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ALASKA HEALTH CARE COMMISSION

DENA'INA CENTER

600 WEST SEVENTH AVENUE

ANCHORAGE, ALASKA 99501

FRIDAY, OCTOBER 11, 2013

8:05 A.M.

VOLUME 2 OF 2

PAGES 210 THROUGH 322

1 points.

2 So for the Commission members, if you want to just review
3 those bullet points, which, again, were just kind of a stream
4 of consciousness after a long day of listening and learning
5 yesterday, the second and third pages, though, what I did was
6 I took a stab at trying to identify some of the major themes
7 from your discussion yesterday and tried to clarify some of
8 the points and organize them a little bit. So they're not
9 really even in draft form in terms of finding and
10 recommendation statements, but I just tried to synthesize it a
11 little bit and make sense of it.

12 So if you want to take five to ten minutes right now,
13 review those bullet points from the brainstorming session and
14 then look at what I've done on those next two pages, we'll go
15 back and discuss all of those points in about five to ten
16 minutes.

17 8:09:21

18 (Pause - Commission members review notes)

19 8:21:51

20 COMMISSIONER ERICKSON: So let's just start walking
21 through this, starting with the second page of your handout,
22 and I've also got it up on slides, and folks on the webinar,
23 hopefully, are able to see them.

24 So there were a couple of items that came up that I just
25 moved to the parking lot. One was the question about rural

1 sanitation, and I explained that I already had it on something
2 that we'll look at a little bit later this morning as a
3 proposed agenda for the Commission for 2014, and I have that
4 item on that list and then the suggestion that we bring Andrew
5 Sykes, who is the Health and Wellness Actuary, to present to a
6 future Commission meeting. So those two items are in the
7 parking lot right now for addressing in the future. Does
8 anybody have any questions, comments, suggestions?

9 CHAIR HURLBURT: I have a comment. Go ahead, Jim.

10 COMMISSIONER PUCKETT: I just had a question. What topic
11 does the Commission want Mr. Sykes to present on or do we have
12 that decided?

13 COMMISSIONER DAVIS: My thinking, Jim, was that just the
14 whole science of health and worksite wellness and the impact
15 of -- proven impact of certain interventions and certain
16 neuropsychological interventions and sorts of things. Yeah
17 (affirmative). He's, clearly, very fascinating.

18 CHAIR HURLBURT: On the first item, I have to say I'm
19 totally convinced that water and sanitation and water sanitary
20 engineers did far more for the health of Alaska Native people
21 than everything I ever did as a doc. However, I also think we
22 cannot be all things to all people. I agree, Deb, we have to
23 put this on the list, and the Legislative Audit people have
24 pointed that out. It was a part of our charge, but my
25 suggestion would be that we do incorporate that on there,

1 being responsive to Legislative Audit, but I think getting too
2 deeply into that would divert us from areas where we may be
3 able to provide more value to the state. Val?

4 COMMISSIONER DAVIDSON: I think, given the funding trends
5 for sanitation facilities federally, which impacts the State
6 match, I think that would be a mistake. I would recommend
7 that we include it. We can do -- have folks from the State
8 and ANTHC, who do sanitation facilities, to do a very brief
9 presentation on the impact of health in Alaska. It's not just
10 Alaska Natives. It's everybody who lives in a community that
11 doesn't have adequate sanitation because it is one of the
12 biggest determinants of people's health.

13 CHAIR HURLBURT: But by that, do you mean we should get
14 more deeply into it beyond taking a stand that this is
15 critically important for the health of rural Alaskans and is
16 something that government, at state and federal levels, needs
17 to continue to support?

18 COMMISSIONER DAVIDSON: I think, if you look at what
19 impacts the health of Alaska and you look at on-time
20 immunization, I mean, when you look at all kinds of things
21 that impact people, the fact that one out of every three
22 infants in a community without adequate sanitation can expect
23 to end up in a hospital every year is a pretty big impact on
24 the health status of Alaskans, and I think there is probably a
25 lot we could accomplish in about an hour.

1 COMMISSIONER ERICKSON: And we will -- and it's an
2 important discussion. We will actually make a preliminary
3 decision later this morning about whether to include it in the
4 draft that will go out for public comment as the list of
5 things the Commission will study next year.

6 CHAIR HURLBURT: Yeah (affirmative), but I think what Val
7 just said, she said better than I did, but to do within an
8 hour. I wasn't saying that it wasn't important, but I think
9 that's what I intended to say, but you said better.

10 COMMISSIONER ERICKSON: You guys will get to vote on
11 whether to include it or not a little bit later this morning.
12 Yes, Val?

13 COMMISSIONER DAVIDSON: So we also had a conversation
14 about oral health before, I recall. Is that one of our issues
15 that we're doing next year as well?

16 COMMISSIONER ERICKSON: No. It was -- let's discuss that
17 later today.

18 COMMISSIONER DAVIDSON: Okay.

19 COMMISSIONER ERICKSON: So this parking lot is for after
20 this meeting, later. Let's put oral health on today's parking
21 lot to discuss later this morning.

22 COMMISSIONER DAVIDSON: Okay.

23 COMMISSIONER URATA: So this is a parking for the future?

24 COMMISSIONER ERICKSON: Yes.

25 COMMISSIONER URATA: So now I have to talk to you about

1 this, about quality for a future parking, and we had talked
2 about -- what's his name? It will come to me later.

3 COMMISSIONER ERICKSON: Well, and later this morning -- I
4 was just showing you just a -- I'm making the process too
5 complicated here. I was just showing you what I took from
6 yesterday's discussion to move into the parking lot for what
7 we're doing in the future. We're actually going to have the
8 conversation and make some preliminary decisions later this
9 morning about what our future parking lot agenda is going to
10 look like. So when you remember that name, write it down, and
11 we'll have an opportunity to discuss it later, but for now,
12 I'd like to go straight to the employer engagement discussion
13 and continue that from yesterday afternoon.

14 So the major themes I had pulled out of the conversation
15 that you all had at the end of the day yesterday were in these
16 groupings that you found on the paper on page two, the issue
17 related to market forces and scaling or aggregating covered
18 lives, a series of issues that seem to relate to employer
19 coalitions. I pulled that together in another grouping. The
20 opioid discussion stood out as kind of a separate, but
21 important, issue, and a note about worker's compensation. And
22 then I wasn't quite sure where to put the Cadillac tax, so I
23 just left it separate, but there was enough of a discussion
24 about that, and I actually found what I think is a really good
25 informational piece on that, that I brought you all copies of

1 that I found last night. When we get to that point, I'll hand
2 it out to you.

3 So do those groupings make sense to you, just in terms of
4 major themes that we might end up with some finding statements
5 eventually on? Is there anything missing? Yes, Jeff?

6 COMMISSIONER DAVIS: I just have a couple technical
7 corrections on this one, the last big bullet and then the sub-
8 bullets.

9 The Division of Insurance regulation requires insurers to
10 set UCR at no less than the 80th percentile. So insurers to
11 set UCR at no less than the 80th percentile, no percent.
12 Thank you.

13 And then on the next bullet, State statute requiring
14 acceptance of assignment of benefits. Thank you.

15 COMMISSIONER ERICKSON: I knew that you would correct
16 those for me today. Thank you.

17 CHAIR HURLBURT: I think, on the references to the opioid
18 issue there, it is a cost containment opportunity, but in that
19 particular, I would say, that's probably the least important.
20 That's a safety issue. It's a quality issue. It's a law
21 enforcement issue, and yes, by doing the right thing, like so
22 often happens, your costs will be contained, but that's
23 probably the least of the reasons to pursue that.

24 COMMISSIONER DAVIDSON: This is just a small edit, but on
25 the first bullet, it's really hard to always never, ever do

1 something, so I think the word "impossible" maybe could be
2 challenging because it seems to go against all of the
3 following bullets.

4 COMMISSIONER DAVIS: Maybe "challenging" rather than
5 "impossible."

6 CHAIR HURLBURT: We're Marines; nothing's impossible.

7 COMMISSIONER ERICKSON: Yes, Jim?

8 COMMISSIONER PUCKETT: Just another, little technical
9 thing. In the bullet about the Department of Administration
10 and down toward the end of that where it talks about
11 "implement strategies that could help to improve the plan," we
12 need to specify that that's the retiree plan because, the
13 active plan, we can, you know, make plan design changes and so
14 forth, and we do have a network that we steer the employees
15 to, but we're not able to do that in the retiree plan.

16 CHAIR HURLBURT: And even with the retiree plan, isn't
17 it, at least, potentially possible to have a tradeoff that you
18 change things in a way that are not a diminishment in benefits
19 -- maybe an improvement in benefits -- but would make it more
20 rational, quite possibly ending up being legally challenged,
21 but nevertheless done with good supporting rationale in a way
22 that would improve that?

23 COMMISSIONER PUCKETT: Well, the way that the Supreme
24 Court has ruled is that, if we can demonstrate an actuarial
25 equivalence or improvement, then that would stand litigation.

1 It's just then you get into the actuarial alchemy is what I
2 call it.

3 COMMISSIONER ERICKSON: So I don't want to spend time
4 trying to wordsmith and actually write this together as a
5 committee. What I'd like to do is move through each of these
6 groupings and see if there are any corrections or suggestions
7 that you all have, like we just did with the market forces
8 piece, and then see if there is just some general agreement
9 that you want me to go back and actually take these ideas and
10 craft them into some draft finding statements for you all to
11 respond to.

12 And just a note about process. We're going to do the
13 same thing we've done the last couple of years when we've
14 gotten to this quarterly meeting of the year in October.
15 We've had some time afterwards. What I'm going to do is take
16 everything and get it back out to you on Monday, from the
17 results of this meeting, and we'll have a teleconference in
18 about two weeks. We'll work on scheduling that on Monday,
19 too, but -- and then we'll -- in that two-week period from
20 when you receive and when we have the teleconference, you all
21 will have a couple of weeks to review and make your comments,
22 and you can either call or email -- call me to talk through
23 them, if it's quicker and easier for you, or email them to me,
24 and I'll aggregate everybody's comments and get them back out
25 to you in advance of the teleconference and then we'll have an

1 opportunity to review and discuss. And assuming that not
2 everybody will have a chance to tie-in into the
3 teleconference, what we might do is have the discussion on the
4 teleconference. I think we did this last year, too, but then
5 did an electronic vote to give everybody a chance to vote on
6 the final draft and that will -- what we'll be voting on is to
7 release, as draft for public comment, the Findings and
8 Recommendations for this year. And during the month of
9 November, we'll have those out for public comment, and you'll
10 get the comments a week or so in advance of our December
11 meeting, and we'll meet then just to review those comments and
12 finalize those statements. Does that process make sense to
13 you all?

14 And just so you have more context for what we're doing
15 this morning, too, and understand what's going to happen next,
16 I have those dates on a slide at the end of this presentation
17 that we'll revisit at the end of the meeting today.

18 UNIDENTIFIED COMMISSIONER: (Indiscernible - away from
19 mic)

20 COMMISSIONER ERICKSON: No. The meeting is December 6th,
21 the meeting where we're all get together again to review
22 those. The teleconference is not scheduled yet, and we'll do
23 a scheduling poll to make sure we can get, at least, a quorum
24 of as many people together as possible.

25 So anything else related to market forces, and do you

1 want to have a finding statement related to these points? I
2 see heads nodding, and I see nobody shaking their head no --
3 and a thumbs up.

4 So then related to employer coalitions, is there anything
5 more you would like to add here, suggestions, corrections?
6 Yes, Jeff?

7 COMMISSIONER DAVIS: With respect to bullet number two,
8 looking at our recommendation earlier about All-Payer Claims
9 Databases, I think we left ourselves sort of that the jury is
10 not in yet in that, and we talked about, you know, working
11 through it with stakeholder groups and identifying things and
12 proceeding cautiously, if there is value. And so I think the
13 definitive statement that there is value, is perhaps, a little
14 too strong because, as Dr. Hurlburt said yesterday, it's hard
15 to find examples of where it's really changed things in the
16 real world. Thank you.

17 COMMISSIONER ERICKSON: I would -- so I'm going to change
18 the word "valuable" to "potential."

19 COMMISSIONER DAVIS: Potentially, yes.

20 COMMISSIONER ERICKSON: Potential. Potential. Well, not
21 even "potentially value," just a "potential data source." I
22 think one of the things that I've been coming across in my
23 review is that this is one place, employer coalitions, where
24 it is actively used and that it's generated, where different
25 employers have wanted to aggregate and have actually been the

1 ones to start an All-Payer Claims Database, either to be the
2 genesis for starting an all-state All-Payer Claims Database or
3 creating their own for their community or their region. So I
4 don't -- yeah (affirmative), Jeff?

5 COMMISSIONER DAVIS: So that is true. And my cautionary
6 comments are because of our experience with the Puget Sound
7 Business Coalition and their database and the fact that it has
8 been absolutely valueless to us over the years, but it's
9 caused a lot -- taken a lot of resources and time and money.
10 So that's, in fact, what our comments to the consultant were
11 based on was experience with that.

12 COMMISSIONER ERICKSON: And I've heard negative comments
13 about that group, too, but positive ones about coalitions in
14 Wisconsin and Tennessee and.....

15 COMMISSIONER DAVIS: It's like anything (indiscernible -
16 simultaneous speaking).

17 COMMISSIONER ERICKSON: Right. You can do it wrong or
18 you can do it right, and if you do it wrong, it's not going to
19 provide much value. So that's a good suggestion. Other
20 questions or comments or suggestions about the employer
21 coalitions piece? Are there other concepts you want to make
22 get captured there? And do you want to include that as the
23 issue of employer coalitions in the finding statements? I
24 don't see heads doing anything at this point. I've got a
25 thumbs-up and a second thumbs-up and a third or is that a

1 question? That's a question. That's not a thumb. I was
2 going to say, that's not a thumb; that's a finger. That's an
3 index finger.

4 COMMISSIONER HIPPLER: So on employer coalitions, I'm
5 trying to think of an example that doesn't involve hospitals
6 doing that. I'm just.....

7 COMMISSIONER ERICKSON: No. No.

8 COMMISSIONER HIPPLER: Off the top of my head, I don't
9 have any.

10 COMMISSIONER ERICKSON: No. The employer coalitions have
11 -- the ones I'm familiar with actually typically don't
12 necessarily include healthcare employers at all or includes
13 them as partners, but not as decision making partners. I
14 don't know that we need to be that specific in our finding
15 statement, unless you want to be.

16 Moving on then, the point about opioids, Ward, you were
17 suggesting that.....

18 CHAIR HURLBURT: Could I give maybe just a stab at
19 rewording that.....

20 COMMISSIONER ERICKSON: Sure.

21 CHAIR HURLBURT:because we're not talking, here,
22 about, like, illegally opioids, although that is a problem.
23 But here, it's -- the revised statement might be, "Abuse of
24 prescription opioids is a critical, personal and public health
25 concern." And I'm looking at Larry's face to see how.....

1 COMMISSIONER ERICKSON: Could you give me the second-half
2 of that again?

3 CHAIR HURLBURT: "Abuse of prescription opioids is a
4 critical, personal and public health concern."

5 COMMISSIONER ERICKSON: So the problem I'm having with
6 this is how we relate it to employer issues. We've -- I mean,
7 it's an issue in worker's comp, and we have a draft
8 recommendation, preliminary recommendation in worker's comp
9 related to that. So maybe that's enough of a connection, but
10 that's just one question I have. Yeah (affirmative)?

11 COMMISSIONER STINSON: In the literature that's out right
12 now, there is no large employer group or coalition group
13 that's not concerned about this. This is rampant throughout
14 the United States as a problem.

15 COMMISSIONER ERICKSON: Should we add "employer" to the
16 list of personal.....

17 COMMISSIONER STINSON: You know, you could even replace
18 "personal" with "employer." That would be probably better.

19 COMMISSIONER HARRELL: Dr. Hurlburt, I was wondering if
20 you'd expand on your comment earlier though regarding the --
21 not lack of importance, but size of impact of addressing this
22 economically. I mean, the worker's comp area -- although my
23 comment is anecdotal, chronic pain and addressing the pain is
24 a significant financial part of worker's comp and worker's
25 comp cases and that was discussed yesterday. So although it

1 may be small in the overall dollar size, it's clearly an area
2 that can be, I think, relatively easily addressed, and
3 therefore, cost containment can be achieved with, I think, a
4 small amount of investment. So why not go after it? I'm
5 trying to understand your.....

6 CHAIR HURLBURT: Yeah (affirmative). I guess -- and I
7 think that's reasonable. I was just trying to narrow it down.
8 I think, you know, we talk about the use of evidence-based
9 medicine to improve quality and to improve outcomes, but it
10 will also have a major, major impact on cost. And since
11 that's true here, it's just the epidemic of prescription
12 opioid abuse is reeking so much havoc on our country that
13 where my mind was, was just narrowing down. Even if it costs
14 us more, we need to deal with that, but yes, I absolutely
15 agree that one of the benefits will be cost containment there.
16 So that was my thinking, but I think what you're saying is
17 reasonable, too, Tom.

18 COMMISSIONER STINSON: I don't know, but we might want to
19 even include the state of Washington experience which, when
20 they've instituted this, they've already had decreases in
21 domestic violence, emergency room visits. There are true
22 downstream improvements in a public health setting when you do
23 this. You get rid of absenteeism. You have a lot of benefits
24 that are maybe not immediately noticed.

25 CHAIR HURLBURT: And I agree, and I think we can learn a

1 lot from what Washington has done, and they've done some good
2 things, but I would suggest maybe, if we're going to specify
3 that, say, like Washington and Oklahoma.....

4 COMMISSIONER STINSON: There are several.

5 CHAIR HURLBURT: Yeah (affirmative).

6 COMMISSIONER KELLER: We're working on HB53. One of the
7 issues became, you know, I mean, in the minds of those that
8 responded, was, who is doing the abusing?

9 In other words, you know, there are two elements to this.
10 One, is the provider not understanding the impact? The other
11 is, you know, the illegal abuse of the prescriptions. And I
12 have no way to make a suggestion to your change of wording,
13 but in my mind, I'm remembering the discussion and visceral
14 reaction by some of the providers, you know, that, in this
15 kind of -- does that not kind of imply that one more than the
16 other abuse -- are we talking an illegal problem or are we
17 talking control, you know? So I mean, that's a question, an
18 honest question. I'm just trying to figure it out.

19 CHAIR HURLBURT: Yeah (affirmative). And there is the
20 illicit use of the legal controlled substances, like selling
21 the pills on the street, and that would be what would be, in
22 my mind, but we're not talking about the heroin on the street.
23 We're not talking about the illegal substances that, indeed,
24 are a problem, but this is a problem related to legally
25 prescribed opioids and that's why I was trying to narrow on

1 that, not to the exclusion that other areas aren't also a
2 problem, but it's a different problem.

3 COMMISSIONER KELLER: Yeah (affirmative). I didn't mean
4 to be -- yeah (affirmative). I mean, in fact, I tried to make
5 that same point. I remember, on the record, I was trying to
6 explain we're not dealing, here, with, you know, illicit,
7 controlled substances. You know, we're talking about legal
8 prescriptions, but that distinction is hard to come by when
9 you have a clinical discussion going on.

10 COMMISSIONER STINSON: To Representative Keller's point,
11 over 60% of the opioids that wind up doing harmful things are
12 prescriptive opioids. So the majority of the medications that
13 are entering into the system that are causing problems are
14 prescription medications, and they're not necessarily
15 illicitly obtained, except if they are stolen prescriptions or
16 one of the other things is that people tend to borrow
17 prescriptions from each other so that they're not even
18 classified as stolen, but that fills in, after the initial 60-
19 plus percent that's from the prescribed route.

20 CHAIR HURLBURT: And my understanding, from what I've
21 heard, is that some states that have been more successful and
22 more aggressive in dealing with issues than we have, one of
23 the things they see is, then, an uptick in the use of heroin
24 and some of the illegal substances, but you still have to do
25 the right thing about this. Val?

1 COMMISSIONER DAVIDSON: We haven't talked about kids in
2 the household, maybe teenagers, who are swiping their parents'
3 medications in the cabinet or maybe their friends come over
4 and their friends do. So it's more than just the employee and
5 the employer. It also impacts the employer by all of the
6 people in the household whose covered lives are included on
7 that plan.

8 COMMISSIONER HARRELL: Do we have enough information to
9 have the Commission recommend a finding that would be more
10 declarative, stating there needs to be action taken to impact
11 the behavior of providers? That's what we're after. We're
12 after -- because there is secondary gain. When you're a
13 provider and you're seeing a worker's comp issue and you're
14 not a pain specialist, you, frankly, don't want to go through
15 the trouble. You write a script and say see you next month.
16 I mean, that's the reality of it. These are very difficult
17 patients to take care of, and we were chatting yesterday about
18 a patient that has pinged back and forth between Dr. Stinson's
19 practice and the Base, and we cut the patient off because of
20 failure of drug testing and failure to honor pain contracts
21 and basically said, we're not going to provide you that care.
22 You are not going to receive these medications at this
23 facility.

24 CHAIR HURLBURT: Larry?

25 COMMISSIONER STINSON: I agree with the Colonel. You

1 know, again, we're not talking about a hypothetical problem.
2 We're talking about the number one cause of death in the
3 United States, and Alaska is the leading state or always
4 within the top three states for this. So when we're saying,
5 while we don't want to offend people -- I'm talking about
6 practitioners -- we want to -- the house is burning.

7 And the State of Washington took some measures to -- and
8 other states -- do an education program for the providers. I
9 don't think that that's a bad idea. If there wasn't a
10 problem, we wouldn't need to do that. People assume that
11 there is not a problem; the statistics say otherwise. There
12 is a problem. It's a severe problem. So I don't think that
13 there would be -- that would be inappropriate, and I think
14 would that would just be the first step.

15 I think House Bill 53, or something like that, goes a
16 long way towards helping some of these other issues. Again,
17 when people say there is no problem, all you have to do is
18 look around you. It's a real problem.

19 COMMISSIONER ERICKSON: So I want to make sure I
20 understand. Are you suggesting adding a recommendation or is
21 there an additional finding statement you want to add?

22 COMMISSIONER HARRELL: Well, I think both. The finding
23 statement would be that the Commission recognizes that impact
24 on providers practices is necessarily to curb this issue. And
25 then the recommendation would be to follow what we think is a

1 reasonable way to go after that, and the truth of the matter
2 is, human nature being what it is, until you impact somebody's
3 pocketbook, you're not going to change behavior. So you need
4 to stop reimbursement in some areas related to worker's comp
5 where chronic pain is going on. We know what is the right
6 thing to do, and providers aren't doing it. I mean, I hate
7 over-regulation. I hate the government and bureaucracies
8 being involved in my practice of medicine, but at the same
9 time, I recognize that there are some folks that are not going
10 to respond any other way, until you pinch them in the wallet.

11 COMMISSIONER STINSON: There was one study from Gary
12 Franklin, who is the Worker's Comp Director for the State of
13 Washington, that showed, if somebody after a work-related
14 accident was on opioids for six months, their chances of ever
15 returning to employment were eight percent. Now that could be
16 for different reasons, but it also makes you want to think
17 twice about maybe addressing whatever the underlying issue is
18 in other ways, getting it fixed as quickly as possible instead
19 of having them come in every month and writing them a
20 prescription, and all of a sudden before you know, you have a
21 disabled person who is still in pain, who is just not getting
22 the right care.

23 COMMISSIONER DAVIDSON: So the challenge that we have is
24 that what we're really dealing with are drug dealers and
25 junkies who, unfortunately, don't know that they are because

1 they have a legal way to be able to do it. They can legally
2 prescribe, and the people who are receiving it and who are
3 abusing the drug think that they're okay because they have a
4 prescription, and until we change that dynamic and that public
5 perception, this problem is not going to go away.

6 COMMISSIONER KELLER: I don't know if we have time or
7 want to deal with this, but one of the most visceral reactions
8 was from the addiction treatment centers in some of the
9 statements they made on the record and to me, personally. You
10 know, they're really concerned this one element -- you know,
11 they're saying that -- well, I'll give you an example.

12 One told me that they have a patient that is a productive
13 worker on the North Slope and is over 120, and you know, is
14 making the case that, without the opioid, it would be
15 something. And the reason I'm bringing this up is that, you
16 know, if we are recommending a policy change, maybe it would
17 be worth the time to hear from one of them in the Commission
18 because they seem to be really passionately interested in what
19 happens with HB53, and it might really clear some air to have
20 them in a setting, like this, and talk it out.

21 COMMISSIONER HIPPLER: Focusing on the payment end, does
22 the State of Alaska have the authority and discretion to
23 change payment guidelines for Medicare and Medicaid that it
24 oversees? For example, for opioids, could the State of Alaska
25 simply have a cutoff per year of opiates for any individual

1 person, and then beyond that, it would have to go to some kind
2 of committee or is that beyond the scope of the authority of
3 the State of Alaska?

4 CHAIR HURLBURT: Not for Medicare, but for Medicaid, I
5 believe the State could. It could, for example, do what
6 Washington did where you have some of these high doses -- and
7 what we just heard there between the Base and Larry's practice
8 is you could lock somebody into one provider and one pharmacy.
9 Now that would not prohibit them from going and paying cash on
10 the barrel head to see somebody else, but as far as what
11 Medicaid was paying for, it would have the ability to do that.

12 Part of it is just informing physicians. There are bad
13 apples, as you know, we all recognize, but not a lot of bad
14 apples. Mostly -- but back before Washington really
15 implemented their policy, we started, in our Medicaid program,
16 just sending letters to the docs -- and I've said it before
17 here, I think -- saying, did you know that your patient is
18 also getting prescription opioids from other providers and
19 other pharmacies? And the response was not, you know, get out
20 of my face. The response was, I didn't know that; thank you
21 very much. So the vast majority of the docs are going to
22 react with knowledge that way or with a five-minute
23 availability of the online information, like Oklahoma has now,
24 and will see that as a resource to help them practice the way
25 they really want to practice. Allen, yeah (affirmative)?

1 COMMISSIONER HIPPLER: A quick question and then a little
2 more of a question. So you said that the person who needs
3 opiates could pay cash on the barrel head; what does that
4 mean?

5 CHAIR HURLBURT: If you have insurance, Medicaid
6 insurance or other insurance and you qualify for that and you
7 go to your provider and say, you know, I'm just having
8 terrible pain, can you get a prescription for opioids, then
9 your insurer, e.g. Medicaid, will pay for that. And then if
10 you go to the pharmacy to get that prescription for opioids
11 filled, it will pay for that and that will go into the claims
12 database that Medicaid gets. So they will see that that's
13 happening.

14 If, the next day, you go to your dentist and say, oh,
15 this is really hurting, doc, you know, and I need a
16 prescription, and you get another prescription and you get
17 that filled, that goes into the Medicaid database, as long as
18 they're paying for it. If you become savvy then to that and
19 you know that that's going to happen and your provider will be
20 informed or you may get locked in, then you can go to the
21 dentist or the doc or the podiatrist and say I have these
22 pains, and you don't give your Medicaid information, but you
23 pay your \$100 for the visit. And you go to the pharmacist,
24 and you don't give them your insurance card or your Medicaid
25 card, whatever, and you pay for the prescription, then that

1 doesn't get into the payer's database. If the State is
2 operating a database, like Washington State does now or
3 Oklahoma does now, that's captured, but if you're just
4 depending on, say, Premera doing that from their database,
5 Jeff will know if somebody goes out and just pays cash out of
6 their wallet on it.

7 COMMISSIONER ERICKSON: So while we're -- I don't want to
8 break this up, the conversation on this topic. Do you want to
9 make some suggested recommendations before we move back to
10 going over these findings related to the opioid issue?

11 Right now in our draft recommendations, we have a sub-
12 bullet for Worker's Comp related to regulation of opioid
13 narcotics, but would you like a separate recommendation or set
14 of recommendations?

15 COMMISSIONER HARRELL: Yes, but I don't feel savvy enough
16 in the program to be able to speak the best way at it. I
17 mean, what I want is -- what I think is necessary is that we
18 need to stop the behavior by not rewarding the action, and I
19 don't understand the financial vehicles of which that can be
20 accomplished well enough to craft you a recommendation, but
21 that's what has to happen. You have to stop paying the doctor
22 for doing this, whether you cut that off at a dosage level.
23 We're not going to pay you beyond this dose, whether that's an
24 artificial time level that would trigger a secondary review by
25 a specialist. I don't know the right vehicle to get at, but

1 you've got to stop paying the provider for doing this.

2 And see, it's nice in a closed system. That's why it's
3 very interesting for me to hear the discussion because I work
4 in a closed system. Every provider that's in our hospital has
5 their practice regulated by virtue of putting on a uniform.
6 So we can see our database, and we look at the providers that
7 are providing a large number of opioids to patients, and the
8 Chief of Staff directly engages them. So we have a vehicle to
9 stop it. It's not financial; it's simply behavioral. What's
10 going on here? But you don't have that capability in the
11 market in which you work in, so I find myself very blessed
12 that I'm in a situation where I can control poor behavior,
13 poor prescribing practices, mostly out of ignorance. They're
14 not bad apples. But you don't have that and so I struggle
15 with this whole financial piece because I don't have to deal
16 with that. I just simply say, stop it; this is bad medicine.

17 CHAIR HURLBURT: I think, for the place -- where there
18 are the pill mills, like -- you know, there used to be so many
19 in Florida, and as I said, have moved up to Georgia now that
20 they are clearly designed to make money on doing that, but my
21 bias would be that the bigger part of the problem -- you know,
22 that's a big part -- that's a serious problem that needs to be
23 dealt with legally, prosecutorially, through licensure and all
24 those things, but in the aggregate, the bigger part of the
25 problem is more the doctor shopping, the more it's easier to

1 write prescriptions than just say no, and it's not people
2 intentionally doing it to make money. That's there -- and
3 then that needs to be a part of this, but it's -- I think --
4 you know, it's providing the information to the providers and
5 the pharmacies to locking in, I believe, these individuals in
6 the usual circumstance -- go ahead, Bob?

7 COMMISSIONER URATA: Well, I think a component of what we
8 would recommend would be, you know, education. You know, I
9 mentioned yesterday I still have a license in Washington, and
10 I had to take an online course, and it had to be part of my
11 continuing medical education credits on a yearly or every two-
12 year basis. I had to take "X" number of hours. I can't
13 remember anymore. Maybe after another cup of coffee it will
14 come to be me.

15 So education of the providers, of the dangers of opioid,
16 and you know, a key component where a red light should go on,
17 if you get above -- in the State of Washington's case, they
18 recommend 120 milligrams a day. I'm not sure if that's
19 evidence-based or something they just picked out of a hat, but
20 something along those lines. And then there is an online
21 thing I have to do every few years, too, to keep up-to-date.

22 And then another component which, you know, is a little
23 bit more uncomfortable is, you know, where they watch your
24 prescription practices, where, if you are a person where
25 you're prescribing lots of opioids from your podiatry practice

1 or from your family practice, it doesn't seem -- that seems
2 out of line, and there should be a red light that goes on to
3 somebody as well, but you know, those could be a couple of
4 components of what we'd recommend.

5 CHAIR HURLBURT: I think the 120 milligram morphine
6 equivalent dosage -- flying in the face of the concepts of
7 evidence-based medicine -- was kind of a consensus.

8 UNIDENTIFIED COMMISSIONER: (Indiscernible - away from
9 mic)

10 CHAIR HURLBURT: Was it evidence-based? And yet, what
11 Wes said, how some of these treatment centers gave them the
12 anecdote about the Slope worker on more than 120 milligram
13 equivalent dose is credible. I think that somebody -- you
14 know and I both know -- can build up to that, but I think any
15 of us around this table, if we got 120 milligrams, we wouldn't
16 make it to the bottom of the escalator. So yeah
17 (affirmative). It came there. I think Keith and then Allen?

18 COMMISSIONER CAMPBELL: Well, I'm trying to get my arms
19 around how you do these things because, in my experience,
20 there are very canny patients out there who will shop and
21 they'll hit the ERs or a series of ERs, even with the
22 distances here in Alaska. And I'm trying to visualize a
23 system that could track and catch those people, ultimately.
24 Somebody smarter than I am can do that, but I do know it
25 happens all the time.

1 CHAIR HURLBURT: Allen?

2 COMMISSIONER HIPPLER: Well, I would like to make a
3 recommendation. It won't be as robust as some of you want,
4 but it's something I can get behind. I would like to
5 recommend that the State of Alaska adopt maximum reimbursable
6 opioid guidelines for Medicaid, worker's comp, and the state
7 active employee plan. That's something I can get behind
8 because it's one thing for the State to say it's not going to
9 pay for anything more. It's another thing for the State to
10 forbid me from getting a drug that I think I need.

11 COMMISSIONER STINSON: I actually don't have any problem
12 with what Allen said. I also agree with Dr. Urata about the
13 CME requirement. I think that that -- we have a problem. So
14 when we were having drunk drivers at all hours of the night,
15 they restricted bar hours. They put in other measures. You
16 know, they dropped the legal limit. You have to respond when
17 there is an issue.

18 Another thing I think that some of the people are
19 pointing out, people don't realize the sophistication and the
20 amount of money that's involved with this.

21 And I have a patient that all of the medical students
22 that rotate with me -- she comes through about once a month
23 and so Stephanie hasn't seen her yet, but she will -- next
24 week, I believe -- and she had a real problem. She had had
25 seven surgeries the first time I saw her, and she came to me

1 for medication, and I told her, you do have a real problem,
2 and we can take care of it, but I'm not going to write
3 anything for you. She screamed at me, screamed all the way
4 out, screamed in the waiting room, I'm the worst doctor ever,
5 and I've heard all that before. So three months later, she
6 was on my schedule, and I thought, oh, joy. And she came in
7 and said, "Can you really help me?"

8 Now, this was about ten years ago now. I said, yeah
9 (affirmative); I can. She was in a walker, and she had other
10 problems. She is walking around fine now. Her pain is under
11 control. She's on a very minimal amount of medication that we
12 closely -- Tylenol No. 3, ten a month -- monitor. She gets
13 tested, and she said she had to give up six figures because
14 she had seven different physicians providing her with
15 medication that she distributed every Friday, for which she
16 was making six figures.

17 And so she has actually been like some of the other -- I
18 have a couple of others like this, too, who kind of, once they
19 decide, flip over and tell you everything, which is what our
20 deal is. And she will take the medical students onto the Web,
21 on protected website password areas, and they have a profile
22 on every provider in the state of Alaska, what they'll
23 prescribe, how much, what you have to say to get it, how long
24 they'll do it. It is organized. This is not random. And so
25 people who think that these are people who just kind of wander

1 in, they come into your clinic because they know what clinic
2 to go to, and they know what to say, and they know how to get
3 it, and they know where to go to next, and they have
4 deliveries they've got to make. So they've got to be on the
5 ball with this. And now is that everybody? Of course, that's
6 not everybody. But is that a lot of them, or at least, a
7 significant percentage? It is. It's something to keep in
8 mind.

9 COMMISSIONER ERICKSON: So would real-time registry help?

10 COMMISSIONER STINSON: It would help immensely because
11 there.....

12 COMMISSIONER ERICKSON: Do you want a recommendation
13 related to that?

14 COMMISSIONER STINSON: Oh, I think a real-time registry
15 is very critical because, if you think that they don't how to
16 manipulate the gaps in the reporting system, they're very good
17 at it.

18 COMMISSIONER HIPPLER: Mr. Chairman, there is a motion on
19 the table; there is no second yet to the motion that I made.

20 COMMISSIONER HARRELL: I'll second that.

21 COMMISSIONER ERICKSON: Oh, I didn't hear that as a
22 motion. So okay. Sorry. Sorry, Allen.

23 CHAIR HURLBURT: Do we have some discussion, Colonel
24 Harrell?

25 COMMISSIONER HARRELL: I assumed you wanted a second to

1 Allen's comment -- recommendation because I think it is
2 correct. You're absolutely right to point out that we don't
3 want to get in between a provider-patient relationship in
4 terms of the ability to make an appropriate clinical decision,
5 but we do want to put some checks and balances in place and so
6 I think that was a very reasonable thing to recommend.

7 And then to Keith's comment and also back to yours, Dr.
8 Hurlburt, and that is that I believe physicians, the majority,
9 are very good, like you said, and they're simply in a system
10 that is overwhelming and with patients that are
11 extraordinarily difficult, and they take the path of least
12 resistance, not a path of malfeasance, simply a path of least
13 resistance to treat these patients.

14 And so anything that we can do to educate them, as Dr.
15 Urata was saying, is appropriate. And that's a good place to
16 start because it keeps us out of -- directly out of the
17 physician-patient interaction, educates the staff. Like you
18 said, knowledge is power, and we do the same thing, and I
19 failed to mention that. Not only do we screen our providers
20 for who is providing the most number of opioids, but we screen
21 our patients to figure out that they're going to different
22 providers in our hospital and then provide that information --
23 did you know -- and then there is always the a-ha, oh, my
24 gosh, I had no idea. And then we get focused on the proper
25 patient care.

1 CHAIR HURLBURT: So Larry, was yours a friendly
2 amendment?

3 COMMISSIONER STINSON: Yeah (affirmative).

4 COMMISSIONER ERICKSON: Can I interrupt for just a
5 second.....

6 COMMISSIONER STINSON: Sure.

7 COMMISSIONER ERICKSON:if you're going to make a
8 friendly amendment? I just wanted to point out, if you look
9 at the screen, before Allen had made his motion, I had typed a
10 suggested recommendation related to the state program
11 purchase. It's a little more general than the more specific
12 motion, that the state programs responsible for purchase of
13 medical services establish payment policies that control
14 opioid prescription practices. So I don't know if you want to
15 be as specific as the current motion on the table or if
16 you.....

17 (Pause - background discussion)

18 COMMISSIONER DAVIS: So I think we're discussing the
19 motion that's been made and seconded and so, Allen, I think
20 the recommendation was good, but I think some of the things
21 that Deb has added are also important to consider.

22 So we've talked about the ones who are intentionally
23 abusing the system, okay, and your motion gets to that. I
24 appreciate what you said, you know, about others who are
25 outside the state control and to the concern that's been

1 expressed that the providers just don't know. We've actually
2 created a program to monitor and help the providers to know,
3 but it depends on the database that exists and we heard is
4 going to go away.

5 So I think a real-time database is very important for the
6 non-state payers to have access to, to help the physicians in
7 a confusing situation. I think the CME requirement makes
8 sense because, to Dr. Hurlburt's point, people may just not
9 know enough to be able to manage this, so you give them
10 information and you give them education about what's
11 appropriate. That makes sense. So I think those two things,
12 if you were willing to add them as Deb as put them up there,
13 would be meaningful additions for the non-state payers. Thank
14 you.

15 COMMISSIONER KELLER: Just as I look at these, you know,
16 I can't help but see myself in a position of really being
17 involved in helping the Commission implement these
18 recommendations because of the bill that's on the table. I
19 just can't help but go there in my mind, and I confess that it
20 puts me in a little bit of an uncomfortable position because,
21 you know, of our discussion here, but I just want to point
22 this out, that last item, the real-time registry, has a fiscal
23 impact that the rest of it doesn't have. So it does change
24 the landscape, and I'm not even saying that it has to be part
25 or that I'm presuming that it should be part of HB53 as it

1 goes forward, but if we include that, it is a different
2 element that, at least, I'll have to think about, and I wanted
3 you to know about.

4 COMMISSIONER CAMPBELL: To Wes' point, in the real-time
5 registry, does it have to be a state standalone registry or
6 could it be a contractual thing with somebody who has got one
7 that's up and running and just have a sub-category for Alaska?

8 CHAIR HURLBURT: I think that all of the states have a
9 prescription drug management program now, as we heard
10 yesterday, but then there is a wide array of that.

11 Getting at the point that Representative Keller raised
12 and what you do, one of the options might be to invite some
13 input by phone, like from Oklahoma, which is a state that's
14 politically aligned similarly to Alaska and would help with
15 the credibility of that, but to see how they do it. I'm,
16 personally, not aware of it being done other than by state
17 governments, but there might be; yeah (affirmative).

18 COMMISSIONER ERICKSON: I think what Keith was suggesting
19 was that the cost wouldn't have to be as high as if the State
20 established our own technology, that we could with another
21 state that already has the technology in place and just -- our
22 state population is a small city in another state, and the
23 amount of data that would be going through it -- you were just
24 suggesting a more cost-effective approach for a smaller fiscal
25 note for Representative Keller or whatever legislator who

1 might be carrying the bill, ultimately. Allen and then Dave?

2 COMMISSIONER HIPPLER: Mr. Chairman, I would point out
3 that the motion on the floor doesn't say anything about an
4 opioid registry. To my knowledge, it would have very little
5 fiscal impact, and perhaps, a positive since it caps what the
6 State, on a normal basis, would reimburse for opioids, and I
7 think that, although we can have discussions about an opioid
8 registry perhaps in a minute or two, the motion at hand is
9 very limited. It should be politically feasible and correct
10 and that's why I made such a limited and specific motion.

11 COMMISSIONER ERICKSON: So does anybody want to -- we can
12 do one of two things, amend the motion to make it less
13 specific and continue the conversation of all the elements or
14 call the question on this specific motion?

15 COMMISSIONER MORGAN: Well, I have to agree with Allen
16 that his motion had nothing in it about a registry. That
17 doesn't mean we can't.....

18 COMMISSIONER ERICKSON: So do you want to call the
19 question?

20 COMMISSIONER MORGAN: Yes.

21 CHAIR HURLBURT: Can you read the motion?

22 COMMISSIONER ERICKSON: Yeah (affirmative). I want to
23 make sure I captured what Allen said correctly, in writing
24 here. Adopt -- the recommendation is that, "State programs
25 responsible for the purchase of medical services should adopt

1 maximum opioid prescription dosage policies." This was
2 actually the -- I'm sorry, Allen. This was the way you worded
3 it before. "Adopt maximum opioid prescription dosage policies
4 in state programs responsible for purchase of medical
5 services."

6 COMMISSIONER HIPPLER: Sure.

7 CHAIR HURLBURT: So it's been moved and seconded, and the
8 question has been called. All in favor of the motion, say
9 aye.

10 COMMISSIONERS IN UNISON: Aye.

11 CHAIR HURLBURT: Opposed, the same?

12 COMMISSIONER ERICKSON: Barb, can you help with capturing
13 the vote? Thanks.

14 CHAIR HURLBURT: It was unanimous, I believe.

15 COMMISSIONER ERICKSON: It was unanimous, and it was
16 moved by Allen and seconded by Dave, right?

17 CHAIR HURLBURT: Representative Keller?

18 COMMISSIONER KELLER: While we're waiting, this is just
19 parenthetical, but I want to throw it out. I do want you to
20 know that Senator Coghill -- Commissioner Coghill, in this
21 sense -- couldn't be here today, but he is following very
22 closely with very competent staff. I'll be in contact with
23 Renita (ph), those of you that know her.

24 COMMISSIONER URATA: So I'd like to make a motion to
25 require CME, a small amount of CME on opioid prescription use,

1 evidence-based use of opioid prescriptions, and how to spot an
2 -- what's a better term -- abuser or.....

3 UNIDENTIFIED COMMISSIONER: Potential.

4 COMMISSIONER URATA:potential abuser and how to
5 help him.

6 CHAIR HURLBURT: California has also done that. My
7 license is not active there, but in the past, I've had to take
8 their pain management CME.

9 COMMISSIONER KELLER: Do we want to include other
10 providers, nurse practitioners, for example, et cetera?

11 COMMISSIONER URATA: Yeah (affirmative). We could expand
12 that to healthcare providers, including nurses, possibly.

13 (Pause - background discussion)

14 COMMISSIONER URATA: Oh, sure. That makes sense. I'll
15 accept that as a friendly amendment, but there is no second.

16 CHAIR HURLBURT: Larry?

17 COMMISSIONER STINSON: Second.

18 CHAIR HURLBURT: Okay. Allen?

19 COMMISSIONER HIPPLER: I have a question for the maker of
20 the motion. Does this replace something in existing
21 continuing medical education or will this be an added
22 educational burden for medical care providers?

23 COMMISSIONER STINSON: There is already a requirement of
24 so many hours per year anyway, Allen, and it's different in
25 different areas because different hospitals also require

1 additional. So this could be well within the already required
2 number, which I think is 30 in a lot of places -- and actually
3 40 in some of the places -- hours per year. So you know, we
4 could designate a certain amount of hours that should be
5 included in that.

6 COMMISSIONER URATA: So the State of Alaska requires 17
7 hours to re-licensure every two years, which is very small.
8 In order for me to maintain my American Board of Family
9 Physicians and American Academy of Family Physicians, I'm
10 required 150 a year. So I think that's right -- or 150 every
11 three years in order for me to get to continue my American
12 Academy of Family Physicians. So it's well within that, but
13 you know, this is something that somebody needs to work on
14 specifically. Take a look at the State of Washington and
15 State of Oklahoma and see what their CME requirements for
16 opioid prescriptive use or safe prescription use education is
17 and go from there.

18 CHAIR HURLBURT: Wes?

19 COMMISSIONER KELLER: If I could, just keep in mind that
20 we're dealing with a number of licensure boards, not just the
21 physicians. I wish I could remember how many, but it seems --
22 what jumps to mind is, at least, three.

23 COMMISSIONER ERICKSON: Well, yeah (affirmative), but
24 this would only be for those types of providers or clinicians
25 who have prescription authority, which would limit it more.

1 CHAIR HURLBURT: Any other discussion, questions?

2 COMMISSIONER ERICKSON: Can I ask, first, who had
3 seconded that?

4 COMMISSIONER MORGAN: Dr. Stinson.

5 COMMISSIONER ERICKSON: Thank you.

6 CHAIR HURLBURT: So can you read the motion for us, Deb?

7 COMMISSIONER ERICKSON: So the Commission recommends that
8 the -- I will re-craft this with your permission, so it reads
9 a little more smoothly and is specific to the boards that
10 license clinicians that have prescription authority. "Require
11 CME for licensure and re-licensure of clinicians with
12 prescription authority on over-prescription of opioids and how
13 to spot potential abusers." Larry?

14 COMMISSIONER STINSON: If I could offer a friendly
15 amendment, you could even say, "The hours to be determined by
16 each respective board."

17 COMMISSIONER ERICKSON: I didn't understand that.

18 COMMISSIONER STINSON: The continuing medical education
19 hours required for recertification with -- for opioid
20 management could be determined by each of the respective
21 boards of the different prescribing specialties.

22 COMMISSIONER URATA: Well, can I have a second thought on
23 that? There is a curriculum available that any provider
24 should be able to understand and remember when they see a
25 patient and that curriculum -- why would that change, hour-

1 wise, from one board to the next because they're all doing the
2 same thing? So somebody has to figure out what the curriculum
3 is, how many -- what's a reasonable amount of hours to learn
4 that curriculum and then that should be the hours. And
5 Washington is already doing it. Oklahoma is already doing it.
6 So we don't have to reinvent the wheel. We can look at their
7 curriculums and go from there, actually.

8 CHAIR HURLBURT: Val, yeah (affirmative)?

9 COMMISSIONER DAVIDSON: I'd recommend deleting that
10 second suggestion because the number of hours they'd choose
11 could be zero. You don't need to specify that they have the
12 option because they can do that already, but if you give them
13 that latitude to choose zero, they just may well.

14 COMMISSIONER ERICKSON: So the maker of the motion didn't
15 accept that friendly amendment, and we've had another one
16 instead.

17 COMMISSIONER STINSON: Yeah (affirmative); I'll withdraw
18 it.

19 COMMISSIONER ERICKSON: It's been withdrawn. So the
20 motion on the table is that, "The state boards responsible for
21 licensing clinicians who have prescription authority require
22 CME for licensure and re-licensure of clinicians with" -- it's
23 a little redundant, but I'll clean that up again, too.
24 Remember, you're going to vote on this again. So I don't know
25 that we need to get that -- be that careful on our process

1 here. Over-prescription of opioids and how to spot potential
2 abusers. Somebody want to call the question?

3 UNIDENTIFIED COMMISSIONER: I'll call the question.

4 CHAIR HURLBURT: All those in favor of the motion, please
5 say aye.

6 COMMISSIONERS IN UNISON: Aye.

7 CHAIR HURLBURT: All those opposed, the same. It's
8 unanimous. David?

9 COMMISSIONER MORGAN: This is more of an informational
10 request. I only know enough about pharmacy regs to be
11 dangerous, to put it frankly, but I know we're dealing with
12 Class II narcotics here, and I know pharmacies, in order to
13 stop Class II and to accept scripts for it, have reporting
14 requirements to the federal authorities that grant them, to
15 allow them to dispense the Class II narcotics. And as I
16 remember, a lot of the individuals that -- or types of
17 providers that can write script for Class II narcotics have to
18 go through a process to be allowed to do so. You could be a
19 dentist and lose your privilege to write a script. It's tough
20 to do dentistry without it, but it's happened.

21 It would be interesting just to get a couple of page,
22 maybe, synopsis from the Pharmacy Association or whoever does
23 that and from the State Medical Association, maybe dental.
24 Just ask them to talk about to talk about how they do that,
25 and there could be, especially on the pharmacy end, some -- we

1 may have some processes and some things in place that we just
2 don't know because this is a big, broad subject. Not to
3 impede what we're doing, but you know, a couple of pages from
4 the pharmacy board or -- as a Chief -- (indiscernible - voice
5 lowered) had, as Chief of Medical Officer for the State, that
6 a simple couple of pages of how they regulate and do reporting
7 of misuse of Class IIs. You know what I'm getting at here?
8 You see what I'm getting at?

9 COMMISSIONER URATA: It seems, to me, the pharmacists are
10 doing something because sometimes I get a note from them or a
11 phone call from them that a person seems to be getting a lot,
12 and did I really mean to write a prescription for this person.
13 And so they must be doing something, but I'm not aware.

14 COMMISSIONER STINSON: The only requirement to write for
15 Schedule IIs or any of the narcotics is to have a DEA license,
16 and you can get a DEA license by having a diploma from one of
17 the accredited -- you know, podiatry, PA, nurse practitioner,
18 dental, medical. So that's all you need to write for it.

19 However, there has been an emphasis from pharmacies,
20 since this last summer, on some of the preliminary getting
21 ready for the Affordable Care Act, where they are taking an
22 increasingly stringent look at the number of medications being
23 written and trying to establish some guidelines. I know
24 Walgreens has been -- has sent letters to all the different
25 providers. Some of the other pharmacies have as well. And

1 they're taking a greater interest, I think, for a variety of
2 different reasons, including their own exposure, on filling
3 some of these prescriptions. However, it's still a lawful
4 prescription. It will still be filled. They might contact
5 you and say, "Are you sure you want to do this?" If you say
6 yes and you are a licensed practitioner, they will fill it.
7 But I do agree with Dr. Urata; they are taking an increasingly
8 critical look at this, which I feel is appropriate in
9 addressing -- and for all the same reasons that we're taking a
10 look at it. It's a problem.

11 COMMISSIONER ERICKSON: So is this -- I mean, I'm a
12 little concerned that we're spending a lot of time on this,
13 and we've got a lot more to cover this morning. So was that a
14 suggestion for a motion or.....

15 COMMISSIONER MORGAN: No. (Indiscernible - simultaneous
16 speaking).....

17 COMMISSIONER ERICKSON: That's fine. There is one more
18 opioid-related suggestion that's been discussed this morning
19 related to the registry. Would you like to include that? If
20 so, we need a motion. Otherwise, we need to move on. Yes,
21 Jeff?

22 COMMISSIONER DAVIS: So moved.

23 COMMISSIONER ERICKSON: Second? Larry seconded. So the
24 motion on the floor is that, "The State should establish and
25 support a real-time prescription opioid registry." Yes, Dr.

1 Urata?

2 COMMISSIONER URATA: So question, what's the delay of our
3 current system, a couple weeks, a month, and does that make a
4 difference?

5 COMMISSIONER STINSON: Yes.

6 CHAIR HURLBURT: Any further discussion? Allen?

7 COMMISSIONER HIPPLER: I didn't understand that exchange.
8 Can you enlighten me, Dr. Urata?

9 COMMISSIONER URATA: Currently, there is a system in
10 place, and my understanding, from the ER, they're very happy
11 with it. I didn't realize that there was a two-week delay in
12 getting that information. So for example, if a person came to
13 another ER a week ago, got 100 OxyCodone pills and then comes
14 into your ER a week later and asks for 100 because he lost a
15 prescription or something, then you would probably have to get
16 it because your system, if you looked his name, you wouldn't
17 see that he got a prescription a week ago. (Indiscernible -
18 simultaneous speaking).....

19 COMMISSIONER ERICKSON: So the system that they're
20 discussing, Allen, is the State currently has a registry, but
21 my understanding is it was created, and it's fully funded with
22 federal dollars that are about to run out, and it has the two-
23 week delay. So there are a couple of different issues related
24 to that, that existing registry that the State has. Is that
25 correct? Yeah (affirmative). Yes, Jim?

1 COMMISSIONER PUCKETT: From the research that I've done,
2 it's my understanding that, unless it is a real-time registry,
3 it's not going to be effective at all. It's got to be a real-
4 time registry.

5 COMMISSIONER URATA: Call for the question.

6 CHAIR HURLBURT: Let's do it by a show of hands this
7 time, since it may not be unanimous. All those in favor,
8 raise your hands. And all those opposed, raise your hands.
9 Allen was.

10 COMMISSIONER KELLER: Let the record reflect that I'm
11 learning; I didn't vote.

12 CHAIR HURLBURT: And one of the things that maybe we
13 should take on, pursuant to that, is getting some specific
14 information from, like, Washington and Oklahoma, both for the
15 Commission and as a potential resource.

16 COMMISSIONER ERICKSON: I've a note to myself to craft a
17 potential -- or yeah (affirmative) -- draft finding statement
18 that captures some key points from the Washington and Oklahoma
19 programs, so we'll work on that.

20 CHAIR HURLBURT: I think we're ready to move on.

21 COMMISSIONER ERICKSON: Yeah (affirmative). I'm just
22 looking at the room to see if we're missing any voting
23 members. I don't think we are. We have all voting members in
24 the room. You might want to make a note of that, Barb, for
25 the voting record. Thanks. So I assume we are done

1 discussing opioids.

2 COMMISSIONER DAVIS: Probably could do it some more, if
3 you want.

4 COMMISSIONER ERICKSON: So going back to the potential
5 finding statements, we have one related to -- and it's
6 specific. It's -- the only one that came out in the findings
7 discussion yesterday related to worker's comp was that,
8 "Worker's Comp fee schedules demonstrate" -- "The Alaska's
9 Worker's Comp fee schedule demonstrates an inefficient
10 allocation of resources." Is there anything related to
11 findings and worker's comp that, just conceptually, we want to
12 catch? We don't need to have a detailed discussion or
13 wordsmith today. Yes, Allen?

14 COMMISSIONER HIPPLER: Are we discussing findings or
15 recommendations now or both, can you guide me?

16 COMMISSIONER ERICKSON: What I did was I left the middle
17 of the finding statement while the conversation was on
18 opioids, so you guys didn't lose that track. I've gone back
19 to finish the finding statements, and we're not going to get
20 into specific details now.

21 Just to check on process again, I appreciate wanting to
22 keep control of the conversation by using a more formal
23 process through Robert's Rules, but we're not going to be able
24 to wordsmith, enough, everything in here. And so that's why
25 this next two-week process, where I'm going to mail out -- try

1 to make things as clean as possible in writing for you all to
2 review, offer suggestions back in writing. Then I will get
3 that out to you for discussion on the teleconference, and
4 we'll have an electronic vote on each of those points. And
5 it's still to go out as draft, but just to vote to approve for
6 release for public comment. So does that process make sense?

7 COMMISSIONER HIPPLER: At what point would we propose
8 recommendations to the Commission for voting?

9 COMMISSIONER ERICKSON: Well, we're doing -- we'll do
10 that through the -- right now, we're just trying to understand
11 what you all want me to go back and do some staff work on to
12 clean up because you would like to consider them as potential
13 Finding and Recommendation statements. Then you'll vote in
14 two weeks. You'll have an opportunity to review those, make
15 comments back to me, have a conversation together, and a
16 teleconference about the suggestions that were made, based on
17 my next draft, and then vote electronically in two weeks.

18 COMMISSIONER HIPPLER: So at this time, we would discuss
19 proposed findings and perhaps proposed recommendations, but we
20 wouldn't make an actual recommendation and vote on it; is that
21 what you're saying?

22 COMMISSIONER ERICKSON: I'm suggesting that we don't need
23 to do that at this point. If I can just -- if I can get
24 enough of a sense from all of you of the concepts that you
25 want to make sure are covered in the findings and potential

1 recommendations, but we don't have, I don't believe, enough
2 time, while we're all together here, to work on it. And it
3 still will be draft for public comment, and the final vote
4 that the Commission will make on each of the individual
5 Finding and Recommendation statements will be at the December
6 meeting.

7 COMMISSIONER HIPPLER: Mr. Chairman, I have a couple of
8 draft recommendations that I could submit for Deb's
9 consideration.

10 First is, for Worker's Comp, there is the issue of
11 clinicians not using standardized coding for prescription
12 drugs. So I would recommend that anything that the State is
13 either paying for or is mandating, such as Worker's Comp,
14 subject itself to normal standardization as far as coding for
15 prescription drugs.

16 And the next thing is I think that we're going to have to
17 go down the road of recommending that the UCR basis of
18 Worker's Comp is undesirable and needs to be replaced with
19 something else.

20 CHAIR HURLBURT: And in a sense of the second part of
21 that, basically, it's an artificial interference in the
22 marketplace that we would be suggesting be removed.

23 COMMISSIONER HIPPLER: Yeah (affirmative). I think, for
24 90% UCR, if you own 11% of the market, you set UCR. I don't
25 think that's desirable and that's not, generally speaking,

1 what most people would consider a private market result.

2 CHAIR HURLBURT: I should know, but I don't -- and maybe
3 you do, Jeff -- on the initial recommendation of using the NDC
4 codes, does that impact any on the use of J-codes or would it
5 just be more limited than that, do you know?

6 COMMISSIONER DAVIS: I don't know for sure, but what I
7 understood was being said yesterday was that these are drugs
8 that have an NDC number, which is a standard way of reporting
9 and paying, and the current practice allows them to be
10 repackaged and submitted with something like a J-code, which
11 is uncontrollable.

12 COMMISSIONER ERICKSON: Can I interrupt for a second?
13 I'm sorry. You guys are losing me here. I need to stay
14 focused on one issue at a time, so I'm going to use this --
15 take the second one first, and I'm going to be -- I told you
16 earlier today that I was going to be really bossy today, and
17 I'm going to be really bossy right now.

18 I'm going to take this first issue related -- and I'm
19 going to take the second issue that Allen brought up related
20 to fees, and based on his suggestion, I'm going to make a note
21 that I will include a finding statement related to the fee
22 schedule, and I will include a suggested recommendation
23 related to the Worker's Comp schedule, and we're not going to
24 wordsmith that or vote on it. I'll include that in the draft
25 that I'll get out to you early next week. Does that sound

1 acceptable? I see heads nodding. I see heads nodding. Okay.

2 So let me make sure I have those two notes in my slides
3 here. Okay. Now can we go back to -- and you need to start
4 from scratch for me and go back to the discussion related to
5 coding for prescription drugs. First of all, is that inside
6 or outside of the worker's comp issue? It's outside the
7 worker's comp issue. So what is -- just give me the general
8 concept related to -- for a finding statement.

9 COMMISSIONER HIPPLER: Well, I thought this was inside
10 the worker's comp issue because employers have to have
11 worker's comp. Worker's comp is governed by the State of
12 Alaska. The State of Alaska says worker's comp insurance has
13 to pay, and.....

14 COMMISSIONER ERICKSON: It's broader than -- it's a
15 broader issue. It'd be for all payers. So it would be inside
16 and outside, both. Yeah (affirmative). I wasn't clear when I
17 said outside. It's more general than is what I meant, and it
18 is. So the issue related to coding for prescriptions is what,
19 in a nutshell?

20 COMMISSIONER DAVIS: Well, I don't know if this will be
21 in a nutshell or not, but it is that, in certain instances,
22 providers are submitting claims without NDC numbers resulting
23 in extraordinarily lopsided reimbursement.

24 COMMISSIONER ERICKSON: NCD?

25 COMMISSIONER DAVIS: NDC.

1 COMMISSIONER ERICKSON: NDC.

2 COMMISSIONER DAVIS: And Larry will -- or Colonel Harrell
3 will tell you what that means.

4 COMMISSIONER ERICKSON: And what's the issue related to
5 that?

6 COMMISSIONER DAVIS: So what Mr. Monagle said yesterday
7 is that providers are, at least under worker's comp and
8 probably in other areas, purchasing prescription drugs,
9 repackaging them, and rather than submitting a claim with an
10 NDC number, which has a value associated with it, they're
11 submitting them with some other code, like a J-code, or maybe
12 no code, and Worker's Comp is paying, he said, between 10 and
13 50 times what they should be paying for that medication.

14 COMMISSIONER ERICKSON: So this is about the clinician
15 dispensing issue that he was talking about?

16 COMMISSIONER DAVIS: Yes. Yes.

17 COMMISSIONER ERICKSON: And so we're just getting more
18 specific about what the real issue is, and I don't know if we
19 need to get this specific, but.....

20 COMMISSIONER DAVIS: Well, for some reason -- excuse me.
21 If I may? For some reason, Worker's Comp knows the issue
22 exists and has not addressed it. So maybe they need a little
23 help, which is just to simply say you can't do that anymore;
24 you've got to use the NDC code.

25 COMMISSIONER ERICKSON: Exactly. I'm not suggesting.....

1 COMMISSIONER DAVIS: No. No. No.

2 COMMISSIONER ERICKSON:that we don't address it.
3 I'm just wondering if we need to get so specific about NDC
4 numbers or if we want to make more general findings and
5 recommendations about physician dispensing.

6 COMMISSIONER STINSON: If you don't make a specific
7 recommendation, then the Legislature and the Governor -- no
8 one will have any idea what you're talking about.

9 COMMISSIONER DAVIS: I agree, and it's such an -- should
10 be -- it appears -- everything is easy from the outside,
11 right, but it appears to be an easy fix -- and to stop paying
12 50 times what you should for a drug.

13 CHAIR HURLBURT: It might be an area where it would be
14 well to get Chad Hope to help us with the wording on it, get a
15 pharmacist. Yeah (affirmative). But even so, I think Chad
16 is, I guess, the only pharmacist working for the State, but
17 he's quite good. He works with the Medicaid program, and he
18 would instantly be able to put that into language that would
19 be understood in reimbursement circles. Yes, Allen?

20 COMMISSIONER HIPPLER: Going back to worker's comp, there
21 is an evidence-based medicine issue where the perception of
22 both employers and their worker's comp insurance companies is
23 that those entities are unable to influence the recovery
24 process of an injured party at all. This -- the consequence
25 of this is that there is a perverse incentive by the clinician

1 and the injured party to not necessarily seek the most cost-
2 effective or evidence-based best method of treatment. And I'm
3 not sure what the solution is. Maybe -- but somehow, I think
4 the insurance company, who is ultimately paying, should
5 somehow be involved in the decision making process.

6 Right now, we have -- for most insurance, just normal
7 insurance, to some extent, the insurer is a little bit
8 involved. They require preapprovals of some things. They
9 have deductibles and whatnot. But for worker's comp, you
10 don't even have to talk to your insurance company, I don't
11 think. That's been my experience is you don't even have to
12 talk to the insurance company. You just do what you want as
13 either the clinician or the injured party, and it doesn't
14 matter if the evidence doesn't support it. You can just do
15 it. I'm not sure what the solution is, but that's a problem.

16 CHAIR HURLBURT: And this -- I need to find the article
17 again, and Mike couldn't remember it, but I think he's the one
18 that initially shared it. Wisconsin did that, and as I said
19 yesterday, the results blew me away. They were already
20 spending less in terms of dollars for medical care, but by
21 applying the evidence-based principles to their workman's comp
22 population, they reduced the medical care costs by almost two-
23 thirds, which was wonderful, but what was even way better,
24 they increased, by two-thirds, their return to work rate,
25 which is the basic success of the whole Workman's Comp

1 program.

2 COMMISSIONER ERICKSON: Jeff?

3 COMMISSIONER DAVIS: Thanks, Allen. That's a really good
4 point, and thank you for the statistical backup on it. I
5 think the way it was described in the recommendations from the
6 earlier Worker's Comp Task Force was "established practice
7 guidelines." That's sort of the medical shorthand for doing
8 what you're suggesting needs to be done, and I agree with you.

9 CHAIR HURLBURT: And Mike Monagle's national organization
10 is doing that.

11 COMMISSIONER ERICKSON: So in the interest of time, I've
12 made a note that I will draft both a finding and a
13 recommendation statement related to application of evidence-
14 based treatment guidelines in worker's comp, sound good?
15 Thumbs up? Heads nodding. Good.

16 Let me just go down this list. Since we captured so few
17 in the finding statements yesterday, I'll just automatically
18 come up with a finding statement related to any recommendation
19 statement you want included, so that there is some sort of
20 backup and connection there.

21 So going down this list of issues that you all brought up
22 yesterday in discussion related to worker's comp reform, there
23 are the treatment guidelines, the fee issue, regulation of
24 clinician dispensing, regulation of opioid narcotics. So
25 we've captured all of those, and you all have talked about

1 those this morning. So I'll work on those recommendation
2 statements.

3 The other two items that were on the list were collection
4 of data on medical costs and evaluation of the impact of the
5 reforms by an independent research organization. Do you want
6 to include either or both of those in a recommendation
7 statement or not? I have one head shaking no.

8 COMMISSIONER URATA: Was the collection of data on
9 medical costs, was that part of the thing on All-Payer Claims
10 Database or something similar to that? I mean, it would seem
11 like.....

12 COMMISSIONER ERICKSON: It was a recommendation of one of
13 the earlier Worker's Comp Reform study groups that was on the
14 bulleted list on Mr. Monagle's slide, but we were making the
15 connection to potentially -- All-Payer Claims Database could
16 serve as a data source for that need.

17 COMMISSIONER DAVIS: I think I was on that task force,
18 and one of the things we struggled with was there was no
19 aggregated information, at least at that point in time. This
20 was years ago. And so the group said, okay, we're going to
21 recommend you do these things, and we also recommend you study
22 the outcomes of that. So I think it's a recommendation that's
23 outlived its usefulness, which is why I was shaking my head no
24 on that one.

25 COMMISSIONER URATA: So we should strike it?

1 COMMISSIONER ERICKSON: Does anybody disagree with taking
2 it off the recommendation list? Okay. How about the
3 evaluation piece, evaluating the outcomes of the reforms, take
4 that off? Heads are nodding to take it off. Does anybody
5 disagree with taking it off? Okay.

6 Let me go back up and see what else we might be missing
7 from yesterday's discussion and then see if I can summarize
8 real quickly what we have and then we can take a break.

9 (Pause - background discussion)

10 COMMISSIONER ERICKSON: You know, I -- we had -- after a
11 meeting like this, I'd lost all of the notes. No. What I had
12 to do was sit and listen to the whole meeting and recapture
13 them all over again. It worked. It was painful. It was very
14 painful.

15 COMMISSIONER DAVIS: Dr. or Madam Chair?

16 COMMISSIONER ERICKSON: Yes?

17 COMMISSIONER DAVIS: In looking for things that we've
18 missed, I -- well, fools rush in where angels fear to tread,
19 so here goes. But we talked about the inherent nature of
20 current UCR regulations and the specific application with that
21 to worker's comp, but it's also a huge employer issue. In
22 fact, it's one of the things, you know, being considered, if I
23 may, by the state chamber as something whether they're going
24 to work on or not. So I will -- had drafted a recommendation,
25 which I'll give to you, Deb, and we'll see what the will of

1 the group is, something along the lines of "Modify the UCR
2 regulation to establish a ceiling in addition to the floor set
3 by the current regulation." "Modify the UCR regulation to
4 establish a ceiling in addition to the floor set by the
5 current regulation." So let me pause and explain what I'm
6 talking about here.

7 Current law says that the minimum that UCR can be set at
8 is the 80th percentile of market for a given procedure in a
9 given geography. So if you are a provider who controls 21% of
10 the given procedure in a given geography, what you charge
11 becomes a minimum UCR required by this regulation.

12 So let me give you a hypothetical example and then some
13 real examples. A hypothetical example is I am a provider. I
14 control 21% market share of a particular thing. I charge \$100
15 for it today, but I decide that I'm going to charge a million
16 dollars for it tomorrow and for the next year. In 12 months,
17 a million dollars is going to be the minimum required by this
18 regulation. That is, clearly, absurd.

19 I was told, the day before yesterday, by our Manager of
20 Provider Contracting that there is a provider in Anchorage,
21 one of three groups, who controls more than 21% market share,
22 who raised his rates 72% in the last 12 months, and has,
23 single-handedly, raised UCR by 27%. That is a problem. It's
24 not my problem. It's Allen's problem and the people Allen
25 represents. I mean, it's the state's problem because that

1 drives what everyone gets charged.

2 So what I'm suggesting is it makes sense to have a floor.
3 It makes no sense not to have a ceiling. So methodology needs
4 to be developed that does both of those things.

5 COMMISSIONER URATA: But it's not going to solve the
6 problem, in my opinion, because you could put down that 110%
7 of UCR for this year is the ceiling or 120% and then so --
8 gee, I feel like I'm going against my colleagues. So a doctor
9 could go up and say.....

10 UNIDENTIFIED COMMISSIONER: We're all here (away from
11 mic).

12 COMMISSIONER URATA: Yeah (affirmative). We're here for
13 the good of the state. So the business person could say,
14 well, I'm going to charge 119. So next year when you
15 recalculate the UCR, then it goes up by that amount anyway.
16 So it's inherently inflationary. It's going to continue.

17 So my suggestion, we need to not use usual and customary.
18 We have to go somewhere else, and they suggested RV, you know,
19 relative value and that might be a good thing to do, but I'm
20 not so sure that I want to suggest a specific way of doing it.
21 You know, I don't know that we're knowledgeable enough, but
22 you know, it should change away from UCR completely.

23 CHAIR HURLBURT: Yeah (affirmative), but before you
24 respond because it will respond to both of us, I think, why
25 should the state be prescriptive in the methodology that's

1 being used? If all the language related to UCR were just
2 removed, then you would have more of a level playing field
3 between provider and payers, and if they wanted to tie it to
4 Medicare rates as a percent above that, in our state, or a
5 case rate methodology or something, why would want to continue
6 to have prescriptive language tying to UCR?

7 COMMISSIONER ERICKSON: Jeff?

8 COMMISSIONER DAVIS: So my oldest children used to tell
9 me I think way too much about insurance, and I think they're
10 probably right. I've spent years on this issue, and Dr.
11 Hurlburt, that would be -- you know, problem one leads to
12 solution one, which leads to problem two, which leads to
13 solution two, which leads to problem three, which leads to
14 solution three, right?

15 So in thinking about this, the regulation we have today
16 was established as a consumer protection so that a payer
17 couldn't come in and pay ten cents on the -- sell you a policy
18 that you think is going to cover your care and then pay ten
19 cents on the dollar. That's why it was established. I think
20 that is a legitimate reason for this regulation to exist.
21 However, problem one leads to solution one, which leads to
22 problem two.

23 Problem two is it establishes a floor, which I think
24 makes sense, but it establishes no ceiling. And I gave you a
25 hypothetical abuse. I gave you a realistic abuse. How about

1 a vial of injectable drugs for \$1,600 that costs \$8 at Geneva
2 Woods? How about an air ambulance company who came in and
3 doubled and tripled their charges, and now, a transport to
4 Seattle is \$150,000 instead of \$50,000? I could on and on
5 with real examples.

6 So trying to be practical, if we eliminated the whole
7 thing, I can almost guarantee we would have a whole bunch of -
8 - if we suggested eliminating it, we would have a whole bunch
9 of opposition, rightly so, from those who are concerned about
10 big, bad, evil insurance companies -- people people love to
11 hate -- coming in and paying based on Alabama rates instead of
12 Alaska rates. I think that's legitimate.

13 So by suggesting that there needs to be a methodology
14 that employs -- that gives a ceiling, we, I think, can control
15 both. We have looked at dozens of ways to do this, our
16 actuaries have. And you're absolutely right, Dr. Urata. If
17 you simply -- the problem is you have one or two or three
18 providers in area. If you just are looking at what they
19 charge -- I mean, we run into this with -- after the Milliman
20 report, you know, it says that this particular group of
21 providers is all charge 200%, and they said, oh, well, we
22 looked a Fair Health, and we were right there. Yeah
23 (affirmative). That's because you're all charging 200%, you
24 know. Self-fulfilling prophecy.

25 So there is a methodology that I have suggested to maybe

1 one or two Commissioners that would say minimum UCR at the
2 80th percentile not to exceed a percent of a reference like,
3 for example -- and I'm not trying to solve it here; I'm just
4 saying we recommend that a methodology be used to establish a
5 ceiling, but something like 130% of that procedure, as Fair
6 Health defines the 80th percentile in some other closely-
7 related market, like maybe King County, Washington. Okay.
8 That's the only way to say to put -- and 130%, King County
9 should be enough to cover anybody's added -- or 140 -- I don't
10 even care what the number is. And then things would ratchet
11 down. And then production is not to exceed ten percent per
12 year until it gets down to that.

13 So there are ways to do it that get around your
14 objection. Are they perfect? No. Does it need to be
15 changed? Absolutely. I believe, again having done this 16
16 years next month, that, without a change to this, we will
17 never get a handle on the market forces that we're fighting
18 against.

19 COMMISSIONER ERICKSON: So we need to break in one
20 minute. Do we -- so I have a note here to craft a
21 recommendation for your consideration, as draft, that we
22 recommend the Division of Insurance modify the UCR regulation
23 -- and I'll clean that up, so we're specific about which
24 regulation it is -- to establish a ceiling, in addition to the
25 floor, establishing the current regulation. So does anybody

1 disagree with including that?

2 CHAIR HURLBURT: Val and then.....

3 COMMISSIONER DAVIDSON: So I think -- I mean, right now,
4 I mean, I think your comment about insurers being the hated
5 group in Alaska or the kicking post or whatever, I think we do
6 the same to providers unnecessarily, and I worry about this
7 sending that message.

8 On the other hand, you've identified some providers who
9 have been, you know, unfairly raising the price in a couple of
10 instances, but I think, if you talk to those providers, they
11 might offer a different position, which is that they have been
12 unsuccessful in getting the one or two insurance providers in
13 the state to be able to come to the table to negotiate a fair
14 rate.

15 So I think you should be careful about -- I think we
16 should be careful about stepping into this arena without
17 necessarily having sufficient information or expertise with
18 the people around this table to be able to take this on.

19 I think the Worker's Comp Board, if they are interested
20 in doing that, they have made a recommendation. They've made
21 several recommendations. I just think we should be careful
22 about pitting insurance companies against providers in a way
23 that is unhelpful.

24 COMMISSIONER DAVIS: So it's not my money. It's Allen's
25 money. It's employers' money that's being spent. Do we want

1 a regulation -- is it good public policy to have a regulation
2 that allows a provider to drive up reimbursement 27% in a 12-
3 month period or another one to drive it up 300% in a three-
4 year period or another one to charge whatever the multiple of
5 1,600 divided by eight is for a drug? And when we have called
6 them on that, they said, oh, but you can't. This regulation
7 allows us to do this. And so it's been pointed to by the
8 providers who were doing it and were called on it that that's
9 what they're doing.

10 And I am not vilifying providers. This Commission is
11 built on no pointing fingers. But we have a market that is
12 out of balance. We have small supply, large demand, and this
13 just exacerbates it in certain areas. The vast majority of
14 physicians or providers this does not apply to; it is not a
15 problem. But where they have concentrated market power, it
16 enables behavior that is not good public policy, and it may be
17 intentional; it may not be intentional, but it is what is
18 happening. So thank you for listening, and it will be a
19 draft, and we can argue it later, and I will be one of 11 or
20 12.

21 COMMISSIONER DAVIDSON: I suggest that we take a break.
22 I think we need one. We're at the point where we need one.

23 CHAIR HURLBURT: Bob?

24 COMMISSIONER ERICKSON: Bob, real quick and then we'll
25 take a break.

1 COMMISSIONER URATA: Well, I agree with Mr. Davis, and
2 I'm a provider. And I think we have been doing really well
3 under this rule, but I think it's hurt other people and so we
4 need to really look at this and change it so it's more
5 equitable.

6 COMMISSIONER ERICKSON: Tom?

7 COMMISSIONER HARRELL: Just for the record, I agree as
8 well because I'm in a unique position of being both a CEO and
9 a provider, and what you say, Jeff, is exactly what's
10 happening, and it drives me nuts.

11 COMMISSIONER CAMPBELL: This discussion was triggered by
12 the Workman's Comp UCR, and it seems, to me, that we have an
13 Advisory Board or a board that's supposed to be in charge of
14 the workman's comp system in this state, and I guess you're
15 right. We're not supposed to point fingers, but a lot of
16 these things could be laid at that board's table, I think.
17 Enough said.

18 COMMISSIONER ERICKSON: So let's.....

19 COMMISSIONER DAVIDSON: (Indiscernible - away from mic)

20 COMMISSIONER ERICKSON: Let's take a break. Let's take a
21 break. Let's take a break.

22 10:04:19

23 (Off record)

24 (On record)

25 10:26:02

1 CHAIR HURLBURT: I guess we're ready to get started
2 again, and Deb, I'll turn it back to you.

3 COMMISSIONER ERICKSON: So the question before us right
4 now is whether we include, for now, as draft, a recommendation
5 related to the 80% UCR regulation of the Division of Insurance
6 or not, and we're not taking a formal vote at this time. I'm
7 going to suggest, since this is going to -- I can tell it's
8 going to be an ongoing debate. Would it be okay if we just
9 did a show of hands to see if we have a majority of folks
10 willing to put it on for additional consideration? Again, you
11 will vote all of these, whether to release them to the public
12 or not, later.

13 COMMISSIONER HIPPLER: So you're just asking, is there
14 enough interest to discuss this in the future?

15 COMMISSIONER ERICKSON: And to have me draft a suggested
16 recommendation for you to look at with the body of
17 recommendations for this year. Yes, Larry?

18 COMMISSIONER STINSON: Does the recommendation go to the
19 Division or the insurance.....

20 COMMISSIONER ERICKSON: It would go to the Division of
21 Insurance who is responsible for the regulation.

22 COMMISSIONER STINSON: Because this is complicated, and I
23 don't know, except for maybe Jeff, if the rest of us have the
24 expertise to do this adequately.

25 COMMISSIONER HIPPLER: Actually, I can speak to that. I

1 have read this regulation. The regulation is literally 150
2 words long. It is not a big deal. You can read through it in
3 one minute. It's not very complicated.

4 COMMISSIONER STINSON: It's not the regulation I'm
5 worried about. What I'm worried about, as Jeff already said,
6 when you do a solution, you go on to the next problem. And if
7 we're going to put a ceiling on it, I would like to have
8 people who are really good at understanding what the
9 ramifications of putting a ceiling and in what manner.

10 COMMISSIONER ERICKSON: So the question is, do we want to
11 consider including this in our recommendations for this year
12 or not? Yes or no?

13 COMMISSIONER URATA: Call for the question.

14 COMMISSIONER ERICKSON: Let's -- by a show of hands, who
15 would like to include it, just voting members?

16 CHAIR HURLBURT: Well, maybe clarification on that. Your
17 suggestion is that you will work to draft something that we
18 could vote on at a later time, but the question to proceed to
19 do that and then come back and discuss it and vote on it
20 later?

21 COMMISSIONER ERICKSON: Correct.

22 CHAIR HURLBURT: This is not a vote to send a
23 recommendation to the Division of Insurance.

24 COMMISSIONER ERICKSON: Absolutely correct. It's to
25 continue considering it or not.

1 COMMISSIONER DAVIDSON: So how are we treating this
2 compared to all of the other things that we did before? So
3 the other recommendations, we voted, we moved on. We didn't
4 necessarily say, okay, we're going to vote whether or not we
5 take it up later or not. So what's our process here?

6 CHAIR HURLBURT: We're treating this differently than we
7 treated the others. The others were issues that we were ready
8 and able to come to a vote on almost always, with one
9 exception, by consensus with a vote. This is an issue where,
10 with the press of time today and with the apparent difference
11 of opinion, we'll require more discussion, but Deb will draft
12 something that we can take as the focus of discussion. The
13 proposal is to do that when we come back together.

14 COMMISSIONER DAVIDSON: I think then we should treat this
15 like we have all other issues where we don't yet have adequate
16 information and we put it in the parking lot for 2014. That's
17 been our practice, and I think we should stick with our
18 practice.

19 COMMISSIONER DAVIS: I would be fine with that.

20 COMMISSIONER ERICKSON: Does anybody disagree with --
21 yes, Colonel Harrell?

22 COMMISSIONER HARRELL: I do. This is an issue that needs
23 to be addressed, and kicking the can down the road further
24 just kicks the can down the road further. We need to go ahead
25 and stand up and deal with and understand we may not make the

1 right decision, we may not make the right recommendation, but
2 it is, at least, one of those two and allows an opportunity to
3 move forward and then prove ourselves right or wrong. I do
4 not agree with kicking it down the road.

5 CHAIR HURLBURT: And we would basically, following that
6 scenario, take a vote at our one-day meeting in December as to
7 whether or not it would be a part of the recommendations for
8 this year.

9 COMMISSIONER DAVIDSON: I think that we have -- I don't
10 think we've received sufficient information on this topic for
11 us to be able to make an informed decision.

12 COMMISSIONER ERICKSON: So what I'm going to do, since we
13 have disagreement, is go ahead and use Robert's Rules, at this
14 point, and what we're voting on is whether to include this in
15 the next draft as a recommendation or -- I'm going to need
16 somebody to make a motion about this and then.....

17 CHAIR HURLBURT: Yeah (affirmative). And why don't I go
18 ahead and.....

19 COMMISSIONER DAVIDSON: I'll make a motion. I move that
20 we add this to the 2014 parking lot issue so that we have
21 adequate time to be able to study the issue, as has been our
22 practice for every issue that this Health Care Commission has
23 taken on.

24 COMMISSIONER ERICKSON: Is there a second?

25 CHAIR HURLBURT: Motion on the floor. Is there a second

1 to the motion on the floor?

2 COMMISSIONER STINSON: I'll second.

3 COMMISSIONER ERICKSON: Larry seconded.

4 CHAIR HURLBURT: Larry seconded that. Is there any.....

5 COMMISSIONER ERICKSON: Did you capture that, Barb?

6 Barb, did you capture that?

7 CHAIR HURLBURT: Yeah (affirmative). Is there any

8 discussion? Then -- yes, David?

9 COMMISSIONER MORGAN: It's more of a declaration. I may
10 have a conflict, and therefore, I can't vote either way, and
11 I've notified you of that and will follow up on it. If we
12 vote on it in two weeks or whatever, then the Ethics Officer,
13 as you or your office, can say, you can vote, you can talk, or
14 you're out on this one, whatever it is.

15 CHAIR HURLBURT: Yeah (affirmative).

16 COMMISSIONER MORGAN: So I can't vote yea or nay. I
17 guess I'll have to vote, like our current President, present
18 or something or whatever.....

19 CHAIR HURLBURT: I guess I don't know, and I'm asking for
20 advice, and maybe Allen is our resident expert, but do you
21 need to declare what your conflict is or do you need just to
22 state that you have a conflict?

23 COMMISSIONER HIPPLER: Is he obligated to vote, unless he
24 has a conflict? That would be the answer to your question.
25 If he's obligated to vote, unless he has a conflict, he must

1 explain himself.

2 CHAIR HURLBURT: I believe we have had votes where there
3 has been a vote of present; yeah (affirmative). Okay.

4 COMMISSIONER ERICKSON: Are there other discussions?
5 Yes, Allen?

6 CHAIR HURLBURT: Allen?

7 COMMISSIONER HIPPLER: Okay. At first, this was going to
8 be where we look at a draft recommendation later this year and
9 now it's turned into, is this the way it's going to be or
10 should we review it in 2014. I kind of like the first idea of
11 let's get a draft recommendation to review at the end of this
12 year and see what we do then. At that point, we could
13 postpone it to 2014.

14 For example, there is a very specific solution proposed;
15 namely, there is the problem of a price floor, so the solution
16 is a price ceiling. Well, there's another solution, too. If
17 the problem is a price floor, you just eliminate the price
18 floor and let the market work it out. There are a lot of
19 solutions to this. All of the solutions do have potential
20 problems, and maybe, if we want to have a specific solution,
21 we do, indeed, need to postpone it to 2014, but if we simply
22 recommend to the Division of Insurance that this is a big
23 problem they need to look at, that does not require as much
24 research.

25 So I would be more interested in seeing what's going on -

1 - what we have drafted to review in December, and then at that
2 time, seeing how general it is and how comfortable we are.
3 The more specific it is the more I tend to agree with Ms.
4 Erickson -- or Commissioner Erickson -- or Davidson -- I'm
5 sorry -- Commissioner Davidson. And the less specific it is
6 and more general, I would agree with just getting it done.
7 Thank you.

8 CHAIR HURLBURT: (Indiscernible - simultaneous speaking)

9 COMMISSIONER ERICKSON: Additional discussion? Go ahead.

10 CHAIR HURLBURT: So I think that we have -- Deb, as our
11 Executive Director, made a suggestion. Actually, Deb is not
12 able to -- is not a member of a Commission to make the motion.
13 There was no motion made on Deb's suggestion, at the time, and
14 then Val made a motion to -- a different motion to defer until
15 2014. So I think that, if you want to give the Commission the
16 opportunity to discuss the draft document that Deb would bring
17 at our next meeting, you should vote against the motion that
18 Val made that was seconded. Do you disagree with that, Val?

19 COMMISSIONER DAVIDSON: I would put it another way. I
20 would say that, if you would like to discuss -- to study this
21 issue further in the way that we have discussed every other
22 issue before we have taken a recommendation, then you would
23 vote yes, so that we may study the issue thoroughly in 2014.

24 COMMISSIONER ERICKSON: So we have two perspectives on
25 the question. Is anybody prepared to call the question?

1 COMMISSIONER DAVIDSON: I'll call the question.

2 COMMISSIONER ERICKSON: The question has been called.

3 CHAIR HURLBURT: The motion on the floor then is to defer
4 making a decision related to the recommendations that will go
5 to the Governor and to the Legislature in January.....

6 COMMISSIONER ERICKSON: I think Val needs to state the
7 motion the way she stated it and then we'll.....

8 COMMISSIONER DAVIDSON: The motion that I had was to put
9 this on the 2014 agenda for further study and analysis about
10 what the impact would be in Alaska.

11 CHAIR HURLBURT: Okay. You've heard the motion restated.
12 It's been seconded. All those in favor of addressing this
13 issue by putting it on the agenda for next year for further
14 consideration raise your right hand. So Val Davidson and Dr.
15 Stinson.

16 All those opposed to the motion to put this on the 2014
17 agenda for further consideration during that year raise your
18 right hand. And that's.....

19 COMMISSIONER ERICKSON: So I'm going to go around and
20 name them. Barb, you're capturing them.

21 CHAIR HURLBURT: Leave your hands up, so that.....

22 COMMISSIONER ERICKSON: Jeff, Ward, Tom, Allen, and Bob
23 are voting against.

24 CHAIR HURLBURT: And Keith.

25 COMMISSIONER ERICKSON: And Keith. Voting against the

1 motion.

2 CHAIR HURLBURT: And those voting "present" raise your
3 hand.

4 COMMISSIONER ERICKSON: And David Morgan abstained.

5 COMMISSIONER DAVIDSON: No. He didn't.

6 COMMISSIONER ERICKSON: He declared.....

7 COMMISSIONER DAVIDSON: He declared a conflict.

8 COMMISSIONER ERICKSON: He declared a conflict; no vote.

9 CHAIR HURLBURT: Okay.

10 UNIDENTIFIED COMMISSIONER: Emily is not here.

11 CHAIR HURLBURT: She had to.....

12 COMMISSIONER ERICKSON: And Emily is absent for the vote.

13 CHAIR HURLBURT: Okay. So is there another motion to be
14 made?

15 COMMISSIONER DAVIS: Yes, Dr. Chair. I really like
16 Allen's suggestion of rather than suggesting a fix, declare to
17 the Division that this a -- we believe this is a problem that
18 they need to look at, and if appropriate, come up with a
19 solution, something along those lines. Allen said it better.
20 Because there are lots of ways to do it. Mr. Puckett and I
21 were having a discussion about that, about an alternative way.
22 Allen has suggested another way, but I think encouraging the
23 problem to be looked at makes sense, with a motion.

24 COMMISSIONER ERICKSON: So can you state that in the form
25 of a motion?

1 COMMISSIONER DAVIS: Yes. I move that the Commission
2 recommends the Division of Insurance consider modifying the
3 current UCR regulation to eliminate the unintended adverse
4 pricing consequences.

5 COMMISSIONER HIPPLER: I'll second that.

6 CHAIR HURLBURT: Is there discussion? Do you have it,
7 Deb? Okay. Is there discussion?

8 COMMISSIONER URATA: Call for the question.

9 CHAIR HURLBURT: Okay. And now just for clarification,
10 the impact of that vote would be to, essentially, nullify
11 Deb's suggestion to bring it back to the next meeting?

12 COMMISSIONER ERICKSON: No. It'll still be part of the
13 body.

14 CHAIR HURLBURT: It'll be a part of the body.

15 COMMISSIONER ERICKSON: We'll vote to release to the
16 public or not.

17 CHAIR HURLBURT: Okay. Any discussion otherwise? Could
18 -- Keith? Oh, okay. Could you read the motion, Deb, please?

19 COMMISSIONER ERICKSON: "The Commission recommend the
20 Division of Insurance consider modifying the current UCR
21 regulation to eliminate the unintended adverse pricing
22 consequence."

23 COMMISSIONER DAVIS: Consequences.

24 CHAIR HURLBURT: All those in favor of the motion raise
25 your right hand, please.

1 COMMISSIONER ERICKSON: So I will name them, and Barb is
2 capturing them. Bob, Allen, Tom, Keith, Emily, and Dave, and
3 Ward are voting for the motion.

4 CHAIR HURLBURT: Jeff.

5 COMMISSIONER ERICKSON: Jeff?

6 CHAIR HURLBURT: Yeah (affirmative).

7 COMMISSIONER ERICKSON: I'm sorry. Thank you. I was
8 looking at Dave.

9 CHAIR HURLBURT: One of those guys.

10 COMMISSIONER ERICKSON: Not Dave. Dave is not voting.

11 CHAIR HURLBURT: We haven't -- all those opposed raise
12 your right hand.

13 COMMISSIONER ERICKSON: And Val and Larry oppose.

14 CHAIR HURLBURT: And note that David is not voting.

15 COMMISSIONER ERICKSON: David's not voting, due to a
16 declared content.

17 CHAIR HURLBURT: Declared conflict, yeah (affirmative).
18 Val?

19 COMMISSIONER DAVIDSON: So when you're recording those
20 votes, because Dave did not abstain and he was present for the
21 meeting, his vote under Robert's Rules and under Alaska Rules
22 counts as a yes vote for both motions because he didn't
23 abstain.

24 CHAIR HURLBURT: Thank you. Wes?

25 COMMISSIONER KELLER: Welcome to my world.

1 COMMISSIONER DAVIS: You can have it back.

2 COMMISSIONER ERICKSON: That's why it's always helpful to
3 have an attorney on your board. Okay. Let's -- let me make
4 sure I saved that, but we're recording in multiple ways so
5 that's good.

6 So moving on, we had nothing else. We had two other
7 issues related to findings. One was about the Cadillac tax,
8 and there was a third general item that came up under the
9 recommendation discussion that I moved up to findings because
10 it, really, I think, was meant to be more about a finding and
11 that was the disease management bullet. So we have nothing
12 else related to recommendations, but some potential findings
13 related to the Cadillac tax and disease management.

14 The issue related to the Cadillac tax was that it is
15 beginning to show evidence that it's influencing employers'
16 and others' decisions regarding the design of the health
17 benefits plans. Is that something that you would like to
18 maintain in the findings statements? Heads are nodding yes.
19 Anybody not want to include it?

20 I actually brought an article that does a really good job
21 of capturing this concept from *Governing* magazine last night,
22 and I brought you all copies, but I'm not going to give them
23 to you until the end of the meeting because I don't want to
24 get sidetracked, but they do a good job of explaining what's
25 going on with that and how it is starting to play out in state

1 and local government negotiations with unions. Yes?

2 COMMISSIONER URATA: I would hope that we'd keep track of
3 that and follow the potential -- or follow the impacts on what
4 it does to our employers and employees in the state.

5 COMMISSIONER ERICKSON: So related to the disease
6 management and the point that fewer than one percent of the
7 sickest members in a plan drive a significant amount of cost
8 and that complex case management is an important strategy for
9 addressing that -- do you want to have this as a finding
10 bullet, something related to this? I'll work with Ward and
11 come up with something that makes sense, but if you want a
12 finding related to disease management and complex case
13 management and high cost plan members? Heads are nodding yes.
14 Anybody opposed? Yes, Allen?

15 COMMISSIONER HIPPLER: So is this finding stating that
16 evidence-based care applies to less than one percent of the
17 sickest members of any group? That's how I'm reading it.

18 COMMISSIONER ERICKSON: No.

19 CHAIR HURLBURT: No. The less than one percent is the
20 complex case management, and (indiscernible - voice lowered)
21 should be evidence-driven. The State, for example, had in
22 their almost 50,000 active employees -- pre-65 retirees and
23 dependents had, I believe it was, 61 cases that were more than
24 \$250,000 last year. That's not much more than one-tenth of
25 one percent, maybe 15/100th of a percent of that, and you can

1 manage that with one nurse. As you -- but those are your most
2 expensive cases. That's where there is the most confusion,
3 often the least coordination, and the sickest of your people,
4 and having somebody that helps facilitate and coordinate that
5 care can significantly improve the quality of care and also
6 assure that resources are being used appropriately there. So
7 that addresses complex case management, which is different
8 than disease management that takes in a broader population.

9 COMMISSIONER ERICKSON: And I changed the "S" to a "D" so
10 it now reads "applied" and maybe that makes more sense. But
11 I'll work with Dr. Hurlburt to craft a statement that will
12 make a little more sense than the way it's worded right now on
13 this screen, for your consideration.

14 So we are done with employer engagement, unless, in the
15 notes that we captured and the discussion we, so far, this
16 morning, is there anything significant that we've omitted that
17 you want to make sure gets captured either as a finding or a
18 recommendation? Okay.

19 Hearing none, let's move on to evidence-based medicine,
20 and hopefully, you all had a chance to look at this paper
21 either last night or sometime this morning. Let's see. I'll
22 find the slide.

23 So the first point -- I'm going to, but try to make it
24 quick, through this point-by-point, but the first point that I
25 had pulled from the discussion of the last meeting was we

1 didn't need a whole lot more in the findings, but there had
2 been a suggestion that we add a few definitions to the
3 findings. And so these are some suggestions here, and again,
4 we don't need to wordsmith now, in the interest of time. If
5 you have suggestions for improving these, I would ask that you
6 get those to me later to include or you can make it when I
7 circulate this in draft, but just, in general, the concept of
8 including these three definitions.

9 And the other point we had discussed, if you remember, at
10 that meeting was that the consultants who are with us had
11 suggested that we maybe add some qualifiers in our summary
12 statements, and they had shared some of those suggestions with
13 me, but I thought it confused and complicated rather than --
14 it was a little too academic for our audience. So I thought
15 just adding the definition of high grade evidence would meet
16 their concerns.

17 CHAIR HURLBURT: Just some -- I made a number of notes on
18 this, the concept of the State implementing a web-based system
19 for making information available. I don't think,
20 realistically, with our size state, that we can develop a lot
21 of expertise and make information available on the website,
22 but what might be useful would be a website where folks could
23 go and the State could point out resources that are available.

24 COMMISSIONER ERICKSON: I'm going to be bossy. I'm
25 sorry. Are we talking -- is this an additional finding you

1 want to suggest?

2 CHAIR HURLBURT: No. No.

3 COMMISSIONER ERICKSON: Okay. Can you hold off on that
4 for now?

5 CHAIR HURLBURT: It's in the recommendations. Yeah
6 (affirmative). Sure. Yeah (affirmative).

7 COMMISSIONER ERICKSON: Thank you. Does anybody object
8 to including these definitions in the findings? Nope. Okay.
9 Are there any other additional findings that were -- that you
10 think we need to add to the current body of findings related
11 to evidence-based medicine, just even in concept, that I could
12 capture in a suggested next draft?

13 Hearing none, moving on to the recommendations, and we'll
14 get to yours, Ward, in just a second. The first thing I did
15 was -- we're moving to being more specific, and especially,
16 being more specific in terms of who we're directing the
17 recommendations to, where, in the past, we've been, as
18 generalists, just saying the State of Alaska should do this.
19 Now we're getting specific to the individual agencies that can
20 make -- actually would have to affect the change. So that's
21 the first change I made to the earlier recommendation that's
22 on the books from 2010. Dr. Urata?

23 COMMISSIONER URATA: I would like to add something
24 regarding prior authorization requirements because, when I see
25 prior authorization, that means a half-hour on the phone my

1 nurse has to do. I mean, I used to do it myself, but then it
2 would take 30 minutes. Most of the time, you're on hold. And
3 so if there is some way in which we can make prior
4 authorization more provider-friendly -- I guess you could add
5 "provider-friendly" or add the words "efficient prior
6 authorization," something of that sort -- to make sure that
7 we're not calling somebody in Virginia or Texas in some other
8 time zone and then being put on hold for more minutes than is
9 comfortable that would be nice. It may be an impossible
10 recommendation, but something's got to be done, if we're going
11 to do more and more prior authorization because it just wastes
12 time.

13 COMMISSIONER ERICKSON: Do you have a suggestion, Ward?

14 CHAIR HURLBURT: Within the industry, there are
15 performance standards addressing that, and because I agree
16 that's such an important issue, when I've been in a position
17 of making those decisions, we used the standard of the average
18 response time being -- needing to be 20 seconds or less and
19 getting somebody -- to somebody that can resolve your problem
20 on that call.

21 So I think that, in terms of the State as the payer,
22 there are recommendations that the State foster fairly
23 aggressive accessibility standards. Now the balance is, if
24 you get too accessible, you're wasting money by having people
25 sitting around waiting for a phone call and that's a

1 management issue, but both for your injured individuals and
2 for your providers, good business performance is to be
3 promptly responsive so it doesn't waste your expensive time.

4 COMMISSIONER URATA: Then I need a 1-800 number that I
5 can call to complain, and I don't know that there is one
6 available. Is there one available to me to call to complain
7 about a company that is overworked, or you know, they don't
8 seem to have the time available for our requests?

9 CHAIR HURLBURT: Yeah (affirmative). In meeting Monday
10 with some of your other colleagues as well as you there in
11 Juneau, that was a request. Give me one number either with
12 the State or with Aetna, because we were talking about Aetna
13 coming in for the employees and the retirees, that I can call
14 if there is a problem. I need one point of contact.

15 And one of the selling features that Aetna had there was
16 what they called a concierge service was the intent, is to be
17 user-friendly that way, but I think that, as the party
18 contracting for the services, it behooves the State to have
19 some fairly firm and clear expectations of what the service
20 is. I think Aetna's intent is to be responsive that way. I
21 know it is with Jeff's shop and Premera there. But the issue
22 that you raise is a valid one and has to be a part of whether
23 you're willing to enter into the network, if you're going to
24 get that quick response, one point of contact there. Yes,
25 Larry?

1 COMMISSIONER STINSON: Ward, my experience with prior
2 authorization is exactly like Bob's and nothing like yours,
3 and our people are on the phone for -- I'm seeing other
4 patients, and then when they finally come on the phone, if you
5 don't get on the phone with them within about ten or 15
6 seconds, they click you off and they say, well, you're non-
7 responsive and then you have a denial. And so you're waiting
8 for half-an-hour. Meanwhile, I've gone on to see a couple
9 more patients. And then someone will come, quick, quick,
10 quick, they're on the phone. And you go, hello? And they're
11 already gone and then you get a denial. And so my experience
12 is the exact opposite of what you're saying, and I'll bet my
13 experience and Bob's experience is probably by 90-plus percent
14 of the other providers, I'd guess.

15 CHAIR HURLBURT: And that's not acceptable; I agree.

16 COMMISSIONER KELLER: I can't help but add that both
17 those are providers' perspectives, and the patient would -- a
18 patient with skin-in-the-game is going to be interested in
19 getting a pre-authorization, and I have been in the process of
20 trying to get a pre-authorization, and you know, even the
21 pricing is impossible, you know, just to make comparisons. So
22 it's kind of an exercise in futility anyway, but I'm just
23 suggesting that, if we could get to the point where the
24 patient is engaged, the provider wouldn't have to pick up this
25 load completely.

1 COMMISSIONER ERICKSON: So Bob, you were making a
2 suggestion to add the word "effective" in front of "prior
3 authorization," would that.....

4 CHAIR HURLBURT: Efficient.

5 COMMISSIONER URATA: User-friendly.

6 COMMISSIONER ERICKSON: Yeah (affirmative); you did say
7 efficient. I meant efficient.

8 COMMISSIONER URATA: Yeah (affirmative). Efficient or
9 user-friendly, put a smile on my face type.....

10 (Pause - background discussion)

11 COMMISSIONER URATA: Well, you use prompt, but you know,
12 I want it to be easy. Prompt. Easy. Efficient. Put a smile
13 on my face.

14 CHAIR HURLBURT: Yeah (affirmative). I think.....

15 COMMISSIONER ERICKSON: I'll work on addressing that. I
16 think we need to move on, unless we need a change, an
17 additional change here because we've got minutes left and
18 several things to do.

19 Let's see. So we were just addressing sub-bullet A, and
20 I assume it was obvious. What I did was I took what, in our
21 current body from 2010 of evidence-based medicine
22 recommendations, items two, three -- recommendations two,
23 three, and four and made them sub-bullets under what we're
24 asking the specific agencies to do.

25 So this next one is regarding coordination between the

1 agencies and information sharing. And the one after that --
2 and that would be no change, in effect, to what we currently
3 have on the books. That's just reformatting it a little bit.

4 The next bullet, 1C, is an addition based on the
5 conversation, and if you recall, the conversation at the last
6 meeting was, should the State add staff who have expertise in
7 critical appraisal or not, and the suggestion was that might
8 not be a realistic recommendation and that it was also
9 important to make sure that all staff who are involved in
10 decision making have that knowledge and that skill. And so I
11 took a stab at crafting an additional recommendation, based on
12 that conversation related to the State providing training for
13 those staff. Any questions or discussion about that addition?

14 Hearing none, the next one, sub-bullet D, again, this was
15 involving providers and consumers and decision making related
16 to the application of evidence-based medicine and public
17 policy. There was a lot of discussion at the last meeting
18 about, should state government have a responsibility for
19 helping to provide tools to providers and some question about
20 that. This, I thought, was maybe both an efficient use of
21 resources, and a more appropriate role for state government
22 was that, if the State is hosting -- just like the Commission
23 did at our last meeting -- training opportunities for staff,
24 why not open that up to the provider community? And so that's
25 my suggestion there in the one addition that's underlined.

1 Any questions? I see a thumbs-up. Any questions or comments
2 or discussion about that suggestion?

3 Hearing none, the next one is, again, just formatting.
4 I'm not changing -- it's that the process the State uses in
5 setting these policies be transparent.

6 And then I need to do some wordsmithing because I used
7 too many of the same words, over and over again, in "F." But
8 "F" is an addition, again, to provide patient decision support
9 tools, and this was, again, to what is the appropriate role of
10 government, and we were kind of struggling with, should the
11 State do that for everybody? Should the State create a
12 website? Because of that debate, my suggestion here was just
13 to direct the programs that purchase insurance, like the
14 Employee Health Insurance Plan and the Medicaid program,
15 provide, as an insurer for their covered members, these
16 patient decision support tools. So that was the balance and
17 compromise I tried to strike there. Yes, Bob?

18 COMMISSIONER URATA: And to Ward's point or Dr.
19 Hurlburt's point, I think you could, like, provide links to
20 existing programs, such as the Pacific Northwest Evidence-
21 Based Practice Center, Choosing Wisely, and the Technological
22 Assessment Program that's listed on the next page from Oregon
23 and Washington and not reinvent the wheel.

24 COMMISSIONER ERICKSON: Right. That's a good suggestion.

25 COMMISSIONER URATA: So you could just put it in links or

1 whatever.

2 COMMISSIONER ERICKSON: Are you suggesting that we do
3 that separate for the public somewhere else because the
4 insurance companies are coming up with their own tools, I
5 think, for helping with that?

6 COMMISSIONER URATA: Well, I think you could do for it
7 your own programs and then you could -- and the public has
8 access to your websites, Alaska.gov, and it would be in there.
9 So anybody has access to it. So do we have to specify whether
10 it's the public or not?

11 COMMISSIONER ERICKSON: I'm thinking about who in the
12 state would be responsible for doing this, if it's more
13 generally available to the public, but what if I just take a
14 stab at thinking about that and adding an additional bullet?
15 It seems, to me, to be a separate bullet from.....

16 COMMISSIONER URATA: That's fine.

17 COMMISSIONER ERICKSON: Okay. So I will add something
18 related to providing access and links for the public. So
19 that's it. "G" is the old four, didn't make any change to
20 that. And I'm assuming that somebody is going to raise their
21 hand if there was a 2010 recommendation that I've just
22 reformatted that you want to see changed. So I'll stop, at
23 this point, at what was the old four, which is now "G" on here
24 and see if there -- was there anything that you wanted changed
25 that I haven't made a suggested change? Heads are nodding --

1 or shaking no.

2 And then the final suggested addition was there was some
3 discussion about making sure that clinicians are receiving
4 training in this area and so again trying to be as specific as
5 possible for the State of Alaska and state government,
6 suggesting that the University incorporate these principles in
7 their training and education programs. So that came out of
8 that part of your discussion last time. Yes, Bob?

9 COMMISSIONER URATA: That's for their health students?

10 COMMISSIONER ERICKSON: Correct.

11 COMMISSIONER URATA: Yeah (affirmative), Department of
12 Health.

13 COMMISSIONER ERICKSON: Yeah (affirmative). That's what
14 I said, in clinical training and education. Yeah
15 (affirmative).

16 COMMISSIONER URATA: So that's WWAMI students, nursing
17 students, physical therapy, et cetera?

18 COMMISSIONER ERICKSON: Right. I wasn't specific to the
19 College of Health because it's in UAA, and I don't understand
20 the university structure enough and if there are programs that
21 train clinicians at UAF or UAS. I just wanted to make it as
22 general as possible to that system.

23 COMMISSIONER URATA: I think it's great.

24 COMMISSIONER ERICKSON: So just up through two then at
25 the top of that third page, any other questions, comments,

1 discussion, changes that you would want? And then we'll
2 discuss the point that, I think, Ward was trying to make
3 earlier. Okay.

4 Hearing none, I'm going to clean this up, and it will be
5 incorporated in the paper that I'll get out to you this next
6 week.

7 The next point, Ward, the Commission recommends the
8 Department implement a web-based data system for public health
9 information. I think this was specific to the IBIS and
10 Instant Atlas program. The Commission had wanted to endorse
11 it, and it came up in the course of discussing evidence-based
12 medicine and the data needs for that. The two aren't really -
13 - this isn't the type of data, this public health data, that
14 supports evidence-based medicine, but it is part of
15 strengthening the health information infrastructure in the
16 state, and it is already underway in the Department of Health.
17 I was just suggesting moving it out from under evidence-based
18 medicine to where I thought it made the most sense was in the
19 information infrastructure set of your recommendations.

20 CHAIR HURLBURT: Yeah (affirmative). And then my comment
21 did not address the public health site. It was more further
22 down on the clinical.

23 COMMISSIONER ERICKSON: So getting on to the part that
24 you actually were making a point about, Ward, the final
25 question that I had was, when we left the meeting at the end

1 of that day, the recommendation that we had scrambled together
2 -- it was on the slide -- was a recommendation that the State
3 implement a web-based system for making information about
4 critical appraisal to medical evidence available for patients.
5 So this gets back to, I think, in part, the compromise you
6 were suggesting, Bob, that we have and Ward's suggestion that
7 it might not be an appropriate role of the State, or at least,
8 not as realistic to expect, essentially, a new program to be
9 created, but just provide the links, links to the federal and
10 national programs. That seems like a good compromise, to me.

11 COMMISSIONER URATA: And you might, you know, WebMD or
12 something, if that's considered critically appraised.

13 COMMISSIONER ERICKSON: I'll work with Ward to make sure
14 we identify it, but I don't know that we'll get real specific
15 in this recommendation, but maybe in the discussion part, we
16 can make sure we're getting the accepted sources of that
17 information. Any other questions, comments, suggestions about
18 evidence-based medicine findings and recommendations?

19 Hearing none, I'm going to move to one more point that I
20 want to make sure -- I'm not going to even address hospital
21 discharge data and All-Payer Claims data because you all did
22 vote to include those as draft recommendations at a previous
23 meeting. We don't need to revisit those now, but you'll have
24 an opportunity when I send out this paper, if you want to take
25 a red pen to them and have some conversation before they're

1 released for public comment, we will do that.

2 So the one last thing that I want to make sure we have a
3 little time to discuss, if I can find it in my slides, is the
4 2014 plan and the continuing conversation on the employer's
5 role that we'll have related to the employer survey, at least,
6 if not others.

7 And also at one point, we had tabled evaluating other
8 states' transparency laws as an additional mechanism for
9 addressing the question of transparency beyond, and
10 potentially, instead of an All-Payer Claims Database. So in
11 terms of continuing analysis of strategies, those two are on
12 the list right now.

13 And then coming out of the discussion with the
14 stakeholder group that we had in early August at our August
15 meeting -- and this is for Larry's benefit, since he wasn't
16 able to be with us in August -- we had added both some work
17 that the Commission will do in the future related to insurance
18 access -- and I think the convergence of the survey of
19 employers will contribute, hopefully, some valuable
20 information to that conversation, but the question of
21 insurance access in the state and also the value or potential
22 harms of pharmacy benefit management was raised, and we, at
23 this last meeting, had decided to put it in the parking lot
24 for 2014.

25 And then the two -- fraud and abuse and rural sanitation

1 are two issues that we haven't addressed directly here that
2 are on the Commission's duty list in statute that we need to,
3 at least, learn about a little bit more at some point, if not
4 do something about. So those are on the list.

5 And Val, you were noting earlier that we studied oral
6 health earlier in the year, and I just haven't gotten the
7 notes from that out to you that will, at a minimum, have some
8 information from that presentation in our annual report, but
9 do you want to add that in here so it doesn't get lost, in
10 either strategies or continuing study?

11 COMMISSIONER DAVIDSON: Yes.

12 COMMISSIONER ERICKSON: Maybe it doesn't matter for now
13 because probably the logical next step would be
14 recommendations.

15 COMMISSIONER URATA: We didn't do recommendations on that
16 meeting -- or after that meeting?

17 COMMISSIONER ERICKSON: I don't believe so. Let me go
18 back and pull the notes. I'm just going to put them on the
19 list, so we don't lose them. Is there anything missing here
20 that you -- and I brought, to show you on the screen, but we
21 don't have time to do it, and I don't think it's going to add
22 any value for you, at this point, to do it.

23 Ward and I -- just to number three here, III, Ward and I
24 have begun having conversations with the different state
25 programs that are involved, in some way, in implementing, and

1 we're starting to capture in the next phase of that framework
2 that I showed you last time that -- your recommendations
3 providing the framework for the state health plan. So I was
4 going to just show you that on the screen. I don't want to
5 share it more broadly because it will be a product of the
6 commissioners of those agencies, ultimately, and they need to
7 be able to see the draft work first before we start sharing
8 it. Yes, Bob?

9 COMMISSIONER URATA: You know, I mentioned earlier the --
10 to consider the issue of quality of care. Quality of care is
11 responsible for -- or errors in medicine is responsible for
12 thousands of deaths a year, and I believe, millions of dollars
13 of poor care costs extra, and we talked about possibly having
14 somebody talk about that. And I wrote the gentleman's name
15 down, but I can't find it now.

16 CHAIR HURLBURT: Once he gets over running for governor,
17 if he's not elected.....

18 COMMISSIONER URATA: Well, yeah (affirmative).

19 CHAIR HURLBURT:we could get the guy who wrote the
20 book because he likes Alaska.

21 COMMISSIONER URATA: And so I thought that we might
22 consider that. Don Berwick. Dr. Don Berwick.

23 COMMISSIONER ERICKSON: That's on the list now. Anything
24 else you want to add or anything on the current draft list
25 that you want to question?

1 Hearing none, this will be on the list that I send to you
2 next week because it's something that we always ask the public
3 to comment on as well, and it will be part of the public
4 comment draft.

5 Anything related to our draft Findings and
6 Recommendations that you have questions or comments about, at
7 this point, before we move on to the next point on our agenda?

8 So hearing none, I believe we are not going to have
9 Commissioner Streur with us today because he was double
10 booked, but we have Josh Applebee here, and Mr. Kolb was going
11 to join us, too. I'm not seeing him in the room.

12 UNIDENTIFIED MALE: He's here.

13 COMMISSIONER ERICKSON: Oh, he's hiding. Do you both
14 want to come up to the table while I -- I'm going to just,
15 real quickly, because they're just -- I only have, like, three
16 slides, I think, to our regular update where I tried to
17 capture the major things that happened, to the extent that I
18 could, over the past couple of months since met last.

19 No significant changes in terms of states' decisions
20 related to the Insurance Marketplace and the Medicaid
21 expansion, but significantly, just a couple of weeks ago, CMS
22 granted Arkansas their requested Medicaid waiver for the
23 expansion population that will put that population into the
24 Exchange and use the Medicaid funds to pay for their premiums.
25 And I put just a couple of highlights about that Medicaid

1 waiver and a note that Iowa has a similar waiver currently
2 pending in CMS. And also, of course, the event of note that
3 we can, perhaps, hear a little bit more from Director Kolb
4 about, and you can ask some questions, was the go-live date
5 for the insurance exchanges hit October 1, and just the week
6 before that, the U.S. Department of Health and Human Services
7 released a summary of the premiums for health plans that were
8 -- are being sold on the Insurance Marketplace, at this point,
9 and I just pulled a couple of summary points of the weighted
10 averages of Alaska compared to the U.S. average, and I pulled
11 the high cost state. Wyoming, on average, has the highest
12 premiums in the country, and Minnesota the lowest, and Alaska
13 comes in number two, on average, for the highest premium costs
14 on the Exchange. So I just pulled those figures in on slide
15 four.

16 And a note that that Long Term Care Commission released
17 their final report. It's on the Web, if you want to go check
18 it out.

19 And not as many -- I think everybody has been busy with
20 other events -- regulations released this past couple of
21 months, but a few and so I have those listed here as well.

22 So I just provided that update for the Commission, and
23 I'll go ahead and turn the mic over to Josh and Bret and see
24 if they have anything that they want to share, in particular,
25 and see if you all have questions for them.

1 MR. KOLB: My name is Bret Kolb. I'm the Director of the
2 Division of Insurance, and there is really not a lot to add.
3 I can tell you, for the Division of Insurance, in the last
4 week-and-a-half, almost two weeks now since the go-live, we've
5 had ten, 15 phone calls total. That's it. And the calls have
6 typically been the same thing: We can't get on this website;
7 what do we do? And we've been trying to tie people back to
8 the federal phone number. We've been giving them the number,
9 letting them know that's the number.

10 The other thing for people to remember is October 1st was
11 not a deadline. It was a go-live date, and the date that is
12 really the next big one for them is probably more December
13 15th, in order to have coverage effective October 1st. I
14 know, yesterday, there was information released so that people
15 can actually go in and look at what rates would look like
16 without having to do go through the whole sign-in process and
17 the validation process, so they can put information in.

18 Like, for example, I decided, hey, I'd like to see what
19 this looks like, just for curiosity. I put in a family of
20 five that lives in my area and found out that, for \$800 a
21 month, I can have a \$12,000 deductible with no coverage. It
22 wasn't that great of a deal for me, I didn't think, but
23 nonetheless, that was the least expensive plan that was
24 available for a family of five living up in the MatSu Valley.

25 So that is available. I've made sure that our staff is

1 aware of it so, when people call in and are asking, how can I
2 see something -- now, the one thing that does not take into
3 account is any type of subsidies or -- that's just pure
4 premium cost, is my understanding of what they've put out
5 there. But beyond that, there hasn't really been a lot. My
6 staff was prepared for quite a few questions and have gotten
7 next to none, at this point.

8 I've tried to get a feel for enrollments, and at this
9 point, I know nothing. I haven't been able to get information
10 as far as enrollments. I would assume, if it were a large
11 number, someone would be sharing that, but that's purely an
12 assumption. I don't have any way to know. I don't know
13 whether Premera can shed any light on that from their
14 perspective or whether you're even in a position where you
15 can; that I don't know.

16 COMMISSIONER DAVIS: So this -- well, not anecdotal.
17 This is secondhand. As of yesterday afternoon, I was told
18 that -- well, I had learned that, the day before that, we had
19 gotten one application actually through the Exchange and that
20 our competitor in the Exchange had gotten two. So we have 33%
21 market share, apparently. No. Three. So three have made it
22 through and that's certainly not what we're expecting, but
23 it's just because, as you said, you can't get through the
24 registration. At some point in time, it bogs down and kicks
25 you off, and it's just impossible to get through. So thank

1 you.

2 COMMISSIONER DAVIDSON: So what has been the experience
3 for states who actually did their own exchange rather than
4 relying on the federally-facilitated exchange?

5 COMMISSIONER DAVIS: I can speak to two, Washington and
6 Oregon. Washington spent \$150 million in a couple years
7 getting theirs up and running, and it's actually working, and
8 we're receiving files from the Washington Exchange. Well, a
9 few bumps on the first couple days, but it's actually working
10 pretty well.

11 The Oregon Exchange, who spent \$300 million in federal
12 dollars in several years in bringing it up, is -- it's not
13 live for the public yet. It's live for brokers and agents,
14 was supposed to be live for the public on the 15th of October.
15 That's been delayed. I don't know if there is a new date, but
16 we've been told we won't receive any files until after
17 Thanksgiving from the Oregon Exchange. So at least, those two
18 states -- it's a tale of two cities, but Washington is
19 working.

20 COMMISSIONER MORGAN: I can speak to Maryland and
21 Kentucky because I was there. Maryland spent above \$200
22 million, and theirs is working reasonably well. Kentucky
23 spent considerably less, and also, it's a state exchange, and
24 it's not working very well. They may pull it off and give it
25 a couple of weeks and try again. So it's mixed. That's two

1 state exchanges that I was in those states.

2 South Carolina, when I was there a week ago, did not have
3 a date of when they'd bring up -- you know, get that going
4 there either, but I don't know if it's working or not. There
5 are two-and-a-half.

6 MR. KOLB: But beyond that, there is not too much. As I
7 said, from the Division's side, really, our next big thing, as
8 I've indicated in the past, I'm sure we'll start seeing rate
9 filings in April for the next year. Beyond that, it's dealing
10 with consumer questions and if anyone does buy a plan. You
11 know, these plans that Jeff referenced that have been sold,
12 they're regulated insurance.

13 So when it all comes down to it, who regulates insurance
14 in our state? The Division of Insurance does. So these are
15 regulated products. So if there was a problem, as far as not
16 complying with state or federal law, that could and would be a
17 complaint that I would anticipate -- not that I'm not
18 anticipating any complaints, of course, but if there was one,
19 we're not going -- our consumers are not going to be left high
20 and dry. The Division of Insurance is here. We regulate and
21 oversee the regulated products, and whether they purchased it
22 off that website or another website or from an independent
23 agent, what they purchased was regulated insurance and so that
24 hasn't changed.

25 COMMISSIONER DAVIS: So just not to leave anyone with the

1 wrong impression, so our other understanding from the market
2 is there has been a lot of interest, that brokers and agents
3 are being approached, but most, I think, are taking the
4 position that, until the federal exchange is actually working,
5 they're just taking leads and will get back to people when
6 it's available. So it's not only three people who have been
7 interested. There have been significantly more than that.
8 And we are receiving a lot of phone calls, and the nature of
9 the calls -- about 90% of the calls are people who just want
10 to be reassured. They want to understand the dates. They
11 want to know when they're going to have to do something. They
12 want to understand why their plan went away, and we walk them
13 through all that and say, well, you know, do you want to take
14 the next steps now? No. No. No. I'll get back to you.
15 That's about 90% of the calls. And we have had a significant
16 number of walk-ins to our office, also with the same set of
17 questions. So it's more educational than buying at this point
18 in time.

19 COMMISSIONER URATA: Question: Is the federal exchange
20 part of the shutdown? That's question one. And are we going
21 to talk about some of things, components of the Affordable
22 Care Act in the future, such as, you know, what are we getting
23 in Alaska for bronze, gold, silver, et cetera? Is that part
24 of something we would talk about?

25 COMMISSIONER ERICKSON: Let's let Bret answer your first

1 question and then we'll go to the second question.

2 MR. KOLB: The first question is no; it's not part of the
3 shutdown.

4 COMMISSIONER ERICKSON: And to your second question, we
5 don't necessarily have plans to study that, but perhaps, if
6 that's the one part of the Affordable Care Act that you're
7 interested in, I am sure that we'll spend some time learning
8 about that when we -- assuming that we keep the insurance
9 access learning sessions on our agenda for 2014. Other
10 questions related to insurance? Yes, Allen?

11 COMMISSIONER HIPPLER: I'm sorry; I may have missed this.
12 On slide four, you show weighted average monthly premiums, and
13 you show the lowest cost bronze plan in Alaska is \$385 a
14 month. Is that for a single person or for a family?

15 MR. KOLB: I believe it's a single person.

16 COMMISSIONER ERICKSON: Yes?

17 COMMISSIONER HIPPLER: And maybe it's not an obvious
18 question, but a question I would have is, if a single person
19 were looking at this, that person might decide that this is
20 rather costly. Is it legal in the state of Alaska to sell and
21 buy an insurance plan that does not meet minimum Affordable
22 Care Act guidelines?

23 MR. KOLB: No. It is not.

24 COMMISSIONER HIPPLER: So I could not -- so if I was a
25 single person and I used to have a catastrophic healthcare

1 plan that cost me, you know, \$50 a month or whatever.....

2 COMMISSIONER ERICKSON: There actually is a catastrophic
3 plan option for under 30-year olds and that's not reflected
4 here. One of the things that I could do is share this report
5 with the Commission members from HHS. It's not very long, and
6 it would have a little bit more information that would answer
7 your questions.

8 UNIDENTIFIED MALE: But if you're 31.....

9 COMMISSIONER HIPPLER: So if I was 31 and I was paying a
10 small amount for catastrophic healthcare and then this came
11 out, I would lose my existing plan and have to either not have
12 a plan and purchase this; is that correct?

13 MR. KOLB: That's correct.

14 COMMISSIONER DAVIDSON: And you might be eligible for a
15 subsidy, based upon your income.

16 COMMISSIONER ERICKSON: The numbers that I've provided
17 here don't incorporate the potential subsidies. Again, it's
18 just some summary information and also a few examples, but
19 when I provide that, this other paper for you, it does include
20 some scenarios of with and without subsidies for young,
21 individual folks and families. Other questions about the
22 Exchange before we go to Department of Health and Social
23 Services issues and questions? Josh?

24 MR. APPLEBEE: Good morning. It seems so long ago that I
25 was sitting in this very chair, looking forward to another

1 update. It's so great to be here. I'm very honored that you
2 invite me every meeting to give you an idea of, you know, what
3 I've been up to and kind of the process that we're going
4 through.

5 As many of you know, we're still very much in the
6 deliberative process of developing the recommendations to
7 forward to the Governor in regards to Medicaid expansion.
8 Part of analysis is monetary.

9 Another part of the analysis is looking at how other
10 states are tackling the same problem. Deb mentioned that CMS
11 approved the Arizona Private Option Plan with a couple
12 changes. But one of the things that I do is I look at all the
13 different states and kind of what's happening and not just
14 what governors are doing, but what legislators are doing and
15 how states are moving either towards or away the expansion
16 discussion, and there were a couple states that I wanted to
17 bring you up-to-speed, states that I found interesting.

18 Specifically, there has been a lot of talk about what's
19 been going on in Michigan. Governor Snyder was sent a bill,
20 finally. Once it passed the Senate, it was very contentious.
21 And he signed that bill for expansion on the 16th; however,
22 it's another one of those plans that increased co-pays and
23 other fees and so CMS is looking at it very critically in
24 that, you know, as much flexibility as they'd love to give
25 states, they really don't want to put an undue burden on

1 additional Medicaid recipients.

2 There is also an issue, specifically in Michigan, that
3 they didn't put an immediate effective date on the bill, and
4 certainly, this is something that Wes knows all about. If you
5 don't put an immediate effective date, then the bill won't
6 become effective for 45 to 90 days, depending on the type of
7 bill, after the Governor's signature. So it could be that, in
8 Michigan, even though the Legislature has passed a bill, the
9 Governor signed it -- CMS might even sign off on that plan --
10 they might not even get into the expansion until March, April,
11 maybe even as late as May or June of next year because they
12 didn't put an immediate effective date on the bill.

13 In New Jersey, Governor Christie, of course, signed, back
14 in June, a budget that included the expansion, but he vetoed a
15 piece of legislation that would make the expansion permanent.
16 So he said, I'm okay with the expansion for now, but I won't
17 put it -- you know, I'm going to cut off this permanent
18 because I want to be able to remove this as quickly as I added
19 it, if the federal funding goes away.

20 New Mexico is also running into problems with CMS.
21 They've developed their plan. They've submitted their plan
22 amendment, and they're in constant negotiations with CMS to
23 kind of fit their unique situation into, you know, what CMS
24 will allow them to get away with in terms of a waiver.

25 I know that we talk a lot about Arkansas and the

1 expansion model, but there are several states that are looking
2 at Arkansas and doing their own take on it. Indiana,
3 specifically, is looking at doing a private option plan, like
4 Arkansas, but in this political age of holding things hostage
5 and kind of, you know, trying to get your way by, you know, do
6 this for me and maybe I'll do this for you sort of thing that
7 we read about each and every day, Indiana is doing something
8 interesting. They said, okay, CMS, if you extend our current
9 Medicaid program and all the waivers that are associated with
10 it -- a program they call Healthy Indiana -- then we'll
11 consider and go down the road of Medicaid expansion and those
12 discussions, but we won't do that unless you extend what we
13 have for a year. And so they're kind of in this tug-of-war
14 with CMS over whether or not they're going to get this one-
15 year extension on their current plan before they start talking
16 about Medicaid expansion.

17 Iowa and Tennessee have both submitted plans similar to
18 Arkansas with different twists in terms of how much they want
19 in terms of co-pays and different private option premiums, and
20 CMS is looking at both of those plans and seeing if they can't
21 make those waivers fit or get the state to back off on what
22 they're requiring from the recipients.

23 Pennsylvania submitted their proposal earlier this month,
24 and they're doing a more significant Medicaid program change,
25 but interesting there is that the Governor did it, and he

1 still needs the Legislature to buy off on it. So he kind of
2 has made the change, submitted his waiver plans to CMS, and
3 now he's got to get the votes in the Legislature, and you
4 know, it's really -- it's going to put the Legislature in an
5 interesting position -- and I'm sure Representative Keller
6 knows this, too -- it doesn't like being cornered, you know,
7 into making a decision that it might or may not want to.

8 On the states that aren't currently moving towards the
9 expansion, there are a couple states that I want to talk
10 about. Idaho established a Legislative Health Care Task Force
11 that has been meeting over the summer. They're going to meet
12 again in November to make a recommendation to the Governor.

13 In Maine, the Governor vetoed legislation that passed the
14 Legislature on explaining Medicaid. New Hampshire -- I don't
15 know if many of you have read this, but New Hampshire set up a
16 Commission, a Medicaid Commission made up of members from both
17 bodies of the Legislature and some other stakeholders, and
18 they, earlier this week, voted to recommend expansion, and
19 they're going to submit an official recommendation to the
20 Legislature that they move forward with that, but you know, if
21 you count the votes in the New Hampshire Legislature, it's
22 probably 50/50 right now.

23 I've found, on some states, that there has been
24 grassroots support for ballot initiatives in those states
25 where not only expansion has been declined by the Governor,

1 but even those states where it's been passed.

2 In Arizona, for example, Governor Brewer had actually
3 held hostage and vetoed several budget bills until the
4 Legislature gave her the expansion bill. There is a public
5 initiative process going on to override the Governor on that.

6 In states like Montana -- I don't know if I told you
7 about Montana. So they came up with an expansion bill. It
8 made it all the way through the process, and it got to the
9 Senate, I believe, and one Senator voted wrong by mistake,
10 which put it on the table, and they don't meet again until
11 2015. And so they're working on getting that put on the
12 ballot for 2014 in the November election there.

13 So in looking at these states that are -- where you have
14 adamant opposition by the governor, the grassroots effort to
15 do an initiative kind of reminds me of the Alaska way of doing
16 things. We have a lot of initiatives on the primary ballot
17 coming up next August, I'm sure that you know, ranging from
18 the legalization of marijuana to overturning an oil tax bill.
19 And so we're definitely keeping an eye on those states and
20 those processes of how they go.

21 I think the last one that I would mention is Wisconsin,
22 and I think I made a comment about Wisconsin in our last
23 meeting, but I've done some additional research, and what
24 they're doing in Wisconsin is the Governor -- Governor Walker
25 has decided that he's not going to expand Medicaid, but what

1 several local municipalities are doing is they're meeting with
2 CMS, and they're trying to find a way for those residents
3 within the local municipality, if they can offer sort of an
4 expanded Medicaid type program without the entire state doing
5 it. I see some people kind of shaking their heads. It's an
6 issue of, you know, if it's a state program, can a local
7 municipality administer a program that's supposed to go
8 through the state, and it's going to be an interesting
9 discussion of money flow and local authority versus state
10 authority in conjunction with federal authority. It certainly
11 isn't something that's being looked at in other states. This
12 might be unique to Wisconsin, but it is something that, as
13 they progress and as they have their discussions with CMS,
14 it's certainly something that I'll be very interested in to
15 see how far they get and how the federal government and the
16 state government treat the local governments in terms of, you
17 know, not necessarily sovereignty, but you know, just serving
18 the residents that they've been elected to serve.

19 So as we continue -- as I said before, we're on target to
20 wrap up our deliberation process and deliver our
21 recommendations to the Governor sometime towards the end of
22 this month, beginning of next month, and he, the Governor,
23 should be on target to make his decision and meet his decision
24 point of December 15th in terms of how he's going to proceed.

25 COMMISSIONER DAVIDSON: So you indicated that the

1 Governor hasn't yet weighed in and so -- but just based upon
2 the adjectives and the states that you chose to highlight,
3 there were a lot of states that appear to be having challenges
4 with Medicaid expansion. So can you also share the
5 experiences of the states who have chosen to do Medicaid
6 expansion and are looking at this as a positive opportunity?

7 MR. APPLEBEE: Absolutely, and I think I mentioned
8 several states that see this as a positive opportunity. You
9 know, Michigan and New Jersey, New Mexico, Arizona, they've
10 all made the decision to move forward. They're certainly
11 experiencing some opposition, whether it be in the
12 Legislature, or in the case of Arizona, possible ballot
13 initiatives, but they made the decision, through the political
14 process, to expand Medicaid and to, you know, bring their
15 policies up to, you know, their individual plans to CMS.

16 Iowa, Tennessee, Indiana, for example, are all trying to
17 make, you know, those plans, those private option plans, based
18 off of the Arkansas model, work for the plans in their state.
19 And so how CMS is going to address those issues and how they -
20 - you know, CMS has been very public about saying there is
21 lots of flexibility out there and so it's a matter of, are
22 they going to prove that the flexibility is there, in the case
23 of Arkansas, or are they going to limit the number of people -
24 - the number of states that they're going to allow to do those
25 sort of plans? We're very eager to see how that's going to

1 pan out, but there are a lot of interesting options out there,
2 a lot of state-specific options, you know, some that would be
3 applicable to Alaska, some that have no applicability at all,
4 whether it be with managed Medicaid plans, and so on and so
5 forth. But I think -- I didn't highlight specific states that
6 said no, but I also highlighted those states that said yes
7 that are moving forward through the process.

8 COMMISSIONER DAVIDSON: So how many states have chosen to
9 take on Medicaid expansion, in some form or another?

10 MR. APPLEBEE: The total states -- and this slide here
11 shows the Kaiser Foundation information as of the end of
12 September.

13 COMMISSIONER ERICKSON: So for folks on the phone who
14 don't have webinar access, it's 24 states, plus Washington
15 D.C., plan to expand in 2014, and 26 states, including Alaska,
16 do not plan to expand at this point in time.

17 MR. APPLEBEE: Commissioner Campbell asked if I was
18 having fun. Yes; I am having fun. It's an incredibly complex
19 problem, one that, you know, doesn't provide much sleep, but
20 you know, the best thing about not having much sleep is,
21 sometimes, you end up in a place that you don't intend to be
22 at and then you wake up and then you're there.

23 COMMISSIONER ERICKSON: Other questions for Mr. Kolb and
24 Mr. Applebee, other comments? Hearing none, thank you,
25 gentlemen, both very much.

1 MR. APPLEBEE: Thank you.

2 COMMISSIONER ERICKSON: Well, I think we're ready for
3 next steps.

4 CHAIR HURLBURT: Okay. So the next part in the process
5 will be getting the draft recommendations together, and they
6 will go out for public comment during November. And then we
7 will be back together the second week in December. Is it.....

8 COMMISSIONER ERICKSON: Actually, the first week.

9 CHAIR HURLBURT: The first week?

10 COMMISSIONER ERICKSON: Yeah (affirmative). Friday,
11 December 6th is our next meeting. Yes, Dr. Urata?

12 COMMISSIONER URATA: When will that meeting end, does
13 that end at noon or 4 o'clock?

14 COMMISSIONER ERICKSON: No. Well, it's scheduled for the
15 whole day. We were able to get through everything and adjourn
16 at noon at this last meeting, but you should plan on being
17 there for the whole day.

18 COMMISSIONER URATA: Okay. Yeah (affirmative).

19 COMMISSIONER ERICKSON: It's hard to say. We'll be done
20 when we're done. So I have, up on the screen and you all have
21 in the slides in your notebook, the more specific dates about
22 the process that Ward just went over and our meeting schedule.
23 So that was it. Does anybody have any suggestions for
24 improvement for the process generally and for how the meeting
25 went today?

1 COMMISSIONER HARRELL: I'm a happy guy.

2 COMMISSIONER ERICKSON: A happy guy. More heads nodding.
3 Good. Very good. Any questions about next steps or the
4 process generally or anything that happened the last couple
5 days?

6 COMMISSIONER URATA: (Indiscernible - away from mic)

7 COMMISSIONER ERICKSON: Oh, that's in the Discussion
8 Guide. Dr. Urata asked where is the slide that I have up on
9 the screen. It is behind tab four, and the cover looks like
10 this. It's the Discussion Guide PowerPoint, and it's behind
11 Dr. Guettabi's slides. Any final comments for the good of the
12 order before we adjourn? But then I need to turn it back over
13 to the Chair to adjourn.

14 CHAIR HURLBURT: Thanks, everybody, for being here, and
15 we will see you in December. We're adjourned.

16 11:44:28

17 (Off record)

18 **END OF PROCEEDINGS**

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