ALASKA STATE LEGISLATURE
JOINT MEETING
SENATE HEALTH, EDUCATION AND SOCIAL SERVICES STANDING COMMITTEE
HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES STANDING COMMITTEE
Anchorage, AK
October 6, 2005
10:06 a.m.

MEMBERS PRESENT

SENATE HEALTH, EDUCATION AND SOCIAL SERVICES

Senator Fred Dyson, Chair
Senator Kim Elton

HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES

Representative Peggy Wilson, Chair
Representative Paul Seaton, Vice Chair
Representative Berta Gardner
Representative Sharon Cissna

MEMBERS ABSENT

SENATE HEALTH, EDUCATION AND SOCIAL SERVICES

Senator Gary Wilken, Vice Chair
Senator Lyda Green
Senator Donny Olson

HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES

Representative Tom Anderson
Representative Vic Kohring
Representative Lesil McGuire

OTHER LEGISLATORS PRESENT

Senator Bettye Davis
Representative David Guttenberg
Representative John Coghill, Jr.
Representative Carl Gatto

COMMITTEE CALENDAR

Health Savings Accounts
Hospital Billing

Commonwealth North: Health Care Task Force Findings
Division of Public Health: Concepts for a Web-Based Health Tool Kit

PREVIOUS COMMITTEE ACTION

No previous action to record.

WITNESS REGISTER

Jim Frogue
State Project Director
The Center for Health Transformation
Washington, DC
POSITION STATEMENT: PowerPoint presentation - Transforming Health and Healthcare in Alaska

Greg Scandlen
Consumers for Healthcare Choices
Washington, DC
POSITION STATEMENT: Commented on HRAs & HSAs

Laura Trueman, Executive Director
No address provided
POSITION STATEMENT: PowerPoint presentation - Health Savings Accounts

Duane Heyman, Executive Director
Commonwealth North
Anchorage, AK
POSITION STATEMENT: Reviewed the Alaska Health Care Taskforce report

Dr. Tom Nighswander
Commonwealth North
Anchorage, AK
POSITION STATEMENT: Reviewed Alaska Health Care Taskforce report

Tammy Green, Section Chief
Division of Public Health, Department of Health &
Social Services
PO Box 110601
Juneau, AK 99801-0601
POSITION STATEMENT: PowerPoint presentation - Concepts for a Web-Based Health Tool Kit

ACTION NARRATIVE

CHAIR FRED DYSON called the joint meeting of the Senate and House Health, Education and Social Services Standing Committees to order in Anchorage at 10:08:11 AM. Present were Senators Dyson, Elton and Davis and Representatives Gardner, Gatto and Seaton. Attending via teleconference were Representatives Wilson, Coghill, and Guttenberg. Representative Cissna arrived during the course of the meeting.

CHAIR DYSON announced that the joint committee was meeting to hear about some of the solutions for providing quality and affordable healthcare to Alaskans.

He introduced Jim Frogue.

Transforming Health and Healthcare in Alaska - Saving Lives and Saving Money

JIM FROGUE, Director, Center for Health Transformation, gave background information on the center and presented the following slide show:

Slide 2: Center for Health Transformation

MR. FROGUE explained that the organization is three years old and that it acts as a catalyst to accelerate transformational change in the healthcare sector. The job is to identify better solutions that provide more choices, and better health at lower cost. They share ideas with the widest array of opinion leaders and decision makers across all sectors to accelerate adoption by all in the system. They also help create, advance and improve state and federal public policies to accelerate the transformational changes they talk about.

He directed attention to the Medicaid Web-cast event held on September 20 titled, "Creating a 21st Century Medicaid System." He noted that it is archived on the business website.

Slide 3: Health Transformation

He said this slide indicates that the current healthcare system is in a box. Changes to the system should include raising co-payments, raising deductibles, and increasing co-insurance. However, those are solutions that only marginally change the current system. What really needs to happen, he said, is to

decide what the ideal system would look like and then work backwards. He suggested that most bureaucracies prefer to explain failure as opposed to creating a brand new system that may have little in common with the current system.

Slide 4: What if in 1985 someone told you...

Don't limit future possibilities by what you know now, he said. If you had explained the Internet, DVD players, TiVo, Ipods, and cell phones that double as cameras to someone back in 1985, you would have been viewed as irrational.

Slide 5: Current system versus the 21st Century System

This slide indicates the current system and where we need to go to create a new system, he said.

Current System	21st Century System
Provider-centered	Individual-centered
Price-driven	Values-driven
45 million uninsured Americans	100% coverage
Hidden price	Transparent price
Knowledge-disconnected	Knowledge-intense
Slow diffusion of innovation	Rapid diffusion
Disease-focused	Health focused
Paper-based	Electronically-based
Third party controlled market (patient - provider - payor)	Binary mediated market (individual - provider)
Process-focused govt.	Outcomes-focused govt.
Limited choice	Increased choice
Litigation system	Health justice system
Overall cost increases	Overall cost decreases
Quality and price measured	Quality of care & life

Slide 6: The Consumerism Grid - Generations 1 - 4

This slide talks about the different generations in the move toward more consumerism in healthcare.

First Generation Consumerism:

• Personal Care Accounts:	Initial Account Only
• Wellness/Prevention Early Intervention:	100% Basic Preventive Care
• Disease & Case Management	Information, health coach
• Information Decision Support	Passive Information Discretionary Expenses

• Incentives & Rewards	Cash, tickets, Trinkets (meager)

Second Generation Consumerism:

• Personal Care Accounts:	Activity & Compliance Rewards
• Wellness/Prevention Early Intervention:	Web-based behavior change support programs
• Disease & Case Management	Compliance Awards, disease specific allowances
• Information Decision Support	Personal health mgmt, info with incentives to access
• Incentives & Rewards	Zero balance acct, Activity based incentives

Third Generation Consumerism:

• Personal Care Accounts:	Individual & Group Corporate Metric Rewards
• Wellness/Prevention Early Intervention:	Worksite wellness, safety, stress & error reduction
• Disease & Case Management	Population Management, Integrated Health Mgmt, Integrated Back-to-Work
• Information Decision Support	Health & performance info, integrated health work data
• Incentives & Rewards	Non-health corporate metric Driven incentives

Fourth Generation Consumerism:

• Personal Care Accounts:	Specialized accounts, Matching HRAs, Expanded QME
• Wellness/Prevention Early Intervention:	Genomics, predictive modeling push technology
• Disease & Case Management	Wireless cyber-support, cultural DM, Holistic care
• Information Decision Support	Arrive in time information and services, information therapy
• Incentives & Rewards	Personal developed plan incentives, health status related

Slide 7: Health Savings Account (HSA) vs. Health Reimbursement Accounts (HRA)

It's important to point out the key differences between the two accounts, but the ideal vehicle for consumer directed care is a blend of the two.

HSAs	HRAs
Individually owned	Employer owned
Interest bearing	No interest
Fully portable	Remains with employer
Always tax-free if 213d	Not addressed by IRS
Penalties if non-213d	Healthcare expenses only
Everyone eligible but Medicare	Eligible if employer allows it
Funded by owner and employer	Funded by employer only
Min/max deductibles	No min/max deductibles
Max contribution limits	No max contribution limits
No incentives for compliance	Incentives for compliance

Slide 8: More Information on HSAs

www.cahi.org
www.hsadecisons.org
www.hsainsider.com
www.ehealthinsurance.com
www.treasury.gov

Slide 9: Consumer Driven Health Care

The slide lists eight companies that changed to consumer driven health care plans. Most are HRAs. All the companies listed had been expecting double digit increases in healthcare costs. After the change in plans, all but two saw double digit decreases

Slide 10: Effects of Consumerism

With consumer directed care plans, it has been found that:

- The use of generic substitutions has led to a 15 percent decrease in pharmacy spending.
- Preventive care increases from 2-3 percent to 5 percent of total money spend.
- Outpatient doctor visits are decreased by 18 percent.
- 62 percent of the participants rolled money over into the following year.
- 44 percent of the consumers report they have increased their knowledge in managing their own healthcare.

- 27 percent of consumers report they are more actively pursuing healthy behaviors.

REPRESENTATIVE BERTA GARDNER asked who funds the Center for Health Transformation.

MR. FROGUE informed her that former Speaker of the House, Newt Gingrich, founded the organization. He described it as a combination of think-tank and consultation.

REPRESENTATIVE CARL GATTO questioned whether slide 10 represented fourth generation consumerism.

MR. FROGUE explained that slide 6 represents second-generation consumerism so there is still significant potential for further decreases.

REPRESENTATIVE PEGGY WILSON referenced an Alaska Medicaid demonstration program and asked about ways to make in-home care less expensive.

MR. FROGUE pointed out that a true comparison analyses the same population as it moves from one program to another. He then said he understood that the eligibility requirement for the Alaska experiment was very loose. More people were attracted to the program so there was an overall cost increase. In addition, some people were getting care for the first time so they were spending more than zero, which is what they spent previously. The companies listed on slide 9 included the same populations. They simply moved from one plan to another.

Slide 11: CHT Georgia Project

MR. FROGUE explained that the organization has a satellite office in Georgia and the governor is making the Georgia Project a key part of his 2006 reelection bid. The effort is to:

- Bring together employers group for pay-for-performance.
- Increase diabetes management of state employees and the Medicaid population.
- Advocate public policies that increase screening, education, and management.
- Identify and provide incentives for physicians who follow protocol.
- Impact key populations impacted by diabetes.
- Educate and impact women as key decision-makers.
- Use technology to communicate and manage.

Slide 12: CHT Georgia Project

The slide lists the various participating employers and companies that are actively involved. Employers in cooperation with selected physicians and the Bridges to Excellence Program provide optimal care. By paying physicians $100 per diabetes patient, there is a $350 annual saving. Absenteeism goes down and quality of care and life goes up. In 2004 a RAND study indicated that only 55% of all care given was effective. The four leading chronic conditions, diabetes, asthma, congestive heart failure, and depression, result in 140,000 deaths and cost $143 billion per year.

Slide 13: Consumer "Right to Know"

The slide reflects polling the organization has done on whether consumers think that they have the right to know about their healthcare services. The results indicate that 93% of the population believes that they do have a right to know the price and quality of information from healthcare providers. This compares to 91% who think that the word "God" should be in the Pledge of Allegiance.

Slide 14: Suggested Goals

- Pursue full replacement of consumer directed plans in the state employee health plan by January 1, 2007.
- Provide electronic health records for all state employees by January 1, 2007.
- Provide a publicity campaign that is led by the governor with involvement at all levels of government and private industry to highlight new and effective advances in health care consumerism and disease treatments.
    - Emphasize examples that simultaneously save lives and money.
    - Involve interest groups that represent various diseases.
- Create a culture of entrepreneurship in the state bureaucracies that values innovation. Make sure that the phrase "but that's the way we've always done it," is never heard again.

MR. FROGUE concluded the presentation and stated that the aforementioned ideas are a radical departure from current

practice, but in the long run the result will be better care at lower cost.

CHAIR DYSON asked about success stories.

MR. FROGUE replied Mr. Scandlen could provide the best response, but he understands that about 40% of those who bought HSAs were uninsured previously. He wasn't sure of the drop in cost for any individual state that embraced consumer directed care but as HSAs and HRAs bring the cost of health care down, it is feasible to cover more people. Reflected in the discussion about the third generation of consumerism on slide 6 is the fact that if companies can begin to cut healthcare costs, that is the equivalent of a huge tax cut. That is a competitive issue for the entire country, he asserted.

10:48:00 AM

CHAIR DYSON introduced Greg Scandlen.

GREG SCANDLEN, Consumers for Healthcare Choices, explained that his organization was new in September. It is funded by membership dues and currently has 125 members. The goal is to have 1,000 members by December and 4,000 members by June 2006.

He stated that the notion that healthcare discussions don't need to include the consumer is incorrect. His contention is that if it's not doing a good job for the patient then it's not doing a good job at all. For the last 20 to 30 years consumers have been paying outrageously high prices for questionable quality of care.

MR. SCANDLEN said that the essential problem is that the consumer has become too reliant on third party payment. The result of that is that people become divorced from the responsibility of payment. A triangular relationship is established that has no accountability. The patient doesn't know what's happening between the insurance company and the doctor, the doctor doesn't know what's happening between the patient and the insurance company, and the insurance company has become far too curious about what is happening between the patient and the doctor. He asserted that insurance companies should restrict themselves to financing care and not get involved in the delivery of care.

He outlined some of the consequences of becoming reliant on third party payment. As of 2002, third party payers pay 86 cents

on the dollar while the patient pays just 14 cents on the dollar directly out-of-pocket. Certainly there is need for insurance in health care, but it should focus on covering expenses for unusual situations. It's time to restore the balance between direct pay and insurance coverage, he said. Different programs are testing different dimensions to determine how much the consumer should pay and how much should be covered by a healthcare policy. Currently it's unclear whether it's better to have a $2,000 deductible, a $5,000 deductible or a $10,000 deductible, but the research is underway.

MR. SCANDLEN informed members that the early results on the consumer driven programs has been positive; the uninsured finally have a health product that they're willing to buy. In addition, the prospect of being able to save funds in an HSA allows people to continue coverage even after they lose a job. This is far better than the COBRA option, he said.

CHAIR DYSON asked him to comment on how HSAs might work for small and medium size businesses, and nonprofits.

MR. SCANDLEN responded HSAs are advantageous to people with income surges interspersed with dry periods throughout the year because they minimize the amount that must be paid on a monthly basis.

SENATOR KIM ELTON acknowledged that an HSA might be advantageous to small businesses and non-profits that didn't previously offer an insurance program, but he questioned whether larger corporations or governmental units might not reduce insurance costs by forcing employees to select a HSA program.

MR. SCANDLEN stated his belief that large self-funded employers will find HSAs more attractive than HRAs. He reasoned that a self-funded employer doesn't have the monthly premium obligation so it's hard to have premium savings the way a fully insured employer would and it's those premium savings that go into funding the HSA. Large employers don't pay anything until a claim is due and that's the way an HRA works.

MR. FROGUE chimed in to agree and said the additional reason some employers like HRAs is because the money that goes in can only be used for healthcare. Some large employers have expressed hesitation about putting money into an HSA because the money might be misused. The evidence hasn't proved that to be true, but the hesitation isn't totally unjustified. That's another reason that employers like HRAs. It's critical to remember that

the employee owns the HSA, he said, and in his view that outweighs everything else.

With regard to the question about employers saving money with consumer directed plans, he said, yes they do. Furthermore, consumer directed plans aren't meant to help only the healthy and young. They work better for everyone, he asserted.

SENATOR ELTON remarked it might be a correct statement that third party payments might tend to divorce patients from healthcare decision-making. The flip side is the assumption that consumers would make good healthcare choices. That might or might not be the case.

MR. SCANDLEN agreed that might be true but ultimately the person that receives the care has to make the decision on whether to receive the care or not. Certainly there isn't a guarantee that every decision will be the right one. However, once people have an HSA they have a real reason to pay attention to cost.

MR. FROGUE used the analogy of defined contribution retirement plans and noted that in the 1980s when companies began moving from defined benefit programs to defined contributions, the same opposing arguments were used. He further made the point that evidence indicates that people make better decisions when they are paying.

CHAIR DYSON informed members that Dr. Mandsager has a comprehensive patient/consumer information system that is laudable.

REPRESENTATIVE SHARRON CISSNA said she is interested in the difference between the incentives for HSAs and HRAs. She asked for suggestions on how to maximize incentives for both.

CHAIR DYSON asked her to wait for Laura Trueman to respond to the question.

MR. SCANDLEN concluded his comments acknowledging that HSAs and consumer driven healthcare won't solve every problem. However, they are a big step in the right direction. Consumer driven healthcare does inspire people to pay attention because they have the incentive to do so. Finally he applauded Dr. Mandsager's work on the patient/consumer information system because that's what is needed.

CHAIR DYSON asked Mr. Frogue about his ideas for adding incentives for providers and patients with chronic conditions.

MR. FROGUE suggested that Florida would probably serve as a model for the country. It is creating enhanced benefits packages for patients who meet certain health metrics. Pay for performance gets you half way, he said, and the other half is pay for compliance. There is a lot of potential there, especially for those who are sick. Every discussion of health care should use the word "incentives" with great regularity. In parallel with getting dollars in the hands of patients there has to be a strong effort to provide quality information. With that in mind, he applauded the work Dr. Mandsager is doing. He encouraged legislators to work with medical societies and hospital groups so that information is gathered in a cooperative manner.

CHAIR DYSON introduced Laura Trueman.

11:20:08 AM

Health Savings Accounts: What You Need to Know

LAURA TRUEMAN, Coalition for Affordable Health Coverage, stated that 2004 Census data indicates that 18 percent of Alaskans are uninsured. That is the eighth highest rate in the country. However, Alaska has the eighth lowest 3-year poverty rate, which means that many Alaskans have a good income. Of course goods and services are high so the comparison isn't exactly "apples and apples."

She explained that the coalition works on a national level to do what is being discussed here on the state level. They bring together the major stakeholders in the country that want to improve the healthcare and coverage system. They advocate in Washington DC on how to help people get access to more affordable health coverage in the private sector.

MS. TRUEMAN said her discussion and PowerPoint presentation would focus on Health Savings Accounts (HSA). She noted that every state is facing a crisis with its Medicaid program and it's been said that in about ten years every state will be bankrupt if Medicaid isn't brought under control. A second problem that states are facing is that the uninsured population is growing. That is draining hospital resources and causing all health insurance premiums to rise. She suggested that HSAs are an interesting option for changing the system because they make

premiums affordable for more people. She gave several examples from other states.

MS. TRUEMAN explained the purpose of her PowerPoint presentation is to help members understand HSAs and to encourage legislators to consider this as one option for state employees and a possibility for Medicaid recipients. Addressing the needs of those two populations could begin to change the dynamics of the healthcare marketplace in ways that could possibly affect everyone's healthcare premium.

Slide 1: What is a Health Savings Account?

HSAs are a new way to have health insurance and establish a tax advantaged savings account for medical expenses.

- HSAs allow people to put money in and take it out tax-free as long as the money is spent on medical care.
- HSAs were created in Medicare legislation in December 2003 and were in the marketplace by January 2004.

Slide 2: Who Can Open A Health Savings Account?

- Anyone with a qualified "High Deductible Health Plan" (HDHP) may open a HSA.
- For 2006 HSA plans, a high deductible health plan would have a minimum deductible of $1,050 for individuals or $2,100 deductible for families.

Deductibles can be higher than the minimum qualifying amounts, she said. For instance, in South Carolina the deductible for state employees with HSAs is $3,000.

Slide 3: Do HSA Owners Have Any Protections on How Much they Must Spent Out of Pocket?

- Yes.
- The annual out of pocket expense including deductibles and co-pays cannot be over $5,200 for an individual and $10,500 for families.
- The amounts are indexed annually for inflation.

After meeting the annual out of pocket limit, additional expenses are totally and completely covered.

Slide 4: Won't HSA Owners be Tempted to Skip Medical Care Since it Comes out of their Pocket First?

To answer she said you must remember that:

- All preventative care is paid for at 100% coverage. There is no co-payment. The incentive is to encourage people to be proactive in managing their health.
- All physicals, mammograms, colonoscopies, vaccines and other such preventative services and drugs are covered

The reason for this is to provide incentive for people to take care of themselves because in the long run, everyone saves money. She reiterated that drugs that are considered preventative such as Statins or insulin are 100% paid for. There is no co-pay.

Slide 5: HSAs Do More to Encourage Preventative Care Than Traditional Coverage.

- Many traditional policies require that you meet an individual deductible or family deductible before they begin making payments. Then, they require co-payments - usually 20%.
- In comparison, HSA owners have no required deductible or co-payments in order to receive 100% payment for preventative care, drugs, or diagnostic services.

Slide 6: HSA Rules for 2006

MS TRUEMAN showed a table and explained that single people have a minimum deductible of $1,050 and they could contribute a maximum of $2,700 into their account. The out-of-pocket limit is $5,250. For a family, the deductible is $2,100 with a maximum annual contribution of $5,450. The out-of-pocket expenses would be no more than $10,500.

Slide 7: Shows the 2006 HSA contribution rules for single and family in more detail

Slide 8: What About Prescription Drugs?

- Current status: HSA owners can have a separate prescription drug plan and receive insurance coverage for their expenses on drugs even before the deductible is met.
- Beginning in 2006, the transition period will end. Prescription drugs will be treated just like all other healthcare expenses. Individuals would pay the negotiated rate for prescriptions and the payments would count toward

the deductible. Once the deductible is met, insurance with co-payments would begin.

It's important for people to think about prescription drugs in terms of whether or not the drug is need, whether there is a less expensive alternative, whether an over-the-counter medicine would work as well. It's important to ask those questions, but when the out-of-pocket expense is minimal you're less likely to do so. Research indicates that employers are seeing cost savings for drug coverage with the increased use of generic drugs.

- Important Exception: Preventative drugs are covered at 100% before any deductible is met.

Slide 9: If I Pay Cash for Drugs and Medical Services by Using My HSA, Won't I be Stuck With the Highest Dollar Charge for Those Services?

- No. You will receive the best negotiated rate that has been obtained by the insurance carrier. You will not be paying the usual and often highest, prices that cash paying customers are often charged.

CHAIR DYSON noted that individuals could use their annual contribution to the HSA for predictive, preventative and remedial care that typically isn't covered. He asked her to give some examples.

MS. TRUEMAN referenced Slides 10 & 11 and explained that qualified medical expenses would include mental healthcare, dental or orthodontia treatment, premiums for long-term care insurance, over-the-counter drugs, and plastic surgery. The list is extensive and allows individuals to decide what's important to them. It's not a one-size-fits-all kind of thing, she said

SENATOR ELTON observed that this might result in individuals shifting costs to elective treatments such as lasic eye surgery while not leaving enough money for treatment that is necessary such as blood pressure medicine. That would create a future cost, he said.

CHAIR DYSON pointed out that once the deductible is met then the insurance company would meet all those costs.

MS. TRUEMAN acknowledged that it's a reasonable concern because people sometimes do make poor choices. However, because the

money carries over from year to year the incentive is there to use your own money carefully.

REPRESENTATIVE CISSNA asked if disincentives might not be worth considering.

MS. TRUEMAN responded in addition to paying the tax there is also a 10% penalty if you remove money from the account and use it for non-medical expenses. With regard to "frivolous" expenditures, she said additional data is needed. She said she has seen reports indicating that people's behavior has changed in several ways: emergency room use is reduced; generic drugs are used more frequently, and preventative care is used more.

Slides 12 - 14: Other HSA Advantages.

- Portability is one advantage. HSAs are owned by the individual and not by the employer. If the employee leaves the job, his or her savings goes too.
- Choice is another advantage. Employers cannot restrict how individuals spend money from an HSA.
- HSAs roll over from year to year so there aren't the same problems that are associated with flexible spending plans.
- The money can grow. It's like a 401 K in that it can be managed and invested.
- HSA owners are rewarded for healthy lifestyles.
- HSAs offer protection for occurrence of catastrophic or chronic illness. By limiting the total out-of-pocket expense for HSA owners, those who do have illnesses are protected.

Slide 15: Who is Offering HSAs?

- The federal government offers several HSA options for federal employees.
- States such as South Carolina, Arkansas, and Florida are all offering HSA plans to state employees. In the first year, 30% of the state employees in South Carolina switched to an HSA plan.
- Small businesses - Blue Cross Blue Shield indicates the strongest HSA customers are small business owners.
- Individuals are purchasing HSAs. About one third of those individuals were previously uninsured.

REPRESENTATIVE CISSNA asked if it is possible to invest separately to put extra money away in anticipation of additional expenditures.

TRUEMAN answered yes, but there is an annual contribution limit to receive the favorable tax treatment. An additional account would be similar to a regular savings account.

CHAIR DYSON noted that Florida has limited purpose flexible medical accounts that allow the use of pre-tax dollars. He asked Ms. Truman to elaborate.

MS. TRUEMAN explained that is to address the fact that many people have flexible spending accounts, which aren't allowed once you have an HSA. However, an adaptation of a flexible spending account is allowed for certain purposes, she said.

MS. TRUEMAN made the point that she and others advocate increasing the contribution limit, which would take some of the pressure off Medicare in years to come. For that to be successful, contribution limits must be increased because as Blue Cross Blue Shield has said, right now people are pretty much spending what is in their account each year.

11:52:30 AM

SENATOR ELTON questioned whether government employees in the three test states who chose a high deductible HSA could cash out the account at some point in the future and return to a different plan.

MS. TRUEMAN answered yes.

SENATOR ELTON observed that to get a true sense of the potential savings over time you'd have to take into account the ability for people who develop a chronic condition to opt for a more expensive plan.

MS. TRUEMAN cited an article from the "Washington Post" that compared the Blue Cross Blue Shield plan federal workers with AETNA's high deductible HSA health plan for federal workers. Comparisons were made for out-of-pocket expenses and savings under three circumstances: a good health year, a mediocre health year, and a catastrophic health year. In two cases the HSA plan came out far ahead and in the third case there was a $12 difference.

If, over the course of ten years, you experienced three bad health years and seven good health years, you would come out way ahead with the HSA. You're presuming that an HSA plan isn't a

good deal for a diabetic and I'm not sure that's correct, she said.

SENATOR ELTON questioned whether it wouldn't be smart for a savvy consumer to join an HSA plan at age 22 and then return to "the old system" at age 45.

MS. TRUEMAN embraced the question to counter the criticism that HSAs are for "the healthy, wealthy, and young." She pointed out that the demographics indicate that the purchasers of HSAs mirror the age breakdown of regular insurance buyers. Assurant Health has sold a lot of HSAs and it says that 57 percent of the purchasers are over the age of 40. She asserted that it hasn't been true that HSAs have gone to just the young.

CHAIR DYSON added that the idea that the savings accounts can be rolled forward and then moved into a retirement account on a tax-free basis is attractive.

REPRESENTATIVE GATTO remarked he couldn't help but think that there would a zero sum gain if there isn't a limit beyond the deductible. If a family had major legitimate medical expenses in one year, some might take advantage of the situation by having elective procedures done. He questioned whether that wouldn't affect the ability for HSAs to be beneficial to the public as a whole.

MS. TRUEMAN responded it's too early to tell how people that have major illnesses would contend with the situation so she would reserve further comment.

CHAIR DYSON added the catastrophic healthcare program would have significant limits on what would be paid for.

MS. TRUEMAN agreed that insurance companies won't pay for all sorts of elective surgery.

12:00:43 PM

CHAIR DYSON asked Ms. Trueman to continue.

Slide 17: How Much Cheaper are HSAs than Traditional Plans?

- Average price for a traditional individual policy is $1,800.
- Ehealthinsurance.com indicates that the average 2005 premium for an individual HSA policy is $1,344.

- South Carolina state employees HSA plan costs $1,200 vs. the traditional plan for $2,640.

Slide 18: Do HSA Plans Save Employers money?

- Yes. Studies by Humana, Blue Cross Blue Shield, and others show a significant decrease in healthcare cost inflation for HSA premiums.
- Why? Decreased use of emergency room, increased use of generic drugs. No evidence of savings coming from delaying or avoiding needed care.

Slide 19: HSA Plan Design Questions to Consider:

- Should the employer make a contribution to the HSA Account?
  - The federal government decided it should. Florida decided that it should and South Carolina decided not to make a contribution.
- Should the deductible be higher than the minimum so that the premium is even lower than the traditional policy?
  - South Carolina said yes while Florida and the federal government said no.

Slide 20: The Banking Questions on HSA Accounts:

- Who can be an HSA Trustee or Custodian?
  - In Alaska unions are fund custodians for health insurance dollars. They could do that for HSAs as well.

12:04:00 PM

CHAIR DYSON thanked Ms. Trueman for her work.

REPRESENTATIVE PAUL SEATON asked if she had reviewed the new retirement plan and HRA that Alaska adopted last year. In that plan 3% of the average salary for all employees went into a personalized account. After 5 years it became vested as an individual portable account. He observed that it seems to have the portability element of the HSA and the flexibility element of the HRA.

MS. TRUEMAN said she knew the retirement program was changed, but she didn't know the particulars.

REPRESENTATIVE SEATON asked her to familiarize herself with the specifics and then provide feedback to the committee.

MS. TRUEMAN agreed to do an assessment if someone provided her with the information.

CHAIR DYSON called a break at 12:06.

CHAIR DYSON reconvened the meeting and outlined the integrity in billing legislation he had introduced. He followed up with a discussion on hospital cost shifting and asserted that the incentives are at the wrong end. Those who self pay are penalized, those who pay nothing are rewarded, and those who have a third party payer have increased insurance costs. His legislation would shine light on the situation and force providers to tell patients what's really happening. At the least, you should get a tax break if you're supporting the poor, he said.

He noted that he had distributed copies of new federal healthcare legislation that Congressman Lipinski recently introduced.

12:20:15 PM

CHAIR DYSON introduced Ms. Fink and asked her to inform members what the industry is doing to bring more integrity to the billing system.

LINDA FINK, Vice-President with the Alaska State Hospital and Nursing Home Association, read a letter into the record stating that the hospital shares the concern about hospital billing practices. They need to be more understandable to the consumer and to fairly reflect the actual cost of providing care. Furthermore, the hospital would like bills for services for the self-insured and uninsured to more closely parallel those for patients covered under group plans. Although some patients must pay more to cover those who don't pay enough, the uninsured shouldn't be billed two and three times more than others.

During a previous meeting the association had expressed concern with Senator Dyson's bill. At that time commitments were made to move forward as an industry and as individual community hospitals to find more solutions and avoid the complex billing process set forth in the proposed legislation.

She reported that all Alaska hospitals signed an American Hospital Association (AHA) confirmation of commitment pledge to help uninsured or self-insured Alaskans. One change is to make billing systems more understandable to the consumer. She explained the new billing system employed by the Fairbanks Memorial Hospital, and the new explanation-of-billing website developed for the Central Peninsula Hospital in Soldotna. In addition to an improved billing system, Providence Hospital in Anchorage also offers financial counseling.

MS. FINK reported that Alaska hospitals are revamping charge systems so that the amount that self-insured and uninsured patients are charged is closer to the charges for patients in negotiated insurance arrangements. To make the point she provided several examples. She then reiterated the view that this is a better solution than instituting the complex billing requirements called for in SB 11.

12:31:22 PM

CHAIR DYSON asked Ms. Fink to send a copy of the new standards the national association calls for, a copy of the pledge that Alaska providers have signed, and a timeline for instituting the pledge.

MS. FINK agreed to do so.

SENATOR ELTON referenced an example Ms. Fink cited and made the observation that for the cost for uninsured patients to be less than the cost for covered patients, the rate for group coverage would have to increase. He asked if there is another explanation.

MS. FINK said she didn't have a short answer.

SENATOR ELTON said he would like hospitals to post the costs for services so that anyone could make better decisions regarding where to seek healthcare services.

MS. FINK responded that is part of the pledge and facilities are working to make that possible.

CHAIR DYSON asked other hospital personnel to send their testimony to the committee.

He asked if it's reasonable to infer that hospitals would continue to cost shift.

MS. FINK replied the problem is that hospitals have a mandate to take everyone who walks through the door so costs are incurred. To assume that no one is going to pay for those costs begs the question, she said.

CHAIR DYSON commented the answer is probably yes. He acknowledged that the federal government has forced hospitals into a tough situation and it should take responsibility for doing so.

12:36:45 PM

Commonwealth North
Alaska Primary Health Care Opportunities & Challenges

CHAIR DYSON announced that the Commonwealth North summary was next on the agenda.

DUANE HEYMAN, Executive Director, Commonwealth North, said many points that were already made are consistent with what the taskforce found. He continued:

> We don't think it's so much the amount of money that's being spent in healthcare in the country and in the state because right now, in terms of percent of gross domestic product, the US is already spending way more than other industrialized countries. On a per capita real dollar basis, we're spending over $4,000 a person - way more that other industrialized countries. Unfortunately the trend is going in an unsupportable way. And it looks like by 2013 we'll be spending 18% of our gross domestic product on healthcare costs and it just can't keep going this way.
>
> Are we getting benefit from all that we're spending right now? Unfortunately no. By various measures - diabetes, obesity, lung cancer, infant mortality, life expectancy etc - we're hardly even in the middle of the pack compared to other industrialized countries. So we're spending more and we're not getting the benefit of that.
>
> On page 10 of our report somebody had suggested that Chilkoot Charlie was a kind of dynamic aspect of our US healthcare policy. We cheat the other guy and pass the savings along to you. Unfortunately, that's more true than not.

The impact in Alaska has been substantial. Providence and Alaska Regional last year wrote off almost $90 million in charity and uncompensated care. It's a very significant percentage of their revenues. Even much higher than what we've indicated in the graph here because they don't collect anywhere near what they bill.

It's not just on institutions. The impact is also on individuals. A great percentage of the bankruptcies in the state and in the country are because of medical costs even if people already had some type of coverage before they started. The costs of medical care are going up dramatically in Alaska and pretty much the rest of the country. Unfortunately, it's a national issue.

What can we do about it here? We thought that with a coordinated and focused effort continuing the kind of meetings that we've been having that we think that there are things that can be done that are controllable here in Alaska that are a whole series of small solutions. What we call three percent solutions things that can be done. A lot of the issues you've just been talking about and dealing with. Transparency [and] information to enable people to have consumer-based choices are very important. And to help facilitate that we have put together this Alaska Healthcare Round Table, which is a continuation of the type of efforts that we've had to try and keep working on these types of specific solutions. We have identified 34 of them starting on page 27 of the report.

DR. TOM NIGHSWANDER, Commonwealth North, gave data on the uninsured in Alaska. About 114,000 people or 18% of Alaskans are uninsured. That doesn't include the 100,000 Alaska Natives that have coverage or the 100,000 military personnel that have coverage. That translates to about 25% of the Alaska population that are uninsured.

The weak link in HSAs is the knowledgeable consumer. The patient/consumer doesn't know the cost for or the quality of the healthcare service they might receive. There's also a need for an infrastructure for electronic health records. More than likely, the Legislature will have to help with that, he said.

There's a consortium of healthcare providers and others that have formed an alliance to work in that direction. Another problem in Alaska is the aging population of physicians.

Both the commissioner of health and the president of the university are calling for a physician workforce study group to make recommendations. One will be to ask legislators to double class size for medical students. Another recommendation is how to better recruit physicians back to Alaska. A third recommendation relates to preventative strategies that emphasize physical education and nutrition in schools.

CHAIR DYSON remarked the Commonwealth North report was disappointing because it didn't address accountability and the connection between a patient's wallet and the service provided. He asked Mr. Heyman for a response.

MR. HEYMAN replied the long-term answer is that the individual must take responsibility. Health is the goal rather than healthcare.

CHAIR DYSON responded the report doesn't give a single recommendation for getting someone with a third party payer to make better choices.

DR. NIGHSWANDER acknowledged they didn't get into national issues, but he assured members that this would become part of the national agenda because of rising costs.

SENATOR ELTON said he would like to participate in the future and commented that it's important to figure out how to get more representation to the consumer element.

DR. NIGHSWANDER agreed.

SENATOR ELTON mentioned his legislation relating to school vending machines.

DR. NIGHSWANDER responded some businesses have offered compensation to make up for what vending machines make.

REPRESENTATIVE SEATON asked how patient consumers would find out about the quality of particular healthcare services and who might do the evaluations.

Dr. NIGHSWANDER replied it would probably be the Center for Medicaid/Medicare Services (CMS). The federal government and

insurance companies are starting pay-for-performance programs to improve service quality by both hospitals and doctors. England has already established such a program. Hospitals are rated on a 1,000-point scale evaluating such things as how many women employees have had a mammogram in the last year or how many diabetics have acceptable hemoglobin levels. Another part of the score is the patient's experience of care. If a family practitioner meets the 1,000-point quality standard, he or she receives an additional $70,000 per year, which provides real incentive.

DR. NIGHSWANDER explained that such a program isn't possible without an electronic health record system and noted that the CMS already has a pay-for-performance pilot program in New York. He added that the best system in the US is the Veteran Affairs (VA) because they have electronic health records. Instituting such a system would allow the director of public health to get population data.

REPRESENTATIVE SEATON said it sounds like it's only under a single payer system.

DR. NIGHSWANDER answered emphatically, "No." He asserted that the US will have electronic health records and he thought that there would be incentive pay if standards were met.

He acknowledged that Alaska has to get up to speed on electronic health records.

CHAIR DYSON added establishing the standards that are used in England is necessary as well.

DR. NIGHSWANDER responded the standards are already established, but physicians have been slow to adopt evidence-based medicine. This is a step in the continuum, he said.

REPRESENTATIVE CISSNA questioned how to ensure that the broad healthcare solutions fit into the localized solutions that tribal governments come up with.

DR. NIGHSWANDER responded the roundtable hasn't come up with all the definitive answers and there will be other iterations.

MR. HEYMAN added that suggestions or ideas are welcome.

1:02:50 PM

CHAIR DYSON asked Ms. Green to testify.

TAMMY GREEN, Section Chief Chronic Disease Prevention and Health Promotion, Division of Public Health, Department of Health and Social Services, said she was speaking on behalf of Dr. Mandsager.

MS. GREEN said she would focus on ways to develop a consumer population that is informed about healthcare issues. She further explained that the major risk factors that underlay all chronic diseases are obesity, poor nutrition and the use of tobacco.

She reviewed several websites to show that the division envisions a site that is consumer based and interactive. The site will include a health promotion section, a self-management section, and a healthcare resource and provider section. She encouraged members to give the division feedback.

REPRESENTATIVE CISSNA asked about the system used by the Municipality of Anchorage.

MS. GREEN said she wasn't aware of the system, but would look into it.

CHAIR DYSON suggested that including information regarding the quality of the providers would be helpful.

MS. GREEN responded that's a huge order, but you have to start somewhere.

REPRESENTATIVE CISSNA indicated that she would like an assessment of the pieces of the budget that have something to do with prevention.

MS. GREEN added you need the evidenced based information rather than the suggestion that the idea is good. She said the division is aware of the need.

CHAIR DYSON said he would encourage Governor Murkowski to take some visible leadership. He made the point that a significant part of the budgetary battle is won if the needed resources are in the governor's budget.

MS. GREEN stated that the division appreciates the bills that Senator Dyson and Senator Elton have introduced.

CHAIR DYSON adjourned the meeting at 1:17:36 PM.