ALASKA HEALTH CARE COMMISSION

DENA'INA CENTER

600 WEST SEVENTH AVENUE

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P R O C E E D I N G S

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(On record)

CHAIR HURLBURT: I'd like to call us to order here, if we can. I didn't go by the office, so I don't have my gavel. I told Deb, we can't start, but yeah (affirmative).

I'd like to welcome everybody here. I think we're going to have another really super meeting. It will be very interesting and will inform the Commission members in some very valuable ways as we work toward the end of this year in developing our recommendations, and specifically, in working with the Department of Health and Social Services on developing recommendations related to a health plan, but we'll get some very useful information here.

So as is our custom, if we could start and have the Commission members introduce yourselves first? David, we'll start with you and go around the table.

COMMISSIONER MORGAN: Dave Morgan representing community health centers.

COMMISSIONER STINSON: Larry Stinson, a physician representing providers.

COMMISSIONER PUCKETT: Jim Puckett with Division of Retirement and Benefits representing the Office of the Governor.

COMMISSIONER ENNIS: Emily Ennis representing the Alaska

Mental Health Trust Authority.

COMMISSIONER CAMPBELL: Keith Campbell. I am representing the public as a consumer representative.

COMMISSIONER HIPPLER: Allen Hippler, Alaska Chamber of Commerce.

COMMISSIONER HARRELL: Tom Harrell, the Department of Defense and VA.

COMMISSIONER KELLER: Representative Wes Keller, the State House.

COMMISSIONER DAVIDSON: Good morning, (indiscernible - speaking Native tongue), Valerie Davidson representing tribal health.

COMMISSIONER ERICKSON: Deb Erickson with the Health Care Commission.

CHAIR HURLBURT: Were those of you in the audience able to hear okay for the mics? Okay.

COMMISSIONER ERICKSON: (Indiscernible - away from mic)

CHAIR HURLBURT: Yeah (affirmative), and to turn it off when we don’t use it. If those -- the public attendees are here. If we could start and you could just introduce yourselves, and if you’re representing, just say so, please.

MS. SCISETH: I’m Stephanie Sciseth. I’m a WWAMI Alaska student.

MS. PENWELL: I’m Vicki Penwell. I’m a volunteer with the National Patient Advocate Foundation.

MR. YOUNG: Jonathon Young, Administer of Medi Center in Kenai.

MR. BROWN: Fred Brown, the Executive Director of the Health Care Cost Management Corporation of Alaska.

MR. MCCLUNG: Peter McClung with the McDowell Group.

MS. BARTHOLOMEW: I'm Lydia Bartholomew, the Senior Medical Director for Aetna.

MR. LESMANN: Good morning, Mike Lesmann, the Office of the Governor.

MR. KNAPP: Gunnar Knapp, Director of the Institute (indiscernible - away from mic) ISER.

CHAIR HURLBURT: And if you could introduce yourselves?

LAWRENCE (LAST NAME UNKNOWN): Lawrence with the audio/video here today.

UNIDENTIFIED FEMALE: (Indiscernible - away from mic)

MS. MORRISON: I'm Sunny Morrison with Accu-Type Depositions, and this is Miranda.

CHAIR HURLBURT: And Bob, we.....

COMMISSIONER URATA: Bob Urata, primary care from Juneau, Alaska.

CHAIR HURLBURT: Is there anybody on the phone? Okay. There will be others coming. We do welcome you here, and we'll go ahead and get right into our agenda.

The first hour-and-a-half that we have, we're going to be talking about the Workman's Comp area, and a part of what

we've talked about with the Health Care Commission, right along, relates to the State being, really, a major buyer in terms of healthcare and that there are two ways to look at government and the role that we play here.

One is to look at government as a regulator or a legislator, and our tendency has been to think that we really will come to the best solutions when they are worked out on market-based forces. And clearly, there is a role that government plays in protecting its citizens and providing safe water and providing speed limits and engineering highways, so that they're safe, but that, coming to good solutions, sometimes, it's cumbersome. It's always cumbersome. Sometimes, it's messy, but it tends to work, going through the market-based processes.

And in that role, and particularly in Alaska -- really, in any state in our country, but particularly in Alaska, government is a huge buyer of healthcare services, and as an employer and buyer of those services, it needs to do it well. It needs to do it well in terms of responsible stewardship for the resources that come from the citizens of our state that are entrusted to government to spend wisely and well and not more than is necessary, leaving the other resources for the citizens. And so then the State becomes a buyer for safety net programs that society has decided are desirable, like Medicaid, for those who are not as well off,

socioeconomically, and that, in our state, is about a billion-and-a-half dollar program with federal and state money there in the Medicaid program.

The State, as a state with a huge amount of geography, we are widespread and so there are quite a few government employees here, and the State, as an employer, provides health insurance for those employees and their retirees and then other political jurisdictions, and we'll hear, later this morning, from Mark Foster, for example, from the Anchorage School District, the largest in the state, that other government jurisdictions -- school districts, municipalities, cities, so on -- here, all those individuals, as they retire, then fall into the medical benefits portion of the plan administered by the State by Jim Puckett's division in the Department of Administration and that's about, what, $600 to $700 million a year now that's all state money that goes into providing that, some of that money. The care is provided through a union trust that Fred Brown is engaged with and working with that in providing care for those active employees, but then the retirees do come on with the State at age 65. That is partnered with Medicare, with a mandatory requirement for Medicare, but that's the next biggest chunk.

And then our opening talk this morning is going to be on Workman's Comp where we spend more than anybody else on a per capita basis, with a bigger percentage for Medicare for

medical care, of the Workman's Comp dollar. That's another drag, you might say, on employers and on business people because that's a cost to them. It's another cost that offsets their ability to give their employees raises or to do other things. Now, the State's a big buyer there.

There are some others. The Department of Corrections is a significant buyer of healthcare services. The Juvenile Justice Division is here. Any aggregates -- the State buys a big chunk, probably $2.5 billion or more, of healthcare out of the total of whatever it is now, (indiscernible - voice lowered) billion dollars a year that the State buys in health insurance.

So before I introduce Mike, Jeff, we've already gone around. Could you introduce yourself, please?

COMMISSIONER DAVIS: My apologies for being late. Jeff Davis, sitting in the chair reserved for health insurers, and like all my fellow Commissioners, representing all Alaskans. Thanks.

CHAIR HURLBURT: Thank you. Welcome, Jeff. So our first.....

(Pause - background discussion)

CHAIR HURLBURT: Our first presentation this morning gets at the Workman's Comp area, which was the one, as I was going through the list in terms of magnitude (indiscernible - recording interference), number three there. And there have

been some really exciting and interesting things going on around the country.

Mike Monagle is the Director of the Division where Workman's Comp is located and has been interacting with his counterparts and colleagues around the country. He has been beginning to be able to introduce some newer concepts, and the kinds of things that are happening around the country are evidence-based, which is a concept that we've talked about. Our last meeting was devoted to that, looking at doing what really makes a difference in people's lives, in terms of both reduction in medical care costs in some other states, and conversely, much greater success in getting people returned to work, which really is the bottom line of the definition of success in what Mike does here. It has been impressive. And so Deb and I have been really excited, hearing some of the things from Mike. So Mike, I'll turn it over to you and appreciate your being here.

MR. MONAGLE: Well, thank you, Dr. Hurlburt. I'll jump right in. To kind of set the stage a little bit for folks that may not know a lot about Worker's Comp, in Alaska, Worker's Compensation insurance is mandatory for all employers, whether you're self-insured, commercially insured. If you have one or more employees, you must carry Worker's Comp insurance.

And the other thing about Worker's Comp in Alaska is

that, in our state, medical care is the employee's choice. So the employee can choose which doctor they wish to go see for treatment.

So let me jump right in. We'll start with the good news. Well, the good news, historically, for the last 20 years, 30 years, is that Alaska's economy has continued to grow, and we've managed to avoid most of the economic turmoil that has faced the rest of the United States. We, perhaps, don't have the big spikes in the economic gains, but then we also manage to avoid some of the bubbles or bursts that happen along the way as well.

And the other thing -- and this is probably for our state, one of the most important things to keep in mind, and that's frequency. The number of injuries taking place has continued to decline at about five percent a year, between four and five percent. So this really is a saving grace for our Worker's Comp insurance rates. Sort of lock that in the back of your mind because that comes into play throughout my presentation.

So with an increasing economy, more people at work. We see declining frequency, and one would expect that we would see a corresponding decline in costs, but in fact, the bad news is that's not the case. Despite the declining number of injuries, despite the growing of jobs, we see that our Worker's Compensation system costs continue to go up.

So how do we compare? The state of Oregon produces a premium analysis survey once every two years. They go out to all 50 states. They compare like job classifications. So they don't pick salmon fishing or something unique to Alaska. They pick office clerical, retail, construction, jobs that are common to all 50 states, and they compare the Worker's Comp premium rates.

And in 2012, Alaska ranked as the number one state. Our Worker's Comp premium rates are the highest in the country. If you look at the second column, the 2010 ranking, you'll see that, in 2010, we were number two. And if you go down toward the bottom of the slide here, you'll see that Montana was number one. In 2011, Montana undertook some legislative reforms. Those reforms resulted in a 25% premium reduction, and between 2012 -- excuse me -- 2010 and 2012, they dropped from number one down to number eight.

So we're number one. We like being number one in some things, but having the highest Worker's Comp premium rates in the country is not something that we like to see.

So let's take a look at where things have happened in Worker's Comp. In 2000, we were on that -- using Oregon's premium rankings, we were 28th in the nation. In 2002, well, it rose to 15th, and by 2004, we were number two. And since 2004, we have dropped back and forth, between number one and number two, with the state of Montana. From about 2004 to

2012, it's always been Alaska and Montana as number one/number two.

So what's driving these premium costs? Why did we go from about middle of the pack to number one? So the main cost driver's in Worker's Comp are medical costs, indemnity benefits, that is those benefits that are paid to injured workers to replace lost wages, legal costs, and re-employment benefits. And mostly today, what I'm going to talk about is the medical portion.

The Division collects data from all insurance companies and self-insured employers on an annual basis, and if you break out the allocation of where those expenses go, about 62% of the total cost is medical. But if you factor in what are called "lost costs" -- and those are those items that make up the premium rates. What Alaska does is they use a rating organization and National Council on Compensation Insurance. They collect data from all the insurance companies, and their actuaries project future rates, based on historic losses. When they take the medical lost costs and the indemnity lost costs, in Alaska, about 75% of all costs are medical. And this, really, is a radical change, and it's not unique to Alaska.

In the early '90s, medical costs made up about 35% or 40% of claim costs, and as regulators and bureaucrats, we focused on cost containment on the indemnity side. We tweaked with

the indemnity rates and the benefit rates that impacted those wages that went to the injured worker. But starting in the early '90s, we started seeing this drastic rise in the allocation of medical costs to the point that, countrywide, most of the claim costs in Worker's Comp are medical, and Alaska is one of many states that is struggling with, how do we address these issues of rising medical costs in the Worker's Comp systems?

This slide is put together by NCCI, National Council on Compensation Insurance, and it's a comparison of this previous slide I showed here about this pie. Alaska's medical rate is 76%. You'll see that, countrywide, it's about 59%. So we're significantly higher than the rest of the country as far as what percentage of our total costs are medical versus indemnity.

When we look at medical costs, we look at fees-for-service. We look at utilization, the type of service that's provided and then frequency, things like chiropractic care, physical therapy, how frequent those services are provided, prescription drug use, and we break those out into use of opioid narcotics and physician dispensing, which are kind of hot topics around the country right now.

So let's take a look at fees-for-service. Alaska's fee schedule is based on a statutory requirement that the rate be at 90th percentile of usual and customary. And the

methodology that the Fair Health uses to produces our fee schedule is based on the bill charges. So right off the bat, we're paying, basically, full retail on our fee schedule.

In 2004, the Legislator froze our existing fee schedule at that time to put a Medical Services and Review Committee and a task force together to take a look at Worker's Comp issues and see if we could come up with some solutions. As the earlier slide shows, about 2004, we started seeing that dramatic increase in our premium rates and our standing in the country.

In 2010, a new fee schedule was adopted, basically the same methodology as the 2004 fee schedule. And you'll see, from about 2010, that our rates were a little flat between 2004 and 2006, but after 2006, you started to see a rise.

In the last five years, medical costs have gone up, on average, about seven to eight percent a year in Worker's Comp medical costs. That's about double the consumer price index for Alaska for the Anchorage -- using the CPI for Anchorage for medical urban.

If we look at -- again, using NCCI's data on an indemnity case -- that is a case that involves somebody missing time away from work -- in Alaska, the average cost on that case for medical treatment is $48,200 compared to $28,000 countrywide. So again, the disparity between what's being paid on an indemnity claim in Alaska is significantly higher than the

rest of the country.

Again looking at NCCI's data for Alaska, going back to 1997, you'll see that the cost on an indemnity case was about $16,900. By 2012, NCCI's projecting that to be $54,000 on an average indemnity case.

I pulled this next slide from the Worker's Comp Research Institute. They are an organization that does statistical analysis. They're economists and statisticians. They don't specifically produce information on Alaska. They use benchmark states, which are 16 states that they have identified, which covers about 80% of the country's employees, and they use those to analyze what they call benchmarks.

We do participate, to a limited degree. One of the things that we do with WCRI is they contact every year. They provide us a list of procedure codes, common procedure codes based on their research. We provide our fee schedule data to them and then they produce a fee schedule comparison. They do this every year. Their most recent one, June 2012 -- what they do is they benchmark Worker's Comp to Medicare allowance in their state, and you'll see Alaska is all the way out on the right-hand. We are almost 170% in Alaska, overall, of what Medicare allows, and we are, by far and away, the highest state as far as that difference between our allowance under Comp and what's allowed under Medicare.

I mentioned before the change in the fee schedule between

2004 and 2010. When we sat down and compared the common procedure codes and the maximum allowable reimbursement, these are the percentage increases that we saw.

Again, one disclaimer here. When I say that the fee schedule is at the maximum allowable reimbursement, that doesn't mean that all doctors and all hospitals and clinics are charging at that MAR. All right? But this chart shows the difference between the old fee schedule and the new, and it was, as I say, rather stark in difference. The 2004 fee schedule was frozen for almost seven years. So one would expect an increase, but these kinds of increases we saw produced by Fair Health were rather significant.

And I put these next two slides together because I think it's -- one of the things that we try to wrap our heads around in Worker's Comp is the comparison between general health and Worker's Compensation. This slide and the next one were actually produced, again, by the Worker's Comp Research Institute, and they came out this summer. And what they had done is compared, again, their benchmark states, those 16 states that they study in great detail, and they looked at their fee schedules and what Worker's Comp allows, and for the same procedures, they looked at what general health allows. And what they found in their studies was that there was a large disparity, in some states as high as 40%, a higher allowance for Worker's Compensation than there was for general

health.

And so part of our discussions when we go around and talk to folks about this is how to bring those two fee schedules more in line with each other.

COMMISSIONER DAVIDSON: So where's Alaska?

MR. MONAGLE: Alaska is not on their study because WCRI does not include Alaska in their benchmark states.

COMMISSIONER DAVIDSON: (Indiscernible - away from mic) to show where Alaska is.

MR. MONAGLE: We are in the process of doing that right now. Now again, this slide here shows the price disparity for a common knee arthroscopy, which happens to be, in Alaska, according to NCCI's data, the number one item that's the highest cost of any in our system. Again, when we're dealing with Worker's Comp, that's not a surprise.

This slide is a similar slide. Again, the difference here is the shoulder surgical episode, again showing the disparities between healthcare and Worker's Comp.

But I think this slide here, the next slide, is probably the one that you're talking about, and this is a work-in-progress. So what we're doing is we've -- the National Council on Compensation Insurance, several years ago, because of the issues that states were having with medical costs, started doing a medical data call. So now for all insurance companies writing Worker's Comp insurance in Alaska, they

collect medical data. 2010 was the beginning of their project, late that year. January 2013 was the first cut of the medical data that we received.

This chart here shows the top 25 procedure codes based on dollar amount paid, which is the surgical component. So each category is different, but I picked surgical just for comparison. And if you look down the list, you'll see what's allowed under the Worker's Comp fee schedule in Alaska, what the Medicare allowance is, what Washington State's Worker's Comp medical fee schedule allows, and we're starting to compile average healthcare costs. We're reaching out to the top healthcare insurers in Alaska and getting their data together. We hope to build on this, so we can actually start looking at actual dollars paid. It's going to take a collaborative effort between us and Division of Insurance and the State because a lot of this information is confidential, and we have to be able to safeguard the data that we get, but we really want to start taking a look at this information.

COMMISSIONER HARRELL: All right. So I'm very curious, any detail or insight as to why orthospine surgery is, across the board, the highest reimbursable not only in Alaska but in Washington State as well, but significantly higher? They're all orthospine procedures.

MR. MONAGLE: They are. You know, I really can't tell you that for sure. I mean, we have some ideas. I've talked

to the Director of Division of Insurance last year and that group, as a whole, was the only group that would not agree to any kind of group health plan with any of the top insurance companies, Premera.....

COMMISSIONER HARRELL: Yeah (affirmative). It was a loaded question; yes. It's a small community, and.....

MR. MONAGLE: And part of it, I think, too, is, you know, marketplace competition. I think that has a big factor.

COMMISSIONER MORGAN: One is a confirmation for you. I serve on the Anchorage Municipal Health Commission -- or Commission for Health and Human Services, and their Workman's Comp has spiked. It actually -- we're seeing some of the same data for the Municipality, and the spike seems to even be greater than what you're showing.

And I guess, you know, it's been a couple of months since I've enjoyed getting, at least, 600 phone calls at home. So I've got to ask this question. I know you're looking at costs and you're breaking these down, but has anybody -- I mean, I don't know how your department is set up, but have you actually looked or had somebody, like a certified auditor of coding or someone like it, actually look at these bills and look at the diagnoses and look at what you're paying for compared to the health record itself? And that's not a loaded question. I have no idea how you're set up to process these bills or the contractors that you use.

MR. MONAGLE: Sure. No. That's a good question. The State, itself, Division of Worker's Comp, we are not the payer of these medical benefits. Now, the State, as a self-insured employer, is. Division of Risk Management oversees, for example, all state worker's comp claims, but they contract that out. They contract that out to independent claims adjusting organizations. Most insurance companies have bill review. I can't think of one that doesn't, but they have folks that take these bills, they review them. They look at the ICD-9s. They look at diagnostics. They look at treatment.

But again in our state, the requirement is that the insured -- the employer must pay those bills, unless they have evidence, substantial evidence that the statute says that that treatment is not warranted and that's tough. Basically, you have to take the injured worker, send him out for an IME, independent medical exam, and then based on that substantial medical evidence, you can then say, okay, I'm not paying for this treatment anymore because I've got a conflicting medical opinion. Then we end up in a dispute. We end up in our judicial process because you have dueling opinions from different doctors and then we have another IME, and we have a second independent IME, and things get really wrapped around the axle, and legal costs go up and those kinds of things. But I'll come back to that because I think that's a good

question.

But on this particular slide, one of the things we are seeing is that there really is a tremendous disparity, at least initially from what we're seeing, between Alaska, worker's comp systems in the Northwest. We're also expanding this to look at Oregon and Idaho, and we're, as I say, bringing in more of the healthcare industry so we can get a better picture of our costs. But you know, I've heard comments that have come out of the Commission before and from the State, itself, that say, if you take a look at some of these, the advantages of medical tourism, right? I mean, for some of the prices listed here, you could readily put somebody on a plane, fly them to Seattle, put them up in a hotel, get them treated and returned home and save yourself $5,000 or $6,000 per treatment.

I pulled this slide in here because I think it kind of speaks to the question that people bring up with me, and they say, well, you're talking about fee schedules where you're talking about the maximum allowable reimbursement, but not everybody bills at the max, I mean, when you have a fee schedule.

So NCCI addressed this question this spring. They took a look at worker's comp systems, and again, general health, and what they found was that, for a worker's comp system, as soon as a fee schedule is revised, within a short period of time,

well over one-third -- depending on the category of type of service, as high as 50% of providers are billing at the MAR or billing at the maximum when that fee-for-service type fee schedule comes out. So it does drive what folks are billing in the system.

And I know this is a little bit busy slide, but I think it really does speak to that idea of, well, a fee schedule that sets the MAR doesn't necessarily determine what people are billing; it does within a short period of time.

So that's a little bit about the fees, and I'll come to the end of the presentation. We'll talk a little bit about what's being discussed on how to address fee schedules.

The other component in Comp, obviously, is utilization -- the type of treatment and the frequency of treatment. Obviously, if you go into a doctor with a complaint of low back pain and the first thing they want to do is an MRI versus an x-ray, you're talking thousands of dollars in difference in costs right there.

But this, again, is a slide that NCCI put together. The green bars show utilization as the factor on overall costs, whereas the blue is the price. And utilization in our state becomes a big driver as well.

So what the Worker's Comp Research Institute had done -- had taken, again, their 16 benchmark states. On the right side of this slide -- at least, on my right -- I'm not sure

what it’s on; I think it’s your right as well -- those states that did not have any type of treatment guidelines -- and this particular analysis was for a lumbar MRI -- and the states on the left did have utilization review or treatment guidelines, and what you see is there is a huge disparity in the frequency of the MRIs in states that didn’t have any utilization or treatment guidelines versus the states on the left that do. And the same analysis -- this is a lumbar MRI. This is disk surgery for backs. You’ll see the same type of percentages. States that have utilization review or treatment guidelines on the right; that don’t have, states on the left. And you’ll see that huge difference in the frequency, as much as 30% higher in states that don’t have any type of guidelines.

One of the presenters at the WCRI conference this last year was Dr. Wickizer. Dr. Wickizer had worked with the state of Washington. They had set up -- Washington is a monopolistic state. In other words, the only place you get worker’s comp insurance is from the State, itself. They don’t have voluntary markets for it. That closed system they have gives them some advantages, and one of the advantages is they can contain costs. They can do a lot of things different.

They set up what they call Centers for Occupational Health and Excellence. In working with Dr. Wickizer, this is very much a utilization review or treatment guideline approach, and what their studies are showing in the red blocks

are a fee-for-service type approach versus the green blocks, which are a utilization review approach, and what their studies showed is that there was a significant cost reduction in those centers when you focused on utilization review or managed care.

This is another measure of that same study that Dr. Wickizer had done, showing the outcomes. The Centers of Occupational Excellence had fewer disability days, lower disability costs and lower medical costs and rather significant.

And I know I'm going through this fast. The other thing that we have been talking about in Alaska, and quite honestly, nationwide is prescription drugs. Prescription drugs make up about 20% of total worker's comp costs. Of that 20% -- and I'll have a slide that speaks to it here in a minute -- about 40% of that is narcotics or opioids. Starting about 2007-2008, death from overdoses from legal prescription drugs passed the number of people in the United States that were dying from traffic accidents. Using the language that the Center for Disease Control used, this has become an epidemic nationwide, and a lot of states are now reacting to this and trying to address it. And this is, to me, really startling.

So in 1997, the average distribution of opioids was about 96 milligrams per person. By 2007, ten years later, it had risen to 698 milligrams per person. In 1999, there were 2,900

deaths from overdoses of legal prescribed drugs. In 2007, it had risen to almost 15,000.

The percentage of injured workers who received opioids is almost 80%. Again, intuitively, you're talking about strains, injuries, breaks, so it's not surprising that there would be an initial treatment of painkillers. The problem is, when they get on those painkillers, how long they're on them and whether they get off them. I'll come back to this in a minute.

There is a number of states that are trying to come up with policies dealing with this, and I'll speak, a little bit, about -- at the end of the slide -- this particular one.

The percentage of, again, narcotics as part of the total overall worker's comp costs in Alaska. We are one of the states that is higher than 27%, again according to NCCI's information.

These are the top prescribed drugs in Alaska, based on those pain medications, probably, again, no surprise to those in the room that are doctors.

The other thing that drives our costs in Alaska is physician dispensing. What happens with most pharmaceuticals is, if you go down to the retail pharmacy, they identify their drug by an NDC code, National Drug Code, which is used by the Food and Drug Administration. In repackaging, the doctor is getting pills directly from a wholesaler. He's putting them

in separate packaging, but he's not required to use the NDC code, at least in (indiscernible - voice lowered) states and including Alaska. He's not required to use the NDC code that that drug originally came in. They can come up with their own non-NDC identifier, which, basically, what that does is it takes them off the fee schedule. So the payer doesn't have a point of reference or a fee schedule to base that on, and what we're saying is, in some cases, people are picking up their prescriptions from the prescribing doctor. They're paying five to ten times higher for that pill than they would if they walked down the street to a retail pharmacy and picked up that same drug.

We were talking about this at one of our Worker's Compensation Board meetings, I think it was, in September, and after that discussion, I actually got a call from one of the companies that markets this as a profit-making vehicle to doctors in Alaska, and he wanted to have a further conversation trying to get his head around what the Worker's Comp Board was discussing because there are companies that market this practice to doctors as a way of maximizing their profits.

Again, this is another slide showing the growth in Alaska on prescription drugs, and the yellow bar is the percentage of drugs that is dispensed by physicians.

Alaska is one of the states that physician dispensing is

a problem. We are at one of those top ends of the states that NCCI has identified as a cost-driver in prescriptions.

So let me run through some of the history of what's happened with this. As I mentioned earlier, in 2004, we had jumped to number one. I think 2002 was the first time we hit number one. So the Legislator froze our existing fee schedule. We put in a Worker's Compensation Legislative Task Force. There was a Worker's Compensation Medical Services Review Committee established. Because that 2004 fee schedule was frozen, in 2007, the Legislature increased the maximum allowable reimbursements in that 2004 fee schedule by 8.5%. They came back in 2009 and bumped it another 8.5% again.

The fee schedule -- the assumption was that we would have resolution or the Legislature would have come up with some solutions to the Worker's Comp system and that fee schedule would not be needed. So it was set to sunset as of December 30, 2010, but that reform legislation never happened. So what we realized is that we were quickly approaching the end of the existing fee schedule, and the consensus was, well, even though the existing fee schedule was very generous, the prospect of having no fee schedule was even more alarming.

So in 2011, basically, the same language that was there in law in 2004 was re-adopted. So we produced a new fee schedule, but really didn't change any of the methodology, and it's the same methodology that was in place in 2004.

The Worker's Compensation Legislative Task Force made several recommendations to the Legislature, and one of them was to change the methodology of how we put together a fee schedule from usual, customary, and reasonable to a fee schedule based on relative value scales, which is what most states do, and I'll speak to that in just a minute.

They also urged the Legislature to deal with an opioid narcotics issue. Again, this was back in 2006. They were -- the Task Force was ahead of the curve on this a little bit and recommended that Alaska adopt medical treatment guidelines.

The Medical Services Review Committee met, and they made their recommendations in 2009, again very similar recommendations to what the Legislative Task Force had recommended. Again, you see our fee schedule changed to a resource-based fee schedule, development of treatment guidelines, improved data collection, and the recommendation that we contract with an organization to get some of this better information for us.

And then the Worker's Compensation Board has been meeting, and they formed a workgroup this summer and went around and took public testimony, and last month, made some of their own recommendations, and the recommendations pretty much are the same as what was made by the Task Force and the Medical Services Review Committee.

So what we're basically still having a discussion about

is, how do we get Alaska from being 76% of our worker's compensation costs down closer to the national average of around 55% to 60%? As I mentioned, in the 1990s, we really didn't talk a lot about medical costs.

One of the conferences I was at a couple years ago asked the question, if your agency isn't staffed with the medical staff, doesn't have a medical director, doesn't have a medical steering committee, you're not dealing with worker's comp in the right way because our work has changed. The paradigm has shifted and now we need to talk about how do we control medical costs and how do we have better outcomes.

In an ideal world, the injured worker goes to a doctor, gets the adequate treatment, and he quickly goes back to work. Unfortunately, that's not often what happens. So if they're going to be off work and they're going to be receiving medical treatment, what can we do to ensure that it's at a price affordable to the employer.

One of the things that happened in the legislative reform since 2005 -- and it's an unusual thing -- the Legislature actually put language into the Worker's Comp Acts stating their intent. This is what we intend the Worker's Comp Act to be, and it's rare that the Legislature does that with the statutes, but in this case, they did. And the intent was that the Worker's Comp system pay benefits to injured workers, that the process be fair, quick, efficient, and predictable, and

the punch line was at a price affordable to employers. And I think where we're at in Alaska right now is getting to those end questions. You know, how do we do it quickly, fairly, efficiently, but yet allow it to be predictable and an affordable cost to employers? And so that's the question that we're asking ourselves. So any questions?

COMMISSIONER KELLER: I actually have a couple, but first of all, you were just talking about the Legislature. Are you aware of any drafted legislation to make a new stab at workman's comp reform either from the Governor's Office or you know?

MR. MONAGLE: No. It's being discussed, but I have not seen anything or heard anything. I know the State Chamber of Commerce is going to be talking about this at their meeting in Fairbanks next week as well. I know there are a couple of bills that were introduced last year dealing with some of the periphery of this. There was -- there is a bill, I think, that provides that, if you're treated out of state, the fee schedule in the state where you receive the treatment controls, not Alaska's fee schedule, which, if you sent somebody to Seattle, obviously, would make a huge difference based on those price comparisons, and also sets up timelines.

Right now under our law, there is no timeline for a medical provider to submit a bill. So they could bill you two years later for something they did. And the question came up

over here about, you know, how do you do medical review if you have a bill that's being submitted two years old? But right now, I think that's all I've seen being discussed. Yes?

COMMISSIONER KELLER: If I could, one more. When you were talking about utilization, are you aware or has anyone looked at it or am I just making up the question here on whether or not utilization is driven by federal mandate or state mandate specific to the workman's comp arena? In other words, are the things that law requires that drive up the utilization compared to general healthcare?

MR. MONAGLE: You know, I don't think so. I think, when we talk about utilization, what we're really talking about is, what is the most -- if our medical costs are as high as they are, how can we maximize that cost to impact that quick return to work?

For example, at one of the conferences I was at last week, they were talking about medical treatment guidelines, and two of the subjects that came up, based on medical evidence -- and I know you had some folks come speak to this group about medical evidence -- was the use of steroid injections for back pain, and I think the other one was talking about -- also related to back was discectomies and back surgery, and in the long-term, is that injured worker better off with surgery or more conservative care?

And I think the consensus that came out of that is the

evidence is showing that, too often, people go to surgery too quick, that there should be more focus on conservative care. Is there a need for surgery? Yes and that's the doctor's call on that, based on his particular patient. But what treatment guidelines -- what states are doing with treatment guidelines is they're looking at medical evidence and saying, for this diagnosis, what is the best practice for treatment for that person? Again, keep costs down and get the best treatment for that injured worker.

There are a number of states that use -- there are two national organizations out there publishing treatment guidelines. There is the Occupational Disability Guide and then there are the ACOEM Treatment Guidelines. There are others, McKess (ph) and some others, but those two are the biggies. Colorado has developed their own treatment guidelines. A lot of people use Colorado's. New York developed their own treatment guidelines. I don't think that those kinds of approaches would work for Alaska because those states also have large state medical teams that produce these things. We don't, not to say we couldn't put something like that together, but that's sort of the goal of treatment guidelines is to identify treatment that is the least expensive and the most productive in getting that injured person back to work.

COMMISSIONER CAMPBELL: Your last two recommendations on

regulating physician dispensing and opioids, did the Workman's Compensation Board discuss how that might be accomplished, recognizing that most physicians abhor the thought of regulation?

MR. MONAGLE: Yes. There are a couple approaches. One is that, on the physician dispensing, actually for most states, that's been a relatively easy remedy. Basically, what the states require is that you can repackage those drugs, but you have to use the NDC identifier. So you can't repackage them with the code that's not used by the NDC. And so basically, the code would be the same code on that prescription drug that you would see down the street at the retail pharmacy, and they would be held to the same fee schedule as a retail pharmacy, but states are allowing a dispensing fee. I think probably what I've seen, on average, it's, like, a five dollar dispensing fee. So you would pay the same price you're going to pay with the five dollar charge to the doctor.

On opiates, that's a little more complicated. The meeting I went to last week is the International Association of Industrial Accident Boards and Commissions. That's a mouthful. But they came out with a recommendation. It's not a model, but it's a list of recommendations. I have that, and it's also available on their website. It was endorsed by the National Council of Insurance Legislators, NCOIL, National

Association of Insurance Commissioners. There were about five organizations that endorsed this, and what they're looking at are things like there is a prescription drug management database requiring that doctors consult that database before they prescribe opiates. That was one of their recommendations, to make sure that the person is not drug seeking.

A lot of times, they'll find that the person goes from doctor-to-doctor trying to get more of these narcotics. There is a requirement that, if you're on a high dosage, which they describe as 120 milligrams or higher, and you're on that dosage for more -- and this varies from state-to-state, but I think anywhere from 30 to 60 days, if you're on that level for that period of time, that you have to sit down with your doctor, and the two of you have to come up with a plan. A treatment guideline has to be in writing to get you off that dosage to reduce that prescription drug, if there is no increase in functionality. If you're just saying, I hurt, but the drug is not doing anything to get you functionally improved, then the plan is to step you down, to get you back off those drugs.

There are a number of studies that have shown the longer you're on these drugs the less likely you are to return to work. I know we had a case a couple years ago where there was a fellow; he was in his early 50s. He had multiple surgeries,

but the doctor said he was physically able to return to the job he was doing before, except he was on these narcotics for such a long period of time that he had developed psychological problems, and because of that, the doctor said he could not go back to work, and he was rated as permanently disabled, all because he was on these high doses of these opioids for a number of years.

The other recommendations that came out of this list were that there be mandatory urine testing. A number of states that have put this in place have found up to 30% of people being tested, the drug is not showing up in their urine. So they're either not taking them or they're selling them, and the idea is it's probably the latter. So there are a number of recommendations, like this, that are out there in this policy paper.

The Board, itself, did not specify any course of action. We had these discussions. I think what the Board was looking for was these kinds of discussions with policymakers on coming up with either a legislative or a regulatory solution.

CHAIR HURLBURT: Mike, if I could maybe just add a little bit to that, and I'll bet Larry will have some also. This is, clearly, a huge Workman's Comp issue that we have, and the numbers that you showed, actually, were kind of startling to me on the percent of prescriptions, but it's a problem. The prescription opioids are a problem for Workman's Comp, but way

beyond that.

The abuse of the prescription opioids now is resulting in more deaths than automobile accidents every year in our country. Every state, all 50 states have a prescription drug management program that Mike referred to, but that said, there is a wide difference in the program's that they have. Ours is fairly weak here. Washington State has a program where an individual that is identified -- because the data is collected on the prescription opioids -- as an abuser, whether it's Workman's Comp, whether they're on a health insurance plan, on Medicaid, whatever, can be locked in to one provider and one pharmacy because, clearly, there are providers who operate prescription mills, and Florida was famous for that. And the Legislature and Governor Scott clamped down on that, and the mills moved north to Georgia, and Georgia is facing that problem now. But again, as Mike said, that is a reality within our medical profession that we need to look at and be sensitive to, but these are also substances that have a lot of value. I've heard Senator Dyson say, a number of times, the street value for an OxyContin pill is $85 here in Anchorage. You probably know better about that than I do, Larry.

The State of Oklahoma, where Dr. Terry Cline, a psychologist, is the Secretary of Health and who was the Substance Abuse and Mental Health Services Administrator during the Bush 43 Administration has taken this on, and in

their prescription drug management program, they have the online ability to draw on the database where the pharmacist is filling the prescription or where the physician is being asked to prescribe it, and they have five-minute availability of that data. So it's very quickly available to the providers and to the pharmacists, and they have seen some significant improvements there in that state. There will always be ways to go around it.

And in my last job with the Medicaid program, when you had individuals with drug seeking behavior, we could monitor where we paid for it, but on the other hand, if you're getting a substance that has street value -- that's economic value to you -- you can pay out-of-pocket, both to the provider and the pharmacist, so that the payer of the health plan doesn't get that information, but it's like anything else, that you have to keep evolving in what you do, but this is huge. And Larry, you probably have some really helpful things.

COMMISSIONER STINSON: For the last several years, just like Ward said, it's been the number one cause of accidental death in the United States, but more specifically in the last three years of statistics for Alaska, we varied between number one and number three out of the United States as the cause of death. Eighty percent of the hydrocodone in the world is consumed in the United States, six percent of the population, 80% of the consumption.

Representative Keller introduced a bill trying to put a top end on narcotic use in Alaska, which I think fell because of misinformation, misunderstanding, turf, and a variety of different things, and we have to remember, too, when we're talking about prescribers, it's not just physicians. It's PAs. It's nurse practitioners. And everybody doesn't want to have a top put on anything that they want to do, and I think that that's a matter of education and looking at the data. There are reasons why we don't let people drive around with a blood alcohol level of 0.3, you know. Problems happen. So at some point, this has to be reined in.

I'm giving a talk to the medical students and the PA students tomorrow at the Health Sciences Building at noon on this topic, and I would more than happy to give a talk on this topic anytime, anywhere with current data, with current support about limits, about what the top dose that actually provides benefit is. That's been studied. I have an idea about where Alaska is on all this, which is several times over what the top limit is.

And part of my practice is, when I see people for pain management, they come in with two problems. They come in with their pain problem. Then they come in with their secondary problem of the over-medication that they're on, which really doesn't do anything for their pain problem. It is easier to address their pain problem than it is to get them -- bring

them back from their over-medication, which is quite difficult. The best way to do that is to prevent it in the first place.

And so I have some very strong personal feelings on this, and I'm very sympathetic to that part of it because, for the most part, that should be completely prevented. It should be completely unnecessary. And I hope Representative Keller tries to reintroduce this again, and whatever we can do to support that, I would be more than happy to do so.

COMMISSIONER KELLER: The bill is not dead, but it definitely has a -- you know, it has the problems you described, and we're looking for a way forward on it.

One of the questions I have is, if -- maybe Dr. Hurlburt knows, but the Alaska Prescription Drug Monitoring Program, that was part of the reason that you didn't mention that the bill stalled and that is because it put an added burden on that, and there were questions about its funding, and I don't know the current status. That's some of the research that has to be done. But the requirement that, you know, when you buy a prescription drug, it goes into a database and is accessible and that program was started here in Alaska, but there was some question of where it was going.

CHAIR HURLBURT: I don't have an update on that. Bob?

COMMISSIONER URATA: So I have a medical license in Washington and have gone through the class, online class

that's required. It's very good, very educational. And I do agree that we have a problem; we have to fix it. But in the process of fixing this problem, I have to remind you, since I'm a Hospice Medical Director as well in Juneau, that there are people who require higher doses of medication, and we have to remember that, for the dying patient, we are allowed to give as much as we need. I mean, I have a patient with cancer in his spine which is excruciatingly painful for him, and we had to use high doses of morphine drip, and I want to make sure that we don't limit that part of it, you know, as a fallout from what we're trying to do.

CHAIR HURLBURT: Yeah (affirmative). In Washington State -- for example, let's use the 120 milligrams morphine equivalent doses of what whatever the agent is, but that kind of patient that you've talked about is always excluded from that, but I think it is important to keep that in mind. Yeah (affirmative), Wes?

COMMISSIONER KELLER: Yeah (affirmative). I just wanted to confirm that. And incidentally, that's -- Dr. Stinson mentioned, in different words, but that's one of the problems with the bill. Yes; we exempted, you know, that category of user, but it became a Christmas tree very quickly because of all the providers that wanted to be exempted, and it's really difficult. We can't find, you know, where to put the limit on the Christmas tree and that is the biggest problem with the

bill right now that I see.

MR. MONAGLE: I think, on your question, Representative Keller, I believe that the provision providing for the prescription drug database runs out of funding as of the end of this fiscal year. I think it's funded through a federal grant, and of course, you know, with sequestration, I'm not sure what the status of that is.

And then, Dr. Urata, I think, when we talk about treatment guidelines and prescription drug guidelines, we always want to keep in mind that they're guidelines, that there can always be or should always be a provision that allows the treating doctor to speak to the payers and have that -- because not every patient is the same. Everyone is different, and while a particular treatment may not be recommended for a particular group of patients or for a particular diagnosis, there always must be a provision that allows the doctor to present his case to the payers that says I agree with you, but in this particular -- you know, we've tried the conservative approach. We've tried these things. We've tried those things, and this particular circumstance requires this deviation from the guidelines. So I think there always has to be that allowance.

COMMISSIONER HIPPLER: I have a question for you on California's workman's comp. One of your slides shows California as ranking third in workman's comp premiums with

155% of median, and then in another slide, it shows California as having a negative premium over Medicare for pretty much the same time period. How do these two slides reconcile? What's the different baseline of comparing?

MR. MONAGLE: So the first slide I think you're referring to is the Oregon premium analysis?

COMMISSIONER HIPPLER: Yes.

MR. MONAGLE: So the Oregon premium analysis looks at class codes. So insurance rates are different depending on the type of business. So if you have office clerical folks, your insurance rates are different from a construction contractor or an ironworker.

And so what the State of Oregon has done is they've taken these different class codes, and they've looked at each state and said, what are the insurance rates currently in place for these groups of classifications?

The second study was the Worker's Comp Research Institute, the WCRI study, comparing each state's allowance over that state's Medicare rate. So at the end, it's saying that Alaska's Worker's Comp fee schedule is at 170% of Alaska's Medicare rate. That same slide discusses California's fee schedule to California's Medicare rate, and my understanding -- and I'm certainly no expert in Medicare, but my understanding is that Alaska's Medicare rates are not considered, by most practitioners, to be adequate. That same

argument may not be made in other states, such as California where maybe their Medicare rates are more closely aligned to an allowable charge that does meet the needs of that state. Does that answer your question?

COMMISSIONER HIPPLER: Yes. Thank you.

COMMISSIONER PUCKETT: Are you aware of any state that, for their workman's comp, has used a network where they've negotiated with providers or Centers of Excellence?

MR. MONAGLE: That's a direction, I think, that most states are heading towards. There are a number of states that now require utilization review or allow networking, preferred provider networks. That's not something, currently, that's available that's available in Alaska per se.

In 2005, the Legislature did put a provision in law that says that employers may enter into a preferred provider network. They can approach doctors and approach clinics. The problem is the legislation also said, but you can't require the injured worker to go there, which, you know, basically gutted the idea because, if you can't steer your patients in that direction, the provider has no incentive to give you a discounted rate.

I think part of the problem in Alaska as well is simply lack of the number of providers and the lack of competition. I know, when I go down to Seattle, I'm inundated with commercials on media for, you know, surgical centers and eye

doctors and dentists. I mean, they just have a lot more locally available, and I think that competition, to some degree, drives costs.

COMMISSIONER MORGAN: This is probably a dumb question, but I'm good at those. You have 14 recommendations on three pages. I was just wondering, how many or which ones have been implemented either by the Legislature or your department? I mean, it says these are the recommendations, but have they accepted all of them or are you in transition on some? You don't have to go through each one, but generally.

MR. MONAGLE: Sure. No. You know, the -- I think, of those recommendations, none of them have been put into legislation. You know, why I really can't tell you. I will say, you know, that what we're talking about, whether it be, you know, a more restrictive fee schedule, an implementation of treatment guidelines, impacts doctors. It impacts the revenue that doctors will receive and that's not without consequence. In states that have undertaken these reforms -- and you can pick any state that's gone through this.

Montana. I spoke with my counterpart from Montana last week. They just went through this process in 2011, and they heard what a lot of states heard. If you do this, if you put in more restrictive fee schedules, if you put in treatment guidelines, injured workers will not be treated by me in the state. So that's always been sort of a concern, and I think,

from Legislature, from policymakers is that, you know, where do you push this or what's the -- you strike the right balance to make sure you still you have quality of care? Because I believe most providers would rather have their patients treated in Alaska than putting them on a plane and sending them, and I think most injured workers would prefer that, and I think most employers would prefer that. It's just a matter of striking that balance.

I think one thing about Comp that is true, in talking to doctors, is it's not the same as healthcare. So if I go in and see my healthcare provider, I'm probably going to see them for an initial visit, maybe a couple follow-up visits before I'm all better and I go back to work.

With Comp, you've got the Claims Administrator contacting the doctor, saying filling out this report. I want progress reports once every two weeks. I may have a lawyer for that insurance company now contacting that doctor, saying I want to take your deposition. We have a hearing; we want you at the hearing. We have all this paper. So it really is different from healthcare. There are a lot more administrative costs.

When Montana looked at this, recognizing that they have those higher costs, their approach was to say we're going to put in a fee schedule that cannot be higher than what the healthcare industry allows plus ten percent. So they factored in, recognizing those additional costs. They also have, in

their payment fee schedules, adopted codes, procedure codes that Medicare and Medicaid don't allow, but that's paying the doctor for the time to fill out those reports, the time to go to depositions, and the time -- they can bill for those hours spent filling out reports and doing these things and that's necessary, I think, in Comp because of the adversarial nature of the system.

CHAIR HURLBURT: Any other questions or comments from the Commissioners? Yes, Wes?

COMMISSIONER KELLER: To state the obvious, I'm very interested in what we do, as a Commission, as far as a recommendation in this area. Thanks.

CHAIR HURLBURT: Thank you, Mike. That was very helpful. We're a little bit ahead of schedule. Why don't we take a 20-minute break and be back?

Commissioner Hultberg is here, and so rather than starting with her presentation at ten, it will be 20 minutes until ten, and I think we're going to find our time is going to be very tight with her presentation and Mark Foster's. His will be equally interesting. Thank you, Mike, very much again. So we'll adjourn until 20 minutes until ten.

9:20:21

(Off record)

(On record)

9:43:14

CHAIR HURLBURT: The next session we have, Commissioner Becky Hultberg, the Commissioner of the Department of Administration, is going to be here talking with us, and she brings a unique and exceptional background to what she did coming into her job, understanding the legislative arena and then working with Providence Health Systems here in Alaska and seeing how that worked as a business challenge here in providing services for our state, and then came in as Commissioner of the Department of Administration, which does a whole lot of things, but I'm not sure what she does, other than related to the healthcare.

We talked earlier -- I think maybe just before you came in and kind of set the context of the State as a huge buyer of healthcare services with Medicaid being the next, but with $600 or $700 million for our state employees and retirees and the dependents there. And Commissioner Hultberg has had a lot of contact with her counterparts around the country from other states in looking at what other states are doing innovatively, where all states are faced with the challenges that we are, but ours are, on a percentage basis, a greater magnitude.

We know that one of the things that Representative Keller and his colleagues and those in the Senate will be wrestling with every year is this huge overhang that we have of pension and medical care costs, and I'm sure Commissioner Hultberg will mention the $4 billion -- $4 billion -- that's with a "B"

-- for the healthcare component for retirees in Alaska. But there have been some really exciting things going on.

Dr. Lydia Bartholomew, who introduced herself here earlier, is here from Aetna. The State is partnering with Aetna as the new third-party administrator beginning January 1.

So I'll turn it over to you, Commissioner Hultberg. Thank you very much for coming.

COMMISSIONER HULTBERG: Thank you for having me here, and I want to thank Dr. Hurlburt, who has been helping us as well in managing our plans. I can't really think of anybody better to have as one of advisors in managing those costs than Dr. Hurlburt, and I've learned a lot from him, and you'll see some of that reflected in some of these slides.

I also want to thank all of you, just for being here and sitting on the Commission and to those in the audience as well because I'm not going to spend a lot of this presentation talking about the macroeconomic view of healthcare, which I have, and some of you have probably heard me talk about that before, but I do firmly believe that healthcare really is the challenge of this generation, and if we can get this right, if we can fix this, we're going to have a dramatic impact on the quality of life for our children and our grandchildren. And we really have some choices to make that are difficult choices, but if we can navigate those choices well, we're

going to be leaving a sustainable system to the next generation rather than one that has a significant burden of debt.

And I told you I would not view into macroeconomics, and I'm about to do that. But if you look at Social Security, it's fixable with relatively -- with politically difficult, but relatively minor tweaks. Healthcare is -- Medicare is different. Medicare is not -- there is not a good path forward on a national level right now for Medicare expenses, and I think Medicare is, obviously, the huge -- you know, the huge elephant in the room when it comes to healthcare costs, but then you have Medicaid commercial pay. All of those entities are facing the same type of challenge with regard to cost growth that Medicare is. So I think that, again, how we address this challenge is going to be a huge determinant of the future prosperity of our country.

With that said, I have some slides on the presentation I did last week for the State of Reform that aren't in here that kind of talk about that. Happy to share them with you, if you are interested, but I think what I really wanted to focus on in this presentation is more the question that was asked, which is, what are employer healthcare cost-drivers and then what are some solutions to those cost-drivers?

So I hope this is a conversation that -- I'm sure you'll interrupt me and ask questions, but I did want to say I

welcome that, and I could probably take up more than an hour, but I will try to keep it to less than an hour so we have plenty of time for questions.

This graph -- and I apologize it's not updated for 2012, but it's on a fiscal year basis. But this graph shows you the big picture of state healthcare spending. The big teal bar, of course, is Medicaid, which dominates the graph. But if you add up all the other layers of the chart, you'll see that the State spends a lot of money in other areas besides just Medicaid.

And so the Department of Administration has a role in a couple of those areas, and we have a role, first, in the little, tiny purple bar, which you can barely see sandwiched in between the green and the teal. That's worker's comp. We manage worker's comp for the State of Alaska. And if you will notice, you can actually see the purple on the right. On the left, you can't even see it. So that does say that worker's comp is growing.

We have a role in our retiree health system, which is represented by the TRS, PERS, and JRS lines on that chart. AlaskaCare, which is our employee self-insured health plan, is the line on the bottom and that plan drives our contributions to union health trusts, which insure some of our active employees, which is the pink bar on the top.

So all total, we have over $700 million in spending every

year that flows through the Department of Administration in some way. So that gives you a magnitude of the obligation that we're managing on an annual basis.

So just to kind of directly answer the question of what drives cost -- and then I'm going to -- as I talk about some elements of our plan, I'll kind of interweave some of these concepts.

So what really is driving cost in healthcare and specifically in our plan? Well, it's what services your population uses, and this is stating the obvious, but again, I'll refer back to some of these concepts. How often do you use those services? And together, you know, those two are utilization.

The unit cost of those services -- and this is the area I'll probably spend the least time on in this presentation -- but is our biggest challenge, and I think, as your previous speaker articulated and as I suspect your next speaker will also articulate, this is really -- as I said, the biggest issue for our plans is the unit cost of service.

What's the quality of those services? Do they work? Does the treatment work? Is it evidence-based? Do you end up -- can you treat someone once or do you have to treat them 20 times? Does the treatment improve their quality of life or not? So really, the quality of the service is a significant variable in what's driving costs in your plan.

The numbers of members in your risk pool. Now to many of you in this room, our plan feels big, but when I go out of state to conferences and I talk to my peers, I realize how small we are compared to many other plans of my peers and how difficult it is for us to employ some of these very sophisticated cost management strategies because we lack scale.

Healthcare is extraordinarily complex. I don't need to -- you know, I especially don't need to tell any of the physicians that. I mean, you all understand how complex this issue is, which is why the problems are so difficult to solve. But to deal with these complex, very difficult questions requires a certain scale in order to have the data tools and then to develop the interventions that can actually help you manage costs. And so the number of members in your pool is extremely important.

And then the simple one, growth of the population.

So this is a snapshot of our employee health insurance plan because I think it's not quite well understood, and it's good context for the rest of the conversation. We don't insure all of our active employees. We insure the bargaining units and employees on the left side of the chart. That represents about 6,700 employees, about 17,000 covered lives. On the right side are union health trusts. Our largest bargaining unit is in a health trust, which is why we actually

have more employees outside of our plan than in our plan, and I've been very transparent in the past, and I'll be very transparent today to say, what's important? What is the cost management strategy scale? So what do you have when you have union health trusts? You have just fragmented your pool and so that's a concern, I think, for me going forward.

We manage our plan based on a -- we provide a benefit credit every month for our employees in the active plan. And then on behalf of the union -- of those employees in union trusts, that benefit credit is subject to bargaining. If you can see back on this slide, other than the last line, the partially exempt employees, these are all the bargaining units that we have contracts with, and they come up on a rotating basis. So we're negotiating, at least, three of these contracts every year. So change in that benefit credit or at the bargaining -- I mean, the bargaining cycle takes three years to get through all the bargaining units and so any kind of change to it would have to be effected through bargaining -- would take that period of time to implement, not that I'm suggesting anything. I'm just giving you a theoretical.

I just say, I try to stick my neck out just far enough that it doesn't get chopped off, which I'm occasionally successful at.

The amount -- the benefit credit for FY14 is $1,389 per month or $16,668 per year. And as we've talked to employees,

we've started asking them the question, what's the value that you're getting for your benefit credit? Because that's an important question to ask, especially when 70% of our members use 60% of the resources in our plan. Did you realize that are paying for the equivalent of a new car every year for you, for your healthcare? What's the value you're getting for it? And we want our members to be more engaged and to really be seeking what value they're getting in our health plan beyond just the times they go to the doctor and the plan pays for the coverage.

This graph represents the State costs for active employee health insurance, which were about $256 million in 2012. This cost represents the cost both in our active plan that we manage and for our employees covered by union health trusts, which are plans that we don't manage.

The population-adjusted increase for those plans is about seven percent a year, which isn't terribly bad. Some plans are worse than that. It's not great either. Certainly not -- I think Medicaid is certainly lower than our rate of growth, but seven percent a year when your spend is $256 million is a lot of money.

A little bit of information about the premium share in our active plan, and I just think this is important as context because, as we, I think, learned last year about this time from John Torinus who spoke, changing the healthcare market --

the employers have a big obligation in terms of their behavior in the healthcare market because how employers pay for services and how employers manage their plan and the plan designs that those employers put in place really drive how their employees engage with the market.

And so we have a plan that covers 100% of the premium share for the employee, which is extremely rare in today's market. Private employers average about a 30% employee premium contribution, and public employers average about a 20%, and we don't have a premium contribution. And I think this is significant because I think there -- it contributes to less ownership of our employees and their health plan, and less ownership impacts behavior. And so we need to get to a point where our employees have more ownership in their plan, more engagement with their plan, and I'll talk a little bit more about how we want to do that going forward.

A few demographics, and I'll try to kind of tie some of this back to those cost-drivers. About 17,000 members in the active plan. Even distribution of men and women. Average age is 35. So we're fairly young in our active plan. You can see our top five prevalent chronic diseases, which I think would probably show up on just about any list of plans of a similar size and demographic composition.

0.18% of our membership, 31 people accounted for 14% of the cost of medical claims paid out. Now you'll see this on

our retiree plan as well in a few slides. That's a stunning number. And what does that say? We have some really, really sick people that, when they get sick, drive an extraordinary amount of cost. So we have -- I sort of draw two conclusions from that.

One is we need to become much better at managing these cases because they're just going to cost a lot of money, but 14% of the cost of the plan. So we need to become much better and much more sophisticated at how we manage these cases when we do have people that reach that disease state.

And then we need to keep people from getting there as much as we can, recognizing that, sometimes, catastrophic things happen that you cannot control, but some of these conditions are manageable before people get to that disease state.

End-stage renal disease is a significant issue for our plan. We have people in the pipeline coming. We know that they're going to be there in a couple of years if we don't do a better job of managing them, and once they're there, they're very expensive. Their quality of life is bad. It's just a situation we don't want people to end up in. So we need to do a much better job managing people when they get to that state and then try to keep them, as best we can, from getting there.

I would also note psychiatric disorders. We've highlighted in our plan as a -- when you look at our high cost

claimants, psychiatric disorder is a comorbidity in about half of them. Now can I tell you what that is or what we should we do about it? No, but it is kind of an observation in the data that we think we need to deal with. Something is going on there -- Dr. Urata?

COMMISSIONER URATA: Do psychiatric disorders include alcoholism?

COMMISSIONER HULTBERG: Yes.

COMMISSIONER URATA: So is alcoholism the most in that category?

COMMISSIONER HULTBERG: We have not mined the data, and one of the things I'm going to talk about is our need to become more sophisticated at mining our own data. But I suspect that substance abuse plays a large role in that, not just with alcoholism, but also related to the discussion you were having earlier, prescription drug dependency, I think, is probably also a significant factor in that.

COMMISSIONER CAMPBELL: The renal failure, does the plan, after the two-year waiting period, shuffle those people off to Medicare?

COMMISSIONER HULTBERG: We have talked -- I cannot -- I don't have a definitive answer to that question. I don't believe we're doing it now, but we have talked about it and that's something that we are looking at right now.

COMMISSIONER MORGAN: And maybe it's later on in your

presentation, but have you formed a group or a team to work with that 31 people or the 31 that are coming soon on top of that?

COMMISSIONER HULTBERG: We have a Case Management Program right now through our existing TPA. We're transitioning TPAs, which I'll talk about a little bit later, January 1st and so the kinds of case management services that we're going to be providing are going to, I believe, enhanced by that new TPA. So we're talking about, how do we manage that pipeline that's coming and then do a better job of case management? So we do have programs in place now, but I think we're going to be able to enhance those programs in the near-term.

So utilization of services. Again, utilization drives cost, what kind of services you utilize and how frequently they are utilized, and this just gives you -- this is relatively old data, but I think the percentages probably haven't changed very much. It just shows you the percent of our active plan membership that uses resources in our plan, and you can see almost 60% of the resources in the plan are used by five percent of the population. So not probably as surprising to those of you that work with these patients all of the time, but nevertheless, what does it show? What's really driving our cost? It's those folks that get very, very ill, and we've got to a do better of, again, keeping people from getting to that five percent and then helping manage when

they're there.

So unit costs. Like I said, I just pulled a piece of the commercial pay slide from the Milliman Report. I'm not going to spend a lot of time on this because I think it was well-covered by the previous speaker, and again, probably will be covered by the next one.

Just a significant concern for us is unit cost, and I think we're going to be -- you know, one of the things that we're really looking at doing is, how do we grow our network in Alaska because, you know, growing the network helps us in a couple of ways, and I'll talk about this a little bit more later. But growing our network helps us with evidence-based medicine. It helps with a lot of the cost-drivers. It helps us with evidence-based medicine. It helps us -- the quality piece. It helps us with unit cost. It helps keep our members from getting bounced (indiscernible - voice lowered), even more importantly than that, and it -- you know, it helps in a variety of other ways as well.

So one of the things we're going to be looking at very closely with Aetna is, how do we continue to grow the network so that we can help with unit cost, utilization, and quality? Because a network helps us with all three of those cost-drivers.

So I think, when we talk about network, sometimes, the assumption is just we want to drive down unit cost. That's

part of it because unit cost is one of our biggest problems, but network has value to us beyond unit cost. The network value really is, how do we ensure -- how do we manage utilization also, and how do we help address some of the other cost-drivers as well?

So a couple of notes on our challenges in our active plan. We had a 20% increase in our plan cost last year. We had a spike in high-cost claimants that was a primary driver of that. Those kind of numbers are not out of the norm. If you look at our plan over the last two decades, we've had relatively low growth followed by a spike, you know, which averages out to about seven percent. But again, you know, if you look at a $256 million spend, 20% growth in the plan costs in a year is a heck of a lot of money. And so we're going to be able to mitigate that cost increase this next year through a variety of strategies, but a spike in high-cost claimants.

I think our culture and plan structure are challenged, and I want to spend a little bit of time talking about that because what we want to see are engaged consumers. Go ahead.

COMMISSIONER CAMPBELL: Along this line, what has the Affordable Care Act done to you in your planning and adjustments?

COMMISSIONER HULTBERG: The Affordable Care Act (indiscernible - voice lowered) impacting our active plan because we're subject to it. We're currently grandfathered

under the Act. We have not lost our grandfather status yet. So while we have had to add -- you know, we've added dependent coverage to age 26 and had to comply with various other things, we have not yet had to fully comply with all the provisions because we're grandfathered. However, plans cannot stay static.

So grandfather status is great until you need to do something to manage costs and then you're really prevented from doing it because, if you adjust certain levers beyond a certain threshold, then you lose your grandfather status. And so really, the idea that you could maintain your plan is not really true because you can maintain the same static plan you've always had, but plans can't stay the same. They have to change and evolve. So we've not yet lost our grandfather status, but we see it on the horizon. It's just a question of timing.

So again back to culture, plan structure and organizational culture, I think, have a really big impact on utilization of services in your plan, and right now, we have a culture that's -- we have a very traditional plan that covers people without requiring a lot of engagement of them. And I think we really need to make a cultural shift toward engagement of our members, and I'll talk a little bit about some of the strategies to do that. But I think that traditional plan structure is not helping us to engage people

as consumers in their healthcare, and it's really critical for people to be engaged as consumers in their healthcare.

So moving to a culture of consumerism and personal accountability is going to be a big shift. It's going to have to be supported by plan design changes. And so that's a big hurdle that, I think, the State is going to have to get over in the next couple of years, if we really do believe that it's important that people be engaged as consumers and engaged in personal accountability for their health.

The other -- I think some of the other things on here I've mentioned, and I don't want to belabor this in the interest of time, but network development and access and then geography in a dispersed population, which I know is not unique to us.

So moving on to the retiree plan, let me give you a little bit of an overview of the retiree plan and then I'll move into some more concrete solutions.

Costs for retiree healthcare were about $451 million in 2012. They could top half-a-billion dollars this year, which, to me, just is a stunning number because we're talking real dollars, really big dollars.

So I don't have a slide in here that I presented last week, but to Dr. Hurlburt's earlier point, we have a $12 billion unfunded liability for pension and healthcare in the state. That is the largest in the country on a per capita

basis according to a report I just read. Four billion of that is related to healthcare.

As I look at managing those costs, which are going to top a billion dollars in operating funds a year, if we don't -- if we stay on the same trajectory and the same -- what's level dollar amortization, which is the amortization schedule that we're on -- it's like a mortgage payment -- that's just going to be an extraordinary burden for the State to bear. So we have to protect the retirees who we made promises to and figure out how we're going to manage these costs. So you know, from my -- as I look at these costs, I think, well, of $12 billion, eight is really based on a formula. It's a pension formula. That's relatively -- that's pretty static. Four of that is related to healthcare. That can be managed.

So how do we better manage those costs in order to reduce that obligation to continue to provide really good healthcare to retirees, but to help the State manage this cash flow crunch that's coming? So that's kind of the lens that I look through when I consider this plan.

So the active plan population is relatively stable. This population is growing. So growth alone is going to drive costs. You can see kind of where we are in 2013, and you look out to about 2022 and that's a pretty steep growth curve over a relatively short period of time. So we're going to be adding -- Jim Puckett could probably tell you the number

specifically -- between 15,000 and 20,000 retirees into this plan in a relatively short amount of time. So we've got to make this plan sustainable now because that wave is coming. It's already starting to come, and we've got to be able to manage these costs as this population grows.

Demographics. I'm not going to run through this because I don't think there's too much that's really interesting on this page, other than to note we have a slightly higher distribution of women. Women consume more healthcare. They're a little more expensive. So you know, that demographic difference in this plan drives costs.

We do have some challenges specific to this plan. I'll highlight that. Specialty meds are a challenge for all plans, particularly in this population. We're seeing dramatic growth in specialty medication. Unmanaged diabetes, which is leading, again, to those costs toward the end of life. And then specialty surgery. And by specialty surgery, I just mean cardiac surgery, orthopedic surgery, surgery performed by a specialist, I guess, is a better way to -- although all surgeons are special. So anyway, the more narrow the surgery the more expensive it tends to be, the smaller numbers.

So challenges in the retiree plan, and again, we talked about the $4 billion liability related to health in this plan, which has really, I think, developed partly just because the healthcare costs have grown faster than the actuaries

anticipated, but partly because we don't have a flexible plan that can adjust -- that is mainstream that can adjust with the times.

The retiree plan is covered by a provision in the Constitution called the Diminishment Clause, which basically says retirement benefits shall not be diminished, which has been interpreted to mean, if you diminish any benefit in the plan, you have to add a corresponding enhancement. Well, what's a diminishment of benefits? Something that might cost someone more or they might have to get different services in a way that they didn't get them before, as in through a network. So this plan has become relatively -- it's basically been unmanaged because we have not been able to control those cost levers that would drive utilization, unit cost, all of the things that we talked about that lead to good plan management.

So we think this plan has to change. We think it needs to become more responsive to the needs of retirees. There is no preventive care covered in this plan because who, in their right mind, is going to add a service in, if all you're going to do is just grow your costs because you're adding a service and you have a $4 billion liability? So it doesn't have preventive care. It doesn't have dependent coverage to age 26.

So we think there are some things that we could do to enhance the plan and make it better for retirees, but manage

costs. Require some level of network utilization. Adjust -- recognize that deductibles need to be periodically adjusted, just to keep up with basic CPI, let alone medical cost inflation. I think the pharmacy co-pay is four and eight dollars in this plan, which is really, really low. And so we need to look at how we can manage this plan, how this plan can become flexible and mainstream, which it is not right now. It is static and costly. It needs to become flexible and mainstream.

So I'm going to try to rush or kind of hurry -- not hurry. Yeah (affirmative). Actually, I am going to hurry. I'm going go quickly through some of these solutions because I think I'd like to make sure we have time for Q&A, and some of these will probably be fairly obvious to you.

This is just kind of a high level slides showing you what we want to do and what our goals are in our plan, and I'll refer back to some of the solutions in these three buckets of increasing member engagement, supporting evidence-based medicine, and collaborating with providers.

So the first step kind of in our process was to go through this year-long RFP to establish some vendor partners going forward. We view our vendors as strategic partners, and as I said before, we don't have scale. We rely on vendors to really bring tools and innovation to us because we don't have the scale internally to develop them ourselves.

And so we have new vendor partners coming onboard January 1st of this year. Aetna is going to be our third-party administrator. ActiveHealth Management, which is owned by Aetna, is going to provide wellness and disease management. And then Moda Health is our new vendor for a dental network. We've never had a dental network before. Surprisingly, it saved us a lot of money. We probably should have done it a few years ago. But again, I think it's important that we, you know, periodically go out and look at what's in the market that may not have been in the market three or four years ago, and we did that, and as a result, we have a new dental network vendor that is going to save us some money.

So I'll spend a little bit of time on this slide, not a whole lot, kind of talk through this. When we're talking about diabetes, we really want to slow an individual's progression, to the right on that top chart, because, once we get to this area, the pink and the red areas, that's when those costs really start to balloon up. People's quality of life is greatly diminished, and we're just in sort of management mode. But if we can slow the progress to the right before people get into that area, then we have a chance of either keeping them static or moving them back and that's really the goal, and we want to do that by helping them improve their health so that, as a whole, we can move the population to the left, to a healthier state.

One of the ways we're going to do that is through disease management. I've got a list here of 42 conditions that we're going to focus on. We're going to have a dramatically increased capacity, I think, for disease management than we've had in the past, recognizing that, when people get -- when people are diagnosed with a chronic disease, we, as the plan, need to help them, in partnership with their physicians, to manage that condition.

So I talked a lot about membership engagement, and this is another tool we are looking at for member engagement. We have, as a goal -- it's a goal, not yet a final plan -- to offer a consumer-directed health plan beginning in January of 2015. It would not replace our existing plans. Although right now, we have a premium plan that probably is just being so unaffordable it may eventually go away, but our core economy and standard plans would stay the same. We would just offer this an alternative selection.

Ultimately, I think we will be successful, only if we can drive people into that plan, and if that's the case, I'll walk through some of the results of what Indiana did and how they accomplished that. But for now, we want to offer it. And I think one of the benefits for this is, if you look at that 70% of the population, they're only using six percent of your plan resources. And I ask the question, what value are they getting for the plan? There's value in peace of mind, and

there is value in the few times they may have to go to the doctor. But if we can offer them a way to fund an HSA, which then they have available so when they do have that medical emergency, they have resources to pay for first-dollar coverage, then they're getting better benefits out of the plan, and I think that's an important consideration for that 70% that really aren't utilizing our plan.

But I want to walk through, quickly, just a couple highlights on the case study of Indiana. In 2006, the State of Indiana implemented a consumer-driven health plan. You can see kind of the fiscal structure of their plan. They offered one in 2006 and a little bit richer plan in 2007. And the data that you have below is from, I think, probably the 2006-'07 to 2011 timeframe. But there are a lot of criticisms of consumer-driven health plans and a lot of advocates for consumer-driven health plans. I just want to look at -- show you the results of the plan, what they did.

The health plan -- so the State saved money, first of all, which you would expect because they implemented it. If they didn't expect they were going to save money, or at least, slow their growth, why would they do it? But they estimated that they saved between $17 and $23 million for the State. The employees saved money, between $7 and $10 million, and they had $38 million in their HSAs, and to me, that says those employees are then better prepared, in the future, when they

have a health crisis because they have resources they can draw upon. The average in the HSA was about $2,000 per employee, and their participation was above 90%. Now it was above 90% partly because they structured their plan design to incentivize people to move into the high deductible health plan. I don't want to hide the eight ball on that. There was a very intentional strategy to move people into that plan.

But most importantly, I think, on this slide, the criticisms you hear about CDHPs are that people won't go to the doctor because they don't want to spend the money and that was not what the State of Indiana's experience demonstrated. CDHP participants did put off or avoid using important healthcare services because they were in a CDHP. So I think their experience was really -- it was a win for the employees, and it was a win for the state, and I think it's something that we need to take a serious look at for our state, especially given our cost structure, to see, can we structure something that is a win for the employee and it's a win for the state?

So a couple that, in the next couple of slides, I'll walk through are some membership engagement strategies that we have through Aetna, who will be our new TPA. The traditional call center model, I think, is going to look a little bit different with the new TPA. It's more of a concierge service, and I think this really -- these next two slides really go back to

the recognition that, if you're asking people to be engaged in their health and to be better consumers, they actually have to have information upon which to make decisions, which is very difficult right now because, if any of you have ever gone through the exercise of trying to figure out what something is going to cost and then working with your plan and working with the provider, it's really, really hard, even if you know what you're doing. And for someone who doesn't really know that they need to go ask for a certain code for a procedure and then tell their insurance company, I'm not asking you what my coverage is, I'm asking you what I'm actually going to have to pay, it's really, really hard.

I did this with my husband a couple -- I think it was a year-and-a-half ago. Went through the exercise and said I need to know what this procedure is going to cost, worked with two providers to get cost estimates, worked with the health plan, ended up realizing that, if I went to Provider A, I would pay $800. If I went to Provider B, I was going to be paying more like $4,800. Because it was an out-of-network provider, I was going to get a pretty hefty balanced bill.

So we need to have resources available to protect people from those -- to help people protect themselves from those consequences. So our call center needs to be a place people can go, not just to ask a question, but to have someone help them navigate. So it's really more of a navigator function

than an answering questions function. So that's one way we're going to help people as we ask them to become more engaged consumers.

It's hard to have -- you know, you have to have an app, obviously. So we're going to have an app called iTriage that's going to help people identify, if I have a condition, let me look up the symptoms and see what should I do. Should I go to the ER? Should I go to -- can I wait and see my primary doctor? Should I go to urgent care? It's going to identify those facilities that are in their network, where they are on a map, and give them driving directions. So it's pretty much trying to take as much difficulty out of that decision making process as we can, again, to help people navigate. It is hard to navigate the system. We want to do as much as we can to help our members to be able to navigate it.

One of the things that's not yet integrated into this tool that we're very interested in is the transparency product. I think iTriage is going to be working on integrating transparency and cost information into this tool. It's not there yet. We're going to see how that evolves or we're going to be looking at a service, like a Castlight, to help people be able to understand, before they go, what's the cost going to be to the plan and what's my out-of-pocket cost going to be?

So I'm going to move on to evidence-based medicine. I've, I think, become a convert on evidence-based medicine. And we want to become better -- it's -- evidence-based medicine, when you talk about it, sounds like a no-brainer. Why would you not do that? But what's hard is in how you integrate it into your plan in a meaningful way. And so we've been working with Aetna on how we do that. We're very, I think, impressed by some of the capability they're going to bring for that, but we've also been looking at our own plan and what can we do within our plan design.

So we're going to expand our pre-certification list. I know pre-certifications are not popular sometimes with members or providers, but really, pre-certification is one way that we can have a touch of that member and we can help them as they have to make a decision. And so we can help them understand the consequences of their choices from a financial standpoint. We can help them understand what the evidence says about their condition. So we're looking at expanding our pre-certification list.

We're going to adopt Aetna's clinical policy bulletins. We've been going through our plan, looking where our plan does not align with evidence-based practices. And then we'll consider plan design changes.

Again, I'll get through these next few pretty quickly. These are just tools that we're using.

ActiveHealth has a tool called CareEngine that's going to -- inputs all this data that you can see on the left and outcome gaps in care, and as gaps in care are identified for our members, those providers and the members are going to get alerts that there is a gap in care, and those alerts are based -- there are levels of severity. So obviously, something that is life-threatening is going to get an immediate flag. Things that are more, remember, you need to have this test or you need to go see your primary care physician are going to be handled more through correspondence. But we're looking forward to implementing this tool to see what the impacts are for our plan.

And then as I said before, we really need to get better at making -- at mining data and making decisions based on data. So for now, we're going to adopt ActiveHealth's data warehouse, but we're looking at whether or not we maintain -- we continue that data warehouse or go out and procure our own data warehouse. But it's really -- as I said before, healthcare is really complex, and what we found that's very easy, is to identify a trend. What's really hard is to figure out, what are the underlying drivers of that trend and then what can you do about it? And to develop those solutions is going to require a level of sophistication of data analysis that we don't have right now and so we're looking at how do we grow our capability to analyze our data.

And I just thought, you know, I'd throw as many hyphens in that title as I possibly could.

So the last slide and one of the more important slides, I think -- and I'm almost done. This is my second-to-last slide. We want to collaborate with providers to help transform the market. Again, as I mentioned before, we want to improve access to contracting physicians and providers. Having contracts is really important to us. It's important because it helps us manage several of those cost drivers, not just unit costs, but it helps us manage utilization. Again, it helps us to manage a variety of cost levers, and I think it helps us in terms of we want to have those relationships with physicians. We want to work in a collaborative way.

We want to improve the predictability and the performance of the cost of our contracts. There is, as you all know, significant variation among providers in terms of cost. If you ever -- if you have access to health plan data, go pull your J-codes. Look at your J-code data, if you want to see significant variation in cost. It's absolutely stunning, the level of variation sometimes that you can see. And I think, sometimes, it's not that people are trying to bill in an egregious way; I think, sometimes, there is just a lack of awareness. Did you know that the practice down the street is charging 25% for this J-code drug? Did you know that this drug is -- you're paying -- and literally, we've had this

before -- 50 times more for this particular drug? So sometimes, it's just a matter of raising, I think, that level of awareness of what is the reason -- you know, what charges are.

That kind of feeds into the next one, which is we need to address some of those, and not all charges are egregious. As a matter of fact, the majority aren't, but when we do have egregious charges, we need to address it because we end up with patients who suffer the consequence with large balance bills. We've had a $20,000 balance bill this year. We've had a $3,000 balance bill this year, and there's nothing more heartbreaking, as a plan administrator, than having someone come to you and say, I had this unexpected medical event, and now, I have this bill, and how am I going to pay for this bill?

Financial health is a part of health. It has to be a part of health. It has to be part of our conversation. And so we have to make sure that our members are aware of the choices that their making and that they can make the best choices so that we can help them incorporate financial health as a part of their overall health.

So we want to collaborate with Aetna to identify and engage delivery system partners that are committed to designing transformative solutions. We don't have all the answers. I'm presenting a lot of the problems and sort of

what I think are some of the strategies, but we don't have all the answers, and we need to be working together with delivery systems to say, how can we better manage this population in a way that helps us manage our costs and that helps you to continue to be in business as a provider as well? It's in all of our interests that, in 20 years, we have a healthy, successful medical community and a financially healthy state. That's the successful end state. The question is, how do we get there? And we can only get there if we're all together at the table. So I think that's the way -- the hope that -- the way we want to approach these questions.

And then we want to encourage delivery system investment in integrated care delivery. We want to support innovation in the market and so that's really the message we want to send. Whether it's a patient-centered medical home or an ACO or procedure-based integration opportunities, like bundled payments, we want to be helpful in supporting innovation in the market when they are providers willing to help us and to work with us in engaging and designing innovate solutions.

And then the last slide -- and I have 15 minutes for questions, at least. So I think I'm on schedule here.

Things we're watching. As I said before, as a public plan, you have to be careful. We're a large employer plan. So you want to stick your neck out just enough that you're making progress and not so much that it gets chopped off. So

because we have -- we're scrutinized, and we get a lot -- we can do things -- if we take actions that a private sector employer will take, sometimes, they might actually be newsworthy, which always amazes me because I'm not sure that we're that newsworthy. However, we can be newsworthy when we make changes that private sector employers can make and it's just a normal part of business. So we're watching these things to -- we don't want to be, necessarily, the first adopter because there is a lot of risk in that, and you don't even know, if you're the first adopter, if it's going to work. But we don't want to be the last adopter either. We want to hit that sweet spot where, when we see innovations in the market, we're monitoring them, and we can implement them where it's appropriate.

So we're watching onsite clinics. The State of Montana has just opened several onsite clinics, and they're expanding. We're watching what the Coalition is doing with their onsite clinic in Anchorage. Don't know if that's a direction we'd move. It's just a market innovation that's happening in many other places and so we're watching it.

Centers of Excellence. Again for all of the hubbub about that issue, we've actually not expanded our travel benefit. We're continuing to watch the Centers of Excellence networks that are developing around the country, how other large employers are handling this issue.

Narrow networks. This has gotten more press lately because of the narrow networks in the exchanges, but I think the trend is going to be toward narrow networks. Although in Alaska, I just say I'd be happy to have a network and then let's talk about narrow networks. So I think there is sort of an incremental approach to narrow networks. However, I think that's where the market is moving is toward narrow networks.

Reference pricing. CalPERS just had an interesting foray into reference pricing on, I think it was, knees and hips or it was some orthopedic procedure where they basically set a price for their members. Here is the maximum amount we'll pay for this. Go find your provider. You know, find your provider. What they found is that all of the -- that the variation in prices changed, that they saw providers moving down to meet more the reference price. And so again, we're not a mature enough market to even consider some of these things, but I think they're important for us to watch because they show us where the market is moving.

Private exchanges. IBM and a few others have made news lately because they've either put their retirees or active members in private exchanges, again something that is not mature in this market, but I think we're starting to see more employers saying this is really complex, we don't do it very well, but we think these benefits are important to offer for our employees and so we believe that a private exchange is a

way that we can best manage this population.

Consumerism and transparency tools. We, again, are watching this trend. We will look at -- we want to adopt a transparency tool. It may be our iTriage tool. It may be another tool, but we think it's important, if we're asking people to be good consumers, that we actually help them make -- give them information to make decisions.

And then the impact of public plans on the healthcare market. Public plans tend to be a little richer in terms of benefits than private sector, large employer plans, and we have to be conscious of the fact that, as large public sector employers, we're helping to shape the market by the decisions we make regarding plan design. And so we need to be good stewards, not just of our resources, but we need to be good stewards of our behavior in the market. And so we cannot become -- get so far out of alignment with the private sector that we are impacting the market in a negative way. So as a public plan, I think that's something that we're very conscious of as well.

So with that, I am here, at your disposal, to answer as many questions as Dr. Hurlburt says we have time for.

CHAIR HURLBURT: Thank you very much, Commissioner Hultberg. We have plenty of time for questions. Keith?

COMMISSIONER CAMPBELL: The Moda Health, on your dental provider, could you expand a little bit on how they're going

to recruit and things of that nature or do you know or do you care?

COMMISSIONER HULTBERG: We required, as part of the RFP, you know, that they provide us with their network. So we knew what the breadth of their network was. And we're not penalizing our employees. We're not incentivizing them, through the plan design, to use a network provider at this point. So our employees can still use whatever dentists they've been using, but we're going to have -- but by having a network, we're going to be able to get some discounts that we weren't getting before and then protect some employees from balanced bills. If they do use a network provider, they'll be insulated from a balanced bill.

So right now, Moda has a fairly extensive dental network in the state already. That was one of the reasons why they prevailed in the RFP was the size of their network right now. So I think, with the State's volume, they're going to be able to actually go out and have some other conversations with some other dentists whether it's a value to join the network.

So I think it's really been a win-win for us because we're not changing our fiscal structure of the plan. We're just going to really enable people to have access -- or we're going to save the plan money and potentially save them money, if they were at risk of a balanced bill. And I think then we'll look at how this evolves over the next year or two and

then see if it's worth making other plan changes, but they've been a really good partner in terms of talking to us about even getting services to areas that may not have services. So it's been a really positive relationship, and I'm looking forward to seeing how it matures.

CHAIR HURLBURT: Yes, Val?

COMMISSIONER DAVIDSON: Great presentation, by the way. I just had a question on slide 12. That's the unit cost of service. And I think, initially, you said that what drives cost are the services that are used, how often they're used, and the unit cost of services, and I guess I'm struggling a little bit with the rationale for why these procedures were chosen to illustrate the cost differential when they don't seem to be in alignment with your list of the top five prevalent chronic diseases for either the active population or for the retiree population. So do you have that data that shows that?

COMMISSIONER HULTBERG: This is just a slide that I had used and I've used in probably four or five presentations in the past. It just demonstrates areas where there is a large variation in unit cost. So it is not tied to -- although, you know, you look at some of these, and we do have -- we have a -- between our active and retiree plan, we have a lot of members and so you're going to see a significant amount of members in -- or a significant amount of procedures for each

of these, but I was not attempting to try to tie this to any -- and again, I really was hoping to avoid spending most of this presentation talking about unit cost because I think that's an important thing, but I think it's been really well-discussed and established, and we really need to figure out how to move beyond just talking about how expensive things are, and I hope that's the conclusion you draw from this is not that we're complaining that things are expensive. We're acknowledging that they are, and we're saying, how do we move forward together in addressing what can we now do to make these costs sustainable for the State and sustainable for the providers? So I guess that's really -- I mean, there was no attempt to tie this to the highly prevalent conditions in our plan, although I could certainly do that.

COMMISSIONER DAVIDSON: That would be actually really helpful. Thanks.

CHAIR HURLBURT: Representative Keller?

COMMISSIONER KELLER: Thank you. And thank you, Commissioner, for your obvious commitment to spend public money responsibly. As a huge purchaser of healthcare in the state, you know, I just commend you.

The question I have -- especially in light of the fact that we know that, currently, we're in an unsustainable situation; we have to deal with this, and you're carrying the ball up there. Thank you.

The question I have is this projected plan that you have in 2015 is going to come out as an optional thing. That's what you're anticipating. You mentioned, when you were talking about the apps, that there is nothing there as far as transparency is concerned, and I wish you would talk to us a little bit about that. Why not? I mean, is there something -- is there resistance? To me, an engaged consumer -- it's just a no-brainer that you have to have transparency on prices in order to make, you know, quality decisions, and I'm just curious, you know, is that anticipated for sure or what?

COMMISSIONER HULTBERG: So I'll just kind of tell you what our plan is. We have access, through our Aetna relationship, to this app called iTriage. It does not yet have a transparency tool integrated into it at the level we'd like to see. There is some information about network versus non-network, but we really want more information than that, and I think -- in iTriage, we've been told they're going to work toward that transparency.

So I think we will just be, at some point, making a decision about whether we think that tool is going to provide the data that we need or whether we need to go out and procure another transparency tool, like a Castlight. So we'll make that decision. I don't have a specific timeframe, but certainly, our goal would be, as we launch a consumer-directed health plan, to have a transparency tool that's robust and

meaningful available for our members because I don't think it's responsible to ask people to take on more responsibility as a consumer if you're not going to help them do that.

CHAIR HURLBURT: Bob?

COMMISSIONER URATA: So one of our core values that we -- or core strategies for healthcare transformation is transparency, and we've heard that the All-Payer Claims Database is the best. Is that something that you've noted as well?

COMMISSIONER HULTBERG: You know, that's really kind of outside the purview of our plan. I mean, in general, obviously, we're going to support increased transparency, but I know I would defer that question to Dr. Hurlburt and Deb because it's really not something that we've done policy research around from sort of a big picture standpoint. I think it's clear that the market is moving towards more transparency and so the mechanism for that, I think, on a large scale is really more of a global health policy issues; whereas, I'm really trying to focus -- I really focus more on how do I manage my population.

COMMISSIONER URATA: Well, you know, I'm just looking from the point of view of duplication of efforts, and if we recommend something like that and if it seems useful to you, then perhaps we could save you some money that way, but I guess that's something that you folks have to get together on.

COMMISSIONER HULTBERG: And to respond to your question, I think whether or not there was an All-Payer Claims Database we'd still be looking at a transparency tool because we what we want to be able to identify is not just the cost of the service, but how that service then interacts with the members' deductible, co-pay, network because we want them to be able to say, if I go here, I'm going to pay $500. If I go here, I'm going to pay $437. And there is kind of a complex set of interactions there with some variables within our plan that would have to occur as well.

CHAIR HURLBURT: Other questions or comments? David?

COMMISSIONER MORGAN: This is more of a general question. It's probably more directed towards Representative Keller, and if our Senate colleague was here.

These numbers of $4 and $5 billion of unfunded liabilities, and these graphs, and I imagine, over the last four years, all of us on this Commission have seen about 100 of these graphs. The only version we haven't seen is in Hebrew, but we've had it left, right, up, down, over, and under. How does the Legislature, especially through the Finance Committees -- I mean, how they are internalizing this and looking at this as they develop budgets in the long-term or the short-term or whatever?

COMMISSIONER KELLER: Leave it to Dave to ask a question that's impossible to answer. I'm not going to speak for the

rest, but if you would go back to that slide 12, I would appreciate it.

The way I internalize this is we're looking at a half-a-billion a year just to cover the medical portion each year for the unfunded mandate for the foreseeable future, and you know, that just -- you know, that's $4 billion of the $13 billion of the shortage in the PERS/TRS liability.

So the way I internalize this is I look at a half-billion dollars a year and go, oh my goodness, you know, and this is going on, you know. And so, you know, I really welcome the efforts of this Commission. I really value it, and I -- you know, I think that our emphasis -- from my perspective -- you asked about a legislative perspective. From my perspective, it's absolutely critical that we look at ways to save money, you know, to provide the best care we can, but look at how to do this effectively with the dollars we spend. So thanks for the open door to walk through there.

COMMISSIONER HULTBERG: And I would just add that I sit on the Retirement Management Board so I have a bit of exposure to these issues on a fairly regular basis, and the Retirement Management Board has been doing -- is well aware of the burden that these costs are putting on the State's operating budget every year, and they've been working to make recommendations on how to manage that cash flow. It's really a cash flow issue and how you manage the cash flow. So I don't think --

if there were easy solutions, it would have been implemented a long time ago, but I do think that there are a lot of people who are both in the Administration and on the Retirement Management Board who are looking at, how do we help the State in the next couple years to manage this cash flow in a way that keeps the Trust healthy, that continues to help us pay down the liability, not make it worse, but also helps the State to be able to afford its other obligations?

It's a really -- I mean, this is one of the biggest issues, I think, facing the state budget right now because these costs are real. They're growing, and behind them, are people who are relying on retirement checks and retirement healthcare. And so that's a really weighty obligation, I think, to manage -- to balance the needs of the State from an annual operating standpoint with how do you make sure that we are appropriately caring for the health of the trust funds and having the resources available.

So I think everybody is committed to looking at this issue with those two perspectives in mind, and I do think there are a lot of really talented people who are working really hard right now to help us to develop a path forward. So I just didn't want to -- I wanted to make sure you knew that, from an Administration standpoint, we're very -- we spend a lot of time working on this issue.

CHAIR HURLBURT: Maybe we can just go back to Bob's

question on the All-Payer Claims Database. We have the two databases that we've been talking about. One is the Hospital Discharge Database, which we've had, but which has been voluntary, and we've gotten most of the hospital discharges, but we came to a situation, as was discussed in our last meeting, that Valley Hospital is not participating, and Providence said, well, you know, if the rest of you guys aren't going to participate, why should I share all my data? But then we had the Administrators from the two hospitals say, if it's mandatory, fine. That's fine with us. We'll play the game. We just want it to be fair, and we want to have a level playing field there.

And that, I think, gives you good epidemiologic information about knowing what's going on. It does capture one component that the All-Payer Claims Database doesn't of what's happening in the hospitals where it's charity care, where there is not that. That's not a huge component, but it's a significant component there. And so that's on the table.

We're in that kind of dark hole period right now where various things have been sent to the Governor's office, and they're going through that, looking at it with this huge overhang of dollars and what things are costing, but also the All-Payer Claims Database. So that if you have a payer like Premera and Jeff, Jeff has that data on the business that they

do, and as the biggest company in Alaska -- depending on how you slice and dice it, 70% of the market there -- there's pretty good data that he can look at, and the State, likewise, could. The State, in using a TPA that's not been a full service insurer, has not been in that sophisticated of a situation as Premera would be in looking at that and that's working with Aetna now. We're hoping to become more sophisticated and have that.

But in looking at what is the overall market doing -- and one of the things, through the Milliman Study, that we saw, even in Alaska, there is this vast difference, and as Mike Monagle talked first, generally, Workman's Comp is the biggest payer, and there will be a huge difference in what they pay, what Medicare pays, Medicaid pays, commercial insurance, self-pay, and so on.

So I think that the State, as a very significant insurer, can make information available to their employees, but if you have an All-Payer Claims Database, theoretically, then that information is available both on cost data and quality data that can be made available to all employers. So if you're a smaller employer with a couple hundred employees, it enables you to make a better decision of how do you want to design your plan and where do you want to go. But as I've said before, while I think it's a good thing and I think it's a good place to go, realistically, it doesn't seem as though

they've been used a lot.

Deb and I had a conversation the other day, and it looks like Colorado, which was maybe the last state to come onboard a little over a year ago, may be moving along in using it more profitably, but I think we ought to be able to, but the reality is I have to be a little disappointed in seeing what they do. So then that becomes a part of the decision process at the Governor's office and in the Legislature because they both would take some funding to do, and can we afford to do something if we're not pretty confident that we're going to get something that's really going to make a difference to us?

Any other comments or questions? Any last thoughts from you?

COMMISSIONER HULTBERG: Again, I just appreciate the chance to be here and would hope that what you take from the presentation is that this is really complicated. It's really hard. It requires a lot of scale to do well, and while we all can see that we have a sustainability problem. The devil is in the details about how we sit down together and fix it, and I think that's where we all need to be. And I'm here saying we don't have the solution, but we want to sit down and talk. So with that, thank you very much for your time.

CHAIR HURLBURT: Thank you very much, Commissioner Hultberg, for your presentations and more so for what you're doing.

So we'll move right into our next presentation. Mark Foster has been working with the Commission since our earliest days, from a former life when he was working with ISER, and some of the very underlying data that we've used right along was data that Mark developed for us, looking at healthcare as a segment of our Alaska economy, what the changes have been in that, what's made up of that, and now, Mark is the OMB Director, Finance Director for the Anchorage School District and is working with them, the largest school district in the state, another big buyer of healthcare services in the state, and like the state active employees, were faced last year with a big per person increase in cost, which then overlaid contract negotiations with the Teacher's Union. If we're spending all this more for healthcare, can we have more teachers or do we have to have less teachers or what can we do with salaries?

And so Mark wakes up and goes to sleep dealing with that every day now, seven days a week and so thank you, Mark, for coming again, and we're really looking forward to your presentation.

MR. FOSTER: Thank you very much. Just a couple of quick background -- I'm currently the CFO and Executive Director of the Office of Management and Budget for the Anchorage School District. We have approximately 6,000 full-time equivalent employees and about 8,400 people that we employ this year, the

most recent payroll. So that gives you a sense of the scale.

We cover directly, under a self-insurance plan, about 2,000 employees who are not teachers and then we negotiate with the teachers for a price for their health trust plan that they manage on their side. So we have only seven bargaining units to deal with and so it gets to be fairly interesting engagement when you want to talk about salaries and benefits and really drill into the benefits side of the equation.

I think on the fundamental challenges that we have is how do we offer competitive compensation in an environment where healthcare costs continue to rise rapidly. And like the State for, at least, a portion of our plans, this last year, we saw double-digit increases that were in the 18% range, not quite the 20, and how long can you keep doing that?

I'm going to go ahead and move on to the slide that talks about K through 12 education investment levels, and I'm looking at dollars per student across the last 30 years. And you can look at the salaries in the blue and benefits in the red. And what do you detect? It's basically salaries, on an inflation-adjusted basis per student, haven't gone up particularly rapidly. It's basically maybe a percent above inflation over that 30-year time period. And if you look carefully at the 20-year time period, it's less than one-half of one percent. So if you look at it and think about it, at 20 years, 7,300 days, the salary increase above inflation is

less than a penny a day. So it's basically tracking inflation on the salary side.

The benefit picture is very different. We've gone, basically, from maybe 25%-30% benefits just 20 years ago to now where the benefit puzzle is maybe 40%-45%. What's going on?

These are the audited financial results. So they do reflect the retirement. So let's look at the growth over that time period, over the last 30 years, and just look at what are the growth elements and a compound annual growth rate. If you look carefully, you'll see that the health/medical completely dominates the equation. The active medical is a little over five percent compound annual growth rate. The retiree medical that goes to my books adds on top of that. So my total picture for medical care costs over the past 30 years, on a dollars-per-student basis, real growth above inflation is approaching 15%.

Pensions, themselves, are around a six percent growth. The salary, as I've alluded to before, is basically flat. The compensation packages have grown rapidly. The salary portions have remained, essentially, flat. What value are we really providing in this environment relative to our competitors? I would submit to you the answer is we're losing ground because we have excessive healthcare cost inflation.

If I step back and look at a slide I've shared with the

Commission before, I think it's useful to keep in mind it's not just the school district or public employees. It's all of the buyers of healthcare services that are facing the challenge in Alaska.

Prior to 1990, we were actually less, on a dollars per capita basis, than many of the Western states. I just picked Wyoming because it was sort of in the middle of the pack. Subsequent to that, the cost momentum has taken us well above the other Western states on a dollars per capita basis.

To give you a sense of the scale, what does this mean on a dollars per capita basis? If I compare us to Wyoming, we have $2.4 billion per year more than Wyoming on a per capita basis that we're spending on healthcare costs. Just for reference, the oil tax reduction is $0.7 billion. It's three times smaller than the tax that we're essentially paying for excessive healthcare costs.

What's driving the growth? Well, if we step back and look at the United States, we can see that it's technology, income, relative price inflation, and some due to the change in insurance coverage. I want to remind folks that it really isn't just the insurance coverage that where, really, the challenge lies; it's the underlying the medical care, the technologies that we import, the miracles that we're performing. They're not free. And as we get wealthier, we expect more from our health system. It's a pretty natural

phenomena across the world, but it’s a large and growing challenge.

Someone asked earlier, well, what are the tradeoffs and what are the implications? Frequently, schools in the United States and in Anchorage are compared to international competitors. The Mayor had a recent summit where he compared schools in Alaska to schools not only around the country, but around the world and said, well, the performance of our schools -- we’re not doing very well.

Well, I was intrigued by that because I like comparisons in data, and when I drilled into it, what did I find? Those other countries have very different systems, and they pay their starting teachers’ salaries at well above the dollar per capita. We’re well below. I’m not attracting and retaining because I’m not nearly as competitive as those other countries are in paying starting teachers a decent salary to get the best college graduates. Look carefully. Alaska and Anchorage, we’re paying about 0.6. We’re paying about 60% of the per capita for our starting teachers’ salaries. Finland the United States are up around 80%. Singapore, Germany, Korea are above, you know -- basically, approaching one and then getting to 1.2. They’re paying. They’re investing in education. How can they do that, and how come we’re having such a hard time doing that here in the U.S. or in Alaska?

Let’s go to the salaries as a percentage of GDP per

capita and compare physicians to teachers in those countries that we're competing against. This, by the way, is the McKinsey Analysis, for those of you who've looked at the McKinsey Global Consulting Group and their analysis of healthcare costs and education systems. And I've just basically updated that analysis to reflect Alaska and Anchorage data.

What we've got is basically, in the world class education systems, physicians maybe paid 20%, 25% more than their teachers. Think about how radically different that is than what we have here in our country.

Anchorage, by total salary pool as a percentage GDP, begins to approach about 100% of the average per capita salary, but when I look at the physicians -- and I pooled both primary care and specialists into one category -- we're up at about 4.5. We have a very different distribution of priorities.

So what are the results of that different distribution of priorities and the medical cost inflation? As those benefit costs grow and the State faces challenging budgets, they've provided, essentially, flat nominal dollar revenue. So as an employer, that means I have to reduce positions and find other ways to reduce costs. We're about an 85% personnel sort of budget, so that's really where we go. We go to positions.

So what did we do last year? We cut support positions,

instructional support, the teachers' assistants, the people in the back office who are helping out. We cut the secretaries and admin assistants. We cut custodians, and we cut a whole bunch of central office folks. We tried to preserve the classroom as much as we could and added a few more teachers. Those were the tradeoffs last year.

In recognition of that, we also got the honor and privilege of sitting down to negotiate. And we got to negotiate in an environment where we said, at the beginning, it is absolutely essential that we control the long-term growth in medical care costs. We can't afford the continued cost growth because we'll just wind up having to layoff more and more people, and we won't be able to sustain the momentum that we do have in turning around test scores, in turning around the performance.

So with that, we negotiated a three-year contract. And the thing I want you to look at is that inflation plus one percent benchmark. Over three years, the total compensation package we were able to negotiate is less than inflation plus one percent by about $14 million in year three.

I'd like you to sort of look around and see how many other contracts have come in close to that and then try and understand what's driving that. How are we able to get that price down for medical care costs in that package?

I'll give you a hint. It's associated with the

Affordable Care Act. What part of the Affordable Care Act has people looking very carefully at cost growth on both the buy and the sell side, the employer and the employees? It's the tax. It's absolutely the tax on what some people call high cost plans, and I will say it's the excise tax that will be on all plans soon enough. And that's really what enabled us to sit down and go let's look at the projections and let's look at the total compensation package and understand the relationship between the value of the medical benefits and the value of salary to the employees, keeping in mind, when you're in negotiations, you're frequently dealing with folks who are closer to retirement than, potentially, the group that you're really trying to bring into your pool. So it's a very delicate balance. And yet, we were able to get them to go, yep, we want to avoid that tax. So that portion of the Affordable Care Act is very real, and people are beginning to digest it and understand it.

I think it's also useful to think in terms of the life cycle of public employees that we have, both teachers and the Public Employee Retirement System folks, and look at their age and how much they cost because I generally have them until, in the case of teachers, the Tier I teachers, they're about 55 when they're then eligible for a very generous retirement and then I turn them over to the state retirement plan where they get them from 55 to 65 as the primary payer. That's what

we're paying for. And as you can see, the cost across that 55 to 65, which is circled in red, is a steep profile on a dollars per person basis as they get older.

I would submit to you that we need to look at the life cycle of that employee across their active and retired life to really address the medical care cost challenge, and I look forward to working with everyone who is interested in that particular challenge because I think investments that we make on the front end, if we truly believe that aggressive wellness programs can be effective, the payoff will frequently be in that 55 to 65 zone and that, of course, crosses organizational boundaries, which makes it a very interesting public/private conversation about how we can make a difference there.

A slightly different presentation of data that you've already seen is the distribution of medical spending per patient. I've looked at the MEPS data, which is frequently easy to get, and compared it against Alaska patterns which remain, generally, private, and they're not too far apart.

So I present the MEPS data for the purpose of this conversation, and it's just a reminder that, if I look across my covered population, 15% don't get any healthcare in any given year. Thirty-five percent show up for probably about one visit and maybe get a few things with that, so that's 35% and three percent of the claims. That next tier, 40% of the covered population, gets to about 30% of the claims, so maybe

about a third. And it's that nine percent and that one percent which is really where the action is.

So why do I come back to these sort of stylized facts that we all know? To what extent do our benefit design options influence this distribution? I would submit to you, from the data that I've seen, mostly what the benefit design does is it helps me with the first 60% on the low cost side. So there is some value there in a given year, but over time, it doesn't get me a lot because the cost growth challenge I have is in those high cost patients over time.

Nurse practitioners/PA scope of practice. Let's reduce costs. Again, I get some value, but it tends to be in that lower end of the distribution.

Employer clinics. I've been pitched by a number of providers trying to get me interested in an employer clinics. Being a sort of trust but verify person, I've been able to get a fair amount of data from them after the initial pitch, and the data tends to show me that there are some initial opportunities to capture value, but they don't go beyond about that 60th-percentile in this cost distribution. It's really sort of front-end, and it's faith that, long-term, I'm going to get some benefits because there is aggressive wellness packaged in as part of the program. If my retirees are living at 55, I can't make that pencil out. Yeah; there's a one-time savings. I'll do that probably because I need to do something

to try and control costs, but it doesn't get me a long-term bend on the cost curve. Enhanced wellness, again as I mentioned, is part of that.

So where do I go to get something that helps me bend the long-term curve? In the end when I look around both to the insurance industry and to large employers, the solution that emerges inevitably is scale. You have to get to a large scale to be able to negotiate whether you're an insurer negotiating with a hospital or an employee negotiating for a package for care, you've got to get to scale so you have some negotiating power or market power in the economic sort of phrase.

How do we get there? How do we get to scale? There are some ideas that are being put together in the Legislature and other places, public and private, to try and get to scale. I think those areas are worth some more attention. How do we get there?

And then the other thing we need to understand is, what's the minimum scale we really need, if we're going to turn the corner? And I think the key that you want to look at there is it's the sub-specialty care where I see the rapid price growth. Not surprisingly, the more specialized you are, you have fewer competitors in a relatively small market. I don't think I have enough volume, even at 50,000 lives, to really bend the negotiation on these sub-specialists. I've got to get larger than that to have enough book of business to be

able to mount a credible conversation about I think I have enough to go take this somewhere else. Then we begin to have a productive conversation about what's a real, reasonable price and value proposition.

Short of that, a fragmented market. We'll get a few percent on the benefit design, scope of practice, and retail clinics.

I think one of the more interesting articles and underlying research reports that's worth looking at and referring back to came from the *New England Journal of Medicine*, working with RAND in November of 2009, attempting to separate the promising from the unpromising approaches. Where are we going to get the most change in healthcare spending over time, not a one-off, one-year, what can I get in any given year, but over a ten-year time period, where do we really think we'll get sustainable change in bending the cost curve?

Look carefully at retail clinics, scope of practice, and benefit design. We're down around the zero to one percent range. I get good motion in any given year when I implement the change, but it doesn't help me in the long-term growth curve. So it's a necessary, but not sufficient, condition, in my view, to look at benefit design and clinics where you can to get some value, but I'm not going to get to the point I need to be, if I really want to control the long-term costs so

my competitive compensation package allows me to provide salaries to attract and retain quality people, so I can deliver on the surface.

Disease management. Let's look at that one. You'll see it's about a -1.3. So I'll get some potential savings, but there's also a plus-one tail on that. We've had that done, worked with disease management for a few years, and what do we see? We see some increase because there are folks who are underserved, and we're getting to them earlier and providing them with a fuller span of preventative care. We have not seen the return. Why? I expect the return to occur, basically, downstream in the retiree plan.

Bundled payment, you'll notice, is at the top. What does that really amount to? What's the bundled payment program? Really what we're saying is we want to construct a reference price system, not on procedures, but around care, episodes of care that we can bundle up and then we can set, essentially, a price, not unlike the CALPERS experiment, around care. That's ultimately where I think we need to go, if we're serious about enabling all of the employers in Alaska to provide competitive compensation.

So how do we do that, and why is it sort of a serious thing? Step back for just a moment and remember that I put a little oil tax slide presentation in there earlier. Step back and ask yourself, what drives the Alaska economy? It's oil,

and potentially, gas. One of the things that we're looking at, of course, is a $50 billion gas pipeline, roughly. How can we build that if our healthcare costs are that much higher than any of our competitors, whether it's Canada, the Lower 48, or anyone else in the Pacific Rim? I'm paying a premium if I'm coming to build in Alaska, not just for salaries but the benefit package. And remember as a proportion of our total GDP, it was about $2.4 billion, and as it turns out in any given year, Alaska's gross domestic product is, right now, about $50 billion, about the same as a gas pipeline.

So the gas pipeline has got to pay a premium of about $2.4 billion because of high healthcare costs. If we don't get our arms around it, we present a risk to the industry that's the economic engine. I don't think it's an acceptable risk. I think we have to get to bundled payments by reducing the barriers to looking at price. I think an All-Payer Claims Database would be very helpful along those lines because, ultimately, it's not just the claims; it's bundling them up into pricing that we can then basically say, look, this is what we can afford because we have to become competitive in international markets. We don't have a choice.

Open for questions. Thank you for the opportunity to come and speak. I really do appreciate it.

CHAIR HURLBURT: Let me go back to the point you just made, Mark, and thank you. In terms of bundled payments, my

understanding is, the bars here on that page 13, those are the changes in the trend line that will go on from year-to-year?

MR. FOSTER: That's correct.

CHAIR HURLBURT: So in terms of bundled payments where, as in so many areas of the necessary "getting our arms around it" that you refer to, we're kind of toward the back of the back, like at the absolute back of the back in the country in doing it, which means that it may save us from some mistakes, and we can learn from some others.

But in terms of looking at what bundled payments mean -- and I might have to ask what your level of familiarity is, but one of the useful tools that payers have found is to look at the episode of treatment grouper data that companies, like Optum, can provide where they can draw, actually, from different data warehouses and aggregate it, and you can say what is the aggregate cost of that, which translates to a bundled payment so that, even without bundled payment, you can make the comparisons of what does the whole cost treat us, and the pharmaceutical industry will say, well, yeah, we're charging you $10,000 a month for this new pill, but look at all this other money you're going to save us, and usually, that would be self-serving, as I said it, but sometimes, there might be some truth to that.

So have you looked at that concept of looking at what we're doing now and an episode of treatment grouper type way

of getting us toward being able to deal, in an intelligent way, with bundled payments and negotiations?

MR. FOSTER: Yes is the short answer. We've done that with our third-party administrator and begun to bundle up and look at where the opportunities are, but having been through that, it's very clear to me I still don't have scale. And as I contemplate potential mergers and alliances with the State of Alaska, for example -- a concept that's been put on the table by one of the Senators -- I look at that, and I think, you know, I still don't have enough scale there when I look at where my cost growth exposure is in the specialties and sub-specialties. So that's where I'm troubled. I think I can make some progress, but I don't know that I will get to a spot where I will get more than a percent or two when I think the potential might be there for five or six. And given how far ahead we are of all the other states on our price growth, I think we need to look for a fairly substantial bending of that curve. Otherwise, I do think we present ourselves with risk for the economy here. Yeah?

COMMISSIONER ERICKSON: Do you have an estimate of the number of lives you think are needed to achieve scale?

COMMISSIONER URATA: 750,000.

MR. FOSTER: I think -- actually, I see breaks, when I look at national data, of around 300,000 where people are starting to get to scale, but that's looking at what gets

published in the *American Economic Review* and other places where they're trying to look at insurance markets versus medical care markets and see where the bargaining power begins to emerge and you can see where the cost grows, but it's somewhere around that 300,000 in national studies. I'm not so sure it may not require more scale here for a variety of reasons, not the least of which is we're largely fragmented here in a way, and of course, that is the entire private market. So I think that's the challenge.

CHAIR HURLBURT: But to get to Bob's question and your response, in a way, and the map that we all have in our minds of Alaska overlaying the rest of the country, the Lower 48, the scale might be one thing in terms of the Anchorage market and the reality of getting scale, but the reality of getting scale in Sitka will probably never be there.

And while we can look at the other countries that spend half to two-thirds of what we do in terms of dollar equivalents or GDP and live longer and have babies die less, I think we all believe, yes, they're doing that, but the Canadian system is not the solution for our country, nor the Swiss, nor the German, nor the Dutch, or any of the others, and we need to come to our American solution, and it is not going to include 730,000 or 750,000 Alaskans in one bargaining chunk, but nor will it be 300,000 in Anchorage, to take on the whole city.

So we have to figure out then -- you know, you could aggregate government buyers in Anchorage, the Municipality, the State, the School District, and so on, but that would not get you close to the 300,000.

MR. FOSTER: And it would create, I think, a typical imbalance where the government payers are driving their costs down in the private sector, except the remaining margin and overhead.

I would submit that the U.S. -- and Maryland, for example, in its All-Payer system, is a classic example of where businesses have basically said, we can't afford to continue it, and they did, essentially, bundle up and get to scale, and I think we've got other examples of that in the U.S.

CHAIR HURLBURT: But Maryland has set hospital rates.....

MR. FOSTER: Yes.

CHAIR HURLBURT: .....and we won't do that.

MR. FOSTER: We can decline to do that. I think, if we get to reference pricing and you have bundled reference pricing, you begin to illuminate the market in a way that enables competitive forces to work without having to set those prices.

COMMISSIONER CAMPBELL: And that's even with our fragmented, small suppliers of medical services around the state?

MR. FOSTER: (Nods head in affirmative)

COMMISSIONER DAVIDSON: So I was intrigued by your slide eight where you compared the salaries as a percent of GDP per capita for physicians and teachers, and your graph, over on the right, talks about world class education systems. Are those the systems on the left are the same?

MR. FOSTER: Yes. That’s correct. That’s the red ones.

COMMISSIONER DAVIDSON: And then how many of those countries provide universal healthcare coverage, and is that a driver of the scale, the difference between physician and teacher salary?

MR. FOSTER: I haven’t done an independent analysis to confirm that, but I would suggest that that’s probably one of the factors to consider.

COMMISSIONER DAVIDSON: Because that’s certainly one way to get to 100% of the covered -- 100% of the population.

MR. FOSTER: It’s one way. I think there are other ways to get, given the political realities I believe we work within here in Alaska.

COMMISSIONER DAVIDSON: But I think we’re talking about political realities, and I mean, you met your -- the whole point of today’s conversation is that we should be thinking differently, not necessarily with what is right now because we have to do things drastically to be able to change the environment as we know it and to change those trends. So we

shouldn't be bound by current realities, if we're really trying to tackle something that we have been unable to do yet.

COMMISSIONER URATA: So I have a couple of questions. The first one is, you know, when I see a Medicare patient, I'm told that they -- when they turn 65, they have to become Medicare, but there must be something here where state workers can continue their insurance or TRS and can continue their insurance over Medicare; is that correct?

MR. FOSTER: They become the secondary payer, in my experience.

COMMISSIONER URATA: Right. So if they're secondary, then.....

CHAIR HURLBURT: It depends on if you're actively employed. If you're actively employed.....

COMMISSIONER URATA: Right.

CHAIR HURLBURT: .....then you're.....

COMMISSIONER URATA: But if you retire, then you become a Medicare primary so that should be cheaper, shouldn't it, for the system, for TRS?

COMMISSIONER HULTBERG: So you're absolutely correct that Medicare does become secondary at 65, but the -- so we do have costs in that post-65 population, but the majority of our costs are in the pre-Medicare retiree population, which is, you know, probably, on average, 55 to 65, although we do have much younger retirees, even than 55. And so you're talking

about picking up a really large cost for people at a time when their healthcare is as expensive as it's probably going to be, pre-Medicare.

CHAIR HURLBURT: And the $4 billion number is predicated on the assumption that Medicare will be primary for retirees.....

COMMISSIONER HULTBERG: Yes.

CHAIR HURLBURT: .....at 65, as far as what the State's liability is?

COMMISSIONER HULTBERG: Correct.

COMMISSIONER URATA: So there is still a significant dollar amount that we have to cover or the State has to cover for retirees?

COMMISSIONER HULTBERG: The State does still cover -- does become secondary, and I don't have the percentage breakdown in front of me. I'm sure we could get that, but when we are looking up those populations, we actually -- although we manage them under one plan, we look at them as two very distinct populations from a management standpoint.

COMMISSIONER URATA: All right. And the other question -- or actually, it's probably a comment. You know, I think, in these other countries where they have single-payer systems, they have a healthcare system, and in our country, I've always said that we have a sort of -- and all due respect to Mr. Davis -- an insurance system, which, heretofore, has not

covered prevention or any of that sort of thing. So now, in my opinion, it's kind of catching up to us. It's starting to cost more and more money, and we have to do cost-shifting to cover costs of some of the entitlement programs that don't cover prevention either. So now we're trying to come back and develop these preventive systems and trying to do healthy lifestyle, wellness to prevent the older people from spending a lot of money for disabilities that, possibly, could have been prevented. So we're trying to catch up, and I think we're finding it very difficult.

And so sometimes, I wonder, in the middle of the night, you know, gee, should we develop a single-payer system and work on all aspects of a person's health, you know, with a primary purpose of keeping people healthy and lower our infant mortality rate, increase our, you know, length of life statistics, which, you know, rank around 30th in the world? And then maybe, you know, our costs of healthcare will go down, but that's a big change, and I don't know that that's, you know, politically possible in this world, but certainly, the costs -- we're looking at costs, and we're trying to do all these fixes to a system that, you know, isn't really designed to keep people healthy. And so, you know, it's a major challenge.

COMMISSIONER MORGAN: That was good. I've known you a while, and I've -- I think your linguistics, sometimes, on how

you answer questions is some of the slickest I've ever seen. And believe me, I'm from a state that produced Henry Clay.

So I think the one thing you forget, when you look at the chart running up the side that has Finland and those, is you also have to look at their budgets for their country and see how their -- you know, what do they say about statisticians? There are liars and then there are damn liars. So sometimes the way you move around expenses and costs inside the governmental accounting system can -- when you take a snapshot of this is what we pay teachers and this the healthcare cost, you also, sometimes -- you're going -- I know that you're going to expand it out into looking at the government receipts and the government expenditures for each of those countries to really get a true macro sense of the costs and the process of how they deliver services or goods, whether it's teachers and education or healthcare, but I digress.

The real question -- that's just a comment. My question is, I was on a three-week vacation, and I thought I lost my phone. No. It wasn't packed, and therefore, the phone was in my living room. But while I was in Lexington, the mayor there had an article -- have you seen that -- in the *Wall Street Journal* where they met this same problem. Especially, they had a little problem with their bonds, sort of like Detroit, i.e. no one would buy them. So they had to finally address the education issues and the healthcare issue, just the same

stuff. And I thought that was pretty interesting what he did, and it finally had to become a crisis mode before everyone would sit down in a room, like this, unions and -- they have a slightly different system with education, and it's basically all the same. You know, the school board matches the districts of your assemblymen or city council.

The description in his article -- and basically, they went through a process of six weeks, eight weeks of everybody pointing to the left as to the problem, and everybody that should pay more or take a change in lifestyle pointing to the right, but it took about six or eight weeks of stark reality, like your charts before you brought them around, and finally got some compromise around everybody around the table on expenditures, costs, and that -- you know, the whole deal.

My question is -- I see your charts -- did any of this actually enter into your negotiations with the unions, and was there a dialogue or a process working with those trusts and whatever one of your three bargaining -- was it three bargaining units -- six bargaining units -- what -- I'm assuming you've walked this with them and you've started talking about how they're going to have to change the relationship there in costs. I'm not so much asking what the outcomes were. I'd just like to know, did you go through the same process as the mayor in Lexington went through to get to wherever he's going to get to on dealing with this?

MR. FOSTER: I don’t know the Lexington process well enough to be able to compare. I do think there are a few things that, I think, are very helpful at setting the table before you enter into negotiations.

One is to present a six-year -- basically, you know, not a plan, but a six-year forecast. What do we have to face if we assume level, nominal funding and increasing benefit cost, based on historic trends, and look at both how many layoffs that requires to balance and then look at the Affordable Care Act excise tax and what that means to the total compensation package. Get that out on the table and just look hard at the tradeoffs, and hand those across and go, here you go. Here’s the tradeoffs we all face. What can we do prior to entering into the formal negotiation process?

So you’ve got plenty of open space to have that dialogue before you sit down at the table, and I think that and probably a combination of other sort of dynamics that people can speculate about probably helped contribute, but in the end, there is just a fundamental logic that people face when they stare at an excise tax of 40% on their benefits and they realize that that’s coming quickly. Even those who are close to retirement who are just going to get clipped by it in 2018 or 2019 get it. And I think the closer we get there the more opportunity we’ll have to bend the cost curves there.

CHAIR HURLBURT: Yes, Jim?

COMMISSIONER PUCKETT: Just a quick comment, then a question. Thank you for giving your long-term perspective and your information that you shared with us, and I don't know if I should thank you for the strong reminder of the big job that we have at Department of Administration with the retiree health costs that are coming in that age group.

But my question is, you've identified that, from your perspective, some of the effort for wellness and plan design and all that probably doesn't pay off in the time that you have them as an employee. In the research, did you see where it was a payoff, it was a good return on investment in that 55 to 65 age group or did you not go that far?

MR. FOSTER: I think we've been through a couple of phases of wellness sort of fashion, some of which has resulted in folks really getting down to understand what drives a wellness program and gets value. And keep in mind, in a wellness program, frequently, the value isn't typically measured on the back end on my return. It's on the up front and referral patterns and the touch on the customers to get higher customer satisfaction. So you've got to, I think, sort of understand and appreciate that's part of what you're doing.

From my perspective going along, I'm beginning to see, in the public information and the research, some returns on wellness programs, but they would be, as I would characterize it, aggressive. They're aggressive, and they use biometrics,

and they really get after people about what they're doing, and they measure their progress and that takes an investment. And because the payoff is long and I've got folks retiring at 55, 60, 65, I don't see good payoffs on that from the point of view of an investor just going, all right, is this a good payoff relative to keeping another teacher in the classroom?

So it really is -- I think, if I look at that entire cycle of care into the retirement program, then I begin to see there is a productive data log opportunity there about the value you can get from a wellness program. So I'm just negotiating out loud.

CHAIR HURLBURT: Jeff?

COMMISSIONER DAVIS: So I'll just pretend I'm on the other side of the table. Not really, but just an alternative view of wellness I've had the chance to notice and sitting here thinking he would be a great presenter to spend some time with Andrew Sykes from Health at Work, who is a Wellness Actuary, and could show us, you know, really from his perspective, what's going on from the data.

But what he recently shared with us is, you know, the -- if you look at determinants of health, it's about 10% to 20% access to medical care. It's about 10% to 20% genetics. It's about 10% environmental. It's 50% lifestyle. And if you look at what effects -- what you can do, it's really a few things. It's activity. It's nutrition. It's sleep. It's smoking and

alcohol and wearing your seatbelt. But activity, by far, is the biggest -- you get the biggest bang for your buck, and we're not talking about running marathons. Active is defined as 30 minutes, four days a week of walking. That's active. That's fit. And it doesn't even have to be 30 minutes straight. It can be five minutes, six times in a day. But that affects positively 46 different medical conditions, and the return is almost immediate.

So I would argue that there is pretty good data that says, with the right program -- and that's the big deal because, up to this point, it's been hard to measure activity, but now, there are ways to measure activity and reward people for activity and that's the thing that drives the change. So wellness is not wellness, and the science has changed, and I'm just amazed at what can be done now with programs that are designed correctly. So just an alternative view on the value of worksite wellness. Thank you.

MR. FOSTER: And we look forward to exploring those opportunities in this marketplace. Thank you.

COMMISSIONER DAVIS: We're implementing them.

CHAIR HURLBURT: In his report, Jeff, to what extent was success in implementing those tied to incentives or bribes or whatever?

COMMISSIONER DAVIS: So it is all about the engagement and that requires structure, which is the program, and how

that gets structured around incentives to engage is really important, and there is this new thing called neuropsychology that's part of that, but some really good evidence about what works and what doesn't work. Then you need an employer who is willing to say yep, makes sense, we'll do, but that's really where engagement has to be driven. So somehow through that, you have to support the employer in that journey around engagement because, if you don't, you don't get the results. But there are some pretty good examples, and they're fairly new now.

What Andrew presents is not just his own, but data from a lot of sources to make the argument, and I think it would be informative just for us to see that in a state where there are a lot of lifestyle issues that are driving a lot of the numbers we see. I mean, 50% of the consumption and wellness is -- your health is driven by these personal decisions.

So we spend all our time talking about medical care, but we're not -- I mean, we have a drippy faucet that we're worried about when the river is flooding through our house. So it's just -- I think that's one of the different things that we can do, and since I'm on a role, I don't think it matters who pays the bills. Insurance is just a financing mechanism. So if you don't change the way you are engaging people around their health, if you don't change the way medicine is delivered, if you don't change the way we're

paying for things, if you don't change the market in terms of supply and demand and you just have somebody else writing the checks, you don't fix anything. So thank you.

CHAIR HURLBURT: Keith?

COMMISSIONER CAMPBELL: Can we talk about that over a glass of wine?

COMMISSIONER DAVIS: Maybe something stronger.

CHAIR HURLBURT: Now Mark, thank you very much. Before we break, we need to probably get our logistics straight. Who will pay the cashier and who won't? The Commissioners and Speakers, I assume, don't, just so we know what to say to -- when we go by the desk there. There will be tables, two tables at the front for the Commission members. This next noon hour, I think you will really enjoy -- be very good, and like the session last October, jointly sponsored by Commonwealth North and the Health Care Commission -- so Deb?

COMMISSIONER ERICKSON: I don't think I have a whole lot to add to that. The speaker who we have addressing the Commonwealth North forum, Gaye Fortner, is the President and CEO of a business coalition on healthcare from Tennessee, and it was a group that formed about 17 years ago. She's going to tell us the story about what generated this group of employers who came together over these similar frustrations to work together and learn together and to employ some strategies together, and because of their maturity at this point, they've

evolved to the point where they are implementing some real innovative and exciting projects, collaboratively working with healthcare providers.

I don't think I have anything to add to logistics. It's just down the hall to your left when you go out the doors, and we'll be -- nope. To the left. And all of the Commission members' names and our morning speakers' are already on a list as having been paid for. Any members of the public who would like to attend, if you haven't already registered with Commonwealth North, you can pay at the door, if you would like to participate in the lunch, and we've provided some seats in the back for members of the public who aren't interested in purchasing the lunch part. So it's open to the public. And we will be, assuming the technology works, webinaring her presentation for those of you who are on the phone, and Gaye's presentation is posted on the Commission's website as well, and we'll be video recording it and posting the recording for folks to view later, too.

Are there any questions? It is about quarter to right now. So we have about a 15-minute break. It would be good if you could find your seat in the next room before noon because they start -- Commonwealth North is good at starting promptly, and we will be back here -- that should go for an hour. We'll have a bit of a break, and we will reconvene in this room at 1:30.

CHAIR HURLBURT: And that will be the public comment period for half-an-hour, so if anybody here would like to comment, just use the sign-up sheet that's out on the table out there and indicate that you would like to comment. Anybody on the phone here, we will, at that time, at 1:30, ask who may have comments on the phone.

COMMISSIONER ERICKSON: I just got a question about whether this room will be secure. I don't think the door will be locked. So if you have any valuables with you, I would not leave them in the room.

And one other thing, Barb just told me that she already checked all of you in, Commission members and our morning speakers, so you shouldn't need to even go, unless you want to pick up -- write yourself a name tag -- to the registration desk. You can go right in the room. Thanks, Barb.

11:45:07

(Off record)

(Gaye Fortner presentation at Commonwealth North event)

(On record)

1:36:23

CHAIR HURLBURT: The next session that we have will be the regular time for public comment that we have, and so far, we have -- we've got about a little over 20 minutes left now, but we just have two people signed up. We will go ahead. The folks who are here with us, we will go ahead with those folks

and then come back and open it up. We've not had anybody sign up online who are on the phone, but if you didn't have access to the Web, then after we hear from the two folks that are here, then I think we could plan to take probably not more than five minutes. We should have plenty of time to do that, and I'll open it up again for anybody online. So if anybody is listening and has something that you'd like to share, we will give you that opportunity.

So the first person is Vicki Penwell, who comes -- who introduced herself this morning representing the consumer advocacy group. If you could introduce yourself for the record, turn the microphone on there, and then speak into it? And we appreciate your being here, Vicki.

MS. PENWELL: Okay. Thank you very much. My name is Vicki Penwell. I live off of Nabesna Road in kind of the eastern interior in Wrangell-St. Elias National Park and Preserve. I've been in Alaska since 1989. I'm here as a patient advocate.

I volunteer for the National Patient Advocate Foundation, and I want to share a little bit of information about that organization, but first, I just want to tell you that my interest in healthcare and healthcare advocacy comes from years of experience, starting when my son was young. He has cystic fibrosis and so I have been, first-hand, experiencing the medical field for more years than I would like. I'm a

breast cancer survivor. My husband has some chronic health problems, and in fact, we're actually here in Anchorage because he, just last week, had a nephrectomy and is recovering from that. So like I said, I'm way more familiar with the medical care field than I would hope anyone would have to become.

I want to advocate a little bit today for the participation in the expanded Medicare program under the Affordable Care Act as well as making efforts to actually reduce the cost of healthcare in Alaska.

The Patient Advocacy Foundation, we advocate for state and federal policies relating to access to affordable and quality healthcare for everyone. We go to Washington D.C. every summer and visit congressional offices. Last summer, we were there and visited over 200 congressional offices.

We advocate for things. This past year, for instance, we advocated for a law that will help reform specialty tier medication pricing and also to preserve funding for community centers. We have a nonprofit arm that provides direct case management, and we served almost 2,000 Alaskans, including direct mediation for 43.

Nationally, 34% of our clients are uninsured, 30.8% are commercially insured, and 23% are on Medicare. Nationally, a little over 80% of our patients are receiving assistance related to a cancer diagnosis, and most of our households have

incomes of less than $35,000 a year. Issues of debt and financial crisis, that's one of our biggest things that we hear from people about.

We do an annual report. This is available online, and it gives the results, demographics, and stuff of the people who have contacted us regarding their conditions and stuff.

So I've given you each a copy of the Patient's Bill of Rights that evolved as part of the Affordable Care Act and so I'm not going to take time to read through that, other than just to point out that, really, these are insurance things. These are -- I feel that the Affordable Care Act is actually not healthcare reform. It's insurance reform and that we still have to address issues of the actual cost of what people are paying, what things cost. We've heard it over and over today that the overwhelming burden of the actual cost of coverage of the care is for people.

We are dominated by huge, highly-profitable national and international pharmaceutical and medical device industries as well as for-profit and nonprofit hospital conglomerates. Billing is often tailored to the insurance coverage of the patient, with those who are uninsured bearing some of the highest billing rates. Consumers find it difficult to find out how much things actually cost. You can call up and find out how much a car is going to cost, but you can't really call a hospital and find out how much an appendectomy is going to

cost.

It's also difficult for people to even negotiate their bills, and often, people just assume the bills are correct. They trust that insurance companies are going to make good decisions about what should be paid and what shouldn't be paid or they just feel intimidated by the bureaucracy and just sort of, I guess, walk away from greater involvement in that process.

Back in February, *TIME* magazine published an article called "The Bitter Pill." I hope you all saw that or will take a moment to look at it. It addresses many of these issues. The author looked at some specific cases that he documented, and he also makes some suggestions for reforms. And among those were banning the charge master, amending patent laws, and requiring pharmaceutical companies, medical device manufacturers, and hospitals to be more transparent about costs and profits. You know, the bottom line is they cost too much.

And I also in the.....

CHAIR HURLBURT: Maybe if you could have about a minute or two more and you've nicely provided this, but if you could kind of summarize it for us? Thank you, Vicki.

MS. PENWELL: Okay. All right. Well, I do want to speak about the importance of expanding the Medicare/Medicaid provisions for Alaskans. These are -- I think that there are

a lot of misconceptions about who these people are. These are people who are generally the working poor. They may be single parents who have a child already on CHIP or children that are already receiving benefits, but the parents are not. Forty percent of the people in Alaska who would be eligible are Alaska Native; 11% would be in fair or poor health compared to insured people. We can reasonably guess that these people are seasonal workers, people who are critical to the economy of the state. It also applies to minimum wage workers, others who work for employers that don't provide benefits. These are people who are hardworking and deserve access to medical care that insurance is the key to, and without the Medicaid expansion, they may still remain uninsured.

Chronically ill individuals are another group who will be severely affected by the failure to implement the Medicaid expansion.

I'd like to tell, just briefly, about my son, who is now 30 years old. He, as I mentioned, has cystic fibrosis, and he has been uninsured for about the last five years. He had some great insurance until the recession hit and he lost his job. So when you have cystic fibrosis and you're uninsured, you don't receive treatment that helps prevent lung infection and other problems that decrease life expectancy. So he is not in good health, and I suppose that one could say that he doesn't really have a lot of good luck, and fortunately, he has

received a lot of assistance from the charity programs at Providence, but even in spite of that, he has tens of thousands of dollars of medical debt that he probably will never be able to pay for. He knows he needs to get a different type of job -- he's been working in the tourism industry -- but most jobs these days do credit checks. His credit rating is extremely low. It's hard to get a job. It's hard for him to buy car insurance because they check credit ratings. He can't rent an apartment in Anchorage because they check credit ratings.

So the impacts of people with chronic illness or low income working people, the impacts to them of a medical crisis are life-changing and cannot and do not disappear in the course of a few years and may not disappear even if a bill is resolved or written off or covered by charity.

So I would just -- I really hope that you all will think about the people in Alaska who maybe don't have a voice at the table. They don't speak up as often as they should, but they aren't involved in politics, but they want solutions.

So I ask that you all work with the Governor and ask the Governor to have Alaska participate in Medicaid expansion and then work to continue to improve transparency and decrease the cost of medical care. Thank you.

CHAIR HURLBURT: Thank you, Vicki, and thanks for helping keep it in front of us that we need to talk about this in

terms of aggregate numbers, but the aggregate numbers are made up one at a time.

MS. PENWELL: Yes, sir. They are.

CHAIR HURLBURT: And thanks for sharing your story with us.

MS. PENWELL: Thank you.

CHAIR HURLBURT: We'll have one more person here in the room to testify, Fred Brown, who is with the Health Care Coalition, and then again if there is anybody online that has not been able to contact us, we'll open that up, and we'll have a few minutes left for that. Fred? Thank you.

MR. BROWN: Thank you. My name is Fred Brown. I am the Executive Director of what has been referred to as the Health Care Coalition. Our full name is the Health Care Cost Management Corporation of Alaska, and as you can imagine, our purpose is to try to aggregate for the purpose of controlling medical costs.

I was struck by a number of comments that were made earlier that I just wanted to follow-up on briefly. Mark Foster talked about the need for scale, and the question was asked, well, what is scale by definition? The suggestion was, well, 300,000 covered lives.

Our Coalition, which Commissioner Hultberg referred as being an entity that she is watching with regard to our initiative, has about 75,000 covered lives in Alaska and an

additional 100,000 covered lives in Washington. So we're not to 300,000 covered lives yet, but we're on our way.

What that has allowed, even at 175,000 covered lives, is the opportunity to negotiate with groups, such as Aetna, such that we have been able to achieve pricing, which we think is unparalleled, at least, here in Alaska. So we're very happy about our success thus far.

Now real briefly in terms of my personal background, I spent 25 years as a Worker's Compensation Hearing Officer here in Alaska and so I was particularly interested by the Worker's Compensation presentation earlier today.

But in the course of those years, I also became the Chairman of the State's health benefit package of state employees, and in the course of shifting away from the state and becoming independent, in the year 2000, we were able to take on what was described earlier as being the political risk the State was not able to encounter. So we were among the first to negotiate preferred provider pricing arrangements with providers, and it was only as a result of the arrows that we took and the political heat that we endured that the State later was able to follow our lead and initiate its own preferred provider organization arrangement since then.

But that is the description of us as not only an individual trust, but also that trust is part of what is now about 37 various trusts that have joined together to grow this

coalition, which, by description or definition, is entrepreneurial in nature. And so Commissioner Hultberg described the healthcare clinic that we are opening, first, on October 16th and that will be here in Anchorage and then we plan to expand that at other locations throughout the city, the state, and even the Pacific Northwest region.

So my ask for you is that, as we have been able to pioneer in new areas of taking on political risk and taking on new ventures, in the private sector, I would encourage this Commission, if it has the capacity, to encourage the Legislature to apply the same principles to the worker's compensation arena. There are opportunities in worker's compensation to bring down costs, and some of those opportunities were mentioned earlier. There is no reason why a preferred provider network shouldn't be applied to the worker's comp system here in Alaska, and there are other opportunities as well, and I'll be happy to address them at some future time, if you like. Thank you.

CHAIR HURLBURT: Thank you very much, Fred, and from the earlier conversation that Fred and I had, you truly are involved in doing some things and looking at some innovations and ways to change and improve what we do. So thanks for what you're doing, and thanks for coming and sharing with us.

MR. BROWN: Thank you.

CHAIR HURLBURT: Is there anybody online now? And we'll

open up the -- take you off mute, so you can speak. Anybody online who would like to make comments? We're off mute. Okay. Thank you very much for folks who are online for calling in and listening. So with that, we will close the public comment time, and thank you again very much, both Vicki and Fred, for sharing with us.

MS. PERDUE: Would you have time for three minutes?

CHAIR HURLBURT: We absolutely do, Karen. Please, if you could introduce yourself and your role?

MS. PERDUE: Hello, everyone. I'm Karen Perdue, the President of the Alaska State Hospital and Nursing Home Association. There's kind of a feedback here.

I wanted to mention a couple things that our Association is doing that are relevant to the conversation you're having today and really picking up on our lunch speaker's view -- and also Commissioner Hultberg's -- of honing down on the high utilizers. We see those individuals in our emergency rooms, and often, they're individuals who really are inappropriately there.

We have been very honored to participate in a project that the State is working on with the National Governors Association to focus on what's called super-utilizers. And the project is just beginning, but it focused on trying to provide more of a case management approach to those individuals who present themselves over and over and over in

our emergency rooms.

And a component of that is drug-seeking behavior and trying to arm physicians who are working in those settings with timely information to help, you know, diagnosis whether or not that's occurring.

We're looking also, at the Association, at some work that's been done in the state of Washington, which has been a partnership between physician groups, the Hospital Association, ER physicians to focus in this area.

So I think this is an area where we're eager to participate. I'd like to see some pretty fast savings, I think, in terms of some of the populations. So I wanted to mention that to you.

I wanted to also just say that ASHNHA will be resetting its priorities for Policy of Priorities next month, but we're actively working on actively working on our top priority now, which is the Medicaid expansion. We do believe that that is something that not only will help 40,000 people in Alaska, but also will provide some relief to businesses because of the cost-shifting that's occurring for hospitals for those individuals who are presenting to us who cannot pay -- $200 million in those costs this last year.

So thank you for your time, and those are my comments.

CHAIR HURLBURT: Thank you, Karen. And it may be redundant, and I can't remember if it was before you came in

this morning or not, but we did talk about the prescription opioid challenges that we face as a country.

Dr. Stinson was pointing out that, with six percent of the world's population, we use 80% of the prescribed opioids, but if the Hospital Association is looking at that, one of the things you might be interested in looking at is what I mentioned before. I'm impressed with what Oklahoma has been doing where the state, in their prescription drug management program, has fostered an online, five-minute ability for ERs for docs, for pharmacists, and so on to look at the database that the state has developed, and at least from what I've heard, it sounds like maybe the most impressive one in the country right now. So you may have some interest in looking at what Oklahoma is doing.

MS. PERDUE: Just a follow-up on that, and perhaps some others here, maybe Dr. Stinson and others would know more than I, but it seems like our database that we do have, which is funded federally, is going to expire because we don't have state dollars to participate in the database that we do have. So that might be an inquiry that this Commission could look at in the next few months or weeks before the Governor's budget is completed.

CHAIR HURLBURT: The organization for my counterparts from the other states and territories and myself each year takes on one challenge (indiscernible - voice lowered). Like

a couple years ago, it was premature and low birth weight babies. But for the coming year, starting the beginning of this month with Terry Cline, who is a Ph.D. psychologist, Secretary of Health in Oklahoma there, the prescription opioid misuse is the focus for that organization with my counterparts, and part of the intent, obviously, will be working through AASHTO and working with the Feds to, hopefully, continue to have that be a federal priority, but we'll see. But I think, clearly, you're spot-on in identifying it. Yeah, Larry?

COMMISSIONER STINSON: Karen is right. I believe it is going to expire. It's also not real-time, which limits its effectiveness. So perhaps that would be a very important point to make as a future recommendation.

CHAIR HURLBURT: Thank you, Karen. I think we're ready to move on, and Deb, you were going to chair this, this afternoon now.

COMMISSIONER ERICKSON: Yeah. If Gunnar and Mouhcine could come to the front of the room, and Dan, we know that you're online, and Barb is going to unmute you now. Dan, are you there? You should be able to talk to us now, if you are. Could you guys come to the head of the table, please? Dan, are you online? Dan, if you're online, I'm going to -- and you're not able to -- we're not able to hear you. If you're talking, we're not able to hear you, and why don't you send me

an email message? And I'll check and see if we can figure out how to get you connected.

But for now, we're going to go ahead and turn over the mics and the presentation to Gunnar, who wasn't going to be with us today. I told him I was sorry to see him when he walked in the door this morning, and several of the Commissioners looked at me like, well, that was rude. And he can share more with you, if you're interested later, but he was supposed to be in the Grand Canyon right now, and his trip was starting the day after the shutdown. So he's back in Alaska, and we're actually really glad to see you here.

And Mouhcine Guettabi, am I pronouncing your last name correctly? Dr. Guettabi is an economist with the Institute for Social & Economic Research and an economics professor at UAA, and he is working with Gunnar and with Dan Robinson in the Department of Labor on the employer survey project.

And one of the things that we had asked ISER to do, in addition to conducting a survey of Alaska's employers about their health benefits and employee health management programs, is to also see how deeply they could dig into federal survey data that's done. There is a survey that's conducted annually, I believe. Is it annual? The MEPS survey, the Medical Expenditure Panel Survey. There is a component of that that surveys employers, and since it's a national survey, we don't -- you know, our population of employers isn't

specifically targeted and so trying to understand what we're able to pull and analyze that is statistically relevant from the sample size that gets pooled from Alaska is something that we had asked ISER to do in conjunction with this other survey project.

And Mouhcine has been able to do the preliminary analysis of that federal data, and he's actually going to present the preliminary data to you now. And then Gunnar and Dan will talk a little bit about the survey project that we're launching right now. So I'm going to go ahead and turn it over to you, but first real quick, Dan, are you online? We'll see if we can get you unmuted, and we'll turn it over to Gunnar and Mouhcine.

MR. KNAPP: Hi, folks. I am Gunnar Knapp, Director of the Institute of Social & Economic Research at the University. And just briefly, I had the opportunity to talk with you folks, I think it was, in June at your meeting, and I said then -- and it's still very true -- it's a very a high priority of mine to increase the involvement of ISER in studies of health economics and health policy issues because I think these are among the most critical economic and policy issues facing the state.

And in line with that, we're very pleased to be working on two kinds of research for the Commission, which Deb mentioned. And so briefly, our plan here is, first, for Dr.

Guettabi to talk about this analysis that he's been doing of the MEPS data, and then after that, we'll talk about the employer health insurance offerings survey that we're undertaking in collaboration with the Alaska Department of Labor. Mouhcine?

DR. GUETTABI: Good afternoon. Thank you for having me. Like Deb and Gunnar have just said, what I'm going to be presenting to you is, essentially, preliminary findings from this ongoing project that tries to data mine what's collected through the Medical Expenditure Panel Survey.

It's a relatively large project that's funded by the agency, the federal Agency for Healthcare, and the Census Bureau administers the actual survey. And so they start from about 45,000 establishments nationwide and then they proportionally assign different weights, if you will, to different states, and so for Alaska, they essentially end up sampling about 690 businesses -- establishments, I should say, and the distinction here is that a business is one unit, one location of business. And so a firm can either be a one-establishment firm or a multi-establishment firm. Here, they actually look at establishments themselves. And so they have about an 80% response rate year-over-year, and they've been conducting it since 1996 with a couple of gaps in 2002 and in 2006. And so what we're going to be looking at are, essentially, their findings. They only provide them in

summary tables, based those 690 respondents who are representative of the Alaska establishments.

And so just to set the stage, clearly, one of -- it's still one of the most important sources of health insurance. Employer-sponsored health insurance is still one of the most important sources in Alaska, like the rest of the nation. While it's been declining -- if you can look at that table, covered by private insurance was at about 67% and has declined to about 62%. Same thing, same kind of rate of decline for employment-based. Now again, we come back to the statistical significance. Everything there -- this is from the American Community Survey and so this is from the Census, but it's from the American Community Survey that actually speaks to households and tries to determine their sources of health insurance. And so it's broken down by whether it's government, whether it's employer, or if it's through direct purchase.

And so the decline that we're seeing from 62% to 58% is indicative of less of a role for employers in that particular market; however, you can see the standard errors. And so when you view these statistics, they're best viewed in terms of intervals. And so the intervals, themselves, overlap, so it's really difficult to tell exactly by how much employment-based health insurance has changed.

The reason I'm showing you this as a precursor for the

actual analysis is to, again, as I'm sure you all are aware, re-stress the importance of this source of health insurance.

And so just quickly before we delve into some of the numbers, it's -- the best way I think about these types of statistics is really analyzing them from the employee standpoint, meaning, how many employees work at firms that are offer insurance, and how many employees actually are eligible for insurance? And then once they're eligible, how many of them decide to actually enroll? So that's one way of examining the data.

The other way is to look at it from the actual employer standpoint, meaning, how many employers actually offer insurance? What are the determinants or what are the factors that influence the provision of health insurance? And then we're going to delve a little bit into premium prices and so on.

And so to start off, this is looking at private employees. So in 2012, based on accounting business patterns, there were close to 250,000 employees in Alaska's labor force that were employed in the private sector. And so about 77% of those are working at establishments that offer health insurance.

Just to put it in perspective nationally, about 84% of all employees that are in the private market actually work at establishments that offer health insurance. And then clearly,

even firms that offer health insurance have some requirements for eligibility, meaning the amount of time that you've been at the firm, your employment status, whether you're full-time or part-time. And so a smaller proportion of that -- 189,000 -- are actually eligible, based on the different sets of requirements.

And then the last number that you see is the percent of overall employees that actually have health insurance through an employer, meaning these are people that are working at an establishment that offers health insurance and have accepted it.

And so you clearly see that there are these different sets of cutoffs, if you will. Do you work for an establishment that offers it? If yes, are you eligible? If so, do you accept it? And so that's what this, essentially, tries to.

And an alternative way to do it or to examine the data is to potentially look at, how does full-time versus part-time status influence the offerings and the take-ups, if you will, of said insurance?

One little note before examining the data specifically is that, unlike the survey that Gunnar is going to talk about in a second where we're actually defining full-time and part-time based on 30 hours of work, MEPS allows the respondent to define what full-time is and so they don't pre-specify a

number of hours that an individual has to work in order to be labeled as full-time. And so each respondent essentially determines what they mean by full-time, and therefore, these numbers are based on that self-specification of what full-time is. And as you can see, the numbers are quite staggering in terms of, how much does full-time status actually matter?

And it should be rather intuitive, I think, to all of us that, when we think about full-time status, these are people that have less turnover, they usually make more money, which means the employee contribution as a share of their incomes is lower, and as you can see there, once offered health insurance, they're more likely to actually accept it.

And so when you think part-time workers, as I'll show here in a little bit, you have a completely different demographic. You have a self-selection of sorts of people working in certain industries that have a higher turnover. And so (a) part-time workers are less likely to be offered health insurance because of those cutoffs in terms of the number of hours to qualify for it, and then (b) even if you were offered health insurance as a share of your income, the employee contribution is going to be higher. Therefore, you're less likely to actually accept it.

And this puts the previous slide in perspective. The full-time employee is almost twice as likely to accept health insurance, if offered it, than his part-time counterpart,

which again, I think, for most of us, it makes intuitive sense, but it's quite staggering when you actually see it in numbers. And these are numbers that are based on the 2012 data, i.e. the latest data.

And one of the other things that I thought would be interesting is actually examining why these people don't have health insurance. Why? So there are 192,000 or so full-time employees in Alaska in the private sector. About 90,000 of them don't have health insurance. And so when you start breaking down that 90,000 employees, 90,000 full-time employees that are not covered, what you find is that about 30,000 of them are actually working in establishments that don't offer health insurance and that's what the "Not Offered" refers to there.

And so you have the universe of full-time employees that don't have health insurance, 90,000 or so. About 30,000 of them are employed in establishments that do not offer health insurance and so it's never part of the conversation. Another 30,000 or so are not eligible. And so for this category, these may be people that either work in establishments where they haven't met that waiting period yet or there is some requirement that they have yet to meet. And so about another third of that 90,000 are not eligible, and the last 30,000 are people that were offered the health insurance, but declined to take it. And that's interesting to try and see where, for

example, one can make a dent, if somebody's trying to prove these numbers.

The picture looks quite a bit different when we examine the part-time workers. There are about 52,000 or so part-time workers. A good 40,000-some of them, 46,500 don't have health insurance. About half of that 46,000 are employees that work at establishments that don't offer health insurance, and again, that's where that breakdown starts to happen where the vast majority of part-time workers are either in industries that are less likely to offer health insurance or they're actually working in establishments that just do not offer it.

And then you look at the next bar, the gray bar, and you see that there is about 20,000 or 22,000 employees that are not eligible, and those are people that are working in firms that offer health insurance, but don't qualify because of those requirements that are then imposed, as I stated a little while ago.

And this is really fascinating to me. The graph that you see on the right, the tables that you see on the right are indicative of the actual labor force. So let's look at, for example, just Retail, Other Services, and Unknown. This is the breakdown that the Medical Expenditure Survey uses. And so I'm just repeating it here. So if we focus on what you have on the right and look at the tables that are titled "Insured and Not Insured by Industry," we have, essentially,

the overall bar, both the dark and light gray, containing the overall labor force in the retail industry. So there are, basically, about 92,000 people that work in the retail industry. Only 26,000 of them have health insurance. And so you have about 65,000 or so of those retail employees that don't have health insurance. So again, the overall bar, the combination of both, gives you the overall number of people employed in that particular industry. And then the dark shows you how many people in each of those industries are actually insured. And you can see that, for industries that tend to use a lot of part-time workers, such as retail, there is a pretty big gap between the overall labor force and the ones that are insured.

If we turn our attention to graph on the left, that actually constrains the universe of employees to the ones that are actually employed at firms that have insurance, meaning that -- for example, looking at retail again, we have about 37,000 employees that actually are working in firms that offer health insurance and that have been offered insurance. And you look at how many of them accept it, and it's around 26,000 again. And so there, we actually are examining how does the breakdown -- after being offered health insurance, how many people accept it versus the ones that decline it? And then you can see that it varies across industries, and again, there is no mystery there. The breakdown is due to the wages that

people make in these industries, and it's due to the usage or the share of their usage of full-time and part-time workers. And so -- and it's quite consistent across the industries.

Moving forward, I thought that it would be interesting to start thinking about the beginning of the data set versus the end of it and look at the changes over, basically, the 11-year period that we are examining. And so our first year is 2001; our last year is 2012.

And so this just looks at the share of eligible workers who actually take up insurance, meaning conditional on being eligible, how many of these people actually accept insurance? And so we started out in 2001, and 82% of all employees that were offered insurance accepted it. When you look at the 2012 data, it's gone down to about 75%, and I'm referring to that total there. So when you see that 6.2% decline, that refers to the fact that, in 2001, 82% or 83% of all people that were offered insurance accepted it. Now we look at the 2012 data, and it's only about 76%. And as you can see, it varies across employment sizes.

So in the x-axis, if you will, the breakdown is establishment size by number of employees. And so smaller employees, smaller employers are seeing a bigger decline, if you will, of take-ups, meaning people that work in establishments that have less than 50 people are less likely now to accept insurance than they were a while ago or in 2001.

And the groups that saw the smallest decline are employees that are working in establishments between 100 to 999, and I was curious as to why that is, and it looks as though it's due to the fact that the percent of eligible workers in that particular subgroup has increased substantially.

In 2001, only about 60% of people that worked for establishments that have between 100 and 1,000 workers were eligible. Now, it's close to 80%. So there has been a 20% increase in the percent of eligible workers for that particular subgroup.

And this is the big number, essentially, that looks at percent change in employees who are enrolled. In general, what is the percent of people that are enrolled? And so this is, out of the overall labor force, what is the percent of people that are actually enrolled in health insurance? And again, the outlier is the group from 100 to 999, and it goes back to two things. The percent of eligible workers for that subgroup has increased substantially, and the other thing that I didn't look at initially, but I found and I think is really driving this is that the share of full-time workers that they have out of the whole economy has increased substantially. It went from about 12% to now 20% of all full-time workers work in that particular group. And so there has been a shift, if you will, of utilization, and because of the increase in eligibility and an increased reliance on full-time workers,

you can see that the percent of people that are enrolled in that particular size has increased, and the total is about 2.5%, largely driven by the two biggest employers, essentially.

Shifting focus completely to now examining the picture from the employer standpoint. How does size matter? How does industry matter, meaning, what are the attributes that actually influence the offering of health insurance? What we were looking at earlier is, essentially, what are the factors that influence the take-up? What are the factors that influence whether or not an employee actually accepts health insurance? This is looking at, what are the factors that influence the offering of health insurance?

And again, as clearly as can be, size really matters. The bigger employer you are the more likely you are to offer health insurance. And as we'll see here in a couple of minutes, not only is that the case, but the declines, the most pronounced declines have been witnessed in the smallest categories. And so the two biggest employers, 100 to 999 and more than 1,000, are both essentially offering -- almost all employers in those two categories are offering health insurance.

And this puts it in perspective. We just broke it down by more than 50 and less than 50, so you can think about big employers versus small employers. Ninety-six percent of big

employers offer health insurance. Only 23.5% of small employers offer health insurance.

And one thing that I always here in the media and I always hear people talking about is that Alaska has a lot of small businesses. But to put things in perspective, there are 18,000 establishments -- or almost 19,000 establishments; 14,000 of them are small. Those 14,000 employ about 90,000 out of the 250,000. There are 160,000 or so employees that are working in the large employers. And so out of those 4,390, you find the vast majority of the labor force. Yes; there are a lot of small establishments in Alaska, like in a lot of places, but they don't employ the majority of employees.

And just quickly because I'm going to start running out of time here in a little bit, I thought it would be interesting to look at the trends over time by size, again, of offerings, and just so that it's clear to you, we have the total, less than 50 and more than 50, and the large category or employers of more than 50 people. The trend is essentially flat. Nothing has been going on.

When you examine the less than 50, the first data point is 2001. In 2001, 32% of employers that had less than 50 workers were offering health insurance, so 32% in 2001. You go to 2012, and it's only 23%. Overall -- so when you look at that middle line, in 2001, about 45% of all employers offered

health insurance. Right now, it's about 40%. So those two categories, less than 50 and the total, have seen pretty significant declines. The trend is relatively flat for the largest employers, and this is a more pronounced, if you will, breakdown. Rather than just looking at big, small, and total, we're actually looking at them by size groupings. And so if you look at the less than 10, and you know, it's been pretty much decimated in terms of offerings. The lowest line there shows you the offerings for employers that have less than ten people. In 2001, about 24% of employers that had less than ten workers gave insurance. Right now, it's a little less than 15%.

And again, you can see that, you know, the trends show that drop around 2008-2009 in almost all of the groupings, coinciding with the financial crisis, but the two largest groups, not much going on there. As you decrease in the size of employees, the drops in offerings start to become much, much more pronounced.

And as you can see -- and the interesting thing -- I'm not going to -- I don't have the data to comment about it, but one of the problematic things about the MEPS data is that they combine employers between 25 to 99, which means that it captures 50-plus. Some of the 50-plus are in that little subgroup. And so as you can see, the percent of offerings has declined across the board, except for that particular subgroup

of 25 to 99, and my guess is it has a lot more to do with employers between 50 to 99 than it does for employers between 25 and 49. But yeah, the trend is indicative of considerably less offering as time progresses.

Just a quick summary of what we've looked at. The majority of Alaskans still work at establishments that offer health insurance and that percentage really has not changed. It's been very, very persistent. Large employers are considerably more likely to offer health insurance, and part-time employees are less likely to obtain it, even when eligible.

Remember that graph we showed a little while ago? A full-time employee is about twice as likely to accept health insurance than his part-time counterpart and that's quite telling.

And then the declines in insurance offerings, while we've seen declines in just about every single group of employer, the most pronounced ones are in the smallest categories.

Just quickly, we'll talk about premiums since they matter a great deal. Considerable increase in premiums over time. Everything here is in real 2012 dollars. And so we're looking at in -- so these are premiums for family coverage, and in 2012, premiums in Alaska for family coverage -- the average premium for family coverage was about $17,900. So just to put it in perspective, I thought it would be interesting to

compare it to what the premiums are nationwide, and it's about $2,000, a little more than $2,000 less. So for the U.S., family premiums were about $15,000, $15,500. In Alaska, about $17,900. And they have been increasing over time, increasing across the board, meaning for all employer sizes.

This graph here just, essentially, looks at the 2001 to 2012 change. Overall, we're seeing, you know, about a 45% increase between 2001 and 2012 for family coverage. And like I said, the premiums, themselves, have increased across the board, but they're still a good $2,000 higher in Alaska than they are in the U.S.

This is for single coverage. Single coverage premiums are considerably lower than they are for family coverage, obviously, and they were at about $7,400 in 2012 for Alaska. You compare it to the U.S. average, which is about $5,300. And so for both family and single coverage, it is basically a $2,000 gap between the U.S. and Alaska in terms of average premiums.

The interesting thing -- and in the interest of time, I'll just show you this quickly. There has been about a 57% increase in premiums overall between 2001 and 2012, but one of the things I found fascinating is, when you start to look at the share of the premium that's paid by the actual employee, what you notice is that -- so for family coverage, it's 22%. For single coverage, it's 15%. What I mean by this is that

the premium, obviously, refers to the overall fee that's agreed upon for coverage and that premium can be paid by either the employer, the employee, or a combination of both.

Plans that offer health insurance with no employee contribution have declined significantly. This shows you the share of the premium that's actually paid by the employee. So for Alaska, it was about $1,164 for single and about $4,000 for family. So 22% of the premium is paid by the employee for family coverage, 15% for single coverage.

Now, the interesting thing is that the amount of the contribution that's paid by the employee is identical between Alaska and the U.S., meaning, in the U.S., the actual amount is $1,184, the actual employee contribution for single coverage, and for family, it's $4,200. And so what you see is that we have, essentially, higher premiums, but the actual employee contribution is the same as the U.S. As a result, the shares here are going to be a little bit higher, naturally.

And so it's really interesting to see whether or not that share of the premium has changed over time and so I looked at those changes. And so for Alaska, in 2001, employees were paying 13% of the premium for single coverage. Now they're paying 15%. For family coverage, they were paying 25% in 2001. Now they're paying 22%. So you have that for Alaska. You contrast it with the U.S. where, for single coverage in

2001, it was 17%. In 2012, it's about 21%. So there has been an increase in the share of the contribution by the employee in the U.S., just like in Alaska, but for family coverage, we're paying a smaller share of the premium. It went down from 25 to 22. In the U.S., as a whole, in 2001, the employee contribution was about 23%. Now, it's about close to 28%.

And so it's really interesting to look at these comparisons for both premium and -- and I'll skip over these because they just show you the actual employee contributions, which have a lot of noise in them. And then I'll show you the average waiting periods, and the only reason I'm showing you this is because one of the questions we're asking in our survey is (indiscernible - voice lowered).

So these are those contingencies that we were talking about earlier. Even if you work at a firm that offers health insurance, there are some requirements to actual eligibility, and the waiting period clearly is going to knock out a lot of part-time workers that have high turnover, a lot of seasonal workers. If you have a 12-week waiting period, a lot of your part-time people are changing jobs; a lot of your seasonal workers are never going to make it past 12 weeks. And so as the waiting periods increase, the likelihood of a part-time employee having insurance goes down quite a bit.

And this is just what I told you a second ago about premiums, how much they are for single coverage versus family

coverage, and the fact that employers are still paying a bigger share of the actual overall premium, and there doesn't seem to be a pretty big shift in cost sharing because there has been a lot of talk about cost sharing, especially among the smallest employers. I'm not finding a lot of that in this data. It doesn't mean that it's not happening, but in the aggregate, I'm having a hard time finding the shift in cost sharing or in having employees pay a significantly larger share, especially not in Alaska.

And so these are just some general thoughts about it. Immensely useful data set. Allows us to really, at least, try to paint a picture. Because the sample is small, it's difficult to draw statistically inference from it and that's one of the reasons why, as Gunnar will speak to, we're doing a survey that, hopefully, will target about three times as many employers, and therefore, allow us to speak with a greater degree of confidence as to the premium amounts, the average waiting periods, the share of employers that are offering health insurance, and it will also allow us to speak about wellness programs and transparency, things that have been happening in the healthcare market that are not necessarily targeted by this survey that samples employers on a national scale, year-over-year. And hopefully, we'll compare those two findings, see if there are some things that stand out. And seasonality -- clearly, Alaska fisheries, tourism, and retail

are highly seasonal industries, and MEPS uses average employment, which means that it, to a large extent, misses a lot of that.

And another aspect that we didn't really discuss is the fact that we're going to be defining those cutoffs for full-time and part-time, and I'm curious as to if that will potentially lead to different results than what they have when they allow the actual firm to identify what's full-time.

Thank you. I went over my time. My apologies.

COMMISSIONER ERICKSON: Does anybody have any questions? Yes?

COMMISSIONER MORGAN: Actually, I have two questions.

DR. GUETTABI: Sure.

COMMISSIONER MORGAN: Evidently, you didn't do it, but the question I would have is, could you break out the groupings by age, i.e. in the firms less than, say, 50 firms, how many were between zero and 21 and 21 to -- you know, the normal breakouts by age of the individuals that either don't have insurance or declined insurance, whatever, in those categories? Is that possible?

DR. GUETTABI: It's -- they issue -- so the summary tables that they provide are not at the micro level, meaning that these responses are obtained from the firms and so the firms just give them the overall number of employees as opposed to what is the age of each of the employees. That

would be potentially feasible, if these answers were coming from employees themselves, meaning you actually observed the characteristics of the individual and you know how old he is and whether or not he refused it, but it's not possible based on the data that is available to us, to the public. Yeah.

COMMISSIONER MORGAN: Because usually in retail -- I have two sons who are in their 30s and have jobs, you know, what I would call real jobs and families, but when they first started, they may have worked at Lamonts when they were 18 or 19 or while they were still on my insurance. So you know, technically, they didn't have an insurance policy, but they had their healthcare coverage covered either through my pocket or whatever.

The other question is -- and probably the same answer. It would be interesting to see -- a couple of questions -- what they use. Like, have you visited or used a community health center or a primary care health center in the last year for any healthcare services?

In my own mind, I haven't really seen 90,000 people laying in the street without healthcare. So they must be getting some somewhere. Evidently on a hospital level, there is charity care or write-offs, but I know community health centers had about 120,000 visits last year. And so it would be interesting to see if they are getting primary care through a sliding fee scale in community health centers.

And the question is, have you been to -- had a hospital visit or an ER visit? It's the same thing. I'd say your answer is the same on the age.....

DR. GUETTABI: Yep.

COMMISSIONER MORGAN: .....but it would be very interesting.

DR. GUETTABI: Oh, absolutely.

COMMISSIONER MORGAN: And if we could have something like that, maybe your colleague can address that. Have I got it pretty well right? If you can't get the age because of where the data comes from, you probably can't get information on where are they getting their healthcare.

DR. GUETTABI: Right. So in order to tackle both of the questions you've asked, essentially, your target audience would need to be the employee himself or herself, right? And so we would potentially need to do a survey of people under the age of 65 who are employed and then ask them whether or not they obtain health insurance through an employer, and if yes, are they using some of these services and what are their age groupings.

The only way that you could potentially, I guess, use a proxy for what you are describing is, based on the data that we have, you can look at the industries. And so there is self-selection by industry. And so you can get to a question like what you're describing, for example. Once you start

breaking down retail, we know the demographic characteristics of people that work in the retail industry, so from other sources. And so we can use the Bureau of Labor Statistics and the Census data, and basically, transpose the data that we have, based on the characteristics of those employees on those insurance offerings and try to infer whether or not some of the things you're describing.....

COMMISSIONER MORGAN: A community -- the 23 community health center programs and their 183 sites do do detailed reports because (indiscernible - voice lowered). It's called the UBS report that breaks out age and insurance status, and you might be able to back in, at least, on the primary care in that way.

DR. GUETTABI: Yeah.

COMMISSIONER MORGAN: And I guess my third question -- because I didn't catch it -- are any of these 90,000, are they tribal or are these all non-tribal or does that enter into this at all?

DR. GUETTABI: So these are all private employers. So these are employees that work at private institutions. And so there are no character -- there was a different component to the survey that the characteristics of the employees themselves. This, basically, looks at it from the employer standpoint and whether or not your employees are covered, and if they're covered, how much are they paying and so on and so

forth.

COMMISSIONER MORGAN: Not by insurance?

DR. GUETTABI: By private insurance, yeah.

COMMISSIONER MORGAN: Okay. Yeah.

DR. GUETTABI: But there is no information in the summary tables about the type of insurance that they're actually on.

COMMISSIONER MORGAN: Or if they're tribal, non-tribal, Hispanic or whatever?

DR. GUETTABI: Yeah.

COMMISSIONER MORGAN: All right. Well, hey, you know, I just had to ask.

DR. GUETTABI: Sure. Absolutely. Very good questions. Unfortunately, difficult to get at.

COMMISSIONER ERICKSON: Any other questions? Well, why don't we go ahead and turn the mic over to Gunnar, and Gunnar, I'll set your presentation up. Dan, were you able to hear that part of the conversation okay?

MR. ROBINSON: Well, can you tell me, can you hear me okay? If not, then I sent my points to Gunnar, and they could probably just look at their emails and cover them, if you can't hear me very well.

COMMISSIONER ERICKSON: Can you all hear?

COMMISSIONER MORGAN: I can hear him.

COMMISSIONER ERICKSON: We can hear you fine, Dan.

MR. ROBINSON: I'll just standby then.

COMMISSIONER ERICKSON: Sounds good. And I'm going to set up Gunnar's presentation real quick.

MR. KNAPP: While she's doing that, I'll just tell you the story of why Deb said she was sorry to see me here. And I was -- my wife and I, as of October 2nd, were supposed to begin what everybody assured me was going to be the best, most life-changing, wonderful experience of my entire life, rafting through the Grand Canyon. And so we flew down to Flagstaff on September 30th, and the company informed us that, well, they're closing the Grand Canyon, and you can't take your trip. So we came back, and I'm absolutely delighted to be here.

So for just a little while, we felt sorry for ourselves, but we're actually going to get to go back and do the trip next year, but it really was pretty amazing to see the effects down there of all the -- you know, all the rafting guides that were out of their opportunity to work, and you know, 18,000 people per day normally visit the Grand Canyon that were being, you know, shut away from the opportunity. So sort of strange to experience that, in that way. But anyway, I am glad to be here.

COMMISSIONER ERICKSON: Do you want me to run your presentation?

MR. KNAPP: So Dan and I will talk, real briefly, about the Alaska Employer Survey that we're doing about health

insurance offerings and related topics, which ISER and the Alaska Department of Labor and Workforce Development are cooperating on in research we're doing for the Health Care Commission.

Basically, this survey is a follow-up on a survey that was done in 2006 by several departments of state government that collaborated on a survey of Alaska private sectors employers' health insurance offerings. And so this survey that was done in 2006 was sort of looking at similar questions as the federal data that Dr. Guettabi was just describing, but in a different way by doing a more detailed survey of Alaska employers and getting at some things that the federal data wasn't able to get at, and this is a very interesting survey to read. It was written up in 2007 in *Alaska Economic Trends*.

And key findings of that 2006 survey were, first of all, that there are much slower rates of health insurance offerings for very small employers -- this is consistent with what the federal survey showed -- but that there was also very little opportunity for part-time and seasonal workers to obtain employer-based health insurance. And so, for example, this was one of the charts that came out of the report on that 2006 survey, again sort of showing the same thing as the federal data did and showing how, among our very large seasonal workforce in Alaska, there is very low enrollment of those employees in employer-based health insurance.

So we are collaborating on a follow-up to this 2006 survey, and our objectives are to gather updated information about Alaska employer-sponsored health insurance, partly, to be able to say, well, what's changed since that previous survey that was done and also to gather, in addition, certain new information that the earlier survey hadn't asked about and get more detail on the types of benefit offerings and also on employer-sponsored wellness programs. And ISER's role in this is primarily in the design of the survey and the analysis after the survey is done. And the Department of Labor and Workforce Development is doing the hard work of administering the survey and sending it out to the employers and getting the responses back and so on.

This is work that's underway, so we don't have any results to show you. Our main purpose is to let you know that it's underway and sort of what you'll be getting. We've presently drafted a survey and are involved in pre-testing it to make sure the questions work. We're going to be administering this survey in October and November and analyzing the survey results in December and January. And so hopefully, you'll have them then in mid or the end of January.

And that's basically my purpose is to let you know that we're doing this survey, and I would refer you to the interesting write-up of the 2006 survey to show you sort of more details of the kind of information we're going to be

getting, but what I want to do now is turn it over to Dan, who is patiently calling in via cell phone and can tell us a little bit about the actual administration of the survey. Dan?

MR. ROBINSON: Are you able to hear me okay?

MR. KNAPP: You better turn that mic up.

MR. ROBINSON: Should I keep talking? Tell me when.

COMMISSIONER ERICKSON: I think that's working fine. I think folks can hear fine now.

MR. KNAPP: Go ahead.

MR. ROBINSON: Good. I just want to quickly (indiscernible - phone interference) about not knowing the future, I'm not sure about an economist who goes to the Grand Canyon on September 30th when there's this big economic cataclysm happening the next day. So if anyone (indiscernible - phone interference), then we'll blame Gunnar.

I just have a few quick comments. Several of them have already been covered by Mouhcine and Gunnar. As Gunnar mentioned, we've helped with this kind of survey before. This will be our fourth time. Each time, the focus is a little bit different, and we're really more than a support role because we have access to the data. We have employer databases to administrative records. So we will help with the -- we will conduct the survey itself.

To give you a rough idea of the numbers, we plan on

mailing surveys to about 3,000 employers. We'll stratify that group by size, so that we'll be able to meaningfully talk about the type of coverage that's offered by four size classes, very small, small, medium, and large.

And then I wanted to reinforce one point that Mouhcine covered quite well. When we talk about -- when the survey results are out and if you were to look at the '06 write up that Gunnar mentioned, it's a pretty different question, the percentage of employers who provide coverage. That's a different question than the percentage of employers, the percentage of workers or Alaskans who have access to healthcare or for coverage. We have, again as Mouhcine covered, I think a high percentage of small businesses, but the majority of our workers are in large businesses. So that's kind of an important concept to keep separate.

As Gunnar said, we're working on the survey instrument itself. We've learned through, I think, the hard experience that that part can't be rushed. The question has to be clear, and the survey can't be too long or else response rates fall and you don't have usable data. But we did have good results last time we did the survey in terms of response rate, about 60%, which is high for this kind of survey. So we know what to expect, and I will leave it at that and answer any questions anyone has.

COMMISSIONER ERICKSON: Does anybody have questions for

Dan?

COMMISSIONER CAMPBELL: I have one. Keith Campbell. Is this survey -- are they going to be enough similar questions to be able to draw conclusions from one survey to the next?

DR. GUETTABI: Yeah. So we're essentially repeating the vast majority of the questions that were asked in the 2006 survey and adding a few other ones that target transparency, wellness, and a few questions regarding benefits. So we will be able to compare, at least, the findings from the 2006 survey and speak with some confidence as to what's the data telling us in 2012 and how has the landscape changed relative to 2006.

COMMISSIONER ERICKSON: Other questions? Well, thank you very much. We'll look forward to hearing continuing reports, especially the final report. And thank you, Dan, very much for your patience with our technology.

MR. ROBINSON: It was probably something I did on my end.

COMMISSIONER ERICKSON: No. I don't think so. It was us. We'll talk to you later. Bye-bye.

MR. ROBINSON: See you.

COMMISSIONER URATA: Deborah?

COMMISSIONER ERICKSON: Yes, sir?

COMMISSIONER URATA: Are we going to have that report in our packet next time, the 2006, or is this something (indiscernible - simultaneous speaking)?

COMMISSIONER ERICKSON: No. Our next meeting will be in December.

COMMISSIONER URATA: Or when their new information comes out so we can compare the two.

COMMISSIONER ERICKSON: Oh, both reports? Oh, yes. Yes. And I can make the 2006 article available to you. I can send you all a link to it and post it on our website.

MR. KNAPP: I'd just add, certainly, our report will -- yeah. That's a major goal of our analysis is not just to say here's what we find in, you know, 2013, but also here's what we find and here's how it compares with the earlier results.

COMMISSIONER ERICKSON: Well, thank you both very much.

(Pause)

COMMISSIONER ERICKSON: And the slides that Gunnar just showed, he had just emailed those to me. So we will make sure and -- you didn't have those in your notebooks, like all the others. I will post those on the website next week, and they'll be available there.

What we are about to do -- you've had a very long day of mostly listening, but we are going to transition into the segment of our meeting -- after all of our long learning sessions, you have a little bit of time to reflect back on what you think you learned throughout the sessions today. And then if there are some ideas you want to start throwing out, just in a brainstorming session, of additional recommendations

you might want to make with our focus today on the employer's role in health and healthcare.

In your binder, it's not necessarily real easy to find, but it's right behind Dr. Guettabi's presentation behind tab four is the Discussion Guide chart pack, and we actually aren't going to use most of that today, but I just wanted to point it out to you, and it's actually in a couple of places.

I wanted you to be able to reference, if you would like, last year's Findings and Recommendations regarding employer engagement, and those -- the Findings are on slide three, and the Recommendations on slide four, if you're looking at your discussion guide pack, but there is also a one-page handout in the back of your notebook that looks like some of our other handouts where I pulled -- and to use as a handout with employer groups, the Findings and Recommendations. So you have that available in a couple of spots, if you feel as though you want to reference it.

I am going to open up the chart pack, so I can start capturing. So nobody is allowed to talk until I get this open, so I can capture your thoughts. And just the same as we've done in the past, we'll just be brainstorming initially, and I will be capturing your thoughts, and we'll go from there.

COMMISSIONER URATA: Would this be a good time to take a break?

COMMISSIONER ERICKSON: Is that a motion?

COMMISSIONER URATA: While you're getting ready?

COMMISSIONER ERICKSON: Why don't we take a five-minute break, is that okay, Chair, Mr. Chair, Dr. Chair? Five-minute break.

CHAIR HURLBURT: Anyone want to bet on five minutes?

2:54:17

(Off record)

(On record)

3:09:23

COMMISSIONER ERICKSON: I'll refer you again, too -- I don't know -- if you could be thinking about if there are some additional issues you want to bring to the table, if anything that you learned today will contribute to you wanting to make some revisions to either the Findings or Recommendations, I'll point you again to this two-page flyer. It's in the back pocket of your notebook, our Findings and Recommendations related employer engagement.

And just to paraphrase quickly, the Findings addressed the importance of the role that employers play in driving improved value and outcomes and improved employee health and that CEOs who take control of healthcare, like other supply chain issues, have been successful in driving improvement. And then the Findings identified the four essential elements of successful employee health management programs, price

sensitivity, price and quality transparency, focus and emphasis on primary care, and support for healthy lifestyles.

And then the two recommendations you all had made last year were to implement a mechanism for providing the public with information on prices for healthcare services and also information on how quality and outcomes compare. Then we had recommended that the Legislature and the Governor support the work that Commissioner Hultberg has been doing and that she play a leadership role for Alaskan employers.

So that's currently on the books. And now I'm just going to open up the floor. If you all -- and why don't we just start with -- before we go to ideas for potential, additional recommendations, just start with some things that you thought you've learned throughout the day that we'll potentially capture in additional finding statements. Dr. Urata?

COMMISSIONER URATA: Well, I think we've already dealt with this, but that's approve the All-Payer Claims Database. I just want to put another checkmark by it, I guess, or an asterisk, you know, because I think I heard that it would be an important part of proceeding.

COMMISSIONER ERICKSON: And you all did vote at the June meeting. I included the voting.....

COMMISSIONER URATA: It's page 16.

COMMISSIONER ERICKSON: Yep. Slide 16 has -- and I thought we would revisit those -- not -- I don't want to

revisit them, but I just wanted to point them out and take a look at them again tomorrow, just in the context of the body of recommendations that will be going out for public comment.

COMMISSIONER CAMPBELL: Who is tracking the rural sanitation projects that get (indiscernible - voice lowered) by lots of different pots? Is there a central clearinghouse someplace in the Department?

COMMISSIONER ERICKSON: ANTHC and the State Department of Environmental Conservation both play real important roles in that, and I have that on the list of potential agenda items for 2014, since it's in our statute and we haven't addressed it, but at a minimum, we'll have some learning sessions about rural sanitation. Yes, Dr. Urata?

COMMISSIONER URATA: I was wondering if there is a way to increase scale and if there is somebody who could tell us how to break the barriers that prevent, you know, bigger groups and such? It sounds like that might be important in the future; is that true?

COMMISSIONER DAVIS: Well, market power is important. Someone told me once that there is one law you can't amend and that's the law of supply and demand. And so I think, you know, scale is important to a degree, mostly -- and as to Commissioner Hultberg's comments, a lot of times, scale is important because then you understand your data enough and you have the resources to do something about it. It's more about

that than it is about leverage, in my opinion.

But there are other things going on that are supporting the current cost structure. There are lots of things going. She pointed out, several times, it's complicated. But Milliman, for example, pointed out two things that really interfere with the market power situation in the state, and one is the current structure of the regulation dealing with usual, customary, and reasonable that establishes a floor and no ceiling, and I could give you a number of examples of how it's been abused by those who have market share.

And the other that Milliman pointed out was the statute that requires payment -- that requires assignment of benefits, prevents payment for care directly to a member who uses an out of network provider, and Representative Keller has introduced a bill, last session, that would modify that.

So there are things, like that, that I think are -- you know, in the beginning, are more elemental and more important than scale would be.

Sometimes, people talk about scale, and there is this underlying thought that, if you have more people in a pool, somehow, the costs magically are less and that's just not true. If you have 1,000 people who all cost $1,000 a month, your average cost is $1,000 a month. If you have a million people who are $1,000 a month, your average cost is still $1,000 a month. So scale doesn't get you anywhere there, and

it does get you to predictability, a little bit more in predictability, but we're dealing with an unstable system. So you can predict claims incidents, but you can't control the things that are outside of your control, such as on the price side and other things.

So I am -- I agree with almost everything Commissioner Hultberg laid out. I think we are aligned with what needs to happen in the market, but how that needs to happen, I don't think, is dependent on somehow having 770,000 Alaskans all, you know, banded together.

Though, I could just say that I think that the presentation that we had at lunch was very interesting in that that was an example of using scale not for negotiating leverage, but using scale to say let's all work on some things that are really important that are patient care centered and that we can all agree on. That was a very different role for a coalition, and I was impressed with that and think that, perhaps, there are things along those lines that competitors could get together to work, and they would be win/wins for Alaskans. So probably a longer answer than you wanted, but.....

COMMISSIONER URATA: No; that was good. Thorough and very good.

COMMISSIONER DAVIS: Thank you.

CHAIR HURLBURT: There is -- go ahead, Allen.

COMMISSIONER ERICKSON: Please continue, Chair.

CHAIR HURLBURT: In terms of scale, I think maybe three different things, and I think that it's unrealistic to ever think of getting to the 300,000 lives, even, that Mark mentioned, much less the 750,000 that you did, kind of tongue-in-cheek.

But in terms of the State as a big buyer, we've talked about that. Certainly, Medicaid is the biggest buyer. But even if you take just the Department of Administration, as Commissioner Hultberg pointed out, the interpretation of the State's constitution is that you cannot reduce any benefits for retirees. And since -- as we all know, when you go to the hospital, other than for having babies, when you get older, it tends to be -- and so the older your population gets, the more you go to the hospital there. And so the State has the 17,000 lives that -- the unretired and the active employees and dependents, but there is not a whole lot of hospitalization there.

The biggest group that the State is responsible for is the pre-65 retirees and their dependents, where Medicare does not kick in and pick that up. However, at this point, the State can't use those lives with negotiating steerage without figuring out a way to make sure that there is a net win, being compliant with the State's constitution. And that doesn't really make any difference in Juneau where you have one

hospital, but clearly based on what the hospitals say here in Anchorage, even with that low of a number of the pre-65 retirees, plus the 17,000 lives in the active employees there, that's enough that they would be willing to look at it, so as far as steerage, that's just within the state. That should be a piece of cake, just within one department in the state. You're not even bringing in Corrections and Medicaid and so on. So that's there.

The second thing is -- and can I tell about your recent conversations with those groups that you're going to be meeting with on the large employers?

COMMISSIONER ERICKSON: (Indiscernible - voice lowered) doesn't know what you're talking about. Go ahead. I mean, there's not much to tell.

CHAIR HURLBURT: Yeah. There's not much to tell, but what we've become aware of is that some of the really large employers in the state -- and when Gunnar mentioned that you could only do things with large employers, I don't know what was in his mind. I thought, what do mean, over 200 or do you mean, like most places, where you're talking more than 500, more than 1,000 commonly? But some of the truly large employers here do talk with each other, and we've not been in that forum, and I think there may be a chance to talk with them there. And clearly -- and particularly, if you're negotiating with a larger payer, they're a larger group. Say

if you had a company -- and I have no idea if Alaska Airlines is in that group or not or if Safeway if is in that group or not, but if you were talking with employers like that, say, with the Providence system where they're in Washington, and Oregon, and Alaska, then you can take that whole group.

And the last thing, as Fred said, Fred Brown this morning, that bringing some of these union trusts together where they now -- some folks from the Northwest outside of Alaska are participating -- you can aggregate. So I don't know that, at this point, other than an alignment of interests with the State as an employer and Nana as an employer and BP as an employer or Exxon or whatever, that, where there is an alignment of interests and the chance to talk, I don't think you can aggregate those lives for leverage in negotiating, but within those entities, depending on how you bring them together geographically for the whole Northwest, including Alaska or the State, even in one department, I think there are some opportunities to look at and to pursue. So I'd kind of respond that way.

COMMISSIONER STINSON: I'm not sure where this would fit in, but we heard it through Worker's Comp. We heard it at the noontime meeting. The rational use of prescribed opioids, either education or some mechanism to help bring those costs under control because it's also a public health issue. If it's the leading cause of accidental death in the United

States and Alaska is in the top three states year-after-year within in that, within the United States, that has to be addressed at some point.

CHAIR HURLBURT: And with your comment, just on the break, about getting that in real-time to make it actionable and functionable, should maybe one of the tasks be for us to get some more information on Oklahoma? At least based on what I know, I think they're the closest to real-time of any state.

COMMISSIONER STINSON: I think that would be great because the system that we have now I use every day in our clinic, but it's dated information on the patients that we're seeing.

COMMISSIONER PUCKETT: I just wanted to give a piece of information to Deb to put on a previous bullet point. We have 17,000 active employees. It should also say "and dependents." And then for the pre-65 retiree and dependents, that's 31,000.

COMMISSIONER ERICKSON: Was Allen next? Allen?

COMMISSIONER HIPPLER: The worker's comp fee schedule seems to demonstrate an inefficient allocation of resources.

COMMISSIONER DAVIS: Well, we're kind of jumping around here, but if I might point out the obvious, when we talk about scale today, we've been talking about this employer and this employer and this employer, and oh, gee, we need a way to aggregate when, in fact, all of our clients together are aggregated. I mean, I'm just speaking from (indiscernible -

voice lowered) example. So if you're with an insured, you become part of their scale, or you're with an administrator, you become part of their scale. So for us, for example, that's 150,000 people today in the state. And so there is aggregation and that scale is important, back to having enough data to be able to get things done.

And then just kind of taking it out further. That's 1.8 million people in Alaska and Washington. That's 100 people in the country. So there are some -- there's aggregation going on to create scale today in a lot of places, and the same would be true for, you know, Aetna's 14 million people or United's 90 million people or whatever the numbers.

COMMISSIONER URATA: Earlier, I was ranting about our insurance system versus healthcare systems in other countries, but our insurance companies, I believe, are now becoming more of a healthcare system, and as such, I think they're instituting -- at least some of them that I'm familiar with are instituting wellness programs, and I think that that's a good thing, but it'd be interesting to see, in the future, if it pays off.

COMMISSIONER DAVIS: May I? On that line, I don't know, Dr. Hurlburt, Deb, if it would be interesting and profitable and possible to have Andrew Sykes, or someone like that, come -- we have a business relationship with him. We could arrange that, if that was something to talk -- to look at the science

behind worksite wellness and the studies and the results it shows. I think there was not unity of understanding around that today. I think it would be useful.

COMMISSIONER URATA: I might add, as part of that group, I think Medicare is attempting to add preventive services to their system.

COMMISSIONER DAVIS: The Affordable Care Act requires preventive services to be included in any non-grandfathered plan after January 1st in the individual and two to 50 -- you've got to qualify everything -- plan after January 1st. So we had them in for years, but anyone who didn't, they'll be there now, and they're pretty broadly defined. But our experience with worksite wellness has been that you don't have to be a big employer to have successes, if you've got the right support for that employer, and I think it would be great to hear that from Andrew.

COMMISSIONER ERICKSON: And for those of you who are going to be in Fairbanks next week, Andrew Sykes is going to be the keynote luncheon speaker at the fall Alaska State Chamber of Commerce meeting up there, and they're taking registrations just for the luncheon, for folks in the community, too, but we can certainly look into bringing him to a Commission meeting.

(Pause - background discussion)

CHAIR HURLBURT: How much advance notice does he need to

have on his calendar?

COMMISSIONER DAVIS: He seems to be pretty flexible, if you give him enough notice. So if we decided, for a future meeting, we wanted him, we could arrange that and just have him working on other things with us when he's out here.

CHAIR HURLBURT: So if we have two or three months' notice?

COMMISSIONER DAVIS: Oh, yeah. That should be reasonable. Yeah.

COMMISSIONER ERICKSON: Other thoughts about learnings from today?

COMMISSIONER DAVIS: Learnings?

COMMISSIONER ERICKSON: Learnings for Findings, yeah.

COMMISSIONER DAVIS: I sat quietly all morning. Now, I can't seem to keep my mouth shut.

So going back to -- and I know not of what I speak, but Dr. Stinson does. It seemed like I was on one of those Worker's Comp Review Groups years ago who did those recommendations, but it seems like there are some really pretty solid frameworks of stuff to deal with the opiate question. I mean, this whole provider repackaging and billing as a J-code, that should be, you know, something that could be fixed like that, but it didn't sound like there was any forward movement to make any of those things happen in the Legislature. So if we're the group that needs to grab onto

those and push them forward as a recommendation to the Governor and the Legislature, I think that sounds like that's a huge opportunity and a huge public health issue that could be fixed within inputting money or chasing it with money, but just chasing it with stopping some really egregious practices.

COMMISSIONER STINSON: I agree. I think it's a horrible conflict of interest, but I will also remind everybody it's not just physicians. Podiatrists, dentists, nurse practitioners, they all do it, and if you think that people don't come to our offices and try to tell us how much money we can make by doing something like that, that kind of thing happens all the time. We just rebuff it, but I know of several practices that do do it, and I think it's a conflict of interest.

CHAIR HURLBURT: And you can cloak it in a cloak of nobility. Yeah.

COMMISSIONER URATA: Are you talking about physicians dispensing opioids?

UNIDENTIFIED MALE: (Indiscernible - away from mic)

COMMISSIONER URATA: Yeah. I learned that as something new today, too. I didn't realize I could do that.

COMMISSIONER MORGAN: I asked the question, but they had 14 recommendations, and I believe the guy from Worker's Comp said not one of them had been adopted. Was it? Is that right?

CHAIR HURLBURT: Mike's still here.

COMMISSIONER MORGAN: Oh, hey, Mike. How you doing? But it just seems, to me, like what you're saying, take the 14 or ten or whatever we think is rational and just say, hey. How old are those? I mean, a couple years?

MR. MONAGLE: Six years.

COMMISSIONER MORGAN: Six years.

COMMISSIONER URATA: Should we go over some of these recommendations by -- on workman's comp that were presented or is that automatically going to be in.....

COMMISSIONER ERICKSON: So Dr. Urata's referring back to Mr. Monagle's presentation this morning and the list in those last few slides of recommendations that they've considered.

COMMISSIONER URATA: Yeah. There are four slides. They start with discontinuing the medical fee schedule based on UCR. You know, I don't know enough about each of these individual recommendations, but should we say something like recommend to the Governor and Legislature to improve our workman's compensation system or something? Is that too general or how should we make a recommendation?

COMMISSIONER ERICKSON: Jeff?

COMMISSIONER DAVIS: So I was specifically referring to the ones that have to do with the dispensing of opiates. So they're the last two on the last page, regulate physician dispensing, regulate use of opiate narcotics in some other

way. I don't know if regulate is the right word, but I mean, Michael talked about it just simply requiring that they use an NDC code. Well, that doesn't cost anything, but that would save a lot -- for spending ten to 50 times more for the same than you spend at the pharmacy down the street. That's just craziness, you know. We should -- we just need -- I'm looking for some really concentrate things, like that, or whatever else Larry would throw in there. I mean, this is -- we heard the problem next door as well, you know, discussed -- opioids. It's craziness, and it's not really, as far as I know, getting much attention in the public discourse, and it needs to.

COMMISSIONER MORGAN: I don't know if it's out of order. Could we just ask him to come back and just say, you know, out of this list of recommendations, what would you like -- if you had a wish list -- and then we'll kick it around, I guess. But the opiates, it sounds like what you're talking about, is -- I hate to borrow a term -- a no-brainer here, but the other ones are pretty good, too, I thought.

CHAIR HURLBURT: No. We have the precedent where we've had speakers participate in the discussion. So Mike, if you're willing to come up to the table, to the microphone, it would be very helpful.

MR. MONAGLE: So just to summarize on the presentation that I did, it was more or less to give you a legislative history. A number of these items have come up numerous times.

In 2006, there was -- actually, a couple years before that, 2004-2005, a Legislative Task Force was created, and it made its recommendations. So I'm not sure what page of the slides this is, but there were the recommendations made by the Legislative Task Force.

Subsequent to that in 2009, there was a Medical Services Review Committee that met and made recommendations at the end of its approximately two years' worth of meetings, and most recently, the Worker's Compensation Board had adopted a resolution, at the end of September, again getting medical costs because medical costs really are the elephant in the room as far as cost-drivers.

The one thing that I would be reluctant to do would be make specific recommendations beyond that because, obviously, that would be up the Governor's office and the Administration and the Legislature, which is why some of these recommendations are broadly couched where -- you know, a regulation concerning physician dispensing, for example, while something as something as simple as an NDC code, I think, would solve the problem, that would be something that the Administration or the Legislature ultimately would have to come to, but I think there are important policy decisions that would have to be made to help control those costs in Worker's Comp.

If there is anything -- any questions about any of the,

you know, specific recommendations made by the Task Force, the MSRC, or the Board, I'd be happy to answer those.

COMMISSIONER PUCKETT: In our prior meeting, didn't you -- maybe I'm not remembering correctly, but didn't you folks learn that the Legislature was looking for more specific recommendations than they had gotten in the past?

CHAIR HURLBURT: That's correct. Yeah. They are, and the Legislative Audit Committee has done that. I think what Mike was referring is that, basically, all the employees in the Administration are working for the Governor, and it doesn't make for good, efficient state government for the individual employees to get out in front of the Governor in terms of what priorities are, and I think that's what Mike is being sensitive to, but he has given us, which is totally appropriate and helpful, the recommendations of the Task Force here that was a working group. And we're also accountable to the Governor, but part of our charge is to develop recommendations to go to both the Legislature and the Governor.

So I think that, as Mike just invited us, if there are some specific questions, he's comfortable and able to expand on any of these.

COMMISSIONER PUCKETT: No. I can personally identify with him being so circumspect. I just wanted to make sure I did remember correctly from the prior meeting that we were --

this time, we were going to be looking at much more specific recommendations than there had been in the past. So no; I understand being circumspect.

COMMISSIONER MORGAN: I wasn't trying to put you on the spot or anything. I just -- the ones on opiates just -- I mean, it's almost like kismet. You know, everything kind of came together on that, and there were one or two other ones that seemed rational to me, and they are general, specifically through that, but I just thought I agree with Robert that we should -- if the work has already been done and another group has recommended them and they seem rational, I don't see any harm in doing something that doesn't cost money to do, for a change. How unusual.

MR. MONAGLE: The one comment I would make, you know, the Legislative Task Force had industry, labor, and the medical community, and the Legislature participating on that Task Force. The Medical Services Review Committee had the medical community. Under statute, there was representatives from, I believe, hospital association, nursing home association, chiropractic care, physical medicine, labor and industry, and of course, our Worker's Comp Board is representative not with the medical community, but with labor and industry, and there was a consensus on all three of those groups on those recommendations. So there wasn't a lot of opposition. I think we strove for consensus in all three result sets as far

as what recommendations were being moved forward.

COMMISSIONER URATA: So what you have listed on these four pages is what came out of that Task Force?

MR. MONAGLE: No. The Task Force recommendations were made in 2006. So I think I have a separate bullet under 2006 for the Legislative Task Force. And the Task Force existed in statute for a limited period of time. I think it only existed for a couple years and then it sunset.

The Medical Services Review Committee still exists in statute. I think I heard someone say they were on that Task Force, and I think part of our challenge was keeping that Medical Services Review Committee engaged after they had, you know, done two years of hard work and made recommendations and saw no action. So it was difficult to get them back at the table and continue meeting when there was no action on those recommendations.

COMMISSIONER URATA: So from this list, we've already got down the parts about opioids and physician dispensing. So I wonder if the Commission would support implementing treatment guidelines? We've already put down improving data collection on medical costs, including collection of group health cost data. I think that's being covered under our All-Payer system that we've already supported. It says here to "contract with independent research organization to study the effects of recommended changes." I guess we could put that in, but I

don’t see that -- that’s maybe something that they could do, but certainly, I think implementing treatment guidelines would be really important to improve quality, and I think we already have that in other places for improving quality as evidence-based treatment guidelines. So that’s what I would add to that.

The business about fee schedules and RBRVS, I would have learn more about before I could recommend all that.

CHAIR HURLBURT: Allen, go ahead.

COMMISSIONER HIPPLER: Implementing treatment guidelines. I’m a little concerned about this. Currently, Worker’s Comp, the way I understand it, is that the injured party and whatever medical provider the injured party chooses, choose the treatment. That’s my understanding and that there is no oversight. A treatment guideline implies there is some kind of oversight and somebody else is looking at this and approving treatment before it can happen; is that what you have in mind?

MR. MONAGLE: Yes. It happens in healthcare. Healthcare already decides what the in-network providers -- which procedures will be covered and which ones won’t. It doesn’t happen in worker’s compensation, unless, typically, the employer disagrees with the course of treatment and they have the injured worker seen by an independent medical evaluator, who opines that that particular course of treatment isn’t

warranted because of the diagnosis.

The idea or concept behind treatment guidelines in worker's comp is to get to the evidence-based medicine so that, if you have a particular diagnosis -- and I think one of the examples I used was the steroid injections for chronic pain, you know, spinal steroid injections.

At a meeting I was at last week, there were some new studies out, some new evidence that those injections may not have a long-term solution. So if you have an injured worker who is off work and you're asking the payer to pay for those injections, which, often times, they can receive, you know, depending on where the injection sites are, as I understand it, up to three, four, or five times. They're very expensive. There is a lot of risk, and the evidence is that it doesn't produce the desired outcomes. So that's where evidence-based medicine comes into play, where you would have that type of -- depending on the guidelines you adopt that would say this type of treatment is not recommendation and then you would have the option of the provider coming to the regulators and making an argument why there should be an exception for the treatment in a particular case.

COMMISSIONER HIPPLER: Okay. Well, I do -- to the best of my ability, I represent the business community, and certainly, this is a huge issue for us that somebody will be injured and the perception is, sometimes, the injured party is

even benefitting from a massive cost that the business community is incurring indirectly through increasing worker's comp insurance rates, based on service. So that's it. This sounds like improvement, but I haven't thought through the impacts on the injured party yet. So from the business community's perspective, this sounds like a fantastic idea, but I want to make sure we've thought that through.

CHAIR HURLBURT: I think, as I see it -- and my bias would be that Mike was a little understated in what he just said -- that what this is saying is consistent with the theme that we've had in a lot of our meetings is that we think there should be good, solid, high grade evidence-based clinical decision making in the decisions between the provider and the patient and good, high grade evidence used in coverage decision making on that, so that what you're doing does have a good chance of helping, that there are benefit ratios favorable, and so that you don't waste money doing things that are not that way. It does not preclude the individual from going to somebody who really believes, for example, that the steroidal injections are really good and getting them, but they would have to pay for it themselves, if the evidence isn't there. Bob?

COMMISSIONER URATA: I think you can improve that bullet by putting down "implement evidence-based medicine treatment guidelines" or "evidence-based treatment guidelines."

CHAIR HURLBURT: Yeah and that's totally consistent with.....

COMMISSIONER URATA: With what we've been talking about, quality, and I think that's important.

COMMISSIONER KELLER: We've got this under workman's comp, and workman's comp is a very small percentage of the spending anyway. So I'm just stating the obvious, that these recommendations, as they go forward, if we did them under that umbrella or just (indiscernible - voice lowered) very small segment, referring to Commissioner Hultberg's slide two.

CHAIR HURLBURT: Yeah. In the conversations between Department of Administration and Aetna right now, it's an area that Dr. Bartholomew, who is here with us, oversees there, but one of the things the State wants Aetna to use is their clinical practice guidelines. There are sets of guidelines that InterVol has, Milliman has that are used widely nationally. Aetna develops their own, but that's the principal. So I think where we say yes, this is addressing workman's comp, but Department of Administration is looking at that for the coverage for employees and retirees and dependents on the principal, but I think I would agree we want to be clear. We're not just talking narrowly about this, that the whole approach is based on that. And Allen, you had another comment?

COMMISSIONER HIPPLER: I had a question for you, sir. A

couple of these recommendations are talking about moving from a UCR-based fee schedule on worker's comp to something else. How does that UCR schedule differ or how is it affected by the regulation that requires reimbursement at either 90% or 80% UCI? I thought it was 90, but it's written as 80. Can you explain that to me? Thank you.

MR. MONAGLE: Sure. The current methodology under the statute says that the fee schedule must be at the 90th percentile of usual and customary charges.

The organization that use to produce that data is Fair Health. Fair Health collects copies of bill charges from all providers, physicians, hospitals, clinics and then they determine the 90th percentile, but what they determine it at is the billed rate, the charged rate. And basically, it's the full retail value. Nobody pays full retail on medical, except for the uninsured, and even there, they may work out a payment plan with the doctor. So it's artificially inflated to begin with, and what we find is, when we reproduce that fee schedule at the 90th percentile UCR, it keeps raising that maximum allowable reimbursement, which the providers keep coming up to.

So the 90th percentile is not a methodology that most states use anymore. Most states have done away with that. What they use now is -- what the recommendation says -- is a resource-based relative value scale system. So basically,

what that is, is the Medicare calculation. So Medicare produces a rate for each procedure code. So a code will say, for this procedure, we take into account the doctor's knowledge, training, expertise, the costs associated with the doctor's practice, you know, operating costs and personnel, and their insurance costs, and we come up with what the Medicare determines to be a relative value factor. It's a number. So it's -- I don't know. You know, any particular procedure would have a dollar value.

Then what Medicare does is they come up with what they call a conversion factor. I think it's -- I don't know what it is this year. I think it was, like, $23.40, and you multiply the conversion factor times the relative value to get to the maximum reimbursement, and they do this for every single procedure code.

CHAIR HURLBURT: But that does not imply that the result would be the Medicare rate.

MR. MONAGLE: Correct.

CHAIR HURLBURT: (Indiscernible - simultaneous speaking) lowest payer in the state, unlike Medicaid and (indiscernible - simultaneous speaking).....

MR. MONAGLE: So what the recommendations of the MSRC, the Task Force, and the Board were is that we use that relative value that Medicare comes up. What we don't do is use the Medicare conversion factor, the $23.40. Instead what

the regulation would be is a conversion factor specific to Alaska for worker's comp. That would be a process that you would have to come through by proposing a regulation. I think what the Board has talked about, what the MSRC talked about was collecting data, which is one of the recommendations, to find out what healthcare allows. We have to go out, meet with healthcare, find out what generally is allowed, and bring worker's comp more in line with coming up with a conversion factor.

So for example, right now if I took that procedure code for a diskectomy, a surgical procedure, and I looked at what Worker's Comp allows under that, I'd probably find that the allowable maximum reimbursement is probably 400% or 500% above what Medicare allows and then probably 200% to 300% higher than what healthcare allows in Alaska. So the idea is that you come up with a conversion factor that better approximates what currently is allowed in the marketplace instead of on the UCR price.

CHAIR HURLBURT: On the UCR, frequently, even in a community your size, Juneau there, for primary care, there will be enough competition that you will come out with a more competitive rate and that's what Milliman showed us that primary care reimbursements are significantly higher than Puget Sound, but not nearly as much as some of the sub-specialties with smaller numbers of people. So the result is

that, even in a city the size of Anchorage, if you have one or two groups in a specialty, and just by them arbitrarily establishing their bill charge rate, they can establish what UCR is, and unless you're going to send somebody to Seattle, there really is not any competition there. Jeff?

COMMISSIONER DAVIS: There is not a scale, right? So just one clarification, Allen, because I think I know what you're thinking about here.

The regulation that Mike is talking about that requires them to reimburse or to allow up the 90th is specific to Worker's Comp. The regulation that is specific to other payers is the 80th percentile is the minimum.

And as Dr. Hurlburt pointed out, if you have 21% market share, you can -- you set the floor, regardless of what you charge and how outrageous it may or may not be.

So I just probably should comment, UCR is inherently inflationary. I mean, for that very purpose, as prices are raised, it goes up. RBRVS reimbursement with a set conversion factor is more negotiated, and it doesn't just go up automatically. Same for the APCs, which is, essentially, the same methodology, but it groups things together, and for DRGs, there is a wait for something that happens. There are just three methodologies that fit for outpatient, inpatient, and physician services. Thank you.

MR. MONAGLE: What a number of states have done is they

will have a separate conversion factor for minor surgery, one for major surgery, one for radiology, one for physical medicine, one for evaluation and management. So you don't put all of the categories with one conversion factor because what would happen is, if you came up with one conversion factor for the entire scope of practice, you would be taking orthopedic surgeons from 400% down to 200% and that would be disastrous.

As the Chair, Dr. Hurlburt, said, we don't see the same things happening with evaluation and management. So your general practitioner, your office visit, they are more in line with what healthcare charges. It's when we look at specialties, like some of the specialty surgeries, radiology, anesthesiology, that's where we see the current fee schedules with the huge variance between what's going on in Alaska and what's going on with the other payment systems within Alaska, like healthcare and Medicare, and what's happening in regional states, like Washington, Oregon, and Idaho and those other states.

CHAIR HURLBURT: Thank you very much, Mike, again.

COMMISSIONER ERICKSON: Should we move on, beyond worker's comp? Are there anymore, generic to all employers, either findings or recommendations you want to make sure get captured this afternoon or do you need to sleep on it? Go ahead, Jeff.

COMMISSIONER DAVIS: We haven't circled back to it, but I

thought Mark Foster's references to the so-called Cadillac tax and the excise tax that will be applied was very interesting. It's not -- I don't know where we go with it, but it was interesting to hear the impact that that had, at least in his experience. And I think I said this before; our actuaries have looked at healthcare costs in Alaska and project them forward. They are fond of saying all roads in Alaska lead to the Cadillac tax. And so that is going to be a factor. A 40% excise tax on the difference could be real money. And so I don't know what we do with that, but at least, capture it as something we thought about today.

COMMISSIONER PUCKETT: Just for a point of clarification, and correct me, if I'm wrong, Mr. Davis, but this tax is 40% above the Cadillac tax threshold, right?

COMMISSIONER DAVIS: Yes.

COMMISSIONER CAMPBELL: Would somebody want to expand on where that Cadillac tax is liable to drive both employers and patients in the long run, other than a catastrophe?

COMMISSIONER DAVIS: The policy (indiscernible - voice lowered). So I don't remember the exact numbers. It's like $18,000 for an individual and $30,000 for a family or something along those lines. So what happens, Mr. Campbell, is, once the value of your plan exceeds that number, when it's one number nationally, then you have a tax penalty, an excise tax penalty of 40% of the difference between those two.

So the issue that we run into in New York and we'll run into in Washington D.C. first is that, you know, our costs are higher and so we're going to exceed that number pretty quickly, maybe even the year it's implemented, in 2018, for a lot of employers. So it's going to start -- it's already started to drive conversations, as Mark pointed out, but it's going to really start to drive conversations over the next couple years as it becomes more real. And it's complicated for a couple of reasons. You think, well, raise the number, you know, for Alaska. Guess what? You raise the number, you increase the deficit because the deficit projections and the cost (indiscernible - voice lowered) were based on some assumptions about collected that tax from certain entities.

The other thing I'll just, for whatever it's worth, share is that, really, this is one example where stuff got put together that didn't really make sense. The Cadillac tax concept was a Bush era concept that was designed to encourage employers to offer high deductible health plans that didn't cost so much because that was the way, as Commissioner Hultberg described, to get people -- one of the mechanisms to start to get people engaged, and it really works, but it got put into a law that actually requires richer benefits. So it's two things moving the opposite direction and that's the collision that's going to happen here. So stay tuned.

COMMISSIONER URATA: I just remembered somebody mentioned

disease management for the top five percent of patients who incur the greatest costs. So in other words, they're the sickest, and disease management may be a helpful thing.

I have talked to some people who are Disease Managers for insurance companies, and they've been of great help to me taking care of some difficult patients. For example, I was able to send a home care nurse in, even though they didn't have home care benefits, but in talking through the case, we were able to keep a person out of the hospital and treat them at home with home care attendants. So to me, that is an example of disease management, I believe.

CHAIR HURLBURT: Disease management is more broadly targeted, and my experience has led me to some skepticism, but I -- from what Jeff was reporting, that, where it's being applied in a more sophisticated manner along with some of the wellness activities, it sounds like it may be good. Conceptually, it is. And sometimes, I think it's just the right thing to do, for an employer to do.

But the other thing that, from the way you were talking, it's possible you may have in mind that may be applied to the patient you talked about -- there is what's called Complex Case Management, but that refers to a very small subset of your patients, less than one percent, I would say, maybe significantly less than one percent, but your very most costly patients, and those are -- because their care is complex and

they'll have one doctor for their lungs and one for their heart and one for their gut and one for their lungs, and they don't always communicate together, a nurse, Complex Case Manager, can facilitate that communication, can work with the family, can make sure that rehab is lined up or whatever you need, and it can really improve the quality of the care as well as minimize the wastage of resources.

So I think that's -- that the disease management is -- you know, maybe you pick up your kids that are getting into the hospital or the ER with asthma or your diabetics that are, you know, not doing that terrible, but getting decay and going in the hospital and put them in a disease management program, but the Complex Case Management is another aspect that I think is very, very helpful.

COMMISSIONER DAVIS: In Commissioner Hultberg's presentation on slide 19, she has a graphic that I think helps understand this. There is this progression, and disease management fits in the middle in that chronic disease arrow. So people with diabetes or other chronic conditions -- asthma -- might be counted for disease management. She gave you, what, 41 categories of disease.

What Dr. Hurlburt is talking about, as you progress to the right into the, I guess, that's pink or flamingo or whatever it is, those are people who now have gone into some serious complications in progression. That's where complex

case management would be. And then Dr. Urata, you'd pick them up at end-of-life in hospice, right? Try not to. And the pre-chronic, so the light green, this is what you hope you're picking up there, and the at-risk with your metric screenings and with your health risk appraisal and your worksite wellness programs, so that you stop the progression. The real goal is to get no worse. I mean, you don't even have to get better. You just have to get no worse. And so if you pick people up at the right point and keep them from getting worse, that's what this is designed to do. But I just thought it was a good way to show why those different things are applied and they have a different stage in which they have some utility.

CHAIR HURLBURT: Any other comments? Bob?

COMMISSIONER URATA: We should add the words "evidence-based Complex Case Management," I guess. Maybe we should say "evidence-based" in everything that we recommend.

CHAIR HURLBURT: I didn't notice; did you write down -- because I thought it was important. Larry made the comment on the next to the last or the last -- those recommendations that Mike Monagle had, that it's not physicians; it's definitely (indiscernible - simultaneous speaking) providers.

COMMISSIONER ERICKSON: I captured it as clinicians.....

CHAIR HURLBURT: You got that; okay.

COMMISSIONER ERICKSON: .....instead of physicians. Well, are we out of steam for the day? It's okay if we are

because I'm giving you a homework assignment, if you get off early. It should be a simple one.

So we're going to do what we have been able to do. Oh, that was a nasty face. We're going to do what we've been able to at all of the past meetings, except the last meeting where we just did brainstorming and captured your thoughts at the end of a long day of listening, but then came back fresh the next morning, and I'm going to go back to the office and pull these bullets together so you have them as a handout tomorrow morning.

And what we'll do after you've had a chance to sleep on it and we've integrated some of these thoughts, we can see if we can refine what you've thrown out and also add to it, if you think of something that you wish you had said this afternoon. We didn't have an opportunity to do that at our last meeting because our first day of listening went the entire day and so we didn't have that chance to come back and revisit.

In your packets, in your notebooks behind tab four, behind the slides, the discussion slides is a handout for -- the header is Evidence-Based Medicine, and it's just two pieces of paper. It's four pages. On the fourth page on the back of that handout are all of the bullets from the slide from the brainstorming sessions we did that next morning after the day-long workshop on evidence-based medicine and critical

appraisal with the Delfini Group, and we had a brainstorming session that next morning. Those are all the bullets from that brainstorming sessions.

COMMISSIONER URATA: Is that page ten?

COMMISSIONER ERICKSON: Well, it's also in your slides. I pulled it into the slides as well. So there is this document, Dr. Urata, behind the slides. It might be a little easier to look at.

And what I did -- and I hope I wasn't too presumptuous. You can ignore this entirely, if you think that I was, but in considering the comments and the discussion that we had on evidence-based medicine at that meeting, I've made some suggested modifications to the 2010 Findings & Recommendations.

And so your homework is to look at these and think about them tonight because, when we're done with revisiting the employer's role and refining the thoughts from this afternoon, we'll do that first tomorrow, but then we'll go back and revisit it and think again about evidence-based medicine and see what you want to do to refine, add to, change last year's.

Let me just -- I don't want to go over these in any detail, but I want to point out and explain one other thing. If you will recall in that discussion, this group was a little frustrated with trying to figure out how to -- and maybe this was just my perception, and you can correct me if I'm wrong.

My perception was you all were a little frustrated that next morning with taking the learning from the day before and translating into policy and what the State could and should do in terms of policy, and a couple of you had asked our faculty who were sitting with us the first part of the morning, a couple times, what are other states doing, and how does this translate.

So I hope this isn't too hard to read, but on the bottom of page three in the purple italics, I pulled together just a little bit of information. They referenced and Dr. Hurlburt referenced something that happens in a couple of other states. Washington State actually has a Technology Assessment Committee, a whole program that they have funded to do their own reviews of looking for evidence and applying those in policy decisions made by state medical purchasers.

The federal government has a real significant initiative run out of the Agency for Healthcare Research and Quality, the Effective Healthcare Program, and I brought some examples of some of the work that they do in comparative effectiveness and just straight effectiveness research and then they translate that into research documents, patient decision aids, other sorts of tools, continuing medical education modules, and they also support regional evidence-based practice centers. There is one based out of Oregon that was mentioned that day, and there are a number of states that participate in that regional

evidence-based center. And then the choosing.....

CHAIR HURLBURT: Including Alaska.

COMMISSIONER ERICKSON: Including Alaska, yep. Is it just our Medicaid program that participates in that?

CHAIR HURLBURT: Just Medicaid.

COMMISSIONER ERICKSON: Just the Medicaid program participates in the Oregon program. And then there is the Choosing Wisely campaign, which is an initiative of the ABIM Foundation, and it's based out of the medical community. So I've provided some links to that and a little bit of information.

So that's just a little bit of additional background information that I pulled together for you and so take a look at this. I've lined through the parts that I would suggest changing, and anything that's underlined are suggested additions. But I tried to be true. These weren't my own ideas. I tried to be true to the discussion. So read those bullets first. It was just a stream of consciousness, but read those bullets first and see if you can recollect the conversation that we were having that day before you go to look at the suggestions that I've made here. And it's not as much as it might appear to be.

COMMISSIONER URATA: Thank you for doing all this good work.

COMMISSIONER ERICKSON: Well, I don't.....

COMMISSIONER URATA: I just glanced through it. I think it captures what I recall.

COMMISSIONER ERICKSON: Well, we can discuss it tomorrow, but I wanted you to have a chance to look at it and think about it first. Are there -- oh, one other thing. We'll mention these, since we're wrapping up early.

I had mentioned, over email at one point, that I participated in a screening that was held at the University of Alaska, and it was sponsored by -- well, we actually helped host it, and the College of Health and the State Public Health Association participated in it as well.

Anyway, this documentary is called Escape Fire, and it really is a very well done program. Well, the subtitle is The Fight to Rescue American Healthcare, and it's based on a speech that was given by Dr. Don Berwick of the Institute of Healthcare Improvement and then the head of CMS for a short while and now a candidate for the governor of Massachusetts, but in this speech, he told the story of the Mann Gulch fire from the mid-'30s, I think it was, '39 or maybe it was the mid-'40s.

CHAIR HURLBURT: I think more recently than that.

COMMISSIONER ERICKSON: Mann Gulch, I don't think so. It was a long time ago. Anyway, it was a wild fire in which all but one of the firefighters -- I think it was 13 or 14 firefighters lost their lives, and the one person who survived

was the one person who did everything wrong. He threw away his tools and lit a fire around him and laid down in the patch of burned up ground and saved himself that way. And so Dr. Berwick makes that analogy and says that's what we need to be doing in healthcare right now, and we need to throw out everything we know and think differently and think outside the box to come up with solutions.

Anyway, they go over -- they spend a lot of time on the problems, but they do get to some solutions at the end, including employer's role, including the importance of pain management. They profile, as just one story, a soldier who has a horrible addiction problem to painkillers and the new pain management program that they've been testing in the military now. And I was just talking with Dr. Harrell about that earlier, and he was describing some of the things that they're doing that are really innovative and alternative that are having a good effect.

So anyway, we brought three copies, but since Dr. Stinson was the first one here this morning, he got one as a prize. So we were talking about the pain management program, and he got excited about it. So if anybody would like to -- I didn't buy one for everybody because I didn't want to push it on you. I just wanted to make the offer, if you're interested in watching this. If you want to borrow it, there are a couple more available here, and we can circulate it. If everybody

wants a copy, we'll buy a copy for everybody because they're not that much, and you can also download it off iTunes for $4 or $5, too. Yes, Keith?

COMMISSIONER CAMPBELL: Maybe Dr. Stinson could give us some Cliff notes in the morning on that.

COMMISSIONER ERICKSON: Are you going to watch it or are you going to go see patients?

COMMISSIONER STINSON: Well, now, I'm going to go see patients.

COMMISSIONER URATA: Isn't there a book with the same title?

COMMISSIONER ERICKSON: Yes. There is a book in the same title.

COMMISSIONER URATA: Yeah. You can get it on Amazon. I think I have it or read it.

COMMISSIONER ERICKSON: These are available, if you want to come pick one up. Does anybody have any questions or comments from the day, today or questions about what we're going to do tomorrow?

COMMISSIONER HIPPLER: Do we leave our stuff here?

COMMISSIONER ERICKSON: You may leave your notebooks here. I would not leave any valuables.

COMMISSIONER KELLER: Or your homework.

COMMISSIONER ERICKSON: Or your homework. Take your homework with you. Thank you all very much.

4:19:52

(Off record)

**SESSION RECESSED**