Just another procedural question;
2 is the method of how we proceed at this point, someone makes a
3 motion to adopt the changes?

4 MS. ERICKSON: Yes.

5 COMMISSIONER HIPPLER: There's a second and then at that
6 point, there will be discussion and perhaps a motion to
7 separate the question or something?

8 MS. ERICKSON: Yes. Yes, I.....

9 COMMISSIONER HIPPLER: Thank you.

10 MS. ERICKSON: Yes, I would entertain a motion right now.

11 COMMISSIONER MORGAN: I would make a motion that we adopt
12 the corrections and additions and changes proposed. I add
13 further (indiscernible - voice lowered) when I talked to the
14 legislative auditors and to -- I know this is to everyone's
15 surprise after three.....

16 MS. ERICKSON: We need a second before we discuss.

17 UNIDENTIFIED VOICE: Second.

18 MS. ERICKSON: Okay, discussion.

19 COMMISSIONER MORGAN: After -- they actually said they
20 couldn't take any more talking to me after three hours. So
21 basically what I got on a lot of these changes was they're
22 getting us into conformity to the statutes and basically
23 getting us in sync to the Governor's orders, to the
24 regulations and to the law.

25 They're not, in my mind, radical, go climb out on the

1 fence kind of stuff. It's basically getting us caught up, I
2 think, and that's the impression, because I asked them point
3 blank and that's what I got.

4 MS. ERICKSON: Other discussion? Jeff.

5 COMMISSIONER DAVIS: That being the case, if the statute
6 is a statute and that's our charge and if this reflects
7 accurately the statute, as I believe it does, then I don't see
8 why we would do anything other than adopt them. Thank you.

9 UNIDENTIFIED VOICE: Call for the question.

10 MS. ERICKSON: All in favor of adopting the changes?

11 COMMISSIONER HIPPLER: As a point of order, ma'am, the
12 question has been called. That is itself a motion and we can
13 vote on that.

14 MS. ERICKSON: All in favor of.....

15 UNIDENTIFIED VOICES: Aye.

16 MS. ERICKSON: Any opposed?

17 COMMISSIONER HIPPLER: Nay.

18 MS. ERICKSON: Okay, let's move on. Barb, can you
19 capture that vote for us? Thanks. I just wanted to point out
20 most of you have your 2013 financial disclosures to.....

21 COMMISSIONER HIPPLER: Ma'am, is it -- I'm sorry, as a
22 point of order, we still haven't voted on the actual motion of
23 adopting the bylaw change.

24 MS. ERICKSON: What's the.....

25 UNIDENTIFIED VOICE: So now (indiscernible - too far from

1 microphone).

2 MS. ERICKSON: Now, we're voting on the motion. All in
3 favor of the motion. I need Val. Pat, tell Val she can't
4 miss any more meetings. All in favor of the motion to adopt
5 the changes to the bylaws signify by saying aye.

6 UNIDENTIFIED VOICES: Aye.

7 MS. ERICKSON: Any opposed?

8 COMMISSIONER HIPPLER: Nay.

9 MS. ERICKSON: So Allen -- and make sure you capture
10 exactly who's here, too, of the voting members. Thanks, Barb.
11 So for the 2013 financial statements, I have all of them
12 except Emily, Val's, Jeff's, Dr. Urata's and Pat Branco's.
13 For the three of you who are here who haven't had a chance to
14 fill them out yet, Barb will get you envelopes to mail them
15 in, if you can't get them filled out and to us by the end of
16 the day.

17 If you didn't get one in your notebook like -- everybody
18 had them in their notebooks, but I think a couple of them were
19 missing. So if any of you were missing yours, let us know and
20 we'll get them to you on the break.

21 Okay. So we were just going to update you on the status
22 of the sunset audit and I think I'd explained the process a
23 little bit in the past just over email and so I'm going to
24 give you a chance to ask some questions about that, but just
25 as an overview again, as a matter of course, automatically,

1 any state body that has a sunset date, the Division of
2 Legislative Audit will, 18 months in advance of that date,
3 begin a process to conduct an audit to see, you know, to check
4 on the operations just to make sure that procedurally and
5 administratively things are happening or working appropriately
6 from that perspective, but they also take a look at the
7 legislative intent behind the creation of that body and make a
8 determination and a recommendation regarding whether the
9 commission is meeting the legislative intent and the intent of
10 the statute and they also will make a recommendation to the
11 Legislature.

12 Ultimately, the recommendation is going to the
13 Legislature regarding whether the body is meeting a public
14 purpose and a public good and so the process that we went
15 through for a period of several months here that just is
16 wrapping up was the auditors from this group going through all
17 of our records and all of the documents that we've produced
18 and conducting lots of interviews of folks and the actual
19 written reports from the legislative audit will -- are
20 confidential, but what they'll do is they'll work with the
21 agency responsible to review initial management findings and
22 recommendations to get some feedback on whether the agency
23 complies or not.

24 If the agency complies, what is their plan for -- or if
25 they agree, what is their plan for implementing

1 recommendations and that will go back and forth between the
2 auditors and the department a few times. It will go on then -
3 - their final -- their report will go to the Legislative
4 Budget and Audit Committee and the document remains
5 confidential while the legislative Budget and Audit Committee
6 works with the department to make sure that they all --
7 everyone understands and where they agree and disagree and
8 without going into the fine details, at some point, it will
9 become a public document when the legislative Budget and Audit
10 Committee releases it to -- or passes it onto the Legislature.

11 So I can't share anything in real fine detail with you at
12 this point and can't share any of the preliminary memos and
13 documents with you at this point and we're probably a few
14 months away from that, being able to do that, I would imagine
15 sometime in the fall, but generally, I think it's okay to
16 share some main points with you.

17 I expect we -- I think overall, and Ward, you can chip in
18 on this, too, as well, the process was really helpful from my
19 perspective. It was a lot of work. It was -- and I was
20 feeling, I know it still was nothing anywhere near approaching
21 the level that health care providers go through in their
22 audits, but I was feeling your pain.

23 They looked at everything and did a real deep dive and it
24 was a lot of work to pull things together for them and they
25 did some real intensive work over a period of time, but

1 overall, I felt it was real helpful to get -- to hear from
2 them where they think some improvements could be made and
3 we're already implementing them and the bylaws was just one
4 example of that, just in terms of administrative procedure.

5 In terms of our approach, something that we've been
6 working with Commissioner Streur on, and I think we had just
7 gotten to that -- to this point and this was the perfect step-
8 off point between -- and Ward mentioned yesterday, the
9 auditors suggesting that there needs to be some more
10 specificity at this point in recommendations and the
11 conversations we've been having with Commissioner Streur, and
12 just so you know, he was here a little bit ago. He will be
13 back later this morning and so if you want to check in with
14 him on any of this or ask him any questions about next steps,
15 that would be a good time to do it, but their -- Commissioner
16 Streur is planning on working with Commissioner Hultberg and
17 other state agency programs affected, like Worker's Comp and
18 Corrections, to start coordinating and collaborating around
19 the development of action plans based on our current
20 recommendations and working with us and seeing the Commission
21 more in a role as being an accountability check and helping
22 with implementation in terms of being a convener for the
23 leaders of state agencies to come together periodically and to
24 share with you the actions that they're working on putting in
25 place, a place to document it, a place for accountability for

1 that.

2 So is there anything you would add to that, Ward?

3 CHAIR HURLBURT: No, I think, as you say, that I thought
4 it was gratifying and important to note that it was a very
5 collaborative process. It was not adversarial and you and I
6 both commented that some of the things they pointed out would
7 have been nice if somebody had been taken that perspective and
8 looked at two or three years ago.

9 Some of them, I don't think are substantive in the fact
10 that they don't really make a difference in what we've done or
11 what's happened, but it -- but they were looking at it from
12 the standpoint of exactly what does the law say and are we
13 being fully compliant with it, and so there are some things
14 that I might say, "Well, they're details," but we really
15 should be cognizant of that and I think it was a helpful
16 process to go through and then, of course, they'll be making a
17 recommendation and the Governor's Office and the Legislature
18 will make a decision, but in the absence of a renewal, then we
19 will sunset a year from this month.

20 MS. ERICKSON: Just another point about that procedure,
21 too, our sunset date is June 30th of 2014, and a body that
22 sunsets, stays in place for a year following their sunset date
23 and I assume it's just to allow time for administrative wrap-
24 up activities. So the Commission technically wouldn't go away
25 then until, yeah (affirmative), June 30th, 2015.

1 I don't know what that would mean for how we would
2 operate during that last year, if we would continue in
3 meetings like this or just try to do some wrap-up work, but
4 overall, the experience was positive. The feedback was
5 positive, I thought, and recommendations for improvement were
6 really helpful. So any questions about the sunset audit
7 process in general?

8 I also wanted to mention, we'll talk about this more in
9 next steps, but something I wanted to give a heads-up about is
10 that the Commissioner plans to convene a meeting, and this is
11 the first time it's being noted publically and invitations
12 will go out hopefully by the end of next week, plans to
13 convene a meeting on August 9th that initially you all were
14 going to be requested or invited to attend, but not required
15 to attend, but we're talking about adding another component to
16 it.

17 August 9th for three hours in the morning, he intends to
18 convene a group of stakeholders to have a conversation about
19 next steps with the Commission and with the development of a
20 state health plan. One of the areas of alignment, I have a
21 slide about that and we'll put it up later today, but one of
22 the areas of alignment between the department and the
23 Commission is that the Commission statute directs the
24 Commission to be the state health planning and coordinating
25 body and charges us with fostering the development of a state

1 health plan and at the same time, the bill that created the
2 Commission changed authorizing statutes for the state health
3 department, Department of Health and Social Services,
4 authorizing them to develop a state health plan based on the
5 recommendations of the Commission.

6 So essentially what we're doing is kind of taking the
7 next step where you all have laid out so far a vision, a set
8 of core strategies and some outcomes to shoot for and some
9 specific policy recommendations that the next steps in putting
10 an action plan together is going to be that state health plan
11 and that's what we will be collaborating -- the department
12 will be collaborating more with stakeholders on the
13 development of that action plan, but we -- and we'll have a
14 facilitated conversation that morning.

15 Craig Holt, as I mentioned yesterday, we've had a
16 facilitator, a shared facilitator that the Legislature has
17 been using for work on results-based accountability and
18 results-based budgeting that both Governor's OMB has been
19 using (sic). Our department has been using that same
20 consultant and he will be the facilitator for that discussion.

21 What we were just talking about this morning was if we
22 could convene at least a quorum of the Commission that day,
23 that we would continue the conversation just with the
24 Commission and Commissioner Hultberg and Commissioner Streur
25 that afternoon and have a facilitated conversation with the

1 Commission about how the work to coordinate and communicate
2 between the Commission and the department and stakeholders
3 will happen into the future as we work on developing the state
4 health plan.

5 The 9th -- so August 9th is a Friday and so we can follow
6 up with you later to see if that date will work. What we
7 might do is have the second part of that conversation on
8 August 22nd, if we can't get enough of you together, which is
9 the second day of our August meeting, if we can't get enough
10 of you together on the 9th.

11 So if you have any questions about that for me right now,
12 I can answer them, but if you want to ask Commissioner Streur
13 about them later today, you can do that, too. Yes, Dr. Urata.

14 COMMISSIONER URATA: Is that in Anchorage?

15 MS. ERICKSON: Yes, that will be in Anchorage and the
16 Commission will pay for the voting members who would need to
17 travel. Yes, Keith.

18 COMMISSIONER CAMPBELL: Do you want a commitment now or
19 as soon as you can get it or.....

20 MS. ERICKSON: Why don't we follow up by email
21 afterwards? Okay, so now, I think we're ready to continue our
22 conversation from yesterday and regroup a bit and see where
23 we're at.

24 I'd like to start with the hospital discharge database,
25 just because I don't know -- we got going in some circles

1 yesterday afternoon, I felt, and we had lost part of the
2 group. So one of the things that we noted yesterday afternoon
3 in our conversation that we started jumbling up a little bit
4 the differences between a hospital discharge database and an
5 all-payer claims database and Barb, this is probably a good
6 time to switch control of the computer over to me.

7 Let's see how much I can multi-task. Turn this off, and
8 bear with me for a moment, while I find the screen here. So
9 we were making the -- we were just going back and reclarifying
10 the differences.

11 Two main differences between a hospital discharge
12 database and an all-payer claims database is that providers
13 are compelled to report to the hospital discharge database.
14 They're not compelled to right now. It's voluntary. It's the
15 question whether they should be compelled to or not, but the
16 data is coming from providers and the -- any of the data
17 that's specifically related to spending is charge data.

18 It's not actual paid claims data. So we know what the
19 charges are from that data, but we don't know what the
20 providers are actually reimbursed in the end.

21 An all-payer claims database, it's the payers that are
22 compelled to report and we did clarify that it's not just the
23 state regulated insurance, health insurance companies, but
24 also the other states that have all-payer claims databases and
25 are implementing them have included the ERISA plans by self-

1 insured employers, Medicaid and Medicare data and there are a
2 couple of states -- Oregon is working with the Indian Health
3 Service there to see if they could bring Tribal health system
4 data into their system as they develop it, but they actually
5 haven't gone live yet.

6 Maine has experimented with trying to figure out how to
7 capture data on uninsured and self-paid folks. So they're
8 playing with that, trying to figure that out and we had
9 identified that as a gap.

10 If we have only an all-payer claims database, what we
11 lose by not having hospital discharge data is the self-pay and
12 uninsured service data and -- but the all-payer claims data
13 provides data on paid claims. So we spent some time making
14 that distinction because we were getting a little confused
15 about the two systems.

16 The other thing that we spent a little time clarifying,
17 too, because we were talking about this -- we've looked at
18 these two data systems as part of the health information
19 infrastructure where we had identified in our overall strategy
20 that while we work on designing policies that focus on
21 enhancing the consumers' role and taking responsibility for
22 and being engaged in their own health and health care and also
23 looking at ways to improve health care delivery and being more
24 innovative in a health care delivery system, the importance of
25 having a strong foundation for the health care delivery

1 system, including the health information infrastructure that
2 supports decision-making by payers, providers, policy makers,
3 patients, having a sustainable workforce and maintaining some
4 statewide leadership to oversee and support moving that system
5 forward.

6 So we were looking at those two databases as
7 opportunities for strengthening the health information
8 infrastructure, but at the same time, we were looking at them
9 for supporting a couple of our other strategies around price
10 and quality transparency and payment reform, especially two
11 and three here on this screen.

12 Since we were having the conversation about transparency,
13 I think we got kind of a little mixed up there yesterday, too,
14 with whether this is the only -- if it's a good solution for
15 transparency, if it's the only solution for transparency or
16 not.

17 So I think there might be some value in trying to tease
18 those apart a little bit and make sure that you're thinking
19 about the importance of having data for decision-making,
20 generally, for improving the system and then the transparency
21 for consumers is a separate question and if we can't get
22 beyond -- we have a recommendation for transparency right now.

23 Actually, why don't we start with that? Let me show you
24 our -- I mean, the recommendations, when we first started
25 talking about, during 2011, the importance of transparency,

1 the two specific recommendations that came out of that
2 conversation -- we have a bunch of findings about the
3 importance of transparency, generally, and it includes the
4 importance of price sensitivity and the importance of
5 accessible and understandable information for patients.

6 That was something we talked about yesterday, but what we
7 came to at the end of that conversation was, "Well, we need to
8 investigate strengthening these two data sources as potential
9 sources for supporting transparency for the public," and so
10 that's what we had was a recommendation for encouraging full
11 participation in the hospital discharge database and a study
12 for the need for and feasibility of an all-payer claims
13 database.

14 Move ahead to 2012, especially around the learning that
15 we did about how can the state better engage and support
16 employers in improving health and health care for their
17 employees, we have a recommendation that the state Division of
18 Retirement and Benefits, Department of Administration provide
19 leadership for that and we outline from those presentations,
20 kind of four main elements of a strong employee health
21 management program and it included price and quality
22 transparency as one of those four elements. Price sensitivity
23 was another one of the four.

24 The other recommendation we made related to it was that
25 then -- the one thing that the group identified that maybe the

1 state could do in addition to providing leadership through the
2 Department of Administration for other employers in the state,
3 that the state investigate mechanisms for making price and
4 quality information more transparent to the public, generally.

5 So that's -- I just wanted to help and hopefully, this is
6 helping regroup a little bit by revisiting what we've -- where
7 we've come from so far in this conversation and where we're at
8 today.

9 So the question we're considering today, and another
10 little piece of history; at our last meeting, we had the
11 gentleman, just a member of the general public, come to our
12 meeting and share his story about his frustration with getting
13 stuck with a bill that seemed unreasonable by a local provider
14 and having all the work he did to do his own research to check
15 with all of the other providers in the area to see how, if he
16 had an opportunity to do price shopping, what the difference
17 would have been and it was significant and he asked this body
18 to -- well, you might be considering a database that might be
19 helpful three years from now. There are other states that
20 have laws that compel providers to make their prices more
21 available to the public and so that's why -- and you all were
22 interested in that and even suggested naming, at that point,
23 the new state law after Mr. Hanson (sp), but that's why I had
24 invited Dr. Delbanco to come to this meeting.

25 Since right after our meeting, she released this report

1 on the state report card on state transparency laws and it was
2 specific to, it wasn't about databases, it was specific to
3 what states currently do now, and in what form, to compel
4 providers to report in some way, whether it's to the state,
5 whether it's to the public, whether it's through a website or
6 not and so that was the report card she shared with us and the
7 other information she shared with us yesterday.

8 So the -- so one of the questions about transparency is
9 whether we need a law or whether we need to study further
10 whether the state should have a law compelling providers to
11 make their price and quality information more available to the
12 public.

13 Then the next questions are about these databases, in
14 part to support transparency, but not exclusive -- it would
15 not be the exclusive use. There are many uses, other uses for
16 these data systems. So why don't we start with the
17 transparency question about state law? Yes, Dr. Urata.

18 COMMISSIONER URATA: Well, I was wondering, and maybe I'm
19 going too fast, but I was thinking of a motion to talk about
20 the hospital discharge database and is it better to have a
21 motion on the table to discuss and tease this out or should we
22 continue to do more discussion about transparency?

23 MS. ERICKSON: You know, if you're prepared to make a
24 motion, why don't you do that?

25 COMMISSIONER URATA: Well, what do the rest of you folks

1 think? You want to hear my motion, first, I bet.

2 UNIDENTIFIED VOICE: (Indiscernible - too far from
3 microphone).

4 COMMISSIONER URATA: All right.

5 MS. ERICKSON: Yeah (affirmative).

6 COMMISSIONER URATA: All right, I'm going to take a stab
7 at this, okay, and I'll accept any friendly amendments, as
8 long as they don't change things too much. So I move that the
9 Commission recommends a mandatory hospital discharge database
10 that will lead to health -- for the purpose of providing data
11 that will lead to health care policy decisions that will
12 improve the health of Alaskans and to possibly provide price
13 and quality transparency. So that's a two-part motion, one
14 for -- the purpose is for price and quality transparency.

15 UNIDENTIFIED VOICE: Bob, could I -- do you have that
16 written down (indiscernible - too far from microphone).....

17 COMMISSIONER URATA: Well, yeah (affirmative), I.....

18 MS. ERICKSON: Do you have it written down? Could I get
19 it?

20 COMMISSIONER URATA: Sure. I hope you can read it.

21 MS. ERICKSON: Oh.

22 COMMISSIONER URATA: But I.....

23 MS. ERICKSON: Could we have -- could we have somebody
24 who's not a doctor write it down?

25 COMMISSIONER URATA: You know, I -- the hope is that it

1 will cover -- to continue the current database system that we
2 have, because it would be terrible to lose something
3 that's.....

4 MS. ERICKSON: Let me try to read your writing so I
5 can.....

6 COMMISSIONER URATA: Yeah (affirmative), all right.

7 MS. ERICKSON: So I can capture it, both for the folks
8 who are watching the webinar and for the group watching from
9 around the table. This isn't so bad. This is good. So we
10 have a motion. Do we have a second?

11 COMMISSIONER BRANCO: I'll second and then I'll offer a
12 friendly amendment when you finish.

13 MS. ERICKSON: Why don't you discuss the friendly
14 amendment while I decipher the writing here?

15 COMMISSIONER BRANCO: I've got to make sure I heard it
16 completely and (indiscernible - too far from microphone) in
17 writing. Actually, I'll just -- I'll begin the discussion
18 piece and if it shows up on there, terrific, but as the
19 database is currently structured, it's only a narrow range of
20 hospitals that are required or would be required to report to
21 this database.

22 I think part of our discussion yesterday was making sure
23 that everybody who does discharge information in any form or
24 fashion should be included in this database and especially if
25 there's a mandatory element to it, it should be all inclusive,

1 rather than a narrow range in which broader decisions would be
2 based.

3 So my friendly amendment would be to add all health care
4 providers who -- let's see, I don't want to get trapped in the
5 two-doc practice that's going to spend \$200,000 to produce a
6 piece of information that isn't going to be meaningful. So I
7 don't have a size metric or the recommendation, but to include
8 health care facilities that generate discharge data would be -
9 - that currently produce discharge data would be compelled or
10 required to report.

11 MS. ERICKSON: So first, let me check with Dr. Urata and
12 read this back, that the motion was to recommend a mandatory
13 hospital discharge database for the purpose of providing data
14 that will lead to policy decisions, that will lead to improved
15 health of Alaskans and to provide price and quality
16 transparency.

17 COMMISSIONER URATA: So I accept that friendly amendment
18 that (indiscernible - too far from microphone).....

19 MS. ERICKSON: So you need to speak into your mic,
20 please.

21 COMMISSIONER URATA: I would accept the friendly
22 amendment. Although, it does open up a round of debate over
23 that, I think.

24 MS. ERICKSON: Did -- okay, Pat, you had seconded this,
25 right?

1 COMMISSIONER BRANCO: Yes.

2 MS. ERICKSON: Can you pass this back to Bob? Yes,
3 Larry.

4 COMMISSIONER STINSON: Colonel Harrell, I'd be
5 interested, from your point of view, since we can't compel any
6 of the federal facilities to do anything, how would Elmendorf
7 and VA come in on this?

8 COMMISSIONER HARRELL: Well, the short answer would be,
9 we wouldn't without federal guidance. I would not be in a
10 position with local authority to be able to engage it. I
11 would be forced to ask the question and then we would have to
12 wait on the reply.

13 I will tell you that this sort of discussion is happening
14 within the Department of Defense and the military health
15 system right now with Dr. Woodson (sp). So it would not be
16 surprising to me at all to see in the very near future, and
17 the near future for me would be anything in the next 16
18 months, directions of this sort because of the move within the
19 military health system toward quality-based and outcomes-based
20 decisions and data that we'll find ourselves in this position
21 and therefore, would be more easily to volunteer into the
22 state system, Alaska being one that would be one of the
23 easiest to do, frankly, because of the environment we have
24 here, but right now, the short answer would be, no. From a
25 federal perspective, we would not engage in the database until

1 directed from the DOD perspective.

2 MS. ERICKSON: Yes, Larry.

3 COMMISSIONER STINSON: And I know Valerie's not here, but
4 I would imagine the Indian Health Service would be in the same
5 situation and they provide a significant amount of care here
6 and.....

7 MS. ERICKSON: Well, yeah (affirmative), go ahead, Pat.

8 COMMISSIONER BRANCO: Just to add, I'm a retired naval
9 officer. I do understand DOD and VA and Indian Health
10 Service, that they can't be compelled to do anything against
11 their will, but forces are -- new forces are being applied
12 today and the Affordable Care Act, as one element of the
13 triple aim is that we engage in population care management and
14 that population bridges all, and including our soldiers,
15 sailors, airmen, Marine, Coast Guardsmen, who integrate into
16 civilian health care systems and DOD/VA.

17 So this is a population issue and so I would urge that we
18 accelerate the process to have cooperative reporting, even if
19 it's not compulsory. That's what I would.....

20 MS. ERICKSON: Yes, Jeff.

21 COMMISSIONER HARRELL: That's what I would -- sorry.

22 COMMISSIONER DAVIS: Go ahead, (indiscernible - too far
23 from microphone).

24 COMMISSIONER HARRELL: I would just simply say you're
25 absolutely right. From our perspective, again, because of the

1 unique relationship that we have, particularly here in Alaska,
2 it's not a stretch for me or the VA to engage in this, but you
3 recognize in my position that I have no authority to move out
4 on my own to do that. So I would have to ask for permission
5 to voluntarily engage the system.

6 UNIDENTIFIED VOICE: Understood.

7 MS. ERICKSON: Jeff.

8 COMMISSIONER DAVIS: Thank you. So I think I am of one
9 mind on this today, which is good, since I have to present
10 later on. I wouldn't want to argue with myself. So I had a
11 conversation, brief conversation with Peter yesterday and he
12 really helped me with clarity around this, which is these
13 really are two different things.

14 The hospital discharge database is -- that the all-payer
15 claims database is the "what happened," you know, the detail
16 of what happened and the discharge database is the "why," and
17 without those -- and maybe it's the "what happened," too,
18 because without both of those, then we -- I don't think we can
19 accomplish what we set out previously to do.

20 So having said that, then the hospital discharge
21 database, the continuation of that is very important and as
22 Pat pointed out yesterday, we've basically been put on notice
23 that without a change, it's dead.

24 So we're, I think, really in a place where we have to
25 take action that makes -- that compels participation that

1 makes sense. Whether or not it goes to all facilities, I
2 think Allen raised a really good question yesterday, which was
3 around the cost of that and I don't have a good feel for it,
4 but I would like, if you could help with -- anyone around the
5 table could help with understanding what, you know, how
6 significant that is, then that would be helpful in knowing
7 whether that extension makes sense.

8 Certainly, from my perspective, compelling the hospitals
9 to do so in some fashion makes sense. Otherwise, we lose that
10 data and that would be going the wrong direction, but I am
11 uncertain about that extension downstream, if you will. Thank
12 you.

13 MS. ERICKSON: Can I -- before we move on in the
14 conversation, I just wanted to check back with Pat, since I
15 was typing the first motion when you made your friendly
16 amendment. You -- if I heard correctly while I was double-
17 tasking, you said that you would include additional
18 facilities, including ambulatory surgery centers. Did you
19 list others?

20 COMMISSIONER BRANCO: (Indiscernible - too far from
21 microphone) imaging centers.

22 MS. ERICKSON: So including ASCs and imaging centers.

23 UNIDENTIFIED VOICE: Yeah (affirmative), let's think
24 about this.

25 COMMISSIONER BRANCO: I believe the term "hospitals" is

1 too restrictive in this language, even though it's hospital
2 discharge data.

3 MS. ERICKSON: And the other part of that was including
4 federal facilities, as well?

5 COMMISSIONER BRANCO: I would -- I would friendly -- I
6 would amend my friendly amendment and as for approval and
7 acceptance to say -- to qualify the language with "invite or
8 encourage DOD and Indian Health Service participation."

9 MS. ERICKSON: Encourage, okay, very good.

10 COMMISSIONER BRANCO: Okay.

11 COMMISSIONER URATA: Accepted.

12 MS. ERICKSON: Would it be okay if I just said "federal
13 facilities?"

14 UNIDENTIFIED VOICE: Yes, you should say "federal"
15 (indiscernible - too far from microphone).

16 MS. ERICKSON: Yeah (affirmative). Yes, Colonel Harrell.

17 COMMISSIONER HARRELL: So I freely confess to being on
18 the shallow end of the gene pool regarding this discussion,
19 but I've got to say, particularly with your last comment,
20 Jeff, regarding the what/why, very nice clarity in that in my
21 mind and I appreciate that.

22 However, even the what -- let's just open this up for
23 discussion here, even the what is going to require an
24 administrative burden on the provider delivering the service
25 and I still remain very apprehensive about mandating actions

1 that are going to even further, in my opinion right now, and
2 I'm happy to talk at the break about it, further burden the
3 patient/provider interface that we saw all the providers that
4 spoke yesterday comment on.

5 You still can't get to the what without documentation
6 that has to get to the payer to be able to get there and
7 that's going to induce, I'm afraid, an increased
8 administrative burden at the point of care delivery and that
9 causes me anxiety as a provider.

10 MS. ERICKSON: Jeff.

11 COMMISSIONER DAVIS: So I wonder if part of this is from
12 the federal view of the world that in the private sector, if
13 you will, billing us, billing someone is just a matter of
14 course. That's how it has to happen and perhaps, in your
15 world, that's -- I don't -- I'm on the shallow end of the gene
16 pool about that. I don't know.

17 So for the providers who are billing anyone, there is no
18 additional burden from the all-payer claims database, at least
19 that I am aware of. They are simply -- business as usual and
20 then the payers are the ones who now have an additional burden
21 to report back, but since we're the people, people love to
22 hate, who cares about that?

23 So I don't know if that gives you any more comfort, but
24 that's certainly the way I understand it and maybe some of the
25 other providers on the private side could weigh in on that.

1 Thank you.

2 MS. ERICKSON: Can we clarify for the purpose of hospital
3 discharge database from Pat, who actually participates
4 voluntarily currently in this system, so.....

5 COMMISSIONER DAVIS: So -- so what -- may I -- so we're
6 mixing them up again. So the "what" is the all-payer claims
7 database. That's the detail. This is what happened. So
8 that's kind of over here, but that's what I heard you asking
9 about. This, the services database is something different.
10 It's the "what" or the "why," excuse me.

11 UNIDENTIFIED VOICE: The "why."

12 COMMISSIONER DAVIS: The "why," yeah (affirmative), and
13 that's -- that is an additional burden, but we were trying to
14 draw the line so it doesn't end up in the physician's office
15 as an additional burden. It's at the facility level and
16 again, you don't care about that, right?

17 MS. ERICKSON: But the other.....

18 COMMISSIONER DAVIS: I'm being facetious.

19 MS. ERICKSON: The other clarification I thought was
20 important, though, is that my understanding of the hospital
21 discharge data is that it's essentially the claims data or the
22 medical claim that currently the hospitals are submitting to
23 the payers that in turn, go into this database. That's -- no,
24 not -- okay.

25 COMMISSIONER BRANCO: No.

1 MS. ERICKSON: Clarification, thanks.

2 COMMISSIONER BRANCO: That's incorrect. This is a
3 separate reporting. This is not generated off our routine
4 billing processes. This is labor intensive, which is why the
5 independent practice, two-doc -- it's a manual system in which
6 they would have to gather all of their encounter information,
7 plug it into this program. We have automated systems in our
8 larger facilities that can self-feed it, but it's not part of
9 the billing process.

10 MS. ERICKSON: Colonel Harrell and then Larry and then
11 Allen.

12 UNIDENTIFIED VOICE: (Indiscernible - too far from
13 microphone).

14 MS. ERICKSON: Sorry, and then Ward, have you had your
15 hand up for a while?

16 CHAIR HURLBURT: (Indiscernible - too far from
17 microphone).

18 COMMISSIONER HARRELL: So Pat just helped to clarify, and
19 again, I apologize that I do continue to mix these fruits
20 fairly readily into a puree, but in my mind right now,
21 regardless of whether we're talking about the discharge
22 database or the all-payer claims database, there will be a
23 necessary administrative burden put down on the person that
24 provides care, either way you slice this, from what I'm seeing
25 and I can't move away from that at the moment and my concern,

1 even though we're trying to be very good here and begin to
2 tease out at just how low we're going to go, you're going to
3 drive additional secondary behaviors with any definition you
4 put, because people are going to either want to include
5 themselves in that or exclude themselves from that and so I
6 just can't get there right now.

7 COMMISSIONER STINSON: I agree and we heard Dr. Cates
8 yesterday, I mean, he's already thinking about concierge
9 medicine just from all of the upcoming inevitable changes that
10 are going to add additional burdens.

11 There's a cost. There's the time. You see fewer people.
12 If you're going to require that in a two-person practice right
13 now, which doesn't have to be an electronic health system, at
14 least right now, you're talking about thousands of dollars in
15 start-up.

16 If we're going to go for this type of information, I'd
17 say at the very most, if you kept it to the three most common
18 procedures or diagnoses per specialty or something like that,
19 because you know, a general surgeon -- a general surgeon does
20 everything.

21 Are you going to list the 55 procedures of fistula
22 repair? He might do two or three of those a year. Are you
23 going to list that? You know, if you keep it to a hernia
24 operation, a gall bladder and something like that, that would
25 be something that on a database, people are reviewing.

1 If the idea is transparency and getting to the consumer,
2 that would be helpful. Listing everything that everybody
3 does, I'm not sure is -- if anything, it would be confusing
4 and it would be time-consuming for the providers. It would be
5 expensive. It would be a very negative event and they
6 probably wouldn't participate anyway. They would be looking
7 at every possible way to get out of it, which I wouldn't
8 necessarily blame them.

9 So if you're going to do it, I think it should be focused
10 and in keeping other costs -- and interfering with care (sic).
11 In the process of trying to help care, we don't really want to
12 impede it.

13 COMMISSIONER URATA: Can I make a clarification?

14 MS. ERICKSON: Yes.

15 COMMISSIONER URATA: Excuse me, so what we're focusing on
16 is the hospital discharge data and trying to maintain what
17 we're going.....

18 UNIDENTIFIED VOICE: (Indiscernible - too far from
19 microphone).

20 COMMISSIONER URATA: This does not include anything on
21 the -- that all-payers thing. That's a separate motion. So
22 just for clarification, Larry.....

23 COMMISSIONER STINSON: Stay focused on (indiscernible -
24 too far from microphone).

25 COMMISSIONER URATA: What you just said doesn't apply to

1 this. Is that correct?

2 UNIDENTIFIED VOICE: Well, (indiscernible - too far from
3 microphone) a question on that point.

4 COMMISSIONER HARRELL: It does for the sub-bullet,
5 because (indiscernible - speaking simultaneously).....

6 COMMISSIONER URATA: Okay, so for the friendly amendment.
7 Yeah (affirmative), that's why I was hesitant to put that in,
8 because I thought that this might distract from what currently
9 happens and so maybe in order to get this through, we should
10 consider removing the friendly amendment, because it does then
11 go down into the surgery centers and the, you know, the two-
12 doc operations or the three-doc operations, but I wonder if we
13 could ask Pat why the surgery centers and imaging centers?

14 Now I know that they take the cream of the crop away from
15 the hospitals. So I can see why hospitals want them included,
16 but are they as important for data and decision-making, you
17 know, which is what we're doing this for?

18 COMMISSIONER BRANCO: The answer is absolutely yes, and
19 I'm happy to withdraw this friendly amendment, but I will
20 assure you I will not support a mandatory reporting system
21 that only applies to 12 hospitals in the state and then
22 allowing a broader definition or use of that information.
23 That's the way I'll do the -- do my -- withdraw the amendment,
24 if desired.

25 COMMISSIONER URATA: Should imaging centers be part of

1 this as well, because they just do X-rays?

2 COMMISSIONER BRANCO: Imaging centers do -- they do
3 invasive therapeutic.....

4 UNIDENTIFIED VOICE: (Indiscernible - speaking
5 simultaneously) therapeutic (indiscernible - too far from
6 microphone) intervention, as well.

7 UNIDENTIFIED VOICE: Just like hospitals.

8 COMMISSIONER BRANCO: Correct. So it's a limited range
9 of data that would come out of that. I do like the concept of
10 focused information. Knowing how many wrist X-rays they do in
11 an orthopedic imaging center doesn't add to the population
12 health knowledge base that we would be looking to try to
13 improve cost, quality and access for.

14 MS. ERICKSON: We were going to hear from Allen and Ward
15 and then maybe we should take a vote on the amendment to the
16 motion.

17 COMMISSIONER HIPPLER: Thank you. My ignorance will show
18 through here, but I don't really know what a surgery center or
19 imaging centers are. For example, I imagine a dental office
20 that does X-rays. Is that an imaging center? I don't know.
21 No, it's not?

22 UNIDENTIFIED VOICE: No.

23 COMMISSIONER BRANCO: If you don't mind, it's -- very
24 quick clarification, these are private enterprises that stand
25 up, often typically, they accept primary insurance or cash as

1 their operating -- and they do not tend to offer services to
2 indigent populations or sometimes to federal payers. So it's
3 a closed access, nicely run private enterprise.

4 COMMISSIONER HARRELL: And generally, they're going to be
5 engaging in procedures that are of the higher end nature,
6 consultant type procedures. So you can see imaging centers
7 that specialize in fluoroscopic type procedures that I would
8 do as a cardiologist. They'll take on and do peripheral
9 vascular type procedures that would ordinarily be done in a
10 hospital, but they'll be done in an outpatient arena. So
11 they're usually more technically intensive complicated type
12 referral medicine procedures across the gambit. Does that
13 make sense?

14 COMMISSIONER HIPPLER: Thank you. Thank you. That does
15 help. I'm a little confused as to the benefit here of
16 including these smaller facilities or I understand there would
17 be a benefit. Did the Milliman report suffer from lack of
18 having this data, for example? I assume the Milliman report
19 had access to hospital discharge data, maybe it didn't have
20 access to the data from these centers. I'm wondering what the
21 impact of not having had this data in the hospital discharge
22 information has had on the state as a whole over the last many
23 years. Thank you.

24 MS. ERICKSON: It would probably be a question for
25 Commissioner Streur.

1 CHAIR HURLBURT: This is not my point, but doesn't the
2 Milliman data derive from claims paid data so that with the
3 diagnoses that we asked them to look at, they also looked at
4 the hospitals, but with the claims payment, it would include
5 what was paid in Alaska for the services.

6 MS. ERICKSON: Just for the physician services, the
7 professional services portion, not all of the -- not -- and
8 for the facilities, we only looked at non-federal hospitals.
9 We didn't include ambulatory surgical centers and imaging
10 centers. So it did not include it. Did -- go ahead, Ward,
11 you had another comment earlier.

12 CHAIR HURLBURT: Yeah (affirmative), my question, maybe
13 for both Bob and Pat, but as the motion is written, the last
14 part, to provide price and quality transparency, one, what is
15 the interpretation of price? Does that mean the charge master
16 charge or does that mean the price that's actually paid?

17 Two, what aspect is in there in quality that's being
18 reported and it may depend a little on the definition of the
19 word "price," but do either of those aspects of the motion
20 impose a new burden that you're not engaged in now in
21 providing that information? Do those expand the current
22 hospital discharge data set or are they contained in it now?

23 COMMISSIONER BRANCO: This is going to require a really
24 artful answer and this is where I demonstrate my swimming
25 around the shallow end. I've, personally, I've contended that

1 I've not been able to understand how you can derive quality or
2 price information simply by listing discharge information
3 relative to patient population, ages, socioeconomic status, et
4 cetera, but there are smarter people than me who can take raw
5 data, public health data and make generalized statements about
6 the quality of medicine.

7 Obesity is one of those in which if we can determine a
8 diabetic patient, grossly obese, has these health indicators,
9 you will hit a quality factor by extrapolation. There will be
10 a price impact because they tend to access care more often at
11 a higher cost.

12 Directly in the hospital discharge data, it would be a
13 real stretch to say you can impact price and quality through
14 the use of this data alone.

15 CHAIR HURLBURT: So again, if you -- if there were
16 legislation that mandated this and if it included that wording
17 of price and quality data, would you see that as being a new
18 job for you, an additional job, above and beyond the discharge
19 data by code of what the discharges were?

20 COMMISSIONER BRANCO: I'd only have to hire a couple of
21 more analysts and data entry folks and increase the cost per
22 patient by some percent. Yes, it would have a profound
23 impact. It's new information. It may be able to be mined
24 from our current data sources that we input anyway for federal
25 regulation, pricing, billing, all of the other components,

1 health medical record information.

2 It could be there, but I don't know today and so it would
3 take an analysis and probably another -- a large amount of
4 work to produce new information.

5 MS. ERICKSON: Can I suggest that we're maybe getting a
6 little too far down in the weeds again? Once we start getting
7 too operational, and this has been our check all along at
8 every one of our meetings in discussion about recommendations,
9 if we get to the point where there are so many questions, we
10 can't answer them about how something's going to work, this
11 group isn't going to be prepared to make that type of
12 recommendation and we need to, at some point, decide whether
13 the concept is the right thing and what some main principles
14 about the concept are and then turn it over to the department
15 or the appropriate entity to implement. Yes, Jim.

16 COMMISSIONER PUCKETT: Point of clarification, and I may
17 be -- I may be misunderstanding this myself, but I thought
18 that the all-payer claims database provided the price and
19 quality transparency. The hospital discharge database was not
20 going to help with that and so I think for a point of
21 clarification for a friendly amendment, remove that from this
22 database.

23 It's my understanding, as a plan administrator, that this
24 database would help me to compare my health plan with other
25 health plans in the state. It would give me population health

1 information. This database would not help with the price and
2 quality transparency issue.

3 COMMISSIONER URATA: Yeah (affirmative), and as I have
4 written down here, it says, "to possibly -- to provide price
5 and quality transparency" and I would be happy to remove it,
6 because that -- I believe -- now that you've discussed it, I
7 believe it does add another element that does not currently
8 exist and the intent was to continue what exists with possibly
9 expanding it.

10 MS. ERICKSON: Just procedurally, I want to check with
11 Allen on something. Allen, in our bylaws, we wanted to avoid
12 having procedure get in the way too much of process and we
13 said that we would only use Robert's Rules of Order, that we
14 would use more of a consensual process and we would use
15 Robert's Rules of Order for if there was disagreement among
16 the group and then, certainly, for our actual official
17 decisions, we'll use it.

18 Is it -- I'm asking your permission to not be too
19 procedural in terms of Robert's Rules of Order in order to
20 more quickly get to a motion that everybody is -- seems to be
21 agreeing on. If there are points that we're agreeing on,
22 would you have a problem procedurally if we circumvent the
23 process?

24 COMMISSIONER HIPPLER: As long as your Chairman is fine.
25 If people object, they make a point of order to bring it back

1 into what they perceive. At this time, I would highly
2 recommend that you or the Chairman enforce Robert's Rules of
3 Order to keep the conversation focused. We should be talking
4 about the amendment and nothing but the amendment right now.

5 MS. ERICKSON: Okay, so we will -- let's stick with our
6 first friendly amendment and then we can go back and make
7 another amendment.

8 COMMISSIONER BRANCO: I might be able to ease this whole
9 process and get to a decision quicker if I remove my friendly
10 amendment.

11 MS. ERICKSON: Entirely?

12 COMMISSIONER BRANCO: Modify and make a separate friendly
13 amendment that asks for the removal of provide -- everything
14 from "and to provide price and quality transparency."

15 COMMISSIONER HIPPLER: I'll second that.

16 MS. ERICKSON: So I just want to make sure I got this
17 right, remove the first and also remove, "and to provide price
18 and quality." Are we prepared to vote? Yes, Wes.

19 COMMISSIONER KELLER: If I could ask a question on the
20 second friendly amendment? Would there be any benefit of
21 instead of saying "providing price and quality," talk about
22 revenue source, does that help us in the, you know, making
23 policy decisions? That's -- your financial guy that was here,
24 Ken, you know, that's what he did, you know, is he started
25 there. He said this is where we get our funds, you know,

1 Medicare, Medicaid and he listed -- and that was the emphasis
2 and that's the way the hospitals encourage us to look at, you
3 know, your accounting system and so how about requiring
4 something in the aspect in the discharge database?

5 COMMISSIONER BRANCO: Those are -- those are polar
6 opposite pieces of information. The payer source, again, when
7 you cross the threshold into the emergency room, we don't
8 check your wallet for who the payer is. Your episodes of care
9 are done regardless of the ability to pay.

10 It's not an element -- typically not an element of the
11 discharge data whether you're a Medicaid patient or a Medicare
12 patient or a federal patient. It doesn't -- these don't
13 connect yet.

14 MS. ERICKSON: Well, the reimbursement doesn't, but my
15 understanding is the billed payers are included. The charge
16 data and the billed payers are included in the hospital
17 discharge database.

18 COMMISSIONER BRANCO: They are.

19 MS. ERICKSON: For what it's worth.

20 COMMISSIONER BRANCO: So it could be extracted. Does it
21 add benefit? Perhaps.

22 MS. ERICKSON: Colonel Harrell.

23 COMMISSIONER HARRELL: So just an aside, regarding the
24 amendment we're talking about now, in removing the first
25 friendly amendment, I am still -- I would still like to see in

1 the base amendment there an encouragement of federal facility
2 participation. I'd like to have that, because it provides me
3 leverage to go back to the DOD and the military health system
4 to say, "The state of Alaska has requested," so I can have a
5 dialog.

6 So I would somehow or another as we move through this, I
7 wouldn't like to strike the entire friendly amendment piece.
8 I'd like to keep somewhere in there "encouragement of federal
9 facility participation."

10 COMMISSIONER DAVIS: I'll second that.

11 UNIDENTIFIED VOICE: Okay, because the Robert Rule's of
12 Order thing, you know, I'd do this. I salute -- so and make
13 messes.

14 MS. ERICKSON: So should we vote on the second friendly
15 amendment?

16 UNIDENTIFIED VOICE: No, you have to vote on the first
17 one.

18 MS. ERICKSON: The first, okay. No.

19 COMMISSIONER HIPPLER: The second -- the second one is
20 the first one to vote on and defacto, it takes.....

21 MS. ERICKSON: Yes.

22 COMMISSIONER HIPPLER: The most recent one is the one to
23 vote on first.

24 MS. ERICKSON: Right.

25 COMMISSIONER URATA: (Indiscernible - too far from

1 microphone) clarification. So this means we're not going to
2 include ambulatory surgery centers and imaging centers, is
3 that correct?

4 MS. ERICKSON: Jeff.

5 COMMISSIONER DAVIS: Well, not at that moment, but
6 there's -- asking -- nothing preventing a second motion that
7 expands the scope and encourages federal facilities, which is,
8 I think, where Pat was going.

9 COMMISSIONER URATA: Yeah (affirmative), okay
10 (indiscernible - too far from microphone).

11 MS. ERICKSON: So can we call the question on the second,
12 the most current friendly amendment? All in favor of adopting
13 the second friendly amendment to remove the.....

14 UNIDENTIFIED VOICES: Aye.

15 MS. ERICKSON: Any opposed? Okay. So now, we have --
16 let me change the motion that's on the floor to reflect the
17 amendment. So the motion that's on the floor currently is to
18 recommend a mandatory hospital discharge database for the
19 purpose of providing data that will support policy decisions
20 that will lead to improved health of Alaskans. Is there
21 further discussion?

22 COMMISSIONER BRANCO: Yes, there is. The -- when I
23 withdrew the first amendment, that erases it. We voted on the
24 second friendly amendment. Now I have a friendly amendment to
25 add, and you can use much of the same language there.

1 MS. ERICKSON: The new.....

2 COMMISSIONER BRANCO: I'm sorry, to include additional
3 facilities, including ambulatory surgery centers, imaging
4 centers, and to encourage federal facility participation.

5 MS. ERICKSON: So if I understand correct, Pat, you're
6 adding that initial friendly amendment back, just as it was
7 worded before?

8 COMMISSIONER BRANCO: I had to withdraw it in order to
9 vote on the (indiscernible - speaking simultaneously).....

10 MS. ERICKSON: Right, so you want the exact same one,
11 just to clarify, so I don't have to retype it?

12 COMMISSIONER BRANCO: Correct.

13 MS. ERICKSON: Okay, thank you.

14 COMMISSIONER BRANCO: I did move commas, but that's okay.
15 It doesn't lose content.

16 COMMISSIONER URATA: And I accept it, I guess.

17 MS. ERICKSON: Yeah (affirmative), so the original maker
18 of the motion accepted the friendly amendment. Wes.

19 COMMISSIONER KELLER: Another ignorant question, you said
20 that the imaging centers do some therapeutic -- I mean, to me,
21 I have a real brain freeze when I think about discharge from
22 an imaging center and I just don't understand, haven't seen,
23 don't know what you're talking about and there's two things,
24 you know, one is my confusion, but I also want to illustrate
25 the confusion that might be there by including that

1 terminology.

2 COMMISSIONER BRANCO: I'll give you one quick example,
3 stereotactic breast biopsy or biopsies performed in imaging
4 centers with the guidance of imaging devices are -- can be
5 therapeutic. They can be diagnostic. They can be both.

6 COMMISSIONER HARRELL: The same concept, there are
7 oncologic procedures and (indiscernible - voice lowered)
8 procedures that can be performed in an outpatient setting that
9 an invasive radiologist, it's within their scope of practice
10 to perform that procedure at the request of a specialist. I
11 can't imagine too many specialists that would give that up,
12 but those sorts of things do exist.

13 CHAIR HURLBURT: Yeah (affirmative), I'm a little
14 troubled by this amendment in that I think we're mixing two
15 things in there. I'm very sympathetic to Pat's concern that
16 these new forms of competition that are cherry picking, need
17 to bear the same burdens that hospitals are saddled with,
18 although, I think that might make the whole thing harder to
19 get at, but I think that is a separate issue than encouraging
20 the federal facilities to participate, DOD and IHS facilities,
21 and so I'd rather see those two separated out.

22 MS. ERICKSON: You know, I just wanted to make an
23 observation, too, I think one of the -- one piece of
24 information we're missing right now is how the department
25 might need or use data from these additional facilities as

1 part of a hospital discharge database to support certificate
2 of need decisions, and if we don't know the answer to that
3 question, we maybe don't have enough information to make a
4 decision at this level of detail again, and we might be
5 getting too far in the weeds. Yes, David.

6 COMMISSIONER MORGAN: We're in the same building. Can't
7 we take a five-minute at ease and we ask Commissioner Streur
8 or someone just to come down to clarify that?

9 MS. ERICKSON: I don't know if we could do that, that
10 quickly. I don't know his schedule and we are already 15
11 minutes behind on the agenda. So the answer would be no.

12 COMMISSIONER MORGAN: No.

13 MS. ERICKSON: Yes, Keith.

14 COMMISSIONER CAMPBELL: Well, my -- the way I look at the
15 imaging centers and surgery centers is that this is a large
16 chunk of numbers that if you're going to make policy, you need
17 as wide -- and as many numbers as you can get. That's the way
18 I look at it. I think we can get down operationally in the
19 weeds, but that's my overview of these discharge numbers
20 (indiscernible - voice lowered) irregardless (sic) of where
21 they come from. I think you need as many numbers in the pool
22 if you're going to make (indiscernible - voice lowered) you
23 know, down the stream.

24 MS. ERICKSON: Other discussions on the amendment?
25 Allen.

1 COMMISSIONER HIPPLER: Thank you. The -- I'm concerned
2 about the cost here for these surgery centers. I know that's
3 been said a lot, but there's a reason why there's surgery
4 centers and it's because they want to escape the regulation of
5 the larger hospitals and the costs associated with them. That
6 is unfair for hospitals. I get it, but by imposing these
7 costs on small practices is a disproportional burden for them
8 and would not result in a reduction of health care costs to
9 the consumer or an increase in access to the consumer.

10 I do understand we want to have numbers in the pool, but
11 which pool; the all-payer claims database should have this
12 information anyway (sic) and I just -- I'm getting the
13 impression that the Milliman report and other studies have not
14 relied very heavily on the hospital discharge data.

15 I could be wrong and if I am wrong, I would like to be
16 told. I'm getting the impression that this data that we've
17 been collecting for many years from hospitals has not really
18 been used as much as we would like.

19 MS. ERICKSON: Other discussion?

20 COMMISSIONER PUCKETT: From my perspective, it probably
21 hasn't been used, but the new reality we're facing with the
22 increase in health care cost is we have to begin be more
23 active managing health plans and we -- the way we can be more
24 active is rely on the data that it produces and I know for my
25 department and division, we are going to be using data

1 analysts internally for our own plan. So the data's going to
2 have to be there for us to look at it, but in the past, health
3 plans were not actively managed like we're going to have to
4 that (sic) in the future.

5 COMMISSIONER HIPPLER: Now, you get the data from paying
6 people. The hospitals and doctors send you the data in little
7 pieces of paper saying "please, pay us." So you don't need
8 that from the discharge database, right?

9 MS. ERICKSON: Again, I think we've gotten too far into
10 the weeds and we don't have enough information without -- we
11 had a conversation with folks from the department a couple of
12 years ago when we made the first recommendation to --
13 initially, the first recommendation -- the first time we made
14 a recommendation, it was to mandate and we scaled back on the
15 mandate, but that was -- the whole discussion was following a
16 conversation with folks from the department talking about how
17 they'd use the data and so we -- we either need to reconvene
18 that panel to have that conversation again or we need to
19 understand where we're going with our relationship with the
20 department and how operational we get and how far down in the
21 weeds we get and how much we want to just start having them
22 come back to us and share with us what they're doing to
23 implement our more general recommendations.

24 COMMISSIONER URATA: You know, at some point, you can
25 just call for the vote.

1 MS. ERICKSON: Yeah (affirmative), I was waiting for
2 somebody around the table to do that, but I will do that.

3 COMMISSIONER URATA: Well, if there's no more discussion.

4 MS. ERICKSON: Yeah (affirmative).

5 COMMISSIONER URATA: Then you can call for a vote.
6 Otherwise, we'll have to vote on the vote.

7 MS. ERICKSON: Right. Okay, so let's.....

8 UNIDENTIFIED VOICE: (Indiscernible - too far from
9 microphone).

10 MS. ERICKSON: No. Yeah (affirmative), nonvoting member.
11 Okay, so -- yes, Larry.

12 COMMISSIONER STINSON: I agree with what was said
13 previously about breaking out into two separate amendments,
14 the ambulatory surgery center and imaging center requirement
15 and encouraging the federal facility participation, because I
16 think they're entirely two different things and one is the
17 regulatory burden that is going to result in increased costs
18 and will also not be apples to apples on the data that was
19 previously collected and is also recoverable through other
20 means anyway, while the other, encouraging federal facility
21 participation, is something that we need to have in without
22 question.

23 MS. ERICKSON: So were you proposing an amendment to the
24 amendment to break out?

25 COMMISSIONER HIPPLER: That is what you're proposing.

1 You could just have the maker of the motion and his second say
2 this is what they meant, they intended to say. It's a lot
3 easier to do it that way, just have them clarify and agree
4 with each other and then we can move on.

5 MS. ERICKSON: Pat, do you agree?

6 COMMISSIONER BRANCO: That's exactly what I intended. I
7 don't know why you wrote it down that way.

8 COMMISSIONER URATA: And I agree with you.

9 MS. ERICKSON: That's okay. We could go into Executive
10 Session if you want to call me to task. Are we prepared to
11 take a vote on the first, so friendly amendment number one to
12 include additional facilities, including ambulatory surgery
13 centers and imaging centers in the initial motion, all in
14 favor signify by saying aye.

15 UNIDENTIFIED VOICES: Aye.

16 MS. ERICKSON: Any opposed, nay.

17 UNIDENTIFIED VOICES: Nay.

18 MS. ERICKSON: So for -- Barb, I need you to write these
19 down. We're going to go around the table. It was enough of a
20 mix that we're going to do an individual head count and ask
21 you each to vote separately. Jeff.

22 COMMISSIONER DAVIS: Aye.

23 MS. ERICKSON: Jeff, aye.

24 COMMISSIONER CAMPBELL: Aye.

25 MS. ERICKSON: Keith, aye.

1 COMMISSIONER BRANCO: Aye.
2 MS. ERICKSON: Pat, aye. Tom.
3 COMMISSIONER HARRELL: Nay.
4 MS. ERICKSON: Nay. Bob.
5 COMMISSIONER URATA: Aye.
6 MS. ERICKSON: Aye. Ward?
7 CHAIR HURLBURT: Nay.
8 MS. ERICKSON: Nay. Jim, you are not a voting member,
9 sorry. Allen.
10 COMMISSIONER HIPPLER: Nay.
11 MS. ERICKSON: Larry.
12 COMMISSIONER STINSON: Nay.
13 MS. ERICKSON: Nay, and David.
14 COMMISSIONER MORGAN: Nay.
15 MS. ERICKSON: David's nay. Do you have the count on
16 that, Barb? We have three -- six nays and four -- four yeas.
17 So the first amendment fails. On the second amendment, to
18 encourage federal facility participation, all in favor signify
19 by saying aye.
20 UNIDENTIFIED VOICES: Aye.
21 MS. ERICKSON: Aye. All opposed, nay. The second
22 amendment to include encouraging federal facilities to
23 participate passed unanimously, so.....
24 UNIDENTIFIED VOICE: It's (indiscernible - too far from
25 microphone).

1 MS. ERICKSON: All in favor of the motion to recommend a
2 mandatory hospital discharge database for the purpose of
3 providing data that will support policy decisions that will
4 lead to improved health of Alaskans and to encourage federal
5 facility participation in that database, all in favor, signify
6 by saying aye.

7 UNIDENTIFIED VOICE: Aye.

8 MS. ERICKSON: Any opposed?

9 COMMISSIONER BRANCO: Nay.

10 COMMISSIONER HIPPLER: Nay.

11 MS. ERICKSON: And two -- the only oppositions are Pat
12 and Allen, is that correct? Is anybody else opposed? So that
13 motion passes with eight for and two against. Ward, what if -
14 - can I suggest that we spend another 10 minutes wrapping up
15 this discussion and then cut our next agenda item by half an
16 hour and Jeff -- Jeff and Director Kolb.....

17 UNIDENTIFIED VOICE: (Indiscernible - too far from
18 microphone).

19 CHAIR HURLBURT: We -- for the amendment, let's cut it by
20 15 minutes and let people just go to the bathroom if they need
21 to, but not take a break, because we're going to end at noon.
22 I think we want to hear what Jeff and Bret have to say.

23 MS. ERICKSON: Very good.

24 CHAIR HURLBURT: Yeah (affirmative).

25 MS. ERICKSON: Very good. Okay, let me find out where we

1 are. That was the easy one. What I want to do is go to the
2 all-payer claims database and what we had in draft from
3 brainstorming at our March meeting is initial recommendations
4 and it's essentially -- I mean, that first bullet that you're
5 seeing on the screen right now, really was more of a finding.

6 So what you had considered and thrown up from the
7 brainstorming session last time on all-payer claims database
8 was that you recommend the state proceed cautiously and take a
9 phased approach to developing an all-payer claims database and
10 that the state engaged stakeholders in planning for it,
11 establish ground rules for data governance, ensure appropriate
12 analytic support to turn the data into information and support
13 appropriate use, focus on consumer decision support as a first
14 deliverable, that's the price and quality transparency, start
15 with commercial Medicaid and Medicare data first, then
16 collaborate with other federal payers and address privacy and
17 security concerns.

18 Does it make it easier, after the discussions yesterday,
19 to start -- use that as a starting point or would you rather
20 not discuss it at this point? Yes. I heard a yes. Would you
21 like to consider this as a motion for discussion? So
22 Keith.....

23 COMMISSIONER CAMPBELL: I will (indiscernible - too far
24 from microphone).....

25 COMMISSIONER HIPPLER: Can you (indiscernible - too far

1 from microphone) what you're suggesting (indiscernible - too
2 far from microphone)?

3 MS. ERICKSON: That the Commission recommend that the
4 state proceed with caution and take a phased approach to
5 developing an all-payer claims database with these other
6 conditions.

7 COMMISSIONER HIPPLER: So moved.

8 MS. ERICKSON: Well, Keith had.....

9 COMMISSIONER CAMPBELL: That's all right. I'll second.

10 MS. ERICKSON: Okay. So Allen motioned. Keith seconded.
11 Discussion.

12 COMMISSIONER DAVIS: I think that the motion and the
13 conditions that are included are consistent with the input
14 that we've had from the public and from (indiscernible - voice
15 lowered) and from the Hospital Association, whose opinion I
16 respect in this.

17 MS. ERICKSON: Yes.

18 COMMISSIONER HIPPLER: I have a question for
19 clarification. In our previous discussion, I believe it was
20 Dr. Urata who had mentioned that both the discharge data and
21 the APCD would result in an additional burden to providers.

22 That was not my understanding and I wanted to clarify
23 that the all-payer claims database really doesn't affect
24 providers, that all they do is just submit their normal claim
25 like they would before and they don't really see an impact.

1 Maybe I misheard. I just want to make sure that this is not
2 an impact to providers.

3 MS. ERICKSON: I think I would clarify and say it does
4 not impose an additional administrative burden. It does
5 certainly impact them in that it's making this information
6 available and they're going to want to be engaged in decision-
7 making about how the data is used. Would that be accurate?
8 Dr. Stinson is nodding his head and Dr. Urata is nodding his
9 head. Yes.

10 COMMISSIONER HARRELL: So I'm going to beat this one more
11 time, though, the payer provides this report. I got it. Is
12 it unreasonable to conclude or assume that with additional
13 focus placed on this data and a burden placed on the payer to
14 provide this data, that will not in turn drive other questions
15 down to the provider level?

16 I'm basically dog piling (sic) on Allen's comment. I
17 want to be absolutely certain that we are not setting up a
18 situation that will have a secondary consequence that will
19 ultimately flow back down to the provider.

20 Any time you measure something, you're going to drive
21 extra data collection, extra scrutiny, which will drive
22 further regulation and that can be pushed down. I do want to
23 be absolutely certain we are not moving in that direction,
24 even though we're taking a cautious approach.

25 CHAIR HURLBURT: I think that the data, as I understand

1 the all-payer claims database, and as I have used that kind of
2 information on the health plan side, is totally generated by
3 claims information.

4 However, if you're looking at quality and you use that
5 data for quality, for example, to look at what your
6 mammography rates are for women aged 50 to 65, if Dr. Hurlburt
7 is doing a lousy job, then you may go and say, "Dr. Hurlburt,
8 you're not doing very well on encouraging your patients to
9 have mammograms and we would like you to do better," because
10 we're measuring what our HEDIS rates are. We're measuring
11 what our mammography rates are and I think you can have that
12 kind of a burden come back to the physician, but not in terms
13 of collecting the data. The data is all claims' generated.

14 MS. ERICKSON: Bob.

15 COMMISSIONER URATA: The bottom line is that the burden
16 that the provider would have presumably would be for the
17 benefit of his patients or the consumer and so that's the idea
18 with the quality part.

19 MS. ERICKSON: Pat.

20 COMMISSIONER BRANCO: (Indiscernible - too far from
21 microphone).

22 MS. ERICKSON: Other discussion? Yes.

23 COMMISSIONER STINSON: I agree with what everyone has
24 said so far. I would still, you know, when you say focus on
25 consumer decision, I think focus is a good term for this and I

1 would still think maybe focus on whatever the, like I said,
2 the top three to five diagnoses per specialty or something
3 like that, because otherwise, you could -- it's eventually
4 turned into more information or actionable information. You
5 could have unlimited information, but maybe not much help and
6 I think it needs to be combed down a little bit.

7 MS. ERICKSON: So what -- what if -- again, I don't want
8 to get too far down into the weeds, operationally, about how
9 it will work. What if we stay focused on process that we're
10 recommending here? What if we strengthen engagement of
11 stakeholders and planning? If we could do something around
12 those first two bullets with engaging stakeholders and
13 planning and establishing ground rules for data governance, I
14 mean, I see the issue that you're bringing up, Dr. Stinson, as
15 making sure that we have strong processes in place for those
16 two and maybe we need to strengthen those somehow. You agree?

17 COMMISSIONER STINSON: (Indiscernible - too far from
18 microphone) agree (indiscernible - too far from microphone).

19 MS. ERICKSON: I don't have a good suggestion for how to
20 do that, though.

21 COMMISSIONER HARRELL: Well, perhaps just a simple
22 additional bullet, essentially paraphrasing what Dr. Stinson
23 has said, focusing on the top three to five diagnoses, you
24 know.

25 MS. ERICKSON: You know, I think what I was suggesting,

1 though, is that if that's too operational, but that what we
2 need to do is to make sure that we are fully engaging the
3 providers who will be making the decision in design of the
4 database and the use of the data and was feeling that maybe
5 those first two bullets, that I think are intended to get at
6 that, just need to be strengthened. Pat.

7 COMMISSIONER BRANCO: On the first bullet, you might add
8 the word "engage stakeholders in planning and establishing
9 parameters."

10 MS. ERICKSON: And that addressed your concern, Dr.
11 Stinson?

12 COMMISSIONER STINSON: Yes.

13 MS. ERICKSON: And Dr. Harrell, does that help yours,
14 too? Allen?

15 COMMISSIONER HARRELL: Yes.

16 COMMISSIONER HIPPLER: Are we -- can I move onto a new
17 comment or are we still (indiscernible - speaking
18 simultaneously)?

19 MS. ERICKSON: You may move onto a new comment.

20 COMMISSIONER HIPPLER: Okay, I'm not sure where I'm going
21 with this, but that's never stopped me before and Dr. Hurlburt
22 mentioned something that I think he thought was in support of
23 the all-payer claims database just a second ago. He says,
24 "Well, you could look at this data and see that Dr. Hurlburt
25 hasn't been ordering enough mammograms and you could tell Dr.

1 Hurlburt he's not doing well."

2 I understand you think that could be a benefit of this
3 system, this -- but the idea that we're already discussing the
4 potential for the state government to look at this private
5 health data and criticize both the consumers, because you
6 know, how dare this woman not get a mammogram, and the doctor
7 for not providing that is a little scary to me.

8 MS. ERICKSON: Can I offer some clarification on how the
9 all-payer claims database in other states are being used to
10 support improving clinical practice is -- and this is the sort
11 of thing that with those first three bullets that we would
12 have the providers engaged to make sure they were providing
13 that guidance, but just an example of one of the ways that's
14 being done is that the data is taken with guidance and
15 direction from the providers who are affected to design the
16 system, essentially providing report cards to them that they
17 want to get that nobody else sees.

18 An individual physician in a practice would get a report
19 on their patients and their patient encounters and then they -
20 - but then there will be reports generated to look at both
21 practice-wide practice, how their peers in their own practice
22 are doing all aggregated together. They wouldn't even
23 necessarily see theirs if it's designed that way and then all
24 of the other providers in the community and they could use
25 that as a touch point for identifying where they might make

1 improvements in their own practice and nobody else sees it and
2 it's with their participation in designing the system that way
3 that it guarantees that's how the data's being used. Yes,
4 first Colonel Harrell and then Dave.

5 COMMISSIONER HARRELL: So I would seek to reassure you
6 that, as a physician, that's absolutely the kind of
7 information we want. We have a very hard time in the
8 physician community rolling out and getting concurrence and
9 practicing of established guidelines, things that we know
10 improve patient care (sic).

11 It's very hard to have that information penetrate actual
12 practice patterns and so a physician wants to have that data
13 back and engendering some measure of competition based on how
14 you structure the report is actually very good.

15 If I'm in a practice and I find that I am not providing
16 my patients an ace inhibitor to the standard of my colleagues
17 or others in the community, that becomes a good-natured drive
18 to meet that standard. So I don't think you'll find a lot of
19 providers that would throw up a hand to that kind of
20 information, because it -- we're all about quality
21 improvement. We just do a terrible job in having that
22 information penetrate practice. It takes years with well-
23 established data for it to actually penetrate practice
24 patterns and make an impact for patients.

25 CHAIR HURLBURT: And I say, Allen, that at least to me, I

1 think, it's reassuring, this is not data that the state is
2 going to take for all the citizens and try to impose quality
3 of care.

4 This is data that payers would use -- setting it up, you
5 probably would contract for it. There'd be a firewall there.
6 So the state, as a payer, whether it's for Medicaid, whether
7 it's for state employees, state retirees, as a payer, they are
8 concerned about the quality of care that their enrollees
9 receive, like any other payer in the country and that happens
10 now, but for say, if you and your firm have your insurance
11 with Cigna, Cigna would be the one, if they're a TPA acting on
12 your behalf as an employer, they would be the one that would
13 be concerned about the quality, but it doesn't operate
14 anywhere that I'm aware of from my reading and from anything
15 that I've seen that the state takes this data and then they go
16 out to all the citizens and get involved in that.

17 MS. ERICKSON: Dave.

18 COMMISSIONER MORGAN: As -- I'm not a physician, but I
19 did spend a night in a Holiday Inn, so -- but I manage -- but
20 I manage a lot of health care and the information that we pull
21 this way and the example I like to use is diabetes.

22 So I have these groups of patients and only the
23 organization I work for as we process with and, in fact, we
24 share, now that we have a VA contract. We sit down and share
25 it with them on that.

1 If you use HEDIS measures and you follow HEDIS in the
2 management and making sure that a certain percentage of your
3 patients with the diabetes diagnoses, and you follow those
4 eight things you're supposed to do each month, like training
5 them to do their sticks and training them to measure sugar and
6 not forcing them, but encouraging them and helping them, that
7 is where you really control cost.

8 You can drop bed days -- well, to the chagrin of my
9 friends in the hospital business, you can drop bed days. You
10 can drop ER visits and you can stabilize and reduce use of the
11 pharmacy and scripts.

12 This is the kind of data that we're all going to (sic)
13 anyway, whether you do it through your own system where you're
14 paying or if you're managing in a system, a large group of
15 patients and you have so much money to deliver so much care
16 and as accountability organizations begin happening, that's
17 what they're going to do.

18 My friend down at that end of the table with state
19 government is probably going to start doing this in order to
20 get some restraint and to help manage the care, so he can
21 reduce the cost, but there's -- you never use that data
22 outside the organization you're working for or with the
23 provider.

24 Now, a lot of the state's organizations in the state that
25 have a large number of patients that they manage, do drop it

1 down to the level of the physician and work with the physician
2 or primary care team and the patient, but there's no -- none
3 of this is going in the "New York Time." It's all being
4 utilized to make the situation better and it's not escaping.
5 We're keeping it very close in.

6 MS. ERICKSON: So are we ready to call the question or
7 are there.....

8 COMMISSIONER URATA: Just one more comment.

9 MS. ERICKSON: One more comment and a question from
10 (indiscernible - speaking simultaneously).....

11 COMMISSIONER URATA: All this points to the importance of
12 quality of care and in order to provide quality care, you need
13 data and it should go down to the patient. It should go from
14 the system, the hospital, the outpatient surgery center, down
15 to the clinics, down to the physician, the providers, whether
16 they're a nurse practitioner or a physician and then down to
17 the consumer or the patient and with high quality of care
18 throughout your system, you're going to save millions of
19 dollars. That's what this is all about.

20 MS. ERICKSON: Representative Keller and then Keith.

21 COMMISSIONER KELLER: This is another different little
22 point, if that's okay at this time, but government rarely does
23 things right and when it does, it's rarely on time and that's
24 a premise that I have picked up and if we start this
25 recommendation in saying that we proceed with caution, that

1 might be interpreted, frankly, or implied, I guess is a better
2 word, as put this thing on the slow roll and so I would just
3 suggest maybe, for what it's worth, include the word
4 "immediate," because I think this is really important stuff
5 and a lot of work has gone into it and somehow recommend the
6 state immediately proceed with caution, so that the emphasis
7 is on do this, not don't do it.

8 MS. ERICKSON: Do you want to accept that as a friendly
9 amendment? Does anybody disagree?

10 COMMISSIONER HIPPLER: Well, I don't mind the slow
11 approach, given that it's only had two percent utilization
12 where it's being rolled out now and our -- I can't -- what is
13 your title? Our Commissioner -- what is.....

14 MS. ERICKSON: Director.

15 COMMISSIONER HIPPLER: Our Director of Health, Jim, says
16 that.....

17 MS. ERICKSON: Yes.

18 COMMISSIONER HIPPLER: Says that he.....

19 UNIDENTIFIED VOICE: (Indiscernible - too far from
20 microphone) DRV.

21 COMMISSIONER HIPPLER: DRV, there you go. All right, Jim
22 says that in the future, he's projecting a large increase in
23 consumer-driven accounts, which would utilize this service
24 more, but it's not here yet.

25 He's seeing this coming down the pike. So I would hate

1 to roll this out too quickly and then have it not be used and
2 then both, first of all, having spent that money for no value,
3 but second of all, looking like we're wasting money.

4 MS. ERICKSON: Yeah (affirmative), the -- I just wanted
5 to clarify, Allen, the two percent utilization wasn't about
6 utilization of the all-payer claims database. It was two
7 percent in the measure from the catalyst for payment reform
8 about the use, generally, of consumers of price and quality
9 data.

10 It wasn't about utilization of the all-payer claims
11 database and it doesn't get at all of the other uses beyond
12 price and quality transparency for consumers of an all-payer
13 claims database like the quality improvement by clinicians.
14 Yes, Keith.

15 COMMISSIONER CAMPBELL: Well, we've heard great concern
16 and trepidation about the coercive or potential coercive use
17 of this number on practitioners. I would just suggest that
18 those people have not sat around a utilization review
19 committee and watched physicians point out foibles or apparent
20 foibles to their brethren and so I'm not particularly
21 concerned about that.

22 CHAIR HURLBURT: I'd like to call the question.

23 COMMISSIONER URATA: (Indiscernible - too far from
24 microphone).

25 MS. ERICKSON: So is it okay with you, Allen, if we keep

1 "immediately," and everybody else nodded assent?

2 COMMISSIONER DAVIS: Can I make a comment about that?
3 Remember immediate would be -- it would take three years to
4 get this done. So I think, to Wes' point, we don't want it to
5 take 10 years. So that's -- I think that's the nuance.

6 COMMISSIONER HIPPLER: Okay, I'll yield to that.

7 MS. ERICKSON: Okay, so calling the question, I'm not
8 going to restate the motion as it's stated -- as you can read
9 it on the wall. You're all comfortable with that? All in
10 favor, signify by saying aye.

11 UNIDENTIFIED VOICES: Aye.

12 MS. ERICKSON: Any opposed, nay. So it passed
13 unanimously and I guess I'm going to ask at this point, we had
14 one other issue to consider. Would you like to table it or do
15 you want to have a conversation about whether there should be
16 additional statutory requirements compelling providers to make
17 their prices more transparent to consumers?

18 CHAIR HURLBURT: I'd like to table it. I think we've had
19 a really good agenda laid out for us and it's important -- I
20 think we should move on the agenda.

21 MS. ERICKSON: Everybody is comfortable and we can delay
22 that conversation until later, another meeting?

23 COMMISSIONER HIPPLER: I didn't -- I didn't -- where is
24 that in the tab or in the tabs?

25 MS. ERICKSON: Behind Tab Three, in the -- there's

1 actually quite a bit. First of all, in the document that I
2 had asked you all to review before the meeting that you may or
3 may not have had a chance to look at, there was the notes from
4 our March meeting and it included in red italicized fonts the
5 questions for you to consider related to compelling providers
6 -- the question about whether there should be a state law
7 compelling providers to make their prices more transparent and
8 then we have the report card on state transparency laws that
9 are specific to state laws that compel providers to make their
10 prices transparent and the presentation by Dr. Delbanco
11 yesterday was essentially about that point.

12 COMMISSIONER URATA: It's page two.

13 MS. ERICKSON: Page two of that document.

14 COMMISSIONER URATA: I.....

15 MS. ERICKSON: Yes.

16 COMMISSIONER URATA: I agree with Ward that we should
17 (indiscernible - speaking simultaneously).....

18 MS. ERICKSON: Okay, so why don't we -- I mean, we have a
19 suggestion that we table that discussion for a future meeting
20 and not take any action on it right now. Is that okay with
21 the rest of the group?

22 COMMISSIONER CAMPBELL: So moved.

23 MS. ERICKSON: What? Okay, so we are not taking a break
24 before -- what, Keith.

25 COMMISSIONER CAMPBELL: Do you want a formal motion to

1 table or just by consensus?

2 MS. ERICKSON: I was thinking we would do it by
3 consensus, but we could take a formal motion, if Allen's okay
4 with that?

5 COMMISSIONER HIPPLER: If our Chairman is, unless anyone
6 objects.

7 MS. ERICKSON: Okay, it will take a couple of minutes to
8 transition to the next presentations and Director Kolb, do you
9 want to come join us at the head of the table, and we'll put
10 Jeff's presentation up first and then it will just take a
11 couple of minutes, and again, we are not going to take our
12 scheduled break today. So as you need to get up and move
13 around, feel free to do that.

14 COMMISSIONER HARRELL: So while we're doing that, it was
15 interesting this morning on APR, there was an article about
16 price transparency here in the Anchorage area and physicians
17 being concerned about not being totally aware of prices that
18 were being charged to patients for procedures.

19 CHAIR HURLBURT: Okay, let me go ahead and introduce the
20 panel that we have. Welcome, Bret. We've looked at
21 hospitals. We've looked at physicians. We've looked at the
22 pharmaceutical industry, we -- in terms of for the whats and
23 the whys of some of the pricing.

24 We've talked today or talked yesterday about the
25 methodology and the procedures that are used, particularly on

1 the hospital side in generating what the pricing is there.
2 The question was raised, well, a part of this three-legged
3 stool, I guess that we have, looking at the payers side, how
4 do the health payers, specifically the health insurance plans
5 generate the prices?

6 It's certainly an industry that, at least in some
7 segments of our country, are an easy target and are bashed a
8 lot as having outrageous profit margins and salaries and
9 prices and that they're a big driver of the cost.

10 With the AMA, in their wisdom, pronouncing that obesity
11 is a disease and so that NutriSystem and Weight Watchers now
12 need to be paid for by the health insurance companies, my
13 prediction is as the bills go up, they will be blamed for the
14 cause of the increase in prices there.

15 So our own Jeff Davis has talked about this in other
16 settings and I've heard him and I think you will really enjoy
17 the presentation where Jeff talks from many years' experience
18 in the health insurance side and then Bret Kolb, who probably
19 not everybody knows here yet, but we all remember Linda on
20 there (sic). Bret is Linda's replacement as the Director of
21 the Insurance Division for the state dealing with all kinds of
22 insurance, but specifically the health insurance that we deal
23 with and so, Jeff is going to share his perspective and Bret
24 will, in his role the Insurance Director. Thank you both very
25 much for coming. Jeff.

1 COMMISSIONER DAVIS: Thank you, Dr. Hurlburt. Well, I
2 see my time is up. So are there any questions? No, thanks
3 for the opportunity to speak with you on this subject. It's
4 not often that people are relieved to now be listening to a
5 presentation on health insurance, but I think we all are after
6 the pain of the morning.

7 So we'll just jump in here. I'll take you through what
8 I'm going to talk about now. I know this is a surprise to
9 everyone around the table that health care costs are
10 unsustainable. I'm going to just do a little bit with that
11 and then talk about what is health insurance, which may not be
12 as obvious as you might think.

13 I'll talk about where the money goes. That's the topic
14 that everyone's interested in. Will the Affordable Care Act
15 fix the problem? We'll talk about that just briefly and then,
16 I think what's been done by insurers to address cost is a
17 legitimate and important point. So that's where we're going
18 to go and then, we will have questions, hopefully.

19 Okay, so unsustainable, this is -- this line is
20 historical federal revenues just under 20% of GDP. This line
21 -- get to -- if you look at Social Security and other non-
22 interest spending by the federal government, it's pretty flat
23 over this period from 1970 to 2040 or projected to be.

24 However, if you now look at what we spend on Medicare,
25 Medicaid, CHIP and the new exchange subsidies coming in, you

1 see a very different picture of an increase that's much
2 greater than what's going on with federal -- with GDP and
3 then, it gets really scary if you add interest on the debt.

4 So by 2040, we'd be looking at an amount equivalent to
5 35% of GDP would be the required federal revenue and that's
6 not very far away, you know, that's 27 years from now. So
7 many of us have children who will just be in their peak
8 earnings at that point, but if that's not scary enough, how
9 about this one out to 2080? I mean, that's apocalyptic if you
10 look at it. So that's my version of shock and awe.

11 We have a problem, Houston, and why is that? Well, it's
12 very clear. It's because health care costs are rising faster
13 than GDP. So if GDP goes up two percent, health care costs go
14 up six, you continue to consume more of the -- of GDP. When I
15 was in -- a young lad of four (sic) in graduate school in
16 1982, we were consuming eight percent of GDP for health care
17 and we're now at 18. We thought the sky would fall if we got
18 to 10, but clearly, we've gone past that, but the sky will
19 fall.

20 Okay, so now, let's bring it closer to home and look at
21 Alaska compared to other markets, actually compared to
22 Washington. This number by itself is pretty shocking to me.
23 Alaska's small group premiums from our -- this is our book of
24 business, on average are \$650 per person. So if that's a
25 family of four, that's \$2,600 per month. That's a lot of

1 money.

2 As Deb said yesterday, I didn't put these slides in, but
3 we're at a point now, if you look at employer spending and
4 personal spending that on average, health care, health
5 insurance is consuming 24% of household income.

6 In Washington, that number is half. So as Dr. Hurlburt
7 is likely to say, you know, the U.S. has the highest health
8 cost in the world. Alaska has the highest in the nation.
9 Actually, we find out we're third, behind Massachusetts and Ne
10 York. So Alaskans are paying the third most for health care
11 in the world and that's not good. I'm not proud of that.

12 Employers are -- and individuals are being crushed under
13 that financial burden. We're seeing that. We're seeing
14 people drop coverage. We're seeing our employer clients look
15 for other options. "Gee, I've been with you for 20 years and
16 I'm being crushed under the burden of this. You must be the
17 problem. We'll go try someone else." So being crushed by the
18 financial burden is not part of a sustainable health care
19 system.

20 So what is health insurance? There is a technical
21 definition of insurance and it's important, I think, to look
22 at that because what I'll be going to is that health insurance
23 is really is not pure insurance any longer. It's been changed
24 in a number of ways.

25 So three things make an event insurable. First, it has

1 to be undesirable. Getting a new Mercedes E350 is not an
2 insurable event because I would really like that, okay. It
3 has to be unpredictable to the individual. So you think about
4 houses burning down, not a good thing. We know houses will
5 burn in Anchorage, but we don't know whose houses will burn,
6 okay, but we know that they will.

7 So it's unpredictable to an individual, but it is
8 predictable to a population. So actuaries could tell you how
9 many houses they predict will burn in Anchorage over the next
10 period. So undesirable, unpredictable to the individual, but
11 predictable to a population. Those are the three
12 characteristics that make something insurable.

13 So originally, insurance was financial protection,
14 something to protect you from going bankrupt. We are all
15 going -- let's look at homeowners' insurance. We all put a
16 little bit of money in the pool so that unlucky family whose
17 house does burn down has -- there's enough money in the pool
18 to pay for that house to be burned down (sic), rather than
19 going bankrupt. So that was the -- that's -- the concept of
20 insurance is risk pooling and that's what health insurance
21 was.

22 However, it's been blended with social policy. This is
23 where things started going a little differently. One of the
24 reasons it's blended with social policy is that access to
25 health care does impact health status.

1 Now it's only a determinant of about 10% of our health
2 status is access to health care, but it is important and you
3 don't have to go very far to find examples of people who need
4 health care now, because they're in a catastrophic situation.
5 So it -- so access to health care impacts health status and
6 access to health insurance impacts access to health care.
7 Therefore, it has become viewed by many as a right.

8 Gee, how can that be? How we can we have in this country
9 in our egalitarian view of the world on many things, how can
10 we have some people who have access to health care and others
11 who don't, and that's why we have programs like Medicare and
12 Medicaid and those other things, but when you start to look at
13 insurance as a right, that's something very different than the
14 three factors that makes something an insurable event. Then
15 finally, access to health care is not always an undesirable
16 event, which was the first characteristic of something that's
17 an insurable event.

18 Going to the dentist and getting my teeth cleaned and
19 making sure they're healthy, to me is a desirable event, not
20 that I like going to the dentist, but the outcome is
21 desirable. So dental insurance really isn't insurance at all,
22 it's prefunding of dentistry.

23 Going and seeing my primary care doctor, with my family
24 history of heart disease, every six months, to me is a
25 desirable event, because I'd like to be around to be my

1 youngest child graduate from college.

2 So those things, viewing it as a social policy, as a
3 right and knowing that many things that we do and are covered
4 in health insurance now are not undesirable, is where the
5 lines start to blur between is health insurance or is it not?

6 So switching gears a little bit, will the Affordable Care
7 Act fix this problem? Well, the Affordable Care Act, at least
8 in 2014, January 2014, which is the big event, Dr. Kolb will
9 talk more about this, it affects primarily individuals and
10 groups of two to 50.

11 Here are the things that are going to happen that are
12 really big. As we talked about yesterday, there are 11,000
13 pages of regulations. David said stacked up, it's six feet
14 high. So there's lots of things that are going to happen, but
15 these are the big things from a health insurance point of
16 view.

17 First, is guarantee issue. Historically -- well,
18 guarantee issue means that regardless of health status, if I
19 go to an insurance company and say, "I want to buy a policy --
20 " actually, guarantee issue and no preexisting condition
21 waiting periods go together.

22 I want to buy a policy. I cannot be denied and I have no
23 waiting periods for conditions that I might have. Well, if I
24 went to see Colonel Harrell and he tells me I need coronary
25 artery bypass graph surgery, I am a \$400,000 house on fire,

1 right, because that's about what it's going to cost and so --
2 and then I go to whomever, ABC Insurance Company, and buy a
3 policy and as soon as it's effective, I have my procedures
4 done. There's a \$400,000 bill.

5 It was not insurance because it was desirable that I get
6 my bypass graph surgery. It was predictable to me, as an
7 individual, because I've already been diagnosed with it. I am
8 a house on fire. None of us, I think, would figure that it
9 was reasonable if I could drive home and say, "Oh, my gosh, my
10 house is on fire," call Allstate and buy a policy or better
11 yet, buy one the next day, after your house burns down and
12 expect them to pay for it, but that's essentially what we've
13 done or are doing or will be doing with guarantee issue and no
14 preexisting condition periods. So that's going to have some
15 impacts, which I'll talk about.

16 The next big thing is that they'll be federal subsidies
17 in the insurance exchanges. Someone asked me yesterday, will
18 they be up and running? That's a big question, but
19 eventually, they will be, but October 1st, they should be up
20 and -- they're supposed to be up and running. Alaska will
21 have a federally facilitated exchange and if you are -- if
22 you're family income is 400% of poverty or less, which in
23 Alaska is roughly \$118,000 for a family of four -- 72%, based
24 on census information, of Alaskans are subsidy eligible.

25 If you're subsidy eligible and you buy an individual

1 policy through the exchange, the majority of the cost, and I
2 think at least in Alaska, will be covered through a federal
3 subsidy.

4 So that's designed to -- both of these together are
5 designed to 1) provide access, so guarantee issue and 2)
6 provide affordability, at least if you're at 400% or less
7 through the subsidies.

8 There also will be minimum essential benefits that are
9 required. The actuarial value of a plan in the exchange, the
10 minimum is going to be point six. That's richer than what
11 people are buying in the market today, which is closer to
12 point four or five. So that will require -- that will also
13 have an impact on the price.

14 So what's going to happen? So the Affordable Care Act,
15 right, well, yes, it's affordable if you are eligible for a
16 federal subsidy. If you are eligible for a federal subsidy,
17 then you're buying a health insurance policy today, you're
18 likely -- out-of-pocket is likely to go down. Virtually in
19 every scenario, it goes down.

20 However, if you're buying a policy today and you're not -
21 - you're at 401% of federal poverty, particularly if you're
22 young, particularly if you're buying a high deductible plan,
23 which would not qualify under the Affordable Care Act, you're
24 likely to see a significant increase in your rates. I mean,
25 we'll see people whose rates double, because of the provisions

1 of the act. The minimum benefits and the effective guarantee
2 issue are the big things.

3 There's also, I didn't mention it in here, but there's
4 compression of the age spans from today, they're about six to
5 one for us, anyway, going to three to one, which means
6 everyone moves to the mean. Younger people who are buying a
7 policy for less today, will see theirs increase. Older
8 people, people over 50, who would see from, at least that
9 effect, their rates go down.

10 So there's winners and losers in this and who -- it's --
11 people say, "What's the impact going to be?" I say, "Well,
12 who are you? How old are you? How much money do you make and
13 what kind of a policy do you have now?" One of my
14 acquaintances said, "Well, I can keep my 10,000-dollar policy,
15 can't I?" I said, "Well, if you had it on March 23, 2010, you
16 can keep it, but if not, you can't. We're going to have to
17 discontinue that policy."

18 So -- but the reference to March 23, 2010, that was the
19 enactment date and there's this concept called grandfathering.
20 If you had a plan on that date, which you have not
21 significantly changed since then, you can keep that plan and
22 these impacts don't occur.

23 Just for fun, about 50% of our 10,000 individual members
24 are grandfathered or eligible for grandfather status and about
25 half of our small groups. So the ones with -- who have been

1 around for a while in this individual and two to 50 are not
2 impacted as much, but (sic) quite concerned about those people
3 who will see significant impacts, quite concerned and pretty
4 sure I know who's going to get blamed for it.

5 Okay, so let's talk about the health insurance dollar
6 because, as Dr. Hurlburt mentioned yesterday, it's not a
7 surprise, in fact, there were senior people in the Obama
8 Administration who were quoted as saying, "Yeah (affirmative),
9 we kind of looked around and decided that the insurance
10 companies were the easiest scape goats and so we --" that's
11 how they pitched the Affordable Care Act was this -- was --
12 and it's really not about care. It's really about insurance.

13 So you now, unfortunately, when this all comes down, and
14 there's going to be about two years, I think, of significant
15 upheaval here. We've likened to -- likened it to a roller
16 coaster. We had -- we filed with the Division of Insurance in
17 April, the end of April this year, our rates and plans for
18 January of 2014, which we're still pending approval.

19 We don't know who we're going to be covering. You know,
20 there's 120,000 uninsured Alaskans, which this is targeted
21 toward. I think 44 -- the state thinks 44,000 of them will
22 come into the exchange. We know nothing about them. We can --
23 -- we're guessing. So 2014, oh, my gosh, you know, we could
24 lose tens of millions of dollars easily. Who knows, and 2015
25 will be the same. We'll be filing rates in April of 2014.

1 We'll know who's enrolled, but we won't know anything about
2 their health status or their utilization by April -- well, by
3 January of 2015, when -- or '14, when the actuaries are doing
4 the analysis.

5 So it will be interesting. By 2016, we should know more.
6 By 2017, things should level out and they'll be a new normal
7 and we'll all see what that looks like. Okay, so often when I
8 talk, this is the first thing I talk about because if I don't,
9 people are just sitting there and listening and thinking,
10 "Yeah (affirmative), but you make 30% profits and you spend
11 40% on admin." So let's clear -- let's take that elephant and
12 kick it off the table.

13 If we take a dollar of premium -- this is on average.
14 This is over Premera's 1.7 million subscribers. So I'm giving
15 you the big picture. It's going to vary by line of business.
16 It's going to vary by year, but in total, this is where we end
17 up.

18 We spend six cents of every dollar on administration and
19 -- on average. So that's for everything we do; comply with
20 regulation, sell products, pay for me, you know, provide a
21 network, customer service claims. Everything we do, we spend
22 six cents on a dollar -- very different than I think what --
23 than I know you heard if you were listening during the debate
24 about the Affordable Care Act. I remember numbers being
25 thrown around of 40%. That's different.

1 Premium taxes and commissions, we're a taxable nonprofit.
2 I like to think of that as the worst of all worlds. We pay
3 state taxes and we pay federal taxes and -- on our operating -
4 - we pay taxes, premium taxes and then we pay federal taxes on
5 our operating income and we pay commissions to the advisors to
6 our clients. It's sort of -- it's a pass through to us to
7 them and that equals, on average over the 1.7 million people,
8 two percent and we make profit.

9 We make, on average, this is our 2012 number, we made one
10 percent. That, in fact, is our goal is to make one percent.
11 We can live on one percent and that one percent goes back into
12 the company. Again, it's a not-for-profit. It can't go to
13 me. It's got to go to -- there are no shareholders.

14 It goes back into the company to build reserves for the
15 future health care of our members, which I'll talk about more
16 and to build the capacity of the company to serve our
17 customers and just for fun, in preparation for the Affordable
18 Care Act, and we've been preparing since the day it was
19 enacted, and unfortunately, there's still a lot of things we
20 don't know, particularly in Alaska about what the federally
21 facilitated marketplace, they call it now, will look like and
22 how we'll connect with it, but we currently have 245
23 additional people working on projects directly related to the
24 implementation of the act and then we have a workforce of
25 3,000. So that's -- I just think that scale is interesting

1 and we're -- we're not entirely sure we're going to get
2 everything done.

3 So what does this mean? It means a 91%, 91 cents on
4 every dollar goes to pay for health care, all right. So as we
5 think about sustainability, and this is the point here, as we
6 think about sustainability, it's about health care. That's
7 what we've been focused on around the last -- the table the
8 last couple of days. That's where the money is.

9 We could go away, all right, if we went away entirely,
10 someone would still have to pay the claims, okay, but let's
11 say you cut that in half. Well, that's half of one year's
12 inflation on average in health care expenses. So we need to
13 look elsewhere to find our answers.

14 So who makes sure that what I just showed you is what
15 happens year over year over year? Well, this Director Kolb
16 and his very, very capable team are tasked with approving the
17 rates. They are now -- have the authority to approve rates
18 for all insurers.

19 The standard that they use, and not to get too deep into
20 Bret's territory, but I think this is important, is that the
21 standard is that rates must be adequate, but not excessive,
22 okay. Adequate, why, because insurance is a promise to pay
23 and if our rates aren't adequate, we won't be around to pay.
24 So consumers have bought something that will not have a
25 benefit to them, but not excessive, again, make sure that

1 people are -- what they're getting is value.

2 To come to that conclusion, the Division considers health
3 care cost trends, administrative costs. Our administrative
4 costs are scrutinized. They change year over year. Our
5 actuaries are projecting what they think health care costs
6 will -- how they will rise and when you live on a one percent
7 margin and you're predicting the future, it's tricky business.
8 You don't have to -- we don't have to be very far wrong to be
9 in the red, but fortunately, we have a great team and then
10 contingency and risks, that's okay.

11 We need a little bit built in because sometimes we are
12 right. Sometimes we're wrong and we've got on average to have
13 it come out to the one percent and then there are reserves and
14 again, these are -- exist to sort of cover the future health
15 care needs of our clients.

16 So I'm going to say a little bit more about reserves
17 because there's been discussion in the press, particularly
18 from our neighbors to the south. Reserves are not explicitly
19 considered in rate review. Adequate, but not excessive is to
20 help make sure that we have reserves, right, but their not
21 explicitly considered, and again, they exist to cover the
22 future needs of our clients. It's a promise to pay and we
23 need them as a condition of operation.

24 In fact, if our reserves drop below a certain threshold,
25 and this is true in every state, the Division of Insurance or

1 the similar body comes in and actually, you go into what's
2 called receivership and the Division then manages you,
3 hopefully, out of receivership or out of business, one of the
4 two.

5 They're expressed as a percentage of risk-based capital.
6 You know, we -- it's a technical term. I don't even know why
7 I throw that in there, but the question that's been debated in
8 Washington state and other places is; should reserves be used
9 to subsidize rates?

10 I'll just give you my opinion, for what it's worth, and
11 the answer is -- it's no. It's not a good idea. It's not a
12 good idea for a couple of reasons. It's not a good idea
13 because it jeopardizes our ability to cover the future health
14 care needs of our members.

15 Our view of risk is based on historic utilization. What
16 happens when the next pandemic hits? That view of risk could
17 be something very, very different. So you need -- we need to
18 be able to handle that and furthermore, my experience of 30
19 years in and around health care and health insurance is it's
20 always a bad idea to subsidize rates in a particular year,
21 because all you do is put yourself in a catch-up position.

22 So you -- let's just say you do that. You subsidize
23 rates to the point where now the reserves are low. Now you've
24 got to make up for that subsidy and you end up with rate
25 shock. It's just not, in my view, a good idea. Apparently,

1 it wasn't a good idea in the view of the Democrat Chairman of
2 the committee in Washington where the bill, I think it was the
3 Rules Committee, he did not believe it was a good idea, did
4 not pass it out of committee. So I think that, you know, is
5 another opinion that may or may not be worthwhile, but that's
6 (indiscernible - voice lowered) than I have to say about
7 reserves.

8 Okay, so we understand the problem. We understand
9 something about health insurance. We understand the
10 Affordable Care Act's not going to fix it, but what are we
11 going to do about it? What are we going to do about this --
12 the shock and awe pictures that I showed you in the beginning?

13 All of us have a role to play in this. Everyone in this
14 room has a role to play in creating the sustainable health
15 care market. I have a -- I have several hats for this in this
16 role. I have the health insurance executive hat. I have a
17 role to play there.

18 I have a role to play as Commissioner on this body. I
19 have a role to play as just a person walking the planet, who -
20 - because -- although health care services impact 10% of my
21 health status, what I put in my mouth and how much I move
22 impacts 50% of my health status. Seventy-five percent of the
23 dollars we spend are spent on chronic disease and full a third
24 of that is preventable based on lifestyle decisions.

25 So we all have a role to play. Some of us have a

1 governance role to play. Some of us work in the Department of
2 Public Health, but we all have a role to play. So I think
3 it's just important, that you know, we never end up doing
4 this, but we do this instead.

5 Okay, so the first place that we're focused is to focus
6 on improving quality by reducing waste. It's been studied
7 over and over again and all the estimates show that 30 to 40%
8 of what's done in health care is waste and waste is defined as
9 something that's done or given that does nothing to lead to
10 the positive outcome, and in fact, is likely to do harm.

11 That's not a very good error rate, but it's a huge
12 opportunity. We spend three trillion dollars a year on health
13 care. That means a trillion of it does no good and likely
14 does harm. Let's find that. Let's stop doing the stuff that
15 adds no value and as I speak with provider groups, we can all
16 agree on that and that's -- I think we can -- let's just focus
17 there until the trillion-dollar opportunity is gone and then
18 we can go onto the next thing that's more interesting.

19 So how do you do that? Well, we talked about this a
20 little bit yesterday. Our whole discussion about price
21 transparency and getting to cost and quality data is around
22 giving consumers tools to be able to make good choices.

23 The discussion about high deductible health plans, when
24 John Torinus spoke to us last year, do you remember, that was
25 one of the first things he did, put in a high deductible

1 health plan. Guess what happens when you put in a high
2 deductible health plan, even if you supply -- even if you get
3 a health reimbursement account like he did, alongside,
4 utilization drops about 30%.

5 Let's see, waste is about 30%. Utilization drops about
6 30% when I have a stake in it. It's a huge opportunity, but
7 people need to know how to make decisions and therefore, the
8 value of our price and quality journey.

9 We're also developing a forward-thinking program that
10 will encourage people with some of the green stuff in the can
11 here to be educated consumers, to say, "If you will do this,
12 go take this online course before you go have that, we'll send
13 you a check and by the way, we'll consider you as a voluntary
14 participant in this part of a pool and as the utilization of
15 that pool drops because people are more educated consumers,
16 we'll share in that value, too." We haven't implemented it
17 yet, but we're going to.

18 There's also this thing called Choosing Wisely, which I
19 think we've had some discussion about. It's very interesting.
20 Specialty societies have put out a list, usually it's five to
21 10 things, of things that should happen or should never
22 happen. It's kind of a mix of those, but this is by the
23 specialty societies themselves and there are provider-facing
24 versions of Choosing Wisely, the clinical talk and there's
25 consumer-facing versions of Choosing Wisely, in fact, endorsed

1 by "Consumer Report."

2 If you're a "Consumer Report" subscriber, you can go on
3 their website. You have to dig a little, but you can find
4 "Choosing Wisely" recommendations within consumer friendly
5 language there.

6 So we figured out a way to -- not will all of them, but
7 with a number of them, to measure how often they're adhered to
8 and we don't think it should ever be 100%, but there's
9 probably some normal and we're working with some provider
10 groups to say, "Hey, you know, are you interested in this
11 data, because your own speciality society is saying this
12 should happen or should not happen," you know, let's use them.
13 Let's go with it. So it's just another example.

14 Hey, cost transparency, you know, this just is really,
15 really important. Otherwise, I mean, I can -- I'm not going
16 to name names, but I know of -- in this town where there's
17 400% variation in price for the same thing from one provider
18 to another, 400%. Wow, I'd like to know that beforehand,
19 rather than find out later, after I went to the first provider
20 and then went to the second provider and went, "Wow, that's a
21 400% difference." That would have been good to know up front
22 and integrated health management, you know, we heard Dr. Farr
23 yesterday talk about preauthorization and all those sorts of
24 things.

25 There's just a lot that gets done. Thirty to 40% that

1 does no good and in fact, does harm, and you know, we have to
2 do what we can do, hopefully, in a way that doesn't interfere
3 with the practice of medicine, hopefully, in a way that adds
4 to clinical quality and that is our focus of everything we do
5 in integrative management is how do we reduce -- improve
6 quality by reducing waste, and I think as long as we keep --
7 we, personally, keep, as a company, keep focused on that, then
8 we can get -- we can agree with our provider partners.

9 Okay, so what are employers doing about cost? Well,
10 personal health status improvement, a robust effective
11 worksite wellness, we heard about that from Mr. Torinus. We
12 have been working for seven years now with employer clients,
13 but we're moving to -- we've identified and are moving down a
14 path to go from processed-based rewards to actual activity-
15 based rewards.

16 So measuring someone's physical -- again, what you put in
17 your mouth, which includes, you know, if you smoke or --
18 alcohol and drugs and what you eat, what you put in your mouth
19 and how much you move and those things are becoming
20 measurable. Of course, this is all voluntary.

21 High deductible plans, we talked about that already.
22 This is the concept of moral hazard. You know, if I could buy
23 insurance for buying a new car, I wouldn't be driving the
24 truck I'm driving. I'd be driving something different and
25 cost transparency again. We heard, again, Mr. Torinus talk

1 about how they -- it wasn't very sophisticated, but they had
2 cobbled something together. David talked about the
3 purchasers' coalition that has done that work here.

4 It's just -- you'll see it all around and then worksite
5 clinics. We haven't seen a lot of that here yet, but this,
6 again, was something Mr. Torinus talked about and the data
7 around the change in utilization that can occur from a
8 worksite clinic. You don't have to be tens of thousands of
9 people, you can -- actually, we're developing a relationship
10 with a partner who can help us with this with our clients
11 (indiscernible - voice lowered) about 400 employees, you can
12 make it make sense and where it makes is the integration of
13 wellness and taking care of yourself by doing the things you
14 need to be doing and the ease of use and encouraging, through
15 benefit design, the ease of use of the things that do make
16 sense that they can have a tremendous impact, again, another
17 30 to 40% has been shown many times.

18 Then, my friend Pat Branco's favorite thing, medical
19 tourism, which is really pretty much, from an employer's point
20 of view (indiscernible - voice lowered) looking to us a
21 requirement to play. None of us believe that shipping people
22 out of state is the answer, but employer clients, again, are
23 desperate.

24 They're crushed under the financial burden. They're
25 looking for that. We lost our third largest client because we

1 didn't have that capability, but we do now.

2 Then system delivery transformation, we have a role to
3 play in this. Let me talk more about that. First thing to
4 say is to empower primary care and one of my colleagues says,
5 "Pay people to do stuff that we know reduces waste," okay.

6 So we're going down that road, but you need transparency
7 tools, there we go again, and providers need data, like we
8 talked about, the HEDIS data and other data and it's providers
9 asking for that so they know how to do a better job.

10 They need to know, "Gee, these people attribute to me and
11 I've got people who are using the emergency room on a regular
12 basis." Well, if you're a primary care doc, you don't know
13 that. There's no way it exists right now, unless they come
14 and tell you. So how can we, with our data, partner with
15 providers to make that happen?

16 We've developed something. You may have read about it in
17 "Forbes." We call it the global outcomes contract and I'll
18 just brag on Premera for a minute. There was a quote that
19 said something to the effect, "If all insurers thought like
20 Premera, we wouldn't be in the mess we're in."

21 This is about giving -- telling providers, if you -- you
22 know, here, you've got the steering wheel. You've got the
23 ball, figure out how to drive out waste and as you drive out
24 waste, we can -- we'll measure how you're performance for the
25 population you cover compares to the population as a whole.

1 So if you decrease the rate of increase, we'll reward you
2 with that and it's been very successful. We have about
3 100,000 people in Washington who are receiving care from
4 providers who are in global outcomes contracts. We haven't
5 done it here yet. We have kind of a problem of small numbers.
6 It has to be big enough to be predictable, but I think with
7 aggregation of physicians together, voluntarily, we might be
8 able to get there, but this is a key piece to it.

9 In our view, any of this stuff that you do has got to be
10 provider-led. We have to be there in support, because
11 otherwise, there's not the data, but if it's not provider-led,
12 you're wasting your time and when I say "it," it can be
13 anything. There's so many iterations of this, but what I'm --
14 I am not interested in process and adding process.

15 We talk about accountable care organizations. I look at
16 the standard and I -- this is just so much process. I mean,
17 it speaks to what Dr. Farr and Dr. Cates were talking about
18 yesterday. No, let's identify five things that if we didn't
19 do or we did do, are going to improve care by driving quality
20 by reducing waste and pay people to do those things. Another
21 mantra is, "Let's make primary care fun again," you know.
22 Let's give primary care providers the tools to make this
23 happen.

24 So in summary, the status quo is unsustainable. We all
25 know that. The Affordable Care Act will not fix it. Cost and

1 quality are uneven. I don't even have to tell you that
2 because we've been talking about it for the last day-and-a-
3 half and we all have a role to play in this.

4 So I hope that was informative. I hope you know more
5 about health insurance now than you did half an hour ago and
6 thank you for the chance to share. Questions -- are we going
7 to do questions after Bret?

8 CHAIR HURLBURT: I've got a question and part of it is to
9 help us understand the economics and how it works. You've
10 talked -- and I've heard you talked before about a one percent
11 profit margin and you don't have the same level of new
12 technology, cost demands that Pat will have, say running a
13 hospital, but you do (sic).

14 How can you operate at one percent and meet that? Is it
15 because the Blues (sic) generally have pretty good reserves
16 and you can tap into that for your cash and then amortize it
17 as an expense? It's just, you know, from my experience, even
18 in a nonprofit, I would say, "Why is Jeff still in this job 20
19 years later with a one percent profit margin?" It just -- it
20 seems impressively low to me.

21 COMMISSIONER DAVIS: Thank you. That's a great question
22 and that has not always been what we needed to get. There was
23 a period, some of you will remember our desire to convert to a
24 for profit, because again, worst of all worlds, taxable state
25 level, taxable federal level, no access to equity. So that

1 was a problem and the state, both states in their wisdom said,
2 "No, thank you."

3 So what we had to do is we had to actually drive greater
4 margins, two to three percent, for a number of years to build
5 reserves. Well, we've built our reserves to where we think we
6 need them to be. We've built our business, also, up from
7 about a million people to 1.7 million and we think we're on
8 our way to 1.8 pretty quickly. So we have greater economies
9 of scale.

10 We've also applied the Toyota management system. We call
11 it Lean, but it's our Kaizen and what we've been able to do is
12 drive our administrative costs down as percentage of the total
13 dollars. We've significantly moved that down, rough numbers,
14 we've started our Lean journey about six or seven years ago.

15 If we had not gone -- and we applied it to claims, first,
16 because that was the most like a production environment, like
17 building an automobile, that we had. We wanted to learn and
18 if we had not applied it with our current -- if we were still
19 at the same level of productivity with our current client
20 load, we would be employing another 300 people to pay claims.

21 So we have significantly -- you know, it's 300 people who
22 are not drawing a salary and 300 people that our clients are
23 not paying for. So I think the answer to your question is
24 multifaceted, Dr. Hurlburt. It's because our reserves are
25 adequate, because our business is big enough that we can --

1 and the economies of scale are great enough that with that one
2 percent, we can continue to build the infrastructure and
3 continue to build the reserves that we need.

4 COMMISSIONER CAMPBELL: Two questions, I'm astounded that
5 your overhead figure is as low as it is, because when I was
6 Chairman of the Board, we'd scream if it got up around nudging
7 10% and that was before a lot of this technology, I'm sure,
8 but in this age of low interest rates, have you had to adjust
9 rates to overcome what, you know, in the days of six to 10%
10 interest, it was really, really, really comfortable for your
11 reserves and this low interest (sic) has got to be
12 uncomfortable in your planning.

13 COMMISSIONER DAVIS: A good question and I'm glad you
14 raised that because often people think in those terms. It may
15 have been back when you were Chair that those were -- that was
16 a considerable part of the net income to the organization.

17 We operate the business as -- to be self-sustaining. So
18 we operate based on the -- the one percent is our operating
19 margin. That is before any reserves. We don't -- we don't
20 count on or budget any investment gains.

21 We run the plan to generate a one percent operating
22 margin. So it does not affect how we set rates. It does
23 affect reserves, which is good, because it continues to add to
24 reserves and adds to net worth and that's been part of what's
25 helped us through the journey is some -- to where we are now

1 from the reserve point of view to get there is because of
2 prudent investments.

3 COMMISSIONER HIPPLER: So you had mentioned that you gave
4 the example of a house on fire and you buy insurance when it's
5 on fire. Will people be able to obtain insurance from you in
6 a manner similar to right now, if they're using ACHIA. Will
7 ACHIA just go away? Will you take over that market, and I'm
8 honestly curious if the state's projecting 44% utilization for
9 that market, how come ACHIA has such a small market
10 penetration?

11 COMMISSIONER DAVIS: Thank you, good questions. So a
12 couple of things, I think there's another question kind of
13 implicit in what you're asking, which is; can people, as our
14 actuaries call it, "jump and dump," you know, can they jump in
15 when they need their surgery and then dump it? They can.
16 They will and they will do that.

17 There's a federal preexisting condition pool that is
18 operated by ACHIA, has been since, I think it was in July of
19 '11, and that is, in fact, what we've seen there. I happen to
20 be the Chair of the ACHIA Board. ACHIA is the Alaska
21 Comprehensive Health Insurance Association. It's the -- or
22 also known as the high risk pool.

23 So we were asked by the Governor to administer with a
24 firewall, separately administer this federal -- they called it
25 the Federal Preexisting Condition Pool. So it was guarantee

1 issue with no preexisting condition exclusion. So it pretty
2 much looked like 2014, and we've had 40 people in the plan
3 consistently, but it's been different 40 people.

4 In fact, we had one of our participants come and talk to
5 the Board last year at the ACHIA annual meeting and say, you
6 know, "I came and paid my premium and I got my total knee for
7 a quarter of a million dollars done and then I had to drop
8 coverage because it was too expensive. Can you make it less
9 expensive?" We were like, "Sure."

10 Anyway, so the net result of that is that the per member
11 per month cost in the preexisting condition pool has been
12 \$12,000 a month because people are jumping and then dumping.
13 That particular person stayed three months and got a quarter-
14 of-a-million-dollar knee and said, "Oh, and I'll be back when
15 I need to get my other one done."

16 Just parenthetically, the federal preexisting pools were
17 funded with five billion dollars for the Affordable Care Act.
18 That -- they're running out of money and we're kind of on
19 notice, that you know, it could be shut down early. We will
20 shut it down early if we have to. It's supposed to go away
21 January 1st of '14, anyway.

22 Now, to ACHIA, the state ACHIA, there are about 500
23 people in the state ACHIA. I think the reason -- if you look
24 at 44,000 in the exchange, Allen, the difference is the
25 federal subsidies.

1 ACHIA provides access, but not necessarily affordability
2 and the Affordable Care Act is supposed to be access and
3 affordability for the -- at least for those who are
4 subsidized. So we've got about 500 people in the plan today.

5 The Board, with the agreement of the Division, because
6 the ACHIA Board operates under the auspices of the Division of
7 Insurance. Director Hall was here when this decision was
8 made, not Director Kolb, but the Board -- our laid out guiding
9 principles was that our first, and most important guiding
10 principle was the welfare of the people who are being served
11 today, so made the decision that we would do nothing actively
12 to dissolve the pool for that reason, primarily, but also, a
13 second reason is that were the pool to dissolve, our
14 individual market is small enough that those 500 people
15 pouring into the individual market would have a significant
16 impact upwards on rates.

17 So ACHIA will continue for the foreseeable future. The
18 fact of the matter is, unless our colleagues in the
19 Legislature change the statute to make it go away, it will
20 continue on indefinitely. We have no authority to discontinue
21 it. So it will continue on. We anticipate some of the
22 current participants will leave and move to the open market,
23 because of subsidies, if they're subsidy-eligible.

24 We think that a number will stay where they are because
25 it's interesting, high risk pool coverage is deemed to be --

1 get you away from the tax penalty. It's qualified coverage
2 for purposes of the federal tax penalty.

3 So I can -- if I am in the high risk pool with my 10,000-
4 dollar deductible plan, I can keep it, rather than moving into
5 the market where that's not available to me and paying for a
6 richer plan. So we think some will make that decision. So
7 we're going to just let the market forces take over and see
8 what happens. There's just too much unknown.

9 Other states, Nebraska, for example, are shutting their
10 pool down on January 1st and I don't think that's prudent, but
11 that's just me.

12 CHAIR HURLBURT: Okay, Jeff, thank you very much. It was
13 interesting and we'll move on.

14 UNIDENTIFIED VOICE: (Indiscernible - too far from
15 microphone).

16 MR. KOLB: I should be able to get us (indiscernible -
17 too far from microphone) schedule, so I'll keep my comments
18 brief. A lot of the things that you're going to hear me
19 say.....

20 UNIDENTIFIED VOICE: (Indiscernible - too far from
21 microphone).

22 MR. KOLB: Sit down and speak into the microphone, all
23 right. As I was saying, I'll do my best to get us back in
24 line. A lot of the things that I have to say are very, very
25 similar to what Jeff has just shared, but we'll go ahead and

1 get going with that.

2 Again, I'd like to thank you for the opportunity to speak
3 to the Health Care Commission. As was mentioned before, you
4 were used to seeing someone who looked a little different than
5 me, and that being Linda Hall. To that end, I'd like to give
6 a very brief introduction.

7 I moved to Alaska. I was actually looking at it last
8 night, three years ago today I left New York to come to Alaska
9 and I'm not planning on leaving. We'll put it that way. I
10 became the Director of the Division of Insurance just a little
11 over one year ago.

12 Prior to that, spent about 20 years in the health
13 insurance industry working in operations and management
14 dealing with a lot of the things that we're facing today, but
15 from an operational management point of view. So I think it
16 definitely has -- is timely and is something that will be used
17 a lot.

18 As I know the committee is aware, the cost of health
19 insurance and the cost of health care are two different
20 things. They're very related. They definitely tie to each
21 other. The cost of health care feeds into the cost of
22 insurance and today, my comments are going to be focusing on
23 the health insurance rate or the cost of health insurance, as
24 that's what the Division of Insurance actually does regulate.

25 A lot of bullet points that appear, but I can sum these

1 up into three items. One, we're going to look at an overview
2 of the marketplace today here in Alaska. Also, we're going to
3 look at a little bit about how the rate review process works
4 and thirdly, we'll look at some of the impacts that we
5 anticipate seeing, although, I don't think we'll have them all
6 spelled out for years to come, but of the Affordable Care Act
7 and we'll look through those and try to cover those at a high
8 level.

9 Again, as I said, some of the things that I'm going to
10 discuss, Jeff has already talked about and are not going to be
11 all that new. The next three slides that we're going to look
12 at are very similar to something that was brought to this
13 Commission back in March of last year by Linda Hall. I've
14 updated them with 2012 information.

15 The first here is about the individual market share here
16 in Alaska. What this shows is who are the carriers, who are
17 the dominant carriers that are providing the coverage for the
18 insured individuals in our marketplace? Individual health
19 insurance, typically, is purchased by a single person. It's
20 purchased on the public market and is available either for
21 that individual or for their immediate family.

22 As illustrated in this slide, approximately 55 million
23 dollars in premium in 2012 was related to the Alaska
24 individual market alone and that covered approximately 13,500
25 lives here in Alaska.

1 Premera is the -- has the majority of that market share
2 with the other 24% split up among the five other carriers that
3 are listed. So the individual marketplace is about 55 million
4 on an annual basis.

5 A second part of the marketplace or of the market that we
6 have here in Alaska is the small group market. Now, the small
7 group market -- group health offered by employers or
8 associations or trusts or other allowed groups of people, and
9 that's defined by statute as to who is a group, what can be a
10 group, and in group insurance, you could have small groups or
11 large groups and those are also defined very specifically.

12 As we saw on one of Jeff's slides, the small employer is
13 made up of two to not more than 50, or two to 50 employees.
14 As you see on this graph, the small group marketplace is about
15 118 million dollars in premium and that marketplace covers
16 about 17,000, roughly 17,000 lives in 2012.

17 Again, Premera, in this case, is the largest offerer or
18 provider of that with about 50% of the market share and then
19 the additional 41% is split among the other seven, primarily
20 between the other seven providers that are listed here.

21 One thing that was noted also, both the individual and
22 the small group insurance is what will be available in 2014 to
23 be offered on, as well as off, of the exchange, but that's
24 what these two parts that we've looked at, that's who will be
25 served in 2014, potentially, by an exchange or as it's now

1 being called, "The marketplace," which is different than the
2 marketplace (sic). Nothing like confusing terms a little bit
3 more, but again, that is the small group marketplace.

4 The other aspect of our -- of the coverage that's offered
5 is the large group. One thing I want to make very clear on
6 this, this graph represents the insured large group, fully
7 insured. This is not self-funded. This is not the state
8 plans. This is not your large group employers that are -- we
9 typically refer to as ERISA type employers.

10 These are full insured large group plans and if you were
11 to factor in all the self-funded, the graph would change
12 dramatically, but with just looking at the insured market,
13 which is what the Division of Insurance typically looks at,
14 we're looking at 220 million dollars in premium in this market
15 and approximately 34,700 covered lives in 2012 from the
16 insured, fully insured large group marketplace.

17 Large group insurance will not be offered on the exchange
18 until, theoretically, 2017. We'll see. 2017 is a long way
19 away. So we'll see what happens between now and then and how
20 that all plays out. So that's a little snapshot of our
21 marketplace and how things look as of 2012.

22 Health insurance regulations, as was mentioned, beginning
23 January 1st, 2012, all insurers writing health care insurance
24 in Alaska do have to file their rates with the Division of
25 Insurance. Rate files are reviewed by our filing section.

1 Generally, the standard that is applied is, as was mentioned,
2 cannot be excessive, cannot be inadequate and cannot be
3 unfairly discriminatory.

4 So those are the standards that we look at. Rates must
5 be actuarially justified and must meet those guiding
6 principles or those general requirements in order to be
7 approved. Rates, typically, are filed at least 45 or they
8 have to be filed at least 45 days before being effective and
9 technically, they cannot be filed more than six months before
10 the proposed effective date, but due to deadlines imposed by
11 the Affordable Care Act, it's pretty hard to file rates that
12 have to be approved by July 31st that go effective January 1,
13 and not do it at least more than six months in advance. So
14 that has been waived for those policies or those plans that
15 are being offered or potentially to be offered on the
16 exchange.

17 The state is in the process of reviewing filings that
18 have been made for plans to be offered on the exchange. We do
19 have a deadline that's been imposed of July 31st, and we will
20 -- we see no issue of meeting that deadline of getting those
21 filings reviewed and making those available for the open
22 enrollment, which would start October 1st of 2013.

23 Just a little -- one other thing, just looking at the
24 most recent rate filing, rates vary a lot between individual
25 plans, between group plans, between different carriers. In

1 2013, we saw rates ranging between zero to 25%. On the
2 individual side of things, between a seven percent reduction
3 and a 10% increase in the small group plans and again, a lot
4 of that is by -- based on plan features, things that are
5 included, various drivers of that nature.

6 Rates are driven by a variety of factors. I've listed
7 four things here that we saw in our most recent rate filings.
8 The first three are common. We see them -- we've seen them
9 before, that is your provider payments, your provider payment
10 levels, your utilization of health care and any mandated
11 benefits. That's not that uncommon.

12 The fourth one, ACA fees, was new and we expect to see
13 that increasing as things go forward, as the rates and the
14 different fees, taxes, different things that are applied do
15 come into play as the years roll forward. With the
16 implementation of the Affordable Care Act, those things will
17 be more evident and growing into our rate filings and the rate
18 filings that we see here in the state.

19 I won't go over -- I couldn't cover all the different
20 things that are going to be affected by the Affordable Care
21 Act that will drive into our rates. Again, some of these were
22 mentioned earlier.

23 Some of the things that we look at is this may be a
24 positive thing, essential health benefits. That sounds good.
25 Here's 10 things that have to be covered, but as was mentioned

1 by Jeff, the fact -- what that is going to do, what that
2 potentially will do is it causes people who had choice before
3 to say, "I don't want maternity benefits. I don't need
4 maternity benefits."

5 Well, now they have to have maternity benefits if they're
6 going with a plan on an exchange or the parallel plan of, that
7 has to affect cost. If you're going to have to provide
8 coverage for something that someone had a choice to exclude
9 from, by choice, that's going to cost. That will come into
10 play.

11 Another one, the rating restrictions, again, that was
12 mentioned, you could go into a deep actuarial discussion. I'm
13 not an actuary, don't even want to be one, but of rate
14 compression, as was talked about, a six to one or a five to
15 one, down to a three to one. What that's doing, rates used to
16 be able to be spread wider based on age. Now they're having
17 to be compressed.

18 So the people at the higher end, instead of having
19 different layers as they got higher, are now in a broader
20 band, but that affects the lower end also. That is going to
21 be good for some, bad for others. As Jeff illustrated, who --
22 how is that going to affect me, personally, there's a lot of
23 questions to ask. Who are you? What plan are you getting?
24 What's your age? What benefits do you have, things of that
25 nature.

1 So again, between that, the federal taxes, the taxes and
2 fees that are being imposed, all of these things are factors
3 of the Affordable Care Act that have to go into the premium
4 calculations that have to be looked at by plans and then by
5 states that are looking at and reviewing rates and they factor
6 in and function into the cost of health insurance.

7 As I mentioned, the Division has currently received rate
8 filings. At this point, we've received filings from two
9 carriers. As Jeff mentioned, Premera is one of those carriers
10 that has filed with us. We're in the process of reviewing
11 those. We expect to have those completed, our review, by no
12 later than July 31st and those rates would be effective on
13 January 1st of '14.

14 Keeping in mind, rate filings are confidential until
15 they're effective. So the state can't necessarily be talking
16 about those until they become effective. So how that will
17 look -- how people will understand will be interesting.
18 That's one of the questions I've been faced with by a lot --
19 what's it going to cost us? I don't know. I'm not sure.

20 I don't even know who the federal government, who is
21 doing the federally facilitated exchange, who they're going to
22 put on the exchange or not put on the exchange and so a lot of
23 questions are out there. I trust in the months ahead, we'll
24 start to get more answers. That's everyone's hope, I know,
25 both consumers, providers, carriers, government, everyone,

1 we're all affected by this.

2 The Affordable Care Act also has an impact on the
3 premiums and the cost paid by Alaskans. As was mentioned,
4 there are opportunities for subsidies for certain people who
5 qualify under the 400% poverty level.

6 There's opportunities for different cost sharing and cost
7 sharing reductions, depending on where people fall in those --
8 in that range. That will affect things. It may help reduce
9 some of the overall cost, but depending on people's
10 qualifications and where they qualify and if they qualify for
11 these different factors (sic) -- small employers, we haven't
12 talked a lot about employers.

13 A lot of the focus has been around individuals, but even
14 small employers will have the opportunity for qualifying for
15 some tax credits that may help them on a going forward basis,
16 again, if they qualify.

17 The Affordable Care Act also offers the possibility of
18 multi-state plans. At this point, we've heard of one carrier
19 interested in possibly being a multi-state plan. That could
20 change in future years. That carrier may decide not to.
21 That's an open question. Again, that's not a decision that we
22 have an answer to at this point.

23 Though, I've only mentioned that there's two people
24 offering on the exchange, we have made -- it has been made
25 clear to us that the other insurers that are active in our

1 market, I have heard of no one who's not intending to offer
2 just off of the market, as they had done in the past.

3 We haven't seen any filings for those. We shouldn't have
4 seen any filings for those, because it's more than six months
5 out before the effective date. So I anticipate, as we get
6 closer into the fall and into the latter part of the year, we
7 will see filings in our normal course of business as we have
8 in the past and will be able to assess those and get those
9 reviewed in our normal process.

10 I mentioned stop loss insurance trends. That's one of
11 the things the Division will be paying attention to. What
12 that involves is, as employers, smaller employers are looking
13 at how to in some way avoid some of these costs of the
14 Affordable Care Act, they may be looking at self-insuring and
15 looking at the opportunities of backing themselves up with
16 reinsurance or stop loss insurance. We'll be watching the
17 trends of that to see how that plays out, if that impacts the
18 marketplace and where that goes.

19 You know, inclosing, the challenges, they face us all.
20 They face health care providers. They face insurance
21 companies and they face us, as consumers. It's fairly
22 daunting. I can expect that the health care costs, as those
23 increase, as the implementation of the Affordable Care Act
24 continues, that this will continue to have an impact, not
25 necessarily a positive impact, but an impact on health

1 insurance rates, unless something can be done to figure out a
2 way to manage those, which is what I think a lot of the one
3 aspect of it, the health care costs, this Commission is trying
4 to look at (sic).

5 So again, I appreciate the chance to speak with you. If
6 there's anything I can answer for you, I can attempt to.

7 CHAIR HURLBURT: Sorry, Pat.

8 COMMISSIONER BRANCO: You mentioned midway through about
9 the uncertainty of the numbers of people that will actually
10 fall into eligibility or participation in the exchanges. I've
11 heard anecdotally that a number of employers across the state
12 are thinking of weighing the benefit or the penalty and then
13 dumping their employees onto the exchange if it's a fair and
14 equitable opportunity, thus reducing the employer's cost,
15 shifting that cost to others.

16 Do you have -- I know you've already said you don't know
17 the numbers that will -- that may be impacted. Are you
18 getting any sense of that and what the impact might be?

19 MR. KOLB: At this point, I am not. I haven't seen that
20 much of it. I've heard a lot of discussion around that, that
21 is definitely a risk or a decision point that some may be
22 considering.

23 How that plays and what it actually looks like, as Jeff
24 mentioned, I think our next couple of years are going to be a
25 roller coaster. I've had several people ask, "So, we'll know

1 what everything looks like as of January 1?" No. No. We'll
2 know what it looks like as of January 1, and then it will
3 change from there, so.....

4 CHAIR HURLBURT: Bob.

5 COMMISSIONER URATA: I'm sorry. Do you know, under the
6 Affordable Care Act whether the state plan, insurance plan,
7 will be taxed, because it's too good, sort of like a luxury
8 tax?

9 MR. KOLB: Go ahead, Jeff.

10 COMMISSIONER DAVIS: So I don't know the specific answer
11 to that. I don't think it is today. Maybe Jim knows, but our
12 actuaries say that in Alaska, all roads lead to the Cadillac
13 tax. When we look at any of our plans and project them out to
14 -- with the impacts of the act and just what we expect in
15 trend, and unless something changes, they will all hit that
16 level.

17 CHAIR HURLBURT: Keith and then Dave.

18 COMMISSIONER CAMPBELL: You mentioned the stop loss and
19 it's likely to be more popular and I can see why it would be.
20 How do you handle that reinsurance, (indiscernible - voice
21 lowered) or generally, these reinsurers? Do you get a look at
22 that or a say in that particularly rate setting?

23 MR. KOLB: We do look at the rates that are filed in the
24 state. So we would be looking at that. As far as how someone
25 is actually using is, a small employer going out and getting

1 that, we don't look at that piece of the transaction between
2 the company, the small employer in Alaska and their reinsured,
3 but we actually do look at the products that are offered in
4 the state.

5 CHAIR HURLBURT: David, yeah (affirmative).

6 COMMISSIONER MORGAN: Yeah (affirmative), I guess I'm
7 kind of going back to the Cadillac tax. I'm looking at a
8 summary of individuals above \$10,200 a year, that's the total.
9 That's what the employer and you pay, added together, like a
10 1099, and twenty-seven-five (sic), the number I got from this
11 National Insurance Institute, or whatever it's called, we
12 could have as many -- as high as 50% on this.

13 My question was; is this done on the individual tax
14 return like your -- you get a 1099 or is it done inside the
15 marketplace/exchange, assessed and then put onto the cost of
16 your insurance? I was wondering how that -- how that -- now,
17 you haven't -- we -- the exchange now has an extra duty, tax
18 collector, I guess maybe.

19 COMMISSIONER DAVIS: My understanding, David, and as
20 Director Kolb has said, everything is going to change, but my
21 understanding today is it's a non-deductible 40% excise tax on
22 the difference between the ceiling and the amount that's
23 actually paid.

24 Employers are going to have to report the value of the
25 health plan. So presumably, individuals are going to have to

1 do something like that or the exchange would do something, but
2 employers will be required to report.

3 CHAIR HURLBURT: I have two questions. One, are the
4 ERISA plans subject to the Affordability Care Act tax and
5 under the federally operated exchange, will your relationship
6 to the plans that are offering the exchange coverage be
7 essentially the same as they are in the commercial plans now?

8 MR. KOLB: Okay, as far as the ERISA plans, again, we're
9 looking at the insured plans that are dealing with the
10 Affordable Care Act (sic). As far as the relationship, I
11 think that's an important point and I know a lot of people
12 have asked that.

13 Our role as the Division of Insurance, we still regulate
14 the insurance that's offered in our state. So because, as the
15 Division, not every state has this opportunity, we, as the
16 Division, have been given by the Legislature the authority to
17 review rates and form filings for all health insurance.

18 So we have the opportunity and we have that connection
19 and we are reviewing that. The state has been deemed by the
20 federal government as an effective rate review state, which
21 means our rate review, in some cases, their act -- the fed --
22 the federal government is actually looking at our rate reviews
23 to determine -- if we have done them, they're seeing them as
24 credible and useful.

25 So our relationship will continue with the insurers in

1 the state and we will interact with them. Now, if there are
2 issues with something offered on an exchange, it really
3 depends on the specifics of what the issue is and what our
4 role would be in that.

5 CHAIR HURLBURT: So the ERISA plans are not subject to
6 the ACA tax, is that correct?

7 UNIDENTIFIED VOICE: The tax?

8 COMMISSIONER DAVIS: No, it's my understanding, they are,
9 Dr. Hurlburt. They are subject.....

10 MR. KOLB: They are (indiscernible - speaking
11 simultaneously).....

12 COMMISSIONER DAVIS:to the reinsurance tax and the
13 insurer tax. That was -- we knew about the reinsurance tax,
14 but the insurer tax is kind of a new finding, still not
15 subject to, you know, state premium taxes, those sorts of
16 things, but will be subject to those two.

17 MR. KOLB: Sorry.

18 CHAIR HURLBURT: Okay, thank you.

19 COMMISSIONER DAVIS: And I think the effectiveness
20 research tax, as well, the head tax.

21 CHAIR HURLBURT: We.....

22 COMMISSIONER PUCKETT: (Indiscernible - too far from
23 microphone).

24 COMMISSIONER DAVIS: Pardon me.

25 COMMISSIONER PUCKETT: Subject (indiscernible - too far

1 from microphone).

2 COMMISSIONER DAVIS: Yeah (affirmative), yeah
3 (affirmative), got to have an acronym for everything.

4 CHAIR HURLBURT: Thank you, Brad and Jeff, both very
5 much. That was very helpful to us and Deb, we'll turn it back
6 to you for the next section. We've been running a little late
7 all morning, so.....

8 MS. ERICKSON: Gunnar, do you want to come up and join us
9 at the other end of the table or you could come up here, too.
10 It doesn't matter. Barb, could you switch to -- well, this is
11 going to take me a second. While he gets settled, I'll do it.
12 I was going to ask you to do it, but.....

13 UNIDENTIFIED VOICE: (Indiscernible - too far from
14 microphone).

15 MS. ERICKSON: I'm good, yeah (affirmative), and
16 actually, you could take that back. Okay, we're just in the -
17 - tracking our prior recommendations and also looking at other
18 related initiatives and I invited Gunnar Knapp, who is the
19 Interim Director of the Institute for Social and Economic
20 Research at UAA, to come joint us because we've been having
21 some conversations about the effort there to develop capacity
22 to do research to support policy decisions related to health
23 and health care and so I asked Gunnar to come share just a
24 little bit about that with you all, because it's been a
25 particular interest of this group, as in having more capacity

1 to do health economic research in the state and I'm also
2 talking with Gunnar right now about a particular project that
3 I wanted to share with you, but Gunnar, do you want to just
4 explain a little bit about what your vision and plans are?

5 MR. KNAPP: Sure. Hi, everybody. My name's Gunnar
6 Knapp. I'm the Interim Director of the UAA Institute of
7 Social and Economic Research or ISER, actually -- probably
8 quite soon to become Director.

9 I've been an economist working in Alaska and studying
10 Alaska -- Alaska's economy and society at ISER for the past 32
11 years and six months ago, I moved into this director position
12 and in that capacity, I've been thinking quite a lot about
13 ISER and what we do and the kind of research we do and what
14 are our critical strategic research areas?

15 Now, some of these, in the past, you may be familiar
16 with. We -- among our strategic research areas are Alaska
17 fiscal policy, Alaska energy policy, you know, my own major
18 field, especially, has been the seafood industry and so on,
19 but I've long been convinced since well before I became
20 Director, and especially now, that we need to make Alaska
21 health economics and health policy a major strategic research
22 focus for ISER and I'm very committed to doing that and why?

23 I think the reasons are obvious. This is health care and
24 health costs and so on are critically one of the most
25 important issues facing our nation and facing our state.

1 Secondly, the issues associated with health care are
2 intricately connected with other issues facing the state.
3 It's not -- the health care issues that we face are not just
4 about health care.

5 They tie into the entire economic future of Alaska, the
6 cost of doing business here, the future opportunities for our
7 smaller communities in the state and so on. Health care is
8 tied in with everything else and in our role at ISER at
9 understanding Alaska's economy and society, this is a critical
10 part of it.

11 Thirdly, as with many other areas, I feel it's important
12 that Alaska have in-state capacity to study these policy and
13 economic issues, not necessarily at ISER, but I -- but --
14 although, I think ISER's a logical place for this, but in
15 general, I think it's important for us to have people in the
16 state who work on a regular basis with these complex economic
17 issues, in part because the national groups that specialize in
18 these issues and do this work, you know, often are very, very
19 capable and they have the nationwide perspective and
20 expertise, but often they do their research and then they go
21 home and when, you know, they're not there sort of all the
22 time to participate in the discussion and in addition, they
23 may not understand the various subtleties of Alaska and why,
24 you know, why we're different and what's unique. So I think
25 it's important to have people engaged in these issues in the

1 state.

2 Now, we've been involved, actually, in health economics
3 research and health policy research on an occasional basis for
4 a long time and so for example, in the past few years, ISER
5 did these two studies, with which you may be familiar,
6 Alaska's Health Care Bill, 7.5 Billion and Climbing, that
7 looked at, you know, what are the costs in Alaska and who pays
8 them, and another study on primary care access for older
9 Alaskans and so on.

10 So we have quite capable people on our staff who know how
11 to do this kind of research. What -- the main difference
12 about where we're going is, I think we need to be involved in
13 this on a regular and continuing basis. That's how you get
14 the knowledge of the data and the knowledge of the kind of
15 very detailed things you guys have been talking about in this
16 meeting that enable you to be good and effective at doing
17 this.

18 We are presently in discussions with Deb about research.
19 We could do focus -- specifically on the concerns facing
20 Alaska's private sector employees with regard to the cost of
21 health care, what they're doing with regard to insurance that
22 they're offering for their employees and in general, their
23 perspectives on the issue they're facing and what their plans
24 are and how they're likely to react to these changing
25 circumstances.

1 In conclusion, I'd like to simply say, that you know, our
2 mission at the University, in general, and at ISER, in
3 particular, is to, you know, serve the needs of the people of
4 the state. We'd like to do that in any way that we can, at
5 any time, both for the Commission and anybody else that's
6 interested in these complex health economics and health policy
7 issues.

8 We are very willing to discuss what are the issues that
9 need study, how those issues could be analyzed, you know, sort
10 of you're welcome to call us up anytime. We're happy to, you
11 know, talk with you about those kinds of things.

12 We're available and willing to participate in these kinds
13 of analyses when it's helpful and useful and we're very
14 interested in partnering with other people, both in the state
15 and outside the state in helping with that kind of analysis.

16 One final comment, simply on the topics you -- or one of
17 the topics you've been discussing at this meeting, in any kind
18 of policy research that you do and economic research that you
19 do, what you can do is critically limited by the kind of data
20 that you have available and in particular, in understanding
21 how Alaska's sort of health policy and health cost situation
22 is evolving and what's driving it and how it's likely to
23 change in the future, our ability as a state to understand
24 this and the ability of anybody, whether it's ISER or outside
25 groups or someone to analyze these questions, will be limited

1 by the kinds of data that somebody is collecting and that are
2 available for analysis.

3 You know, I read with considerable interest this, you
4 know, Milliman study, which I think is quite valuable,
5 provides a lot of useful information, and yet, I was struck,
6 as I am so often when I read studies of issues we face in
7 Alaska in general, by how many times they had to qualify and
8 say, you know, "We were limited in the way we look at this.
9 Here's how we got the data." It's, you know, it's sort of --
10 the data that they had access to were not ideal for answering
11 the full range of questions that we face.

12 I do think, that you know, I'm not a health care
13 economist or specialist myself, but my -- all my instincts are
14 -- I'd want to learn more about it, that the all-payer claims
15 database, if you were moving in that direction, could very,
16 very substantially improve the ability to understand, you
17 know, the nature of what's driving costs and how costs may
18 change in the future and what public policies would be
19 effective in addressing those.

20 So thanks for the opportunity to talk and I'm, you know,
21 you're welcome to call -- call up anytime, talk to me at ISER
22 and our staff about these things and we'd be happy to try to
23 help.

24 MS. ERICKSON: Before you go, Gunnar, let's see if
25 anybody has questions for you and then I just wanted to

1 explain a little bit about the project that you and I are
2 talking about right now. Does anybody have questions, just
3 generally? Yes, Dave.

4 COMMISSIONER MORGAN: You've been to several of the
5 Commonwealth North Health Group that meets at 7:30 in the
6 morning, by the way, have -- are you going to be engaged in
7 that activity or in the writing of their report? I didn't --
8 now, I go, but I haven't heard how the report tunnels out of
9 the group yet.

10 MR. KNAPP: I, myself, am not a health economist or a,
11 you know, health care specialist. I've been privileged, I
12 might say immensely privileged to have had sort of personal
13 training in this by having the immense good fortune of having
14 had Dr. John and Betsy Tower pioneer Alaska physicians as in-
15 laws, you know, and being part of a family of medical
16 providers and so -- but other than that, I -- all of this kind
17 of question has been new to me.

18 So I thought if I want ISER, as a Director, to get into
19 this issue, I need to understand it myself and so I've been
20 taking advantage of every opportunity I can to try to learn
21 and the Commonwealth North study that's going on has been a
22 wonderful opportunity, you know, for me to do that.

23 So I intend -- so I'm trying to learn, but I also am
24 trying to try to participate in any way I can, you know, as my
25 expertise gradually builds up to writing that report and I'd

1 like to be involved in this discussion, but I have a long way
2 to go before I, personally, would dare to consider myself
3 knowledgeable about these issues, except that I do -- I would
4 say I tend to think like an economist and all my instincts as
5 an economist scream that part of the solution to these very
6 complex issues has to be to get people responding to price
7 incentives and having information about price and always
8 thinking about that as they make choices and that is a
9 critical thing that holds down cost in any industry.

10 When people don't have to look at costs, they don't and
11 when they do have to look at costs, you know, and have to pay
12 those costs or a part of them, then they do, and you know, so
13 I can offer that kind of instinctive thinking.

14 MS. ERICKSON: Other questions? Well, let me just take a
15 minute to explain what we've been talking about. One of the
16 kind of three policy areas that we've been -- had on our
17 agenda to consider this year was continuing conversation and
18 learning about what we could do to better engage and support
19 employers in their role in improving employee health and
20 health plan design and in conversations with some of the
21 leaders of the employer community, the suggestion was don't --
22 you should engage us in conversation about that and we can sit
23 down at the table together and I'm thinking about some ideas
24 of what we might do for our October meeting around that
25 question, but ultimately, what I believe you all would like to

1 get at, so this would be a good time to correct me or we could
2 continue the conversation, is you know, we had the initial
3 learning.

4 We laid out some recommendations this past year that the
5 Department of Administration could consider should be
6 supported in the work that they're doing and to provide
7 leadership for the rest of the employer community.

8 The one other policy area for the state that we
9 identified that could be supportive of the employers' role was
10 activity around price and quality transparency. So the next
11 question is; is there something more that state government
12 could and should be doing to support employers in providing
13 good quality health benefits and in supporting employee
14 wellness, and so to that end, in addition to -- in
15 preparation, I don't know if we'll be able to do it this
16 quickly, but in preparation for that October meeting, I was
17 thinking if we could conduct a survey of employers to get a
18 sense of what their issues and concerns and needs are, what
19 their knowledge is in the first place, that could provide some
20 good base level research and information and also -- and form
21 a continuing conversation with them.

22 In looking at this, I identified and was reminded that
23 there were a couple of studies in the past that were just more
24 about getting a handle on the numbers and distribution and
25 characteristics of employers who offer insurance versus those

1 who don't in this state and there was a study conducted by the
2 Department of Health and Social Services, a survey, with some
3 grant money in 2005, and the prior to that in 2001, the
4 Department of Labor and Workforce Development, and so what
5 we're looking at is actually using those as a starting point
6 so we don't lose the continuity of what we've learned in the
7 past from those two past studies and collaborating with the
8 Division of Insurance and with the Department of Labor and
9 Workforce Development to do a new study that would ask the
10 same questions, but that take into consideration all of the
11 changes in the environment and the opportunities for design of
12 employee health management programs to get a sense of what
13 employers in Alaska today know about those opportunities and
14 what they're doing with them.

15 So that's the conversation that Gunnar and his staff and
16 I are having right now, is talking about -- and one of the
17 things we identified, this really wouldn't be -- wasn't the
18 initial purpose for the study, but if we were able to launch
19 it this summer, it might provide a good updated baseline of
20 where employers in the state were at before the January 1st
21 implementation of the Affordable Care Act and then future
22 studies, if they were done consistently, might provide some
23 trend data on that. So I would welcome any questions or
24 comments on that and then we can move onto the next item.
25 Yes, Dr. Urata.

1 COMMISSIONER URATA: Doesn't the Affordable Care Act make
2 all that information moot?

3 MS. ERICKSON: No, I -- in what way?

4 COMMISSIONER URATA: In (indiscernible - speaking
5 simultaneously). Well, everything's going to change,
6 significantly change for employers and everybody else. So
7 what happened in 2003 or 2005 studies wouldn't be relevant
8 under the new law. Am I way overshooting on that?

9 MS. ERICKSON: Yeah (affirmative), I don't believe it
10 makes it moot at all, because the Affordable Care Act
11 maintains, and I think intends to maintain with the employer
12 subsidies that are also available and the employer mandates,
13 the penalties that will be associated for large employers with
14 not providing insurance for their employees.

15 The Affordable Care Act intends to keep employers engaged
16 in -- and there are also programs related to employee
17 wellness, so in both the employee wellness and providing
18 benefits for their employees, but the big question is; how are
19 all of these pieces of the puzzle with the Affordable Care Act
20 going to come together to change how employers are engaging in
21 improving health and health care for their employees, and so
22 everything's going to change, but what is the -- what we would
23 be researching is what is the impact of that change and the
24 result.

25 COMMISSIONER URATA: So then timing is important as to

1 when you start the study and such. So did you say that you
2 were going to start it after January 2014, or do it right now,
3 which I'm not sure is going to be helpful because it's before
4 -- right before it starts?

5 MS. ERICKSON: Well, we're -- the intention is to start
6 it as soon as possible and we still would be getting a picture
7 of what employers have -- chose to do in the year prior to the
8 Affordable Care Act.

9 So if -- what we might be missing is -- but we could
10 potentially craft some questions about this; is if employers
11 made a decision for this current plan year that we're in, six
12 months to a year ago, to change because of the Affordable Care
13 Act and the plans that they have in place for their employees
14 today are different than they were a year ago in anticipation
15 of the Affordable Care Act, we might have missed that.

16 COMMISSIONER URATA: As an employer, the only thing that
17 I've done differently is pay more money for my premiums.

18 MS. ERICKSON: So that's the sort of information we'd
19 get, is where you're at today. You haven't changed your
20 employees' health plans this year. You're paying more money
21 for them and so if we were getting a picture of where you're
22 at as an employer today and where employers, generally, in
23 Alaska are today, that's what we'd be getting and then a
24 future study could identify what's changed in terms of what
25 employers are providing and how they are providing it. Yes,

1 Jim.

2 COMMISSIONER PUCKETT: Have you gone as far as
3 determining what your baseline would be, what would be your
4 baseline year that you would go back to?

5 MS. ERICKSON: I don't think we'd be doing a
6 retrospective study. We'd be looking at current practice, but
7 we would be basing the research in part on the studies that
8 were already done in 2001 and 2005, so to identify whether we
9 could provide some trend data from those.

10 COMMISSIONER PUCKETT: And it would be comprehensive of
11 the employers in the state?

12 MS. ERICKSON: It's a comprehensive sample, public and
13 private, large and small employers.

14 COMMISSIONER PUCKETT: Okay, union health trusts and.....

15 MS. ERICKSON: Union health trusts, self-insured, yeah
16 (affirmative).

17 COMMISSIONER PUCKETT: Everybody, okay.

18 MR. KNAPP: The goal is to be perfect.

19 MS. ERICKSON: Very good. Thank you very much, Gunnar.

20 MR. KNAPP: Thank you.

21 MS. ERICKSON: I'd like to invite Lisa and Bev up now and
22 we're going to just have a real quick five-minute update on
23 the status of the Healthy Alaskans 2020 Initiative, and you
24 all have handouts that you received this morning of the
25 printout of the presentation that we'll be looking at.

1 MS. WOOLEY: I'm going to go fast, because Deb has now
2 given us our marching orders of five minutes. We will -- and
3 we know we're standing between things and the end of the day.
4 Deb, do you have control? Okay, thank you.

5 First, thank you to Deb for having us here. Thank you to
6 the Commission because you have remained engaged and that's
7 probably the most important thing that can happen with these
8 indicators and objectives as we move forward through the
9 remainder of the decade. Go ahead, Deb.

10 I'm Beverly Wooley with Alaska Native Tribal Health
11 Consortium, as most of you, I think I've met and Lisa Aquino
12 with the state of Alaska. Just to move on with this quickly,
13 here, you see the indicators that we have been or the
14 objectives and criteria selection that we have been using as
15 we've selected indicators going forward.

16 I want to point out that this criteria has been widely
17 shared so that people know what we were expecting as an
18 outcome looking at these indicators, we wanted to make sure
19 that there was a broad audience.

20 Everybody had a chance to weigh in on our community of
21 interest surveys with 1,500 to 1,800 people responding back.
22 We took that community interest -- we took the best data
23 available in the state. There were requirements around the
24 data that it had to be available, valid and reliable, and I have
25 to say that as we go through the indicators, some of our

1 frustration sometimes was, just as we heard Gunnar talking
2 about, the best data is still yet to be mined, let's just put
3 it that way, and so I was delighted to be able to hear part of
4 his presentation. I'm going to talk to him later, too.

5 So we knew it had to be data-driven. It had to be
6 community-driven. It had to be form -- health equity and
7 trying to really increase the overall population health of all
8 people in Alaska and go ahead, Deb, let's just move into it,
9 because we do have just a short amount of time.

10 I'm not going to read all of these. You have them in
11 front of you. We'll go through some of them as we go, but I
12 think the thing to realize is that this data, both from the
13 community and the hard data, went into packets that went to
14 advisory team members and our advisory team had 35 people on
15 it and we had it across sector, across jurisdictions, really
16 trying to pull in people from education.

17 We have -- the Lieutenant Governor's Office was there.
18 We had academia. We had folks working with poverty, teens,
19 elders. We really pulled in a wide group of statewide
20 partners to help us look at the data and what was going to be
21 most meaningful.

22 They went from hundreds, literally, of indicators down to
23 this final 25, and as we looked at those, we really tried to
24 pull in, as you'll see with the first one here, as an example,
25 reducing Alaska deaths from cancer, number one killer in the

1 state. It just needed to be there, but then as you move down
2 and you look at what was chosen, things such as looking at
3 tobacco, overweight and obesity for both our high school
4 students, as well as adults and with the obesity, even looking
5 at young children, these are things that contribute to that
6 cancer and if we're not working with those, then it's not
7 going to be achievable.

8 Go ahead, Deb, and leading up with that also, another
9 root cause we were looking at is physical activity. We will
10 be tracking the percentage of Alaskans who actually meet the
11 physical activity requirements. We'll be looking at both
12 adults who, if they're getting out and working (sic) with
13 their kids, hopefully, we'll build those values in early with
14 their children and then also looking at our adolescents to see
15 how that's paying off.

16 Suicides remain a horrible problem within Alaska and
17 certainly, it rates higher than anywhere else in the nation.
18 The next one, we know that highest group is in that age that
19 are 15 to 44 years of age. So not only will we track that,
20 but we will be tracking specifically that high risk age group
21 and then we know it's also growing in our elderly. We'll look
22 at those that are over 45.

23 Leading, again, to some of those root causes, we'll be
24 looking at Alaskans who are experiencing mental health (sic),
25 as well as how many of our youth are feeling supported in

1 their communities, and under that, we have indicators actually
2 looking at how many adults young people might have in their
3 life that they feel they can go to for help. These are things
4 that, again, have been shown to be very effective in helping
5 them to reduce the risk.

6 Go ahead, Deb, and here, we continue along that same line
7 of things that we know that can lead to suicide and that's
8 that -- early things in life and throughout the lifespan that
9 result in domestic violence and sexual assault.

10 Our young people and our elders throughout and really,
11 across the age that experience these violent crimes are known
12 to have much more risk taking behaviors that can lead to poor
13 health and poorer outcomes for them, their families and their
14 communities and then relating into that again, and we hope you
15 can see that this begins to relate one to the other, is the
16 alcohol dependence and abuse, which again, is a major problem
17 in many areas of the state.

18 Looking at the percentage of people who are -- actually,
19 binge drinking has been shown by some of the experts and we
20 looked at other plans, statewide plans and they find that
21 binge drinking, both with adults and young people, is so
22 vitally important, not only in the alcohol dependence, but
23 it's often the binge drinking that's a preceptor to some of
24 the violence and the driving while intoxicated and some of the
25 other high risk activities they engage in and along with that,

1 is looking at unintentional injury.

2 We'll look at increased proportionate (sic), the Alaskans
3 who protect from vaccine preventable diseases. We know that
4 there are some diseases that are easily preventable through
5 vaccination. We'll continue to look at that and to focus in
6 efforts on those children that are 19 to 35 months of age and
7 really getting that best start in life.

8 Reducing proportion of Alaska experiencing infectious
9 disease, here, one of the rates of sexually transmitted
10 disease, chlamydia, has been really very high in Alaska. It
11 is an indicator of what's happening and many of the strategies
12 that will go into that will help to protect that young
13 population.

14 Increase in proportion of Alaskans with access to
15 (indiscernible - voice lowered) water home and wastewater
16 services, this was very interesting that we still, outside of
17 Anchorage, outside of the road system, we still have a
18 significant number of communities that don't have basic water
19 and sanitation and we have shown through research in recent
20 years that the increase in skin infections and upper
21 respiratory infections and hospitalizations as a result of
22 that are very important and to me, what was very exciting, is
23 when we did our statewide survey of our people across the
24 state, it came out as one of the top one across the state. So
25 others realize it, too. It's not just folks in rural areas.

1 People really understand that's a basic health necessity.

2 Certainly, we want to look at being able to protect
3 against dental carries. Again, we are leaders in the nation
4 in many areas. It is very preventable and one of the ways to
5 be doing that is working with having ultimately fluoridated
6 water systems within our water systems (sic).

7 Finally, here to the last couple, we have reducing the
8 proportion of Alaskans without access to high quality and
9 affordable health care and here, we have three indicators.
10 These are things, I'm sure, you've probably looked at more
11 than one way, some, all of them perhaps, looking at the
12 percentage of women delivering live births who have not
13 received prenatal care beginning in the first trimester.

14 We know this is important. It's not the end all in
15 knowing about access and quality, but it's a very important
16 indicator that's been shown to track how other health trends
17 are going.

18 Looking at the rate of preventable hospitalizations, I
19 think that's one that we have been told by industry and others
20 that if we don't do something about this, there's not going to
21 be money to do anything about anything else. So I was very
22 happy to see the group put this one on and again, I'm hoping
23 that Gunnar will be able to help us track some of these and
24 we'll keep working on having an economist, somebody at ISER
25 who is focused on that.

1 Then also, how many people, the adults, report they could
2 actually not afford to see a doctor in the last 12 months? So
3 we'll be collecting -- we're watching these trends between now
4 and the end of the decade on these and all of the indicators
5 and then finally, knowing if we really want to improve the
6 health of all of Alaskans, we really have to look at health
7 equity and health equity has clearly been shown to be around
8 some social determinants and two that really rose to the top
9 were in the areas of poverty, itself, as well as high school
10 education as a minimum and so if we can get them educated, we
11 can get them jobs, again, their health increases dramatically.

12 So with that, I know I went through these fast, but you
13 have them in front of you and please.....

14 COMMISSIONER BRANCO: I have one quick question for you,
15 and if you'll turn off your microphone, then it will actually
16 make me louder than I normally am. This is a tremendous list
17 and if we make positive impact on these, even most of them,
18 we'll have a profound impact on the cost of health care in our
19 state, in our nation, but I really want to draw everybody's
20 attention to number 13, because it's the first time I've ever
21 seen that in there and it's a less reported incidence by
22 adding girlfriends.

23 The female on male incidents of abuse, I think it's
24 really commendable to begin to acknowledge this does exist.
25 So thank you for that.

1 MS. ERICKSON: Go ahead, Lisa.

2 MS. AQUINO: Thank you. Thanks, yeah (affirmative). No,
3 thank you very much and I love that -- if we could take credit
4 for that, but a lot of that also is there's a national trend,
5 as well, and that's from a national data question that's asked
6 as a part of a statewide survey that we do, but we were so
7 happy to see that, as well. It's really important.

8 So just to quickly talk about our next steps and where
9 we're going from here, so you heard our 25 leading health
10 indicators. They really touch on so many aspects of overall
11 health for Alaskans. Our next steps are the creation of
12 targets for those 25 leading health indicators and that's
13 going to be happening over the next month-and-a-half or so.

14 During that same period, we're going to be really working
15 hard to collect evidence-based strategies from around the
16 state and there are sort of two ways that we're looking at
17 that. One is that we're doing a really thorough literature
18 search. We're going to be working with something to do that,
19 as well as collecting evidence-based strategies from people in
20 Alaska, who are actually working in communities to hear back
21 from them about things that are working.

22 Then our next step is this launch of our updated website
23 and that's really going to be the crown jewel as we move
24 forward in terms of our implementation. So this website is
25 going to be this interactive place where people can go and

1 they'll see these 25 leading health indicators that will be
2 tracked over time.

3 So they'll be able to go in and look at that data.
4 They'll be able to look at it in terms of different
5 demographics, in terms of their community or their region,
6 where it's possible. So they'll be able to really use that
7 data for their grants, for their community plans and it'll
8 also be a place where you can search these indicators in terms
9 of how they're connected to the statewide plans that exist out
10 there.

11 So a lot -- every community probably has a plan,
12 different individual programs have plans. So this website
13 will really connect those things, because we really believe
14 that implementation is about aligning and connecting with
15 what's already happening in the state and having all of us
16 work together and get behind these 25 leading health
17 indicators, because that's really where -- people are already
18 working so hard and many of them are working in these areas.

19 So it's just about communicating and getting us all on
20 the same page and as I say, the website is really the crown
21 jewel, the place where we'll be pushing people, but it's also
22 going to be a lot of the road show, the ANTHC and the state of
23 Alaska road show and getting out there with -- and all of the
24 partners.

25 It really depends on working with all of the agencies and

1 organizations from around the state to really make this
2 happen, but what -- we're also working on a final report from
3 our (indiscernible - voice lowered) where we talk about the
4 process that we've undertaken this year and then in FY14,
5 developing a comprehensive plan to establish a coordinated
6 effort and to reach these targets in this decade, so -- and
7 that's -- those are really our next steps.

8 This is just to talk about some other things we're doing,
9 but if anyone has any questions?

10 COMMISSIONER URATA: I noticed that drug abuse is not
11 listed or did I miss it?

12 MS. AQUINO: You (indiscernible - voice lowered).....

13 MS. WOOLEY: It is not listed. You are correct and there
14 are a variety of reasons. It was one that the public
15 struggled with as we heard things coming in from them. It was
16 things that are subject to matter experts and certainly, our
17 data team.

18 The bottom line is, we don't have good data. We -- the
19 national data that's available to us when we're looking at our
20 requirement that it has to be available. It has to be
21 statewide. It has to be state specific to Alaska and we were
22 looking at it also being able to be broken down by our
23 different regions, as well as by the different type of drugs.

24 Some of them that we're looking at, the national drug
25 (sic), they threw four and five drugs together. You couldn't

1 separate it out and you could not separate where it was
2 happening within your state.

3 So we went, then, to the folks doing SPF SIG, who have
4 been looking at the whole drug/alcohol -- and putting together
5 plans and that's where they said that one of the most
6 important things we could be looking at and reading their
7 reports that was determined by data in our target teams that
8 it was looking at binge drinking.

9 So when those came in, knowing that it's going to be
10 addressed through many of the things that we're doing and we
11 hope to do more.

12 MS. ERICKSON: Please.

13 COMMISSIONER URATA: Do other states have it listed, and
14 is it an important part of health Alaskans, just from your gut
15 feeling, even though you don't have data?

16 MS. AQUINO: Let me just -- yeah (affirmative), I think
17 that's a great question. Some other states do and if you look
18 at national -- at Healthy People 2020, where they have many
19 more than 25, there you'll see that drug abuse is addressed.

20 It was a tough call. Getting down to 25 was really
21 challenging and the choice between an indicator that addressed
22 drug abuse -- it was there. It was right up until the end or
23 nearly the end. This -- it was -- it was not easy to make the
24 decisions and a call was made and many factors went into that
25 call and one of them was the strength of the data, but it's

1 not easy to figure out -- I think that the consensus among the
2 advisory team, I think Beverly really captured that, that just
3 -- that the evidence-based strategies to address drug abuse,
4 many of them -- they're the same ones that -- they overlap so
5 strongly with alcohol abuse and some things and so that was
6 the decision that was made, but it really wasn't easy, and let
7 me just say that the ones that -- the indicators that might
8 not be up there that aren't in our top 25, that doesn't mean
9 they're not important and that doesn't mean that people aren't
10 going to be working on them and where data's available, we'll
11 certainly try to connect people with that data.

12 We just can't commit to as a part of Healthy Alaskans
13 2020 to make sure that data is absolutely tracked over time,
14 but absolutely, there's other people working in terms of drug
15 abuse and we will try to connect people with that existing
16 data wherever possible, because it is a really critical issue.

17 MS. ERICKSON: Well, thank you, both very much for
18 updating us on an important project and thanks for all your
19 work on it.

20 MS. WOOLEY: Thank you, Deb, and thank you to the
21 Commission. We do get reports with what you folks are doing
22 and back and forth and being able to work together as we move
23 forward. Thank you.

24 MS. ERICKSON: So Josh and Director Kolb, do you want to
25 come to the table? Commissioner, would you like to join us

1 right now or do you want to.....

2 COMMISSIONER STREUR: (Indiscernible - too far from
3 microphone).

4 MS. ERICKSON: And.....

5 COMMISSIONER STREUR: I will join the group, but one of
6 the things that I need to say right from the start is I'm
7 going to, for the sake of time, let them launch right into
8 their presentations and -- before I speak, so that they don't
9 have to figure out a way to say, "What the Commissioner meant
10 to say was," so with that, I'll turn it over to whichever of
11 you wants to take the lead.

12 MR. APPLEBEE: Well, good morning. I know Bret already
13 had a chance to kind of go over a whole bunch of things with
14 you in regards to the ACA and coming to this meeting is always
15 difficult. I get tasked with, "Well, we want an update on the
16 ACA," and that's impossible to do in a day, much less a short
17 presentation.

18 So I get the opportunity to find out -- to cull through
19 all of my notes, all of the research that's happened since the
20 last meeting and identify those few items that I think have
21 the biggest effect on what we're doing right now and there's a
22 couple that I want to bring to your attention today.

23 The first is the rising concern of the shortages of
24 primary care doctors as an effect of the ACA. The Doctors
25 Company, nation's largest physician-owned medical malpractice

1 insurer, did a survey of about 5,000 physicians nationwide and
2 some of the results were pretty outstanding.

3 Sixty percent indicated that the pressures to increase
4 patient volume will negatively affect the level of care, and I
5 don't think that's a real shock. The more you push through
6 the system, the less quality you can expect on an individual
7 basis, but nine out of 10 physicians were so disillusioned by
8 these concerns that they are actively discouraging their
9 friends and family from pursuing careers in medicine.

10 So I think what we're finding is that you just can't
11 change a system overnight. You can't put an additional demand
12 on a system and expect instantaneous good things to happen,
13 and this is one of many studies that have started trickling
14 out in concern to what's going to happen when the Affordable
15 Care Act gets fully implemented.

16 I don't know how many of you get information updates and
17 these emails that come in on a daily basis, but the General
18 Accounting Office recently came out with a report in regard to
19 the development of the federally facilitated marketplace and
20 specifically, in this report, they state how far behind they
21 are and how the concern of an October 1 implementation turn-on
22 date for the federally facilitated marketplace is of concern
23 to them.

24 Although much progress has been made and CMS has recently
25 completed risk assessment and plans for mitigating risks

1 associated with the federal data hub, they're really missing a
2 lot of their targets, a lot of milestones that should have
3 been reached in March are still outstanding. They don't know
4 if they'll actually have the ability to turn the switch on.

5 If you asked the people from CMS, the people from the
6 federal government, they will tell you, "We are on track. We
7 are ready. October 1 is going to happen and yes, there might
8 be some bumps, but we're ready to go," but the General
9 Accounting Office tends to disagree.

10 In their assessment, not only did they look at the
11 federally facilitated marketplace, but they also looked at the
12 17 states that are setting up state basic changes. Forty-four
13 percent of those states have not reached their milestones. So
14 it's -- I know the Commissioner uses the term "big rocks" a
15 lot. The federally facilitated marketplace is a big rock and
16 I think the federal government is finding out that it's
17 becoming more and more -- actually, it's becoming bigger and
18 bigger every day, that October 1 is going to be tough.

19 The other point that I wanted to make was about the
20 federal call center. The federal government has signed a
21 contract with a company called Vangent. They're out of
22 Arlington, Virginia. They currently provide the call center
23 support for Medicare. They handle about 60,000 calls a day
24 and they've been tasked by the federal government to take over
25 all of the phone calls that are going to come in on the

1 federally facilitated marketplace starting next month. I
2 know, I love the.....

3 UNIDENTIFIED VOICE: (Indiscernible - too far from
4 microphone).

5 MR. APPLEBEE: The estimates of what's going to happen to
6 these call centers is that starting in July, they're expected
7 to get 42 million calls by the end of the year, about 200,000
8 a day. They're expected to answer about 2,400 letters, 740
9 emails and 500 web chats a day, just on questions about the
10 exchange or the marketplace and about the implementation and
11 really, just general questions about the Affordable Care Act.

12 COMMISSIONER PUCKETT: Did I hear you right, 200,000
13 calls a day?

14 MR. APPLEBEE: That is the current estimate, daily
15 average of 200,000.

16 CHAIR HURLBURT: Jeff.

17 COMMISSIONER DAVIS: I can't resist. Well, how long does
18 it take to say, "I don't know." I mean, you don't have to
19 train people either, so.....

20 MR. APPLEBEE: I have a really good answer for that
21 (indiscernible - speaking simultaneously).....

22 COMMISSIONER MORGAN: Isn't it -- isn't it true from the
23 funding of -- fund the bridges through preexisting conditions,
24 which my understanding is it's out of money right now, but
25 haven't -- basically, they've missed everything through this,

1 either the deadline or many -- most estimates are off by a
2 third or a half through this whole journey down the road?

3 MR. APPLEBEE: I don't think it's fair to say they've
4 missed everything, but certainly, it's -- the delays are
5 compounding and it's becoming more and more difficult, as you
6 miss milestones and target points, to make that time up and
7 continue to move forward.

8 Jeff, specifically to your question, so what they've said
9 is that these are mostly going to be answers from a script.
10 They won't provide the script or even say that it's been run
11 by consumers yet.

12 This company is anticipated to add eight new call
13 centers. They're anticipating to triple their staff with a
14 cost of about 530 million dollars in the first year.

15 In addition to that, they've also contracted with Maximus
16 to help provide assistance to Vangent, but no one's willing to
17 comment on that contract. So there's a lot of things that are
18 going on and a lot of scrambling to try and make this effort
19 not seem so futile and so I wanted to get that in before Bret
20 talks a little bit more about the exchanges, only because it's
21 just -- we hear from the federal government, and you've heard
22 from us, these constant challenges and a continual beratement
23 of, "We don't know. I don't know or we're still waiting on
24 the answer for this."

25 These are examples of the sort of challenges that they're

1 facing that rolled down the hill to us when people say,
2 "What's happening with the federal marketplace?" Well, that's
3 what's happening with the federal marketplace. Do they have
4 the exact design of how we're going to interface with the
5 federal data hub? No. They have some ideas. They have some
6 preliminary outlines, but they haven't turned that switch on
7 and they haven't -- they say they're in testing, but we
8 haven't heard any results from those tests.

9 Certainly, they're going to get their call center up and
10 ready. I don't know if it's going to be by a week from now,
11 but certainly, Vangent is cashing those checks and trying to
12 hire people as quickly as they can, but I think one of the
13 biggest things that we run into is that there is still an
14 issue of 76% of Americans don't know what's happening October
15 1, what's happening January 1, and so it comes back to what is
16 the federal government going to do in terms of a communication
17 plan to let people know that this is coming?

18 In a recent conference that I was at, Cindy Mann said,
19 "We are working on a communication plan and we will tell you
20 about it soon," and so we're looking at probably the month of
21 August before the federal government will roll out their plans
22 for how they're going to distribute information or begin to
23 get the Americans aware that this is coming.

24 Certainly, we live and breathe this every day and we've,
25 you know, some people have their countdown clock, you know.

1 How many people know how many days it is until October 1?

2 UNIDENTIFIED VOICE: One hundred.

3 MR. APPLEBEE: It's about 100, exactly right. There are
4 people who have that clock on their wall. They rip it off
5 every day, 99 tomorrow. It's going to be 98 the day after and
6 it's coming that quickly. We're at 100 days. We're just
7 under 100 days and whether or not the federal government is
8 going to leapfrog those hurdles and move the rocks that they
9 need to, to get to where they need to be is highly
10 questionable. Do you want to say anything else about the
11 marketplace that.....

12 MR. KOLB: Not a lot to add to that. No, as I said, I
13 think our role that we look at, at the Division of Insurance,
14 we're looking at the rates. We're reviewing those. We do
15 know what the deadlines are that we've been charged to meet
16 and we're committed to meeting our deadlines, whether -- once
17 the federal government has the plans that we've reviewed and
18 they can meet their deadlines is far out of our hands.

19 I know consumers are calling. People are calling and
20 that's their question, "Can you tell me anything," and as Josh
21 has illustrated from the news that's out there, the answer is
22 quite often, "Not yet, but hopefully soon," and that's
23 frustrating to people and -- but unfortunately, that's where
24 it places -- one thing that we have done as a Division of
25 Insurance is on our website, so our Division of Insurance

1 website, we've actually added a tab called Affordable Care Act
2 and we've tried to put links, because if you've looked for
3 anything on the Affordable Care Act, to assume there were only
4 a couple would be naive. They are everywhere.

5 So we've tried to put a consolidated place where we can
6 put some links to help direct people to at least get them to
7 the answers that are there and we've made that available and
8 are trying to point people to that as frequently as possible
9 as here's, at least, a central point. It's not necessarily
10 our answers. It may be a link over to the federal site or to
11 one of the different frequently asked questions, but we have
12 tried to make that available so that our state consumers, at
13 least, we have somewhere to point them to get them moving in
14 the right direction, hoping that will continue to update as
15 more information becomes available.

16 So if you are interested in looking at that, if you go
17 out onto the Division of Insurance's website, on the front
18 page, left-hand side under News, there's a link called
19 Affordable Care Act and it has "New" right next to it and
20 hopefully, it will continue to have new things coming into it
21 as the underlying links get updated, so.....

22 MR. APPLEBEE: In addition to tracking and following what
23 the federal government's trying to do in terms of the federal
24 marketplace, the number one task that I fill my days with
25 continues to be the analysis of Medicaid expansion.

1 We are still very much in that process. We are looking
2 at finalizing our recommendations in the next couple of
3 months. Once that happens, those will be shipped up the
4 chain, send it to this guy and then it moves on up from there.

5 We are getting additional information all the time from,
6 you know, some other ideas that other states are doing.
7 Certainly, the last time I was here, we talked a little bit
8 about the Arkansas plan, the Private Option, as it's being
9 called and some of the nuances that they've put into their
10 law.

11 Other states are finding it as difficult as Arkansas in
12 trying to craft legislation to give their departments the
13 flexibility that they hope to give and to pass muster once it
14 gets shipped to the feds for approval.

15 To my knowledge, the federal government still has not
16 officially approved the Private Option plan and has not yet
17 given Arkansas the official okay in other states. Nebraska,
18 for example, is still fighting.

19 In addition, you have other states looking at different
20 levels of, you know, how can we make this work for our state,
21 and you see the constant challenges between governors and
22 legislators. If you look at Arizona, where the Governor
23 started vetoing bills until she got the Medicaid expansion
24 bill through the Legislature. I think she ended up vetoing
25 like seven major pieces of legislation, saying, "I told you

1 I'm vetoing everything until you pass my bill," and so that
2 will certainly affect her ability and her position as Governor
3 moving forward with the Legislature without a doubt, but you
4 see these struggles and using that information and finding out
5 just how flexible the federal government's willing to be has
6 been good input moving forward.

7 If the federal government, despite their initial
8 reaction, if you remember a year ago when we talked about the
9 level of flexibility, HHS said, "No, it's all or nothing."
10 Well, they've certainly backed off of that and they're willing
11 to look at states and look at different state's situations,
12 where they're at and they've shown, at least in rhetoric, some
13 flexibility and movement.

14 So again, certainly in every public forum, I want to make
15 very clear that on the 28th of February, the Governor said
16 that his next decision point on Medicaid expansion will be
17 when he submits his budget to the Legislature in December.

18 If you look on Kaiser, if you look on Urban Institute,
19 they often put Alaska in the firm position of no. I thought
20 the Governor was very clear in that press conference, despite
21 how it was written up in the press. So just to make sure that
22 everyone's clear, the next decision point is in December and
23 we are in the process right now of finalizing our
24 recommendations as it moves forward. Yes.

25 COMMISSIONER HIPPLER: I have a quick question. The

1 expansion analysis that your department is performing, will
2 that be released to the public?

3 MR. APPLEBEE: Yes, it will be released to the public
4 after we've submitted our recommendation to the Governor.
5 That was an easy question. Anything else in regard to
6 Medicaid expansion?

7 MS. ERICKSON: Josh, could I ask, and it's not related
8 directly to the Medicaid expansion, but what's the status of
9 the eligibility information system redesign and the link to
10 the federal exchange for Medicaid eligibility?

11 MR. APPLEBEE: The eligibility information system
12 redesign is still in the process and it's moving forward. The
13 biggest problem that they have is they don't know what those
14 technical aspects of interfacing with the federal hub are
15 going to be.

16 So they're moving forward with their process and are
17 certainly leaving that space open, as they should, and so it
18 would be probably better to bring, you know, the subject
19 matter experts, those people dealing directly with the EIS
20 project to answer those questions, but it is moving forward
21 and I think it hasn't run into any major snags yet. It's
22 still early, of course, but until the federal government says,
23 "Hey, this is our product. This is what you need to interface
24 with. Here it is, go test it, tell us what you need to make
25 it happen," it's difficult for anybody designing any system,

1 and states across the country are upgrading their EIS systems,
2 their Medicaid management information systems and they're
3 still having that, "Well, we'll get back with you on that
4 answer" from the federal government on the data hub.

5 MS. ERICKSON: Any final comments, Commissioner?

6 COMMISSIONER STREUR: Always. First of all, on the EIS,
7 I've given direction to the development crew, both of Deloitte
8 and our own team that they move forward with the state
9 capabilities and when the feds finally come in with a product
10 and some demands from us as to linking with the system, then
11 we'll worry about that, but I can't slow anything else down,
12 because it's a very, very tight deadline to reach by October
13 1.

14 A couple of things, sequestration, I cannot look at the
15 Affordable Care Act without looking at sequestration and its
16 impacts on the state. Dr. Harrell, I know, has some of the
17 same concerns with regard to his services that he provides and
18 many of you as well.

19 Right now, stuff that I have, the WIC program, Women,
20 Infant, Children program, which is near and dear to me,
21 because when I look at that versus food stamps, WIC is going
22 to come out on top, you know, time and time again, is looking
23 at a 15% cut.

24 Just a couple of months ago, we were looking at six to
25 eight percent cut, but with sequestration, one of the things

1 that folks don't often take into account is that the cuts
2 compound. It's not this year, and you know, then you're good,
3 that you've paid your dues. They compound each year and so it
4 gets worse and worse and worse.

5 As the former Commissioner and I used to talk about
6 worse, worser, and worstest, and you know, that's a little bit
7 of what we're facing there. So when I look at Medicaid
8 expansion, it is going to cost the state money beginning in
9 the first year. You can't get around that.

10 When I go to this guy and say I need seven million
11 dollars to support a Medicaid expansion, by the way, I'm
12 cutting the WIC program. I'm cutting foster care and adoption
13 subsidies. He says to me, he says, "Well, why are you cutting
14 essential programs for the sake of growing bigger," and so
15 I've got to be able to present that to them and so when people
16 say to me, "Get that report out, show us. It's a no-brainer."
17 It's not a no-brainer.

18 We have a set of documents from a consultant that
19 presents "what if" scenarios to us. We have to take those
20 "what if" scenarios into a recommendation and the nice thing
21 is, I got Josh here to do the heavy lifting on that.

22 Public health, we don't know what the cuts are going to
23 be to public health and public health affects nearly as many
24 people as our Medicaid program does on a regular basis. So
25 all that needs to be considered.

1 The other thing is I've got the House Finance deep dive
2 that's occurring. Painfully so, I relate to the three days a
3 month I spend with some of my closest friends in House Finance
4 and they do a deep dive into various aspects of the
5 department. It's hard. It's difficult and ostensibly, it's
6 to better understand the department.

7 You know, I could pollyannaish at times and I can be
8 looking for that pony in the pool, but it's really an issue of
9 understanding us so we take a look at what's essential and we
10 have to. There's no doubt in my mind we have to. This
11 department is 2.7 billion dollars and it's a large proportion
12 of the operating budget, and you know, they have to look at
13 the 800-pound gorilla in the room whenever they're looking at
14 stuff.

15 We look at transportation, are they going to cut roads,
16 probably not. You look at DNR, gas and oil is near and dear
17 to their hearts and the department is, you know, really the
18 largest item that they can take a look at and so they want to
19 understand and we need to understand and we need to work (sic)
20 forward, move forward.

21 It brings me to the point that I want to get to. Leg
22 Audit in recent a recent audit of the Commission has made a
23 recommendation that I have taken to heart and that's that the
24 recommendations of the Health Care Commission need to be
25 actualized.

1 In other words, we need to put them in a plan. We need
2 to take a look at everything that you look at, and with the
3 recommendation and those things, and we either move forward or
4 we come back to you and say, "What are you smoking?"

5 It's -- that is the important consideration, because my
6 final word is things are going to get harder before they get
7 easier and I realize that. I understand that and with
8 everything that we're doing in the department to get ready for
9 that with our results-based budgeting and results-based
10 accountability that we have, we are going to be ready and so,
11 you know, keep throwing those recommendations at us and then
12 have us come back to you with, you know, what we're doing
13 because we need to be joined at the hip with the Commission.

14 I throw out that challenge and I throw out that
15 willingness on our part. So that's all I have to say, Deb.

16 MS. ERICKSON: Thank you, Commissioner. Any questions
17 for Commissioner Streur? Dave.

18 COMMISSIONER MORGAN: I was at the House Finance
19 Subcommittee meeting, to the shock of everybody, I was -- I
20 have to say, you and Deb and (indiscernible - voice lowered),
21 Dr. Hurlburt did a great job, but I think you're actually
22 minimizing in that clearly, they're looking to make
23 significant reductions in what's being spent in this division
24 and on health care, generally, throughout state government and
25 I don't think they're kidding either.

1 I mean, they were throwing numbers around that were
2 pretty tough numbers to get to. So anyway, the -- you know,
3 it's sort of the good news/bad news, which do you want to know
4 first? There was no good news, so we'll just go to the bad
5 news, but the -- but on the other hand, I thought the team
6 from your department did an -- as a layman, just watching this
7 process that day at the LIO, I thought they did a very good
8 job.

9 As I've told you, Commissioner, everybody really talks
10 tough to you when things aren't going too good, but very few
11 people say, "Hey, I thought on this one you did a good job."
12 So when you do a good job, people should tell you, get at
13 least reinforcement, anyway, and no, I'm not looking for a
14 job.

15 MS. ERICKSON: Any other questions for the Commissioner?
16 Well, thank you all very much for coming and updating us. We
17 appreciate it. We have two minutes left in the day and we
18 will be adjourning on time.

19 Just real quickly, I'm going to flip through a few --
20 just a couple of next steps slides that you have in your
21 packets in the meeting discussion guide and we have up here on
22 the screen, and just as a reminder, our next quarterly meeting
23 of the Commission is just two months from now will be on
24 August 21st and 22nd, and I included in your packets, I had
25 emailed to you all a month or so ago, the letter of invitation

1 from Dr. Hurlburt to the broader medical community,
2 especially, but also some stakeholders inviting them to
3 actually come and actively participate in the learning session
4 we're going to have on evidence-based medicine that day and I
5 am trying, I'm not making an promises, but for the docs in the
6 room, I'm trying to get CME credit approval for that for this
7 one, since it's a full day of learning on this topic. So we
8 have that coming up.

9 Next month -- I mentioned earlier in the meeting that we
10 will have on August 9th, that we'll start off with a half-day
11 conversation with stakeholders, facilitated conversation with
12 stakeholders on -- and then the next steps in the evolving
13 role of the Commission and the development of the state health
14 plan. Yes, Keith.

15 COMMISSIONER CAMPBELL: Do you have a location for that
16 (indiscernible - too far from microphone)?

17 MS. ERICKSON: It will be in Anchorage, most likely at
18 the University, and thank you, Barb, and our subsequent
19 schedule for the year is on our website and it's in the slide.
20 I think we -- you -- take a look at some of these other slides
21 in here and I also included in your packet, it's not up on the
22 screen, the presentation that Dr. Hurlburt and I gave to House
23 Finance. So you can see how I paraphrased the recommendations
24 of the Commission, but also started off that presentation with
25 an overview of the alignment between the Commission's and the

1 department's statutory responsibilities and some other
2 information there, but does anybody have any questions about
3 next steps? We have one last thing to do before we adjourn.
4 If no questions about next steps, we need to say goodbye to a
5 very dear friend, and I'm going to turn it over to Ward for
6 that.

7 CHAIR HURLBURT: We -- we all have appreciated, Pat, your
8 being here, your perspective, your wisdom, your approach. It
9 will be a huge loss for Alaska, but your -- we'll continue to
10 work in the things that you've brought here and in your new
11 role there and we wish you well.

12 This represents some solid Alaska H2O in case things get
13 dry down there in Idaho. If you come back this way, we will
14 want to see you, but thank you so much.

15 COMMISSIONER BRANCO: Sorry, I get the microphone last.
16 What an honor, what a real honor and privilege to work with
17 each of you and to have learned along this express highway
18 that we've gone through. Welcome to new folks, but most
19 especially, thank you. This has been a rare treasure and
20 Alaska is -- my job here has been the best of my career, will
21 always remain in that special place in my heart and I will
22 miss everyone. So thanks.

23 CHAIR HURLBURT: Okay, we're adjourned. Thank you all
24 very much.

25 12:00:05

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(Off record)

END OF PROCEEDINGS