

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

ALASKA HEALTH CARE COMMISSION

THURSDAY, JUNE 19, 2014

8:00 A.M.

FRONTIER BUILDING, ROOM 896

3601 "C" STREET

ANCHORAGE, ALASKA

VOLUME 1 OF 2

PAGES 1 THROUGH 242

1 that perspective on that kind of a more singular provider side
2 and prior to that, on the political side of the world with
3 Senator Murkowski, right?

4 UNIDENTIFIED SPEAKER: (Indiscernible - too far from
5 microphone).

6 CHAIR HURLBURT: Okay, now, but bring that kind of
7 background and those are all things that we deal with in all
8 the issues that we have. So maybe, Becky, if you could share
9 some of your hopes and aspirations as what you hope to bring,
10 we welcome you.

11 COMMISSIONER HULTBERG: Well, thank you. I think I've
12 met -- I know most of you. I've been to your meetings for --
13 I mean, it seems like three years, maybe not regularly, but
14 I'm really -- I've been in the audience. So it's really nice
15 to be here at the table and Ward did such a great job
16 introducing me, I'm not sure what else I could add, other than
17 to say that I think that the work that the Commission is doing
18 is important work and you're, you know, ably led by Deb and
19 Ward, who I have a great deal of respect for.

20 Ward, I got to know through working at the Department of
21 Administration and really have a great deal of respect for the
22 wealth of experience he brings on all sides of healthcare
23 issues. So I'm just looking forward to working with all of
24 you and sitting back for now and learning your process and how
25 the Commission operates and then hopefully, can add -- add to

1 the discussion, as well, so thank you.

2 CHAIR HURLBURT: Thank you, and now, we'll go around the
3 table, the Commissioners will introduce ourselves and say who
4 we represent and then those in the audience will do that as
5 well. So Bob, do you want to go next?

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

8 COMMISSIONER CAMPBELL: Keith Campbell, Seward, and I'm
9 the consumer rep on the association.

10 MS. ERICKSON: Deb Erickson, Executive Director of the
11 Commission, and this is Casey (sp).

12 COMMISSIONER ENNIS: Emily Ennis, representing the Alaska
13 Mental Health Trust Authority.

14 COMMISSIONER HIPPLER: Allen with the Alaska Chamber of
15 Commerce.

16 COMMISSIONER STINSON: Larry Stinson, representing
17 medical providers.

18 REPRESENTATIVE KELLER: Wes Keller, I'm a state
19 Representative and liaison to the House.

20 MR. PUCKETT: Jim Puckett, representing the Office of the
21 Governor.

22 SENATOR COGHILL: Senator John Coghill, the Senator rep,
23 Majority Leader and active participant.

24 CHAIR HURLBURT: If we could have the members, starting
25 with.....

1 MS. HUDSON: Laura Hudson with Aetna.

2 MS. TAYLOR: Julie Taylor, CEO Alaska Regional.

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

5 MS. RICCI: Emily Ricci, Health Care Policy Advisor,
6 Office of the Governor.

7 MR. HUMPHREY: Mike Humphrey with The Wilson Agency.

8 MS. MICHAUD: Michele Michaud, Chief Health Official for
9 Division of Retirement and Benefits.

10 MS. PEMBERTON: Jocelyn Pemberton, (indiscernible - too
11 far from microphone) hospital group.

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

14 MR. RAPPLEYE: Curtis Rappleye with Guardian Flight.

15 CHAIR HURLBURT: And why doing you folks at the table,
16 who are very critical to what we do, introduce yourselves, so
17 we know who you are.

18 MADAM COURT REPORTER: I'm Sunny Morrison and I'm the
19 Court Reporter.

20 MR. PRICE: I'm Danny Price. I'm with IMIG Audio/Video.
21 I'm running the sound.

22 CHAIR HURLBURT: And I'm Ward Hurlburt. I'm the Chief
23 Medical Officer of the Department of Health and Social
24 Services and the Chair of the Health Care Commission. By way
25 of introducing this -- the Commonwealth Fund came out with a

1 report this past week and I'll just pass this around and you
2 can set the copies on the end of the table, if anybody else
3 wants that.

4 Jeff, we just finished introducing ourselves and Jeff
5 Davis is here, who represents the health insurance industry
6 and this will be Jeff's swan song as member of the Commission and
7 as he moves onto Wenatchee and undertakes a new opportunity
8 there with a group that I was very impressed with in
9 Washington was the Wenatchee clinic there, but I'd just like
10 to acknowledge Jeff has been with the Commission from the
11 beginning and has represented the health insurance (sic) very
12 well, but clearly, has represented all Alaskans, brought a
13 wealth of knowledge, a wealth of experience and has been a
14 true statesman in all the good meaning of that word. So I
15 don't know, Jeff, if you want to say anything, yeah
16 (affirmative).

17 COMMISSIONER DAVIS: I guess not.

18 UNIDENTIFIED SPEAKER: You can use Becky's (indiscernible
19 - too far from microphone).

20 UNIDENTIFIED SPEAKER: Are we missing one there?

21 UNIDENTIFIED SPEAKER: Yeah (affirmative), the speaker's
22 not working or the mic, rather.

23 UNIDENTIFIED SPEAKER: (Indiscernible - too far from
24 microphone).

25 MADAM COURT REPORTER: Wait a minute, Mr. Campbell, turn

1 yours off and see -- there we go.

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

4 COMMISSIONER DAVIS: Thank you, Dr. Hurlburt, for your
5 kind words. It has been my honor and privilege to be part of
6 this group. I am gratified to say that predictions of at
7 least one of my colleagues that nothing would come of it were
8 wrong and that a lot of good things have come from the work of
9 the Commission, mostly, I think, because of fostering the
10 dialog. That's been very positive and it's with mixed
11 emotions that I leave you, but I'm finding life in the desert
12 is pretty good. So thank you all very much for the chance to
13 serve with you and to be here this next two days. Thank you.

14 CHAIR HURLBURT: Are you still sleeping on the floor?

15 COMMISSIONER DAVIS: No, we actually have a bed now. So
16 that was a big improvement.

17 CHAIR HURLBURT: Jeff and his family have a new home in
18 Wenatchee and they were so eager to get in, they were sleeping
19 on the floor for a while. I think I don't have that, but I
20 think I can speak loudly enough without it.

21 So this document that I just passed around was a graph of
22 the Commonwealth Fund report that just came out and it has
23 come out periodically over the last few years. This shows the
24 overall ranking of the -- they have 11 industrialized
25 countries there, but basically, this shows in their ranking of

1 healthcare and obtaining healthcare, the U.S. ranks last and
2 when you look at what each of these countries spend, the U.S.
3 ranks first.

4 The next most expensive country in this survey was Norway
5 and we spend 50% more in terms of dollars and in terms of our
6 GDP than Norway does. The top ranking country in terms of
7 their overall healthcare ranking was the UK and we spend two-
8 and-a-half times per capita in terms of dollars and in terms
9 of percent of our GDP. So that's -- we've talked about that
10 issue.

11 We've talked about it and we will be talking a lot about
12 the financial aspects, but we've also said that we don't need
13 a UK solution. We don't need a Canadian solution and to
14 emphasize that, I brought in a couple of other articles that
15 just came out and this was from the Forbes online with an
16 article by two folks who are at the Fraser Institute in
17 Canada.

18 So these are two Canadians and we've all been hearing on
19 the TV news and reading in the media about the Veteran's
20 Administration and the problems that have been there and the
21 90-day waits for folks to get appointments and so Senator
22 McCain and Senator Sanders have come up with a \$50 billion a
23 year solution, according to the CBO rating on that, but we're
24 saying, "This is a disaster. This is intolerable," and it is
25 because it's veterans and we all know we owe our veterans a

1 great deal of gratitude and we owe them good medical care, but
2 the 90 days is considered absolutely intolerable and this
3 report from Canada says the average wait for a referral from a
4 primary care physician for services in Canada is four-and-a-
5 half months and then they go through some other things and I
6 think the Canadians are tolerating that probably better than
7 we would as Americans and there are good things about the
8 Canadian system and many good folks who are there, but to me,
9 it just underlines that yes, we have some unsustainable
10 aspects of our current system and yes, it needs to change, but
11 it does need to be an American solution.

12 It does need to be consistent with our culture and with
13 our expectations. So I thought the juxtaposition of those two
14 items in the news was interesting.

15 The other thing, and I want to start something that we
16 would maybe keep it up, I think that I was impressed going
17 through the process with the Legislature this year where the
18 legislative audit function came in and looked at what we have
19 all done and they had some suggestions for us, but basically
20 felt it was being of value to the Legislature, to Alaskans and
21 they didn't address that, but I know, and I think Emily would
22 echo that through the Governor's Office, that it's been of
23 value there and there were some comments, even well, should we
24 just extend it for eight years or for a longer period of time?

25 My own response on that was I think that the three-year

1 extension is good because the legislative audit (ph) process
2 was healthy. It was helpful and I think that the Legislature
3 and the Governor's Office, three years from now again, should
4 ask the question; is this being of value to us? We have lots
5 of counsels, lots of commissions in Alaska and we do want it
6 to be of help, but in going through the process and in -- and
7 with Deb and I -- met with the committees there during the
8 legislative session, it was clear that the members of the
9 Legislature are engaged with this issue.

10 They see the challenge that it is \$2.6 billion in the
11 state's budget for healthcare, something north of eight
12 billion for our state's overall economy now, around 21% of our
13 state's economy. So I think that what we're doing is being
14 seen. It is being heard. It is being seen of value.

15 So as members of this Commission, where I think we're
16 really engaged in a critical issue for our state and for its
17 economy, we need to continue to learn and hopefully, these
18 meetings help, but what Deb and I want to say is that we would
19 encourage you to do some reading and if there are books
20 related to that, we can purchase those for you and I brought
21 six or seven books this time.

22 This is the one, John Torinus, who was up here a year-
23 and-a-half or so ago now, "The Company that Solved Health
24 Care." This was the industrial firm out of Wisconsin that was
25 able to align the interest of their employees and the employer

1 and provide information and transparency in terms of quality
2 of care and in terms of healthcare costs and to actually
3 reduce their healthcare while they improved the healthcare
4 that they were giving.

5 In my own experience, and Lydia and I have -- Lydia
6 Bartholomew, were just meeting before this, my own experience
7 in working with health plans with employers is that often the
8 employer would come to you and say, "How can we provide this
9 benefit that's not really a benefit? Can you make an
10 exception," and I would say, "Well, we have to be consistent,
11 but as the employer, you can do it."

12 Employers generally, my experience is, are very
13 humanistic toward their employees. They want to do the right
14 thing. They want to provide care. They are compassionate
15 when they have needs, but they can't afford it. Like John
16 Torinus found, this was sinking them financially. So that's
17 one.

18 This is from the Institute of Medicine, "The Crossing the
19 Quality Chasm," and this deals with looking at quality. We've
20 talked about a third or more of healthcare not doing good,
21 really, or being of harm and this is improving the quality
22 that we have in our healthcare system.

23 "Tracking Medicine" is the one that I've probably
24 belabored the most, not a quick read, but by John Wennberg
25 from out of the Dartmouth Institute now, but to me, this was

1 really mind-opening that everything that we're doing is really
2 not productive, that there are inexplicable differences
3 between small geographic areas on an evidence basis, but it
4 often has to do with what's there. If you build it, they will
5 come and that's true with our industry and this, as I say,
6 this is not a quick bedtime read, but still one that I think
7 is the best.

8 This one, "The Best Care Possible," was the one we talked
9 about when we talked about end-of-life care and I just -- I
10 didn't bring it in with me. I had a recommendation. I was at
11 the dentist at ANMC yesterday and the dentist recommended
12 another one related to this area, but this is an area that's
13 so important and we don't always handle it well and this talks
14 about end-of-life care there.

15 This is another Institute of Medicine book, "Best Care at
16 the Lowest Cost," on this -- and this is one that I actually
17 have not read all of it yet, but chapter three, "The
18 Imperative: Achieving Greater Value in Healthcare," there's
19 good information in here on value.

20 "Overdiagnosed" is a book by a physician named Gil
21 Welch, who works at the White River VA Hospital and is a part
22 of the Dartmouth Institute there. He's an internist. He
23 actually started his career in Bethel and I knew Gil in the
24 early '80's. He was up here a couple of years ago putting on
25 a seminar at UAA on this and Gil is not a therapeutic

1 nihilist, but he talks about things like all of our
2 mammography, the PSA tests, other kinds of things where we
3 are, in fact, overdiagnosing disease, imposing treatments on
4 people that have morbidity associated, occasionally even
5 mortality with them and that's an interesting book and a
6 fairly quick read and this one also is fairly quick.

7 Atul Gawande is a surgeon at Columbia University in New
8 York City who writes a lot in the lay press. He regularly
9 publishes in "The New Yorker." He's published more than one
10 book, but this was "Better: A Surgeon's Notes on
11 Performance," but dealing with quality and appropriateness
12 issues and in some ways, in my mind, some of Gawande's
13 writings are somewhat the lay equivalent of Wennberg's here.
14 This is the more technical, more thoughtful one and I really,
15 my own bias, is if I had to pick one, I'd push this, but I've
16 pushed it a lot before and this is a quicker read, but gets at
17 some of the same concepts.

18 So I'll have these up here. Feel free to come and look
19 through and if you say, "I will read any or all of them," we
20 will be absolutely delighted to get that for you.

21 So that, I think would end our introduction there. Does
22 anybody have any comments? I'd like to welcome Dave Morgan
23 here and as some of you are aware, and I bet you all aren't
24 aware, Dave now has a new life, not a new wife, a new life and
25 they've retired from -- and I think Dave has maybe the same

1 problem I do, he retired from Southcentral and that didn't
2 last very long and he now is Vice-President with Bristol Bay
3 Area Health Corporation and spending a lot of time out in
4 Dillingham and I know they're absolutely delighted to have him
5 and Dave, if you want to say a few words?

6 COMMISSIONER MORGAN: I'm sorry I'm late, but I'd
7 forgotten, after living in Sand Point for five years, that
8 sometimes PenAir doesn't necessarily take off when they're
9 supposed to take off. So yeah (affirmative), my retirement
10 lasted 67 days and 14 hours, but so actually, I will, by the -
11 - by December, actually be a resident and a voter of
12 Dillingham. So I will -- we were house-hunting last night
13 before I came down, so I apologize for being late, but I'm
14 trying to keep my record of not missing a Commission meeting
15 and so, you know, we even looked at charter if we had to.

16 CHAIR HURLBURT: I got my Alaska voter registration in
17 Dillingham and I have number 122 for the state of Alaska,
18 so.....

19 COMMISSIONER MORGAN: Was that 1964? No, never mind.

20 CHAIR HURLBURT: It was in '61. It was when the state
21 was kind of getting things together after becoming a state and
22 so both my wife and I got really low numbers. Deb, I think
23 we're ready to move on.

24 MS. ERICKSON: Good, okay, well, thanks for your patience
25 with the technical challenges. I think they're working now.

1 Barb, is the teleconference working?

2 UNIDENTIFIED SPEAKER: Yes.

3 MS. ERICKSON: Awesome, thank you. Thank you so much. I
4 -- and I just wanted to mention, a couple of these books that
5 Ward referenced were books that we had bought for all of the
6 Commission members at one point and so I have a few extra
7 copies and at least two of you are new. So we have them here
8 and as Ward suggested, just let me know. I'm just going to
9 put them on the corner here.

10 One book, you didn't have in your pile that we picked up
11 at one point, too, Ward, was one, I believe, Jim, you had
12 recommended, "Zero Trends: Health as a Serious Economic
13 Strategy," and so anyway, we have a small supply here, if you
14 want to pick one up to read tonight, otherwise, just let me
15 know.

16 I'm going to try to do this standing up for a little bit,
17 but we'll see how this works, because we are shifting to a
18 little bit different process now than we've used in the past
19 and we'll, again, we'll see how it works, but I mean kind of
20 following on Ward's comments of, you know, where the
21 Commission is at right now, the perception and the work we're
22 doing, we have in our first three years spent a lot of time in
23 learning mode and we'll never -- we'll never leave that mode,
24 but in these meetings, we've had -- spent a lot of time with
25 presentations and panel discussions and learning from others

1 and so we're trying a little bit of a test this time.

2 We're going to try to switch into spending a little more
3 time in kind of a work session mode, where before and after
4 the learning sessions, you all would spend time, a brief
5 amount of time in work session identifying your take-aways
6 from what you learned and that's how we frame, then, our
7 findings and then sharing your thoughts about what you thought
8 was important in terms of recommending for state policy.

9 We're starting to get into a little more detail than
10 we've been in the past with our recommendations, as well. So
11 we're going to try a little bit more of a work session mode
12 again and see how that goes. We're not going to have anywhere
13 near as many presentations or panel discussions as we've had
14 in the past, at this particular meeting.

15 So to that end, I gave you more homework than I normally
16 gave (sic) you. I don't know if any of you, who have two or
17 three full-time jobs outside of your responsibilities for the
18 Commission, had any time at all to look at any of the material
19 in advance. We'll go slow today and give you a chance to
20 catch up a little bit and maybe take a couple of quick breaks,
21 if we have time and if you feel like you need it, to review
22 some of the material or to think a little bit about what we're
23 doing.

24 So I can operate this, I think I will have to sit down.
25 So we're going to spend the first part of the morning, if I

1 can do this without pulling everything off the table, okay.
2 We're going to spend the first part of the morning -- and
3 Barb, do you want to hand these discussion guides out?

4 UNIDENTIFIED SPEAKER: (Indiscernible - too far from
5 microphone).

6 MS. ERICKSON: I don't blame you. It doesn't matter how
7 much time we spend setting stuff up the day before making sure
8 it works, for some reason, we're jinxed in this room when it
9 comes to technology. Yes, sir.

10 UNIDENTIFIED SPEAKER: Can you put that up a little bit?

11 MS. ERICKSON: I will do that, okay. I will do that.

12 UNIDENTIFIED SPEAKER: Thank you.

13 MS. ERICKSON: You're welcome. So we're going to spend
14 the first half of the morning working on transparency.
15 Really, okay, bear with me for a second so I can see if I can
16 figure out why that's not working, okay. So you're just
17 getting today's handout as a discussion guide and that's what
18 we have up on the screen here and we'll try capturing your
19 thoughts onscreen as much as possible.

20 We might go to a flip-chart at some point, depending on
21 how the process is going, but I wanted to start the discussion
22 today with a reminder of what our current transparency
23 recommendations are and our intent, when we put transparency
24 as a continuing strategy to continue diving into, at the end
25 of last year for this year, our intent wasn't to revisit any

1 of these current recommendations, but to look at getting a
2 little more detailed and identify what additional guidance we
3 might be able to provide in the form of more detailed
4 recommendations for policy leaders, for legislators and
5 commissioners.

6 So I just wanted to remind you of those, point you to
7 them. You have them at your fingertips there in your
8 discussion guide, but the three main recommendations related
9 to transparency, the first is a recommendation that the
10 Legislature and the Department of Health and Social Services
11 support implementation of mechanisms for providing the public
12 with information on prices of healthcare services.

13 I'm not going to read all of them in detail, but the
14 second one is related to establishing a mandate for hospital
15 participation in the Hospital Discharge Database and the third
16 is a recommendation that the state create an All-Payer Claims
17 Database and there are some guiding principles related to
18 that, that were -- that you all included in that
19 recommendation.

20 So this is my thought regarding what we should focus on,
21 part of this came from our discussion at our last meeting in
22 March in Juneau, was that related to that, that first
23 recommendation that we spend some time talking about what
24 additional guidance legislators and the Department might need
25 and what form should that additional guidance take, and the --

1 to the second recommendation, I just want to update you on
2 what's happening related to the Hospital Discharge Database,
3 because directly as a result of your recommendation, there is
4 now regulation in process, but very close to being finalized
5 to -- that requires, not just hospitals, but other health
6 facilities, as well, to submit their hospital -- their
7 discharge data to the state and I'll give you more details on
8 that later. So that one will just be an update.

9 Unless you all think so, I don't think there's additional
10 work for you all to do on that point beyond tracking and
11 providing some accountability then, I think that is, again, as
12 we kind of consider what the Commission's evolving role is,
13 that as recommendations that you've made are implemented,
14 bringing public transparency to the state's work to implement
15 those and some accountability to see if your -- what your
16 intent of those recommendations was and if they're having any
17 effect, if there's some way we can evaluate how the
18 implementation is going as well. Hopefully, we can bring some
19 accountability to those -- to that process. Yes, Keith.

20 COMMISSIONER CAMPBELL: In this process, will we have
21 some way to identify some unintended consequences that go
22 along with implementation of all of this stuff?

23 MS. ERICKSON: I would hope so. I mean, that -- I think
24 that's one of the things we talked about at the very
25 beginning, three or more years ago, was our concern that any

1 recommendations we make might have unintended consequences,
2 could very well have unintended consequences and so I think
3 you all have, I think, done -- my opinion is that you've done
4 a pretty good job of looking in a real balanced way at these
5 issues and considering all of the different perspectives and
6 by nature of us just being a study and advisory group that you
7 all are volunteering for and doing in your spare time in a
8 quarterly meeting, we couldn't thoroughly study every single
9 issue as much as we would have liked and we tried to stay away
10 from recommendations that were more operational in nature and
11 the general nature of these recommendations that, you know,
12 this is what the state should do in terms of policy, but then
13 stopped at the point of trying to direct the state as to how
14 they should do it, again, because we didn't necessarily have
15 the expertise and weren't responsible for understanding what
16 all of the considerations and actually implementing any of
17 these recommendations might be.

18 So that was a real long caveat, but I think it's
19 important to -- just to keep kind of reminding ourselves of
20 what our role is, especially if it's changing a little bit and
21 I feel as though we are kind of moving beyond that again and
22 getting potentially a little more operational if we're going
23 to start getting into more detail on the level of policy that
24 we're -- that we're recommending.

25 So for example, we considered at the last meeting in

1 March, the All-Payer Claims Database question and you all, the
2 folks who were at that meeting, suggested that it really would
3 be helpful at this point, because we were getting so many
4 questions and -- and suggestions of interest from some
5 legislators to provide some guidance in the form of
6 recommendations for what should be included in state
7 legislation related to an All-Payer Claims Database, so -- but
8 the answer to your question is yes.

9 So that's the third thing that we'll do this morning
10 related to transparency is look at the draft paper again on
11 key elements for state legislation to create an All-Payer
12 Claims Database and review that in some detail.

13 One other thing that I want to do, this is just a little
14 more detail, I'm on slide nine, so you understand what we're
15 trying to accomplish this morning and hold me accountable for
16 making sure we're accomplishing it, one other thing I wanted
17 to do, we talked about organizing a stakeholder meeting on the
18 topic of transparency and including providers, consumers and
19 patients, payers, and we're looking at trying to organize that
20 for sometime in the fall, looking at October 1st as a
21 possibility, but we can talk about those details later.

22 That's one of the things I want to do is get direction from
23 you regarding who we should make sure we include and if you
24 have any process suggestions, how -- what's the best way we
25 could go about making sure that we get good representation and

1 a strong voice from consumers and patients in the mix, too.
2 So we'll talk about that this morning.

3 I thought it might be helpful, though, to start off with
4 just a few updates and I'll just go through these quickly.
5 I'm not going to go over any in detail, but I think it's
6 important as we talk about transparency and more detailed
7 recommendations for what's happening in our state and what
8 state government can do to support it, there's a lot going on
9 nationally in other states and -- and pretty rapid
10 developments and so I thought I would just share a few just
11 real recent things that are going on.

12 The Affordable Care Act had included a number of
13 provisions related to transparency and there's a lot of
14 activity just in the past month or two related to, I think,
15 all three kinds of major areas, one specific to hospitals.
16 There was a provision that required all U.S. hospitals to
17 publish essentially their charge master for the public in some
18 form, so what they charge for every service, which I know
19 Dave's smirking because he knows that -- what, those are what,
20 35,000, 40,000 units of pricing, potentially, but that's -- it
21 actually was to have taken effect immediately.

22 CMS just issued proposed regulations for that requirement
23 in early May and I don't even know if all hospitals are aware
24 of it. I understand that it was buried in the middle of
25 hundreds of pages of the 2015 or 2016 payment regulations, but

1 it's there and the proposed rule would require that at least
2 annually, every hospital make public a list of their charges
3 for items and services, including diagnostic related group
4 charges and the rule is to go into effect this October.

5 It doesn't direct how the hospital should make it public
6 and it is charge data only. There's no information related to
7 fee schedules, what they're reimbursed by public programs or
8 what average reimbursements might be from private payers. So
9 for now, that's all it includes.

10 As I go over -- over these, if any of you have some,
11 either thoughts or questions, if you have detailed questions,
12 I probably won't be able to answer them, but can go back and
13 find information for you, but if you have anything to add to
14 this, since you're all -- some of you are actively living in
15 the middle of responding to and dealing with some of these
16 federal regulatory changes on a day-to-day basis, so if you
17 have any comments or thoughts to add, feel free to jump in.

18 CHAIR HURLBURT: I have one.

19 MS. ERICKSON: Sure.

20 CHAIR HURLBURT: Just on the perspective on this, I think
21 we -- we all really believe, I believe we all do, that
22 transparency is a desirable thing. As Deb and I, and we'll
23 talk more about this later, but as Deb, particularly, and Deb
24 and I have met with the HR folks from some of the larger
25 private companies in the state, it's clear that they are

1 hurting and it's clear that they want this information, but
2 this was an article from two weeks ago in the "Dallas Morning
3 News," and the state of Texas has had a transparency
4 requirement since 2007 for the hospitals to post their pricing
5 and basically it has had very little access, about 2% of
6 people will access that and what they've found is that once
7 folks reach their deductible maximum, they don't care and the
8 comment was that generally, when you're admitted to the
9 hospital, you reach your deductible by the time you reach the
10 elevator, but that they have not been able to do what Torinus
11 has done and align the consumers and the employers or the
12 payers there, so that it's somewhat aligned with unexpected
13 consequences with Keith's comment there, that as we do this, I
14 think we want to be thinking one very critical audience is
15 going to be the payers or employers or other payers, but the
16 real solution needs to come as we involve the public and how
17 can we be more successful than Texas has been, for example.

18 COMMISSIONER URATA: So you know, and I think that's why
19 I think it would be important to look at other states'
20 experiences because like in Juneau, I mean, Juneau -- I meant
21 Bartlett could publish all of its charges and stuff, but
22 people still -- they only have one place to go because they're
23 surrounded by water and mountains and there's no road in or
24 out.

25 So the market, you know, plays or -- plays a big role, I

1 think, in all of this. I think it -- maybe it might be more
2 important at the clinic level or doctor provider levels where
3 there is more competition and then where you could conceivably
4 compare prices and go, but you know, whenever you have
5 transparency, I think you've got to have quality connected to
6 it or price transparency, you've got to have quality connected
7 to it, because I think that increases your value or you can
8 determine what the value is, what you're getting for your
9 buck. So it's important to look at the quality measures that
10 you're going to use in this website.

11 MS. ERICKSON: We're going to capture that. That's why I
12 stepped aside because I'm going to get a flip-chart down here
13 while we're going through this and just make sure we're
14 capturing some key points. Yes, Becky.

15 COMMISSIONER HULTBERG: I'm -- have not been at this as
16 long as many of you, so I'll probably ask a series of
17 questions throughout this that you may have all answered and
18 if you have, you can enlighten me at break, but I think to
19 Ward's comment, a key question really is if you -- whatever
20 transparency mechanism that you -- that you invest in, whether
21 it's government investing or whether it's the private sector
22 investing, and I hope we're talking about some of the things
23 happening on the private sector side, as well, and having the
24 conversation about where -- where's the appropriate
25 responsibility, government or private sector, because I think

1 that's an important part of this conversation and I think
2 wherever that investment in a transparency tool comes, if you
3 do not have incentives, consumer incentives aligned, you have
4 just spent a lot of money to create great information that
5 will absolutely not be used and as we look at employers, large
6 employers, and I think we have to include the government as a
7 significant and large employer in this state, are we seeing
8 the movement toward incentives that would be sufficiently
9 aligned that an All-Payer Claims Database or a different
10 transparency law would actually have an impact and I think
11 that's a really key, really fundamental question that has to
12 be answered before we consider some sort of investment,
13 especially any kind of a public investment.

14 MS. ERICKSON: It's going to be important to capture some
15 of those thoughts in parking lot (sic) because it's something
16 that we have additional information about one and also, want
17 to make sure we continue the conversation and a little better
18 (sic) around those points, so thank you.

19 The -- another provision is called the Physician Payment
20 Sunshine Act that has just been -- is just being implemented
21 this year and as the federal government implements it, they've
22 renamed it the Open Payments Program, but it requires
23 manufacturers of drugs and devices and biologics to report any
24 payments or any other sort of perk to physicians and teaching
25 hospitals and the manufacturers (sic) and began submitting

1 their data to the federal government last August and plan to
2 make the database with that information public by the
3 beginning of October of this year.

4 Another area which made my head swim, I don't have a
5 whole lot of detail about this, but if you have questions,
6 it's possible that Jeff could answer some of them, but it's
7 for the transparency provisions related to health insurance
8 and I think it's all intended to make health insurance more
9 understandable to the -- to patients, to the lay public and I
10 couldn't understand the regs about how they're trying to make
11 it more understandable for consumers, so we might need Jeff's
12 help, but there are three main areas and the first was one of
13 the first to take affect, was the uniform summary of coverage,
14 which standardized how plan members are informed of the
15 benefits and standardized that and there are a couple of more
16 provisions that are taking effect more recently, transparency
17 and coverage disclosures and quality reporting for private
18 health insurance and this is all meant, again, to make
19 information more transparent.

20 I think it started off with applying to qualified health
21 plans that would be offering plans on the exchange and -- but
22 is expanding to all insurers and all plans over time and I
23 think there will be more provisions taking effect in 2015, is
24 my understanding. So I don't know, Jeff, if you have anything
25 to add to that or if folks have any questions, but -- and it's

1 all, again, intended to bring more transparency for the
2 public, generally.

3 In addition to those new rules that are taking effect
4 driven by the Affordable Care Act right now, there have been a
5 number of other things the federal government has been doing
6 and some for a number of years and the earlier efforts were
7 really around quality and quality metrics.

8 So for some time, CMS, the Centers for Medicare and
9 Medicaid Services, in the U.S. Department of Health and Human
10 Services has been posting quality data on hospitals on the
11 hospital compare website and more recently have been adding
12 other facilities.

13 I think nursing homes and home health facilities have
14 been on for some time and now, they've added renal dialysis
15 facilities and there are a couple of others, so more and more
16 and it's obviously an intent of the federal government using
17 Medicare data to post quality metrics and make them available
18 to the public.

19 More recently, and this is just based on policy, and
20 there's a more general policy related to federal government
21 data that President Obama issued to his agency heads a year or
22 so ago. I think it's called the Open Government Data
23 Initiative or something to that effect, but it's essentially a
24 policy that is any data held by the government is a public
25 resource and should be made available to the public as a

1 resource, of course with all of the security and privacy
2 issues considered and to that end, one of the things that I
3 think has been debated for many years that now the federal
4 government has started doing is releasing charge and payment
5 data from their Medicare payment data.

6 They started with hospitals for the first time in 2013,
7 about a year ago and have instituted now as an annual event.
8 It was released again, the hospital charge data was released
9 just a couple of weeks ago again, I think and they added this
10 year, I think March or April, a release of physician data.

11 So that information is available. It's posted on the
12 website. It's pretty difficult to understand and digest, if
13 you're not a researcher and don't have expertise in this area.
14 It's (sic) giant Excel spreadsheets that would have most
15 people scratching their heads, but something else the federal
16 government started doing in pretty recent years, I don't know
17 if this was the second or third annual, they call it the
18 Health Data Palooza.

19 They've started a big annual -- holding an annual
20 conference of -- and bringing industry leaders and experts in
21 the area of health analytics, entrepreneurs and venture
22 capitalists and the IT world all together in a giant room to
23 address ultimately how -- how can we all work together to make
24 the best use of all of this data and to make it more useful
25 for the public and so just for example, the Health Data

1 Palooza met at the beginning of June, so just a couple of
2 weeks ago, this year's event, and for this event, one of the
3 things they had done was they held a contest and they
4 announced the winners at the conference, so I don't know,
5 several months ago, announced a contest for venture
6 capitalists, entrepreneurs who are working in the mobile
7 health apps world, specifically to take this charge data that
8 they're releasing and to turn it into a form through some sort
9 of mobile application that will help patients to utilize that
10 data for their healthcare choices.

11 So as they are starting to crank out this data and make
12 it more public, they are also thinking about ways to make it
13 more useful for consumers and so that's something to track to
14 see if they're successful at that on their end.

15 As Becky mentioned a few minutes ago, there's a lot going
16 on in the private sectors world as well, but first, I wanted
17 to mention the number of national organizations and I think
18 most of these are nonprofits, well, not Healthcare Financial
19 Management Association. It's a huge member organization for
20 folks who work in financial management in healthcare and I
21 assume Dave, at least, at the table is a member of HCFMA --
22 HFMA, but.....

23 COMMISSIONER MORGAN: Yeah (affirmative), I've been a
24 member since 1976 and I have the -- when you publish and do
25 stuff, they have a national conference, too, which was a

1 couple of weeks ago and it's a full week and has, I don't
2 know, probably 15 to 25 speakers and programs, one-third of
3 them, you could have taken your, what you just did, and that
4 was one-third of the conference, of how to do those things,
5 but also how to, and I can say this, to bend them around as an
6 advantage for your hospital or your health district or your
7 community health center, too.

8 So I mean, there's been -- whether it's coding, the ICD-9
9 to 10 to 28 or whatever it is this week, we all have to
10 understand that there's also a lot of, just like in the
11 private sector, there's a lot of gamesmanship here and there's
12 a lot of very smart people that as soon as a regulation comes
13 out, just like in tax, are already gaming it and utilizing it
14 to their advantage or to gain market share or to get more
15 business.

16 So I mean, I don't think anybody at this table is not --
17 doesn't understand that, but I felt like I needed to get it on
18 the record.

19 I think it's a really -- it's always been a really good
20 organization, and in fact, in Juneau, I gave out some of their
21 monthly magazines that has these types -- or in fact, I
22 brought this month's, which is on capital formation, which is
23 kind of important to the rural districts, but anybody can
24 join. You just can't vote for President if you're not, of the
25 organization, if you're not actually employed or been in the

1 organization for so many years. Is there anybody else on it,
2 NHFMA? Of course, I'm the only -- never mind.

3 COMMISSIONER STINSON: Deb, another thing that comes up
4 with transparency, yesterday, I had a couple who came in to
5 get something done that they needed to have done for a long
6 time and had cancelled a couple of times and I said, "Why,"
7 and they said, "Well, we had to save up and we had gone to the
8 front desk," and they wanted to know what the total possible
9 cost of what they needed to have done for everything that
10 might be involved, what it was and our front desk person,
11 who's a good person, came up with some number, 9,000-
12 something-dollars and they said, "Wow," you know, and I would
13 say, "Wow," too, and then when they came in, I said, "I just -
14 - that's really hard to believe."

15 So I went with them up to the front desk and found out,
16 no, that's not part of it. No, we're not going to do that
17 part. No, that's not necessary and the cost was under \$900,
18 and we went ahead and took care of them yesterday.

19 So -- so it's a real -- it's never as easy as what it
20 seems and if I wouldn't have walked up to the front desk and
21 clarified what was actually necessary or parts of what they
22 needed, I don't blame them. I would have continually
23 cancelled the appointment, but that's why these things are
24 rarely black and white.

25 MS. ERICKSON: Did that last bullet capture your -- I

1 just wrote, "It's complicated." I'll move that around so you
2 guys can see it a little better. Yeah (affirmative), well,
3 let me continue and then we can continue this conversation
4 around some of these points, because these are really
5 important points and it's -- the sorts of thing -- sort or
6 thing I thought we'd do is have a conversation around those,
7 but I did -- one of your homework assignments was to read the
8 recently released Stakeholder Report, the Transparency
9 Stakeholder Report that HFMA released just in the past month
10 or so.

11 HFMA had organized a group of stakeholders into a task
12 force to address issues related to transparency and to support
13 moving it forward and in addition to releasing this report and
14 principles and guidelines, some of the other things that
15 they've done along these lines that I didn't share with you,
16 but are now available on the web.

17 Recently developed are a consumer guide to understanding
18 healthcare prices that I think, Dave, an accountant or an
19 economist must have written. So I don't know if -- how
20 consumer friendly it is, but it's complicated, right, and they
21 also have -- they're -- it seems like they're starting to put
22 out some more tools for providers.

23 So they have a price transparency checklist for providers
24 now and they also have a document that looks like it still
25 might be a little bit of a work in progress, but it's targeted

1 at providers and it's best practices for communicating
2 financial issues to patients, so I think recognizing the
3 challenges while trying to help patients understand these
4 things are -- they're -- some of these organizations are
5 trying to help with that.

6 Of course, we've looked at and actually had a
7 presentation over webinar, live presentation over webinar, by
8 the Executive Director of Catalyst for Payment Reform. It's a
9 national organization that was a nonprofit that was organized
10 by some major corporations, employers, who wanted some help
11 with moving the transparency and payment reform agenda forward
12 from an employers' perspective.

13 Another organization, another national nonprofit, the
14 Healthcare Cost Institute, was actually organized by a group
15 of insurers and they've started compiling together some of
16 their own claims data and have an initiative to make their
17 information available to the public and are working on tools,
18 as well.

19 So I thought it was important for you all to hear that
20 there's a lot of activity going on, folks, I think,
21 understanding these other organizations and the federal
22 government recognizing some of the challenges and trying to
23 struggle through and figure out how to address those.

24 Just a quick update on other -- other states, very
25 briefly, there are currently 45 states that have some form of

1 transparency requirements and state law and we'll look at just
2 some examples of the different approaches that they take in
3 those laws, but that's just informational.

4 We might have the -- now, I can't remember which of you
5 suggested that we might learn from other states' experiences
6 because Alaska is one of five states that has no laws on the
7 books, but having no law is way better than having a bad law,
8 so it's -- just for our conversation here.

9 Eleven states now have operational All-Payer Claims
10 Databases. I think the most recent one to go live was Oregon
11 and six others are almost live, pretty close in
12 implementation. I had an opportunity to sit in on the All-
13 Payer Claims Database Council. It's a council of states and
14 they have a monthly teleconference where only state
15 representatives are invited to come. There were lots of
16 vendors participating at one point and they're invited
17 quarterly, but just for example, Delaware and Virginia are
18 already collecting their claims data and have plans to go live
19 in terms of public posting.

20 I did not include Washington, California and Wisconsin in
21 that count. They have -- all three had some form of voluntary
22 participation in an All-Payer Claims Database, not a legal
23 mandate for insurers to participate. Washington passed a law
24 this past winter, but it's very limited in terms of the
25 mandate. I don't even know that I would call it a mandate,

1 but.....

2 CHAIR HURLBURT: They -- the law was introduced -- it was
3 for a full All-Payer Claims Database with the information from
4 the payers consistent with the recommendation of FMNA and the
5 document that you have in your booklet there, but in
6 Washington, the health insurance industry and notably, the
7 largest insurer in Washington, Premera, became very
8 politically active and was able to shoot that down in the
9 Legislature there and so what they ended up with was just
10 where the state, as a payer, as I understand it, the state, as
11 a payer, is publishing that data, but they are not collecting
12 it from the Premera or Regence or Aetna or any of the others
13 and I guess the sense was that that's proprietary information
14 and it's historically where we -- if we can negotiate a good
15 contract with a payer, that's important competitive
16 information and we'd rather not have that get out.

17 Sometimes there is a most favored nations clause in a
18 contract negotiation where the hospital or the other provider
19 will agree to provide their best rate to somebody, but it was
20 something and Jeff may have strategically left there, I was
21 going to ask him, now as an ex-Premera employee if he was able
22 to comment on that because overall, you know, I think when I
23 was Washington and here, that Premera has been a very good
24 company there, but they felt very strongly about it and had
25 enough clout that they were able to, I think gut that.

1 The Governor, Governor Inslee, tried to put the best face
2 on it and said, "Well, we really have something now," but to
3 me, it seems very, very limited.

4 MS. ERICKSON: And I had some other comments I was going
5 to add, but I'll wait until we talk about All-Payer Claims
6 Database and one of the other things I just wanted to refer
7 you all to, the All-Payer Claims Database was described in an
8 article and the -- in "USA Today" just a couple of days ago
9 and so -- and they did -- they really did a pretty good job of
10 kind of digesting and explaining what it is from a lay
11 person's perspective, the potential uses and potential value
12 and considerations related to that.

13 So if you all are interested in seeing that article, I
14 can send you a link later or we can even make copies while
15 you're still here. We'll do that. We'll do that. I'm seeing
16 other heads nod. Barb, would you make a note for us to print
17 a copy of that article on a break? Thank you.

18 Then I, you know, I don't have anything real specific,
19 just I wanted to not leave out what other things that are
20 happening in the private sector related to transparency that
21 there are vendors developing their own products to sell to or
22 through insurance companies and other forms to help with the
23 transparency drive.

24 So I thought it would be helpful to -- for a little bit
25 more context to -- to Ward's point earlier, I think a lot of

1 research shows that consumers don't necessarily fully utilize
2 data that is available more publically and whether -- if they
3 do, whether it has any effect or not, I mean, that's one of
4 the questions to consider.

5 This -- this is just a couple -- just a couple of simple
6 data points from a couple of recent surveys. This one from
7 the Commonwealth Fund that 91% of Americans feel that having
8 information about cost before they receive care is important,
9 but another recent survey, this one, I think, was from
10 Deloitte, and who had found similar data on consumer
11 perception of importance and desire to have the information,
12 that 12% of consumers report having used the Internet to find
13 information on provider cost.

14 COMMISSIONER CAMPBELL: You know, I'm reminded by this
15 discussion of several years ago, we were talking about -- in
16 the field, we were talking about a tumor registry in the state
17 and mandatory (sic) and the costs and stuff like that and it
18 was a pretty costly thing for institutions to do, pull all of
19 this data out of medical records, and I was reminded by, I
20 think it was a surgeon here in town, who said, "Well, does it
21 really matter to the patient whether he's being killed by a
22 registered tumor or a non-registered tumor," in relation to
23 the cost of receiving that data and I just -- yeah
24 (affirmative), does it matter to those? Is it worth that
25 particular cost. I think those are the kinds of things we

1 have to weigh when we're talking about these kinds of things.

2 MS. ERICKSON: And I thought for context, though, too, it
3 was -- would -- was helpful to remind those of you who were
4 here and to share with those of you who weren't with us at the
5 time when the Commission established those -- that first set
6 of transparency recommendations and particularly the one that
7 the state Legislature should do something related to
8 transparency for patients.

9 We had -- had testimony over a couple of different
10 meetings from folks and this is just -- a couple of these are
11 paraphrased a little bit, except for that last one, you know,
12 we have had brokers share with us, insurance brokers share
13 with us how hard it is for consumers to make decisions when
14 they don't know what their costs are.

15 We had a woman who works on the financial end in
16 healthcare herself, who called in and shared with us at one
17 point that her daughter had a recent experience with asking
18 her provider what the cost of her visit or her procedure was
19 going to be and having the office call back and cancel her
20 appointment later, essentially fire her as a patient, the
21 patient's perspective, anyway.

22 We had, at one point, a gentleman come who was very
23 frustrated and had done a bunch of his own research, had --
24 this is the last, the very last thing he said to this -- to
25 the Commission was, "Secret pricing does a lot of harm," and

1 he shared the story where he and his wife had insurance
2 coverage. They -- one of the family members was at a doctor's
3 visit and was advised to have an MRI. The MRI was performed
4 in the doctor's facility. It was owned by the physician and
5 when the bill came, the proportion of the cost that the
6 patient was required to bear, after the insurance paid what it
7 would pay, was significant and he was so upset about it that
8 he identified, took a day off from work and identified in a
9 three-mile radius the other providers of MRIs, this was in
10 Anchorage, of course, there were four others in a three-mile
11 radius.

12 He talked about having to threaten to go to the newspaper
13 with one of the offices that refused to share the price
14 information with him and once he had all of the price
15 information, found that he could have, at any of these other
16 four facilities, received for below what the allowable
17 insurance cost was and would have only had the co-pay and as
18 it was, he had, you know, over \$1,000 for that one procedure
19 out of his -- out of pocket.

20 So this is an instance where it's not, you know,
21 something that just -- we might be concerned about uninsured
22 folks having access to information, since insurance is
23 providing the others or as insurance is there -- we -- we have
24 findings related to the importance of price sensitivity and
25 it's not going to matter if we're providing patients with --

1 with this information if they're not feeling the pain directly
2 of bearing part of the cost and this was just an example of a
3 particular situation where somebody with really pretty good
4 insurance had -- was frustrated with the inability to access
5 this information. So that's just for context and for -- yes,
6 yes.

7 COMMISSIONER HULTBERG: You know, I used to deal with
8 this quite a -- these questions quite a bit from a health plan
9 standpoint and I want to make a small clarification and I'm --
10 or give you my perspective. It's not that -- I think part of
11 the problem is not that it's impossible to get the
12 information, because it is possible. It takes a lot of time
13 and it's a pain and I've done it personally, but it's that
14 people don't recognize up front that they need to. So they
15 don't.

16 So they don't realize that they need to get the
17 information until they're on the back end with the bill and so
18 there's a piece of that, that is health plan education related
19 as well, because I don't think it's necessarily that providers
20 are hiding information, as much as they're not really set up,
21 a lot of times, to deliver, you know, to deliver good,
22 accurate quotes, as you shared in your -- in your experience,
23 but also that we -- that the consumers are not taking the time
24 ahead of time to even ask.

25 They're just assuming it's covered and then surprised

1 when it's not and very angry and I've dealt with some of those
2 angry people from a health plan standpoint myself and it's --
3 it's not fun because there's not much at that point, from a
4 health plan standpoint, that you can.

5 COMMISSIONER STINSON: To Becky's point and my previous
6 point, whenever we do come out with some kind of transparency,
7 we need to make sure we say it's either average or
8 uncomplicated, because again, back to the point when they went
9 to our front desk and said, "What is the most this can
10 possibly be?" They got a quote of the most it could possibly
11 be, including things that I would never have done ever and had
12 no applicability to that particular patient.

13 So if you contact, I don't think any provider (sic), and
14 say, "What is the most it can be?" Well, you know, if it's a
15 knee replacement that gets infected and you go to the unit for
16 IV antibiotics, I'm sure you could run up into six figures
17 really, really quickly.

18 So if we put out information, again, along the lines of
19 useable information, we ought to clarify that this is either
20 average or uncomplicated for different procedures. That would
21 make it a little bit more portable across different venues.

22 COMMISSIONER MORGAN: I guess I'm sort of torn both ways.
23 Community Health Centers have always -- you can walk into the
24 front and there's a book or in some cases, on the wall or on
25 their website, their charges for every procedure they do.

1 They're also mandated under their 330 grants to
2 rationalize that to the cost of the actual procedure. They're
3 off by a few percent, depending on volume, because you do them
4 once a year and just for giggles, I looked up one of my old
5 hospitals, more than anything else, to see if some of my
6 colleagues had passed away that had worked there, and
7 Bartholomew County Hospital in Columbus, Indiana, they only --
8 they only had a website that had major procedure prices, but
9 they also had their quality measures from what she was talking
10 about. It was pretty -- I thought it was pretty cool.

11 I think what we -- I hate to get down into the weeds on
12 this, but it's what I do, I think you have to look at the
13 segments of the market, especially in electives. The Alaska
14 health insurance underwriters have their own subset. They
15 know pretty well to get the 15 or 20 electives that are pretty
16 expensive like hip or knee replacements in a non-emergency
17 setting.

18 You know, it's time. You know, you're 85 and yeah
19 (affirmative), I know, I was -- got to visit that, almost
20 visit that myself and so they almost have like their own
21 system comparing what providers do and what the cost of those
22 procedures are and then, centers of excellence in the Lower 48
23 that they may suggest going to.

24 I don't call it tourism because they do -- they don't do
25 that much outside the country. It's mainly Seattle and the

1 Cleveland Clinic. Though, they're starting to get batted
2 around a little bit if you've -- there's an article that they
3 have a little bit of a problem on some of their business
4 practices.

5 So in the same way we have a problem is do they
6 understand what they're looking at and are we presenting it in
7 a way that's a normal, average human being can understand it,
8 but also, we also need to look at whatever this transparency
9 data is, it's in those things where it does matter, those
10 segments of the market that the competition is not just in
11 Juneau, that it's in centers of excellence in the Lower 48 or
12 in Anchorage or wherever and I'm not talking about emergency
13 care and I'm not talking about those kinds of things.

14 I'm talking about the 15 to 35 diagnoses that are, "Well,
15 you know, Dave jumped out of a lot of helicopters, and you
16 know, it's time to look at that knee. Arthritis is coming
17 up," and it's not like you decide to do it Wednesday or have
18 to, if you understand where I'm going with that.

19 So in the same way that we have to look at the impact and
20 the unintended consequences, we may want to look at, also,
21 what -- we don't necessarily have to do it all. We can look
22 at certain segments where it's elective and it can -- it's
23 competitive, just not only inside the state, but also in
24 certain areas in the state, we do have some competitive
25 nature.

1 So how that'll -- how that'll bounce, I don't know, but
2 it's not a simple thing, which everyone said and it's not --
3 and it's a complicated thing, but on the other hand, I've
4 heard -- I have had to talk to and help people who were in the
5 bind you were talking about, Larry or Lawrence.

6 I, on many occasion, just like Becky, had to explain why
7 this is so expensive or why it's not covered or all those
8 areas and especially our friends in behavioral health have a
9 lot of exposure on that end, too. So our first duty is to do
10 no harm, but on the other hand, we all know there is some
11 places we have to go and to help with this, to help the
12 consumers and we're all here to help the people of Alaska, not
13 necessarily community health centers or hospitals, which I
14 think in the years I've been on the Commission, I have not
15 really seen that very much.

16 It's been a very, what's best for all of us concept, not
17 necessarily how is this going to affect my clinic or my
18 hospital. So whatever that's worth, I guess. So that's
19 another aspect is looking at the segments and looking at the
20 areas where competition will help, but where there is some
21 competition and there is some, even for some procedures in
22 Juneau and so one -- one -- one size doesn't fit all, but
23 there is some things we can do in some areas and in some
24 segments that will help.

25 If it will help and has no unintended consequences or

1 does no harm, but it helps contains costs and improve quality,
2 I think that's where we're going to end up here, before this
3 is all over, so.....

4 MR. PUCKETT: In the discussion, something just kind of
5 coalesced for me. I'm probably not as quick as most of you
6 and if this is something that everybody had already thought
7 of, well, forgive me, but there's something else that we need
8 to expand on one of the points that you put on the parking
9 lot.

10 Health plan members, education is important, but from my
11 own experience recently with a medical procedure I had to have
12 done, and what Dr. Stinson shared, it's going to take a large
13 education effort for the employees of the providers and the
14 clinics and the facilities to be able to get that information
15 to the consumer, because I went to a provider and they were
16 doing their best to try to come up with some information for
17 me, because they knew who I was and where I worked and they
18 were -- but they -- and they went through an awful lot of
19 work.

20 I mean, it was -- I could see they were doing the best
21 they could, but it was -- it was hard and then, you know, I --
22 they were doing the best they could and so it's going to take
23 a lot of education for the employees of the health care
24 facilities and the providers and so forth, besides just the
25 members.

1 MS. ERICKSON: Well, then I didn't actually read it, but
2 that communication best practices paper that I referenced,
3 that HFMA put out recently, that's targeted at providers, I
4 think other folks have recognized that and that might -- may
5 be as a starting point for helping with that and then, I don't
6 know how we help Alaskan providers understand and adopt best
7 practices that might come out from the national level. Yeah
8 (affirmative), Jeff -- Jeff and then Becky.

9 COMMISSIONER DAVIS: So just building on your point, Jim,
10 because it's a good point, and in the HFMA article, I'm sure
11 everyone read it, they make the point that it's not just one -
12 - there's not just one mechanism. They say, "You know, for
13 insured people, it should be the health plan, for plan
14 sponsors of, you know, self-insured, it should be the plan
15 sponsor making sure they have things, for uninsured, it needs
16 to be the provider," so it's not just one way and I think
17 that's an important point that Jim made. They've got to
18 surround this issue if we're going to have any kind of
19 meaningful impact that's system-wide and not just focused on
20 one, one entity in the mix.

21 MS. ERICKSON: That, actually, is an excellent segue into
22 talking about the HFMA paper. So Becky, why don't you go,
23 because you had your hand up earlier, but then let's spend a
24 little time talking about what you think you've learned from
25 that and I'll see if I can capture your thoughts.

1 COMMISSIONER HULTBERG: Yeah (affirmative), I was just
2 going to briefly add that probably the biggest incentive for
3 providers is when their patients are calling them, asking them
4 what something costs and how they can get that information.
5 So I think there's a lot we can talk about what the state can
6 do, but ultimately, it's when it's those customers are asking
7 for the information and saying, "Well, if I don't have this
8 information, I may have to, you know, look at other options,"
9 and so I think we need to not -- we need to make sure that as
10 we're, you know, as we're having this discussion, we recognize
11 the power of the -- the power of the consumer in asking the
12 question in changing -- changing the behavior perhaps more
13 powerful than the government saying, "We're going to make you
14 do it."

15 CHAIR HURLBURT: Well, then, so how do we get the
16 consumer to do that? The "Dallas Morning News" said 2%
17 accessed the state of Texas database pie chart that you just
18 showed Deb. It shows 12% have tried to access that
19 information and this article also makes the point that their
20 experience is once the consumer reaches their deductible, by
21 the way we're created, they interpret more as better quality.
22 If it costs more, it's better quality and somebody else is
23 paying for it.

24 So -- so then, that's what John Torinus talked about and
25 I think how do we foster an environment where consumers do

1 what Becky described and I think we have a reasonable response
2 to that on the table that's being looked at and being
3 implemented in some places, namely a high deductible health
4 plan and flexible savings accounts.

5 That's the kind of thing that John Torinus used. That's
6 what's being used in other places and when you have that, then
7 the consumer will do what Becky described. They will ask the
8 -- call -- that will motivate the -- the providers, whether
9 it's a hospital or physician or what, to be able to give that
10 response, but as our current system is structured, I think
11 it's a stretch to get to what Becky described of having the
12 consumers call. Yeah (affirmative), Larry.

13 COMMISSIONER STINSON: Well, Ward, I agree with what you
14 -- what you just said, but I'm going to tell you, the
15 marketplace is changing. The Affordable Care Act is changing
16 it. The deductibles are going sky high on a lot of the plans.
17 We are getting more calls all the time where people want to
18 know how much is this because my deductible is now 15,000,
19 20,000 for my family, whatever.

20 We've heard it and Jeff, I beg -- yeah (affirmative), I
21 don't know what their plans are. I don't ever get into any of
22 that. I just do the doctor thing and we have people who do
23 the paperwork thing, but they are asking now more than ever
24 and it's been since the beginning of the year and I have a
25 feeling after 2015, 2016, it's going to be more and more.

1 So I'm -- I'm actually very much of in favor of the
2 transparency and I do believe the marketplace is going to
3 drive it more and more.

4 REPRESENTATIVE KELLER: Yeah (affirmative), when -- when
5 -- Deb, when you were talking about the MRI thing, I was
6 sitting here thinking, "Now, who, you know, who would be
7 competing for these patients that would come in for an MRI,"
8 and this goes back to kind of what Becky said, "If there's not
9 a consumer incentive to look at the price, you know, then who
10 cares?"

11 Okay, so the question is, really, I mean, who is it that
12 would compete? I mean, obviously, if there's four private
13 entities, providers and they each want a bigger market share
14 of the number of pictures that get taken, you know, who are
15 they, you know, and -- and of course, in my mind, I'm not, you
16 know, in healthcare. I think, it must be the insurance
17 companies, the self-insured, you know, bargaining in these big
18 contracts, you know, and so the whole market force is really
19 out of reach of the consumer.

20 The consumer doesn't care at some level, until it goes
21 over the -- and they have to pay the extra, then all of a
22 sudden, there's a huge motivation. All of that is just a
23 setting to say that I think we ought to look more at
24 concierge, you know, options for doctors and smaller clinics
25 because it seems to me like the competitor for something like

1 an MRI, the more local, actually the smaller it might be, the
2 better the competition that may happen there and remember,
3 Noah, his partner called me and kind of pulled my chain and
4 got me thinking about that one again, so anyway, yeah
5 (affirmative), thanks.

6 MS. ERICKSON: I'm going to put that point in a parking
7 lot for the discussion we're going to have later this morning
8 about insurance marketplace regulation.

9 COMMISSIONER DAVIS: Thank you. I know we've talked
10 about this before, but there's really, really good data that
11 says when you have a high deductible health plan with a
12 flexible spending account, that utilization miraculously drops
13 30%, because 30% is the -- also the portion that we predict is
14 waste or not helpful and when people finally have their
15 wallets engaged, then they do think about the financial
16 consequences up to the point where they've met their out-of-
17 pocket match and then -- then it's a different situation, but
18 that's -- the majority of people don't fall into that
19 situation.

20 CHAIR HURLBURT: So that's a trillion dollars a year.....

21 COMMISSIONER DAVIS: Yes.

22 CHAIR HURLBURT:in the United States every year in
23 savings.

24 COMMISSIONER DAVIS: Yes.

25 COMMISSIONER URATA: Just a question on your point is how

1 many of those with high deductibles don't do the things that
2 are valuable like screening exams because they'd have to pay
3 for it, like for example, a colonoscopy, mammogram, in it's
4 heyday, that kind of thing? So how many -- how many -- how
5 much of this high deductible covered people don't get the
6 screening things that will keep them healthy? That's the
7 unintended consequence of high deductible, perhaps.

8 COMMISSIONER DAVIS: Perhaps, a valid point, Dr. Urata.
9 Studies that -- that Premera has done show that people buying
10 their own plan that's a high deductible plan have utilization
11 that is 30% lower than even a plan provided by the employer
12 and that there's no difference in health status. In fact,
13 even if an employer makes a switch to a high deductible health
14 plan, let's say just hypothetically, you've got a \$500
15 deductible today. You go to a \$2,500 deductible and the
16 employer puts \$2,000 into a flexible spending account,
17 utilization still drops.

18 So it's not a matter of not having the means. It's a
19 matter of now being engaged in the decision. Most high
20 deductible health plans also, and under the Affordable Care
21 Act, preventative services are covered first dollar or 100%.
22 So that is a legitimate concern, but I think that there's been
23 some fences built around that.

24 COMMISSIONER HIPPLER: To Dr. Urata's point, this is -- I
25 know this is anecdotal, but my experience with high deductible

1 health care plans is that most of them actually do encourage
2 physicals and other screenings by covering it more generously
3 than the normal plans. That's my anecdotal experience. I'm
4 not sure how applicable that is to everyone.

5 MS. ERICKSON: Yes, Wes.

6 REPRESENTATIVE KELLER: As long as I succeeded in side-
7 tracking you, you can shut me up, if you like, but -- but I've
8 just been sitting here really thinking about that original
9 document that Ward passed out on the quality of the different
10 health care systems and I just was really curious, you know,
11 are they going -- and went to the -- online quick, and looked
12 at the criteria they use for ranking and it got me thinking
13 about the definitions of access and equity, because one of the
14 bases on which they make this ranking is equity and access and
15 it has to do with what we're talking about, because it's cost-
16 related, you know, and defining what it is.

17 In a free market system, equity, from the perspective of
18 the consumer, isn't even important. It's whether or not I can
19 buy the healthcare and that's why so many people come to the
20 United States of America to buy their healthcare is because
21 they have that option to be able to do it, you know, and I
22 would say that, you know, the way they measured us, you know,
23 I kind of measure it a little different, because I put a lot
24 of value in the freedom of somebody, even to not have a test
25 that might prevent them from getting sick, you know, that --

1 the I'd rather not have, you know, personally, somebody
2 overseeing that for me.

3 I'd like to know what it is and I'd like to have the
4 option, you know, of course of having it, but just -- I guess
5 I was just thinking that you got me really thinking about the
6 definitions that we use of accessibility and how cost relates
7 to that. Thanks.

8 CHAIR HURLBURT: There are some -- I think there are some
9 flaws and if you looked at their methodology, maybe you saw it
10 there, that you could reasonably take exception to, and some
11 of that is based on subjective responses to surveys. However,
12 what is objective compared to those other 10 countries, the
13 average life expectancy is lower in the U.S. than any of the
14 others and the infant mortality rate is higher, so that those
15 are more measurable objective outcomes and is why I felt I
16 didn't impugn my integrity to pass it out, but I think there
17 are some flaws in some of the things they factored in and
18 their methodology.

19 MS. ERICKSON: Wes, to that point, I was looking very
20 recently at the last time there was a study and this is
21 something that we're going to talk about later this afternoon,
22 so I'll try to capture that in a parking lot and help me
23 remember, because what we're going to talk about this
24 afternoon is health coverage and what -- it's on your agenda
25 to learn more about that.

1 What we're doing right now is wrapping up a project to
2 the survey of employers to understand better what employers
3 are doing related to their benefits and that's one of the
4 questions, one of the other things you were addressing, that
5 we're asking employers or have asked and data's going to be
6 presented to you this afternoon.

7 Are they starting to move away from more traditional
8 plans to some of these other new models? So that was one of
9 the things we wanted to understand, in addition to just what
10 are you doing today, but I went back a little bit further.
11 The last time a study was done of insurance coverage in this
12 state was started in 2005 and I think most of the information
13 is about 2007 and one of the things that was done as part of
14 that project was survey of Alaskan households and so I was
15 just looking at some of the data from that and those were the
16 sorts of issues that were coming out in that survey, just
17 asking Alaskans, "What do you think about, you know, your
18 access to insurance? What does it mean to you and what are
19 your considerations," and that was one of the things, I think,
20 that they heard and so I'll bring some of that, maybe bring
21 some of that data this afternoon to share with all of you or
22 what are Alaskans' perspectives on these questions and what
23 they think it means.

24 I also wanted to follow up another thought about the --
25 Dr. Stinson, you made earlier, about how the marketplace is

1 driving with the design of the health plans where 60 or 70% of
2 the actuarial values covered in some of these plans, as folks,
3 patients are faced with having to pick that up, we're starting
4 to hear more and more about that now that it's taken effect
5 this year, but the other thing I heard just a few days ago at
6 a meeting with some larger Alaskan employers was that this --
7 they were asking each other, "Are you starting to move away
8 from traditional health plans," and what's -- one of the
9 things that's on their mind driving that question and they are
10 sharing that drives the move is the new Cadillac tax that is
11 on the horizon.

12 We had heard from Mark Foster at one of our meetings that
13 consideration has already come into negotiations with them,
14 the teachers unions around health benefits, but it's just
15 another thing to keep in mind as -- because one of the things
16 we're always trying to do is understand market dynamics and
17 how those dynamics are changing. They're changing really fast
18 right now and significantly. Yes, Emily.

19 COMMISSIONER ENNIS: As we talk about education and
20 access to the information for consumers to help in making
21 choices or to seek additional information, we can't forget the
22 human element that occurs in a medical event or situation that
23 can complicate this, one other piece that can complicate it,
24 and I think there has to be a relationship with the, both the
25 urgency of the medical situation and the relationship with the

1 physician, with the doctor that an individual has and I think
2 this could be a generational issue, but I do think it's one
3 that we need to identify and include as a component of the
4 education.

5 You take an older individual that has a long-term
6 relationship with their physician, something's recommended,
7 it's probably less likely that patient is going to stop and
8 say, "I need to check the price," whether or not they've met
9 their deductible. They have faith and confidence in their
10 physician and they're going to move forward, regardless of the
11 cost of that MRI or other test or procedure.

12 I think that's been a practice. Again, it's going to be
13 also related to the size of a community where there, again, is
14 perhaps not much competition or choice and again,
15 relationships become very, very important for then sort of the
16 younger age patient, they are more aware of quality.

17 They know the knee surgeon that is known to do the best
18 job or perhaps have the best relationship with their patients
19 and sometimes they're just going to go to that person because
20 they have insurance and they've met their deductible, there's
21 really no effort made in looking at the cost or any other
22 factors.

23 So again, as we move toward the concept of educating the
24 consumer, this is, I feel, a very important aspect of the
25 process.

1 CHAIR HURLBURT: Yeah (affirmative), I think that we need
2 to enable the consumer, then, which is a huge challenge,
3 because we need to enable physicians, but to understand
4 evidence to really know what quality is, because I think the
5 consumer, if you talk to your neighbor or you talk to somebody
6 else, that's not a good judge and so if you're going to have a
7 knee replaced, what are the post-op infection rates? What are
8 the readmission rates? What are the re-do rates? What are
9 the rates of full mobility, and so sometimes the orthopedist
10 that has the best reputation may not really be getting the
11 best results. They may have better P.R. skills and so I think
12 that we all need education on that.

13 In going to the slide up there, Jeff, you know what I'm
14 going to do because I'm going to try to put you on the spot,
15 and when you had your phone call earlier, we were talking
16 about All-Payer Claims Database and how Premera really came
17 out with guns blazing in Washington and the Legislature there
18 and I said, "My supposition was that probably the reason why
19 the biggest payer in the market would do that was because you
20 can offer the most steerage and that the information of the
21 contracted rates would be regarded as proprietary and it's a
22 competitive advantage that you don't want share with your
23 competition in the competitive marketplace, and that may or
24 may not be right," and if you just want to say, "Yes," is
25 fine, but I would really be interested in your perspective of,

1 you know, from Premera's side, why they felt that was so
2 important to so strongly come out against it in Washington.

3 COMMISSIONER DAVIS: I'll try. I wasn't intimately
4 involved with that because it was a Washington effort, but my
5 understanding is there were several, several reasons. One is
6 that in general, our experience, Premera's experience has been
7 that All-Payer Databases provide very little value to
8 consumers or to the health plans or to providers in
9 understanding what the costs are, because ironically, they're
10 not all that transparent.

11 You -- there's a methodology that you can discover a lot
12 about, but not understand completely. So when you look at
13 your numbers together, they don't add up. The other part of
14 it, though, and this was part of the discussion we had with
15 the consultants that were working on behalf of the Commission,
16 is that most health plans of any size have spent a lot of time
17 and effort and resource into developing their own consumer
18 tools that are real-time and vetted by the actuaries and are
19 available to them, so that there's a lot of expense with the
20 All-Payer Database without, again, much return, at least to
21 your own members. Now that doesn't apply across the whole
22 population, which is a limitation to it.

23 So I think those were really the -- kind of the major
24 reasons, along with the one that you just described and which
25 was described in the HFMA paper is that there is a competitive

1 advantage to be gained by having the, you know, the best
2 contracted rates and if you have to disclose that, then one of
3 two things can happen.

4 Anyone who is being paid less than that can demand that
5 or anyone who's being paid -- was paying more of that, then
6 that can demand that -- your rates. So it kind of is -- cuts
7 both ways and it's just not clear where the outcome finally
8 will be and I think those were the reasons that there was an
9 effort to say this is not the way to go.

10 MS. ERICKSON: I think we're going to run out of time
11 here pretty quickly, but we have enough flexibility in our
12 agenda that I think we can come back and revisit some of the
13 bigger points that are being raised that we want to make sure
14 we capture and for those of you, can folks on the phone hear?
15 Were they not able to hear for a while, still not?

16 UNIDENTIFIED SPEAKER: (Indiscernible - too far from
17 microphone). I can hear Ward (indiscernible - too far from
18 microphone).

19 MS. ERICKSON: Well, apparently -- that doesn't make
20 sense, but usually it's just a yes or a no. Well, if anybody
21 -- for anybody who can hear on the phone, I'm taking most of
22 the notes on the flip-chart, rather than on the webinar pages.
23 So it's probably kind of hard to track this.

24 So I think we're going to come back and revisit
25 throughout the day, as we have extra time, transparency

1 questions, but I wanted to take a few minutes, especially for
2 those of you who were faithful in doing your homework to
3 capture your reactions to the HFMA paper, the Transparency
4 Stakeholder Task Force Report. Yes, Jeff.

5 COMMISSIONER DAVIS: Thank you. I thought it was well
6 done and very thoughtful and I appreciated the way they broke
7 it out and just didn't just say, you know, there's one size
8 that fits all, but what -- kind of the lasting impression was
9 reading the conclusion and it's like so -- so we all need to
10 get onboard and do this, but how does that happen?

11 You know, there's a lot of work and hard work involved in
12 this. I recall a conversation that our CEO had with one of
13 our clients in Alaska and who was asking about transparency
14 and he said, "It's really hard work and we're working hard at
15 it," and we've identified a lot of the reasons why today.

16 So the -- I think the paper was a great start in terms of
17 laying out the policy approaches, but where's the impetus, you
18 know, to go forward with that, from all of those different
19 stakeholders? I think that's kind of where we are in this
20 discussion, but it was -- it was well done.

21 COMMISSIONER URATA: I thought after reading it, it's so
22 complicated that we would never get a good, fair product and I
23 was wondering, "Gee, should we really be going down this
24 road?"

25 MS. ERICKSON: Can you clarify that a little bit? I'm

1 not sure what you mean.

2 COMMISSIONER URATA: There's so many people
3 participating, I think, you know, the word gaming comes to
4 mind, especially with quality, it would be hard to -- it's so
5 complicated that, you know, it's hard to make sure that it's
6 accurate and fair to all the stakeholders or all the people
7 involved and it just seems like, you know, it's just not
8 simple and when things are complicated and government gets
9 involved, sometimes, it just gets messed up, so-to-speak.

10 I came away very concerned that we could produce a good
11 product, that we, you know, that we probably wouldn't get a
12 good product.

13 MS. ERICKSON: So what was it about the HFMA paper that,
14 specifically that made you concerned about that?

15 COMMISSIONER URATA: Well, when I read the various
16 recommendations, and you know, when you sit back and kind of
17 look at the thing as a whole, you know, I thought it was very
18 good, very, you know, it seemed to capture a lot of areas, but
19 there's just a lot of areas to deal with, you know. It's
20 complex. You know, you do this, you do that, you do this, you
21 do that, you do this and do that and what was there, 12, 14?

22 MS. ERICKSON: And so specifically, from following the
23 HFMA Task Force recommendations, you think it would be
24 difficult to have a.....

25 COMMISSIONER URATA: Yeah (affirmative), 13

1 recommendations and there's, you know, applies to a very wide
2 variety of programs, you know, private sector, public sector,
3 you know, state, federal payment plans, the non-insured, you
4 know, things of that sort. So I think it can be very complex.

5 MS. ERICKSON: So do you think the approach of
6 identifying different roles of the different stakeholders from
7 the different parts of the industry make it more complicated
8 from the provider and from the individual provider and the
9 patient's perspective, is that what you're suggesting, that
10 there's.....

11 COMMISSIONER URATA: Well, gathering data from various
12 providers, for example, I think would be very complex. How do
13 you determine that what they're saying is the truth, you know?
14 How do you do that, and even this morning, we started talking
15 about, you know, insurance and all their, you know, they have
16 contracts with various clinics or hospitals and so, you know,
17 they're discounting and all that, you know, I think it'd be
18 unfair to expose some of that, but on the other hand, you
19 know, how do yo -- how do you get, you know, what they're
20 paying out from the clinics and then, you know, doctors or
21 clinics could potentially game the system by, you know, on
22 their quality numbers, if quality is going to be demanded, and
23 that sort of thing. So you know, I think it's -- can be very
24 complicated.

25 It's kind of a general thing that I would explain, I

1 haven't really gone into details, you know, but it's just that
2 after reading all the details, it just seems complicated and
3 that's what I'm saying.

4 MR. PUCKETT: I whole-heartedly agree with Dr. Urata.
5 It's a very complicated issue, but the paper did clarify many
6 things for me. It was very helpful. I thought it was well-
7 written and I wasn't concerned so much, as I just felt, wow,
8 what a challenge have we -- we're facing here and so I took a
9 little bit of time and was kind of chewing on the challenge
10 and here's just something that I came up with and I'll just
11 throw it out for the group, and they said in a number of
12 places, I'm going to read one quote, but those that read the
13 paper, you'll recognize it, they said it a number of times in
14 different ways; "It will take a -- it will require a
15 collaborative effort among providers, care purchasers and
16 payers to identify and develop the information and tools that
17 will be the most useful to patients," and I -- I was thinking
18 on that aspect and for the purpose of the Health Care
19 Commission, it identified the drivers that will produce that
20 collaboration.

21 What is it that's out there? It may be a number of
22 things. It may be the marketplace. It may be -- I couldn't
23 come up with any other ones, but there are -- whatever it is
24 that's going to drive people into that collaboration, the
25 different people that they mentioned here that need to be

1 involved in this, that's what we need to work on, as far as
2 the Health Care Commission.

3 We're supposed to have that higher level. If we can
4 figure out what that would be and then make those types of
5 recommendations to produce those drivers and then that -- we
6 have something to work with then.

7 COMMISSIONER URATA: You know, and that seems to me that
8 it's so broad and general that you can't really develop a
9 recommendation for legislation, otherwise, you're giving the
10 Legislature an open -- well, maybe not necessarily open
11 checkbook, but you know, something very broad that's hard to
12 figure out what to do. So that's why I was thinking, maybe we
13 should look at other states and how their transparency laws
14 are made so that we can get something specific and the best of
15 the best, utilizing this, you know, make sure we have all the
16 concepts mentioned in this paper, but I don't know, maybe I'm
17 way off base here.

18 MS. ERICKSON: Yeah (affirmative), Larry and then.....

19 COMMISSIONER STINSON: We are going to have to see what
20 other states did and learn from their errors. When someone
21 asks me, "How much does it cost to do this?" Are you
22 Medicare? Are you Medicaid? Are you Blue Cross? Are you
23 Blue Cross Preferred? Are you Aetna? Do you want to do it at
24 a surgery center? Do you want to do it at a hospital? Which
25 hospital do you want to do it at?

1 I am not trying to be evasive. There are different
2 answers for every single one of those questions. There -- and
3 there's different contracts for every single one of those
4 questions and they'll have different contracts with different
5 providers for every single one of those questions. It is not
6 -- it is a moving target.

7 COMMISSIONER URATA: And then, you can make a deal.

8 COMMISSIONER STINSON: And in the end, what I try to do
9 is minimize everything just to get something done, so.....

10 UNIDENTIFIED SPEAKER: How do you make a law out of that?
11 I don't know.

12 MS. ERICKSON: Dave.

13 COMMISSIONER MORGAN: Yeah (affirmative), there's a
14 saying of my Accounting II teacher, who I think was a
15 Peloponnesian, no, he wasn't a Peloponnesian, my Accounting II
16 teacher said to me, "Gentlemen, you're all concentrating on
17 the answers, but the real important thing is the question,"
18 and I think the question that we just finally got to in the
19 last four minutes is; where is -- what is the problem? Where
20 is a system that we can get access to price or cost or
21 quality, but where will it help and where will it not, and
22 every place that's under the not, just move it out of the way
23 and every place that it will is where we might want to
24 investigate.

25 Yeah (affirmative), I think we need to look at other

1 states. It's not going to be that tough. By this report,
2 only five passed and only one got a B, so -- but I don't --
3 but the definitions were pretty narrow, you know, they had
4 very narrow definitions on that. So we could -- you could
5 even get into the definitions, but generally, when I look at
6 the report and I, hopefully, people can see it online, they
7 put everybody that flunked under red and it was bad. I mean,
8 it even -- and a lot of them had some stuff going on.

9 So yeah (affirmative), we're going to have to be careful
10 and I'm assuming we're not going to -- we're going to contact
11 the ones that at least got a C or something when we do this
12 and was it Vermont, or no, well, it was Massachusetts and
13 Maine that got a B, and there's other solutions in other
14 states, but Albert Einstein won his Nobel Prize for defining
15 and understanding one type of force, magnetism.

16 Then he developed the other parts of the universal
17 equation in his later life, but he knew there was one
18 universal equation to define, I guess you could say, reality
19 or force or power or energy. To get there, killed him. He
20 couldn't get there.

21 So maybe we also have to understand that whatever we do
22 is not going to be perfect. If we can just do some stuff that
23 will help is about -- is if we do that, we've done a lot, I
24 think, without doing any harm and helping some people, but on
25 the other hand, we can't let those obstacles or not getting to

1 the perfect system stop us from at least asking the questions
2 and trying to drive us to get there and I think we all agree
3 to that, but hey, if it was easy, anyone could do it. You
4 know, I mean, if you look at that map, it's really bad, I
5 mean, on what we're trying to get done.

6 HFMA, and I left out another state organization, MGMA,
7 which is a little more centered on the physician offices,
8 HFMA, actually, has developed a certification for staff to do
9 what we're talking about, to help explain and get them to
10 programs and it has a core curriculum and some of that
11 curriculum came right out of that paper to help people
12 navigate getting to the best quality and the best price and
13 I'm sure MGMA's probably working on something.

14 I use their salary surveys in the institutional sense. I
15 know there's some individuals that are here today that are
16 members of that or even been officers. I think it'll be
17 interesting to hear their opinion on this because they
18 basically work with physicians and clinics and clinic offices.

19 So HFMA tends to be more hospital or institutionally-
20 oriented, but MGMA's a little closer to what you're talking
21 about, I think, so.....

22 CHAIR HURLBURT: Getting back to Bob's concerns regarding
23 providers, there are 13 recommendations at the end, but page
24 three in the executive summary summarized them and so the role
25 for health plans is for insured patients obtaining care in

1 network, they would recommend that the primary responsibility
2 be on health plans to help their enrollees understand the
3 pricing and it's -- I don't think it specifically says it, but
4 I would editorialize that they need to help them understand
5 the total pricing, not just the out-of-pocket, but what's this
6 costing and that they should seek to educate and inform their
7 enrollees, who elect to obtain out-of-network care, that they
8 need to find out the cost.

9 For employers who are self-insured, they say they need to
10 provide that same kind of transparency, where the employers
11 are at risk, and then the two roles left for providers are one
12 for uninsured individuals or three roles, the other for out-
13 of-network patients, that there, they have to post prices and
14 so then, that's not different than what we're talking about
15 whether it's a physician's office or a hospital and in the
16 role of a primary care physician, like yourself, they should
17 be able to counsel the patient in the referral process to help
18 them understand that and so to me, that doesn't seem overly
19 cumbersome or overly complex, if this is what they're really
20 talking about. Do you sense it differently than that?

21 COMMISSIONER URATA: Well, so that brings to the question
22 -- so if we do have -- try to pass some simple legislation to
23 deal with this issue, then are the health plans not going to
24 participate like it is in Washington and then, if they don't,
25 then you have a product like Washington, and is that a

1 valuable thing to have, because it sounded like, to me, you
2 felt it was less than ideal, but.....

3 MS. ERICKSON: Can we table the discussion about All-
4 Payer Claims Databases, specifically for later?

5 COMMISSIONER URATA: Yeah (affirmative).

6 MS. ERICKSON: I think that's what you were -- I mean,
7 the reference to whether insurers are going to participate as
8 specific to All-Payer Claims Database.

9 CHAIR HURLBURT: But it is more -- it is more than that
10 and I would say, "I don't know," and I think, actually, I
11 don't know why the state of Alaska couldn't do what the state
12 of Washington does by law now where the state, as a payer, and
13 we're -- the state's a bigger payer here proportionately than
14 they are in Washington, the state could publish their rates
15 for Medicaid, for Worker's Comp, for -- for the Department of
16 Administration, for those individuals. The state could do
17 that without a law, I believe.

18 COMMISSIONER URATA: I guess I'm confused, because I
19 thought you said that because Premera Blue Cross was not
20 participating, and so they weren't giving out that data, the
21 all-payer claims data, that Washington legislation has
22 produced was not valuable. Am I mistaken in your
23 interpretation?

24 CHAIR HURLBURT: No, I don't think you are. I think it's
25 far less valuable and that's why I said, I think Governor

1 Inslee tried to put the best face on it, but -- but they
2 really didn't get the product that they were trying to get
3 because -- because most people are covered by private
4 insurance there and they didn't get that and so they're just
5 getting the state's data. So I think it's a far less valuable
6 product, but you know, on the other hand, sometimes a little
7 knowledge is better than no knowledge at all, I guess. It can
8 be confusing, but it can be a step down the road.

9 MS. ERICKSON: And that's yet to be seen, because that
10 was the law that just passed and it is new policy, so.....

11 COMMISSIONER DAVIS: Well, and I would just add that
12 consistent with the HFMA paper, being able to provide
13 information to your participants in a health plan is a
14 competitive issue for health plans. I mean, they compete on
15 that, whether, you know, it's Aetna or Blue Cross or whomever,
16 compete on the consumer tools. That's a big part of the
17 discussion.

18 So it's, again, market forces are making sure that those
19 capabilities exist with people who have major insurance plans.
20 So it's not like the state has to fill that space. It's
21 already being filled because that's what clients are
22 demanding.

23 So in Washington, the space that wasn't filled was the
24 public payment and now, that will -- that will be filled. So
25 is it ideal? Well, I think for a participant in a health plan

1 knowing their coverage and what it's going to cost them out-
2 of-pocket and what it's going to cost under their plan is the
3 right place and the right source of that information and so
4 it's not an average, it is this is what it will cost Emily,
5 because she's getting the information based on her, not on
6 some hypothetical person.

7 So I -- I think the picture is complete there. It's just
8 a different way of getting to it, but it is -- it is a big
9 deal and every request for proposal that consumer tools,
10 primarily around transparency and medical education are good
11 accessible, understandable and cutting edge.

12 CHAIR HURLBURT: Becky.

13 COMMISSIONER HULTBERG: As I read the paper and thought
14 through some things, I guess, I kind of came up with a series
15 of questions in my own mind, which I think, like I said, many
16 of you might have already answered, but really, it's kind of,
17 it starts with what's the problem we're trying to solve.
18 What's the goal?

19 If we -- what's the goal of transparency? Is it reduced
20 costs? Is it lower trend? Is it educated consumers? Is it
21 information for government, but I think a clear articulation
22 of what the goal is, is important and then who is it that's
23 going to be able to solve -- to solve the problem. Is it --
24 is it going to come from the market? Is it payers? Is it
25 providers? Is it insurers? Is it government?

1 Then, what are the potential solutions that exist and do
2 they work? Do we have evidence that these solutions work
3 other places and do they work at -- would they work on our
4 scale, I think is important as well, because we're pretty
5 small and a solution that works, spread over a population of
6 several million may not be economical here. So I think that
7 issue of scale is important and then ultimately, is whatever
8 we would -- if we're looking at any kind of public law or
9 public investment, what's the cost and ultimately are we going
10 to see a return on that investment in a time when budget
11 resources are pretty constrained?

12 So at least in my mind, those are kind of the questions
13 I've outlined. I don't know that I have answered any of them
14 and I would appreciate anyone who can provide insight on some
15 of these issues and I think this applies to whatever -- to
16 many different kinds of transparency solutions, whether public
17 or private.

18 MS. ERICKSON: We're going to wrap up with Senator
19 Coghill's comment.

20 SENATOR COGHILL: Good. Well, maybe this is not worth
21 it. So -- because geographically, Alaska has some real
22 challenges, it's not price sensitivity that is such a big deal
23 as value sensitivity and that's going to be a big deal because
24 I've got to tell you, I lived in a town where I never looked
25 at the price of milk because I just knew it was going to be

1 high, but I wanted milk, but if it was sour, I wasn't going to
2 buy it and the same thing is true with your healthcare.

3 If you only have so much availability, if it's good,
4 you're going to pay what it takes. If it's not so good,
5 you're going to figure out how to go somewhere else and it's a
6 price of an airplane, it's not the price of the actual
7 healthcare. So it's really trying to look at the value.

8 Anchorage deals with it the same way. Many people are
9 looking at the value of their healthcare here and making
10 decisions to fly to some place else and so the value is more
11 of a sensitivity, in my view, than the actual price and so
12 obviously, those are quality and accessibility, all that.

13 So the price sensitivity is such a smaller part of it, in
14 my view, and we call insurance companies, third-party, but no
15 disrespect, but they're really the first party, because many
16 times, that's what I have to do. I have to ask them what's
17 available to me before I know what I can go do with a doctor
18 and then I can say, "Here's what I can bring to the table,"
19 and if my little bit of cash can't spread the difference, then
20 I'm cancelling my appointment and because of the changing
21 dynamics, everybody is probably more interested than ever
22 before because of the rising costs, but it's still a value
23 question.

24 For example, get into my 60's, am I going to go to a
25 doctor and ask for some of the tests that 60-year-old guy

1 should have? I'm going to make a value call on that. If it's
2 costing me 2,000 bucks, it ain't going to happen, you know.
3 So then -- but if I have five people, that are contemporaries
4 of mine, die and 2,000 bucks all of a sudden doesn't seem such
5 a big deal.

6 So those are some of the value judgments that people have
7 to make and so that's why when I was reading, and I -- I only
8 perused through it, honestly, I did not study this, but I kept
9 hearing price sensitivity and collaboration between the
10 various different parties. Those are the two big things I
11 heard, but I didn't see the value question as much, and to me,
12 as somebody raised in a small town, I just paid the price of
13 whatever was there.

14 If -- if gasoline was at such a price or if I had to go
15 see a nurse and the nurse was not totally qualified, but I
16 trusted her, I was going to let her sew me up. So it was a
17 value judgment and there was sometimes, you moved heaven and
18 earth to get to a hospital and you didn't care what the price
19 was when you go there. The appendicitis thing just had to be
20 dealt with, and you know, so -- and I think -- so David
21 brought a good point and that is how do you stratify that
22 based on geography and value and take some of those things off
23 the table that you just know are not going to be price
24 sensitive questions, if price sensitivity is the final
25 analysis.

1 MS. ERICKSON: Well, it's time for a break. Thank you
2 for those thoughts. I think we can shorten the items that we
3 have on the agenda for after lunch and continue with this
4 conversation. So hold onto your thoughts, we're not done yet
5 with transparency and we will -- what time is it? Yeah
6 (affirmative), well, let's take 15 minutes.

7 10:17:15

8 (Off record)

9 (On record)

10 10:37:37

11 MS. ERICKSON: I don't know if we have anybody online or
12 not, but I have Mr. Monagle on my cell phone and we're going
13 to try patching him through the speaker on my cell phone into
14 the -- into the mic here. The problem that we're having, for
15 whatever it's worth, is -- except former Commissioner Hultberg
16 isn't here, but I can't blame her anymore. Where is the
17 Department of Administration? I'm blaming the Department of
18 Administration and the Governor's Office, no -- no.

19 They just switched the phone lines in this room from
20 analog to digital and the sound system doesn't interface with
21 the digital telephone line, only with analog and they put a
22 patch on it real quickly last night to make sure, because we
23 were testing this. We really do test this stuff in advance.
24 You wouldn't believe it, but they put a patch on it last night
25 and the patch just isn't working, I don't think.

1 So -- so -- for folks in the room are fine. Folks on --
2 trying to listen over the phone are cutting in and -- the
3 sound's cutting in and out for them. So if you can hear me at
4 this particular moment in time, I apologize.

5 UNIDENTIFIED SPEAKER: (Indiscernible - too far from
6 microphone).

7 UNIDENTIFIED SPEAKER: Blame it on the audio guy.

8 UNIDENTIFIED SPEAKER: Sorry.

9 MS. ERICKSON: So what we're going to do next is just
10 kind of a quick review of what happened in the state
11 Legislature over the past couple of years related to health
12 and health care legislation and I have summary that I put
13 together for you. It's online, already on our meeting web
14 page for folks who are online. It's just a simple spreadsheet
15 and it probably is not an exhaustive list of all health and
16 health care legislation that was introduced over the past
17 couple of years, but hopefully, I hit all of the main ones.

18 What I did, was I took a stab at organizing them around
19 the eight-year -- eight core strategies and so that the -- I
20 tried to put some caveats in here. It's just because, I think
21 the subject matter is related in some way to a particular core
22 strategy. It doesn't mean that this is legislation where I've
23 identified it here that it actually is aligned with or
24 implements a recommendation. It's just something that's
25 related to either findings or recommendations that the

1 Commission has released over the past three years.

2 I also had highlighted in green the legislation that
3 passed and any legislation that had not passed by the end of
4 this last session, died in committee, will have to come back
5 again with the new Legislature in January, if folks are
6 interested in resurrecting it.

7 Let me just check in with Mike real quick. We have Mike
8 Monagle on the phone. Mike, can you hear me okay?

9 MR. MONAGLE: I can.

10 MS. ERICKSON: Very good, okay. Well, I'm going to just
11 go over here. I'm going to table, for now, any discussion
12 about the Worker's comp legislation and then we'll turn it
13 over to you to brief folks on the legislation that was
14 introduced this past year and whether and how it -- any of it
15 aligns with the Worker's Comp Board recommendations that
16 require legislative action.

17 So just quickly, and you all received this spreadsheet in
18 your packet this morning. You didn't have it in your notebook
19 yet, but it goes behind Tab 5, once you find it and it's the
20 colorful spreadsheet with the yellow and green on it.

21 So I'm just -- I'm just going to hit some of the
22 highlights. I'm not going to go over all of these in detail,
23 but -- and I put this in pay for value, we don't have any
24 recommendations related to medical malpractice in this state,
25 but the Commission, for those of you who are new, did study it

1 and has a series of findings related to medical malpractice
2 and for want of a better place to put it, I thought value
3 might be a good place to put it, so -- but there was a bill
4 that passed this, this past session, House Bill 250, and if
5 I'm remembering correctly, it essentially allows for providers
6 to make apologies to patients without that being brought into
7 legal proceedings.

8 More directly related, and we're going to talk in more
9 general terms, not about this piece of legislation, but the
10 Commission's findings related to marketplace regulation,
11 generally, and more specifically, the 80th percentile
12 regulation and the assignment of benefits law.

13 House Bill 203, would have, if it passed, addressed
14 reimbursement for health insurance claims and patient
15 assignment of benefits to providers and then there's a whole
16 series around mostly recommendations that you all made to --
17 related to the employers' issues, a couple of bills related to
18 opiates.

19 None of those passed and one of the things that I didn't
20 have a chance to spend time putting in more detail that I
21 would have liked to have shared with you, because it's
22 important, it's a real important piece of policy that's made
23 by the Legislature, is appropriation, how policy is made
24 through appropriation and so there are issues related to the
25 budget for the existing opiate prescription database and I

1 don't know if we need to go into any details around that right
2 now. I think there are leaders in the Executive branch
3 concerned enough about that, that they'll make -- patch funds
4 together and keep it going, but there were concerns about the
5 adequacy of the existing database, since it's not real-time
6 and so some funds were actually stripped while you all had
7 recommended that the state support it, but that's some of the
8 things happening with the budget and with the appropriation
9 process behind the scenes related to -- related to opiate
10 control.

11 If -- and if there's something here that you have a
12 question about, feel free to call it out. There were two
13 different bills introduced, neither of them went anywhere. I
14 don't know that either of them even had a committee hearing
15 directly related to one of your recommendations for end-of-
16 life care and that's the advance health care directives
17 registry. So I'm not sure what the -- why there was a lack of
18 interest in that and something that we'll -- we can talk about
19 at a later date is what may or may not be happening related to
20 other recommendations that would require legislation in this
21 area.

22 For example, the Comfort One Program and the
23 recommendation related to evolving that to be a pulsed (ph)
24 program, but there was no legislation related to that this
25 past couple of years.

1 Related to prevention, probably most notably, the
2 Immunization Program was established in legislation by Senator
3 Giessel and that is directly related to one of the
4 recommendations of the Commission from two or three years ago,
5 related to the importance of immunizations and the need for
6 the state, especially with Senator Stevens leaving the
7 Congress, where he used to provide -- assure us that there was
8 sufficient federal funding for a universal vaccine program in
9 this state. We lost that assurance and thus, those federal
10 funds when we lost Senator Stevens and in order to address the
11 problems that resulted, Senator Giessel was successful, after
12 a pretty tough challenge, with getting this -- this bill
13 passed.

14 I think I'm struggling with how much -- how honest to be
15 about some of the way this process works behind the scene,
16 except Representative Keller, one of the things you said at
17 our last meeting that you're hoping the future Health (sic)
18 Commission could bring more transparency to the legislative
19 process, too, so maybe at some point, we talk honestly about
20 how the influence of industry lobbyists in the capital halls -
21 - but it's a pretty amazing thing to watch, I'm telling you.

22 The -- let's see, so does anybody have any questions? I
23 know there was a lot of interest, I think, just -- there
24 wasn't any -- the Commission doesn't have any recommendations
25 related to tobacco control, not because it's not important,

1 but when we were addressing prevention two or three years ago
2 and the recommendations we do have related to prevention were
3 passed, the group was focused on top priorities and tobacco
4 wasn't as much of a concern, only because there was a lot of
5 progress being made in terms of the outcomes, the curve in
6 terms of health status and Alaskan's use of tobacco was
7 turning and there -- it was pretty well-resourced.

8 So that was the only reason we hadn't addressed it, but
9 there was interest and I think some interest on the part of
10 some of you, as individuals, and the regulation of a smoking
11 bill. So if you have questions about that, we can talk about
12 that a little bit.

13 Then moving onto the -- building the foundation, our last
14 category, which is kind of a catch-all for the system
15 infrastructure issues, workforce development, the health
16 information infrastructure and statewide leadership, there was
17 a bill that passed related to out-of-state physician license
18 that addresses tele-medicine and we do have some general
19 recommendations about tele-medicine regulation and so I
20 highlighted that as yellow.

21 Extending the Health Care Commission, of course, was an
22 important one and I think that's it. I don't remember, did
23 you all have two -- two pages?

24 UNIDENTIFIED SPEAKER: (Indiscernible - too far from
25 microphone) back.

1 MS. ERICKSON: Yeah (affirmative). This is not posted
2 online, just the one that's categorized around or organized
3 around the eight categories of the Commission's core services
4 is the one posted online and printed in the back of the room,
5 but the Commission members, I think -- I also just provided a
6 list of -- maybe I didn't for you all.

7 I have a list of all of those bills just in numeric
8 order, if anybody's interested in seeing that or if you can't
9 find something you think should be on here and want me to
10 check the numeric list, I can do that. So does anybody have
11 any, either questions or comments and then we'll -- about that
12 real quick review or about the legislative process in general
13 and then we can talk with Mike about the Worker's Comp
14 specific bills. Yes, Jeff.

15 COMMISSIONER DAVIS: Deb, can you tell us a little more
16 about the tele-medicine out-of-state physician bill and the
17 gist of it?

18 MS. ERICKSON: Maybe later today.

19 COMMISSIONER DAVIS: Okay.

20 MS. ERICKSON: I need to go back and refresh my memory,
21 sorry, which I could do quickly at lunch.

22 CHAIR HURLBURT: Deb, I might be able to respond to that.
23 The most significant change, I believe, on that related to the
24 licensure is, at least my sense, was that the Alaska State
25 Medical Board, over the years, has been the best one I've been

1 associated with and -- where I've been in other states, and
2 there was a sensitivity to protecting that, but feeling that
3 the stumbling blocks sometimes was the individual interview
4 and so I believe what it was, if somebody's out of state, they
5 will still go through all the checks with the federation of
6 state medical boards, felony checks, with the tort claim
7 checks, with the National Practitioner Databank and so on and
8 the Board will still do all that homework, but at their
9 election, they could bypass the onsite, in-state interview
10 process to streamline it and hopefully, that would protect the
11 kinds of things that our Board has done that I think has
12 really helped and protected Alaskans and yet, make it -- reach
13 the objective of trying to make tele-medicine more available
14 in rural areas.

15 COMMISSIONER DAVIS: Thank you, Dr. Hurlburt.

16 MS. ERICKSON: And I think that might have been a
17 different -- different bill. This one was about the
18 prescription of drugs without physician examination.

19 CHAIR HURLBURT: Okay.

20 MS. ERICKSON: Did -- and did you track that one at all?

21 CHAIR HURLBURT: No. So I guess you have to -- I have to
22 erase all that. Yeah (affirmative), go back to what Deb said,
23 yeah (affirmative).

24 COMMISSIONER DAVIS: It was still good. Thank you.

25 MS. ERICKSON: So yeah (affirmative), I just pulled it up

1 real quickly and we can print a copy of it. It is short, but
2 it's something we probably should look at and track, since it
3 is related to our very general recommendation about
4 legislation around tele-medicine and specifically around
5 provider licensing issues and if -- if anyone has any real
6 concerns about it, too, in the future, what we could do is
7 bring the folks who are working on tele-medicine issues to see
8 if, in their opinion, this helps or hurts and what some of the
9 considerations were, because I know the Department was
10 tracking this and working on it with the sponsor. There were
11 a lot of changes made through the process and several
12 iterations of the bill. Any other questions? Yes, Wes.

13 REPRESENTATIVE KELLER: Just a comment, if there's any
14 questions on this, just talk to John. No, my real comments
15 was thanks for your very good coverage in this table.

16 MS. ERICKSON: Yes, Allen.

17 COMMISSIONER HIPPLER: I found this list very
18 enlightening and helpful. Thank you for compiling it.

19 MS. ERICKSON: You're welcome. Well, Mike, are you still
20 with us?

21 MR. MONAGLE: I am, yes.

22 MS. ERICKSON: Well, can you take a few minutes to share
23 with us what happened with -- related to Worker's Comp
24 legislation?

25 MR. MONAGLE: Sure, I'd be happy to. Good morning,

1 everyone, I -- sorry I couldn't be there with you in person
2 this -- this go-round. Hopefully in the future, I'll be able
3 to attend some of the Committee's meetings. I have been
4 following you with great interest.

5 It was a busy session. We had 11 bills that dealt with
6 Worker's Comp in some fashion or another. Although, there
7 were only four bills that we really got any conviction. The
8 bills that did pass were House Bill 141 that deals with out-
9 of-state treatment and those bills for that treatment and
10 House Bill 316, which authorizes the Department and the
11 Worker's Compensation Board to produce new medical fee
12 schedules.

13 None of the other bills passed that were (indiscernible -
14 interference with speaker-phone) in September of 2013, the
15 Board had passed a resolution calling over a lot of medical
16 changes. Most of them were all (indiscernible - interference
17 with speaker-phone) with the exception of bills dealing with
18 opiates.

19 There were Representative Keller's bill and then several
20 other bills, House Bill 370, House Bill 377, that most of it
21 (indiscernible - interference with speaker-phone) opiates, but
22 those bills did not pass. I expect that they'll come back up
23 at the next session because it's still a very hot topic
24 (indiscernible - interference with speaker-phone), as well as
25 (indiscernible - interference with speaker-phone). Let me

1 just pause and ask is the sound coming over okay, Deb?

2 MS. ERICKSON: Yeah (affirmative), I think we can hear
3 you fine. Folks around the table are nodding their heads.

4 MR. MONAGLE: Okay. For House Bill 141 and House Bill
5 (indiscernible - interference with speaker-phone), the
6 Governor has not yet signed off on those bills, but my
7 understanding is that they may be signed next month. House
8 Bill 141 provides that if you were treated out-of-state, the
9 state where you received that treatment, the fee schedules in
10 that state would govern the maximum allowable reimbursement,
11 rather than the bills for that treatment being subject to the
12 Alaska Worker's Comp fee schedule.

13 The other thing that House Bill 141 did is it put 180
14 days into law that a provider has to submit their bills for
15 payment. Prior to 141, there was nothing in Worker's Comp
16 statute in any type of time limit, so employers often times
17 complained that they were receiving bills that were two years
18 and older.

19 The bill also provides that the -- within 60 days of
20 denial of payment or reduced payment, the provider must submit
21 a claim to dispute that reduction in payment. Otherwise, if
22 they don't do it within 60 days, they're time-barred from
23 having that dispute heard by the Work Comp Board.

24 House Bill 316, tasks the Department, the Medical
25 Services Review Committee and the Alaska Worker's Compensation

1 Board, to come up with new fee schedules, a physician fee
2 schedule based on (indiscernible - interference with speaker-
3 phone) Medicaid/Medicare resource-based relative
4 (indiscernible - interference with speaker-phone) scale, an
5 outpatient fee schedule based on BMS ambulatory payment
6 classification systems and in inpatient fee schedule based on
7 BMS diagnostic related group.

8 They also have to come up with an air ambulance fee
9 schedule, a durable medical equipment fee schedule and a
10 prescription drug fee schedule. The schedules need to be in
11 place by July 1, 2015. I think our goal, as a Department and
12 Board, will be to try to get those schedules out at least
13 three months before that, so that providers and payers have
14 time to code their systems and do the things they need to do
15 to be ready to go as of July 1, 2015.

16 To adopt the fee schedules, the legislation tasks the
17 Worker's Compensation Medical Services Review Committee with
18 the initial job of coming up with the conversion factor for
19 the Board and the Department to consider.

20 The Medical Services Review Committee is a nine-person
21 committee made up of -- four of the positions are medical
22 providers. One seat comes from the State Medical Association.
23 One seat comes from the (indiscernible - interference with
24 speaker-phone) Chiropractic Society. One seat comes from the
25 State Hospital and Nursing Home, and the other seat comes from

1 an at-large medical care provider.

2 There are four non-medical seats. With the language in
3 the law, it doesn't specifically state who those seats are to
4 be filled by, other than they are not to be medical seats.
5 The Committee actually has been in law since 2005, though it
6 hasn't met since 2009. We are actually in the process -- we
7 have confirmed the seats and the person representing the State
8 Medical Association is Dr. Robert (indiscernible -
9 interference with speaker-phone). The Chiropractic Society is
10 represented by Dr. William Pfeifer. The (indiscernible -
11 interference with speaker-phone) Association is represented by
12 Dr. Andrew Mayo. The at-large medical seat is still vacant
13 and the Commissioner of Labor and Workforce Development,
14 Dianne Bloomer, has the authority by law to fill that seat.

15 Of the four non-medical positions, they are filled by
16 Kevin Smith, with the Alaska Municipal League Joint Insurance
17 Association, Pamela Scott from the Alaska Timber Insurance
18 Exchange, Vince Beltrami from the AFL-CIO and Tammi Lindsey
19 from Alaska National Insurance Company.

20 We have scheduled an initial meeting of the Committee for
21 July 7th. It will be in Anchorage at our offices at 3301
22 Eagle Street, the Department of Labor building in midtown.
23 The meeting is a public meeting and at this meeting, we will
24 be setting our goals, our (indiscernible - interference with
25 speaker-phone) for meeting and I'm sure kind of laying out our

1 game plans for getting the conversion factors, getting that
2 process underway.

3 The Legislature did provide some fiscal support for the
4 Department to go out and hire -- contract for professional
5 services. We are in the process of getting that RFP out on
6 the street and that will solicit subject matter expertise and
7 EMS billing schedules, such as the APC, the DRG and the RBRPS,
8 and experience for putting these fee schedules together, which
9 they've done in other states. It's our intent to have that
10 contract in place by the end of the summer.

11 We are also going to have a work group on the Worker's
12 Compensation Board. Last year, we met and took public comment
13 in Fairbanks, Anchorage, Kenai and Juneau. We're looking to
14 do something similar this year and get some feedback on
15 bringing some issues before the Legislature and next year's
16 session.

17 Some of the items we will be probably discussing and
18 looking at, I think align with a lot of the strategies and
19 goals of the Health Care Commission. We will be looking at
20 bill and utilization review treatment guidelines and evidence-
21 based medicine, prescription of opioids and have -- regulate
22 the prescription of opioids.

23 We'll be looking at employer-directed care as it relates
24 to the employer's ability to negotiate network pricing and
25 take advantage of medical tourism. We've been looking at what

1 the state of Washington has done as far as regulation of
2 Worker's Compensations physicians (indiscernible -
3 interference with speaker-phone) of independent medical
4 examiners, IME. We're looking at -- we're exploring the
5 possibility of hiring or contracting for a medical director's
6 position within the department to handle a lot of the health
7 care questions, issues, and also exploring the possibility of
8 having them be an adjudicator and by that, I mean it would be
9 at the first level, a decider over disputes over medical
10 billing, things like modifiers and rules due to medical
11 billing.

12 We'll probably also be looking at some of the presumption
13 analysis under Worker's Comp law and how that relates to
14 preexisting conditions and comorbidity things like obesity and
15 diabetes and cardiopulmonary disease and those kinds of things
16 and how they factor in when somebody gets hurt and the last
17 thing, as far as this group might be concerned with, we are
18 exploring expanding electronic recordkeeping, electronic
19 benefit payments, and electronic medical bill payments would
20 be something that a lot of (indiscernible - interference with
21 speaker-phone) are migrating toward.

22 That, from my perspective, is where we're at. We have a
23 lot of work to do in a short period of time. So when the
24 Medical Services Review Committee starts their work, I expect
25 that we'll probably have to meet at least once or twice a

1 month to try to (indiscernible - interference with speaker-
2 phone) something in place on or before March 1st of next year
3 and with that, Deb, I'll take any questions that
4 (indiscernible - interference with speaker-phone) may have.

5 MS. ERICKSON: Thank you, Mike. Does anybody have any
6 questions for Mike? We're not getting any questions here.
7 We've got -- we have one, Allen.

8 COMMISSIONER HIPPLER: So my understanding is that the
9 various proposals regarding opioids did not go anywhere this
10 year, is that correct?

11 MR. MONAGLE: That's correct.

12 MS. ERICKSON: And just for a reminder and for those in
13 the room who might not know and for our new member, the
14 Commission had four recommendations related to Worker's Comp
15 medical cost containment. They were implementation of
16 evidence-based treatment guidelines restriction of
17 reimbursement for repackaged pharmaceuticals, a restriction of
18 reimbursement for opioid narcotics exceeding a maximum
19 appropriate dosage and revision of the fee for service fee
20 schedule.

21 So the one piece that was passed in legislation this past
22 year was the fee schedule revision and which is significant
23 and sounds like a pretty heavy lift for the Division and that
24 Committee to handle and I think Mike mentioned he expects to
25 see other legislation come back again next year, but yes,

1 Becky.

2 COMMISSIONER HULTBERG: I was just going to add an
3 editorial comment that Worker's -- big Worker's Compensation
4 reform packages are really, really difficult to get through
5 the Legislature because there's just a lot of stakeholders.
6 It's really complex.

7 So it this, you know, this year, there were a couple, the
8 big package was broken down into a couple of small parts. So
9 I think it's important from an employer's standpoint and our -
10 - in our association, we represent -- I mean, we have a lot of
11 large employers, largest -- among the largest private sector
12 employers in the state, but that we not just stop, and you
13 know, that it's not just that the fee schedule has been
14 adjusted, so you know, the issue is resolved because there are
15 all these other things that Mike just mentioned that are also
16 key and you have to be careful when you just tweak, you know,
17 it's good progress, but when you just look at one part without
18 looking at the totality of the system, you can have unintended
19 consequences.

20 So I think it's important to recognize that this was
21 really good, but there's more -- there's more work, probably,
22 that needs to be done.

23 CHAIR HURLBURT: Yeah (affirmative), I was impressed how
24 well this was handled by Representative Olson and by his staff
25 person, who had no background, but really was a quick study

1 and was an expert and they were able to pull off getting both
2 the Chamber and the Teamsters in being supportive of the
3 legislation. I was impressed how well it was done.

4 COMMISSIONER CAMPBELL: Is it assumed that just the one
5 piece that was accomplished this year, that the other pieces
6 will be pushed in succeeding years or do we have to start from
7 square one?

8 CHAIR HURLBURT: Yes and yes (sic). It all starts over
9 again, but.....

10 COMMISSIONER CAMPBELL: Yeah (affirmative), the
11 Legislature, I understand that.

12 CHAIR HURLBURT: Right, but it's my understanding is that
13 Representative Olson is committed to pursuing it again.

14 MS. ERICKSON: Any other questions? Go ahead, Mike.

15 MR. MONAGLE: One of the comments that we've heard
16 repeated over and over during the various testimony in the
17 various committees was that the desire to have some type of
18 comprehensive reform this next session as (indiscernible -
19 interference with speaker-phone) and there were 11 bills
20 dealing with Worker's Comp in some fashion or another.

21 I think that from the Chamber, from other stakeholders
22 that testified, the desire to see more of an omnibus
23 comprehensive piece of legislation that dealt with a lot of
24 these issues in a single bill, instead of having all these
25 (indiscernible - interference with speaker-phone) and so I

1 would expect to see something like that possibly in the next
2 session.

3 MS. ERICKSON: It was kind of interesting to watch that
4 process because some of the statewide organizations were
5 supportive of those policy changes. To hear the testimony, it
6 sounded almost negative because there wasn't -- it hadn't been
7 an omnibus approach and they felt that there had been -- too
8 many important pieces were missing. So that, I'm sure was a
9 challenge for the sponsor to handle, having their supporters
10 testify in a way that came across a little negatively for some
11 of these bills. Yeah (affirmative), go ahead, Becky.

12 COMMISSIONER HULTBERG: Yeah (affirmative), just like
13 maybe a specific in our, you know, our organization supported
14 -- was supportive of the legislation with some recommended
15 changes, but -- but if you just address, as one example, if
16 you address a fee schedule side without addressing
17 utilization, the experience in other states is that
18 utilization just spikes. So you've squeezed the balloon, but
19 have you really addressed the system.

20 So I don't know that will happen. It may not, but it's
21 those kinds of things that I think when you take a look at
22 more of a system's -- you're looking at the whole system that
23 has to be addressed and I think, you know, Representative
24 Olson did a -- I mean, he accomplished a lot in one session
25 and it was a huge lift. So it's not to say that's not a bad

1 approach, it's just you can't -- if you're going to take these
2 bite by bite, you can't just stop. You've got to keep moving
3 on all -- on the other pieces as well.

4 MS. ERICKSON: And I actually had invited Representative
5 Olson to come answer some questions and he could have probably
6 shared more about the follow-up, but he did testify publically
7 that it was his intent to bring the other pieces forward next
8 year. So if we have an opportunity to chat with him at some
9 point, we will.

10 We -- I think one other thing I might mention though,
11 too, is that Dr. Hurlburt was invited to testify specifically
12 to how these bills were aligned with Commission
13 recommendations and so he had an opportunity on behalf of the
14 Commission to testify on some of these bills a number of
15 times. I think it was valuable to have that opportunity to
16 bring that perspective, our perspective, this group's
17 perspective and he had -- yes, Dr. Urata.

18 COMMISSIONER URATA: Is there anything else the
19 Commission should do for next year, other than make ourselves
20 available to -- in support of the rest?

21 MS. ERICKSON: I think we'll for sure be tracking the
22 bills when they start being introduced some time, close before
23 the beginning of the session.

24 SENATOR COGHILL: So I can talk to that a little bit.
25 December is when you have your first drafting round brought

1 out under pre-files and then in late January, you have the
2 second round. So before the session starts, generally, you'll
3 have a good idea if there's something that has been researched
4 through the interim and going to be brought out and my
5 expectation is you'll see some of these things.

6 Representative Olson is a part of the National Conference
7 of Insurance Legislators and he gets to look broadly at what
8 other states have done, best practices and so he's been able
9 to bring that expertise back into Alaska and I think that's
10 where the opiate issue came up on, on the issue that he
11 brought forward and the question was, how does that translate
12 into Alaska, and maybe that's why it didn't pass. I don't
13 know, but we might not have been able to get good information
14 coming back in to answer the questions for that bill. He may
15 very well be working on those very issues this year.

16 REPRESENTATIVE KELLER: Briefly, on the opiate thing, the
17 hurdle was largely the cost of maintaining and utilizing the
18 database system and who, you know, who has to report, who has
19 to maintain it, whatever, and we just couldn't pull it all
20 together and say, okay, that belong -- that becomes a
21 responsibility of the pharmacist, for example. They'd love
22 that, you know.

23 You know, so that was the hurdle and I think we'll be
24 able to address it successfully in the future. The money came
25 for the database that is there through the stimulus package

1 and there's a revulsion in just backfilling the money that is
2 there on the, you know, that was brought into the system on
3 the stimulus. So that was a prejudice we had to work past and
4 it didn't make it, so.....

5 MS. ERICKSON: Yeah (affirmative), well, and I think
6 that's what the Commission recognized was that federal money
7 was going away and thought it was important to the state.....

8 CHAIR HURLBURT: There is.....

9 MS. ERICKSON:provide that support.

10 CHAIR HURLBURT: Yeah (affirmative), there's increasing
11 federal attention again. I don't know whether it will result
12 in more money, but there's a conference later this month
13 jointly sponsored by CDC and the White House Office of Drug
14 Policy looking at the issues related to prescription drug
15 management bases, because I think those federal agencies are
16 becoming increasingly concerned where it's causing so many
17 deaths and morbidity and so on.

18 A week from tomorrow, I'll be meeting in Seattle with my
19 counterparts from the other northwest states, as well as our
20 counterpart from British Columbia, and that's one of the
21 things on our agenda is to kind of update and talk.
22 Washington has been a number of years ahead of us and I think
23 they've been able to do some good things with their
24 prescription drug management program, but we're all going to
25 be updating each other on that topic.

1 COMMISSIONER MORGAN: So is the program that we had when
2 we met to discuss this before, is it basically gone or has the
3 state kind of cobbled it together and keeping it going, is
4 that what's going on, but it's -- we -- the problem of not
5 being updated at midnight or within a day or two has not been
6 fixed. It's still kind of stale or slow.

7 MS. ERICKSON: Correct.

8 CHAIR HURLBURT: And there's some other issues with that,
9 but the program is still there, but for example, Chad Hope,
10 the Chief Pharmacist with the Medicaid Program does not -- is
11 not allowed access to that information and he's a pretty
12 critical player in dealing with that with Medicaid enrollees,
13 for example, who develop problems taking drug -- prescription
14 drug medications and it's a high risk population, so that we
15 have what we have and it's absolutely way better than not
16 having anything, but we can do better. Part of it would take
17 a little more funding, but part of it is how it's structured.

18 COMMISSIONER MORGAN: I've got to ask this question and
19 probably everybody in this room's at, why would the Chief
20 Pharmacists for Medicaid not have access to the database when
21 we have a whole unit in Medicaid, which we heard from in
22 Juneau, to help track down abuse and fraud of the Medicaid
23 Program. I -- that's -- that's not -- I can't square that out
24 in my mind, what.....

25 CHAIR HURLBURT: Ours is -- that's the reason why I don't

1 -- I don't know. I'm not sure. I was very surprised and
2 clearly, he gets the information from the Medicaid Program and
3 can pick up on some things and he deals with them and I know
4 he and Larry have worked together at times to address problems
5 and issues, but I was kind of -- kind of astounded like you
6 were when I first heard that. So I repeated it.

7 MS. ERICKSON: Any more questions or comments related to
8 legislation? Yes, Allen.

9 COMMISSIONER HIPPLER: I would like to confirm at this
10 time, there's been no -- there's been no activity on the back-
11 end for opiates, as far as the state will only reimburse up to
12 a certain level of dosage, which wouldn't necessarily require
13 verification up front with the pharmacy, it would just happen
14 on the back-end. There's been no activity on that.

15 UNIDENTIFIED SPEAKER: (Indiscernible - too far from
16 microphone).

17 CHAIR HURLBURT: Yeah (affirmative), I know -- not that
18 I'm aware of, Allen.

19 MS. ERICKSON: And we could ask Margaret that question
20 when she's with us tomorrow. Okay, well, I think we are ready
21 to move on. So Mike, thank you very much for your time and
22 for putting up with our technical challenges.

23 MR. MONAGLE: No problem. Thank you for the opportunity,
24 bye.

25 MS. ERICKSON: Okay, take care, bye. Well, I want to go

1 back and continue the conversation we were having about
2 transparency and I am going to suggest we table the discussion
3 about insurance market reform with the question about
4 concierge and boutique practices on the list now.

5 The question I had had for all of your related to that,
6 and I'd hoped that Lauri, the Division of Insurance Director,
7 could join us, but she was out of town today and tomorrow, for
8 this conversation (sic) -- is we're getting more and more
9 questions about the findings.

10 There was one piece of -- related to insurance market
11 issues and how that serves as a cost driver and there was one
12 bill introduced this past year. I would expect some potential
13 activity, both behind the scenes with the Division of
14 Insurance and conversations with them. I know it's taking
15 place also on that third question of concierge medical
16 services and changes that would need to be made to insurance
17 law.

18 So the question for all of you was, do we continue that
19 conversation publically in this forum and do you all want to
20 work on specific recommendations related to insurance market
21 reform? It's not on our agenda for this year, but is it a
22 conversation you want to start or not? So just keep that in
23 mind, since we don't have time, really, to work on it right
24 now, maybe we'll come back later this afternoon if we do have
25 time or address it tomorrow afternoon if we have time and we

1 don't need to answer that question at this meeting either.
2 It's, do you want to continue that conversation at all, I
3 guess would be part of it or do you want to just watch what
4 happens?

5 So -- so let's take the last half hour we have before
6 lunch and go back to our transparency discussion. Does that
7 sound good? I'm sorry we had to interrupt it and I'm going to
8 see if I can get my screen back here, but I think we had
9 enough of a conversation about the feedback on that particular
10 report and we might revisit in a little bit -- because one of
11 my questions for you ultimately about that report was not
12 just, did you find it useful as an educational opportunity and
13 I think my sense was you did, but it was also about the
14 process that was used with this national group for convening a
15 group of stakeholders and a task force and to address in some
16 way transparency recommendations in some form without going as
17 far as being really dictating, but providing a set of
18 principles and guidelines. So keep that in mind for a
19 discussion about a stakeholder forum.

20 We'll get our -- and Barb, I don't know if -- am I on the
21 webinar?

22 UNIDENTIFIED SPEAKER: No, you need to dial back into it
23 (indiscernible - too far from microphone).

24 MS. ERICKSON: This says I am connected to it. I don't
25 know if it's true.

1 UNIDENTIFIED SPEAKER: (Indiscernible - too far from
2 microphone).

3 MS. ERICKSON: Do you think we've got it back? Do you
4 want to give me the screen back? Okay. You know what I'm
5 going to do in the interest of time, I'm going to skip ahead
6 to one point and then backtrack. One of the things I wanted
7 to do was to update you on the status of your recommendation
8 and the implementation of your recommendation related to
9 hospital discharge database and before I do that, I just want
10 to acknowledge, again, we have in our past conversations,
11 while we've been having these conversations about transparency
12 over the past couple of years, the one part of the provider
13 industry here in Alaska that has voluntarily been working to
14 provide data and make information more transparent are the
15 hospitals and for those of you who are new, the Commission
16 ended up passing a recommendation that the state mandate
17 participation in the hospital discharge database because there
18 wasn't full participation in the voluntary system and it had
19 gotten to the point to make sure that there was some integrity
20 in that database that the state really did need to require it.

21 So one of the things that we debated at the time was
22 should it be just for hospitals or in other states, additional
23 health facilities are included. In the end, the Commission's
24 recommendation was moot on that point. It just indicated a
25 need for a mandate and so as the Department worked to

1 implement the regulations, it's gone through two public review
2 processes.

3 Based on the first public review -- decided to add,
4 essentially, all of the CON facilities. There are, I think, a
5 couple that are exempted from that, but determined from the
6 Department side that the data, to the extent they were using
7 the data to make policy decisions, they needed a more complete
8 picture of services from facilities and the comments received
9 from the industry was that it felt more fair.

10 I'm generalizing a lot, but that it felt more fair that
11 all facilities that were providing similar or related
12 facility-based services should be reporting. So the
13 regulations were released for the second time in March.
14 Public comment is closed right now and it's just going through
15 the final legal review.

16 I would expect those regulations will be final relatively
17 soon, but in the meantime, just this week, the Division of
18 Public Health started holding provider meetings, educational
19 sessions and so they held their first one on Tuesday and I
20 hear that it went well, that it was well-attended and there
21 was good conversation and they have the next one next week and
22 so they're moving forward.

23 While it still isn't -- the mandate isn't official at
24 this point, it's still -- they're reminding providers that
25 it's still -- the system's still in place and that they can

1 participate now voluntarily and that with the mandate coming
2 online soon, there's a lot more provider education, especially
3 for the -- I imagine all those new providers, the ambulatory
4 surgical centers and imaging centers and some of the others.
5 Yes, Dr. Urata.

6 COMMISSIONER URATA: Question, so if a clinic has an MRI
7 machine, are they part of the CON -- if they were required to
8 have a CON to get their MRI machine?

9 MS. ERICKSON: No, actually, that's one of the facility
10 types that is exempted. I have the regulation in my box over
11 here. I could pull it out if you want to look at it, but
12 physician clinics are exempted. So I can get -- I can get you
13 the exact legal language.

14 COMMISSIONER URATA: I'll probably hear from the
15 physicians if they were involved or if they're not exempted.

16 MS. ERICKSON: Any other questions about that or
17 comments? Becky, I don't know if you've been involved with
18 that at all or if other staff at ASHNHA has been.

19 COMMISSIONER HULTBERG: Yeah (affirmative), we've been
20 pretty involved because, as many of you may know, the
21 hospitals managed this data set prior to the state assuming it
22 and we're actually supportive for the reasons you articulated
23 of the state process.

24 I think the regulations were pretty -- pretty brief and
25 so I think there's a body of work that still really needs to

1 be done that the Department's working on, to really turn, you
2 know, you go from statute to regulation to policy. So I think
3 we're at the reg stage and next will be what the policies look
4 like that actually implement the system and those, I think,
5 are in process.

6 So yeah (affirmative), we've been involved in talking to
7 the department about how they manage it and my understanding
8 is it's going to probably be managed much as it has been in
9 the past through the vendor that currently is doing the work.
10 So from our standpoint, I don't know that a lot will change,
11 but we'll see what the policies look like and make that.....

12 MS. ERICKSON: Yeah (affirmative), and -- I mean, it's --
13 this is probably an important role, as we were discussing
14 after Keith's question this morning that the Commission
15 continue playing, is tracking how this is being implemented
16 and see what, if any unintended consequences, and if it's
17 having the effect, because one of the things that happened
18 when the Department and the hospital industry shook hands 12
19 years ago now or so on the voluntary approach, as opposed to
20 the mandated approach, to set up this database, I think one of
21 the negative consequences of that approach was that there
22 wasn't any -- nobody paid any attention to it after that and
23 there was no appropriation that came along with a more
24 structured approach and so the data was never used, as far as
25 I'm concerned.

1 It's possible that individual hospitals were using it,
2 but the Department never built the capacity and focused on
3 turning that data into information that policy-makers and the
4 public would find useful, I think, and so I think it's on the
5 Department, and Commissioner Streur walked in just in time,
6 it's on the Department to see that going forward, while there
7 isn't this time through regulation (sic), there still isn't a
8 special appropriation to support it. I think there's a lot --
9 there will be a lot more attention and I know the Department's
10 committed to making that database a useful tool, so -- but we
11 can track that and we can track some of the other issues that
12 providers might be concerned about and how advisory committees
13 get formed to oversee the process, I think is one of them,
14 too. So any other questions about the -- it's going to take
15 me a while to get used to the new name, Alaska Health
16 Facilities Reporting Program. Yes, Representative Keller.

17 REPRESENTATIVE KELLER: Can you just very briefly give me
18 some kind of idea why a CON facility would be exempted? I'm
19 just trying to understand, as you say most, and I was
20 wondering why not all?

21 MS. ERICKSON: Well, yeah (affirmative), I think those
22 physician clinics would have been -- I'm assuming, and we can
23 ask Commissioner Streur either now or when he's formally --
24 he's shaking -- he's going, don't ask me now, but he'll be --
25 but he'll come sit with you tomorrow afternoon and you can ask

1 him any question you want. He may or may not answer it, but I
2 think, you know, one of the things that as we get deeper into
3 making more detailed recommendations, generally, to the
4 Governor and the Legislature and commissioners, it's one of
5 the balances that I know they're always having to strike is
6 what is -- what's the bang for the buck, as Becky was saying
7 earlier, what's the return on investment from the whole system
8 perspective and where's -- where -- are we striking the right
9 balance between where government is regulating the burden on
10 those being regulated and the community good, the community
11 benefit, so not just a money question and so I assume the
12 Commissioner decided to exempt some of these other facilities,
13 maybe in part because they don't come into play in Certificate
14 of Need considerations as often and also looking at the burden
15 on those provider types. I don't know for sure though. So
16 you can ask him that question tomorrow afternoon or in the
17 hall.

18 Any other questions about that specifically? You know,
19 I'm thinking -- I'm just looking -- getting a feel of the
20 room, folks look kind of tired and we were going to reconvene
21 at 12:30, and lunch came early. Why don't we break early for
22 lunch and take a full, almost hour for lunch, rather than half
23 an hour, and then maybe, hopefully, folks won't be so tired
24 then when we come back. We'll have -- we'll reconvene at
25 12:30. Does that sound okay to all of you? I'm seeing

1 smiles. I assume -- and seeing nodding heads, because we've
2 done a lot of -- a lot of thinking and good conversation this
3 morning. So let's take a break, take lunch early. Is that
4 okay? I should ask the Chair first. Is that okay with the
5 Chair.

6 CHAIR HURLBURT: Yeah (affirmative), let's do that and
7 maybe just to set the normal request, there should be plenty
8 of lunch for everybody in the room, but the request would be
9 that that members of the Commission get their lunch first, so
10 that they can get that done, any phone calls and other things
11 and then back here.

12 I have the sign-in sheet where two of the folks in the
13 group here listening in have signed up to testify. If others
14 of you, something came up in the last few minutes or if you
15 want to sign in, that would be fine. For those of you online,
16 after we have the folks here have their comments, we'll open
17 it up to folks online at 12:30 when we come back together. So
18 with that, we'll adjourn until after lunch. Thank you.

19 11:36:26

20 (Off record)

21 (On record)

22 12:35:59

23 CHAIR HURLBURT: We'll have the testimony of folks here
24 in the room who want to testify and then open it up to you all
25 online. The one person that didn't get to introduce

1 themselves this morning, I will introduce, and I think now is
2 the more appropriate time. Barb Hendricks is the one that
3 keeps Deb going and keeps us all going and she is responsible
4 for that great lunch, so thank you, Barb, for that and for all
5 that you do.

6 The -- we have two folks here in the room, Verne Boerner,
7 representing Alaska Native Health Board, if you could come up
8 to the table and then just press the gray button there and
9 we'll hear you. Thank you for being here.

10 MS. BOERNER: Good afternoon, my name is Verne Boerner.
11 I'm the new President/CEO for the Alaska Native Health Board.
12 I had some advice, take a breath. I did -- I won't disclose
13 to you all that in my interviews with the tribal leaders, they
14 asked me to explain or pick an area that's part of my
15 discomfort zone and speaking publically is one of those.

16 My Inupiat name is Kaanak (sp). I was named after my
17 grandmother. She was one of the first generation health aides
18 here in Alaska and from Kiana, Alaska up in northwest and it
19 truly is an honor for me to be here and to sit with you today.

20 I want to thank you for your time and your consideration.
21 I also wanted to thank Mr. Campbell for personally encouraging
22 me to come up and speak before you. It is my obligation and
23 responsibility as the President and CEO for the Alaska Native
24 Health Board to do so, but having that little bit of a nudge
25 is sometimes what you need.

1 The Alaska Native Health Board is a 26-member board
2 entity of the Alaska Native health organizations and
3 independent tribal public law 93-638 compact and contract
4 organizations here. Our member organizations have signed an
5 MOU recognizing ANHB as the voice on the Alaska Native health
6 issues and my purpose for the testimony today is, 1) to
7 introduce myself. I did start back in July. So I'm almost
8 coming on a year. Public speaking is still one of those areas
9 that gets me every time.

10 The Alaska tribes operate a health system that is truly
11 unique in the nation and that they really do operate as a true
12 system and I take great pride in that. I spent 13 years
13 working with the Northwest Portland Area Indian Health Board
14 working with the federally recognized tribes in Washington,
15 Oregon, and Idaho and got a great education and great
16 experience working with them, but while working down there,
17 there was always great respect for the tribes up here in
18 Alaska and their innovative approaches and they are truly
19 innovative.

20 They are creative by necessity, perhaps, but regardless,
21 they have designed systems that have been emulated throughout
22 the world, particularly in rural and impoverished areas. Some
23 systems here have really been useful to improving the health
24 status and quality of life of folks globally and I take great
25 pride in the work that they do.

1 I also just wanted to talk -- bring up the issue of
2 synergy, working sort of -- in a -- between the state and the
3 tribes, it's truly a mutually beneficial and encouraging
4 tribal involvement in the decision and the policy discussions
5 that are out there.

6 Bringing them in early can really, or on the onset, can
7 really address issues and design programs right from the start
8 and prevent the need to sort of halt and go back. So I just
9 want to offer, as the Alaska Native Health Board and working
10 with these 26 entities, my personal learning curve is
11 extremely steep and I don't -- I don't pretend to be a subject
12 matter expert on any one of the topics, but the Alaska Tribal
13 Health Systems truly does have some great minds out there and
14 we would like to help make those connections to bring forth
15 those experts to help inform the process as it goes.

16 The work of this group is so critical and given the
17 disparities and the inequities, both in socioeconomic terms,
18 but also in health measures affecting Alaska Native people and
19 American Indian people and rural Alaskans, regardless of
20 heritage, working with tribal communities is a key area in
21 promoting public health overall throughout the state.

22 So while my personal learning curve is still very steep,
23 we do offer many of those with the high level subject matter
24 expertise to help enforce -- inform those processes. I invite
25 you to utilize the Alaska Native Health Board and myself and

1 our staff to help reach out to those in those communities to
2 help with your processes. Thank you for your time.

3 CHAIR HURLBURT: Verne, thank you very much and thank you
4 for the openness and the invitation. I -- from experiences,
5 I've had that kind of openness and the kind of collaboration
6 between the Tribal Health System, other parts of the health
7 system and the state is really exemplary. We have,
8 percentage-wise, more Native Americans than any other state,
9 but that's always been characteristic. It doesn't mean there
10 aren't a few bumps in the road sometimes, but that's done --
11 and things that your organization, ANHB, over the years has
12 been real pioneers on like the tobacco efforts have just been
13 exemplary and have been examples for the country. So thank
14 you for coming and thank you for your comments for today.

15 We have a couple other folks here in the room, Sunny
16 Morrand, if you could.....

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

19 CHAIR HURLBURT: Yes, okay, then David D'Amato, if you
20 could come and give some comments?

21 MR. D'AMATO: This one -- I was at the signing yesterday
22 where the Health Care Commission was reauthorized and how
23 exciting that is for the state of Alaska because this
24 Commission really is the fount of a great deal of system
25 change and scholarship in the state of Alaska.

1 This -- the work of this Commission has guided our work
2 at the Alaska Primary Care Association more frequently than I
3 ever would have imagined it could have. The amount of detail
4 we get out of the reports that you produce and the suggestions
5 that are made is excellent and thank you all for that.

6 The Alaska Primary Care Association, as all of you
7 probably know, is a network of 28 CHC systems that operate
8 about 160 sites throughout the state of Alaska. We are
9 working presently on a couple of things that I wanted to bring
10 you up to speed. There's no way you could know what we've
11 been up to the last couple of months. So I thought I would
12 come in and talk a little bit about both -- first, our Patient
13 Centered Medical Home Project.

14 Many of you might have read that in the last month, the
15 Patient Centered Medical Home Project that was a partnership
16 between the DHSS, the Department, the APCA, the Trust, has
17 been funded and has been -- the grants have been awarded. So
18 five sites have been awarded to do PCMH recognition and what
19 we're trying to do with these sites is to take a more
20 systemwide perspective.

21 Some of you will remember that in 2011, the Legislature
22 authorized 400,000 and asked us simply to try to get three
23 sites recognized and to learn what we could about the problems
24 of systemwide change.

25 We went through that process and while we were going

1 through that process, we picked up a little bit of expertise
2 on how to help sites get recognized in the state of Alaska and
3 how they could affect systemwide change within Alaska, because
4 we all know we've got some real issues with systems working in
5 silos and not necessarily working together as well as they
6 could, collection of data, price issues, all of the things
7 that are on your agenda for this particular meeting.

8 So in 2011, we did those three sites. They're finishing
9 up this year. We just awarded the new sites for this year.
10 The next -- we've got five going right now. We'll have three
11 reauthorized in the fall and we hope, we're working with the
12 Department right now on a payment reform plan and we hope to
13 introduce some sort of payment reform suggestion by the fall
14 for you all to consider as well.

15 So the other thing that I wanted to mention to you about
16 the -- about some of the work of the PCA is that we have --
17 we're also very concerned about the issue of uncompensated
18 care. We examine the gap analysis that was done by the state.
19 We've seen the Llewellyn (sp) Report. We've also looked at
20 some of the other reports that are produced by ANTHC and
21 others.

22 Our perspective is this, that we're already one of the
23 leaders in the state in trying to get people enrolled in
24 health care. We're working on an outreach and enrollment
25 program actively. We have navigators on our staff.

1 However, we understand that the gap analysis is going to
2 lead to more coverage and we're excited about that for more
3 people, but we're going to have to continue to face the
4 question of uncompensated care because from a systemwide
5 perspective, nothing -- if we don't address the issue of
6 uncompensated care, we're not going to be able to really have
7 systemwide reform.

8 So to that end, the APCA and a few of our other advocate
9 partners are planning on putting together a symposium of sorts
10 on October 8th where we're going to talk about the issue of
11 uncompensated care and this is the, sort of, first public
12 announcement that symposium is going to take place. It will
13 be at the Dena'ina Center. It will be a one-day event and
14 more information will be made available to you as we have it.
15 So with that, I'm available for any questions.

16 CHAIR HURLBURT: Thank you very much, David, and thank
17 you for your support through the legislative process there.
18 David's actively involved in that and was a real support for
19 us and the other bill he didn't mention that he was there for
20 yesterday was the vaccine bill that David was very helpful and
21 engaged in. So thanks, David.

22 MS. ERICKSON: Wait just a second, and I just -- there
23 might not -- this might not generate more questions for you,
24 Dave, but I wanted to remind the group, and again, tell our
25 new folks, of the Commission's earlier recommendations from

1 two or three years ago now, related to improving access and
2 quality of primary care and not quality, as much as just
3 strengthening primary care systems, and we have -- so we have
4 a series of recommendations about that and including
5 addressing Patient Centered Medical Homes and the
6 recommendation to the Department was that the Department
7 launch, and the state support, a Patient Centered Medical Home
8 pilot project, and related to payment reform, we might have to
9 go back and revisit the earlier learning about that, at this
10 point, and have a conversation about that again, because it's
11 been a little while, but one of the things that we learned was
12 kind of the evolution of change and the different level of
13 payment reform and we had recommended at that time that the
14 state needs to move forward with some form of payment reform
15 and as a first step, use the Patient Centered Medical Home
16 pilot as a first test in a simple, maybe fee-for-service plus
17 case management fee or something like that, but that was the
18 suggestion. There were two kinds of linked recommendations
19 addressing both of those core strategies at the state to take
20 its first steps.

21 So this really is reflecting back on those earlier
22 recommendations, the state's first effort in partnering with
23 the Primary Care Association. So it's something I really
24 appreciate you bringing that update, Dave, and we might want
25 to formalize somehow a line of communication so the Commission

1 can keep up with how it's going and one of the things we
2 talked about this morning is our role going forward with
3 providing more transparency and accountability for the state
4 and their implementation of any of our recommendations and
5 making sure there aren't unintended consequences and that sort
6 of thing. So we might be interested in hearing in the future
7 about evaluation plans and how those might -- how your
8 organization and the state is going to work to evaluate the
9 success of these pilots.

10 MR. D'AMATO: All right, well, the pilots for the -- it's
11 interesting that you mentioned that because the pilots for the
12 Patient Centered Medical Home ran through about a three-month
13 process where we really spoke at length about what we wanted
14 to gather, what sort of data and how we would collect it, what
15 sort of data we would collect, and then we went back and
16 revisited them after all of the grantees were awarded and they
17 educated us a little bit about what was possible under current
18 data collection processes and we kept their feet to the fire
19 and said, well, we need to know more about hospitalizations
20 and this sort of thing and if you can't do it now, we'll give
21 you a two-year exception, but you've got to start reporting it
22 on year three. So amendments were made in consultation with
23 the grantees.

24 Now, when it comes to the -- I wanted to also mention
25 with the payment reform project, we're thinking we are

1 following the recommendations of this group and studies done
2 by the state because the groups that are under consideration
3 at the moment are all Patient Centered Medical Homes. They're
4 operating that model at the moment and we are asking them the
5 specific question, what areas are you having trouble within
6 payment based on this and how could we flatten this out?

7 We've got some generalized criterial fleshed out and they
8 also follow a lot of the guidance that the state and this
9 group have looked at before. So we're relying on you very
10 heavily. Thank you very much.

11 CHAIR HURLBURT: Thank you, Dave, again. Is there
12 anybody online who wished to comment?

13 MS. ERICKSON: The phone line's not working, but I do
14 have an email from an upset public member who wanted me share
15 their -- do we -- their frustration. Fred Brown has testified
16 before you a few times before and he, I think, had hoped to
17 testify here and was particularly interested in following what
18 -- the recommendations related to the All-Payer Claims
19 Database might -- how they might end up evolving.

20 So I promised him over email that we would make sure that
21 if he has any written comments, he can share those in that
22 form and that we always post our transcripts and audio
23 recordings online and we'll make sure we do that and in any
24 follow-up notes. We try to be as transparent as possible.

25 CHAIR HURLBURT: He's calling from Fairbanks, is he, I

1 guess, probably?

2 MS. ERICKSON: I don't know. He lives in Fairbanks. I
3 don't know where he is right now.

4 CHAIR HURLBURT: But -- and we can't get him on.....

5 MS. HENDRICKSON: Deb, I told all the attendees online if
6 they wanted to (indiscernible - interference with speaker-
7 phone) email me and I would get them a cell phone number to
8 call in and no one has emailed me and that was half an hour
9 ago.

10 UNIDENTIFIED SPEAKER: (Indiscernible - too far from
11 microphone).

12 MS. HENDRICKSON: He did hang up and he's not on the
13 webinar part now, but any other people who are, I sent it to
14 all of them.

15 CHAIR HURLBURT: Okay, thank you, and we're ready to move
16 on then with the afternoon agenda. I think you'll find it a
17 very interesting afternoon and Mouhcine, is that the way -- is
18 that correct? Okay, and Gunnar are (sic) here and they have
19 been doing work, both for us and some of the other work --
20 first, we'll have the presentation and the group discussion on
21 the Employer Health Benefit Survey.

22 You have the survey form in your book here that everybody
23 probably looked at it. I don't remember which tab it was
24 behind. Which one? Three, okay, and Tab Three, the survey
25 that went out to employers there and I'm really looking

1 forward to hearing the information there.

2 So if you folks could come up to the table here and then
3 Mouhcine, are you going to go first or Gunnar?

4 DR. KNAPP: I'm just sitting here to smile.

5 DR. GUETTABI: The better looking one and so I just bring
6 him along.

7 CHAIR HURLBURT: So thank you very much for coming and
8 thank you in advance for what you're going to present. If you
9 could just press the gray button there on your mic? Deb, do
10 you want to add any other comments before they get started?

11 MS. ERICKSON: Why don't we just go ahead and go ahead
12 and start and present the results.

13 DR. GUETTABI: Are you going to be scrolling?

14 MS. ERICKSON: I will change the slides for you, yeah
15 (affirmative).

16 DR. GUETTABI: So my name is, yeah (affirmative), my name
17 is Mouhcine Guettabi. I'm an Assistant Professor of Economics
18 at ICER and we've been, in conjunction with Department of
19 Labor, we've administered the survey to a representative
20 sample of Alaska employers in order to understand the current
21 state of insurance provision, also understand a little bit
22 about their implementation of wellness programs and some of
23 the benefits that are being provided as part of the insurance
24 package and so one of the intentions of the survey was to
25 capture, essentially, that representative sample that I was

1 talking about and in order to do that, we had to basically try
2 to get groups of employers by size, given that the
3 characteristics of employers vary greatly by size and so we
4 needed to get enough responses from each of the four group
5 sizes that we've determined.

6 So we have basically employers between zero and nine, 10
7 to 49, 50 to 99, and 100 and more, and so those are the four
8 group sizes of employers that we've targeted and we obtained
9 enough responses from each of the groups in order for their
10 responses to essentially be representative of all employers in
11 the state of that particular size and that we can extrapolate
12 and speak with a reasonable degree of confidence about the
13 current state of insurance provision and so that's what you
14 see there.

15 We, essentially, ended up having about 1,300 responses
16 and those 1,300 responses, like you see, are stratified by
17 size groupings and so everything that I'm going to be
18 presenting you can be perceived as a representation or a
19 fairly good representation of the population of Alaska firms
20 and their provision of health insurance and the benefits that
21 they're providing. Again, this is within a 95% confidence
22 interval.

23 A lot of what you're going to be seeing are point
24 estimates and so I'm going to be giving you, basically, the
25 point estimate, but those really should be taken with a grain

1 of salt because there is a little bit of a margin of error,
2 given that we are not speaking to every single employer in the
3 state.

4 So this is what I was talking about, because one of the
5 things that we always try to emphasize, and so that's a
6 characterization of the Alaska economy, which I think is
7 immensely important in the context of health insurance,
8 because 70% of all firms in the state have less than 10
9 employees, right, and so -- and yet, they only employ about
10 13% of the labor force and so when we're thinking about who
11 gives insurance or who provides insurance or where do Alaskans
12 work, it's really critical to reconcile, A) the number of
13 firms that we have in the state, 15,000 and some, more than
14 10,000 of them are really small and therefore, their profit
15 margins are narrow they're not going to be able to provide
16 insurance for the most part, like we're going to be seeing
17 here in a minute.

18 However, the vast majority of employees are actually
19 employed within very large organizations, who have a tendency
20 to be more likely to provide health insurance. In addition,
21 the graph to the right, and I don't know whether you can see
22 it well or not, shows you the composition of employees,
23 meaning the actual status of employment and that, again, is
24 really critical.

25 Not only is the size of the firm important in terms of

1 the likelihood to offer insurance, but full-time employees are
2 considerably more likely to be provided insurance and so out
3 of the 292,000 or so employees in the state, about 190,000 of
4 them are actually full-time employees and so those individuals
5 are considerably more likely to be offered insurance, as we
6 all know, and going forward, clearly, the mandate is going to
7 change the landscape a little bit and from what you can see
8 there, out of those almost 300,000 employees, about half of
9 them are actually employed in the largest sized category and
10 that largest sized category means firms that have more 99
11 employees -- tend to be the ones where, A) workers are
12 concentrated, B) they're firms that are more likely to have
13 insurance and then, C) the composition of employees in those
14 very, very large firms tends to tilt toward full-time
15 employees and so those are really the things that one needs to
16 reconcile when looking at this picture, because it's easy to
17 get lost in the detail of the vast majority of firms are
18 really small and that's true and they are less likely to
19 provide insurance.

20 However, the majority of the labor force is concentrated
21 in the larger firms. Larger firms are more likely to provide
22 insurance and a lot of the full-time employees are
23 concentrated in the medium to large firms and so when I talk
24 about the percent of firms that offer insurance, that gives us
25 an overall picture of this provision of health insurance, but

1 it does not really tell the story as to the distribution of
2 employees across firms and that's really what that shows you
3 right there.

4 That's the percent of firms that offer any health benefit
5 by size and as you can see, unsurprising, very small firms are
6 considerably less likely to provide any health benefit and so
7 -- and as you go up in size, it becomes very clear that the
8 largest firms are more likely to provide any health benefit
9 and that health benefit here is inclusive of insurance and so
10 this initial question does not constrain it to just health
11 insurance, it's any health benefit and that will become clear
12 here in a minute. Yeah (affirmative).

13 COMMISSIONER MORGAN: Maybe that's what -- maybe I'm
14 early here, but a lot of the individuals in the small firms,
15 do they get health care benefits not through the employer, but
16 through the VA, through maybe CHIP and Medicaid and Indian
17 Health Service, because I know several firms, like in Nome and
18 other places where they'll have 10 employees, eight of them
19 will be tribal or VA or something like that and get it that
20 way. Is that later on?

21 DR. GUETTABI: Yeah (affirmative), what I'm going to be
22 showing you here in just a minute, but that's an excellent
23 point, is that we asked employers to tell us what are the
24 reasons they're not offering health insurance and so -- and
25 they listed some of those reasons and some of the things

1 you're mentioning do come up.

2 Having health insurance through a dependent (sic) or
3 having it through the VA system are certainly some of the
4 reasons that are -- that were listed as part of the rationale
5 not to provide health insurance.

6 COMMISSIONER MORGAN: Sometimes we (indiscernible) in a
7 sense in the front of the definition of -- that if you're not
8 getting health insurance through your employee (sic), you're
9 not getting health care and a lot of the smaller firms get
10 their employees and sometimes the owners get -- they're
11 retired military, they're -- or they get most of their
12 benefits through the Indian Health Service, which is a very
13 large entity inside the state and even, depending on if it's a
14 single mom or dad, even at a reasonable salary can get CHIP
15 for the kids. So you have that going on, too.

16 DR. GUETTABI: I mean, another component of what you're
17 describing, which this survey does not get to, and I think is
18 immensely important is the self-selection of where people
19 actually work, right, and so if you have insurance through
20 another means, you're probably a lot more likely to go work at
21 a very small firm that does not offer those benefits because
22 you're more interested in the pure salary, rather than the
23 benefits and so there's a lot of that that's, again, masked by
24 some of these -- this is an employer-based survey that does
25 not tackle those questions, but they're certainly relevant and

1 valid. Yeah (affirmative).

2 COMMISSIONER HIPPLER: Since we've interrupted your
3 flow.....

4 DR. GUETTABI: There is no flow, as you (indiscernible -
5 too far from microphone).

6 COMMISSIONER HIPPLER: So going back a couple of pages to
7 the survey of Alaska businesses, the size class zero to nine,
8 the survey sample was 1,194, the number of respondents, 503.
9 Does that mean you asked almost 1,200 people, 1,200 businesses
10 and you got 500 responses back?

11 DR. GUETTABI: Yes.

12 COMMISSIONER HIPPLER: Okay. So I'm wondering if the
13 kinds of businesses that would elect to respond to you are by
14 nature more sophisticated, maybe have a little bit more
15 overhead and more ability to understand what you're saying?

16 DR. GUETTABI: So you mean, you're essentially asking
17 about the nonresponse bias, right, and so I've looked at the
18 data quite carefully in order to try and assess the
19 differences between -- we have limited data, right, because if
20 they didn't respond, we only have their size class and we only
21 have what kind of business they're in.

22 Based on the number of employees, the distribution across
23 industries, there does not seem to be any significant
24 difference between the ones that responded and the ones that
25 didn't. Another really important thing, and I'm glad you

1 brought it up, is by stratifying across size, you're already
2 dealing with a reasonably homogenous group, right, and so
3 you're already narrowing down the typical differences that may
4 arise firms by saying these are all firms that are between
5 zero and nine, and therefore, the level of sophistication,
6 while it varies, is not going to be terribly large and so --
7 and by comparing those attributes of the respondents to the
8 non-respondents, you minimize the nonresponse bias and most of
9 these things are the adjusting for that.

10 I mean, had there been a need to go back and reweigh, I
11 would have, but based on the limited characteristics that we
12 have of the non-respondents, right, because they're not
13 answering, so I don't know exactly everything about them, I
14 only know what kind of industry they're in, how many employees
15 they have and where they're potentially located and those --
16 so that's the extent of it. By just comparing across those
17 characteristics that are available, there doesn't seem to be
18 any concern to that. Can we do to the next one?

19 UNIDENTIFIED SPEAKER: Yeah (affirmative).

20 DR. GUETTABI: And so across all sizes, 34% of Alaska
21 firms offer health insurance and I know that one of the things
22 -- so the Alaska Department of Labor had done a similar survey
23 and I'm cautious here in drawing comparisons, because I'm only
24 comparing the point estimates. I don't have access to the
25 original data and so they had found that in 2006, that 39% of

1 firms offered health insurance. We're finding here that it's
2 34% and so again, those are point estimates.

3 There does seem to be a decline. I can't speak as to the
4 statistical significance of the decline, but it's consistent
5 with national patterns. It's consistent with the trend data
6 that we had looked at from the medical expenditure panel
7 survey and so the decline is really not that surprising, but I
8 am cautious in actually making a definitive statement as to
9 the comparability of the two questions.

10 We've also asked this question slightly differently than
11 the previous time, but we are seeing the consistent patten
12 that has occurred across the nation, which is that more --
13 less firms are actually offering health insurance and this is
14 getting a little bit toward some of those concerns that were
15 brought up a second ago.

16 We also asked firms to tell us, if you're not offering
17 any health benefits, can you please tell us a little bit about
18 why you're not actually offering it, and so -- and as you can
19 see there, cost remains king, right, and so in 2006, the same
20 questions were being brought up and expense or cost was the
21 most likely to be chosen as the reason health benefits were
22 not offered.

23 Seasonality shows up again, part-time employees does, as
24 well, and so -- and the size of the firm and so when you think
25 about it, you think about, okay, it's too expensive. We've

1 looked into it, and I'll show you a sample of some of the
2 responses, so you have cost, which is relevant, irrespective
3 of size. We have the size of the firm that came up a lot for
4 firms under 50 and then, one of the things we'll see here in a
5 minute, another component that did come up, which is the
6 turnover of the employees, and so seasonality, the number of
7 part-time workers and the cost really were a consistent theme,
8 whether it was in just them selecting it or even in some of
9 the more detailed responses that they provided to some of
10 these questions. Yeah (affirmative).

11 MR. PUCKETT: And did you represent the entire universe
12 that you (indiscernible - too far from microphone)?

13 DR. GUETTABI: Yeah (affirmative), so that pie chart
14 there is the universe of firms and then here coming up, you'll
15 see it by size and so those differed a little bit and I'm not
16 sure whether you can see it well. Hopefully you have a
17 printed-out version of the presentation and so as you can see,
18 those reasons really do vary.

19 You can see that cost is by far the most important
20 element, even for the biggest firms. One of the things that I
21 would like to point out here is, while you see that cost is
22 important for some of the biggest firms, as well, the number
23 of big firms that don't offer insurance is minimal, right, and
24 so it's 36 firms and so we're talking about a very small
25 number of firms that are basically determining what those

1 responses are, but like I said, the turnover comes up a bit
2 more relevant for some of the bigger firms.

3 The size, the seasonality and the part-time nature of
4 some of the employees are consistently brought up,
5 irrespective of size, which I really think is important and
6 hopefully, one of the things that comes out of this, and I've
7 thought about this quite a bit, is these are structural
8 issues, right, and so the Alaska economy is not going to
9 change any time soon and so 100,000 out of the 290,000 or so
10 employees are either part-time or seasonal and so when we're
11 thinking about potential ways of dealing with the insurance
12 question or the benefit question, that's something that can't
13 be just put aside and so we can't just think about the full-
14 time employee.

15 Those are components of the Alaska economy that are, A)
16 relevant and, B) are not going to change. It's been the case
17 for a long time and it will remain so, and so in thinking
18 about innovative ways of dealing with this, the structural
19 nature of some of these issues can't be disregarded and I
20 think that this really makes it very clear.

21 You can go to the next one, and that just shows you the
22 universe of firms and it's basically a similar story to the
23 previous slide, but I think it's important to, again, just get
24 a sense of -- I showed you at the very beginning that 15,000
25 firms are the universe of firms in the state, 9,000 of whom do

1 not provide any insurance and as you can see, by size class
2 again, it's really important not to think about this insurance
3 provision in a vacuum, but actually by size and look at the
4 reasons by size, as well, because you know, they're not
5 homogenous.

6 They differ in terms of characteristics. They differ in
7 terms of who they hire and they differ in terms of why they
8 elect not to potentially provide health insurance.

9 This is just a snippet and I modified some of these
10 responses just slightly, not in terms of content, but just in
11 terms of wording and I just basically took these from some of
12 -- we asked -- in the previous slide, you saw that one of the
13 categories was "Other," and so these are some of the actual
14 responses from the firms modified slightly for confidentiality
15 purposes as to why they did not want to provide insurance or
16 they elected not to provide insurance and the themes, again,
17 are still cost-related.

18 There's profit margin that shows up a lot and
19 surprisingly, one of the things that I hadn't thought about
20 was the age of the employees. A lot of the companies that
21 weren't offering health insurance said that we have very young
22 workers that, and again, it's the turnover/age of the
23 employees and then there was the remoteness that came up a
24 couple of different times. We're remote. We've got small
25 margins and then there were government contractors, which

1 mentioned specifically about they're competing for the lowest
2 bid and when you do that, you don't have enough money to
3 potentially provide health insurance, but I think this is
4 interesting.

5 I mean, it gives us a little bit of an insight as to what
6 are the actual motives, because looking at the data simply
7 does not do that, but this gives you a little bit of insight
8 as to what they're actually thinking and again, this is just a
9 snapshot. There were many, many others, some of which I can't
10 share, but email me, no.

11 Yeah (affirmative), and this is consistent with what I
12 was talking about earlier and in my mind, I've talked to
13 Gunnar about this before, is that this is really part of the
14 story is, not just who offers insurance, but where you
15 actually -- where do workers actually work and so that gives
16 you a sense of where does the labor -- where is the labor
17 force actually employed and so we see that the vast majority
18 of employees are actually working at firms that provide health
19 insurance and if you work for a large firm, the likelihood
20 that you are working at a firm that provides health insurance
21 is really high and so as you can see there, so for example,
22 look at that 96% for larger than 99, that tells you that 96%
23 of full-time employees that work at a firm that has more than
24 100 employees are working at a firm that provides health
25 insurance and so it's really -- I keep coming back to this,

1 but it's really important to think about it from the employee
2 and the employer -- there are X employers that provide or do
3 not provide, but then the distribution of those employees
4 across firms that either elect to provide or not provide
5 health insurance ends up determining the percent of Alaskans
6 that actually have employer-sponsored health insurance because
7 I don't know if you remember, but when I presented, I don't
8 know, five months ago, we showed that 57-some-percent Alaskans
9 have insurance through an employer, right, and so then, will
10 their dependent have insurance through their dependent (sic)
11 and so -- and it's because of this slide, and it's because
12 while there is less than a third or a little bit more than a
13 third of the firms that provide health insurance, a lot of the
14 workers end up working up at firms that provide these benefits
15 and it's also so you reconcile, are you full-time, part-time
16 or temporary and the size of the firm at which you work and
17 then the third component is, does that firm actually provide
18 health insurance or not and as you can see, as you move up in
19 the size of the firm at which you're employed, you're more and
20 more likely to be at one of the insurance providing ones.

21 So now getting down to actual business, so one of the
22 things, one of the caveats I would like to just clarify here
23 is everything we're going to be seeing going forward is
24 basically among firms that offer any health benefits, those
25 are the percentages.

1 So among firms that offer health benefits, the percent of
2 firms that offer health insurance to individuals who are full-
3 time is 84% and to their families, 65%, and so everything here
4 is a subset of firms that offer all -- that offer any health
5 benefits and so -- and that's really important and I think
6 that looking at it both ways is actually really informative
7 because if we ignore this subset, you can think about, okay,
8 well, there are 29% of firms, for example, that offer health
9 insurance to individuals out of all the firms or you can just
10 say, "Okay, now we've identified firms that offer any health
11 benefits. What are the actual benefits that they offer, given
12 that they offer any health benefits," and as you can see,
13 health insurance is prevalent, given that you offer any health
14 benefits and there are some that obviously, only offer it to
15 individuals and that's the discrepancy you see between family
16 provision and individual.

17 This is looking at select insurance offerings and so this
18 is audio, dental, and vision insurance and again, dental and
19 vision insurance seem to be highly correlated to the provision
20 of actual health insurance. Similarly, there does seem to be
21 a discrepancy between the provision for individuals and their
22 dependents, meaning that while the majority of firms that
23 offer insurance to an individual, offer it to a family member
24 as well.

25 There are some that do not and audio insurance is

1 considerably less likely to be offered than any of the others
2 and just one thing, although we don't show it, there are
3 differences across sizes in terms of the provision of the
4 select benefits and so -- and that's, again, something that
5 unsurprising and I think that's something that's important to
6 be reminded of, is that not all insurance is created equal,
7 right, and so we're treating now a firm that offers insurance
8 as similar to any other firm, but the benefits that are being
9 provided within that insurance clearly vary a great deal, not
10 only what types of plans, but what benefits do people actually
11 qualify for within those plans.

12 This is looking at a few different benefits, employee
13 assistant programs, short-term disability, long-term
14 disability and long-term insurance, and as you can see, they
15 vary a little bit. They go from, you know, a little more than
16 5% for long-term insurance to as high as 32% for short-term
17 disability and we're not showing you part-time and temporary,
18 although we have that data, meaning the percent of part-time
19 and temporary workers that qualify for these things, but as
20 you would expect, the numbers are lower are you go into the
21 part-time and temporary workers and so what you're seeing
22 here, you can think about it as the upper boundary in terms of
23 probability of having these services provided because they're
24 being provided for full-time employees who have a tendency to
25 be most likely to be offered health insurance.

1 I know that this is of -- Deb mentioned that this is of
2 particular interest to the Commission and I think it's --
3 obviously, it's gotten a lot of attention lately, especially
4 the health flexible accounts because of the hard cap that's
5 been imposed, the \$2,500, and so I'm really curious to know
6 how this will change spending patterns by individuals.

7 In the past, you know, we knew that most firms used to
8 put the cap at about \$5,000. Now it's \$2,500 and it's a hard
9 cap and so I'm not entirely sure how this is going to
10 translate, in terms of spending. The health reimbursement
11 accounts, in my mind, are the most fascinating aspect of the
12 survey, but also going forward, because firms that have
13 between zero to nine employees are going to be competing now
14 for workers in a really different landscape in the sense that
15 everybody else has to provide insurance. They don't. How do
16 you provide these alternative services that make you as
17 attractive to an employee?

18 Obviously considering what you've mentioned and health
19 reimbursement accounts are obviously going to be one of those
20 potential sources of making yourself as attractive as the
21 bigger firms that offer the typical health insurance benefits
22 and so going forward, I think that this is something to
23 certainly keep an eye on and I don't have -- I mean, we don't
24 know how quickly this is changing or how quickly are firms
25 setting these up or thinking about them clearly, especially

1 the smallest firms.

2 These are the alternative forms of providing services.
3 Again, where we listed a number of different benefits and
4 services that firms are providing, and I named these
5 alternative forms, because as you can see, these are ways of
6 potentially doing things a little bit differently, right, and
7 so one of the things that came up earlier in the reasons to
8 not offer insurance is that quite a few employers said, "Well,
9 our workers just prefer having more money or prefer having
10 these alternative set ups," and so this gives you a sense,
11 again, one of the things that unfortunately we don't have the
12 answer to is I don't really know, and maybe some of you are
13 more in tune with this, is to whether or not this, we're going
14 to see an expansion of these alternative forms of provision.

15 If so, are firms experimenting with utilizing more of
16 these, because there is a cost awareness. We -- you guys have
17 been talking about cost transparency or price transparency and
18 quality transparency and I think that the cost awareness very
19 much goes into this. We're seeing an attempt to shift some of
20 the cost sharing into employees and as that becomes a reality
21 and as employees become more and more aware of these
22 expenditures, it would be nice to know how much are firms
23 actually implementing some of these measures and whether they
24 think that any of them are actually effective.

25 I'm not entirely -- there isn't much in the empirical

1 literature as to the effectiveness of any of these measures in
2 terms of cost savings and so that's, I think, an open-ended
3 question and these are just plan features and I think these,
4 again, are really interesting to me. You see their price and
5 quality transparency, about 15% of firms offer price
6 transparency and about 12% offer quality transparency.

7 I know you guys have thought about this question a lot.
8 I think it's really interesting. There's a report that came
9 out, I think in March of last year that showed all, but five
10 states are essentially failing when it comes to price
11 transparency and so while about, you know, 33 of them have
12 passed mandates regarding price transparency, the
13 implementation of efforts regarding price transparency have
14 been very weak by all assessments and so -- and the evaluation
15 as to what do employees actually want when it comes to price
16 transparency is still very much an unanswered question and so
17 a lot of small firms, not provided here, but a lot of small
18 firms have -- are more likely to offer just high deductible
19 plans and the type of employee that is interested in price
20 transparency is one that is more likely to incur some of the
21 costs and so employees that have high deductible plans tend to
22 be ones that are considerably more aware about prices and
23 therefore, the ones that are most interested in these price
24 transparency settings.

25 Additionally, and I think the numbers do back it up,

1 price and quality transparency have to go hand-in-hand because
2 throughout research, throughout the empirical literature, it's
3 very obvious that if you provide just price without quality,
4 people tend to think that price is indicative of quality and
5 that's very, very misleading and so again, as we're discussing
6 these innovative efforts in order to inform employees, we need
7 to figure out what are the aspects of price and/or quality
8 transparency that are of most interest to employees, what are
9 the types of employees or who are the types of employees that
10 would benefit the most from such price transparency and how
11 can we couple both price and quality in a way that's really
12 informative.

13 Like I said, that report essentially showed that most of
14 the websites for price and quality transparency are really
15 confusing. They're not simple enough and people really are
16 not making as much use of them as they potentially could be.
17 It's an attractive new feature, but there is yet to be a great
18 deal of evidence as to an implementation that's been very
19 successful and so going forward, I think it's going to be
20 really interesting to see whether or not Alaskan firms follow
21 you and how successful they potentially are.

22 Wellness programs, similar to national firms, I think
23 that this is when you think about cost-cutting, when you think
24 about preventive measures, because again, of this awareness
25 regarding cost, because of the new landscape in which we live,

1 preventive measures are now king, right? Most firms are
2 attempting some form of wellness.

3 Similarly, one of the things that was really curious to
4 me here is we started out with a question that we said, "How
5 important is wellness," and this is irrespective of whether or
6 not you actually provide a wellness program. So we're asking
7 about perception of firms regarding wellness programs,
8 irrespective of whether you offer it or not and when we say
9 "importance," importance in improving productivity, in
10 improving the health of your workers and about 82% said that
11 it's at least somewhat important and yet, as you'll see in the
12 next slide, only about 8% of firms actually offer wellness
13 programs.

14 Now, that's 8% of the universe of firms, right, and so if
15 we say amongst firms that offer any health benefit, it's 19%
16 and so the 8% is out of every single firm in Alaska, again,
17 within a margin of error. It's 19% of firms that offer any
18 health benefit.

19 By comparison, the Keiser Foundation's latest report
20 shows that seven out of 10 firms nationally offer wellness
21 programs and so that's irrespective of size and so that's
22 really -- that's a pretty big gap.

23 Now is that because we have 70% of our firms that are
24 really small? That's probably a huge part of this story,
25 right, and again, I come back to that structure, right. We

1 can't ignore these structural differences when comparing these
2 numbers.

3 It's easy to say seven out of 10 nationally and we have,
4 you know, 20% and so there's an issue, but the structure of
5 the economy plays a huge part in determining the likelihood of
6 offering these wellness programs.

7 If we can go to the next one, and these are offer rates
8 by size, not surprising at all, the bigger firms tend to be
9 ones that are more likely to offer these wellness programs and
10 again, there are statistically significant differences across
11 sizes.

12 Going forward, really interesting to see to what extent
13 are firms trying to evaluate the effectiveness of these
14 wellness programs. I'm very interested in actual
15 effectiveness and how it's actually measured.

16 Again, empirically speaking, weak evidence, at best,
17 inconclusive as to what it actually does because, you know,
18 there are, you know, in terms of cost savings, it's about two,
19 three steps removed, right, and so I think that it's certainly
20 something that is going to continue to grow.

21 To what extent do we know how well it works or even, I
22 think, more importantly is what are the aspects of wellness
23 programs that are most effective? Most surveys ask about a
24 litany of services that are being provided within wellness
25 programs and then they try to evaluate each one of them and

1 see which ones have -- are most cost effective, right, and so
2 it's cost effectiveness here that we're most interested in and
3 prevention of sickness and disease and that's the
4 effectiveness question.

5 This is, again, amongst firms that offer and health
6 benefits, 75% think that it's at least somewhat effective. I
7 would love to know what that effectiveness actually means, and
8 you know, how it's evaluated and whether or not they're
9 actually tracking productivity or tracking health outcomes
10 because I think that for a broader implementation, as I said
11 earlier, the 8.4% of firms that offer wellness programs is low
12 by all measures, but we need to understand what are these
13 potential barriers, maybe, if 75% of those that are offering
14 it think it's effective, then it's clearly something that
15 needs to be, at least, implemented or tried or what are the
16 measures that can be taken in order to facilitate the
17 provision of wellness programs, and then, you know, when we
18 think effectiveness is -- the word effectiveness used
19 homogenously across firms and so those are unanswered
20 questions.

21 We have here a baseline of how they feel about it, how
22 they think about it in a theoretical sense, how many of them
23 actually offer it and then, how many of them actually think
24 that it works and it seems as though the vast majority of them
25 think that it works and it is effective and so I think it

1 opens up some really interesting opportunities to learn more
2 about it.

3 Those are just the services. We did not want to
4 complicate the services that are offered within wellness
5 programs and so we stuck to the ones that are most likely to
6 be offered and, as you can see there, personal screenings,
7 personal health assessments are the most popular and so again,
8 that's amongst firms that offer wellness programs, what is the
9 percent of firms that provide each of those services under
10 wellness and personal health risk assessments tend to be the
11 most offered.

12 We've had this conversation with Deb and it seems as
13 though there is this gradual -- it seems like there's a
14 gradual implementation and they started out with the most
15 broad element of wellness programs and then gradually offer
16 more complicated settings, financial incentives, as you see
17 there, 21% for individuals and so is that growing? Is it
18 static? Is it working? We can't really answer that question
19 (sic), but it does seem like there is, you know, two out of 10
20 firms are now offering it, again, very much tied to the size
21 of the firm, as larger firms tend to be more likely to try out
22 some of these more exotic wellness services.

23 That's just -- the picture is really -- this is really
24 fascinating to me because across size, while it differs, it
25 seems like they go through, essentially, a very similar

1 process of personal health risk assessment, biometric
2 screenings and then the least likely to be offered is the
3 financial incentive and maybe because it's newer. It hasn't
4 been tested as much, but this gives you a sense about, again,
5 that larger firms, maybe because they have the resources
6 necessary because they've done the research, are more willing
7 to potentially offer services that are not necessarily thought
8 of as typical services in wellness, but there is really -- I'm
9 not surprised by it, but it does confirm that hypothesis that
10 they may be trying out or starting with the most basic and
11 then getting into more complicated products as they become
12 comfortable with the wellness provision.

13 That's, essentially -- I -- I hope that I've covered most
14 of what you're currently looking at. It's -- the survey does
15 provide us, I think, a really great baseline going forward,
16 especially in light of all the changes that we are going to be
17 seeing and that we're already seeing.

18 Larger firms are more likely to offer insurance. Full-
19 time employees are more likely to be offered insurance. Cost
20 remains the most important factor in why firms are not
21 offering it and wellness is a really interesting and new
22 aspect that Alaska firms seem to be trying. It's a wait and
23 see approach as to how quickly they're implementing it and
24 what can potentially be done for some of the smaller ones to
25 incorporate it in their offerings, but I think that this

1 really gives us a little bit of an insight as to what the
2 current landscape looks like and going forward, hopefully, we
3 can use it to assess how the changes that are being
4 implemented are going to affect these offerings. Thank you.

5 DR. KNAPP: If I might just add points? One, the
6 Department of Labor worked with us on this survey and they
7 administered it and I want to make sure you're aware of that
8 and say they did a really great job. They worked very, very
9 hard on sort of defining this sample set of firms and then
10 going back to get enough firms to, you know, to respond and so
11 they -- it's not just us doing this. It was a partnership
12 with Department of Labor and they were great partners.

13 The second thing is that what Mouhcine's shown you is
14 just a very small part of the data or analysis that can be
15 done with this and we're writing a report that will have more
16 of it, but even there, our question is sort of what to show
17 of, sort of, all kinds of ways of presenting this information.

18 So among the things we're interested in feedback on, at
19 any time, is simply what are things that you didn't see shown
20 here, but that might be shown out of the data set? Thanks.

21 CHAIR HURLBURT: I'll start out with three questions; 1)
22 do you have any sense from maybe comments where you don't have
23 an exact comparison with a previous Department of Labor
24 survey, but consistent with the national data you mentioned
25 that the average percent has gone down from 39 to 34%, do you

1 have any sense from comments from employers that it's going to
2 continue to go down because of cost or for other reasons?

3 One -- the second question; any sense from the responses
4 of the impact of the Affordability (sic) Care Act and some of
5 the penalties that are part of that, and then third, I think
6 you didn't have anything, and it may be part of the further
7 analysis that Gunnar mentioned, but on question 11, on some of
8 the scope of benefits that you have there related to primary
9 care, sending people to centers of excellence, those kind
10 of.....

11 DR. GUETTABI: Yeah (affirmative), I think there was --
12 there is a slide.

13 CHAIR HURLBURT: I missed that, okay.

14 DR. GUETTABI: Yeah (affirmative), further, yeah
15 (affirmative) the (indiscernible - too far from microphone),
16 no, one forward, yeah (affirmative).

17 CHAIR HURLBURT: I see, the two (indiscernible - too far
18 from microphone).

19 DR. GUETTABI: Yeah (affirmative), patient decision
20 support is -- yeah (affirmative), the -- I didn't really find
21 anything -- the primary copay differentials were the most
22 likely to be offered, right, and so the patient decision
23 support centers, it's really interesting, because they've
24 received a lot of attention research-wise and it's been shown
25 that they do improve the selection of services, meaning

1 employees are less likely to elect elective surgeries or
2 expensive surgeries, but there is inconclusive evidence as to
3 their actual overall cost savings from an organizational
4 standpoint and so -- and I think that's true for a lot of
5 these plan features is, the literature, anyway, is still
6 unsure as to the effectiveness of -- because I think that it's
7 -- we're still really seeing the roll out and a lot of the big
8 firms that have done them, I don't know how much research they
9 have done or if they have, it's internal and so to extrapolate
10 as to how much any of these things work and/or if they should
11 be incorporated by other firms, I think it's still -- it's
12 still too early to tell, at this stage.

13 About your other question regarding whether it will
14 continue to decrease, and I'll answer the first and the
15 second, because I think they're related, it was actually
16 interesting in that there were quite a few respondents that
17 said, "We're actually currently searching for insurance," or
18 "we've looked into it and it's too expensive," or "we're
19 talking to our employees to figure it out," and so if
20 anything, we did not get anybody that said, "We used to offer
21 it and we've decided to no longer offer it," at least that
22 wasn't part of the comment.

23 I mean, it could very well have been the case. There's
24 been no indication that there is going to be a continual
25 decrease. Now, of course, market forces are going to dictate

1 that, right?

2 The ACA was mentioned, I want to say maybe a dozen times
3 or so, but only in the context of, "Yeah (affirmative), well,
4 now because of the ACA, we have to start working on it." We
5 are -- there was somebody that said that we've just set up an
6 account with Aflac. There was somebody else that said, "We're
7 working with our employees to think about alternative ways of
8 doing it."

9 There were, I think, one or two people that said, "Well,
10 we're going to have to start using more part-time workers,"
11 and so anecdotal, obviously, but it's -- I think that it's not
12 different from what we're hearing from national employers,
13 right, and so it's -- this decision as to, A) do you go ahead
14 and get insurance right now or do you take the penalty the
15 first couple of years to see how much it's going to actually
16 affect your bottom line or do you get ahead of it and actually
17 get insurance, but they were all over the place.

18 I wouldn't say that I saw any indication that it's going
19 to continue decreasing or that they were not aware of the ACA.
20 The ACA did pop up and, even if they didn't mention it
21 specifically, and said, "Well, because of the changing
22 environment, we are attempting to get coverage."

23 COMMISSIONER HIPPLER: Well, this is a little
24 embarrassing for me to ask, but what is audio insurance?

25 DR. GUETTABI: Jim.

1 MR. PUCKETT: Hearing aids.

2 COMMISSIONER HIPPLER: Audiology, yeah (affirmative). I
3 guess, well, I'm sorry, for perceptions regarding the
4 effectiveness of wellness programs, was this a -- were only
5 employers that offer wellness programs asked this question?

6 DR. GUETTABI: Yeah (affirmative), I mean, everybody was
7 asked the question, but it was asked after -- to the
8 percentages of those that actually have it, meaning everybody
9 answered it, but the percentages that you're seeing are among
10 those that offer a wellness program, what is the perceived
11 effectiveness of that wellness program?

12 You can, obviously, get a percent of the universe of
13 firms and see how they feel about the effectiveness, but it
14 was a follow-up on the actual provision, yeah (affirmative).

15 COMMISSIONER HIPPLER: Gunnar had asked for feedback
16 about information that might be useful in the next survey.
17 I'm sure you have -- well, maybe you have this data and it
18 just wasn't very interesting. Is (sic) there significant age
19 differences of employees between sizes of employer?

20 DR. GUETTABI: Yeah (affirmative), I mean, it's -- that's
21 -- that's actually one of the missing pieces is that we don't
22 have any information regarding the demographics of the
23 employees, right, and so that's, I think, going forward, it's
24 really interesting to try and figure out, like I said earlier,
25 one of the things is what would be interesting in terms of

1 what do employees value most in terms of the services?

2 Similarly, it would be really interesting to know if the
3 age of the employees plays a role in insurance provision.
4 Unfortunately, I don't have the answer to that, but related to
5 it, and I think something that I failed to mention and has
6 nothing to do with the survey, but I think is immensely
7 important is 22% of people over the age of 65 in Alaska are
8 still in the labor force, right, and so -- and we have a
9 population that's aging really fast.

10 While we currently have very few people that are over the
11 age of 65, that curve is really changing and so in terms of
12 the demands of people that are in the labor force and cost-
13 related expenditures, I think awareness of the age composition
14 you brought up is of great interest and I think it's going to
15 change really quickly, too.

16 DR. KNAPP: If I might just add, we don't presently have
17 any data on the age composition of these employers in the
18 sample, but it occurs to me that the Department of Labor might
19 well be able, because they actually know who all the employees
20 are.....

21 DR. GUETTABI: They do not have that.....

22 DR. KNAPP: They don't?

23 CR. GUETTABI: No, I mean, they -- we have quarterly
24 census of employment and wages data and so it gives us the
25 number of employees that are within each firm, the sectors

1 that are within each firm and so what one can potentially do
2 is reconcile that with data that has the breakdown of age
3 profiles, but we are not going to know how old are the actual
4 workers within each firm, unless you link that with PFD data.

5 DR. KNAPP: I'm not 100% he's -- that -- there may be
6 something in the -- it's a great suggestion. We'll look into
7 it or -- but usually, when I disagree with Mouhcine, I find
8 out I'm wrong, so anyway, we'll.....

9 DR. GUETTABI: You are.

10 DR. KNAPP: We'll follow up. It's a good question.

11 DR. GUETTABI: Yeah (affirmative) -- no, it's a great
12 question.

13 CHAIR HURLBURT: David.

14 COMMISSIONER MORGAN: I did have four questions. I now
15 have two. So my colleague, Allen, knocked two off my list.
16 Again, I go back to health insurance is a mechanism, a vehicle
17 to get the pay, finance and the access to health care. At the
18 same time, you're probably going to look at, as the
19 environment change, as ACA, especially employer mandates,
20 which brings a more -- a different structure of what's in the
21 insurance policies, I think it would be interesting also, you
22 are tracking how people don't get insurance through their
23 employer because they're eligible for other programs.

24 It would be -- you were going to talk about studying that
25 over time to see how that changes by these environmental

1 business effects. It would be interesting to look at that,
2 too. Suddenly, it becomes too expensive to opt through your
3 employer's insurance, but you served in the military. I know
4 that less than 20% of individuals that could enroll in VA
5 health coverages, or 30%, have and more than likely, I would
6 assume that they're getting it this way.

7 So I mean, the question is, it's like if someone used a
8 description of a balloon and you squeeze the balloon, it kind
9 of pops here. I use that when I talk about hospital costs
10 when we're doing budgeting next week. So when you squeeze it,
11 it pops here, you know, there's impacts everywhere.

12 So as the employer mandate hits, even though it's been
13 delayed, and as this environment changes and the actual
14 structure of the policies under that mandate will change,
15 that's defined more rigorously or more robustly, in my mind,
16 it would be a good PhD thesis maybe, to see like capital, like
17 income, like water tends to flow the least resistant path, to
18 see if individuals opt into those other programs, VA,
19 suddenly, you know, utilizing the tribal hospital versus
20 Providence might not be that bad of an option and especially,
21 younger people who are the single mom or dad, there's more of
22 them now with children eligible for CHIP, to me, it's just
23 something that I've been thinking about a lot of necessarily
24 getting caught up into, are you getting insurance through your
25 employer, but are you getting something to finance and to

1 cover your health care costs, you know where I'm going with
2 that?

3 DR. GUETTABI: Yeah (affirmative), I think that dimension
4 is really important. I mean, I've always felt that in order
5 to truly understand this question, you have to reconcile the
6 employees' opportunities and environment, along with that of
7 the employer, right, and so right now, we're looking at it
8 through the lens of the employer, who's given us information,
9 limited information about the status of the employee and so in
10 order to really dig deep into that question, a similar survey
11 to people, to the labor force would very much get to this.

12 Do you have alternative forms of insurance and are you
13 more or less likely to utilize them now, and I think that
14 reconciling those two things would give you a sense of, like
15 you said, that balloon analogy of now that there are these
16 pressures coming from the employer standpoint, are you going
17 to start looking at, you know, whether or not your spouse has
18 opportunities elsewhere?

19 COMMISSIONER MORGAN: Don't mistake what I'm saying -- my
20 question, this is really good.

21 DR. GUETTABI: No, no.

22 COMMISSIONER MORGAN: This is one of the best ones I've
23 seen that actually -- the sample size is actually a really
24 good sample size.

25 DR. GUETTABI: Yeah (affirmative), absolutely.

1 COMMISSIONER MORGAN: This is good. I like -- I mean,
2 you know, the sample -- usually it's -- the samples are little
3 or it's skewed to Southeast, or you know, this was good, but
4 it's like any time I've ever encountered information, it
5 doesn't matter, people want more of it when they start getting
6 good stuff here.

7 The other question is, and this probably doesn't pertain
8 to the study, as much as anything else, or your future
9 studies, but what do you think with the -- especially with the
10 way our firms are skewed, this is a bizarre bell, it's almost
11 an inverse bell curve, almost, the employer mandate, when that
12 does -- when that wave hits, from -- just from what you're
13 looking at and evidently, there's no chatter from the
14 employers, but in your own mind, and even though you are being
15 transcribed, recorded, and listen, we will not hold you to
16 it.....

17 DR. GUETTABI: I'm not running for office any time soon.

18 COMMISSIONER MORGAN: And believe me, a couple of months
19 ago, people were saying, "Yeah (affirmative), but you said two
20 years ago on July 8th at the Health Care," you know, it
21 happens.....

22 DR. GUETTABI: So you're basically inviting me to say,
23 "No comment at this point."

24 COMMISSIONER MORGAN: No, I'm just advising you to not
25 say anything you don't necessarily want to come back at you

1 like on Facebook in three years. No, what.....

2 DR. GUETTABI: (Indiscernible - too far from microphone).

3 COMMISSIONER MORGAN: What do you think, if you care to
4 comment, what do you think that wave or ripple will do or
5 maybe it won't do anything, I don't -- I was -- I value your
6 opinion, after seeing your study.

7 DR. GUETTABI: Thank you, but I think what's most
8 interesting here, like I said, is that I think we may be
9 slightly overstating the actual near-term effect, right,
10 because of that distribution of employees that I was
11 describing earlier and so a lot of employees are working in
12 those very large firms and so you have basically the group
13 that we're most interested in is the 10 to 49, right, and so
14 almost everybody above 50 is already providing insurance and
15 most of the full-time workers are already concentrated in
16 those and so you have the two groups that are of most
17 interest, the zero to nine, the most number of firms are not
18 being affected by the mandate, but I think that there is going
19 to be indirect pressure on them because now, you've, I think
20 touched on this earlier, is that now, they're going to be the
21 only group that is not mandated to provide benefits and so in
22 terms of actually attracting employees, what are the things
23 that did again -- and when I was mentioning these alternative
24 ways of providing services, how quickly are they going to
25 adopt some of these alternative ways of providing services?

1 I clearly don't know the answer to that, but I think
2 clearly, firms are going to have to abide by the mandate. A
3 lot of the 10 to 49 are already providing insurance. The zero
4 to nine -- now, as firms grow and graduate into that bigger
5 category, that's the other thing, right, and so the ripple
6 effects of how do you change the composition from full-time to
7 part-time, most of the empirical research says that there is
8 anecdotal evidence that it's happening.

9 Is it happening on a grand scale? There doesn't seem to
10 be a lot of evidence to support that. I mean, I'm giving you
11 a little -- I'm giving you the classical economist answer on
12 the one hand and on the other hand (sic), but that's really
13 the truth, right, I mean, we don't really know.

14 I think the zero to nine are fascinating because they're
15 the ones in my mind, in order to compete for talent, right, we
16 always talk here about the shortage of talent, the shortage of
17 human capital and so in a landscape where now it's become very
18 clear, they're the only group, they only employ 13%, but
19 they're the only group that are not actually mandated to offer
20 insurance. How do they compete? What are the dimensions
21 along which they actually make themselves look more attractive
22 and so I think that's fascinating.

23 COMMISSIONER MORGAN: As somebody that agrees with
24 classical economics, I find your answer excellent, but I will
25 -- I think it does give some -- all of us something to ponder,

1 to try to -- at one point, we're trying to reconcile a system
2 that has about 80 million moving parts, whether we went -- how
3 we're going to do transparency, but the whole issue of this
4 and this study doesn't have that many, but it has, how many --
5 how many people or 10,000 firms, it has 10,000 moving parts
6 that's affecting this market with so many macro and micro
7 economic hits, pressures on the balloon, like pin pricks, so -
8 - but again, I want to -- this was a good study.

9 I mean, it makes you really -- it gives information to
10 give us a concept of what -- how this thing is rolling through
11 the employer groups, I think, and I know I'm hiding it, but I
12 really liked it. I liked this study.

13 MS. ERICKSON: Senator Coghill had a question and then
14 Becky.

15 SENATOR COGHILL: Thank you. To the slide on perceptions
16 regarding effectiveness, probably one of the things that the
17 smaller groups can do and probably should be asked as we get
18 into a better wellness program, effectiveness, is short-term
19 benefits on employment absenteeism and then the long-term
20 issues, whether it's Worker's Comp issues or chronic
21 conditions.

22 So on effectiveness, those are going to be questions
23 we're going to have to keep asking, "What is that
24 effectiveness," and that might be very well one of the things
25 the smaller firms can offer that has a bigger bang if it can

1 be proven out.

2 DR. GUETTABI: Yeah (affirmative).

3 COMMISSIONER HULTBERG: So just a clarification, because
4 the employer mandate kicks in at 50 employees, you were
5 talking about the zero to nine group is the one that is really
6 kind of left out of the mix and so it's just because that
7 middle group is generally already providing insurance?

8 DR. GUETTABI: Right, I should have said zero to 49, but
9 the zero to nine, because they're really, considerably less
10 likely to offer insurance, right, and so the pressure is going
11 to translate very quickly to the 10 to 49, but really, it's --
12 everybody that is -- that has less than 50 employees will be
13 affected in the way that I describe from the zero to nine,
14 with the special -- I focused on the zero to nine because
15 there are 10,000 firms in the zero to nine, while they only
16 employ a small portion, there are a lot of them, and so how do
17 they now compete with everybody that is forced to offer
18 insurance, but that's a good point. That was a mistake on my
19 end.

20 MS. ERICKSON: Any other questions for Mouhcine and
21 Gunnar? Go ahead.

22 CHAIR HURLBURT: To kind of change the topic a little bit
23 and it's not something you guys, to my knowledge, have done
24 work on, but Deb and I were meeting yesterday with some folks
25 and among them was Dick Mandsager and I suspect, Julie Taylor,

1 that you would echo Dick's question there, and he said, "What
2 we really need to know in the Providence system and I think
3 Regional and the other, particularly the larger hospitals or
4 larger for Alaska, would ask that is what can we project, so
5 that we can prepare for, as you referenced, this rapidly
6 growing over -- 65 and over population, 22% working now, but
7 rapidly growing." We have the projections of what's happening
8 there. We know that percentage-wise, we're growing more
9 rapidly than any other state from a low base and even more
10 subjective, how can we project what will happen seasonally
11 then? Will we be seeing more snow birds and then how do you
12 manage that, where historically, probably more so in the
13 tribal system, historically, things really slow down in the
14 summertime when there was more subsistence fishing and the
15 commercial fishing and that's leveled out to a very large
16 extent now, but this is all a part of needs for capital
17 investment and planning for the availability of services and
18 the challenges of recruiting people and if you have a work
19 load that goes like that.

20 So this is nothing that I'm aware of that you folks have
21 done, but I thought it was a pretty astute question and I
22 think that probably any of the hospital administrators,
23 particularly in the state, would raise that. So any thoughts
24 or comments?

25 DR. GUETTABI: I gave -- I did a little bit of work on

1 the economic impact of seniors not too long ago and just some
2 back of the envelope calculations and so I like to think about
3 the senior population like an industry, right, and so by a
4 very conservative estimate, you find that they bring into the
5 state about two-and-a-half billion dollars or so every year
6 from Social Security, from earnings and from Medicare payments
7 and so as we go forward, it's really important to start
8 thinking about how well do -- does the current state, as it
9 stands, whether from service provision or from even a housing
10 situation fit the needs of those people as they transition out
11 of the labor force, but also as, you know, we have this brain
12 drain that's inevitable, right, and so you have a lot of human
13 capital that's concentrated in people that are going to leave
14 the labor force here pretty soon.

15 UNIDENTIFIED SPEAKER: (Indiscernible - too far from
16 microphone).

17 DR. GUETTABI: But that's out of love, but so yeah
18 (affirmative), I really think it's -- what can we do? I think
19 that there needs to be a real conversation and I mean, when
20 you think about them -- when you think about people over the
21 age of 65 as an asset, I think one of the things that's really
22 -- that has not been discussed is that the mobility of people
23 over the age of 65 and that communities are now competing for
24 people over the age of 65, because the retirement has become
25 an industry, right, and so there is no reason for a person, of

1 course, there is family linkages that now are keeping people
2 in Alaska more here than in the past, but there is really no
3 reason for them not to live in other places and so when we
4 think about, A) the pressures on employers, B) on what are the
5 needs of the elderly, I mean, we need to understand what are
6 the amenities that they deem most attractive?

7 What are the services that need to be provided and from a
8 firm standpoint, how quickly is the dissipation of human
9 capital going to happen, you know? As this really large base
10 of people that have been here for the last 35 years starts to
11 leave the labor force, clearly, there is a health care
12 question, right, a health cost question, but I think more
13 importantly, there is, from a broad economic question is what
14 are the consequences of this many people leaving the labor
15 force within a very short timespan and so I think there really
16 needs to be a very real conversation and at least an attempt
17 to look at scenarios of how quickly people leave the labor
18 force, how quickly are the expenditures changing as the
19 composition of the labor force changes, because I don't know
20 what are the expenditures of people by age, you know, from an
21 employer standpoint and I think that that's something you were
22 trying to get at and it would be fascinating to know that,
23 because you can -- one can extrapolate how much those
24 expenditures are going to increase by as the demographics of
25 the labor force change, but fascinating, I, unfortunately,

1 don't have a great deal of insight as to what's been done, but
2 I think that there are a lot of unanswered questions.

3 DR. KNAPP: So first, I think the question -- that
4 question's a really important one and the significance of the
5 sort of the aging of Alaskans. It's important for what does
6 it mean for health care demands and costs and so on, and then
7 it has a sort of further feedback consequence because, sort
8 of, the -- sort of quality of life and cost of living here and
9 all these things affect how many older people actually stay in
10 Alaska and that has significant economic consequences for the
11 state. So it's really important.

12 The second point is I think that the Department of Labor
13 has a very significant capacity to help analyze these
14 questions and so I would encourage -- I would encourage, and
15 we'd be happy to facilitate this or participate in it,
16 starting a question with them. There is a state demographer.

17 Alaska is fortunate in -- because of the PFD Program,
18 among other things too, have a pretty good ability to know who
19 our senior population is, what ages people are and where they
20 live and how that's moving. I believe the Department of Labor
21 also is able to, you know, and Mouhcine doubts this, is they
22 have information because of the ability to tie in with the
23 Permanent Fund Dividend information to, in effect, track the
24 ages of employees.

25 So a starting question might be, Mouhcine talked about

1 the big firms and the small firms and so on, so you could look
2 at, you know, the age composition of workers in those firms
3 and in effect, find out do the older, you know, do the older
4 people or say people 50 to 65, are they all working with, one
5 might think that they're more likely to work in the big firms
6 and more likely to have coverage than, you know, sort of small
7 firms, but I don't know, but that's the kind of thing the
8 Department of Labor has the ability to look at and certainly
9 an incentive. So I think that these -- these are really
10 questions and it's possible to help advance that discussion.

11 CHAIR HURLBURT: I think that there is national data that
12 we could base it on as far as the increasing costs by say,
13 five-year age cohort or something, and then just apply our
14 higher level of costs here and that wouldn't be an
15 unreasonable assumption.

16 I thought the twist on the question, what are we -- what
17 should we project about seasonality of, you know, not
18 fisherman who have jobs in the summer, but of snow birds who
19 leave in the winter and then probably the safest thing would
20 be to just extrapolate and say we don't have any reason why
21 that would change from what it is now, that you know, that we
22 wouldn't have that from PFD data, but I think from a planning
23 assumption basis, that those were pretty good questions.

24 DR. GUETTABI: Absolutely, and again, I think I'll
25 mention something. The Department of Labor did produce, I

1 want to say about four months ago, a report that looks at
2 where people over the age of 65 actually work, the sectors in
3 which they work and their average wages and I think how long
4 they've been in that particular position or how many times
5 they've changed, from PFD data, how many times they've changed
6 jobs over the last few years.

7 I don't think that there is data about how much they
8 leave the state or how will it affect that seasonality you
9 were mentioning, but one can potentially make reasonable
10 assumptions in order to get to something (sic), yeah
11 (affirmative).

12 MS. ERICKSON: I don't want to -- I don't want to confuse
13 the issue here too much, but this might be a good time to
14 bring it up and to let Gunnar and Mouhcine know that I'm still
15 thinking about it, too, but you all have in your notebooks,
16 we're going to talk about this tomorrow for a few minutes, but
17 let's talk about it now, just keep the employer survey, we're
18 going to come back to that in just a second, but in your
19 notebooks behind Tab Five, yeah (affirmative), keep -- this is
20 just, actually, an exercise that we're going through so we can
21 all practice keeping track of all of the different moving
22 parts and pieces of the health care system and health care
23 financing and implementation of the Affordable Care Act and
24 everything else, we're just practicing, so we're just
25 practicing bouncing around between agenda items, but I want --

1 I want to refer you to, in the document behind Tab Five in
2 your notebooks, the title is Health and Health Care In Alaska
3 2014.

4 This is a new project that we started just in the past
5 month or six weeks or so ago and so I want to take a minute to
6 brief you on it and I've talked, just briefly in passing with
7 Gunnar and Mouhcine and also with Dan Robinson, who's the
8 Director of the Research Unit in the Department of Labor,
9 about helping us under a new contract beyond the one they're
10 just wrapping up with us, with this project.

11 Well, first, a little bit about what prompted this in the
12 first place, since this is a significant work effort that you
13 didn't direct me to do, so I'm asking for your forgiveness, if
14 you decide it was a bad idea, but what prompted it was
15 questions you all were asking at the last meeting about some
16 of the basics about health care delivery in this state, how it
17 works, how it's delivered, how it's organized, how it's
18 financed.

19 At the same time, I was getting lots of similar questions
20 from lots of different directions, from legislators and
21 legislative staff, from other policy leaders in the Executive
22 Branch and I mentioned to you all at the end of our last
23 meeting that we had, the Commission had the Division of Public
24 Health write a paper for us on the health care delivery system
25 in Alaska, how it's structured and how it's financed about

1 three or four years ago, that it was little dated. I had just
2 asked them to update it for us and you all had indicated that
3 would be a helpful tool, not only for you and the other folks
4 who were asking for it, but for the Legislature when they come
5 back on board will have new legislators and a ne Legislature
6 in January.

7 In the course of describing some features of our system
8 and thinking about updating that report, I was referring back
9 to a couple of reports that I am familiar with, historical
10 reports that I'm familiar with and that some of you might --
11 may or may not be familiar with and I brought copies of them
12 here and put them on the back table for Commission members to
13 look at.

14 One of them is posted online now and that is a report
15 that was done in the 1950's and it's the first report that I'm
16 aware of that really provides a good attempt at a
17 comprehensive overview of, both, health issues among the
18 population in Alaska of the day, as well as a description of
19 the health care delivery system at the time.

20 It was a report that was commissioned by the U.S.
21 Department of Interior. They paid the School of Public Health
22 at the University of Pittsburgh to do this report and
23 actually, it was a brand new school. The Dean was a former
24 U.S. Surgeon General, Dr. Thomas Parran, and that report was
25 really significant, not just in providing, documenting the

1 conditions of the time, but there were some significant
2 changes that were made in federal policy related to health
3 services for the Native population, especially, but for the
4 territory in general in Alaska.

5 It was a report that for years, from when I started
6 working in public health in the state in the early '80's, that
7 was a long time ago, it was often referred to as the Parran
8 Report and folks working in the system would refer back to it
9 and I know, Ward, you mentioned that was kind of expected
10 reading of new folks coming in working for the health service
11 back in the earlier days here, too.

12 So it's a significant historical report and something
13 that I thought was important enough. There was not a digital
14 form of it available and was able to work with some
15 publication staff to digitize it and it's available now on the
16 Department's web page.

17 So there's that historical reference point and I was
18 referring folks back to, in these conversations this winter,
19 the only other report that I am aware of that really provides
20 kind of a comprehensive statewide, just very objective look at
21 our health care delivery system and at the population health
22 status, again population-wide, state-wide, and that was a
23 report that was produced in 1984 by the -- Alaska's Health
24 System Agencies, which in 1985, went away and I -- there's a
25 little more background on that. I don't want to spend too

1 much time on the history, but it was -- those were
2 organizations that were formed specifically to do health
3 planning for states and for regions with federally provided
4 resources and so there's -- I put a little bit of history
5 about those, just a brief history and if you have more
6 questions about the background -- but this is the only other
7 document that I am aware of, again, that really provides, and
8 it's just a tome, a good picture and it occurred to me at one
9 point, and I think I might have even been sitting with you,
10 Ward, when it occurred to me that these two documents had been
11 produced, published, one in 1954, the next in 1984, and that
12 it's been exactly 30 years.

13 Well, they were exactly 30 years apart and now that it's
14 2014, it's been exactly 30 years since that last document and
15 was thinking, well, if we're in the process of updating this
16 information and I'm also in ongoing conversation with the
17 leaders of the Healthy Alaskans 2020 Initiative, who've been
18 very focused on first, assessing and understanding population
19 health status in Alaska today, and now working on strategies
20 for improving health and they're going to update on that
21 project tomorrow, but working with the Division of Public
22 Health of an update of the description of the health care
23 delivery system, working with Healthy Alaskans 2020 on the
24 population health status, it seemed like a good time maybe,
25 and at our next 30-year interval to try -- for the Commission

1 to pull all of these pieces together and present this report
2 and thought it would be interesting to have some commentary
3 and some perspectives and understanding where we're at today
4 with health care in Alaska and health status in Alaska, some
5 commentary on the historical context of where we've come from
6 over the past 30 and 60 years and also with some thoughts
7 about where we're headed.

8 So anyway, this project has kind of taken on a life of
9 its own, but I have provided a summary of what we're planning
10 on doing and it still has draft all over it, but I convened a
11 very small team of, and I knew the team could grow large
12 quickly and that it wouldn't be effective if it was large, so
13 set a criteria for current and former state health officials
14 to serve as kind of an expert advisory panel for this project
15 and so Dr. Hurlburt, Dr. Butler and Dr. Mandsager are the
16 three folks who are either current or former state health
17 officials still working in the -- still working in Alaska's
18 health system. That was the other criteria I identified and
19 to my knowledge, those are the only three folks -- the only
20 folks in our state who meet those -- those criteria.

21 So I've outlined what I would imagine this final report
22 will look like, what the reference to either appendices or
23 bibliography reports would include and I've added a couple of
24 those to that and then started documenting some of the major
25 issues that we might highlight, at least briefly or mention

1 briefly in this report. To that end, the one -- both of those
2 reports included pretty extensive demographic information and
3 also some comment on the economy of the state at the time,
4 too, just to provide that context for this -- for those
5 analyses and so I had already had a conversation with Dan, as
6 I was mentioning, and with Gunnar and Mouhcine and need to
7 continue that conversation and want to work on getting new
8 contracts in place with them to help with that part.

9 We'll have Public Health doing the health care piece,
10 again, Healthy Alaskans doing the health status piece and ICER
11 and Department of Labor working together on the demographic
12 and economic piece. The timeline's pretty short, but one of
13 the things we'll want to do, at least for a first cut, to go
14 into our report that has to be published in 2014, so we can --
15 it has to have that date on it.

16 If we decide to do a longer report later, we can do that,
17 but I want to make sure that we're identifying the questions
18 and the main points we want to cover on that. So the reason I
19 decided to skip ahead to that is while we have gone off on
20 what might be a little bit of a tangent about issues related
21 to the senior population, while it may or may not be relevant
22 to a study of employer benefits and health coverages, it's a
23 significant enough question that -- and it's already coming up
24 in the conversations around the issues that we want to address
25 and the data that we want to make sure we include in this

1 other report that we'll be working on this -- that we are
2 working on already this year.

3 So that's -- I wanted to provide a little more context so
4 you can understand where these questions that are coming up
5 now, while they might not seem directly relevant to the
6 employer piece, they will be relevant somewhere else. So now
7 that I've explained that to you, do any of you have any
8 questions about this other report project? Yes.

9 COMMISSIONER URATA: When I looked through it, I thought
10 it was really, really, you know, the goals were pretty good,
11 except I thought that, you know, the number one killer of
12 citizens in Alaska is cancer and the other one is heart
13 disease and I don't see those listed in the things to look at
14 and I just would like you to consider that.

15 I think in the future, obesity and diabetes are going to
16 be replacing some of those, yeah (affirmative), so just a
17 consideration.

18 COMMISSIONER MORGAN: We may have to send Gunnar down to
19 Arizona to interview all those winter Alaskans.

20 MS. ERICKSON: Any other questions or comments on this
21 other report project? So Gunnar and Mouhcine, do you mind
22 sticking with us here at the table in case other questions
23 come up or if you want to chip in on the conversation, because
24 what I want to do, I need to look to see if it's time for a
25 break yet, because what I'd like to do next is just do -- hear

1 from all of you what you think the key take-aways from what
2 you heard from Mouhcine and Gunnar are at this point, just
3 after hearing about it preliminarily and we'll build on that
4 over time, what you think the most important points that we're
5 learning from this employer survey are and then I want to
6 spend time, I've already started building this list for your
7 comments so far, but also want to identify what some of the
8 outstanding research questions are and see -- to inform
9 Mouhcine and Gunnar if there might be information, again, that
10 they can pull from the existing data and if not, if we start
11 building an agenda -- for a future research agenda for
12 questions related to employers and employer-sponsored
13 insurance specifically, but you also have on the books for
14 this year, learning about employer -- insurance coverage,
15 generally, and so if that's what we were going to evolve this
16 conversation into this afternoon was, this is what we've
17 learned about employer-sponsored insurance, this is what we
18 need to still understand better about employer-sponsored
19 insurance coverage and then, what are some of the broader
20 questions about insurance coverage generally. So does that
21 make sense for the conversation we're going to have today and
22 what we wanted to try to accomplish? We're not working on
23 recommendations at this point. It's just, if anything,
24 findings will come out of this at the end of the year and
25 additional learning. I was just thinking of one other context

1 piece that I thought I would mention, but then I lost it. So
2 why don't we just see if you all can throw out some of your
3 thoughts and I have a couple of other handouts I'm going to
4 give to you after we talk about what we think we've learned
5 from this.

6 I just remembered, we want to, at some point during the
7 rest of this year, bring employer representatives, more
8 employer representatives to the table. We've done it a few
9 times in the past, but this time specifically to help us with
10 answering some of those outstanding questions and just having
11 a conversation about what employer needs are related to
12 employee health benefits, you know, ultimately from the
13 Commission's perspective, we want to help answer the question,
14 what, if anything, can and should state government in Alaska
15 do to support employers better in questions related to
16 employee health benefits, and I have asked Gunnar and Mouhcine
17 to actually take on one additional work product related to the
18 employer-sponsored insurance coverage project, in addition to
19 the more academic report, well, they'll describe the
20 methodology and the analyses of the data and the findings from
21 the data, something that would be more digestible for the
22 public, so a second report on the data that would be targeted
23 at employers as the audience and that we all -- the Commission
24 could then use that as a tool for facilitating further
25 conversation with employers in the state. So I wanted to

1 mention that to you, too. So does anybody have any questions
2 about the -- these projects? Yeah (affirmative), Emily, you
3 don't?

4 COMMISSIONER ENNIS: I don't think so, no.

5 MS. ERICKSON: Okay, well, let's just see -- if you all
6 could just start throwing out, first, main take-aways,
7 important points you think you've learned just so far this
8 afternoon from the sharing of some of the main points from the
9 research? Allen.

10 COMMISSIONER HIPPLER: I learned that Alaskans think that
11 wellness programs are very important, but we're too busy to do
12 it ourselves.

13 COMMISSIONER MORGAN: Thank you. Excellent report and
14 presentation, I -- one of the things I think is interesting,
15 it's not surprising, it's just a confirmation that the rates
16 of insurance by firm go up as you go up in sizes. It's what
17 you would expect, but seeing that confirmed and it really
18 helps to focus, you know, if the driving force behind this is
19 understanding better the market and then being able to say,
20 "Okay, what solutions do we need?" It's not just one
21 solution.

22 Health care coverage is a -- is driven by all sorts of
23 factors in one's life and so knowing that, knowing that it's
24 this zero to 10 or nine, I keep wanting to polar it with zero
25 and (indiscernible) does, but.....

1 UNIDENTIFIED SPEAKER: (Indiscernible - too far from
2 microphone).

3 COMMISSIONER MORGAN: Okay, so zero to nine, one to nine,
4 knowing that's really where the biggest gap is, then leads you
5 to say, "Well, let's look at that," and then I think it leads
6 to the question that we were discussing earlier, which is,
7 okay, what other alternatives are available and what are
8 people using and to really do -- then have a more complete
9 picture and say, "Now, here's really the gap," so that's one
10 of the ah-ha's (sic) from your report.

11 COMMISSIONER ENNIS: I found it interesting to consider
12 the senior or baby-boomer population as an economic force. I
13 think that's a great concept in terms of what they will want
14 to purchase in Alaska.

15 I also found it interesting to know that the percentage,
16 22% of the baby-boomers are currently in the workforce right
17 now and it leads me to wonder whether that number will be
18 sustained or grow over the next 20 years as we see this climb
19 and ultimate descent, but -- of this age group.

20 So if, in fact, that is the case and you have an answer
21 to that, whether you think that number will be sustained or
22 grow, what impact will that have on employer insurance
23 coverage as there is some correlation with aging and increased
24 medical care needs and increased costs to employers.

25 COMMISSIONER HULTBERG: So a couple of points and things

1 I -- take-aways, I think your observations about the smaller
2 employer groups were really, really good and it may be
3 something for this group to look at in terms of
4 recommendations because my understanding, and Jeff, maybe you
5 can correct me if I'm wrong, but there's a little bit of IRS
6 ambiguity around, with an HRA, what kind of -- whether
7 employers can or cannot -- employers can't pay premiums for
8 individuals, but there is some ambiguity around whether
9 through an HRA, they can. So it may be something to look at.

10 There may be some potential solutions on the horizon at a
11 federal level that could be, at least, that this group could
12 look at. So I would just point that out as maybe -- and go
13 ahead, because I may have misstated that.

14 COMMISSIONER DAVIS: No, there has been a lot of
15 confusion around that and it seems to have been resolved and
16 that employers can -- HRA funds cannot be used to pay
17 premiums.

18 COMMISSIONER HULTBERG: But there are some companies
19 saying that's.....

20 COMMISSIONER DAVIS: I know.

21 COMMISSIONER HULTBERG: Anyway, there's just.....

22 COMMISSIONER DAVIS: There's still confusion.

23 COMMISSIONER HULTBERG: Yeah (affirmative).

24 COMMISSIONER DAVIS: But the IRS has said, "No."

25 COMMISSIONER HULTBERG: It just may be something to look

1 at, maybe that's a policy change or maybe there's some -- some
2 recommendation that could be made that could enable more small
3 employers to provide a mechanism for insurance.

4 The second observation is just from a large employer
5 standpoint, I think what's -- it's important to know how many
6 people are covered, but what's, I think also of interest
7 perhaps to this group, is what kind of coverage is being
8 offered and what, because that benefit structure, that benefit
9 design is really key if you're looking at then how that
10 employer's actions are going to impact the health care market.

11 So I think that's something to look at maybe in the
12 future is (sic), and I know this Commission has done a lot of
13 work already around that issue, but it may be material to know
14 that we have public sector employers generally behaving one
15 way, private sector employers generally behaving a different
16 way, maybe they're not. Maybe they're all, you know, maybe
17 it's not about whether you're public or private sector, but
18 about something else, but understanding at a deeper level, the
19 benefit design, I think is potentially important.

20 MR. PUCKETT: Thank you. Thank you for your study and
21 your report. It's very helpful. I was, for lack of a better
22 term, done at the difference, the gap between what Alaska
23 employers are offering in a wellness program and what we see
24 nationally, especially with the efforts that we've put into a
25 wellness program ourselves here.

1 So I'm extremely interested if there's any way to find
2 out why we have such a large gap. Alaska's already a tough
3 place to be competitive in the business arena and if we can
4 identify, maybe that's part of it, but what is the reason or
5 reasons why that gap is so large.

6 SENATOR COGHILL: Just on that thought, I'm thinking
7 about Fairbanks, I've got maybe the question to ask on the gap
8 between the rest of the states is, in my area, Tricare is big
9 deal. Indian Health Services is a big deal and how do they
10 deal with wellness, as compared to how we do it in a private
11 market or in the public pay market because those two have a
12 significant impact and the Medicare is probably tracking
13 pretty close to what Tricare does, but those three have a huge
14 impact and so the wellness and chronic issues are probably the
15 questions to ask in that.

16 MS. ERICKSON: Would you have the same question,
17 potentially, Senator Coghill, I'm just thinking that if you
18 have that question, we're learning about what employer-
19 sponsored insurance (sic) -- and employers are doing related
20 to wellness. Your question was about.....

21 SENATOR COGHILL: It was actually with regard to
22 wellness.

23 MS. ERICKSON:public coverage sources. Would you
24 include Medicaid in that question?

25 SENATOR COGHILL: Absolutely. What is the emphasis they

1 put on or what is the incentive that they put on wellness
2 issues and I'm thinking Tricare probably have some impact in
3 Fairbanks, certainly the Indian Health Services have some
4 impact and then the other two, Medicaid and Medicare, how they
5 incentivize wellness.

6 You know one of the questions we keep asking ourselves in
7 the Medicaid world is how do we keep primary care out of the
8 ER, you know, so -- but wellness is one question we don't ask
9 very often.

10 CHAIR HURLBURT: On the wellness of necessity (sic), your
11 question was pretty broad and to some extent, I think the
12 response would be a motherhood and apple pie type response,
13 just this is good. We'd like to do it, but then I think,
14 because there is a cost to wellness, just like any other
15 intervention and we need to then drill down, and I think it's
16 clear that there are some targeted kinds of activities, like
17 smoking cessation activities that do make a difference, that
18 do have an ROI, but there are others more in the feel-good
19 category which are popular and most individuals, most
20 employers would say, "Yes, it's desirable," but where you have
21 limited resources, does it really do it (sic), and then there
22 are probably some times where you may not be able to
23 demonstrate a clear ROI, but as an enlightened employer, it's
24 the right thing to do and I think in -- that -- and those are
25 areas, not specifically, broadly with an economist's

1 expertise, but the economist would provide essential help in
2 looking at the hard reality that there is a cost to anything
3 and resources are limited and then bringing that expertise to
4 bear there.

5 The other thought I had was, and it references -- this
6 morning, we talked about transparency quite a bit and how do
7 you get consumers specifically invested in that and I
8 referenced, for example, the article from "The Dallas Morning
9 News" where Texas, since 2007, has had information on hospital
10 charges and 2% of the population have accessed that, not much
11 interest with the answer then being, it seems, based on one of
12 the books over here and the stories we heard and other things
13 in the literature, it seems that with more skin in the game,
14 through high deductible health plans, for example, or through
15 health savings accounts, that clearly changes the motivation
16 and the engagement of the consumer and the alignment between
17 the interest of the consumer and the employer, but -- so you
18 have a snapshot here of what we have.

19 So I think we'll be interested to see what's happening
20 over time and then, if we can (sic), what is the impact of the
21 Affordability (sic) Care Act's limitation to \$2,500? Does
22 that, in fact, make it so low that it negates the potential
23 for the gain that you would have with a high deductible or
24 consumer-directed health plan to get that engagement, and I
25 think those are going to be kinds of information that will be

1 important to know as we look at what can we do. Gunnar, yeah
2 (affirmative).

3 DR. KNAPP: As I'm sure you're aware, we, in designing
4 the study we did, we just -- there were so many things we
5 wanted, you know, would have liked to have asked about and
6 wanted to probe more deeply and we -- but all experience
7 shows, you have to limit your questions and you have to
8 construct questions that will be understandable to the people
9 that you're doing (sic) and so that you're trying -- trying to
10 get the main information from and yet, we wanted -- and Deb
11 kept reminding us of how great the interest was in making a
12 start on getting some understanding about this wellness
13 program, wellness programs and what is, you know, sort of,
14 what's being offered and so on, but we recognized that there -
15 - we left unanswered way more questions than we, you know,
16 than we addressed and I think that -- my sense is that these
17 are really good questions about wellness programs and the way
18 to get at them is through some other mechanism than the big
19 employer survey that we did, some more -- either some more
20 targeted survey or working with this group of employers that
21 you're working with or some things.

22 I would endorse the value of getting a better
23 understanding of what's going on here and all my instincts are
24 that you get it by talking more in depth to a smaller group of
25 people and thinking very, very carefully about these kinds of

1 -- these kinds of things. So it's tantalizing. We wanted to
2 ask more, but we just had to limit ourselves.

3 CHAIR HURLBURT: Maybe the definition of success that
4 you've provided really good information, but it's led to more
5 questions and that's -- that was part of the desire.

6 MS. ERICKSON: Well, and that's -- yeah (affirmative),
7 that is what we expected.

8 CHAIR HURLBURT: Yeah (affirmative).

9 MS. ERICKSON: And hoped for, and you know, I'm going to
10 hand out in a little bit, maybe right before the break, just a
11 PowerPoint presentation that's a summary of the findings from
12 the last analysis of insurance coverage and that last -- in
13 Alaska and that last employer survey that was done by the
14 Department of Labor and the Division of Public Health back in
15 2006, was when it was administered.

16 Yeah (affirmative), we tried to base this questionnaire
17 off that one, so we could have a little bit of, at least
18 point-in-time trend data, but I just wanted to mention, there
19 were multiple other studies that were done in conjunction with
20 that overall analysis. So the employer survey was just one of
21 them.

22 The team that was doing that study conducted, and
23 actually contracted with ICER, to do a focus group analysis.
24 They also conducted, I'm not sure who did this piece, but a
25 household survey, just calling Alaskans and had a series of

1 questions for what they have and what their practices are.

2 So there were lots of different pieces. It seems to me
3 there was a fourth one, as well, but there were actually three
4 or four different studies that were done and so as we identify
5 some of these other questions and prioritize what's the most
6 important thing to understand, and we can look at some of the
7 other research tools and -- for continuing the conversation,
8 but it really was in part to seed a conversation with
9 employers, too, and we're looking forward to doing that,
10 whether it becomes a formal focus group study or not, I don't
11 -- we'll decide if that's necessary.

12 COMMISSIONER CAMPBELL: It strikes me, does anyone know
13 where the tipping point is in designing a health care policy
14 where the deductible is so large that people delay care, just
15 as if they would if they were uninsured?

16 CHAIR HURLBURT: It seems to me that we may see that, say
17 with the Bronze Affordable Care Act plan because as people
18 picking Bronze because they don't have much money. They're
19 premiums are 90% subsidized, but they're still a big
20 deductible there that I would think most of the people that
21 pick Bronze can't come up with the deductible. So you know, I
22 think we'll see what will happen. David, yeah (affirmative).

23 COMMISSIONER MORGAN: Yeah (affirmative), on that issue,
24 basically you're buying what I call true insurance. That
25 kicks in when you're on the boat and that 1,200 crab pot that

1 they use falls on you and I've had to Medivac those
2 individuals and it's going to be 150,000 to keep the guy
3 either alive or at least reasonably intact.

4 So it makes sense to him, you know. It's true -- the
5 true concept of insurance, catastrophic, the equivalent of
6 your house burning down kind of stuff, but to go back to your
7 study, and this may be so nuanced (sic) that it's -- the cost
8 of finding this out may be impossible, but I kind of go back
9 to the theme, I -- I get on themes, you know, the big picture,
10 I think it would be interesting, besides tracking the
11 individuals that don't have insurance in these small firms,
12 but the ones that -- that they did indicate that they were
13 getting health coverage of some type another way, VA, Tribal,
14 even using health centers with a sliding fee scale.

15 I mean, I think the max visit is in the \$50-range, you
16 know, you get a provider visit, some pharmacy, maybe an x-ray
17 and a lab, if you need it, even a little dental care. That's
18 a good deal, you know, so it -- and there's 330 money that
19 supports it. To me, that's almost a subsidy, you know, takes
20 it from the \$400-range of that visit or \$300 down to 50 or
21 maybe even zero, if you're -- don't qualify for Medicaid, but
22 you don't have any money, but also, looking at that group
23 that's not utilizing that.

24 We know there are large -- we've sat in here and heard
25 that we have a large number of veterans, tribal and non-

1 tribal, that don't avail themselves of VA health benefits,
2 more than before and higher than the national average, because
3 we started Indian Health community health centers started
4 working with VA two years ago. That's why you don't have, you
5 know, maybe a grand jury up here on some issues in the VA, but
6 to know that would also be interesting.

7 Are we leveraging programs, dollars that we already have,
8 but aren't using them to help control the health care cost on
9 the micro level of the firm and on state government, if you're
10 following me? A person that doesn't have insurance and could
11 have VA coverage and just doesn't do it. If he had VA
12 coverage, it would take a lot of those costs out of, from a
13 micro sense of the firm, out. You with me?

14 DR. GUETTABI: We're in the process of administering a
15 pretty large-scale survey of VA benefits and so we still
16 really, I mean, we haven't sent anything out and so that will
17 get us a little bit closer to potentially answering your
18 question is how many people qualify for benefits and don't
19 actually use them or get them and what are.....

20 COMMISSIONER MORGAN: That.....

21 DR. GUETTABI:the reasons why they're not
22 potentially.....

23 COMMISSIONER MORGAN: This is economics speaking, but I'd
24 like to know by those firms.

25 DR. GUETTABI: Yeah (affirmative), no, no, I -- yeah

1 (affirmative).

2 COMMISSIONER MORGAN: Okay, but I would -- I would couple
3 that with Indian Health because then, you know, they may have
4 insurance or maybe not and are opting not to, you know,
5 they're not opting into utilizing some of their Indian Health
6 benefits. It's probably smaller than the VA issue.

7 On the wellness issue, I think what you're going to find,
8 if you really talk to people like the Keiser Foundation, is
9 just like primary care or even medical home, when you -- if
10 you impanel all of your patients, this is the part that nobody
11 likes to talk about in primary care, if you impanel all your
12 patients and put them all in the medical home, the average
13 benefit to the cost saving to the entire macro sense or the
14 accountability organization is marginal.

15 Where you get large payoffs is in what we -- what we've
16 talked about a little earlier, chronics. If you look at
17 wellness programs that kind of key in with economic
18 incentives, more dollars, better insurance, some economic
19 incentive, but those individuals that do smoke or are
20 teetering (sic) or obese or have diabetes or one of those
21 chronics, then you'll, I think this is -- this is my theory,
22 that there, just like in medical home, is where you will
23 impact health care costs, but having medical home and wellness
24 programs for the average guy that may be a little overweight,
25 but has not chronic problems, blood pressure is a little high,

1 but not bad, the marginal effect is probably small and
2 economic resources used, or as my friend from Primary Care
3 Associates used to get upset with me, widgets, you know, but I
4 think the wellness programs that kind of target those areas
5 and medical home programs that are really effective, I know,
6 because I've seen that if you follow HEDIS and you impanel
7 your diabetes patients and you got -- you can track their
8 costs from primary care all the way into the hospital ER and
9 pharmacy and 80% of those patients just follow the HEDIS
10 protocols, you'll save about 25% to 20% (sic) on bed days,
11 which are about three grand a night usually, ER visits and
12 script, pharmacy.

13 If you applied that to the Medicaid program, you're
14 talking about a savings between 150 million to 200 million the
15 first crack out of the barrel. It won't get it every year
16 because you're basically -- it's the first time. So I
17 suspect, and I don't know if you could even prove this or not,
18 if you really look at -- you've looked at what's in these
19 wellness programs, but the very successful ones, and I bet you
20 Keiser knows who they are, that those wellness programs that
21 couple an economic incentive, but also target those with
22 chronic or borderline chronics is where the real pay off is
23 quicker.

24 Now, we had a gentleman, I can't remember his name, I
25 guess I'm getting close to 65, who we shared a program and he

1 brought a book. We had the book. I got it. I looked at it
2 last night, but I can't remember his name, and we did a joint
3 program with Commonwealth North. They approached it that way
4 and they did get some savings. Do you remember -- what.....

5 MS. ERICKSON: It was -- yeah (affirmative), it's
6 the.....

7 COMMISSIONER MORGAN: Is it over there?

8 MS. ERICKSON: Yeah (affirmative), it's over there.

9 COMMISSIONER MORGAN: So that's very nuanced (sic) and I
10 don't know if you can do that latter part, but I think, not
11 only looking what's in the wellness program, but looking at
12 the type of -- how you're steering people in with what
13 incentives may have -- where the pay off is.

14 It's just like primary care. If you put everybody in it,
15 you know, you will lower some of this stuff downstream, but
16 since it's a huge pool and a lot of them, you know, don't go
17 to the hospital a lot, you don't have a lot of effect, but if
18 you look at it by disease or diagnosis and the chronics,
19 there's where the pay off is. Are you following me? Is
20 that.....

21 DR. GUETTABI: Yeah (affirmative), I mean, ideally what
22 you're describing is, I mean, from a program evaluation
23 standpoint, from an economist's standpoint, it's the cleanest
24 way of potentially determining, A) the benefit and, B) the
25 causal effect of a wellness program.

1 If you work in conjunction with an employer or the group
2 of employers and you randomize groups that are high risk into
3 ones that are having access to whatever services we're
4 discussing and you have another group that doesn't and you
5 follow them for a short period of time and try to, again,
6 identify whether or not whatever shock (sic) you're allowing
7 them to receive is actually beneficial, then you can start
8 drawing those conclusions.

9 Now, the broader question, which is really difficult from
10 a wellness program standpoint is the employee turnover, right,
11 who do the benefits actually accrue to, right, and so there is
12 the short-term additional cost that the current employer may
13 get, but he or she is paying for the costs and the employee
14 may change jobs in five years and so those are all
15 complicating factors, but I think working in conjunction with
16 employers and doing a properly randomized trial of some sort
17 that actually gets at what are the subsets of wellness
18 programs that, A) have the most benefits from a cost
19 standpoint and the ones that have the longer-term savings is
20 crucial if this conversation is to be -- is to have a lot of
21 effect.

22 CHAIR HURLBURT: Jeff, yes.

23 COMMISSIONER DAVIS: So I have a comment/suggestion. It
24 turns out there are wellness actuaries, who have studied all
25 of this very extensively. There are lots of groups, but the

1 one that I'm most familiar with is called Health At Work and
2 Andrew Sykes, S-y-k-e-s, is the principle there and they have
3 the data. They have the studies you just described. So I
4 think that could help to move the conversation along and my
5 understanding from learning from Andrew, is that in fact,
6 there are things that can be done in wellness programs, and I
7 mean, they talk about the interventions, the incentives, the
8 lack of incentives, all of those different dimensions, because
9 we're complicated creatures, but there are things that can be
10 done and if you achieve a meaningful change in your BMI,
11 improvement, then you get an almost immediate improvement in
12 health status with respect to pharmaceuticals, particularly.

13 So it's -- I think a lot of people believe it's, you
14 know, down-the-road benefit, but in fact, it's both. It's
15 immediate and it's down-the-road, but they have all that and I
16 know he'd be happy to talk with you.

17 DR. GUETTABI: Yeah (affirmative), in terms of savings of
18 pharmaceuticals or cost savings, the evidence, empirically
19 speaking, I don't know about the specific wellness programs
20 you're talking about, it's actually really tricky to identify
21 true cost savings, even -- there are really no significant
22 differences in terms of expenditures, health care
23 expenditures, for the most part, between overweight and normal
24 weight. It's when you get over that threshold of obesity and
25 so it does become complicated. I don't disagree. I would

1 have to look exactly as to what their -- but I think that
2 would be immensely helpful. Yeah (affirmative), I appreciate
3 it.

4 CHAIR HURLBURT: I -- and it may be a semantic comment
5 and Jeff, I'd be interested in your take, too, but I would
6 call some of what you're talking about disease management,
7 rather than wellness and I think those are two different
8 issues. The wellness, as I described earlier, I think there
9 are some things, and as Jeff was just describing, where you
10 can show that you do have an ROI, that it's worth the
11 investment and you want to do it. Conversely, there are going
12 to be some things where you really don't, but you just think
13 it sounds good.

14 On the disease management, what I've seen, I would say
15 the same thing. So if you take all the people with a chronic
16 disease, everybody with asthma, everybody with diabetes, and
17 you have a broadly based disease management program, I have
18 found it very hard to demonstrate a clear impact.

19 If you take subsets of that, if you take your most severe
20 and put them into case management, which is a one-on-one kind
21 of thing, my experience is with numbers blessed (sic) by
22 finance types, not just clinicians that don't know numbers,
23 but finance types, an ROI of an excess of 15 to one, with real
24 reduction in morbidity (sic).

25 If you take the group that's not quite that bad and focus

1 on them, say as an example, take an asthmatic kid, your bad
2 asthmatic kids and sending them to an asthma camp or maybe
3 sending them there with their parents where they learn how to
4 manage the disease and administer their medications and do
5 that, you really can see a significant reduction in ER visits
6 and admissions and inpatient days, but if you take the whole
7 universe, my experience has been it's hard to see that it's
8 worth it and so much to the extent that, and I've said it
9 before and in my last job before coming back up here, I stole
10 about half of our positions out of disease management and put
11 them into case management because I felt that it was easier to
12 demonstrate the response, and even on the population basis,
13 you got more for your money out of that in reducing morbidity
14 in that population.

15 COMMISSIONER MORGAN: I hadn't come to any conclusions, I
16 just know that looking at the wellness programs and not just
17 looking at or what Jeff said, but also looking at those
18 subgroups, you know, you can get it down to a certain
19 diagnosis, I'm sure, and then the issue of wellness program
20 versus case management versus disease management, I think -- I
21 think this all hybridizes and it's by the firm, but at least
22 it would be, in my mind, to see if there's -- if there's a way
23 to see if there's ROI out of wellness programs versus general
24 wellness programs with incentives that target certain areas.

25 So I'm not saying either or, I'm saying it's probably an

1 amalgam of what we're all talking about, what you're talking
2 about, what he's talking about, what I'm kind of talking about
3 and it may be there's only two of them or something, so
4 therefore, it's not relevant. I don't know, but I'd just like
5 to know, you know, and whatever it is, it is and I've reached
6 no conclusion on that regard.

7 MS. ERICKSON: I think I have captured the questions
8 related to wellness programs and ROI, which are questions for
9 researchers and I want to bring the question for you all back
10 to what questions do you have of Alaskan employers about what
11 they're doing related to employee health and health benefits.
12 Yes, Allen.

13 COMMISSIONER HIPPLER: I seem to recall in the initial
14 questionnaire, there was a talk about have you changed to a
15 high deductible or consumer-driven health care plan and I
16 don't recall seeing much feedback on that in this survey. Was
17 there that question in the survey?

18 DR. GUETTABI: No. There was no question asking whether
19 they've changed to a high deductible. We asked what type --
20 whether or not you offer a high deductible health plan,
21 whether or not you have a comprehensive, catastrophic and/or
22 another plan and define other plan and the vast majority of
23 Alaska firms offer comprehensive plans.

24 Smaller firms are more likely to offer high deductible
25 health plans, the zero to nine or the one to nine and 10 to 49

1 were about at 15% each, in terms of high deductible and then
2 quite a few of them, well, about 10% of them had both
3 comprehensive and high deductible and so one of the things
4 that was really interesting and we talked about it quite a bit
5 is, I didn't present any of it here, is the question of
6 premiums and it seems as though the types of plans that you
7 have or the mixture of types of plans that you have is highly
8 correlated to the premium that the firm actually ends up
9 paying and so I'm not familiar with the underlying picture of
10 plan selection, but there were some pretty significant
11 differences in terms of a comprehensive plan premium dependent
12 on whether or not you offered comprehensive and high
13 deductible or just comprehensive and across sizes, as well,
14 and so we didn't ask that question specifically, but there
15 were some things that are related to it that I'm not entirely
16 clear on, but we're still kind of grappling with it.

17 MS. ERICKSON: Yes.

18 COMMISSIONER STINSON: You ought to repeat the study in
19 two years and compare it against costs for the state of Alaska
20 and see if we've changed our paradigm. Maybe the Affordable
21 Care Act, there could be other factors, but I would be
22 guessing the influence of the federal government.....

23 DR. GUETTABI: Yeah (affirmative), I mean, I was -- when
24 we initially designed it, we really wanted to use this as a
25 baseline going forward and so -- and I think we've achieved

1 that. We -- I feel like we've gotten a sense of where
2 employers currently are at (sic) and so through a wide lens of
3 prices, offerings, eligibility, and you know, a picture across
4 sizes and so whether it's in two years or in three years, I
5 think once the Affordable Care Act has an effect on both the
6 employee standpoint and the mandate kicks in, we should be
7 seeing some short-term consequences that would be fascinating
8 to follow through with, yeah (affirmative).

9 COMMISSIONER URATA: Was there any information gathered
10 on premiums paid?

11 DR. GUETTABI: Yeah (affirmative).

12 COMMISSIONER URATA: Okay.

13 DR. GUETTABI: Yeah (affirmative), there was information
14 gathered on premiums paid, and like I said, the way we
15 structured the question, we asked basically, what are the
16 number of employees that are eligible for a comprehensive
17 plan? What are the number of employees enrolled in a
18 comprehensive plan, and then how much does the employer pay
19 and what's the share of the premium that the employee pays?

20 Premiums ranged -- for individuals for comprehensive
21 ranged between \$7,000 and \$11,000, which is really not
22 different than the Medical Expenditure Panel Survey data.
23 They differed, like I said, quite a bit based on the number of
24 plans that a firm had and so that seemed to drive part of the
25 premium that the firm was incurring.

1 The cost sharing is still, I mean, there is evidence that
2 the cost sharing has been increasing when we looked at trends,
3 but based on this, it was between -- for individuals, it was
4 between 13 and 20% for comprehensive and high deductible, yeah
5 (affirmative), and so that's, obviously, family plans or
6 dependants were higher, but.....

7 MS. ERICKSON: Other questions that you would have for
8 employers that weren't addressed directly through this survey,
9 but we might address in conversations with them or other
10 studies?

11 COMMISSIONER HIPPLER: I'm not sure if -- well, this
12 might only be appropriate for the largest employers, but it
13 would be interesting to start seeing how many of the larger
14 employers, that are not medical care providers themselves, who
15 are starting to actually offer medical care directly to their
16 employees without intermediaries.

17 Especially as time goes on, it may be more common for
18 large employers to simply hire a medical care provider to deal
19 with their employees in some situations. Thank you.

20 DR. GUETTABI: We asked, was the direct provision or the
21 direct purchase of medical services and right now, the number,
22 I think you saw them, were really low and like you stated a
23 second ago, I'm really curious to see how some of these
24 alternative ways of providing services are going to change
25 over time, but whether that's going to happen for the largest

1 or everybody across the board, I really don't know, but like
2 you said, I mean, I'm assuming that availability of funds is
3 going to restrict some of the smaller ones from potentially
4 doing it.

5 COMMISSIONER HIPPLER: I'm also assuming that virtually
6 all of those who provide it right now are medical care
7 providers themselves.

8 DR. GUETTABI: We -- I have in the -- I actually can look
9 at that. I haven't yet, but yeah (affirmative), I'll
10 definitely do that. I'm glad you brought it up. It would be
11 interesting to see if there are some that aren't (sic) and are
12 providing it.

13 CHAIR HURLBURT: You were thinking provider employers are
14 the only ones doing it, Allen, was that.....

15 COMMISSIONER HIPPLER: That is what I thought, yes.

16 CHAIR HURLBURT: Yeah (affirmative), I think, like
17 Providence does, but Ms. Taylor could tell us. They're doing
18 a number of things there through an ACA program, H2U, is it,
19 where our nurse practitioner based clinics, for instance,
20 Carlyle Transportation was the first one there, I believe,
21 that opened up a clinic and I think some others, some of the
22 union trusts have gotten an interest. So I think there are
23 some things happening that when Becky was Commissioner, she
24 had some conversations about that and it continues to be on
25 the table for the state, although nothing's happened yet.

1 So I think there are some things. It's still pretty
2 early, still not a whole lot, but some thing's (sic) happening
3 by employers or by union trusts now, so.....

4 MS. ERICKSON: Well, I think we're ready for a break and
5 Gunnar and Mouhcine, if you're able to at least stay in the
6 room for a little while to see if folks have other questions,
7 we would appreciate it, but it's not necessary.

8 DR. KNAPP: I'll simply say, at all times, we're very
9 interested in sort of brainstorming and helping with
10 conversations about what -- how different kinds of research
11 could be done. I mean, this is -- totally apart from whether
12 we, ourselves, would be involved in it, because there's so
13 many important and interesting questions, and you know, to the
14 extent we can help, we're always happy to talk about that and
15 we'll stick around in the room and be available in case we
16 have anything to add.

17 MS. ERICKSON: Before we take a break, though, I want to
18 make sure that you have a -- I'm going to give you a couple of
19 handouts that you need to look out. I know you're getting
20 tired, but we need to keep working and there are a couple of
21 handouts I'm going to give you that are slides from -- one is
22 actually the set of slides that Mouhcine presented to us last
23 October on data that he mined about Alaska from some federal
24 surveys and so I've brought those back for you to take a look
25 at, just to refresh your memory, to see what information we

1 have, again, going back to the more general question about
2 coverage generally.

3 Then another is the presentation on insurance coverage
4 from the study that was done back in the -- five or ten years
5 ago, yeah (affirmative). So I'm going to hand that out and
6 I'm going to ask that you -- the Commission members, on your
7 break, don't use the time as much to visit, as to study a
8 little bit.

9 CHAIR HURLBURT: And the bathrooms are locked.

10 MS. ERICKSON: Yeah (affirmative), we locked the
11 bathrooms and turned off the coffee pot.

12 3:01:30

13 (Off record)

14 (On record)

15 3:23:24

16 CHAIR HURLBURT: I think we have a quorum, so why don't
17 we go ahead and start? I think you intimidated everybody
18 else, Deb, so they went and hid.

19 MS. ERICKSON: They left. I know, well, half of our
20 members got up and left, no, they -- we just -- we just lost
21 three, and they are thick. I don't want to go through these.
22 So I thought it might be helpful for you just to skim through
23 them to, if nothing else, to seed some thoughts and I guess
24 what my ultimate question for you is, right now, if we can
25 pull back out of -- we've gotten down into the weeds a little

1 bit, even back from the employer-sponsored insurance question
2 and the employer survey that was just done.

3 We actually started that project related to our core
4 strategy to engage employers and we saw that as a way, both to
5 try to understand employers and employer issues better and as
6 a way to engage them through providing them information that
7 we're learning about their issues and to seek conversations
8 with them again, just to facilitate further conversations.

9 So that's what prompted that survey. In the meantime,
10 you all added to the agenda for this year, just for learning
11 about current conditions, not for developing strategies at
12 this point, the question about insurance coverage in Alaska
13 and when you put it on the agenda, it was a very broad
14 question. We don't have any specifics around it.

15 So my question to you all is, and my thought has been,
16 tie that back together again, this employer-sponsored
17 insurance questions we're answering through the survey can be
18 a first step in answering questions about insurance coverage
19 in the state, but pull back from that even, and what I'd like
20 you to do is just throw out questions that you have today
21 about insurance coverage in Alaska and then we'll back into
22 that, not in conversation with you all, but in writing and in
23 summaries, of answers that we do have to those questions, what
24 questions we have answers to now through the survey, through
25 the other work Mouhcine's done and through other sources and

1 then we can maybe build more of an agenda, if you want to keep
2 this on the agenda for next year with answering some of those
3 other questions, because I don't know that we'll have an
4 opportunity to do any more research around this at this point,
5 at least new original research during the rest of this
6 calendar year.

7 So does that make sense, the question I'm asking you now,
8 and I'll just capture on this slide as you throw out ideas,
9 and if you want to throw them out in the form of a question,
10 your questions about insurance coverage in Alaska. Yes,
11 Allen.

12 COMMISSIONER HIPPLER: So I have a question, for purposes
13 of counting numbers, are Alaska Native and American Indian
14 people in Alaska, who have access to Indian Health Service,
15 are they considered uninsured if they have no other insurance?

16 COMMISSIONER URATA: Yes, they're considered uninsured.

17 MS. ERICKSON: So I guess -- I guess another way to
18 answer that question is the Indian Health Service benefits are
19 not considered insurance coverage, which it's -- but the
20 financial access to care is a slightly different question.
21 For the purpose of the -- Mouhcine, what's the name of the
22 census bureau survey, the.....

23 DR. GUETTABI: The American Community (indiscernible -
24 too far from microphone).....

25 MS. ERICKSON: American -- there's one that begins with a

1 C, too, I thought.

2 DR. GUETTABI: Consumer.....

3 UNIDENTIFIED SPEAKER: Current Population.

4 MS. ERICKSON: Their -- Current Population Survey, for
5 the purposes of the Current Population Survey, they're
6 considered uninsured.

7 COMMISSIONER HIPPLER: Well, then we kind of have to
8 adjust the numbers to make them make any sense, right, I mean,
9 and I'm not -- I don't know everything about Indian or tribal
10 health, but for the most part, my experience has been with
11 people who can utilize tribal health is that it's essentially
12 a very low cost to them and in some ways preferential over
13 insurance and if it looks and smells like insurance and it
14 gives you even better benefits than insurance, to not refer to
15 it as insurance kind of makes the numbers less useful than
16 they otherwise would be. I could be wrong on this, but that's
17 my experience.

18 COMMISSIONER URATA: Did this Commission, how does this
19 Commission define it, coverage by tribal health?

20 MS. ERICKSON: The only time we've addressed this is in
21 our very, very first report before we were even formed in
22 statute, when we were still under Administrative Order. I --
23 the first report that I wrote back in 2009, pulled that survey
24 data and I had our epidemiologist, who's a demographer, tease
25 that out to show both numbers.

1 So we looked at it separately at one point. We haven't
2 really defined what we consider to be insurance coverage or
3 not and I don't know if that is something that we want to do.
4 Yes, Becky.

5 COMMISSIONER HULTBERG: I'm going to -- I'm the new
6 person, so I'm trying to struggle -- I'm trying to understand
7 what question we're trying to answer here and if the question
8 is about insurance coverage, that's a different question than
9 if the question is about access to care and so I'm not sure
10 which one we're answering here.

11 CHAIR HURLBURT: Well, let me maybe take the Chairman's
12 prerogative and break our normal protocol. Verne raised her
13 hand and why don't we share your perspective and the maybe,
14 I'd like to share mine also, Bob, to answer your questions.

15 MS. BOERNER: Thank you. Verne Boerner, Alaska Native
16 Health Board. I did want to offer that there is one
17 distinctive difference between tribal access to the Indian
18 Health Service funds or programs and the Indian Health Service
19 programs are not a guaranteed service for a premium, whereas
20 insurance provides certain guarantees to the individual, the
21 beneficiaries of those programs for those premiums.

22 The Indian Health Service is grossly underfunded and has
23 been chronically underfunded historically, since it was --
24 since its inception. Currently, they project that it's
25 underfunding is only at about 56% of the level of need and so

1 it is not -- you are not guaranteed to be receiving services
2 to address your health care needs and in many cases, care is
3 denied, unless it is a life or limb situation. So that is one
4 critical difference and that also addresses some issues
5 whether or not you have access to care, even with being
6 eligible for the Indian Health Service.

7 CHAIR HURLBURT: Thank you, Verne, and I think to say
8 that another way, I would say I think one reason is there's
9 not a defined benefits package, such as you would have with
10 insurance.

11 One of the results of that, back when Dick Mondsager was
12 Director of the Medical Center, one of the innovative things
13 that Dick did there at ANMC was exactly what John Kitsaver did
14 in his first go-round as Governor of Oregon was set up a
15 hierarchy of needs, so that -- the Medicaid enrollees, so that
16 where you had resources, you did it where the need was most
17 and you had the most chance of having an impact.

18 Interestingly, that was, in the Clinton Administration,
19 disallowed by CMS when he tried to do that, but with the
20 limited contract health service budget, particularly at ANMC,
21 when Dick was there, he tried that. So there is no defined
22 benefit package such as you have with insurance, but I have to
23 say after my 30 years in the Tribal Health System that I
24 honestly never felt I had a patient that had something that
25 they really needed that I could not get for them and I think

1 we did provide quality care, but it really was, in some ways,
2 it's like a capitation. You get the money and how, you know,
3 the third-party collections for ANMC are the majority of the
4 budget, not so in the rest of the state, but you get a budget
5 and then you have to do the best you can to manage with that
6 budget and so I think that's probably part of the reason, just
7 saying exactly what Verne said, but maybe in a little
8 different way why there would be a contention it's not
9 insurance, but I continue to have -- I was there yesterday.

10 They allowed me to come for my care as a retired
11 Commission officer and I still go because I have a high level
12 of confidence and I know you do from your years in the system,
13 too, so.....

14 COMMISSIONER URATA: So then -- then I take it that this
15 Commission would not define that as health care, I mean as
16 insurance, but that they do have access to health care, is
17 that correct?

18 CHAIR HURLBURT: I disagree with an insinuation or an
19 implication that the coverage through the Tribal Health System
20 is not health care coverage. You know, I can accept, do you
21 want to call it insurance or not, but I do regard that as
22 available health care coverage for folks. You might call it
23 insurance, but I can say it without using that word, too.

24 COMMISSIONER URATA: Well, I'm just trying to get a
25 working definition so we can move forward and what do you

1 prefer?

2 COMMISSIONER CAMPBELL: In my years on the -- I always
3 had a contract with the health -- Native Health Service and it
4 was treated just like any other insurance within the limits of
5 that dollar amount of the contract. It was a finite number
6 per year or quarter or whatever the negotiation was, but the
7 patient received -- didn't know the difference if they didn't
8 have a Blue Cross policy, for instance, and if you ran out of
9 funds, you had to go pound (ph) them up north to the medical
10 center or let them find some other thing and the thing that
11 always puzzled me was that we had, particularly during the
12 pipeline years, we had many, many of our beneficiaries who had
13 perfectly good insurance coverage from their years as union
14 laborers and yet, they would come in as beneficiaries and want
15 to use that monthly allocation first, before they would touch
16 their insurance and I used to have really, really hard
17 discussions with those people over that, but they felt
18 entitled and they were the boss.

19 CHAIR HURLBURT: Yeah (affirmative), and you might also -
20 - you were, I know, told, "We're out of money, you've got to
21 send them up to ANMC," and you would say, "You know, that's
22 crazy. Why should we send people 130 miles away when we can
23 care for them in Seward perfectly well," and that was because
24 it wasn't a guaranteed menu of benefits, but it was a budget
25 and you'd run out of it and so from your standpoint where you

1 stood, there was that craziness about the system.

2 COMMISSIONER CAMPBELL: Yeah (affirmative), it used to
3 raise my blood pressure considerably.

4 COMMISSIONER URATA: So under the Accountable (sic) Care
5 Act, are they required to get insurance? Do they fall under
6 the mandate or do they -- or do they have an exemption then?

7 CHAIR HURLBURT: (Indiscernible - too far from
8 microphone) exemption, correct.

9 UNIDENTIFIED SPEAKER: They're exempt.

10 COMMISSIONER URATA: Okay.

11 COMMISSIONER HIPPLER: Because they already have
12 insurance.

13 MS. ERICKSON: And rather than -- yeah (affirmative), we
14 could debate this all afternoon and I don't know that it is
15 very.....

16 COMMISSIONER HIPPLER: That was a joke, I know.

17 MS. ERICKSON:very helpful. I mean, what -- I
18 think your -- the question is -- before -- before the question
19 about insurance coverage and what do we know about insurance
20 coverage, I assume the reason we want to know that is because
21 there can be different barriers to care and a significant, if
22 not the most significant barrier to care, is financial access
23 and having some form of financial access, whether it's
24 insurance coverage or services available through some other
25 benefit program, is a form of financial access to care.

1 Now whether it's sufficient for either Indian Health
2 Service beneficiaries with the Indian Health Service
3 underfunded or for folks who have -- who have access to the VA
4 health system and have to wait for months to get an
5 appointment or if it is folks with commercial insurance that
6 has high enough deductibles and high enough copays that they
7 still can't afford services. There's still that question
8 about financial access or not.

9 So I -- and I -- so I think that's in part why I wanted
10 to ask you all the question about the -- what you wanted to
11 learn about insurance coverage, since that's what we put on
12 the agenda for this year. Is it a broader question about
13 financial access? Are we going to learn enough from existing
14 sources with the data that we have from national surveys, the
15 information that we're gathering, that has been gathered now
16 through the employer survey, other studies have been done, is
17 that enough information about insurance coverage to satisfy
18 you all and are you more interested in digging -- in
19 understanding better, the financial access questions, and then
20 what would those be? Jim.

21 MR. PUCKETT: So is this open to like comparing the types
22 of policies that we have up here in Alaska, the design of
23 them, compared to some of our other states that we use in the
24 Milliman Report? Are we looking at doing a comparison of
25 what's available down there and what we have up here? I'm

1 just asking just for my own benefit what type of stuff are we
2 looking for. Do we know what the average deductible is on
3 insurance in Alaska -- is -- compared to our region? Are we
4 looking at that, at what the average out of pocket maximum --
5 are we looking at benefit designs compared to the region or is
6 that even necessary?

7 CHAIR HURLBURT: What do you think, Jim, to
8 (indiscernible - speaking simultaneously).....

9 MR. PUCKETT: Well, I'm -- I am a little interested in
10 that and also, if we could, could the insurance companies,
11 like Premera, Aetna and so forth, show us this policy costs
12 this much in these states in the region, the northwest region,
13 and the same policy costs this much in Alaska. I'd be
14 interested to see if there's -- if something like that is even
15 available.

16 COMMISSIONER DAVIS: That (indiscernible - too far from
17 microphone) part of Milliman, as I recall, that was
18 (indiscernible - too far from microphone) the cost of
19 insurance.

20 MS. ERICKSON: Well -- yeah (affirmative).

21 MR. PUCKETT: Because I agree with you, it's the
22 financial aspect, if people don't have access to health care,
23 it's most likely because of money and so if we're looking at
24 the insurance, health insurance in Alaska, then we probably
25 would want to compare it with what's in the region that we

1 belong in, as long as you could do an apples to apples
2 comparison.

3 COMMISSIONER HIPPLER: So my understanding right now is
4 that the Department of Health and Social Services has been
5 tasked by the Governor in relation to the Medicaid expansion
6 question, has been tasked by the Governor to figure out the
7 gap, how many people are uninsured and it would be interesting
8 to know if one of their thought processes is, of all these
9 people who are potentially uninsured, this many are Native, so
10 they're insured and we don't count them as uninsured. I mean
11 that would -- I -- that would be interesting to know, what
12 their methodology would be in that respect.

13 COMMISSIONER HULTBERG: I think there have been a number
14 of reports. ANTHC has done a report. There have been other,
15 you know, really good reports that before we -- I mean, that
16 there's information already available, because I do think it's
17 -- it's important to understand the nuance here, because you
18 know, the beneficiaries in the IHS system are not -- I mean,
19 they don't have -- I think -- we can't -- we can't call them
20 insured. It is not insurance and there is a big -- there is a
21 distinction there that is really important.

22 Do they have access to care? Yeah (affirmative), so
23 that's why I think it's important for us to understand the
24 difference in the questions that we're asking, because it's
25 very relevant when you're talking about an insurance product,

1 which is -- has, you know, very specific requirements versus,
2 you know, access to care, whether it's IHS or VA or some other
3 system that provides that care. So I think it would probably
4 be good just to do a survey of what's -- of the work that's
5 already been done, because there are, at least, three or more
6 reports, including the gap analysis that just came out, if
7 that's work that the Commission wants to do, but again, I
8 think it's really important to define the question.

9 MS. ERICKSON: That's what I'm trying to do right now. I
10 want you all to define the question, not how to answer it and
11 if you think what we're getting from this survey of employers
12 and understanding that there are other studies that are done
13 or are being done, if you think that's sufficient to answer
14 the question that you had a year ago that brought this to the
15 agenda for the Commission for this year, then that's okay, but
16 the one question that I hadn't heard before was the one that
17 Jim just raised about how insurance plan designs in Alaska
18 compare to the outside.

19 COMMISSIONER HULTBERG: So I think there's two different
20 things and we need -- if there's going to be work done, it
21 needs to be in one bucket or the other or maybe both, but
22 they're distinct and one is looking at employer plans and what
23 kinds of questions do we have around large employer plans or
24 the small -- small employer market and then there's another
25 set of question around access to health care and how does

1 insurance status or other coverage status affect access to
2 health care, very different questions and I think that's
3 where, if -- we need to pick a path or maybe pick both, but
4 make sure we separate them out, because it gets -- because I
5 think it gets confusing when you're trying to talk about both
6 of those questions, about insurance and access to care.

7 They're related, but I think it may be different. We may
8 be asking -- it may be simpler to ask those questions
9 separately.

10 MS. ERICKSON: I think the way you phrased that was
11 really helpful, too, and maybe that's the way we need to
12 phrase our first question -- is how does insurance status
13 affect access to health care and then maybe we can avoid the
14 debates about the definitions that way, too, and it gets at
15 what I think you ultimately want to know.

16 COMMISSIONER URATA: This might not be a good question,
17 but I thought I'd throw it out and see what kind of response
18 there will be. So is insurance, as we know it today, going to
19 be able to cover people who are currently uninsured? Is the
20 Accountable (sic) Care Act going to fill that gap through
21 their mandates and I guess that's it.

22 COMMISSIONER DAVIS: It's interesting. So there's
23 eligibility for insurance and there's -- or access for
24 insurance and then there's whether you exercise that
25 eligibility or not. There's a big chunk of uninsured fall

1 (sic) prior to the Affordable Care Act in the three
2 categories, people who are eligible for a current program and
3 weren't signed up for it, like Medicaid, people who had chosen
4 to self-insure because they have high enough incomes, that's
5 what they wanted to do and then another group, another third,
6 that really were uninsured because they couldn't afford to be
7 insured.

8 Okay, so then the Affordable Care Act comes along and
9 they couldn't afford it or they had some preexisting condition
10 that made it difficult for them and they lived in a state that
11 didn't have a high risk pool. Alaska had a high -- has a high
12 risk pool. So there was always access in Alaska, but there
13 was still a big affordability problem.

14 With the Affordable Care Act, it was -- eliminated the
15 exclusion of people because they had preexisting condition
16 periods, no waiting periods and there was guarantee issue, you
17 have to be accepted.

18 So anyone, after January 1st, 2014, who wants to buy a
19 policy, regardless of health status, can buy a policy. People
20 who are under 400% of poverty are potentially -- down to 123
21 or 133, are eligible for a subsidy. So if they can exercise
22 their economic decision to say, "You know, I want to buy this.
23 I value it enough and I have a subsidy that makes it possible,
24 or I don't, but I still need it," then they can buy it, but
25 it's when you look at the experience through the open

1 enrollment in 2014, there are a lot of people who were now --
2 had guaranteed issue and had -- were subsidy eligible and for
3 whatever reason, did not take advantage of it and then have
4 moved into a period where there's no open enrollment right
5 now.

6 So eventually, you could get to a point where, I mean,
7 this is the grand social experiment, right, you could get a
8 point where the numbers of uninsured are significantly
9 lessened or we might find ourselves having even less momentum
10 in open enrollment in 2014/15 than we saw in '13/'14, it's
11 just -- it's just really hard to know and even with insurance,
12 so the question about how they match up, I know for Premera,
13 individual plans in Alaska are very, very similar to the
14 individual plans in Washington, but now that we've made the
15 move, our newly adopted daughter has been on an individual
16 Alaska plan through Premera and her premiums were \$430 a month
17 and they're going down to \$240 a month. I put her on a
18 Washington plan. So there's, you know, there's a pretty big
19 variation based on the geography.

20 Back to the -- so that's a specific answer to your
21 question. I hope, Bob, did I answer it?

22 COMMISSIONER URATA: Thank you.

23 COMMISSIONER DAVIS: Okay, you're welcome. I was going
24 to say essentially what Becky did and I'll try not to repeat
25 ourselves, but I think she's right, that kind of the

1 underlying question is, do people have economic access, right?
2 That's the underlying question and their -- people get that
3 economic access in a variety of ways. They pay for it
4 themselves, the VA, the Tribal, you know, Tricare Health
5 Insurance, whatever.

6 So we do need to separate those out and look at each
7 piece of that and say, "Where is the group that still falls
8 through the cracks? Of those who do not have economic access,
9 why? You know, is it just because they simply choose not to,"
10 and looking at this survey that was done in 2007, the folks
11 most likely to be uninsured at 18 to 20-whatever-year-old
12 males. Well, why are they uninsured, because they want a new
13 snow machine more than they want a health care policy, right?

14 So I mean, that's a whole different question and after
15 January 1st, 2014, there's a different set of questions
16 because there were people who weren't -- were uninsured,
17 didn't have economic access because of affordability and that
18 was the primary reason in Alaska.

19 So I think by doing as Becky suggested, we'll have more
20 clarity about what we're really after, but I think that's --
21 as I've listened to this, that's the fundamental debate going,
22 I think, or underlying reason that we're having this
23 discussion.

24 CHAIR HURLBURT: Thanks. Sometimes, we can get
25 information from other states of what they've done and what

1 have the outcomes been. I think Massachusetts with Romney
2 Care is interesting in that they have very high levels of
3 coverage now. Their experience has been that their costs have
4 gone up significantly and their utilization has gone up. The
5 ER visits have not gone down by having people have more access
6 to primary care docs and their health measurements have not
7 improved.

8 On the other hand, we can look at Hawaii, which
9 historically, has had the best insurance coverage rates
10 through their laws related to workplace coverage and there
11 may, you know, sunshine and other reasons for it, but their
12 health outcomes are generally among the best in the country.
13 So you know, I think we can look at what some other states
14 have done. Yeah (affirmative), Jeff.

15 COMMISSIONER DAVIS: Yeah (affirmative), I think -- I
16 don't recall if we've talked about this before, but there is -
17 - Oregon did a Medicaid expansion prior to the Affordable Care
18 Act and have gone back now and studied the results and what
19 they found were that -- was that people were happier, now that
20 they had coverage, but their health status had not changed and
21 their use of emergency room had not changed.

22 So it's another tricky thing here, I mean, we assume some
23 -- we kind of have some, you know, everybody knows that kind
24 of conventional wisdom that sometimes in this space is not
25 really what it turns out to be. There has to be other --

1 there's other ways besides economic access that those have to
2 be addressed.

3 CHAIR HURLBURT: But Jim, as part of what you were asking
4 in quantification, aggregately of what Jeff was telling us
5 anecdotally about his daughter's health insurance costs, so --
6 okay.

7 MR. PUCKETT: (Indiscernible - too far from microphone),
8 but I was just bringing the thought out, is that something
9 that we would want to know in this question that you're asking
10 us to define. I'm not saying that should be part of the
11 question. I was just wondering. I would be interested, but
12 maybe the rest of the Commission would not be interested.

13 COMMISSIONER DAVIS: What I recall, Jim, from the
14 Milliman study is they looked -- they were trying to figure
15 out how prices compared, right, and so one of the prices they
16 did look at was health insurance premiums and then they tried
17 to explain the difference why they were higher in Alaska and
18 did that by illustrating the differences in -- for physician
19 services and hospital services, but their -- Deb, maybe that's
20 something we could pull out and just look at again tomorrow,
21 just that section on comparison. Do you have that? Okay.

22 MS. ERICKSON: (Indiscernible - too far from microphone)
23 and if you have anything more to say, I'm not leaving. I'm
24 writing. I'm putting something on my to-do list
25 (indiscernible - too far from microphone).

1 CHAIR HURLBURT: Okay, what else do we want to know about
2 insurance coverage?

3 COMMISSIONER HIPPLER: Okay, in a -- and I -- in a free
4 market world, generally, insurance is a net loss for the buyer
5 of insurance. That's how insurance, in theory, works, you
6 know. Fire insurance for your house, ideally, all you do is
7 you send money to the insurance company every year and you
8 never get anything back, right?

9 That's how insurance usually works, but with health care
10 insurance, there's a factor of negotiated discounts. So I'm
11 not sure if that theory works. Like if you were self-insured
12 for health insurance, would you expect, over time, to pay more
13 for healthcare because you didn't have access to those
14 negotiated discounts that the health care insurance company
15 could negotiate for you?

16 So I would want to know, of the benefits of health
17 insurance, how much of that is negotiated discounts with
18 providers?

19 CHAIR HURLBURT: Then, to our Libertarian friend, one
20 comment would be, where are the costs really lower and that's
21 where there's government-mandated rates, like Medicare or
22 Medicaid, which rates are a lot better than Premera or Aetna
23 or anybody else can get, but then it's more of a big brother
24 system, but that's a part of the same question.

25 The Medicaid rates in Washington state, it was really

1 hard to understand how primary care physicians would accept
2 them sometimes. You know, it just had to be part of their
3 idealism in serving the communities and saying, "We're the
4 only ones there," but I think, yeah (affirmative), that is
5 useful information. Is that a part of the value added that
6 the insurance company will bring to make up for their profit
7 and need for reserves and the other business needs there, but
8 I think then, we have to be prepared to also deal with the
9 issue of mandated rates, which are already paying for half of
10 the health care in the country, just about, with the
11 contention that those rates are low enough that that's the
12 reason when you pay out of pocket or when Aetna goes in and
13 pays, they have to pay so much to make up for that subsidy.

14 COMMISSIONER URATA: I guess I'll ask, I don't know why
15 these things come into my mind, but so, you know, I guess some
16 people believe that, you know, hospitals get overpaid and
17 doctors get overpaid, as part of the big problem with the cost
18 of health care in the United states.

19 So with that in mind, do you think that insurance
20 companies can control the price or the cost of health care
21 through their various means of hoops and demands and things of
22 that sort, and you know, I don't know if that's a question for
23 this Commission, but in order to control costs of care, there
24 has to be some sort of, you know, I don't know if somehow the
25 free market's not working or the market's not working, so does

1 (sic) the tools that insurance companies have, Medicare or
2 Medicaid, can they control the costs?

3 CHAIR HURLBURT: And I know you're not looking for an
4 answer, I think that outside of Alaska, more so than here,
5 absolutely, because where there's more competition, they can
6 offer steerage and that's leverage to reduced pricing and that
7 reduces overall costs.

8 I think that an important and useful and a quality
9 related function is the medical management area where -- where
10 -- in my bias, you often get a more objective look at what is
11 the high grade evidence, does it support doing this procedure
12 or doing that intervention and I think that improves quality,
13 but as a corollary, I think it helps control costs and in my
14 own experience, you know, and when I say when I was on the
15 health plan side of things, I never once ever felt that I was
16 pressured to not do the right thing for the patient, but
17 particularly with publically traded companies, there was
18 pressure to make your bottom line and to -- and to support
19 your stock price in the New York Stock Exchange and to do all
20 those things.

21 So that pressure was there, not to the extent of do the
22 wrong thing, but let's not waste money and I think that, you
23 know, it's just like docs, there a few bad apples among
24 clinicians that nurses and physicians and others that are
25 doing the medical management bring the idealism that drove

1 them into their profession and carry it out in a way to
2 enhance quality, a corollary of which is saving money, but
3 that's my bias.

4 MS. ERICKSON: Just because he opened his mouth, I
5 thought he was going to say something. Yes, Allen.

6 COMMISSIONER HIPPLER: So you said, "Can insurance
7 companies reduce cost," and I get really confused when people
8 talk about cost and then price in medical care because they're
9 so -- there's such a huge barrier between them and it's so
10 difficult for anybody to figure out sometimes what the cost is
11 and even sometimes what the price is, so.....

12 MS. ERICKSON: What a great segue back to our
13 transparency discussion.

14 COMMISSIONER HIPPLER: Yeah (affirmative), that's all I
15 have.

16 MS. ERICKSON: And I did, actually, Dr. Urata, when you
17 said, "Cost," I typed price, because in the context that you
18 were describing it, you were talking about the price for those
19 services, but did we exhaust our questions about insurance for
20 this afternoon?

21 UNIDENTIFIED SPEAKER: (Indiscernible - too far from
22 microphone) you've made more.

23 MS. ERICKSON: We've just made more questions. No, this
24 is good. I'll pull this together tonight and see if I can
25 make any sense of it and you can look at it again in the

1 morning. I'm sure I can. There were some really good
2 questions that came out of that.

3 So I'm going to go back to our morning discussion of
4 transparency, if you're up for that for the last half hour of
5 the day, does that sound okay? Let's see if I can find that
6 slide without my reading glasses. Getting old is not for the
7 faint of heart and specifically, the question about state laws
8 and one of the things we were going to do that we didn't get
9 to, related to the state law question was just, we were going
10 to do a quick overview of what other states have in place, the
11 45 states that have laws related to transparency in some form
12 and I thought just for kind of the framework, and I'm not
13 suggesting that we would adopt the criteria the Catalyst for
14 Payment Reform used to give almost every state an F, including
15 Alaska, and how they're rating those, but if nothing else, I
16 thought that those state price transparency law report cards
17 that they've put out now for two years in a row are helpful in
18 providing some sort of framework.

19 Again, whether we even like the framework or not, it's a
20 framework for describing levels of transparency and scope of
21 transparency. So I just bulleted out real quickly, the
22 framework that Catalyst for Payment Reform has used in those
23 report cards related to, you know, whether prices are under
24 the legal, the state law mandates are reported to state
25 government only, if they are made available upon request by an

1 individual consumer, if they're made available in a public
2 report or made available by -- via a public website and then
3 the scope of transparency, what exactly is being made
4 transparent and what is the scope of services for the
5 transparency requirement and what's included, in terms of the
6 pricing.

7 It's the charge, the average charge, the amount paid by
8 the insurer or the consumer and then the scope of providers
9 included and then the transparency requirement, if it's just
10 hospitals, hospitals, physicians, surgical centers, for
11 example, so that was the framework that they used.

12 These are just some examples of the different approaches
13 that states are using and I think more and more, some of the
14 newer laws take more of an approach of trying to pull in as
15 many of these different transparency mechanisms as possible.
16 Some of the more recent laws, I'm seeing, do several of these
17 things and I -- Ward was just mentioning the experience of
18 Massachusetts where they have most folks, if not almost all of
19 their folks, covered now.

20 Time will tell whether it results in improved outcomes in
21 terms of population health status and what it's doing to cost
22 and pricing for services. In the short-term, so far, overall
23 costs, of course, are up, but prices have increased
24 significantly, to the point that the Legislature was concerned
25 enough that they passed a law, a health care cost control law,

1 about a year-and-a-half ago now.

2 It's about 325 pages long. There's a whole section on
3 transparency. So they've thrown additional new tools into
4 their transparency toolbox through law. In addition to that,
5 there are different forms of price controls, as well, and also
6 some of the new service delivery models, demonstration
7 projects similar to the ones that they're trying in the
8 Affordable Care Act around ACO's and that sort of thing.

9 So it's kind of throwing everything, and maybe including
10 the kitchen sink, at their cost problem to see what they could
11 do. They've also included, and I don't know if this is the
12 first state to do this in state law, but they're -- actually,
13 and I don't know how if -- if and how they're implementing it,
14 but they're imposing fees on providers for raising their
15 prices above a certain factor and analyzing that from year to
16 year and so I was just imaging that would cause an upward
17 spiral in price, as providers raise their price to absorb
18 their penalty that they had to pay, but I don't know, we'll
19 have to watch.

20 So this is some of the things that states are doing, and
21 this was newer one and it was in that 2007 law in Texas that
22 you referenced earlier, Ward, this was another provision in
23 that law, that -- and I understand just from my reading that
24 they're the first state that actually are requiring now
25 insurance carriers to release claims data to employers and

1 group policy holders and I assume that there are carriers that
2 do that voluntarily, but Texas has a state law now that
3 requires insurance carriers to do that.

4 Prohibition of gag clauses in health plans and provider
5 agreements that create barriers to transparency, requiring
6 providers to reveal prices when asked by a patient, mandating
7 in law that they will do that, requiring providers to provide
8 price data to state government, again, and the state
9 government may or may not make that information more
10 transparent in different forms to the public, requiring
11 providers to post prices online for top procedures.

12 I think this is maybe a little bit newer approach, too.
13 I know Wisconsin passed a law not too many years ago requiring
14 hospitals and physicians to post, for their top 50, 75
15 procedures, their prices and I don't know if Wisconsin does
16 this, but I know that there are others that have also looked
17 at like average charges, maybe a table of prices that would
18 include the price charged, but also average reimbursement for
19 a particular service and also the fees that public payers with
20 fee schedules would pay for that same service for patients to
21 be able to see and compare and understand differences.

22 Another area is requiring providers and/or insurance
23 carriers, both, to submit financial performance data to state
24 government and I think they do that for other reasons anyway.
25 There are state agencies in other states that make that

1 information more public, available to the public through
2 annual reports on financial performance of major health care
3 organizations, hospitals, health care systems and insurance
4 companies, too, and then requirements in law that state
5 agencies produce reports for the public on information data
6 that might already be submitted to them related to prices and
7 also public payer fee schedules, but also again, those
8 financial performance reports.

9 So those are just some examples of the forms of
10 transparency mandates in state law in other states and the
11 ultimate question for this group is, you all have a
12 recommendation on the books that the Legislature should do
13 something to mandate transparency. So do you want to dig into
14 this deeper and come up with some more specific
15 recommendations or do you want to just let it lie and see what
16 comes out of the mix, and then I do want to talk about the
17 idea of having a stakeholder conversation about transparency,
18 too, if we do that or not. Yes, Jeff.

19 COMMISSIONER DAVIS: So you may not know the answer to
20 this, but are any of these shown, any of these approaches been
21 shown to be effective?

22 MS. ERICKSON: I don't know. It depends on how you ask
23 the question. I don't know if there's an answer, but I think
24 we've been focused, when we've talked about whether it's
25 effective or not in the conversation today so far, on whether

1 patients are using it to make decisions. That's one question
2 and I think the research is showing that so far, not so much,
3 but it's growing because of the changes driven, in part, by
4 the Affordable Care Act and higher financial pain that
5 patients, even with insurance coverage, are experiencing and
6 going to be experiencing. So that's one question.

7 Another real important -- actually, I think it was
8 suggested in the All-Payer Claims Database article that was in
9 the "USA Today" and you asked for it this morning and Barb
10 printed it and put copies of it at your seats, so you have a
11 copy of that now, and the title is "Claims Data Crack, the
12 Health Care Cost Riddle," and so there's a researcher in that
13 article suggested that, and that particular researcher's
14 opinion, an economist, I think, Mouhcine and Gunnar, was that
15 the transparency in this case provided through an All-Payer
16 Claims Database, that data might be actually more helpful for
17 referring physicians than it would be for actual patients and
18 also for payers in evaluating and understanding -- so the
19 transparency from, not just for the payers -- for the
20 patient's perspective and whether patients will use that
21 information, but do -- do their clinicians want access to that
22 information to help make those decisions and that's something
23 that I can't remember if it was you, Dr. Urata or Dr. Stinson
24 or both of you or some other clinicians on our group, but I
25 remember that coming up in conversations before, the

1 frustration that physicians face when they are trying to help
2 their patients make decisions and don't know, themselves, when
3 they're referring them to -- for specialty services or for a
4 particular type of care, what sort of cost they're asking them
5 to incur and whether they're going to be able to afford that
6 or not.

7 So I think -- and then the other issue that comes up in
8 the literature related to whether it has an effect or not is
9 kind of the moral suasion and will providers, who don't have
10 access to this information already, if they're able to see
11 what they're charging and what others are charging, there
12 might be an unintended consequence of, well, if they're
13 charging that much, I'm going to charge that much.

14 That can happen, but then the other question is, is there
15 -- there's also the red face test and if everybody's looking
16 at that information, is that somehow going to raise enough
17 uncomfortable questions for them, if not in their own
18 conscience, then among their payers and patients at some
19 point, that they'll be downward pressure again.

20 So the answer to your question is I don't -- I think the
21 jury is out, on one hand, but then the question back to you
22 is, are you considering all of the different impacts of
23 transparency, not just on whether a patient's taking it and
24 using it to make a decision or not and how is -- how is the
25 answer to that question going to change over time as this

1 marketplace is evolving so rapidly or devolving, whichever way
2 you want to think about it.

3 CHAIR HURLBURT: I think, you know, you're asking the
4 question, it implies that, to your knowledge, probably not,
5 and I think that probably generally true. Colorado, which was
6 the last one to come up, which was two or three years now, has
7 not seen anything yet and I'm not sure, but it seems, I
8 believe, I've read that New Hampshire has had good experience,
9 but it took them a few years to get there, to get more
10 complete participation and I think the Blues Plan is the
11 biggest in New Hampshire, I believe like it is here, but I
12 think they think that they are getting a handle on cost, but
13 that's the only one, and I might even be wrong, because I
14 don't have it here, that I think of.

15 COMMISSIONER DAVIS: I was more reacting to this slide
16 and thinking about those and thinking, "Yeah (affirmative),
17 there's an awful lot of work or could be," and is there a
18 corresponding benefit to that? The example that was used this
19 morning of requiring hospitals to publish their charge master
20 online, 35,000, that doesn't tell you anything. It doesn't
21 tell you what an episode of care is going to cost or how
22 efficient they are or anything like that. It just is a list
23 of gibberish, right?

24 So that -- most of what's on that list to me just seems
25 like, okay, it's a good attempt, but I think it was David,

1 this morning, who was saying that maybe we can just identify
2 some low hanging fruit. He didn't use those words, but rather
3 than trying to come up with a perfect solution, let's come up
4 with one or two or three or four things that we think really
5 might work and that are simple, because there is a problem.

6 I was sharing with Becky this morning that through my
7 wife's health journey, she was having procedures from one
8 particular provider and they cost X dollars, a lot of zeroes,
9 and then she switched to a Dr. Stinson and his total charge
10 for everything was a fifth of what this other provider was
11 charging, a fifth, so \$5,000 instead of \$25,000.

12 She just had surgery in April and interestingly enough,
13 the neurosurgeon's office was very transparent. They came in
14 and said, "These are -- this is what she's having done. These
15 are the codes. This is how much it's going to cost you," and
16 they had everything there, not facility, but everything
17 related to the physician fees.

18 So I could take that and I called Blue Cross and I said,
19 "Are these within the allowables," you know, so we knew. So
20 that was cool, but then they sent us to a surgery center and
21 she was there for six-and-a-half hours and the bill was
22 \$107,000, and I hadn't looked into that. I didn't know and I
23 don't know if it would have been \$107,000 somewhere else or
24 not, but maybe it's 50 some place else, you know, and that
25 would be -- just because I hate to waste money, that would

1 have been a good thing to know up front, but it would be so
2 difficult right now to figure out.

3 So are there ways that for -- we could put numbers that
4 are real in the hands of the public, if they want it, but
5 maybe more importantly, in the hands of referring physicians.
6 I mean, if her referring physician had known that Dr. Stinson
7 was 5,000 and this other clinic was 25,000, we would have gone
8 straight to Dr. Stinson.

9 So it's things like that, I think, that maybe I just know
10 some outrageous examples, but well, there's one cardiovascular
11 surgeon in town who charges three times what another one does.
12 I wouldn't know that if it wasn't for Premera's health care
13 actuaries. So how do we find -- how do we get it so Dr. Urata
14 knows that. What -- is there something we could do or suggest
15 that would be simply like that?

16 I don't -- I think the jury's out on All-Payer Claims
17 Databases, but I think the way we structured our
18 recommendation around that gives time for those questions to
19 be answered and at any point in time, if the answer is, "No,
20 this isn't worth proceeding," then that's where we would go.
21 If we proceed with phase two, do all these things and go
22 through all these checks -- I'm -- so I'm -- I'm not -- I
23 don't know what the conclusion is, but I don't think I need to
24 know now, but going through that process that we've suggested
25 around all -- the APCD, would answer the questions that need

1 to be answered. So I'm talking about two different things,
2 but -- and I don't know the answer. I don't.....

3 MS. ERICKSON: And I was just wondering if you were
4 suggesting just staying focused on the All-Payer Claims
5 Database and not getting into some of these other.....

6 COMMISSIONER DAVIS: Well, we could do that, but.....

7 MS. ERICKSON: If I -- I -- I thought that maybe was what
8 you were suggesting.

9 COMMISSIONER DAVIS: Yeah (affirmative).

10 MS. ERICKSON: That wasn't what you were suggesting?

11 COMMISSIONER DAVIS: No, I was separating the two in my
12 head.

13 MS. ERICKSON: Okay.

14 COMMISSIONER DAVIS: I mean, APCD may have value. We'll
15 see down the road, but are there other things -- we had that
16 one speaker talk to us about price transparency a long time
17 ago on the phone, you know, is there -- is there someone who
18 has figured out, do these five things and you won't solve the
19 whole problem, but you'll take waste out of the system and
20 improve quality, because you won't go to the guy who charges
21 three times more than the other, you know, that sort of thing.
22 I don't know. I haven't seen it. I know we're working on it,
23 but haven't seen it.

24 MS. ERICKSON: And that presenter on transparency was the
25 one who did the report card, so yeah (affirmative), I mean, I

1 assume what she would say is the ideal state law would meet
2 all of these criteria that they've identified and would get an
3 A in their book, which is making that information available
4 online for the public.

5 COMMISSIONER HULTBERG: I think it might be worth looking
6 at some of the recommendations in the HFMA report, though,
7 because part of the problem is when information is available
8 online, people don't look and so I think it's, you know, going
9 back to the responsibility for, you know, who should be
10 providing the information to people and if you're insured, it
11 should be your insurer or I think looking at that whole -- the
12 whole obligation and who's responsible for each piece, what's
13 the provider's role, what's the role of the insurer, what's
14 the role of the employer, who's self-insured, is really
15 important, because ultimately, you could put everything in the
16 world online and spend a lot of time and a lot of money doing
17 it, but if you get 2% of people accessing it, you've not
18 really accomplished your objective.

19 MS. ERICKSON: Yes.

20 COMMISSIONER DAVIS: I can -- I'm sorry, go ahead. I'm
21 sorry.

22 SENATOR COGHILL: I just -- I tend to agree with that and
23 so if we're going to make recommendations to Legislature --
24 legislators, we will ask what have other states done, what's
25 been successful, but there are two, probably two principles,

1 probably, that will be asked. One is consumer protection, so
2 the right of a person to know the cost. So that will be
3 protected for Dr. Urata, his ability to ask another provider.
4 So providers also have a right to know because they're
5 referers (sic) and so those are the two principles on the
6 right to know that are going to be probably hammered out.
7 That's a consumer protection issue. That's a protection for a
8 doctor referring and a consumer protection for somebody --
9 then it's a matter of how do you dovetail that with people who
10 are the third-party, who have code requirements and paying
11 requirements.

12 That would be the only thing that I could, you know, I
13 would have to have somebody tell me how does that work. So as
14 a legislator, if I'm looking at a consumer protection, then I
15 just need to know what's the business transparency model that
16 has to be looked at, so that I can balance those. So am I
17 articulating that fairly well, but I can tell -- I can tell
18 you, that's what I'll be asking.

19 MS. ERICKSON: The second balancing point is the burden
20 to the industry.....

21 SENATOR COGHILL: Right.

22 MS. ERICKSON:that's being regulated and what's
23 kind of the best practice, best model for that?

24 SENATOR COGHILL: Yeah (affirmative), and I guess I would
25 be probably within the industry because they have to navigate

1 this very complex world where you have Medicaid rates. You
2 have Medicare rates. You have bargained rates and you have
3 people who have bought specific plan entitlements and so
4 that's where I start losing control of how to ask.

5 MS. ERICKSON: I don't want to -- go ahead, and then I'm
6 going to put Becky on the spot.

7 COMMISSIONER DAVIS: Okay, I was just going to build on
8 what you said. I -- because there was -- there was a
9 suggestion in what you put out there that maybe -- maybe we're
10 trying to get too granular in this and the HFMA study laid out
11 some principles. Maybe we go back and look at those
12 principles and say, "Are these principles that we agree with,"
13 and we could just articulate the principles that would frame
14 action in this transparency space. That's what I heard you
15 suggesting. Is that what you were suggesting?

16 UNIDENTIFIED SPEAKER: It sounded pretty good.

17 REPRESENTATIVE KELLER: I'm good on that. We'd have to
18 go back and relook at what the -- where we have come as a
19 Commission because I think the first, one of the things we say
20 on transparency is that the issue is that the public knows,
21 you know, and I think Becky said something that really made
22 sense to me, is we've got to finally figure out what it is
23 we're -- what the question is before we try to answer it and
24 so if we're bringing the Legislature a recommendation, what is
25 it that we're, you know, what is actually our goal and Jim

1 said something, too, that really hit me and that is that we
2 have to find the, maybe the legislative suggestion that maybe
3 will cause the providers to -- the driver to get the providers
4 and everybody at the table, like the report recommended, to
5 get some of these answers together.

6 So maybe we're just trying to go too fast here. If we
7 try to mandate transparency to the public and the public has
8 not need or desire for the data, which it looks like that's
9 the case, I think for logical, you know, reasons, because
10 there's no skin in the game, you know, maybe we have to just
11 go way back and look at just exactly what we're doing with
12 this whole thing. Sorry to dump that on you 10 minutes before
13 -- five minutes before. What is -- like I said, what is.....

14 MS. ERICKSON: You should have waited, yeah
15 (affirmative), eight more minutes.

16 UNIDENTIFIED SPEAKER: And I got to (indiscernible - too
17 far from microphone).

18 MS. ERICKSON: Well, and I just a reminder, too, this was
19 -- all of these strategies are pieces to the puzzle. No one
20 of them is a magic bullet. I'm talking about the eight core
21 strategies. So transparency was identified as an essential
22 element, along with all of the other changes that go along
23 with it, and as a reminder about that, the All-Payer Claims
24 Database was not just about transparency for the public, it
25 was as much to provide a data resource for providers when

1 payment reform starts moving forward and clinical quality
2 improvement tool for clinicians, as well, just a couple of
3 other uses that it was identified that -- as a support for
4 some of those other core strategies that have been
5 recommended.

6 So if we kind of restate the problem that we're trying to
7 solve to make sure that that's real clear and then figure out
8 the best approach to solving that problem using the -- and
9 using as a starting point, I'm hearing, and that was actually
10 one of the reasons I gave it to you and was hoping to get some
11 guidance, if you think that it's a helpful tool for framing
12 continuing conversation, just a place that still might feel a
13 little bit -- a little safer around principles and guidelines
14 and not specific methodologies -- heads are nodding yes.

15 UNIDENTIFIED SPEAKER: I totally agree with that.

16 MS. ERICKSON: And so the question I'm going to ask, but
17 -- and I'm not -- Becky, I'm not going to put you on the spot,
18 but maybe give you a homework assignment, a specific one, and
19 not to put ASHNHA on the spot either, because I don't want to
20 put ASHNHA on the spot, so I -- whether it's appropriate or
21 not for me to ask, I'm going to ask it, and then you can tell
22 me to shut up afterwards.

23 The -- I -- I had looked, at one point, and the American
24 Hospital Association has a policy on transparency that appears
25 to be, at least on the surface, very supportive of

1 transparency and I just noticed recently that they posted a
2 new policy on transparency, acknowledging some of these new
3 things that are happening.

4 I don't think they get too specific in the how, but
5 again, it appears to be supportive of price transparency laws,
6 state laws and the earlier policy was supportive of a federal
7 bill that would have required states, as a condition of
8 participating in Medicaid, to have a transparency law.

9 So the American Hospital Association, that doesn't mean
10 it's the right thing for Alaska or for the Alaska Hospital
11 Association, but I wonder if they have some background behind
12 that policy statement that would give us some information
13 about what they have found works and doesn't work from
14 hospitals' perspective, but -- so you don't need to answer
15 that question.

16 COMMISSIONER HULTBERG: Okay, yeah (affirmative), because
17 I.....

18 MS. ERICKSON: But maybe it's something you can.....

19 COMMISSIONER HULTBERG: I don't, but I can certainly --
20 certainly find out and I think there have been just, you know,
21 hospital associations all over the country have been involved
22 at different levels in this. So it's -- yeah (affirmative),
23 there are a lot of different things to draw from, as well as -
24 - not just from the AHA, but from some other hospital
25 associations.

1 MS. ERICKSON: Well, and that -- I'm just wondering then,
2 too, if there are other provider associations that we might
3 tap into and even -- well, I was just thinking of the
4 insurance group that -- our insurance commissioners, actively
5 involved with -- might have information on experiences of
6 other states that we can tap into, too.

7 COMMISSIONER DAVIS: That's a good thought, Deb, the
8 National Association of Insurance Commissioners may have
9 already started or done work on this and created model
10 legislation. So that's a really good thought.

11 MS. ERICKSON: Yeah (affirmative), I didn't think that
12 they'd have a whole section that works on model legislation,
13 don't they?

14 COMMISSIONER DAVIS: Absolutely.

15 MS. ERICKSON: Yeah (affirmative).

16 COMMISSIONER DAVIS: And it's really good, incredible
17 stuff.

18 MS. ERICKSON: Good. Okay, well, Mr. Chair, I think
19 we're ready to wrap up. The one question -- there were two
20 questions I didn't get answered today, but we can deal with
21 them tomorrow. The one is whether to have a stakeholder forum
22 and if so, what guidance do you have for me for getting that
23 organized. So sleep on that question and the other one was
24 just -- I was imagining we were going to have lots of time. I
25 don't know why I thought that today and thought we could dive

1 a little bit deeper and do a more detailed review of the paper
2 with the recommendations for legislation on All-Payer Claims
3 Database, but that's something that we can maybe do over
4 email, too.

5 I mean, we already did it once and I got your feedback
6 and incorporated that and just wanted to move up closer to
7 being final, so.....

8 UNIDENTIFIED SPEAKER: We could do it on our breaks
9 tomorrow.

10 MS. ERICKSON: Tomorrow, you could do it on your breaks.
11 I think you should do it in your hotel rooms tonight. Do you
12 have any closing thoughts before we.....

13 CHAIR HURLBURT: Yeah (affirmative), just a part of the -
14 - talk about the provider format, that's consistent with, I
15 think, some of the comments that we received through the audit
16 process and that we've talked about is that in the evolving
17 role of the Health Care Commission, one of the things we can
18 do more is be a convenor in bringing stakeholders together.

19 We're not going to be the only people doing that and we
20 need to be sensitive to that, I think, but I think that would
21 be consistent with that evolving role. So any last words?

22 COMMISSIONER DAVIS: Can we leave these here?

23 CHAIR HURLBURT: I'm sorry.

24 MS. ERICKSON: Yes, you can leave your notebooks in the
25 room. The doors are locked overnight here.

1 CHAIR HURLBURT: Okay, so we're adjourned.

2 4:30:22

3 (Off record)

4 **SESSION RECESSED**

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25