ALASKA STATE LEGISLATURE
HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES STANDING COMMITTEE
August 28, 2007
10:04 a.m.

MEMBERS PRESENT

Representative Peggy Wilson, Chair
Representative Bob Roses, Vice Chair
Representative Anna Fairclough
Representative Wes Keller
Representative Paul Seaton
Representative Sharon Cissna
Representative Berta Gardner

MEMBERS ABSENT

Representative Mark Neuman

OTHER LEGISLATORS PRESENT

Representative Mike Chenault
Representative David Guttenberg (via teleconference)
Representative Lindsey Holmes

Senator Fred Dyson
Senator Gary Stevens

COMMITTEE CALENDAR

PRESENTATION: HEALTH CARE REFORM ACROSS THE U.S.

- HEARD

PRESENTATION: RETHINKING INSURANCE

- HEARD

PRESENTATION: CHANGING THE HEALTH CARE SYSTEM

- HEARD

PREVIOUS COMMITTEE ACTION

No previous action to record

WITNESS REGISTER

LAURA TOBLER
National Conference of State Legislatures
Denver, Colorado
POSITION STATEMENT: Presented a PowerPoint presentation titled, "Health Reform in the States."

DICK CAULCHI
National Conference of State Legislatures
Denver, Colorado
POSITION STATEMENT: During hearing, answered questions.

DR. KENNETH E. THORPE, PhD
Emory University
POSITION STATEMENT: Provided a PowerPoint presentation titled, "Controlling Healthcare Spending: Role of State Health System Redesign."

JIM FROGUE, Chief Liaison
to State Policy Projects
The Center For Health Transformation
Washington, D.C.
POSITION STATEMENT: Discussed health care reform.

ACTION NARRATIVE

CHAIR PEGGY WILSON called the House Health, Education and Social Services Standing Committee meeting to order at 10:04:05 AM. Representatives Wilson, Roses, Fairclough, Keller, and Gardner were present at the call to order. Representative Cissna arrived as the meeting was in progress. Also in attendance were Senators Dyson and Stevens and Representatives Chenault, Guttenberg (via teleconference), and Holmes.

Presentation: Health Care Reform Across the U.S.

10:05:04 AM

CHAIR WILSON announced that the first order of business would be a presentation on Health Care Reform Across the U.S. and that this meeting is the second in a series of meetings on health care reform. She asked several experts to present to the committee to educate members on some of the issues concerning health care in Alaska. She noted Commissioner Karleen Jackson, Department of Health and Social Services, Jerry Fuller, Alaska's Medicaid and Medicare expert, and Dr. Butler from the Division

of Public Health were present, as well as several other state employees listening via teleconference.

CHAIR WILSON told members Ms. Tobler of the National Conference of State Legislatures (NCSL) would provide the committee with an overview of what other states are doing to address health care reform. The committee would then hear from Ken Thorpe and Jim Frogue. They will present different models that change the way we view health care today.

CHAIR WILSON told members that Ms. Tobler would be testifying via teleconference. She is a nationally recognized expert on state health care policy issues and currently serves as the program director in the health program at the NCSL. She serves as the lead staff person on health reform, access to health care and health care safety net issues.

10:08:41 AM

LAURA TOBLER, National Conference of State Legislatures (NCSL), told members Dick Caulchi was joining her. He works on financial health care costs and prescription drugs, managed care and the private market health insurance system for the NCSL. She began her presentation:

> ... The first slide just gives you my contact information and I'd just like to offer to the committee that NCSL would be happy to help Alaska as it journeys through health care reform. I am available by e-mail, phone. I'm sorry I couldn't be there today but if there's another meeting that you find would be useful to have someone there in person, please do call and set that up because we're here to serve you. So that's my contact information.
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> The next two slides we won't talk about very much but it's just really to set the stage of why so many states are right now contemplating broad based health reform. The first slide shows the health care costs per resident by country and it shows that the United States has the highest of those. And then the next slide is health care as a percentage of GDP by country and, once again, the United States is the leader in that area.
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> So, health care costs have really driven the discussion on health care reform but I will also add

that it's not just cost. It's looking at quality and how to deliver services in a better way. I know Ken Thorpe will talk about that when he gets up to present to the committee. This year, probably, I've been working on health policy for many years and this year we probably are seeing more of a ground swell of states looking at broad based reforms as opposed to incremental reforms, which is really what the states have been in the business of doing. Incrementally over the last 15 years states have really changed the way that they've delivered health care in their respective states with incremental changes. In some cases, in some states that has made access to care easier for people with low incomes and has made it easier for small businesses to obtain insurance. But, we're seeing more interest in broad based, broad reforms so [we're] including not just covering the uninsured, but looking at quality, looking at prevention and looking at all the other aspects of our health care delivery system.

So we'll go to the next slide.

10:13:04 AM

REPRESENTATIVE GARDNER said everyone has heard anecdotal stories about lack of choices, denied services and long delays with universal health care systems. She asked if the higher U.S. health care costs correlate to more choices, access and more timely delivery.

MS. TOBLER told members the U.S. doesn't actually have the best health care outcomes; it lands in the middle of the pack when compared to other countries. She said health care funds in the U.S. are not providing the best quality of care. The United States uses more services, which is why it spends more money, and has a very large health care market so services are readily available. With regard to the anecdotal information about universal health care systems, she offered to send the committee information that compares different systems.

CHAIR WILSON offered to distribute that information to all committee members.

10:16:08 AM

REPRESENTATIVE SEATON noted a divergence of cost per resident in different countries after 1980 on the graphs. He asked if that is related to specific policies adopted by the United States or the other countries.

10:16:46 AM

DICK CAULCHI, National Conference of State Legislatures, said he could not provide a good answer to that question because his focus has been on U.S. health care structure and finance more than the costs in other countries. He said he could provide the committee with copies of analyses of other countries' health care systems. He said in terms of the United States, the line rises steadily because of the amount of health services available and provided. In some ways, managed care was considered to save costs but it drew millions of new people into an insurance plan so they used services.

MS. TOBLER pointed out that the next slide shows the annual change in total health benefit costs from 1990 to 2007. That graph shows a spike in 1990 and 2002. Costs then leveled off over the last three years at 6.1 percent. Still, the costs outrank inflation and growth in wages, which concerns employers and individuals purchasing health care insurance.

10:19:06 AM

SENATOR FRED DYSON, Alaska State Legislature, said when Ms. Tobler mentioned the amount of money spent and the resulting outcomes, she neglected to discuss cultural and environmental conditions that impact the situation, such as smoking and obesity, etc. He inquired how much of those factor into the problem.

MS. TOBLER said she would address that question later in her presentation.

10:20:25 AM

CHAIR WILSON said Americans have a tendency to file more lawsuits, which seems to cause physicians to do more tests. She asked if that is a factor in health care costs.

MS. TOBLER said it is. She offered to send further information to the committee on the drivers of health care costs.

10:21:50 AM

MS. TOBLER then returned to her presentation:

So I'm going to move on to the next slide, which is just a map showing coverage rates for the total population uninsured for 2004 and 2005. You'll see where Alaska – hopefully you're looking at this in color and you'll see where Alaska falls there. This is someone who reported being uninsured at any time during the year. It's the U.S. Census data.

And then if you'll go to the next slide, it shows – it's just a comparison so it shows what percentage of those uninsured are near poor, so 100 to 199 percent. You'll see that that's not the case in Alaska. You have, you know, a small amount of uninsured that are in the 100 to 199 percent poverty level.

Moving on to the next slide, I've been looking at what's going on across the country and there certainly is a lot of discussion happening across the country on broad based health reform and, in an effort to be able to present this in a more organized way, I've categorized the recent state actions and proposals into four different categories. And then underlying all of those categories is really an underlying focus on cost containment.

So states are looking at reducing the number of uninsured and that's really what you're reading about in the paper. So that's what's getting a lot of the press coverage and that's what's being talked about in the state of the state addresses. More and more governors and legislators are looking at programs that will be able to pull more people into an insurance product so they're looking at reducing the number of uninsured, focusing on quality initiatives, so looking at the care that's being delivered and trying to make that care more efficient, more effective and produce better outcomes.

Focus on appropriate care for chronic disease – this is a biggy and I know Ken Thorpe will talk about this. It's been a very large component in many discussions across the country in many states and looking at making chronic disease management a focal point of reforming the system. I'll give you some examples.

> And then focusing on prevention and wellness initiatives – this is already – we're seeing not just broad based reforms and legislation that is broad in content, but we're seeing many states passing legislation, even specifically on various items like reducing obesity, reducing smoking indoors, that sort of thing, which is a focus on prevention and wellness and so we'll talk about that. And then concurrently all of these are looking at long term cost containment. So we'll go on to the next slide.

10:24:55 AM

REPRESENTATIVE CISSNA referred to a slide entitled, "Near Poor: Uninsured Rates for the Non-Elderly" and expressed concern that an Alaska state agency is working on a survey of its uninsured and has found some unusual factors in Alaska. A large number of Alaskans work at seasonal jobs, such as fishing. They are difficult to collect information on, so an accurate assessment is problematic.

MS. TOBLER said she has not been privy to that information but it's essential to have good data before developing a plan to cover the uninsured. The dynamics of the uninsured vary widely by state so a program that works in one state does not necessarily work in another. Nationally, the uninsured are the working poor, generally with part-time jobs. She encouraged the committee to invest resources to obtain good data.

CHAIR WILSON noted that at the last meeting the committee heard a preliminary report about the uninsured. She noted Alaska's Native population has some sort of health coverage through Native corporations but are counted as uninsured in that data.

10:29:16 AM

MS. TOBLER continued with her presentation, as follows:

> I'm going to talk about the first bullet first – reducing the number of uninsured. We'll go through several different strategies that states are looking at to try to reduce the number of uninsured.
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> The first one that we're going to talk about is the idea of a connector. Now if you haven't been following what's going on in Massachusetts,

Massachusetts and Vermont in 2006 passed broad based reform. In 2003 Maine passed broad based reform but they haven't been as successful in implementation as they would have liked to have been because of some hang ups with financing and then also it's a voluntary program. I'm going to talk about some of the lessons learned from Maine when we get to talking about an individual mandate.

But let's talk about a connector first. You should be looking at the slide that says, "The Connector – Health Insurance Exchanges." The idea of a connector has been around for awhile. The Heritage Foundation was one of the first organizations that started talking to states and actually the District of Columbia about the idea of a connector. Massachusetts passed legislation last year and part of the legislation created a quasi-government organization, division, whatever you want to call it, that's governed by a board that is multi-disciplinary and they call it the connector.

What the connector does is it provides a single place for people to purchase insurance coverage. It also is the facilitator for their subsidized insurance product that was also created last year for low income people. It allows for more transparency so the connector is really about – they're in the business of educating people on the things that they need to know about purchasing good health insurance. The connector was also very, very much involved in writing the rules and regs for implementing the health care reform legislation that passed and they were very involved in the discussion on affordability and what makes insurance more affordable. So they've been a real pivotal contributor to the implementation of the Massachusetts health insurance reform law but the connector doesn't have to be part of broad based reform and we've seen some examples of states, like Washington, that have passed legislation to create a connector but they did not include a lot of the other broad based reforms that were included in the Massachusetts law. So there are a number of states now that are examining this in '07 and I have those states listed.

In addition to connectors, the idea of a connector is to allow employers and employees to have access to affordable health insurance. Massachusetts in their legislation required all employers to offer Section 125 plans. In doing so that allows the employees to purchase insurance through their employer with pre-tax dollars and the connector helps to facilitate that. That's what Washington modeled in their legislation.

Rhode Island and Missouri this year enacted separate cafeteria plan requirements but they did not enact connectors so they didn't create a connector or an exchange. But they are going to require employers to offer Section 125 plans in an effort to encourage workers to buy insurance with pre-tax dollars.

10:33:29 AM

MS. TOBLER continued:

The Massachusetts connector, which is the next slide – we were just recently in Massachusetts because the NCSL annual meeting was there in August and we had an opportunity to sit down with some folks and talk about how the implementation was going. ...Their individual mandate implementation began...July 1 of 2007 and so since then they have had 15,000 new purchasers via the connector and 165,000 newly insured, but that's net growth so that, you know, it's the only number they could give us but it...doesn't really indicate that there are 165,000 newly insured people. It could be people moving from one plan into one of the six plans that are available.

The insurers pay a premium fee of 4 percent to the connector. The other thing that Massachusetts did was they merged their small group and individual market. Right now, what they're saying in Massachusetts is by doing that merger, that there was about a 15 percent decrease for individual plans, that's the projection for the price of individual plans, and about a 1.4 percent increase in small group premium costs. So they're hoping that that makes health insurance more affordable for people who are out there in the individual market.

So that's what I'm going to report on the connector. If you have any questions about that I'd be happy to take them now.

10:35:22 AM

REPRESENTATIVE ROSES asked if the State of Massachusetts has been tracking how many individuals are dropping private insurance to join the connector.

MS. TOBLER clarified that the connector involves private insurance. She asked Representative Roses if he was asking whether employers are dropping non-connector insurance to join with the connector.

REPRESENTATIVE ROSES said yes, as well as individuals who dropped private coverage to get insurance through the connector program.

MS. TOBLER said that was not discussed. They did talk about employers dropping group coverage. She said she would get information on that topic for the committee. She repeated the insurance available through the connector is private insurance. Massachusetts subsidizes insurance for people up to a certain poverty level.

MR. CAULCHI added that transferring to the connector program isn't seen as a negative move for people who want better or more affordable insurance.

MS. TOBLER said she will ask about the number of people who drop existing policies to join the connector program.

10:38:19 AM

MS. TOBLER continued her presentation:

The next slide is just an example of the connector's web page. They did a lot of work to try to get the word out to the individuals in their state about the opportunities through the connector and they created a very nice website where individuals can go not only for information, but to also sign up for insurance. I'm using this as an example for you all because one of the things that we've learn over the years is that how you market a program is so amazingly important in the success of that program.

New York, when they created some reforms a few years ago to create a program for small businesses, they didn't really market it effectively and they had no participation in the first year or at least none compared to what they were hoping for. After a good marketing plan and a little bit more effort to get the word out, they definitely were able to enroll more people in that program and they were happier with their successes. So I think marketing and making sure that the communication is a direct line to those people that you're trying to reach out to is a very big part of not only creating your program but also making sure that you have financing and resources built into the program to do an effective job.

So let's go on to the next slide, which is "Reducing the Number of Uninsured by Requiring All Residents to Buy Health Insurance." Massachusetts made it to the first page of all the major newspapers in the country by passing a law in 2005 that required all residents to have health insurance as of July 1, 2007 with some exceptions. So they will provide waivers to individuals who can prove that they can't afford it. And proving that they can't afford it is based on a formula that the connector has come up with that really equals about six percent of your income.

Although they are saying this is universal health care and that it is a broad based individual mandate that everyone will have insurance, there will be individuals that won't – that will remain out of the insurance market. It could be because they, at that time, can't afford the insurance that's being offered. Those cases will be taken into consideration. The way that they're monitoring this is through the income tax reform and so when they file ... their state income taxes, there will be a question there about their ... health insurance status.

10:41:31 AM

CHAIR WILSON asked what will happen to people who can afford health insurance but are "maxed out" with other payments, such as a mortgage and car payment, so cannot add health insurance to their budget.

MS. TOBLER commented that affordability is the sticking point. The cost of health care insurance premiums prevents people from buying it. Massachusetts had many long debates about affordability and devised a formula that equals about six percent of income. She stated:

> So if insurance is more than that, then you're waived out. However, in our discussions with some of the individuals involved in implementation, I do think that they are going to consider individual family situations so, let's say you had a year where there is a need for that money, you may not have that six percent but there's a need for that money to pay for something catastrophic or something comparative. They are going to take individual situations into consideration. But I also will tell you this is just being implemented – the requirement just went into effect this July. So, next year at this time they'll have much more experience in determining this idea of affordability and waivers. Depending upon whose data you look at, there are some organizations that have been following this law that are saying that as many as 20 percent of the citizens in the state will be waived out of that requirement. So it's really a wait and see ....

MR. CAULCHI emphasized that the Massachusetts plan has received a lot of attention but the situation is very fluid. Standards have been set and regulations have been promulgated but the numbers being used are subject to change if they are not feasible. He asserted the Massachusetts 2007 plan is one example of several. There is no presumption that the structure or dollar amounts are the permanent answer. He would not be surprised to see Massachusetts make readjustments in two years.

10:45:30 AM

REPRESENTATIVE SEATON asked if the Massachusetts' formula uses six percent of net or gross income.

MS. TOBLER believed the six percent formula is based on net income but said a discussion is taking place right now about what expenses should be taken into consideration. There is a movement to include both premium costs and cost sharing. She echoed Mr. Caulchi's comment that the program's parameters are very fluid. She offered to confirm the six percent is of net income for the committee.

10:46:53 AM

SENATOR DYSON opined that mandating state residents to have health insurance raises concerns about infringement on rights. He questioned whether any legal challenges have been made to the Massachusetts law. Second, he asked when the paradigm shift occurred to the belief that the cure to the health care dilemma is to force everyone to have health insurance rather than assuming people would pay their own bills.

MS. TOBLER replied no constitutional challenges to the law have occurred. She pointed out the idea behind the mandate is shared responsibility. When the legislature and governor got together to create this program, the desire was to have the financial burden shared among employers, the public and individuals. She stated employers are bearing a large portion of the burden right now and Massachusetts had significantly expanded its public programs so the public was paying a large percentage of the health care dollar. The philosophy was to create a triangle of shared responsibility. She furthered:

> The individual mandate philosophically and politically does not work for every state, however there are those out there that would argue that without the individual mandate, implementing some of the market reforms and implementing and creating some of the programs that we're going to discuss today will never be as effective because of the way that health insurance works on a pool. By trying to pull as many people into the pool as possible with an individual mandate, you expand that pool to the point where it becomes more effective and you can get some cost reductions and premiums. Whether or not that's actually going to pan out and work in Massachusetts, we'll just see.
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> As far as the paradigm shift and...moving toward individually mandated insurance, I don't think this is anything new. ...The law is new but the discussion around including everyone in insurance has been around for a long time. I don't know what else you want me to comment on other than Massachusetts really is the only state that has an individual mandate for health insurance right now. It certainly isn't the norm and the majority of states certainly aren't considering it right now.

10:50:21 AM

REPRESENTATIVE ROSES asked if Mr. Caulchi said 20 percent of the Massachusetts population would be exempted from the mandate because of lack of affordability. He noted the national map shows that the number of uninsured in Massachusetts is 11 to 13 percent.

MS. TOBLER clarified that she meant up to 20 percent of the uninsured individuals would receive an exemption, not 20 percent of the state's population.

10:51:39 AM

MS. TOBLER continued:

> So let's move on to the next slide, which is titled, "Involving Employers in the Financing of Coverage Programs." This is also something that we're seeing more states' commissions, committees looking at ways to involve employers in the financing of programs or just involving employers in covering more of their workers.
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> Evanation, where an employer-sponsored insurance system – it's been around for a very long time. ... The majority of people that have insurance have insurance through the employer system in the private market there. And so, we have seen in the last three years some movement legislatively to look at what states can do to encourage employers, and that encouragement is happening more at the small employer level, or to require employers to offer a certain minimum amount of insurance, or to pay into a pool, or simply to assess an employer an amount of money for an uncovered employee.
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> So let's look at Massachusetts and Vermont as examples. Before we get into this slide, I just want to say that Maryland passed legislation in 2005 and that legislation was moved forward but then was challenged. The legislation would have required all very large employers, 20,000 employees or more, to offer a certain minimum amount of insurance or pay a percentage of payroll into a pool that then would be used to cover the uninsured. That is sometimes called pay or play type legislation and it was challenged by

the National Retail Leaders' Industry Association on the grounds that it violated [Employee Retirement and Income Security Act of 1974] ERISA. So whenever we talk about involving employers in the financing of a health reform, we have to have a discussion about ERISA, which – you know, a discussion about ERISA can go on for days and days.

I'll just tell you the very little bit I know about what's going on with ERISA and the two states that are implementing employer assessments.

So Massachusetts and Vermont are in the process of implementing employer assessments. Massachusetts hasn't sent out any bills yet or any assessments yet but Vermont has. According to Vermont, they haven't collected any yet but they've sent out the assessments. How this works is that in Massachusetts, the assessment is $295 per uninsured employee annually with some exceptions and $395 per uninsured employee annually in Vermont. So, initially you're looking at that and saying wow, that's a very, very small amount of money compared to what it actually costs to insure an employee and you would be accurate. The idea behind these assessments is to involve employers in the financing of the program so, once again, sharing that responsibility. At this time, there is a very big question as to whether or not states can actually involve employers at a higher dollar level without running into ERISA problems.

So let's talk very quickly about ERISA. ERISA is the Employee Retirement Income Security Act. It was passed in 1974. There is one state in the country that has an employer mandate, and that is Hawaii and Hawaii passed their legislation prior to ERISA passing at the federal level so they were grandfathered in. So Hawaii actually does have an employer mandate and by all intents and purposes it does help to keep the uninsured rate down in Hawaii because employers are required to offer insurance to employees who work at least 20 hours per week with other requirements.

So, ERISA preempts states or ties states' hands in regulating employee benefits. Because health benefits are part of the benefit package, it preempts states from regulating or influencing the way those benefits

are designed by the employer. The reason for the small dollar figure in Vermont and Massachusetts really was to get through the ERISA radar and it was to create a financial participation that, at the end of the day, wasn't going to influence the way employers designed their benefits. So, there you have it.

Whether or not this will remain unchallenged is still a big question. To date, there has not been a challenge in Vermont and Massachusetts. However, we hear that there are shops out there looking for plaintiffs so that there are people out there that are trying to dig up some interest by plaintiffs in taking this on and making it an ERISA challenge but it hasn't happened yet. It's not a lot of money and it certainly isn't comparable to the cost of insurance but it is a financial contribution and it is a responsibility that the state's putting on the employer.

10:57:40 AM

MS. TOBLER continued:

So then the next question that's going to come up is whether or not there's been any indication in Massachusetts or Vermont that employers have dropped coverage because of this, so dropping coverage and saying well, why should I pay for coverage when I can just pay $295 per employee and then my employees can go through the connector and get their insurance. The experience, in Massachusetts at least, has been that there is no indication that employers have dropped coverage. Any questions on that?

10:58:11 AM

MS. TOBLER, upon determining there were no questions, continued:

Let's go on to our next slide, which is "Reduce the Number of Uninsured by Assisting Employees and Employers in the Purchase of Health Insurance." This has probably been the one area where incrementally states have created many programs for small businesses to be able to purchase insurance through a state created or a state run program where they can do buy-

ins. So the employer can participate with the state or the employee can participate with the state. They can leverage some public dollars with the existing employer dollars and try to get as many employees covered with that partnership.

So I have some examples there. The majority of the examples are Medicaid examples where states have created Medicaid waiver programs like the one in Oklahoma where they expand Medicaid eligibility to include new people and those new people that come in have employer offered insurance but they can't afford that employer offered insurance. The state Medicaid dollars help that individual employee to pay for their employer offered insurance. The employee pays a little bit. The employer pays a little bit and the public dollars pay the rest. Sometimes you hear them called three share programs but that's one example of how you could mix dollar financing streams to cover new people without using 100 percent public dollars.

The non-Medicaid programs that I have down as examples are the Montana program. Two years ago Montana created a small business purchasing pool and they subsidized that pool on a sliding scale basis. They use tobacco tax dollars to pay for that. They also, for those employers who were already offering insurance, created a tax credit system so that ... they wouldn't penalize those businesses that were already out there offering the insurance and they acknowledged that.

Healthy New York Reinsurance Program is a non-Medicaid program. It's subsidized by New York dollars and it is offered to small businesses and it is a partnership program. And then Cover Tennessee is a new program that was created in Tennessee and it is also a partnership for small employers and uninsured workers and you have to have a certain income level below 250 percent of federal poverty. They're offering a product that is $150 per month. It's pretty basic coverage and they are just now getting their feet wet with that. But these are examples of ways that the state can create a shared financial responsibility with the individual getting the insurance, paying some, the employer participating, paying some and then public dollars subsidizing for the lowest of income.

11:01:41 AM

REPRESENTATIVE GARDNER asked Ms. Tobler to explain "reinsurance" under New York's program.

MS. TOBLER said New York is the only state with a subsidized reinsurance program. Reinsurance exists nationwide; it is a way to offset high claims. New York, in order to create an affordable program for small businesses, created a program in which the state assumes some of the risk of the claims, perhaps claims between $5,000 and $50,000. That reduces the insurer's risk so the premium can be offered at a lower rate. Usually, the state's risk is a window in the middle so that the insurer picks up the smaller claims and the catastrophic claims. That motivates the insurer to be effective and encourage good health among enrollees. If insurers are responsible for claims costing over $50,000, they would be motivated to create programs that contain costs and manage individuals' health needs well.

MR. CAULCHI said he has a good deal of background on New York's program that he could provide to the committee.

11:04:19 AM

REPRESENTATIVE GARDNER asked if New York State pays those claims from its general fund or whether it has an insurance program to tap into.

MS. TOBLER replied the Health New York program is funded through general funds.

11:04:41 AM

REPRESENTATIVE ROSES asked, regarding Massachusetts' requirement that every resident have health insurance, whether Medicare and Medicaid are considered as insurance.

MS. TOBLER replied they are.

11:05:05 AM

MS. TOBLER continued:

> Okay, I'm going to go to the next slide, "Reducing the Number of Uninsured by Allowing Young Adults to Remain on Their Parent or Guardian's Insurance Longer." This

has actually been a policy or a strategy that more and more states are adopting and, to tell you the truth, we don't have really good data on how effective this is but I could tell you what I know.

So, basically, if you're insured, both in Medicaid and privately, and you become 18 years old, you're dropped from that insurance. If you're covered by Medicaid, you're dropped from the insurance. If you're covered by private insurance and then go on to further education, you typically would be covered until you graduated or turned, depending upon your policy, 22, 23, 21 are some. So, around there you would be dropped but...you would have to go on to school to be able to get that extended coverage.

So there are several states, Utah was the first that looked at the idea of allowing those young adults to remain on their parent or guardian's policy for a longer period of time. And the reason that this came up is because that age group, the young adults, is the fastest growing segment of the uninsured. They also are a hard to reach group. Young adults, if you know any, tend to think that they don't need insurance. They are healthier than the general population and they have less money and the money that they do have they may be saving for a down payment on an apartment or a car or whatever their priorities are - you know, going to Europe, and they don't want to spend it on something as dull and boring as health insurance. So they are a very hard to reach group.

Parents and guardians tend to be more motivated to know that their young adult children are covered and so the idea is that by going through the parent or guardian, the state would be able to more successfully pull some of these young adults into an insurance product.

So you see that I have listed all the states that have passed legislation allowing this to happen. New Jersey goes up to age 30, when they say young adults up to age 30 can be covered by their parent or guardian's policy. Most of the other states are around 24, 25, 26. The experience has been – I'm going to use New Jersey as an example. New Jersey is requiring reporting so when the Department of

Insurance gets reports back, there's a little box that's checked off from the insurers that includes information on whether or not they sold the policy based on this new law of covering young adults. As of four months ago, they've covered upwards of about 6,000 new young adults. When they were contemplating the legislation and they did some data collection, there were about 100,000 young adults that would be eligible for this type of coverage and they covered about 6,000. Utah doesn't exactly collect this data but, anecdotally, when you talk to the Department of Insurance there, they feel that there is a considerable amount of utilization of the law that allows individuals to be covered up to age 26.

So, it's a relatively new policy. It is targeted to a hard to reach group and a group that's expanding in number when you look at who the uninsured are. Each one of these state laws is very different so, if you want examples or I know you all had a bill that didn't pass, but if you want examples and if you want to talk about this in more detail, I'd be happy to do that. I don't know if you want to do that now but I'd be happy to do that at any point in time.

CHAIR WILSON said she would appreciate receiving that information at a later date.

11:10:09 AM

REPRESENTATIVE ROSES asked, regarding the folks covered under Medicare/Medicaid, what is being done to address the fact that some physicians won't treat those patients. He noted some physicians in Alaska are also refusing to take Tri-care.

MS. TOBLER agreed that is a good point. Providing a health insurance card doesn't necessarily mean individuals gain access to services. She said that is a challenge and is another reason that good data is so important, as well as including providers in any discussions. She noted some states have put programs into place that enable people with Medicaid cards or subsidized insurance to get access to providers but that is not an easy task.

REPRESENTATIVE ROSES questioned whether the cost of services in Massachusetts has increased now that everyone is insured.

MR. CAULCHI noted the Massachusetts program is too new to have much of an effect but all of the providers and insurers were at the table from the start and costs were discussed. A separate movement in other states, named transparency/disclosure, has taken root, the idea being that providers must specify costs upfront to allow comparison shopping and to allow policymakers to take a broader look. Some states have provided those costs on a website. That movement is in its infancy as well so it is difficult to pull out one model to follow.

11:14:15 AM

MS. TOBLER continued her presentation:

> Okay, moving on. The next slide is a chart called "The Distribution of Health Insurance Coverage by Age." It just is a graphic to show what we just talked about, that young adults are the largest group for the uninsured and the largest growing group for the uninsured.
>
> The next slide is called "Reducing the Number of Uninsured by Expanding or Leveraging Medicaid or SCHIP." When you look at the broad based reforms that are being proposed and implemented across the country, each one of them has a component of expanding their public coverage. In Massachusetts and Vermont, it was the Foundation for the Universal Coverage proposal. In Maine, it was part of the Dirigo expansion. In Pennsylvania they expanded to children. Pennsylvania also has a program that covers adults as well. In California there was an expansion. So, using Medicaid as the foundation for covering all of the uninsured typically, by expanding eligibility to adults up to 100 percent and expanding eligibility to kids to a higher level, is the way that the states have done it. I've just listed the states and whether or not they're looking at adults or children.

11:15:58 AM

REPRESENTATIVE GARDNER told Ms. Tobler that Alaska passed legislation this past year expanding Medicaid to children so it can be added to the list.

11:16:14 AM

MS. TOBLER continued:

The next slide addresses a problem that exists in every state and that is enrolling those individuals that are eligible for programs but aren't in the programs. You know we were in New Mexico a couple of weeks ago, talking to them down there. They have a large percentage of uninsured, comparatively speaking, when you compare them with other states in the country. The majority of the kids, at least, are eligible for an existing program and many of the adults, up to 100 percent of poverty, are also eligible for an existing program but just aren't enrolled. Many, many states are grappling with this. Minnesota made that a priority as well. They have expanded public programs to include many people that wouldn't be eligible if they didn't live there but yet they still have a number of uninsured that are eligible but just not enrolled.

So enrolling those that are eligible – the governor of New York made this one of his priorities for kids because the majority of kids that were uninsured in that state were eligible for an existing program. Nationally almost three-fourths of uninsured children are eligible for, but not enrolled, in public programs. It's for many different reasons. The family doesn't want to enroll them. The family has no idea that they're eligible for the program or the family feels that the eligibility process is beyond their capabilities. So those are the three reasons.

Creating programs and working with your agencies in your state to maximize enrollment in existing programs probably would be the easy first step in reducing the number of uninsured.

I'm going to ask Dick to talk about the next slide, which is "Reducing the Number of Uninsured by Increasing Choice with Consumer Directed Health Care." This is really his purview here at NCSL so I'm just going to ask him to say a few words about the momentum on consumer driven initiatives across the country.

11:18:12 AM

MR. CAULCHI told members the following:

First of all, a word about the jargon of the words used. Health savings accounts (HSAs) are the things that often make the headlines and that have the policy initiative and there's a lot of legislation filed to facilitate health savings accounts. From a broader point of view, health savings accounts are a federal law created structure that, in fact, require a high deductible health insurance plan along with them. It's actually the high deductible health insurance that provides the insurance coverage so, if someone were to just have an account with money in it, that is not technically insurance.

But, in fact these two are paired and one can have a high deductible plan without actually having an [indisc.]. I don't want to make this complicated structurally because the real point is that there's a growing endeavor, and really movement, across the country because of the federal law to establish and encourage health savings accounts and the HSAs themselves are very flexible and relatively attractive in a financial sense. They are completely tax free. Any money put into them is tax free or tax deductible. Any contribution the employers make also is tax free and then any withdrawals from the account remain that way and then the money in them can be rolled over from year to year. So those are kind of the selling points. They have been particularly of interest, I think, to many employers who feel that the traditional comprehensive is just not affordable. They either never offered it or they've dropped it or considered dropping it because of the unaffordability. So the HSA – or the broader term, consumer directed health care – that kind of package provides a way that employers can be in the game, so to speak, but provide a more limited amount of contribution.

So, you know, a few statistics here that the actual HSAs formally set up under federal law – there's about 1.3 million at the beginning of this year. But there are 8.5 million people that have some kind of high deductible health insurance plan. High deductible under federal law is defined as you have to have at least the first $1,100 for an individual or $2,200 for a family paid out of pocket by the person before the actual insurance comes in. So, it is what might be

called catastrophic insurance primarily. Again, the modern versions of these, or the new versions of them, have some sort of practical incentives. They often cover wellness features so that it's not just those times when you're in the hospital with an emergency but it does cover other things.

A majority of states have passed laws encouraging or facilitating these and the interesting latest development or most recent development is that a number of the comprehensive reforms, including Massachusetts, have integrated use of health savings accounts. So some might have said a few years ago that these were kind of an ideological or a conservative approach but, like many things we're seeing, just as cost containment and expansion are happening simultaneously, so, too, consumer directed or health savings accounts are being integrated into other kinds of expansions and public programs.

... I will leave it there unless there are specific questions and, again, we have a good deal of material specific to these or the comprehensive programs that include them.

11:22:36 AM

MS. TOBLER continued her presentation:

So, the next slide is changing the topic to quality. When you look at the broad based reforms and you look at the activity that's happening nationally, there is an upsurge in interest in creating more statewide quality programs for health care. So most of the new bills and proposals address quality improvements. I have some examples up there. In the Dirigo reform, Maine spent a lot of time collaborating with the various stakeholders around the state on quality and they created the Maine Quality Forum, which is a group that advocates for quality care and helps people make decisions based on their health care needs and choices. This Quality Forum actually reports back to the legislature and it reports to consumers in public forums and on a public website.

Minnesota is probably the state that I would hold out as a model for quality reforms. They have been

actively working on quality improvements for many, many years and just recently the governor has created an initiative to improve quality of health care in their state and I just included one of the initiatives. They created something called the Minnesota Smart Buy Alliance, which is a joint effort between state government, labor unions, and private businesses to improve quality and lower costs. That group gets together on a regular basis and discusses health care costs and discusses issues related to quality and it includes all of the players in the state. So it's actually a pretty powerful group. There are plenty of other initiatives that Minnesota is working on. I just [indisc.] them all.

In the most recent Pennsylvania health reform proposal, there was a big movement to reduce hospital acquired infections and so Pennsylvania went about it in a more specific way as opposed to broad based quality programs. They are actually looking at really specific issues in trying to improve outcomes and quality by addressing those specific issues. The Pennsylvania health reform has now turned into many different bills. They took their big broad health reform proposal and turned it into about a dozen different bills and actually some of the quality initiatives were implemented without going through the legislative process. Hospital acquired infections is one of them.

Finally, at least four states have recently announced or passed measures to reduce disparities in health or health care, New Jersey being one of them. They just came back with a – they did a statewide report on disparities in health care. Disparity is very much related to quality so New Jersey is focusing on quality but also, at the same time, focusing on disparities in health care based on ethnic or geographic areas. They now have a statewide program to reduce disparities, which they are hoping, at the end of the day, will improve outcomes and improve quality of care. Any questions on that?

11:25:59 AM

MS. TOBLER, after determining there were no questions, relayed that the next slide speaks to chronic disease. She continued:

... I won't talk about this too much because I know that Ken Thorpe's there and I know he likes to talk about chronic disease but I will say that more and more attention, from my experience working with legislatures over the years, this is probably the most attention that I've seen being focused on managing people with chronic disease and it probably is about time because this is where we spend all of our health care dollars. So five percent of the population has the greatest impact on the cost of health care.

So basically, people with chronic diseases are where we spend our money and if we can do a better job of managing individuals with chronic disease and improving their outcomes and making them healthier that logically we will reduce the cost of health care and have healthier people have more money to spend on prevention, etcetera, etcetera.

Vermont, when they passed their legislation last year, didn't only look at covering the uninsured, but they actually looked at a more comprehensive system of health care and they created the Vermont blueprint on health, which I'm sure Ken will talk to you about so I'm not going to go into any details. Vermont isn't the only state looking at that. New Mexico is very, very interested in rolling in a chronic disease statewide program in their reform. California is focusing on chronic disease and what can be done, not only through private insurance, but through ... local community and statewide programs to improve outcomes for people with chronic disease.

11:27:53 AM

Pennsylvania established a governor's chronic care management reimbursement cost reduction commission in May so they're also looking at broad based chronic disease management on a statewide level.

So I would say that it is definitely becoming more of a priority for legislators and governors talking about broad based reforms. And, even in some states not talking about broad based reforms, looking at what they can do with their existing resources and focusing on chronic disease as a way to spend those resources.

The reason is, because as a country, we're spending – if you'll go to the next slide – "Health Care Costs Concentrated in Sick Few." This is just a graphic to show where we're spending our dollars and I'm not going to get into the nitty gritty of this slide but you'll have it as a reference.

If you'll go to the next slide, which shows the percentage of U.S. adults who receive recommended care for their conditions. This is just a graphic that shows you that although we have some of the best health care services that are available in the world here in the United States, if you have a chronic disease, let's say asthma, about 54 percent of the time you're not getting recommended care for your condition.

Now why you're not getting that care could be a myriad of different reasons but with a chronic disease management program, the intervention that you would make with that patient would help reduce that myriad of reasons that you're not getting your recommended care. Any questions on that?

11:29:35 AM

MS. TOBLER, upon determining there were no questions, continued:

Okay, let's go to the next slide, which is "Focusing on Prevention to Decrease the Incidence of Disease." There has been a real jump in legislative activity around prevention and disease reduction. Many of the reform proposals, actually almost all of the reform proposals and bills include prevention strategies and policies.

We're also seeing many stand-alone bills focusing on individual issues like reduction of obesity, reduction of trans fats in foods, reduction of smoking in cars. These are just examples, so a lot more legislative activity around the idea of prevention of disease.

Let's get back to obesity. There's more emphasis on reducing obesity and increasing exercise in the legislature. I'm not even talking about in the broad population as a whole. The reason is because health related spending on obese people accounted for 27

percent of overall health spending increases between 1987 and 2001; 38 percent of diabetic spending and 41 percent of heart disease spending so you see that there is a real cost reason why we should try to do a better job of creating programs and creating treatments for people who are obese and have chronic disease especially.

If you'll go to the next slide, it's a pie chart that shows the causes of disease. So you see that tobacco, poor diet, and physical inactivity, alcohol consumption and other preventable about half of the time – and intervention and effective and valuable intervention could help prevent disease from occurring. So that's the reason that there is an increased interest in legislating around prevention.

The next slide, I don't know – one of your other speakers probably will show you this because I know that they have this slide in their repertoire, but this just is a graphic that shows the incidence and occurrence of obesity and the trends among U.S. adults. ... These are slides that are generated by the CDC and I think it's astounding to look at the colors on that map. It's 1990, 1995 and 2005 and, for those that might not be able to see the code on the bottom of the slide, the light blue is less than 10 percent of the population is obese, a little bit darker blue is 10 to 14 percent, the dark blue is 15 to 19 percent of the population is obese, the sort of yellowish color is 20 to 24 percent, and the orange is 25 to 29 percent and then the orange-brown with the little grate over it is over 30 percent of the population is obese.

And so if you look, from 1990 to 2005, you can see that there's been a very, very remarkable change in the population and we're growing into an obese population. Obesity comes with many health concerns. So there has been plenty of activity legislatively to try to reduce obesity. We have databases of laws. If you're interested in taking a peak at those, let me know and I'll send them to Rebecca. Any questions on that?

11:33:20 AM

SENATOR DYSON asked if any state or local governments have made efforts to limit the amount of public dollars going to those patients whose behavior causes their health conditions, such as IV drug users or diabetics who do not monitor their blood sugar.

MS. TOBLER said some states have instituted incentive programs for Medicaid patients. Patients who manage their diabetes or reduce their body mass index when obese get an incentive. Other states provide less of a benefit package if patients cannot accomplish those things. She said a trend is occurring.

MR. CAULCHI noted that several states have added higher employer contributions for employees who smoke as an incentive to quit.

SENATOR DYSON said he would appreciate receiving more information to explore that idea.

MS. TOBLER agreed to send more.

CHAIR WILSON asked Ms. Tobler to skip the Medicaid highlights today, due to lack of time.

11:36:49 AM

MS. TOBLER continued her presentation:

> ... Let's go on to the next slide, "Focus on Wellness/Personal Responsibility in Private and Public Insurance." That is so much of the point just discussed. There has been some legislation to promote wellness, like allowing premium discounts and rebates, employer tax credits, focusing on state employees like Dick just mentioned and creating statewide wellness programs. There was a study that was done at St. Louis University that came out with numbers that said that workplace-based health programs can save an average of $3.50 for every dollar spent. I think there's still some discussion out there as to the return on your investment and I think that some of the hesitation that states have in going into wellness is that they feel that there isn't significant data but I think that that data is coming in now. Hopefully your next two presenters will be able to talk about that.
>
> Rhode Island passed legislation this year creating Well Care, which is an affordable health insurance product that is focused on wellness. It's focused on

prevention, primary care, and actively managing chronic illness and there's some requirement that there needs to be the use of evidence-based medicine. I included a link there because it's very interesting if you have some time to look into it I would check out that link.

And then, last but not least, was something that we talked about a little bit earlier, and that is access to health care isn't just about getting an insurance card. That includes all parameters. It includes not just having access to insurance to pay, but also having access to appropriate physicians in appropriate geographic areas.

Community Health Centers have been a way for individuals who either have Medicaid or don't have coverage at all to get services and health centers provide care for about 15 million people at about 5,000 different locations. In a few states this year, there's discussion about expanding community health centers to not just provide access to those who don't have insurance, but to provide medical homes for people that do have insurance. Community health centers are usually in underserved areas, which in your state is a large part of the state. They are not just in rural areas. They are also in urban underserved areas.

The community health centers are, if you don't know anything about them, they're a partnership with - the federal government provides some financing – less than 30 percent of the financing and then in some states general fund dollars are provided for community health centers but not all states. ... The next slide [shows] the number of federally qualified health centers in your state and then, if you're interested, I also have a comparison chart that shows the number of ... general fund dollars or other dollars that come from public sources that go to help finance community health centers.

CHAIR WILSON requested a copy of that information.

11:41:24 AM

MS. TOBLER continued:

If we'll go to the next slide, which is "Access to Heath Care: Incentives for Doctors to Practice in Underserved Areas," you know, most of the states are in the business of recruitment and retention and so 45 states have loan repayment programs for doctors who practice in underserved and rural areas. But some of those programs are really funded by federal dollars so there are other states who have really taken on this issue, New Mexico being one, California, Arizona that have taken on the financing of those loan repayment programs and have added bonuses and incentives to try to encourage physicians to stay in hard to serve areas. It is definitely an issue that if you're looking at access as a whole and not just as providing access to insurance, it is definitely something that you need to look at and study carefully and I know that you all have done very good work in this area in Alaska.

Let's go to the next slide: scope of practice because this is something that has been a current discussion in health care reform proposals across the country. I'm going to use Pennsylvania as an example. You know you, as legislators, license your providers and you create their scope of practice so you create the ability of them to practice and use their skills at the highest level. In Pennsylvania, with their health reform, one of the components of their health reform was to expand scope of practice for nurse practitioners and physician assistants and pharmacists so that they can practice at the full extent of their knowledge. That is directly related to trying to reduce the cost of services by allowing lower paid providers to provide services that in some other states can only be provided by higher paid providers, like doctors.

And then the other thing that has been coming up in discussions is retail clinics. I did not ask before I prepared this presentation whether or not retail clinics are popping up in your state but they're popping up all over the place. Those are the clinics that you see in chain pharmacies and in Wal-Mart. There has been a little group of legislation that's come up, either trying to overly regulate retail clinics and to reduce the number of RNs and PAs that a

physician can oversee or to encourage retail clinics by increasing. So Texas actually is trying to encourage retail clinics by reducing the restrictions on physician oversight of RNs.

So that's kind of what's happening out there in scope of practice but it certainly is a piece of the puzzle when you're looking at access.

That's the last piece on health reform across the country. I tried to give you the highlights. I hope you'll share the Medicaid slides with the rest of the committee. Please feel free to contact me about the content of that. If you'd like me to go into detail about what's happening in Medicaid reform across the country at a later time, I'd be happy to do that.

11:45:04 AM

REPRESENTATIVE ROSES referred to an NCSL presentation on healthcare in Chicago in April at which Dr. James talked about Utah's attempt to change its scope of practice by establishing a stringent protocol for tests to reduce costs associated with unnecessary testing. He asked if his memory is correct.

MS. TOBLER said that is correct. She said the subjects of evidence-based medicine, scope-based practice, and creating statewide standards for treatment are all part of the discussion. The more information available on successful programs across the country, the better prepared Alaska will be for its discussion. She offered to send information that Dr. James provided about Utah's program, which is well documented.

CHAIR WILSON said she would like that information.

11:46:51 AM

REPRESENTATIVE CISSNA said she has heard that up to 70 percent of a person's health care outcomes are based on individual behavioral choices and habits. She noted mental and behavioral health need to be part of this discussion because the outcomes can be very expensive. She asked what work has been done to address that.

CHAIR WILSON said that question will be addressed this afternoon in another presentation.

MR. CAULCHI said Representative Cissna is correct that a high percentage of the outcome factor relates to individual behavior. Mental health is a large area and somewhat distinct because it covers a whole range of conditions, from institutionalization at an early age to people who cannot work full-time. One practical fact is whether that kind of treatment is fully covered. A movement to increase the amount of coverage and recognition of mental health conditions is underway but is controversial because of the cost.

MS. TOBLER added that integration of mental health and substance abuse treatment with traditional health care services is occurring in the states.

11:50:32 AM

REPRESENTATIVE FAIRCLOUGH asked if any research supports the premise that if insurance is provided to the uninsured, they will actually access the insurance.

MS. TOBLER said the answer is no. She pointed out that New Mexico created a three-share program (employees, employers, and public dollars) that provided subsidies for low income individuals to purchase employer-sponsored insurance or to buy a product commissioned by the state. The employer could also buy in for their employees. There was very little participation due to inadequate marketing and because it would cost some employers more than they were already paying. She said that Massachusetts now requires the uninsured to purchase insurance and Vermont created a voluntary, subsidized program for low income individuals. In New Jersey, a questionnaire regarding why people didn't take advantage of extended benefits to young adults revealed that many people had no idea the employer was paying. She said the dilemma is creating a program that creates a robust private market while recognizing that the lowest income people probably still cannot afford it and providing for those people.

REPRESENTATIVE FAIRCLOUGH responded:

> Laura, I think you provided the information that I thought was true. I guess I'm challenging the hypothesis of 50 states chasing the uninsured if, on your slide that's labeled "Enroll Those that are Eligible. Nationally, 3/4s of the Population of Uninsured Children are Already Eligible." I believe as states discuss the challenge both in the private

> sector and at a state level of wanting people to do preventative care and wanting all people to be able to access that care, that there may be a reality that whether we provide it or not, people won't access it. Whether that's education and understanding the importance of a good diet, of less Trans fats or whatever it is, that we're chasing a hypothesis that says, and it's a very expensive hypothesis, that if we offer the insurance they will come. We already have figures that say they don't come. And so are we putting all of our eggs in one basket the right way?
>
> I understand, back to Senator Dyson's comments about personal responsibility, you know I've talked with our local providers and understand that those uninsured that are coming at critical times to emergency rooms to access their health care are driving up the cost for all the rest of us because that is not the way to access health care. We want them in early. We want those children in for their annual check so that we can start doing some preventative maintenance on their health care systems. I don't know that we change that behavior by offering it in the system. I guess it's not a negative ....

MR. CAULCHI said Representative Fairclough presented a practical caution. A dilemma during the last decade is that policymakers sometimes put the emphasis on the detailed structure of a program rather than on the marketing. He said, as an example, Massachusetts has recognized that general marketing is central to the success of its connector program so it is blanketing the population with ads that tout the program as easy to use and mainstream. He noted the success of that program is yet to be seen but emphasized the need to include marketing costs in any health care program.

MS. TOBLER said the dilemma Representative Fairclough referred to is one reason Massachusetts decided to mandate that individuals get health insurance. She noted the financial penalty for non-compliance is small but will increase in the future. She said that is why individual mandates are being discussed in other states.

REPRESENTATIVE FAIRCLOUGH opined that individuals won't come even if it is mandated. She said the choice is at a deeper level – whether parents have time or that preventative medicine is a part of their culture. She remarked that a parent will not

bring her infant in to be immunized because she is being penalized financially. She felt the marketing needs to be directed at healthy development and the value of preventative services. She wants people to actually receive services. She pointed out she was recently in Dutch Harbor where it costs $1,000 for a parent to take a child to get services elsewhere.

12:02:53 PM

CHAIR WILSON recalled that when she had three small children and good insurance coverage, family members did not go to the doctor because they couldn't afford the deductible. The insurance was used for emergencies only. She believes many people are in that position.

12:04:04 PM

REPRESENTATIVE ROSES said when Alaska had the Denali Kid Care Program, physicians and community health care centers expressed concern about the number of appointments made but not attended. Those appointments were not cancelled or rescheduled, which adds to the cost. He felt people should be accountable for those costs.

MS. TOBLER said recognizing those challenges and working with state experts to address those problems is important. She asked members to call her because she can provide some examples of local successes in addressing those kinds of problems.

CHAIR WILSON asked Ms. Tobler to send committee members any information she has on that subject.

12:06:16 PM

REPRESENTATIVE CISSNA commented that Alaska has not made health a high priority on political surveys. The state spends large amounts of money on health care but not large amounts of time. She felt that legislation alone is not enough; leadership by example is important.

12:08:48 PM

CHAIR WILSON thanked Ms. Tobler and Mr. Caulchi for their presentations. She said they set the stage for legislators to work from. She then announced the committee would hear from two speakers this afternoon and would probably meet until 4:00 p.m. She announced a lunch recess until 1:25 p.m.

Presentation: Rethinking Insurance

1:28:22 PM

CHAIR WILSON called the House Health and Social Services Committee back to order and introduced Dr. Ken Thorpe, the Robert Wood Woodruff professor and Chair of the Department of Health, Policy and Management in the Rollin School of Public Health of Emory University in Atlanta, Georgia. He also co-directs the Emory Center on Health Outcomes and Quality. His presentation is about rethinking insurance. Dr. Thorpe has authored and co-authored over 85 articles, book chapters and books and is a frequent commentator on health care issues in the media. He has appeared on national news broadcasts. He received his PhD from Rand Graduate School, an MAA from Duke University, and a BA from the University of Michigan. Chair Wilson noted paper copies of Dr. Thorpe's PowerPoint presentation were distributed to members.

1:31:02 PM

DR. KENNETH E. THORPE, PhD, informed the committee that he has spent the last 2.5 years working with two states on enacting comprehensive health care reform efforts, Vermont and Illinois, which are restructuring how they pay for and deliver health care services. He will discuss some of the possibilities Alaska can look at to make broad sweeping comprehensive reforms. Health care reform was a nonpartisan issue in both Vermont and Illinois. The policy initiatives of interest are ones of common sense prevention and more effective management of patients. He said it is necessary to define the problem correctly, have the right vision and a political strategy to succeed. In both states, getting people on the same page and moving in the same direction was necessary. He began his PowerPoint presentation, as follows:

> You've heard a little bit about the components of health care reform. The four that I focus on [are] one, that a key issue for people when they think about health care reform is how are you going to make my health care insurance less expensive, more affordable. What are we going to do to make sure that my employer continues to offer it at an affordable price at lower co-pays and deductibles?

I start out with this one because I don't know the specific numbers in Alaska but we've done some national polling in the last election looking at voters. Obviously, when you look at the voting public, nationally about 85 percent of Americans have health insurance – it's closer to 83 percent here. But about 96 percent of people who voted had health insurance. When people are voting and when you talk about health care reform they're focusing on this stuff costs a lot and we'd like to find some initiatives to make it less expensive, better quality, more quality time with my physician, and less complicated because it is very complicated for physicians and families and others trying to deal with the forms and the paperwork involved in health care.

So I think collectively these are areas that I know that you're touching on in different ways: the affordability issue, reducing administrative costs. There are a lot of very simple things that we can do to move paper out of health care that produces no quality but produces higher costs. I'll give you some examples of that.

There are some quality initiatives that we embedded in both the Vermont and Illinois reforms that I think might be of interest here as well. Obviously the debate about what do we do about the uninsured – you know, Vermont is not dissimilar from this state in the sense that it has a lot of seasonal workers. It's a recreational economy, ski resorts, a rural state, although not nearly as rural or big as Alaska, but it certainly has some elements that are similar – the same population size, something in the 600 to 650,000 range.

Policy intervention on the affordability side – I can just tell you my experience working with the legislatures in both of these states. I just started out the first couple of weeks just making sure that we understood the problem, understood the data, and understood the analysis about where we're spending our health care dollar and what's driving health care spending up. I found that once we got everybody sort of bought into the data, the numbers, the analysis, the conversations we had about interventions were a little bit easier.

So I think that the common sense issue is that crafting effective solutions that are going to make health care more affordable, a better value proposition, means that you have to have a clear understanding of where you're currently spending health care dollars and what's driving the growth and spending up. Real simple stuff but I find when I go into a lot of different places and talk to policy makers, and I'll give you some survey data as well, most people really misidentify or have notions of where we spend the money and why it's going up that turn out to empirically not be the fact. So that's an important shortcoming. If you're trying to solve the wrong problem, you're not likely to have much of an effect on really making health care less expensive.

I start out with these six framing issues and this is largely dealing with the affordability issue. I call them the six unhealthy truths, which tell the story of the rise in chronic disease, the impact on health, and health care in the United States. I believe at the end of the presentation the citations are there. If not, I'd be happy to give you the citations of the studies and so on that each of these comes from. I'll walk you through them as I go and tell you where they come from.

1:37:34 PM

DR. THORPE continued:

The first one we know – this is CDC data – that chronic diseases are the number one cause of death and disability in the United States. They account for 70 percent of deaths in the U.S. They kill more than 1.7 million Americans a year. So there's a leading cause of death and I don't think that's tremendously surprising and certainly I think everybody sitting here either may themselves have a chronic illness or certainly know of somebody or somebody in their family that has diabetes, high blood pressure, depression, heart disease, cancer. All of these constitute, selectively, different forms of chronic disease.

Second truth – again these are data that I've tabulated. They're also data from the CDC. Three-

quarters of spending on health care nationally, and we can sort of do an estimate for Alaska as well based on the characteristics of the population and the demographics to see how much are on the margin. This number may vary. Chronic illness accounts for three-quarters of what we spend on health care. Now I think that that's an important statement because remember somebody with a chronic disease by definition has an established medical condition that is expected to last at least 18 months, two years or even longer. So these are people that are already ill and, at that point in time, the issues about insurance [are] important only in the sense of paying for services to make sure that services are delivered. What really is more important is how can we best and most effectively clinically manage that patient, both in terms of [indisc.] to do a better job of self managing his or her condition and also providing the opportunity for physicians and nurses to work with patients to make sure that they do all of the basic blocking and tackling, which is just the primary preventive work of monitoring and managing the course of these diseases.

Medicaid, depending on the state, accounts for about 83 percent of the spending. Medicare owns the chronically ill population. Over 95 percent of spending in Medicare is linked to patients that have heart disease, cancer, and these chronic health care conditions.

The third truth, this is looking at the growth in spending. We've done this now through 2004 and the numbers are pretty much the same. If you look at what we spent in 1987 compared to what we spent in 2000, health care spending increased by over $300 billion. It went from $313 to $628 billion. This was among privately insured patients. Of that growth in spending, about two-thirds of it is linked to the fact that we are treating more and more people with chronic illness. So two-thirds of the growth in spending is due to the fact that we've had a dramatic increase in the prevalence of treated disease.

Now there's a variety of reasons why the prevalence of treated disease could go up. We could actually have a true increase in the number of people that have diabetes and have high blood pressure and have cancer,

heart disease and so on. That's one reason. It could be that we're doing a better job of detecting disease. That's probably a good thing that we're getting at patients earlier in the course of their chronic illnesses. It could be the technology is better to treat more patients today than we were treating 15, 20 years ago. That's certainly the case in terms of drug interventions for treating depression. That's certainly the case with Statins treating hypertension and elevated cholesterol. So what we've been trying to do... all of these pieces are based on work we've been doing at Emory trying to decompose what's going on with spending increases so we can have a clear picture up front for policy makers to sort of really understand what's driving the growth in spending so that they can find the levers of opportunity from a policy perspective and attack them.

We tried to sort of understand here on how much of the increases in spending were for issues that we could potentially intervene, that we had an opportunity to either modify behavior or have an effect on the prevalence of treating disease. What we found is that if you take the issue of obesity – there's a big piece today in the Anchorage paper about obesity rates in Alaska. Just as an aside, I can just tell you that most of the data is based on self reported information so people are sort of filling out surveys – how tall are you, how much do you weigh?

It turns out nationally that if we do it that way, the prevalence of obesity is about one in four, about 25 percent roughly. It has gone up. If you actually do it clinically, actually have a nurse come in and weigh somebody and take their height measurements, the prevalence of obesity is about 35 percent. There's about a 10 percentage point gap between the self reported data and the actual clinical data. That's not probably because people are saying they're too short. They are fudging a little bit on the margin with the weight side. But that's something – the numbers are even worse than what the self reported data shows. We're reaching up to 35 percent nationally in terms of obesity rates, much higher than what the self reported data indicates.

What we wanted to do was on this was to say how much of the increase in spending over time is due to the fact that we've had an established doubling of obesity among adults. So, this first part we're just doing among adults and we're looking at it among kids too.

1:43:30 PM

REPRESENTATIVE FAIRCLOUGH inquired as to whether slide 6 uses the CIP so that the comparison of health care spending is "apples to apples."

DR. THORPE replied yes. The comparison has been done in nominal dollars, inflation-adjusted dollars, and in each year by standardizing age and sex, which weeded out demographic changes, changes in inflation, for age and gender, etc. He further explained:

We took the top 20 medical conditions in the country. Those top 20 medical conditions, heart disease, cancer, hypoglycemia, diabetes, account for just under 80 percent of spending. What we did is we looked at how much we spent on heart disease let's say in 1987, how much did we spend in 2004, [indisc.]. And we had a statistical approach for decomposing how much the increase in spending was due to more people with heart disease versus more spending for heart disease patients. That's what this is reflecting. So if you go across the 20 medical conditions and look at [indisc.] on, about two-thirds of the growth is due to the fact that we're treating more people with these conditions and about one-third of it is due to the fact that it cost more on the spending side to treat them.

If you think about some of these conditions that are big drivers, you know diabetes prevalence rates are up 55 percent over this time period. The amount of cost of treating a diabetic is not much different today in real terms than it was 20 years ago. We've had an explosion though of people under medical management for diabetes in this country. So, depending on the condition that you go through, in some cases virtually all the increase is due to prevalence increase. That's true certainly for depression, that's true for diabetes, hyperlepedemia (ph), elevated cholesterol. It is not true for cancer and heart disease because

those rates have been relatively stable in terms of incidence and prevalence and, in some cases, have gone down. The technology has improved and changed dramatically for those types of things. But, on balance, those increases are really due to the fact we're treating more and more patients with these chronic health care conditions.

CHAIR WILSON said those are behavioral patterns that could be changed.

1:46:29 PM

DR. THORPE said that is correct. He continued with his presentation, as follows:

On this next slide we did another effort study in decomposition and said how much of the increase in spending is due solely to the doubling of obesity? Obviously not all of that two-thirds increase is due to potentially modifiable risk factors. As I mentioned, some of it is due to more aggressive screening and detection. That's certainly the case with certain forms of cancer. That's certainly the case with depression. We're recognizing and catching depressed patients earlier compared to 30 years ago. So some of it is more screening, some of it is technology but a lot of it is just truly a clinical increase in the incidents of disease linked to potentially modifiable risk factors.

The truth number 4 here, our calculations were that about 30 percent of the growth in spending over this time period is due to a doubling of obesity nationally. Again, we've done these calculations on different states, looking at how they play out. In general the range is from 25 to 40 percent, depending on the state. To give an example of how that plays out, if you go back to, again, diabetes and I focus on that because I think everybody's clinically familiar with it and it is a very classic example of what is going on here.

I mentioned the huge increase in the prevalence of diabetes being treated in the U.S. over the last 25 years. If you go back 30 years ago and do it – you know, standardized the likelihood that somebody has

diabetes for demographics, gender, race, ethnicity, education and do all of the appropriate standardizations and then just look at it by weight class, what you find is that 30 years ago, four percent of normal weight adults were diagnosed with diabetes. 14 percent of people who are obese were diagnosed with diabetes. We're only catching about two-thirds of total diabetes so if you look at the total clinical prevalence of diabetes, a third of it we don't treat and don't diagnose; two-thirds of it we do treat and diagnose and that hasn't changed in 30 years.

The prevalence rates go to 2004. In 2004, four percent of normal weight adults are diabetic. The prevalence of obesity in adults is 14 percent. None of those things have changed so we're not detecting more diabetics. The prevalence rates in those body mass increments has not changed. What has changed is the distribution of people in each of those groups. So, virtually all of the increase in diabetes in this country is due to a shift in the weight distribution.

Another...way of thinking about it is that suppose that we could have done something magical and just frozen the rates of obesity today at the levels they were in 1987 so that they didn't double and nothing else changed. There's no change in technology. That stays the same. It stays the same in terms of how we pay for services. Nothing else changes. The only thing we do is just hold those obesity levels after 1987 levels. We calculated that we'd spend about 10 percent less in the United States. That is, the base of spending would be 10 percent lower than it is today, which is over $200 billion. So it's a huge impact on overall spending trends in this country.

If you look at the fifth truth, and it relates to this fourth fact, most of these chronic illnesses could be prevented or certainly better managed. Again, that's from the CDC. It shows that about 80 percent of heart disease and stroke and Type 2 diabetes are preventable because they do link to potentially modifiable, though difficult to modify, risk behaviors. About 25 to 40 percent of cancer is potentially preventable. That's particularly true with certain forms of colorectal cancer, probably less true with other forms of cancer.

The bottom slide – statistics you've already seen. Sort of the irony here is despite the fact that most of what we spend in our health care system is linked to chronically ill patients. We don't do a very effective job of providing clinically preventive health care services to those patients. If you look at what the American Diabetes Association says is the standard of care for treating diabetes in this country in terms of how often you should get your hemoglobin A1C checked, the annual eye exams, extremity exams, blood pressure exams, just the basic ongoing medical management of those patients, they're only getting about 56 percent of the clinically recommended care. That's not because the doctors don't know that it is clinically appropriate to do or the nurses don't know that it is clinically appropriate to do, it's because we have a payment system and a delivery model in the United States that was great in the 1960s, but is not really built for patients that are being treated in the health care system today.

If you go back and think about the Medicare program in 1965 when it was first put together, that benefit design and the way that we pay for services was based on the clinical characteristics of patients who were being treated in the 1960s, episodically ill patients that came in, had a medical event, they were treated and they went home. Well that's not the clinical profile of patients driving and spending the system today. These are not patients that are episodically ill. They are persistently and chronically ill [and] need ongoing medical management of their care.

REPRESENTATIVE GARDNER asked Dr. Thorpe to describe a system that would address today's scenario.

1:52:40 PM

DR. THORPE said he would lay that out and then discuss the specifics of how Vermont's program was redesigned. He continued:

The sixth truth is that if you think about what I've told you today, three-quarters of what we spend our health care dollars on is on chronically ill patients. Two-thirds of the growth is due to the fact that we

have more chronically ill patients that are being treated. About 30 percent alone is due to a doubling of obesity.

If you take a step back and say what are the opportunities from a policy perspective to intervene and do something, the starting point, it seems to me, in terms of really dealing with the big picture stuff, is you're not going to solve these issues by dialing up co-pays and deductibles and having a debate solely on insurance. Insurance reforms play a piece in this. There's no question about it but that's not the primary piece. This is a piece that's more complicated than simply dialing up deductibles and co-pays because it deals with the structure of the delivery model, the payment system, and really building into our culture preventive interventions that can potentially modify risk behavior. We've done this in smoking to a certain extent over the last 30 years. Smoking rates are still way too high but they've dropped from 50 percent to the low 20s. So we've done this with smoking and we need to have a discussion about what are the opportunities and the types of interventions you could do on the diet, exercise, nutrition side. Neither one of them are easy to do.

If you ask the public about this issue, and indeed this is based on a national survey that our group at Emory did and another group I work with, which is called the Partnership to Fight Chronic Disease. It's a group of 70 organizations nationally, ranging from the National Association of Manufacturers [NAM], Chamber of Commerce, Service Employees International Union, [Indisc.] Hospital Association, there's a broad cut of groups that have worked on health care reform for years and years and years, most of them not on the [indisc.] because most of them started and engaged in the debate about health reform on the insurance, the financing and the coverage pieces. They just did not build a coalition and get much traction and much movement.

We sort of flipped this around this time and said let's start with the affordability issue. That's what most Americans think about when you think about health care reform. Let's see what we can do to make health

care more affordable, lay out the facts, and see if you can't build a non-partisan approach to dealing with this, this time around, at the state level and at the national level. That's what this group, the Partnership to Fight Chronic Disease, is really focused on.

I've been surprised at the engagement that NAM, the Chamber and Service Employees have had to date in a) laying this presentation out with us, but also starting to craft policy solutions that they all can agree on, which is, to me, a marvel given the diversity of interests in those groups traditionally.

... If you ask people what percent of deaths do you think chronic disease accounts for, I mentioned it was 70 percent. Well you can see very few people get it right on the left hand side. Only 15 percent of the population is in the sort of the ballpark. If you asked what percent of spending the chronic health care account for, again, only about 14 percent of Americans were in the ballpark on that one.

So part of this, in terms of framing the issue and getting, I think, policy makers and the public focused on this, is just an educational part of it, just laying out the facts about where the spending is, what's driving it and providing opportunities for discussion about here's the real problem that we need to focus on. And then to start to think about some new innovations and new approaches that might be in place that could really attack these problems more effectively than we have in the past.

1:56:55 PM

CHAIR WILSON surmised then that 70 percent of the deaths in the United States are caused by chronic diseases but more than 70 percent of health care costs are spent on those patients. Therefore, if that is where most of the health care dollars are spent, that is the area to focus on.

DR. THORPE said if the desire is to manage funds in the system, better management of patients with chronic diseases will be necessary. Primary care physicians say the typical clinical profile is patients with hypertension, diabetes, elevated cholesterol, overweight with back problems, pulmonary issues or

asthma, and depression. The current health care system was never designed to track this and it was not designed for physicians to manage it clinically. The information technology and payment systems or population based public health delivery model are not in place to help primary care physicians to effectively manage those patients. The payment and delivery model is still based on the 1960s.

The challenge is to define the problem correctly. The six issues he has discussed provide a compelling, simple story that coherently lays out the facts so that interested parties can focus on policy directions.

1:59:20 PM

DR. THORPE told members the key to controlling the level and dollar spending is to do a better job at creating a clinical profile. Patients are not getting the clinically recommended preventive services. They are not engaged in self managing their conditions. No one is tracking patients across the domains of care they get. Prescribing and medical errors occur. Patients use several physicians over the years so a comprehensive patient profile is often elusive. An emergency room physician is often shooting in the dark regarding allergies, drug interactions, and current treatments of patients. The key is to develop a new delivery model for patients treated today. He questioned what a new system should look like and what are the key components of good, best practice integrated models. The persistent rise of obesity and chronic disease must be prevented. The data about each age group shows dramatic increases in chronic disease prevalence and big increases in treatment costs. Adolescents aged 15 to 22 spend the equivalent of what 35 to 44 year olds spent 15 years ago in terms of disease prevalence and spending patterns. He stated:

> This is not quite a tsunami in terms of an increase in the prevalence in disease, but it's starting early and it's starting increasingly early in schools, junior high schools, particularly among girls in school, related to a lot of things we can talk to related to physical activity time and so on.
>
> In each of those cohorts, we were seeing these trends that – as I listen to the policy debate about affordability, which is largely focused on dialing up co-pays, deductibles, insurance based reforms, that's not going to get the job done in dealing with these

more difficult to address behavioral issues and prevention issues.

2:02:49 PM

SENATOR DYSON asked if really significant co-pays might act as an incentive for people to take better care of themselves.

DR. THORPE replied yes and said there are two approaches that could be used. Pitney Bowles and Safeway did experiments in which they offered employees high deductible plans to encourage behavioral changes. They found their spending did not decrease, and in certain elements increased. The data showed that hospital stays, clinical and emergency room visits increased. They traced the increase in cost to the fact that patients with certain ailments, diabetes, hypertension, heart disease, and certain forms of cancer, were not persistently taking medications and self managing. They would end up going to the hospital for treatment and to get prescriptions filled.

2:05:04 PM

SENATOR DYSON asked if those employees had been taking better care of themselves prior to the switch to a large deductible policy.

DR. THORPE said the prescription fill rates for medications taken on a regular basis, such as Statins or insulin, decreased substantially because of the high deductible.

SENATOR DYSON said if he was a large employer, he would provide a gym in his facility, record employees' BMI, blood pressure, cholesterol, etcetera, and offer lower rates to employees who improved their health.

DR. THORPE said Safeway kept its high deductible plan but said it would deposit more money into the accounts of employees who took a health risk appraisal. Asymptomatic employees would follow a specific care plan. Employees with high blood pressure, for example, would be given a plan of services to follow and no cost sharing. The challenge is to make sure employees follow those plans so that by removing the co-pay and deductible costs, employee compliance rates increased. So, financial incentives were used more as a carrot than a stick. Safeway found most of its health care spending is on the employees with conditions so the challenge is to engage those employees in more effective self management. Financial

incentives are very effective, as well as making services readily available. Some large companies have nurses on site once a week and have 24-hour nurse call lines. He agreed the benefit design is important but the challenge is how to structure insurance deductibles and co-pays in the context of employees with six, for example, chronic health care conditions.

REPRESENTATIVE GARDNER asked if the Pitney Bowes/Safeway studies are available or whether the studies are ongoing.

DR. THORPE said he could send copies of their presentations. He noted another study on this topic was published in the New England Journal of Medicine. In that study, the drug benefit deductible was increased. The result was a decrease in the cost of prescription drugs but increased costs in hospital stays, emergency room and clinic visits so no money was saved and mortality rates were slightly higher. He said the challenge is to understand where the money is spent and how to structure a preventive delivery model given the fact that patient characteristics are different. He asserted the issue is much more complicated than simply dialing up co-pays and deductibles.

2:10:29 PM

DR. THORPE continued his presentation:

> I can tell you that if you look at most, what I call, care managements as opposed to – I don't like to call it disease management because when I hear disease management, to me that means you're trying to manage one medical condition. The more problematic issue is that the patients in the system are – they have all these conditions. They come in bundles. You don't just have diabetes. You have at least two or three other chronic conditions associated with it.
>
> So, if you think about it, if you look at most private insurance plans, if you look at most Medicaid programs, certainly the Medicare program, the care management that exists in those programs today are largely ineffective. They're largely ineffective because if you take a step back and say what would one of these best practice programs look like? What would it have to include? It would have to include primary care physicians sort of as the traffic cop or concierge managing this. It would have to include nursing time and nurses working with patients and most

of the care would be provided by nurses that work with patients. You'd include and engage patients that are motivated to self manage their conditions. It would have to include the physician having the information so here she could understand and track whether or not you've had your annual eye exams.

And, just looking at all of the clinically preventive indicators for diabetes and all of these other conditions, you know, have they occurred on a timely basis? Did the patient fill their prescription? Did they refill their prescription? Just the real basics about managing those patients we don't have in the system today. And that physician is not paid to deal with those issues. Take a step back and think about that patient again, the hypertensive diabetic with all the co-morbid conditions, that patient is going in to see a primary care physician today. It's an established patient so that primary care physician is getting paid for a 15-minute established office visit of which he or she probably spends seven or eight minutes with the patient. That patient has 10 different things that they want to tell you about their diabetes, their blood pressure levels, their depression, their back hurts, they're having trouble breathing. The physician is basically, at that point, struggling to figure out triage-wise what is the problem that is the most serious and important that I can deal with in this point in time, take care of that, and then hope the other problems resolve themselves.

So, if you think about it, that primary care doc not only doesn't have the information on those other conditions, he or she is not really paid to monitor those conditions outside the physician's office.

2:13:05 PM

CHAIR WILSON asked how a legislature can get insurance companies to change their system of designated numerical categories for diagnoses.

2:13:33 PM

DR. THORPE told members the two policy challenges that both the Governor's Offices and the Legislatures faced in Illinois and

Vermont were prevention and to clinically manage the funds spent on the chronically ill. They studied best practices of effective programs. They surveyed insurers, state medical groups, and others, and created working groups to determine what best practice includes. The survey found that some elements of identifying patient data through claims data were effective but that system did not work because it was not integrated with the primary care physician, it does not have a sustainable payment system, nor does it have an information technology component that allows tracking. Their approach was to build a health care home model in which patients choose a primary care physician who puts together a preventive age-appropriate package of physicals and risk appraisals and develops a care program that the patient, physician and nurse would work on. It would contain a diet and exercise routine, periodicity of monitoring, etcetera, and the patient's reward for following that program for self management is to get clinically recommended services at no cost sharing and a lower premium. He continued:

> I am going to – me being the primary care physician, if I do this, I'm going to have the information technology ... to really manage it and I'm going to get paid appropriately so I'm not just going to get a fee for service payment to come in and manage this patient. There's got to be a different way of paying for primary care physicians.

2:17:03 PM

REPRESENTATIVE GARDNER noted certain physicians in Washington work on a private contract. Patients pay an annual fee for health care and pay for medication and testing outside of that. The idea is that patients pay one fee for an entire year and have an opportunity to address all health needs, which she believes creates a more satisfying professional role for physicians. She noted the problem is that insurance companies do not participate. She asked if Dr. Thorpe has seen that happening elsewhere.

DR. THORPE replied the distinction between a "concierge" approach where patients pre-pay to get access to a physician and the approach he was speaking about is about more bundling of services and payments. Upfront the physician will be paid a monthly management fee, recognizing the physician and nurse's time to manage a patient. Upfront funding will also be provided for clinically recommended services. Routine office visits will be monitored so that if a patient receives all of the clinically

recommended services, the physician is rewarded; if not they get paid 90 percent of the fee. He noted some experimentation is taking place with case management fees, bundling of services and around fees for service payments with the expectation that if this is structured and done right, over an 18 to 24 month period, clinic visits, hospital stays, emergency room visits will decrease because the patient is being managed on an ongoing, proactive basis.

He said the delivery models are being built community-by-community and, within three to five years, every primary care physician will have electronic health technology on their desk. That model provides payment reform, delivery reform, and information reform.

He pointed out, in regard to Chair Wilson's question about how can a state take a model and leverage it, these two states began by determining the best practice delivery models they wanted to provide with the agreement of all participating parties. They began with Medicaid patients. He explained:

> A Medicaid agency will send out an RFP saying we want you vendors to manage our diabetics and hypertensive patients and here are some metrics that we want you to meet. They sort of turned it on its head and said we don't want that model. What we want is we want you to deliver this model. It's more of a government procurement specification saying this is the delivery model that we want you to deliver so you come and bid on delivering that model in Medicaid. They did it in the state health plan as well. In statute they said the state employees' plan will use this best practice model that we've all agreed upon. So that's – Signa is doing that. And then their uninsured program, called Catamount Health, the state required that all private plans offer the Catamount Health policy and again, in statute, they said that Catamount Health vendors had to use this best practice care management model.
>
> If you think about it from the physician's standpoint, after the first – it took three to five months to kind of get people used to the change, but as they thought more and more about it in their practice, you know, they're treating hypertensive diabetics that were uninsured, Medicaid, Blue Cross, Signa, and BP Health and so on, and there were like 20 different reporting

requirements. Each of those vendors had different care management protocols about how you reported information, how you received information. It was driving them nuts. They just didn't understand why, for the same type of patients, I have 20 different reporting algorithms and 17 different expectations about how I'm going to treat the patient. If that same patient loses their insurance, becomes uninsured, then flows back to Medicaid, gets Blue Cross, that patient within a year could get four different treatment protocols.

So the thought was let's ... come up with our best thinking about this and it's going to differ in different states. The delivery models are different in different states. Let's put together our best thinking about this. ...If we could build it from scratch what would it look like both in terms of the care management model and the prevention model? I'll talk about the prevention model in a minute.

So let's start with that. We can use Medicaid. We can use state employees in some demos, if you want to do it that way. Then, if you do an uninsured product that you have private health plans offering it, you can have that provided through the uninsured product as well.

So, both Vermont and Illinois are using that approach. Illinois is a much bigger state so it's going to take longer to do but my sense is that those two states, within three to five years, five for the Illinois program, all of their primary care docs are likely to have electronic health records. General Electric is building the prototype model for Vermont right now and it's incredibly inexpensive because they want in to this marketplace. There's a lot of competition at the vendor level: GE, Siemens, some of these big data providers that would love to come into different states and take all of the paper and build standardized electronic health records that serve as sort of the health information exchange portal that physicians and others can access.

2:23:26 PM

CHAIR WILSON noted Dr. Thorpe said the primary care providers will be equipped to have this data but in rural Alaska many midlevel providers provide those services.

DR. THORPE replied that Vermont is a very rural state. A lot of services are delivered through community health centers. Depending on the scope of practice issues in different states, patients can allow primary care givers access to the information. The patient controls access to that information.

CHAIR WILSON questioned why midlevel practitioners are not getting their own data.

DR. THORPE said they get that data as well. In Vermont many midlevel practitioners are located in community health centers with information technology portals. He pointed out it would not be wise to roll out a program like this statewide. Vermont has implemented pilot programs in six diverse communities. Primary care physicians are not used to working as team members. They are not used to the information technology. Based on what is learned from those six pilot programs, the implementation will be expanded so that in three years all primary care doctors will have information technology on their desks, run through the Regional Health Information Organization (RHIO). RHIO's role is to build an electronic health record that will integrate all physicians' systems. He asserted that three years ago, the health care debate in these two states focused solely on financing insurance coverage for the uninsured. However, the discussion turned to structural issues and system redesign to make health care more affordable in a one-year period. The financing debate was incredibly contentious; the new legislation passed with only six dissenting votes. He pointed out the state was the policy innovator; Washington D.C. was not involved at all.

2:29:10 PM

DR. THORPE continued with his presentation:

> On the prevention side, we did a lot of studying on is there any evidence out there on prevention programs that are really effective. Perhaps the most notable one that we know through randomized clinical trials that really works is called the Diabetes Prevention Program. That's an aggressive lifestyle intervention that deals with education, the goal of getting a seven percent reduction in body weight over a two-year

period. It's done through diet modification. It's done through working with the enrollees on a weekly basis about calories, fats, trans fats, all the usual nutrition interventions, but it's a fairly intensive program.

They enrolled at-risk adults, meaning that these are people who are overweight. They were pre-diabetic, pre-hypertensive, exactly the group you want to focus on lifestyle intervention to make sure they don't shift into being a diabetic and hypertensive patient and incur a big hike in spending. What they find is that – and again, this is an [National Institute of Health] NIH randomized trial - they compared the lifestyle intervention to Metformin, the older line drug that regulates the blood sugar levels, which we know is effective clinically to do to manage blood sugar levels, to just basically what I call "lifestyle light," which is just don't smoke, don't do this, sort of the usual, non-aggressive, non-sustained types of lifestyle approaches.

What that they found is that after two years, the incidence of diabetes in the aggressive lifestyle intervention program was down by 58 percent. It was a dramatic reduction. Among people 60 and above, it went to 71 percent. Similar reductions in blood pressure levels.

The challenge that we found there is that when they put this program together – take a step back – the good news is that there are interventions out there that through randomized trials have shown we can modify behavior on average – yes. What percentage of the population uses these programs? Probably .0001. Nobody uses it, in part because nobody knows about it. Second is that it was designed expensive because it was done individual by individual by individual. So one of the things that we did in terms of thinking through, you know, trying to take sort of the best parts of this, is to say what is it about the program that works and we replicate it. Can we do it in a group setting to get the economies of scale associated with paying for the program so that we're not doing it person-by-person and in a very expensive way delivering the model?

That's sort of this year's initiative in Vermont, is to figure out how we can provide incentives and work with employers and schools and in the communities to say we know from the randomized trials that this prevention program that has these six elements really works. Our challenge is to figure out how we can pool people together so we can deliver this model in a cost effective way. So that's the upcoming agenda this particular year is to again, just like we did with the care management protocol, find the best practice, find ways to replicate it, and then find ways to find incentives for employers, schools and communities to adopt it. Again, that's another statewide initiative ... there's tremendous enthusiasm from the business community to work on this. AARP has been a big help in the state in helping us push this thing through, labor, so the state employee union wants to be a test site for this as a start of the state health plan and so on.

But that's one example; we do know there are programs out there that are effective. Does everybody enrolled in a program get a 58 percent reduction? No. But I can tell you that the incident rates for diabetes among the unmanaged group over that two-year period was 11 percent compared to 4, 4.5 percent, just a dramatic difference in terms of what this meant in terms of health and what it meant in terms of spending. There are programs like that that work. Safeway and some of these other big employers are taking components of that and trying to figure out how they can integrate that into the work site, provide the financial incentives to people to avail themselves of it. Again, make it easy for patients to do the self management. Wal-Mart's going to be looking at a program that's moving in that direction as well.

What's interesting to me, again, about all of these approaches is that if they're recognizing that for far too long in terms of thinking through this issue, we focused solely just on benefits and insurance design. These things are moving much more towards population-based public health primary care models of prevention and ongoing medical management. I think there's growing recognition that that's where the money is and that's what's really driving the increase up. Yes, you need the benefit design piece in there, you know,

to drive incentives in the appropriate way and obviously you need the benefit design in there too to make sure you continue to discourage discretionary health care services among non-chronically ill patients. I'm not saying that that's not important. It is. It's just that I see this transition into much more of a population-based, primary care, public health model that is likely to be a much more effective way of managing and preventing disease.

And, I think you're seeing some of these states move rapidly because as the legislators on both sides of the aisle get involved in this, they say this just makes sense. This is just common sense. If we can find something that is effective and works and can begin to infuse it rapidly throughout the state, if we can do a better job of clinically managing patients, if we can do something to make health care less of a hassle for our primary care physicians, if we can do a better job of engaging nurses into the care giving team – those are all things that just make good clinical sense and those are things that we should just – it's part of health care reform.

2:35:55 PM

REPRESENTATIVE ROSES asked how the Vermont case connects to the earlier discussion on coverage of the uninsured.

DR. THORPE said that is an interesting political story. The first half of session the legislation was built on the blueprint of building coalitions. The group said it could not start with the financing debate. No one was interested in buying into the reform debate because people felt the reforms were about them. They started with payment reforms, delivery restructuring, the HIT, and prevention. When the model was laid out, people loved it because it made clinical sense and created excitement about building a 21st Century delivery model. We then laid out the proposition that the model be based on a public health model of prevention, risk assessments, early detection, appropriate screening, etc. for everyone. The discussion initially began with creating a universal, preventive benefit program available to everyone – immunizations, [Health Reimbursement Agreement] HRAs, screening, etc. The discussion then moved to access to the delivery model. Over the next two months, the discussion became a debate about how to pay for such a model. The result was the creation of an innovative model that had co-pays and

deductibles except for patients with chronic diseases, who had neither. Vermont ended up with Catamount Health, a private insurance company at a cost of $60 a month if a person earns twice the poverty level, and it is subsidized up to 300 percent of the poverty level, and the cost at that point is about $380 per month. The end result only came about because of the evolution of the discussion; defining the problem and working in a non-partisan manner. He noted that the same strategy may not work in another state.

2:42:00 PM

REPRESENTATIVE ROSES asked if the premium is $60 a month for a person earning 200 percent of the poverty level and as high as $383 per month for a person earning up to 300 percent of the poverty level.

DR. THORPE explained that any uninsured person above 300 percent could buy in at that premium. He said in Vermont, the uninsured contribute 10-15 percent of treatment cost of care, with the remainder loaded into private insurance. He continued:

> So what we did is say, look, in order to make health insurance less expensive for the uninsured, we are going to make sure that when they enroll in this private insurance plan, that the hospitals and the physicians recover their full costs and then some so we pay hospitals at 110 percent of costs for this private package, not 145 percent of costs.
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> If you think about it, the uninsured person who was paying 13 cents on a dollar – they go into a hospital and they're paying 110 cents on a dollar. That was a way of getting the premiums down by about 25 percent. So, compared to the premium that's out there in the commercial market with the same benefits structure, same co-pay structure, it's about 25 percent less expensive. So even if you're not – at that $380, $390 a month pricing point, there's about 25 percent less than what that person would buy right now in the small group market.

REPRESENTATIVE ROSES asked if the number of Vermont physicians willing to treat Medicare patients has changed.

DR. THORPE said in Vermont, he knows of practices that have put a hold on new Medicare enrollees. He told members:

We are trying to help them out by saying at least, if you have a practice that's just Medicare, Medicaid and uninsured, and a lot of the practices in the rural areas - that's basically what they've got, that has not had a very profitable practice profile and so our argument to them was to say look, at least we can take the uninsured population and have them come in at 10 percent above cost so that is a much better paying customer than what you're getting today. It doesn't help the Medicare side obviously, but it certainly, in terms of getting the primary care docs bought in, particularly in rural areas, it was a big benefit.

2:45:55 PM

DR. THORPE told members, in response to a question from Representative Keller, that Safeway went through a debilitating strike with the International Food and Commercial Workers. It lasted a long time and crushed the union. Safeway took a financial beating. The CEO of Safeway decided to learn more about health care. He found that the problem of increased costs was partially due to benefit design and incentives but had more to do with the issues aforementioned. He did not want to deal with ongoing strikes and persistent negotiations about co-pays and deductibles.

2:47:44 PM

DR. THORPE continued with his presentation:

We've talked about most of these things. The slides are just here in terms of the "Prevention Works!" and so on. I can give you the sites for the Diabetes Prevention Program if you want. Just for the sake of time, because it's been a long day for everybody, I'll just leave you with a couple of observations here.

My three lessons in working with these two states in sort of real time politics are that three things are really important. One is getting the problem defined right, making sure everyone is working on the same issue and that there's real data and facts around it that everybody agrees to.

What I find is that in a lot of different places is that you have 10, 15 people sitting around the table.

They all want to solve a different problem and they all have a different opinion about what the problem is. So, if you can't start from the beginning on working on the same problem with a common understanding of what you're trying to solve, your work is much more difficult, if not impossible. So that's sort of lesson number one.

Lesson number two is that on the uninsured side, absolutely that has dominated the attention of health policy for the last X number of years, finding more affordable options and bringing the uninsured into the fold is clearly something policy-wise that makes sense over the long term, mid-term. It's more difficult in states like Alaska and Vermont, just given the seasonality of some of the workers and some of the fluctuations. There are some things you can do to get the numbers down.

Don't forget that when most people out there hear you in the Legislature talking about health care reform, they're not thinking about that. They are really thinking about this is a very expensive product that I am just scared to death that my employer is going to drop. So, lesson number two is that most people have health insurance. Their understanding and definition of health reform is to make it more affordable and, in bringing the physicians into this, to work with them to say that we have something that we're going to do to make it less administratively complicated, less of a hassle and, again, recognize the fact that we have a payment and delivery model here that's really, particularly for primary care physicians, is not working very effectively.

Number three is don't rely on existing models. Most of the existing models don't work. There's a reason why we have high costs and fragmented care and poorly delivered care is that we don't have good models. And again, as I mentioned, these models are based on a delivery system, on patients forty years ago. That's a very different clinical profile than we have today.

So, don't be overwhelmed by it. You have a lot of leverage and power here. You can come back and take these six points as framing issues. They lead to two very clear types of policy directions. Find out, if

you were building it from scratch in the State of Alaska given the demographics and given the patient populations you have, what would those models look like? If we had our dream list of a prevention program and new primary care based delivery models, what would they comprise? How would you build them and, once you've decided that, how best can you accelerate the diffusion of those statewide, using the power of Medicaid, using the power of your state employees' plan, and perhaps if you do programs that expand coverage for the uninsured and rely on the private sector to provide it, use that as a lever as well.

So you have a lot of opportunity as a state to do major structural important things in your health care system that have nothing to do with Washington at all. They really have to do with things that you can control if you can get those first two issues in play – framing the problem right, solving the same issue, having a common understanding of what those key drivers are. That sounds simple but it's not and I can tell you that was 80 percent of the battle in Vermont and Illinois – just getting agreements and having everybody understand these six points. That was 80 percent of it. You frame it, you've got everybody on the same page, the policy directions are pretty clear, then it's a discussion about what's the best way to proceed. At least you're on the same issue, solving the same problems. I think you'd find [you're] working in a completely non-partisan way. That doesn't mean that there are not issues of contention and differences of opinion. Of course there is. But these issues as they're laid out here aren't necessarily inherently Republican or Democratic issues.

2:52:46 PM

REPRESENTATIVE GARDNER thanked Dr. Thorpe for his excellent presentation.

2:53:07 PM

REPRESENTATIVE SEATON asked Dr. Thorpe to review the best way to approach the prevention portion.

2:53:56 PM

DR. THORPE said the collaborators first dissected the Diabetes Prevention Program to determine its components. Then they looked at ways to move that model into worksites, the community and schools. Different pieces of it fit differently in each of those arenas. They worked with the business community to determine how to collectively use the model and integrate in various settings, as well as schools and community health care providers. This upcoming year we'll look at ways to diffuse the model into the three domains.

2:56:05 PM

REPRESENTATIVE SEATON said he recently read that viral incidents account for about 40 percent of obesity. He asked if that's being addressed.

2:56:43 PM

DR. THORPE replied most of the large increases in obesity are among Baby Boomers and children. That's why the focus is on the workplace and schools by taking a proven model. The mean weight reduction was seven percent of body mass in the Diabetes Prevention Program so the goal was to deploy that model in different settings.

2:57:25 PM

REPRESENTATIVE SEATON asked, regarding the electronic medical records, whether states will probably adopt one of maybe five providers in order to avoid insurance companies being faced with a plethora of reporting models.

DR. THORPE said General Electric is working in the New England region to define inter-operability standards. Vermont is doing that through its statewide RIO program and finding the vendors whose programs are consistent.

CHAIR WILSON thanked Dr. Thorpe for his presentation and announced the committee would hear from Dr. Frogue after a 10-minute break.

The committee took an at-ease from 3:00:05 PM to 3:10:47 PM.

Presentation: Changing the Health Care System

CHAIR WILSON called the committee back to order and introduced Jim Frogue. She told members that prior to Mr. Frogue's current position, he was the director of the Health and Human Services Task Force at the American Legislative Exchange. His Op. Eds have appeared in the Atlanta Journal Constitution, the Chicago Sun Times and the Washington Times. He has appeared on Good Morning America, Bulls-eye, Power Lunch, All Things Considered, and many other broadcasts. He holds a Masters of Philosophy from Cambridge University and a Bachelors of Arts from the University of Southern California. He provided members with written materials to accompany his presentation.

3:12:17 PM

JIM FROGUE,, Chief Liaison to State Policy Projects, The Center For Health Transformation, provided the following testimony:

> When we talk about health transformation, we want to talk very broadly. What people normally talk about when they talk about health care reform are things like rates and deductibles, raising co-payments, adding another formula, restricting access to prescription drugs. That's it. That's not the kind of transformation that's needed. That's silly. That's not futuristic. So, what I'm going to do in the course of the next few minutes is define what I mean by saying a 21st Century intelligent health system. That's describing the circle so we'll spend our time defining that and then how we can get there and show a couple of examples of groups and organizations that are already there and having tremendous success delivering better care at lower cost, which are not mutually exclusive. You can do better at lower cost and that's what everybody wants and it can be done.
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> Health before health care - this is the most important thing. I think some previous speakers have alluded to this but if people aren't sick, they are not expensive. At the policy council yesterday, one of the facts that was voted on at a previous meeting was 90 percent of heart disease is due to preventable behaviors. 90 percent of heart disease is due to preventable behaviors or bad diet, bad exercise and a range of things like that. If we could just promote better activities earlier on, people aren't going to get sick. Most importantly, they are going to have a

much better quality of life and they're not going to be in emergency rooms and they're not going to be costing more. So we have a health care system and health care debate that tends to focus on treating the symptoms and very little on the root causes.

This slide I like and it contrasts a little bit with the one right after it but there's one thing about this slide and the next one that are absolutely in sync and that's what I want to highlight. This is from the Journal of the American Medical Association a couple of years back. It says this is what determines your health status. My health status, each individual's health status is determined by these things, behaviors, so use of tobacco, use of alcohol; movement deficit disorder – a fancy way of saying too much television .... They say genetics is 30 percent, environment, public health, that's things like clean water, clean air, that kind of stuff, and 10 percent is health care delivery, so hospitals, clinics, what doctor you go to is only 10 percent of your health status. Now that seems to be where all of our arguments are, right? Most of our arguments, I should say, are about the 10 percent and too little about the other 90. You can't do much about the genetics although that will probably change in the next few years, but for now we'll say we can't.

Now this is another - mediators of health, put together by Al Tarlov, who is a long time professor at Harvard University. Now he runs a department down at Rice in Texas. He says that society and relationships are 55 percent of health status. That sounds a little out there, a little strange, maybe a little touchy feely but I think there's a lot of legitimacy to that. What kind of family environment you're in. Do you have a lot of stress with your family, a lot of stress with your work? Do you react to stress worse than other people? These things really matter. You know, if you have an annoying colleague that sits in the cube next to you, I don't want any of you to respond to that. You'd probably get yourselves in trouble. Probably you have a lot of annoying colleagues in the cubes next to you. That can be very stressful and add to your day and, in the long term, can really impact your health.

They say health behaviors, those are things like tobacco use and alcohol and diets, are about 20 percent. The other one said it was higher – it's about 40. Genetics and biology – this guy says it's only 10 percent, which is much lower than even 30. But look at what's the same or almost the same. 15 percent is medical care. The other one said 10.

Both of these great researchers and these people that follow this for a living say that what doc you go to, what hospital you go to, what kind of care you get is 10 to 15 percent of what determines your health status. That's pretty important to understand because we spend all of our time, a lot of partisan bickering and yelling and screaming over the pieces that actually have the least impact on our health status. It's interesting to note that there are islands in the South Pacific where people have longevity rates as long as we do in the United States and they don't have an MRI machine for a 2,000 mile radius. It's not because – I mean America has by far the best medical technology in the world. There's no doubt about that...but we don't have the longest longevity rates. I would argue longevity rates are not the best indicator of health systems, but that's kind of beside the point because what is a health system is another conversation and almost everyone in the room would disagree on that definition. But, longevity and quality of life are very critical. I think when you look at medical care having such a small impact on an individual's health status, it's important to focus more on the broader things and important to focus on the roots, as opposed to just treating the symptoms.

So I'm going to give you a series of ideas. At the Center for Health Transformation, we do everything we can to talk about solutions. We're not going to ever give a long presentation about the current system or the problems. That's all you get all the time. People could come in and tell you all about the current system, the problems. We try and give you specific solutions and ideally ones that are either cheap or free and that have a huge impact on health status.

So the number one most important thing you can do over the long term to promote health is promote exercise

and good diets in kids. That's the number one most important thing you can do and you can do it in a couple of ways. One, you can challenge your school districts to mandate physical education and a junk-free food campus. There shouldn't be a public school anywhere in the state that sells Coca Cola on campus, whether out of vending machines. They should not do that. Now if people want to do that on their own, that's certainly their own business but the taxpayer shouldn't have to subsidize or even be a party to that. Kids that consume food like that and processed sugars – that has a terrible impact over the course of their health status over the long run.

As I'm sure you're all well aware, there was a report this morning on the front page of the newspaper that we're a nation that's getting increasingly obese. I guess Alaska's not quite as bad as some others but every state is bad and it's getting worse. You just can't have a health care system when 12 year olds are getting adult onset diabetes. No health care financing system, no health care technology is going to be able to handle a system where obese 12 year olds that aren't moving ... you can impact by creating better behaviors at early ages.

One particularly creative solution that I've seen around the country is in West Virginia and it would be even more applicable here in Alaska because I understand there are days where there is a lot of snow up here and it's really cold. I've never been here in the winter. It's always been in the summer and I've never seen it below 60 degrees so I'll assume that it gets really cold here and snowy in the winter time. In West Virginia, they use Playstation's Dance Dance Revolution, which, if you've never heard of it, it's a video game and you get the equivalent of a Twister mat and on the screen little arrows come down and then they play songs. You're supposed to move your feet to the music. It's very difficult. My 10-year old niece dances circles around me at the easiest level when I tried this for the first time at Christmas but it gets kids moving and it's a video game. You basically trick them into exercising. My understanding is, I don't play video games, but the next generation of video games, a lot of them are movement based. Their boxing are actually boxing, their dancing are actually

dancing, their guitar playing – you actually have to move your fingers but that's a great way, especially when people aren't able to go outside and exercise, to get people to exercise inside and it's fun to do. If you were creative and ambitious, you could probably get away for – you know, somebody could donate it or give it to you for low cost or say we want to make this part of our physical education system in the state. They'd probably be interested in doing that.

The other thing is bad food and a poor neighborhood is a serious impediment to health. If a low-income person only has $3 to spend on a meal, they're going to spend it somewhere for 1200 calories and not on something that's maybe a lot healthier but it's only 300 calories. That's a discussion we could get into later but if people live in neighborhoods where the only access to food is very bad food, then it's going to be very hard to impact their health status over the long run.

3:21:13 PM

MR. FROGUE continued his presentation with slide 7, entitled "Nine Surprising Diabetes Risks.", as follows:

These are just nine surprising diabetes risks: watching two or more hours of television a day; drinking one soda a day increases it almost 100 percent; skipping breakfast; a major bout of depression; a large waist, even if you're at normal weight; waking up in the middle of the night and eating fast food more than twice a week; high stress; consuming a lot of processed meat. These are just a couple of things that are worth throwing out there that most people don't associate with diabetes.

Adult onset diabetes type 2 is increasingly common and Governor Huckabee, who is now running for president as a lot of people know, had early indications of adult onset diabetes and then decided he was really going to change his lifestyle. He started running. He lost 100 pounds. Now he runs marathons and has even written a book about his experiences. That's an example of one person who changed their behaviors and, as a result, is considerably healthier.

Silver Sneakers is another program – there are a lot like this. I'm just picking this one because some people have heard of it. It encourages people, particularly older people, to exercise because of free fitness membership for seniors. A lot of insurance companies contract with it. Participating fitness centers throughout the U.S. while traveling – there's customized classes, health education seminars, but 30 percent lower cost for Silver Sneakers members on average but much lower for those who attended four times a week.

So exercise is particularly healthy and it's particularly good for older women who are alone. Women tend to outlive us guys but the biggest risk they have is when they're alone, they get depressed and they get to take drugs and there can be a downward spiral that has a very negative impact on their health. So the idea of getting people together to exercise, maybe to walk around the mall three times a week, if it's a cold day out. Most malls would be happy to let you do that at 6 or 7 in the morning before their stores open. Not only is it exercise, but it gets to the other slide I showed earlier about society and relationships. People who are isolated get depressed, partly because they don't move, but partly because they're not out meeting people and chatting with people and making friends. Again, this sounds a little "foofy" and a little simplistic but it's very, very true and there's lots of studies, and I can give you more than just this, of people who get out and exercise, especially older single women, who show marked improvement in health status.

I have a great, great aunt who just turned 100 in April. She lives in Long Beach, California. I don't see her too often. I live on the East Coast now. I didn't even realize this but there was an article about her in June for her 100th birthday in her local little paper. I never knew she did this but apparently she leads a walking group in her neighborhood for ... all kinds of people. It's mostly older people but it can be anyone. Apparently no one can keep up with her. ... She walks all of the time and she's in great shape, and she's really energetic and I think you could attribute a lot of that to the

fact that she moves and the fact that she has a lot of friends.

So what is consumerism in health care? [Slide 9] We are going to jump ahead a little bit more here. Consumerism in health care – this is how we make purchases in other areas that are non-health. Consumerism is how you bought your car, your personal computer, your last vacation, chose your child's college. You gathered as much reliable information as possible and then made a decision based on price, convenience, and what you value. This isn't some crazy, radical notion and this is how we buy pretty much everything else in our life. Everyday that goes by, there's more information available to us for free on the Internet so we don't just have to ask friends or neighbors ... but there are opportunities to find more information on line.

So what is health care consumerism specifically? It's when employers, insurers, hospitals, physicians, drug and device manufacturers and individual patients know and share accurate price and outcome data for all players. I'll come back to that in just a minute.

Is bottom up where providers respond to empowered, informed patients? Individuals, employers and insurers all have strong incentives to promote wellness prevention and early testing. We'll come back to that too and I'll give a couple of examples of that. It's better for all people, particularly those with multiple chronic conditions. I think one of the biggest myths you hear is that we move toward consumerism, it's good for the young and healthy. That's true for particular vehicles if they're designed really poorly. Consumerism actually works best for the people who are sickest and their ability to buy care and choose what's best for them.

Since I'm talking to several politicians here, this is a good stat for you. Do you have the right to know cost and quality information about your health care provider? That's a 93 percent yes. By contrast, should we leave God in the Pledge of Allegiance only comes in at 91. So, there's probably not too many people out there campaigning around, you know, we should really take God out of the Pledge of Allegiance

but campaigning against people's right to know cost and quality information would be even worse than that.

But we do a lot of polling. Actually we've got another poll that's coming out in a couple of weeks on Medicaid. I'll come back to that in a minute too. This is a great issue – right to know. Do people have a right to know cost and quality information about hospitals, about physicians and about others that are in the system?

These are two examples of what they do in Florida, and I would encourage all of you who are interested in this to go on these websites: Floridacomparecare.gov; and MyFloridaRX.com. Floridacomparecare.gov has price and outcome data for all procedures in all hospitals in the whole state for free. It costs the state about $200,000 to run these websites a year. So this isn't like some big giant millions and millions of dollars in investment. All they do is post data that they already collect, put it on line. When it went live – it's been about two years now since they've had it up. There was no marketing campaign. They didn't run commercials. The governor wasn't out talking about it but they got 70,000 hits on the first and people became aware of it extremely quickly. When you post results from hospitals, half of them are going to be below average – half of anything is below average. So the hospitals that are below average aren't happy about it too much and the ones that were happy didn't offset the ones that were really angry about their results being posted.

3:28:04 PM

CHAIR WILSON said she asked a representative of the Alaska Hospital Association if Alaska hospitals would support a similar website. She was told association members have talked about creating a website but would like to have input on how it is implemented.

MR. FROGUE said it has to be done in the right way and must adjust for the populations served by different hospitals, such as a large number of elderly in an area. Several years ago he did a presentation for some New Jersey hospital CEOs. At that time, his insurance company had data ranking hospitals available to customers. He showed the results of some of the New Jersey

hospitals to the CEOs. They were livid about the data. His point was that was the only information available at the time to patients so if hospitals can provide more accurate information to patients, they should. Florida's websites have been available for two years; they were not originally supported by the hospitals. Hospitals with particularly bad ratings in a specific area put efforts into those weak areas to improve them, which is what patients need. He stated a patient's right to know which hospital is more likely to kill you is greater than the hospital's right to keep that information secret. He continued with his presentation:

> The results of health care consumerism, if done right, this is what you'll have – more choices of higher quality at lower cost with greater convenience, think cell phones, personal computers, flat screen televisions. Every year that goes by, those items, I just picked those three because everyone is familiar with those, you get more choices of high quality at lower cost. Think of the most cutting edge cell phone in the year 2001. Maybe it cost $500 to $600 at the time. You couldn't give it to any 14-year old today because they'd be embarrassed to show it at high school. It wouldn't have colors on it. It wouldn't have games on it. It wouldn't have downloadable ring tones. Think of the rapidity of cell phones...but health care doesn't function like that. Beware of this absurd myth. I don't hear too many people use this anymore but occasionally you hear this. You can't shop for health care when you're lying unconscious. People actually do say this.
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> Emergency rooms will tell you half, roughly give or take, of people that show up in emergency rooms aren't even emergencies. It's something like 99 percent of interfaces we have with the health care system are not emergencies. And even when they are, there's an opportunity usually for people around to make decisions as well. Of course if you're lying in a snow drift and had a heart attack and there's no one around you can't shop for a hospital. But that's a tiny, tiny minority of interfaces with the health system. Most people have the opportunity to shop around most of the time. We had an example of last summer some friends and I were playing football and one of our friends fell and hurt his knee pretty badly and he was in a good deal of pain and really was in no

position to make a decision on whether he needed to go to the emergency room. ... The 20 of us that were not in pain were able to decide over the course of two minutes where to take him.

... I won't go through all of these. I'll just highlight a couple but when I talked earlier about what the circle is, this is one outline of what the 21st Century Intelligent Health System is: individual centered, values driven, 100 percent coverage. Certainly we want a system where everybody is covered.

I'll mention on that one too in Switzerland they have a very interesting system. This is one thing I didn't mention yesterday. In Switzerland they have 100 percent coverage. Everyone has a plan. What they do there is it's not based on what employer you have. There's a mandate you have to buy coverage. Well what people do there, there's about – I think there's something like 75 insurance companies so people have ... different choices. They sign contracts with insurance companies so you might go to Alaska Blue Cross and sign up for five years or ten years or Bern Blue Cross, if they have such a thing in Switzerland. At the end of those five, ten years of the contracting period, if you're actually healthier you get money back. So it's an incentive of the health plans and your incentive to actually be healthier, but what the plan knows is you are going to be with them for five or ten years so they actually care more about your health status.

The way it works now, the average 32 year old has had nine different jobs. That was true for me when I was 32. In fact, it was exactly true. ... But every time you change jobs, you probably have a new health insurer, you probably have a new network, you may get a job where there is no coverage offered. You may have a period of unemployment. In the Swiss system none of that matters because it's not connected to your employment at all. For people who are low-income, they get a subsidy to buy the plan of their choice. They have 100 percent coverage. It's a very unique system and the incentives are on the insurers and the individual to be healthier. Switzerland is actually one of the healthiest countries in the world.

Transparent price and quality information. I want to back up one second. On this one, the MyFloridaRX.com – I skipped over that. They list the prices of the 100 most common prescribed drugs at all pharmacies so I'd just encourage you to go on the website yourself and poke around. You can get any price. When this came out two years ago, there were huge discrepancies in prices. People didn't know this. No one knew – I mean no one knows how much drug prices – they cost $10. That's your co-payment, or $20 if you get something branded.

There was a newspaper – you know, some smart reporters started clicking around on it and said you know, that's interesting. They went to one place in Miami and they found that the exact same drug was something like four or five times more expensive at one pharmacy than it was within the same zip code. So they called up the expensive guy and said why is it for the exact same pill, the exact same dosage, is it four or five times more expensive? The guy said oh, that's not our real price. Okay fine, so this goes in the paper. Well, the next day, this is read in Tallahassee, the Florida capital, by the state health secretary who said that's interesting, because that's the usual and customary price that you've been reporting to Medicaid for the last couple of years. So are you lying to the reporter or are you engaged in fraud? Just tell us. That guy wasn't in business for too much longer. But you're going to have shake-out when you do this and certainly that's an example of it.

Electronically based, as opposed to paper based – doctor's offices are about the last place on the planet - you can go in the background and see manila folders wall to wall. I mean how many businesses do you actually see that anymore? There are very, very few.

3:37:52 PM

MR. FROGUE, in response to Representative Gardner's earlier question regarding Washington State's cash pay system, told members that several doctors in Washington and Oregon belong to a group called "Simple Care." They operate on a cash-only basis. They don't take Medicaid, Medicare or insurance. The overwhelming majority of their patients are low income and

uninsured. They charge per minute versus insurance codes, which is a binary mediated market because the third party is removed. He mentioned that many "big box" stores, such as Costco, have put clinics in their stores with a nurse to do very basic, preventive care, such as strep tests. The cost is lower and it provides another option for services. He pointed out that Illinois has a horrific health justice system. Trial lawyers are chasing doctors out. In 2003, Texas adopted radical tort reform; up to that point it was one of the worst places to practice medicine because of malpractice suits and skyrocketing premiums. Texas now has thousands of doctors returning to the state and they are going to underserved areas. He told members, "In fact, Texas is poaching them from their rival Oklahoma, which has to add a whole new layer of satisfaction." He said the fourth generation of health care consumerism has not been reached yet, but in 5 or 10 years, people will be able to buy a home DNA diagnostic kit at the supermarket and people will know what kinds of food help prevent cancer. He noted the diagnostic ability could save people from a lot of cost and suffering over the long run. For example, bran helps to prevent cancer in 97 percent of the population but causes it in 3 percent.

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REPRESENTATIVE GARDNER asked who the 3 percent are.

MR. FROGUE said no one knows, but the tests will help people determine where they stand.

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MR. FROGUE told members the health care industry will make a huge movement to wireless support and holistic care. He said a new Internet program allows a person to enter symptoms and, through a series of questions, diagnose a problem. A great book entitled, "The End of Medicine" talks about how the population will have so much information about its own health care in the near future.

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MR. FROGUE continued his presentation [slide 16]:

> "What ISN'T Healthcare Consumerism?" Well, everything we have now pretty much is not health care consumerism, public and private, for true costs and quality outcomes are obscured or hidden. A high

deductible plan by itself, absent usable, accessible and understandable information, health savings accounts that are not done right, isn't really a very good health care. I happen to have an HSA myself. I'm still alive. It works. I've had it for two years but there's ways to set it up where it can [have] a lot more impact in improving health.

In a system where prices go, for the same service, up every year, prices as we know in cell phones, TVs and personal computers go down for the same amount of computing power. Think of the Apple 2E computer in 1985 and the thing cost $2500 in 1985 dollars. I mean you can buy hundreds or thousands times more power for an inflation adjusted 10 percent of the cost 20 years later.

This is an example of an employer that's done a particularly good job with moving towards a consumer based model and improving health status and lowering costs. You have a larger, you have about a 10 page – it goes into a lot more detail, I just have two slides on it, but it's this document here. You can read all about it.

... They're an 8500 employee system based in Omaha, Nebraska. They have a few facilities in Iowa. Their CEO was at a Chamber of Commerce dinner in 2005 and a CEO of a railroad company next to him said you're in health care. What are you doing? You know, we can't handle these 10 percent cost increases. What are you doing over at the hospital? And Wayne Sensor said nothing. It was kind of a moment of clarity. We're a hospital – right? We should know about – I have no answer for you. So he went out and made this a priority for his own employees.

By the way, the same guy, he's been there about four years now as CEO. One of the first things he did when he came onboard is he found out his cardiology department was performing below average so he took an ad out in the local paper and said we're below average in cardiology. Can you imagine doing that? That's just crazy and, of course, the cardiology department was just apoplectic. They thought that was the dumbest thing they'd ever heard. Why would you do something like that? Well, four years later they're

well above average. They took the steps required. The sunlight was good. They hated it at the time but in the long run, not only did it make the place – did it improve their results tremendously, he saved a lot of lives. ... What's very, very important about this is he led it.

One of the biggest mistakes you'll see is, this is a vast oversimplification and stereotype but I'll do it anyway. A CEO will read in the Wall Street Journal – turn to his HR director and say what are health savings accounts? That sounds interesting. They're saving some money. Let's do that. Let's do that next year and then forget about it and then delegate it to the HR director. And the HR director may be getting close to retirement, you know, why do I have to do this? It's so much more complicated. I've got all of this work to do. So they throw in an HSA option for the next plan year and, you know, out of 1,000 people in the company, 12 take it. The next year the CEO says I thought we were going to do HSAs. Oh well, we tried it and no one wanted it. It didn't work. That's typical. You get that a lot. So you can find a lot of examples of HSAs not working.

One of the first states to go to HSAs in their state employee plan, which is something I'd highly recommend you do with this, they offered an HSA plan early in mid-2004, which is shortly after HSAs became legal. But the way they structured it was for a single person with a $3,000 deductible. Now you only paid $9 a month for that deductible, which, if you took the difference of what you paid for the old PPO and now that you paid $9, if you put that money into the HSA, you'd have about $900 and they are assuming you even did that so there'd still be a $2,000 gap between that and the deductible. It was something like 35 people out of 50,000 took it. I mean the Governor took it because it was his idea and his family, so he and his family of six – that's probably a fifth of the people right there. But that's just not – I wouldn't take that. That's just not...well structured.

If you structure it correctly, and it's led by the CEO and the CEO is very much involved and engaged and there's an aggressive education campaign and it's a priority of the company or a priority of the state,

then you can get results like this. They made it a choice, first of all. You know, if people wanted to stay in the standard PPO they could do that. For some people they were just more comfortable in the old system. But the employer made such a large contribution – they actually do an HSA-HRA hybrid. It's detailed more in here. I'll just focus on the results. If you want to see how they did it, that's what the 10 pages is for. But this year in 2007 it's up to almost 90 percent of people chose the consumer based option. So these are the results. These are just a couple of the highlights of results for 2006. This is the first full calendar year they had their consumer based model in place.

They had three times the national average in preventive care ... which is 100 percent covered by the way. We want people to get preventive care so this is a good thing. Please go, we'll pay for it. So these are things like mammograms, check-ups, childhood immunizations, these kinds of things, all 100 percent covered, three times more than the national average. They had smoking cessation and weight loss programs; 400 people quit smoking and that's pretty good. That's seven or eight percent of the whole population and, assuming most of them don't smoke, that's pretty high. 670 people enrolled in weight loss programs and lost a combined 6,500 pounds. Each employee was actually paid $100 to take an optional on-line health survey so I'm not going to force you to do anything, but if you'd like to, we could pay you $100 to do it. You don't even have to tell the truth. You just fill it out and it takes 15 minutes and you get your $100. If it turns out you're diabetic or have some other ailment and you enroll with a health coach, you get paid for that. If you meet certain health metrics, for example if you're diabetic and get your A1C down to a more acceptable number, you get paid for that.

It turns out the financial incentives for an employer and for the company of insurers they work with, it's very much in their interest to make you healthy so it's worth paying you a couple hundred dollars to do healthy things than pay thousands of dollars down the road for you to show up for an ER visit that could have easily been avoided. So, at the end of the year

in 2006, nearly $2 million in employee money was carried over into 2007 in their HRA-HSA balances.

So what was the overall cost trend for 2006 with all this new money spent on preventive care, all these payments going out to people to take health risk assessments, with all these payments going out for people to quit smoking and lose weight and enroll with health coaches? Their overall health cost trend for 2006 was 1 percent, not 10, not 12, not 15, not 20 – one. So they got much better health outcomes at much, much lower costs.

3:52:01 PM

CHAIR WILSON asked what happened the following year when more employees participated.

MR. FROGUE said he believes 75 to 80 percent chose the plan in the first year. In the second year, the percentage was close to 90. More people enrolled in the plan the second year because they liked what they were seeing. He hypothesized that a company with 10,000 employees agreed to put 50 percent of the savings from an agreed upon health trend into wages. The employees agreed to a 10 percent trend over the next five years. If the average employee earned $15 per hour, and the average health plan cost $6,000 per year and, with a consumer based plan, the trend was a 1 percent cost increase, the average plan in 2012 would equal $9600 at an annual rate of 10 percent and instead was only $6300 at 1 percent. He said he could provide many examples of the cost savings between a 10 percent trend over 5 years and a savings of 1 percent over 5 years. He said if an employer agreed to put 50 percent of that back into wages, the raise would cumulatively equal $2.35 an hour, just through health savings. That incentive could be offered to employees. He noted similar successes in the private market include: United/Definity - 50,000 employees joined its consumer directed plans and costs decreased 3 to 5 percent in ’04 and ’05; Aetna had 134,000 employees join a full replacement plan with a 1 percent cost trend since 2003; Wellpoint Lumenos had 40,000 employees show an 8 percent decrease in 2005. He emphasized HSAs are not theoretical models; thousands of people are participating in them. He then mentioned a new plan, which has a high deductible of perhaps $2500. For each metric a participant meets, those being [body mass index] BMI, blood pressure, [low-density lipoprotein] LDL bad cholesterol and nicotine use, the deductible decreases by $500. So, the

benchmarks are easier to achieve than those posted on the NIH's website. The program is voluntary but participants can lower the deductible by 80 percent by meeting or exceeding the benchmarks. He said it is better to reward people for good behavior rather than punish them for bad behavior. That changes the dynamic and the way people react.

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CHAIR WILSON asked who is using the new plan.

MR. FROGUE answered the new program is being used in a few states right now. It is unique. There is an almost universal consensus that discrimination against genetics is inappropriate but discrimination based on behaviors is appropriate. That is what these plans do. He then referred to Slide 21, entitled "Florida Medicaid Enhanced Benefit Accounts," which pays people for positive behavior, such as getting children to appointments on time. Medicaid recipients are paid $25 for taking certain measures that make them healthier. The deposit can be used to purchase medical items that otherwise would be paid out of pocket. It has had an off-the-chart satisfaction rate with the beneficiaries.

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CHAIR WILSON asked about the cost changes in Florida.

MR. FROGUE said the program just started at the end of 2006 but in three weeks former Governor Jeb Bush and Alan Levine, former Secretary of Health, will be presenting and reporting their findings at a Medicaid event. He encouraged the committee to watch it on a web cast.

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MR. FROGUE then turned the committee's attention to Slide 22, "New Mexico Care Coordination Model," in which 17 governmental agencies that interface with low-income clients coordinate to create a care model by creating a comprehensive picture of each individual. He noted an unnamed state found it had three departments that dealt with low-income programs with 15 different computer systems that did not interface.

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MR. FROGUE moved on to slide 23, "Gallup Survey on Medicaid Consumerism," and told members:

> Another thing we've done is we worked with the Gallup polling organization. Those of you who are in politics know that the Gallup poll is one of the most reliable polls. They do a lot of great political work. Their political work now is about 2 percent of their income. The overwhelming majority of what they do you never hear about. They actually do surveys all over the world. They do surveys for companies. They know more about hospitals than anyone. In fact, one comment they made that I thought was particularly interesting is you can gauge the quality of a hospital by finding out how happy the nurses are. That's the number one indicator of hospital quality, how happy the nurses are. That's pretty easy. You don't need some long study and a bunch of PhDs spending years, poking around results. Just survey the nurses. If they're happy it's a good hospital. If they're angry and bitter, it's not going to be a very good hospital. So anyway, that's one of the things I've learned in working with them.
>
> But we actually did a survey with them last year. We have a much – actually I have a phone call with them tomorrow to talk about some of the early results. We actually ask people on Medicaid what they think of consumerism. Is it some kind of radical notion? ...Let's ask them what they think of some of these crazy schemes. Is it in your interest? Would you respond differently if you have some of these rewards and incentives? The first survey we did came out September of last year and...they did it very quickly. They had 172 respondents so a sample on the smaller side but they found that 67 percent of those were extremely or very likely to switch to a Medicaid program with shared savings, so 79 percent were extremely or very likely to go to a doctor's office instead of an ER if they were to share in some of the savings. 73 percent were likely to adopt a healthier lifestyle and then if you could use the savings and spend it, where would you want to spend it? They said health care and housing and food were the top three. There were several others as well.

But the next survey - actually I just got some data on it today. They were able to reach 415 people on Medicaid, the majority disabled, and ask them a whole range of questions. ...I helped craft the questions but I haven't seen the responses yet. But this is going to be unveiled at our event on September 18th too. Some high ranking people at Gallup are going to come out and speak to us about what people on Medicaid think. It's fine what we may think in this room but none of us, at least here, are on Medicaid. We should ask people on Medicaid. Is this something that would work for you? Are you interested in this? How would it be different if you were in charge? How would you help people be healthier? So that's going to be one of the highlights.

This is just the summary of what we have coming up on September 18th. We have the Minnesota Governor and Chair of the National Governors' Association Tim Pawlenty is going to speak. Former Florida Governor Jeb Bush and then my boss, Newt Gingrich, [are] going to host. We're going to release the Gallup poll. We have a panel on the Medicaid system that works. ... The Medicaid director in Arizona is a particularly creative guy. They have a very vigorous electronic health record project that they are working on with a bunch of other states. They are actually finding a way to make sure that the Medicaid data can be shared with people that are non-Medicaid, which is actually one of the problems a lot of states have now, so you can create a total picture of people's health status no matter where they go.

It's obviously always extremely, extremely important to make sure that that is done with the utmost respect for patient privacy. In fact, whenever I make any comments about electronic health records, I always implore legislators to create absolutely vicious penalties for people who abuse the sanctity of electronic health records because the benefits are tremendous. ... One of the classic examples is Katrina. People who fled New Orleans and went to Dallas, for example, they could go to Jiffy Lube and find out when their car last had its oil changed. But when they went to M.D. Anderson to see about their cancer or diabetes treatment, their paper records got washed away in the floor.

So the ability to have electronic health records can be extremely helpful to coordinating care but it's got to be done in a way that has utmost respect for people's privacy because as bad as it would be to lose your credit score, for example, to a computer hack, losing your health data would be far more personal and far more devastating. You could never really get that genie back in the bottle so ... even things as simplistic as forwarding an e-mail with someone else's health data that was obtained illegally should be extremely – very harsh penalties because we want the benefits but we don't want the abuse and people are just not going to want to go toward an electronic health record if they think their neighbors or anyone else may see it. I just want to throw that out there.

We also have former Secretary from West Virginia, Governor Manchin has a particularly interesting program now where he is requiring people on Medicaid to sign a contract of responsibility if they choose, and if they choose, then they'd receive more increased benefits so, if they didn't break appointments, if they did certain things around the treatment of their disease or improving their care, then they would actually be eligible for other benefits. So, there's a responsibility on both sides where people who are low income on Medicaid certainly have rights to health care but then people that pay the bill have some rights too. People that pay the bill should be able to say well, we're happy to give you the care. We're happy to give access to care. We're happy to pay for the care. We just want to insure that the care is being used to the maximum possibility to make you healthier in the fastest possible way. ...Nancy Atkins, who was the long time...Commissioner of Health, is going to be speaking on the panel. She's excellent. I was on a panel with her a few months back so that's September 18th.

Some other Medicaid ideas – Governor Pawlenty has incorporated Bridges to Excellence, which is a pay for performance scheme for diabetes and obesity into Medicaid. Know Your Data – this is another interesting one that you might want to look into, especially you as legislators but anyone in the public. You should be able to have real time access

to billing patterns from your hospitals. That's something that no state has right now. It usually takes many months or even years to get billing pattern data but you pay for it, you should know. One example from a couple years back in Kentucky there was a hospital they found where - in nature viral and bacterial pneumonia are roughly – about 80 percent of the cases are viral and about 20 percent are bacterial. Medicaid just reimbursed a lot higher for bacterial. They had one hospital where it was 80/20 the other way. The hospital was having, apparently, all of these cases of bacterial pneumonia. Well, that's one of two things: either it's an outbreak of disease that you really need to know about, or it's fraud that you really need to know about. But they didn't detect it for years because no one had access to it.

Think Google again. We did a presentation for the State of Missouri several months back where we did this for free just to test it. We gave them their data and you can go into any – you can do it by zip code, you can do it by counties, whatever search terms you want, and you can get the billing patterns from any hospital, any provider. You can get their prescribing habits. You can get anything. Now this is not patients specifically because patient privacy is sacred. We don't want to come near that. But billing patterns of providers is not. You should be able to have it. You should be able to know. In fact, if you wanted to get really radical, you could post it all on-line and let anyone look at it.

There was a study...there was a mining company in Canada, in Ontario a couple of years back, called Goldcorp. The new CEO – it's always a new guy that comes in...and said we're just not finding any gold. All you geologists, what's wrong with you? You're not finding anything. So he decides he's going to post all of his mine data on-line, which, you know, the geologists were just appalled by this – oh that's crazy, we're going to open ourselves to a hostile takeover. So he said too bad and the CEO posted it all on-line. It even has a WIKI page and you can just do Goldcorp Challenge. You'll find all of the information about it. They put it all on-line [indisc.]. Anyone who wanted to, from high school

kids in Texas to physicists in Australia, could jump on and they had a $500,000 prize. So they had entries from all over the world in a couple of months when they had the challenge. Two physicists from Australia won. They'd never been to Canada but they analyzed all of the data online and, because they opened up their data to the world and had all these smart people looking at it, they found infinitely more gold than they'd ever thought possible and their stock price increased by 30 times or something but they had the confidence to say we don't have all of the answers. You don't have all of the answers. I don't have all of the answers. But if you, you know, the collective knowledge of the world, people would be interested to look at it. No state does this now but it would be an interesting thing to look at. Academics would do it for free. You wouldn't even have to offer a prize, but they'd look at something. Oh that's interesting, you have patterns here we didn't know about.

4:12:41 PM

One of the things we found in Missouri is there were – it was in the dozens ... of people with their personal data blinded that had over 100 ER visits in a year. ... You're talking about thousands of people in a state of many millions that are 15, 20 percent of the overall Medicaid budget. I mean imagine if you could just isolate those. We hear this all the time, 5 percent of the people are 50 percent of the cost or 20 percent of the people are 80 percent of the costs. Those are roughly accurate for any private health plan or any Medicaid program or Medicare. But most of those people that are high cost are actually the same people year in and year out. It's not one pregnancy or one cancer. It's the same people with chronic conditions year in and year out in all kinds of different situations. If you can isolate those people and put them in different care plans where they actually get much better care out of it, and they have much more coordinated care, the overall costs can come down considerably.

We actually wrote a book earlier this year. It's free - we can send you copies if you want it, called Making Medicaid Work, where we interviewed Secretary Levitt (ph) and nine state health secretaries across the

country. We talked about what kind of incentives, what kind of best practices are out there. In fact, I apologize. I had meant to bring a few copies. It's about 75 pages. It doesn't take too long to read but it's interesting. I've had about 4,000 requests for it from around the country, so hopefully that's a function of its quality, not a function that it's free. A lot of people have found value in it.

4:16:41 PM

CHAIR WILSON asked Mr. Frogue to send a copy for each committee member.

MR. FROGUE agreed to do so. He then advised committee members to ask future speakers to discuss solutions to health care problems rather than to discuss the problems themselves. Many innovative approaches to solving health care program problems are occurring throughout the country. He noted that better care at lower cost is not a mutually exclusive concept. He offered to answer questions.

CHAIR WILSON thanked Mr. Frogue for his informative presentation and said it will spur the committee to investigate further. She asked how many governors are pushing health care reform right now.

MR. FROGUE said governors need to lead this reform to have maximum impact. Successful states had governors who were very involved in the reform at every level – from state employee policy changes to more exercise in schools.

CHAIR WILSON asked whether changes in schools, for example not allowing junk food, were mandated.

MR. FROGUE said if the Legislature prefers to defer to local control, it could create an Alaska Nutrition Council to set standards that define what constitutes healthy food in schools and good physical activity as well. The Governor's web page could post a challenge to school districts to meet those standards and rank them. The cost would be negligible, health groups throughout the state would probably donate time and the media loves rankings. He thought that would have a much bigger impact than anything that could be done on the financial side.

CHAIR WILSON thanked Mr. Frogue again. She then announced the committee will meet on September 18, 2007, in Anchorage, with

the Senate Health, Education and Social Services Standing Committee on the certificate of need program. The committee will also meet on October 16; the location and agenda will be announced.

REPRESENTATIVE SEATON suggested holding the October meeting during the special session.

CHAIR WILSON announced she would consider that suggestion.

ADJOURNMENT

There being no further business before the committee, the House Health, Education and Social Services Standing Committee meeting was adjourned at 4:22:26 PM.