ALASKA STATE LEGISLATURE
JOINT MEETING
SENATE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE
HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE
January 28, 2009
1:16 p.m.

MEMBERS PRESENT

SENATE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE

Senator Bettye Davis, Chair
Senator Joe Paskvan, Vice Chair
Senator Johnny Ellis
Senator Joe Thomas

HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE

Representative Wes Keller, Co-Chair
Representative Bob Herron, Co-Chair

MEMBERS ABSENT

SENATE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE

Senator Fred Dyson

HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE

Representative Bob Lynn
Representative Paul Seaton
Representative John Coghill
Representative Sharon Cissna
Representative Lindsey Holmes

COMMITTEE CALENDAR

Picture of Alaska
Alice Rarig, PhD Health Planning & Systems

What You Need to Know: Health Reform for Alaska
Lessons from Other States and Issues to Consider
Enrique Martinez-Vidal, Vice President, AcademyHealth

PREVIOUS COMMITTEE ACTION

No previous action to record.

WITNESS REGISTER

WAYNE A. STEVENS, President/CEO
Alaska State Chamber of Commerce
Juneau, AK
POSITION STATEMENT: Introduced the topic.

ROD BETIT, Alaska State Hospital and Nursing Home Association
Juneau, AK
POSITION STATEMENT: Introduced the speakers.

ALICE RARIG, Planner IV
Health Planning and Systems Development Section
Division of Public Health
Alaska Department of Health and Social Services
Juneau, AK
POSITION STATEMENT: Presented data about Alaska's current health care system and challenges.

ENRIQUE MARTINEZ-VIDAL, Vice President
AcademyHealth and
Director of State Coverages Initiatives
Washington, DC
POSITION STATEMENT: Presented information about national health care reform strategies and what other states are doing.

ACTION NARRATIVE

1:16:51 PM

CHAIR BETTYE DAVIS called the joint meeting of the Senate and House Health and Social Services Standing Committees to order at 1:16 p.m. Present at the call to order were Senators Paskvan, Ellis, Thomas and Davis and Representatives Keller and Herron.

1:18:13 PM
WAYNE STEVENS, President/CEO, Alaska State Chamber of Commerce, introduced the topic and thanked the legislators for taking the time to hear this presentation and introduced Rod Betit as moderator.

1:19:21 PM
ROD BETIT, Alaska State Hospital and Nursing Home Association, said he was asked to guide the committee through the three parts of this presentation:

1. Background information about the health care situation in Alaska.
2. What is going on around the country; what other states are doing and what is happening on a federal level.
3. A panel of people to answer questions regarding Alaska-specific challenges and to discuss what the legislature can accomplish this session.

He introduced Alice Rarig, the senior planner at Alaska Social and Health Services, to cover her new research into health coverage in the state.

Picture of Alaska

1:21:23 PM
ALICE RARIG, PhD Health Planning and Systems, Planner, Department of Health and Social Services, said she is pleased to have the opportunity to provide information about the status of health care in Alaska and to update the committee on facilities, services and workforce issues that the legislature will need to be thinking about as they consider health reform options.

1:21:56 PM
Slide 2
She hoped to address the questions of who and how many are uninsured, where they are and why they are uninsured or underinsured; state health expenditures; access issues; health status issues; and employers' offerings of health insurance in Alaska.

MS. RARIG suggested the committee look at the economic impact of their decisions and think about who should be covered. Do they want everyone to be covered? Do they want everyone to have access? If so, what are the implications of that? She noted that coverage and access are not synonymous; one can have access without a source of payment or may have the ability to pay but no services at hand.

1:23:36 PM
Slide 3
The newest figures available indicate that 123,000 people in Alaska are uninsured. That is 18 percent of the population, up from 17 percent according to the last survey. The next survey will be done in March and the data will be available six months after that. Using a 3 year average however, 115,000 people or 17 percent of the population is uninsured, including about 21,000 Alaska natives who may have access to some services in their

villages or through tribal entities. This is not portable or comprehensive insurance but is an important opportunity to access primary care and some additional services. If they assume for the United States and Alaska that Alaska natives and American Indians have some access to care, that can bring number of people who need something in the way of access and/or insurance down to below 100,000.

MS. RARIG pointed out that those who are considered covered include private insurance subscribers and their dependents, the military and their dependents, and veterans. She encouraged them to keep in mind the limitations of veterans' care. Also, they count Denali Kid Care enrollees as covered whether they are enrolled for one month or the entire year; so those people may be uninsured for part of the year. Medicare enrollees are counted as covered despite the difficulty in finding providers who will accept Medicare in many Alaskan communities.

Slide 4
The numbers may overlap because some people have veteran's coverage and perhaps Medicare and/or a private insurance policy. With that in mind, 58 percent of individuals are covered through employer-based policies; 6 percent have self-purchased policies; 13 percent are in Medicaid or Denali Kid Care; 8 percent have Medicare coverage, and 14 percent, which is much higher than the U.S. average, are covered by military or veterans coverage. That leaves 17 percent uninsured all year except for Alaskan natives who have access to some services.

Slide 5
MS. RARIG continued that the people most likely to have no insurance are the self-employed, part-time and seasonal workers, people who work for small firms, and young adult males. About 1/3 of 18 to 24 year olds do not have insurance coverage of any kind.

More than half of the uninsured, 52 percent, are employed adults. Only 9 percent are unemployed people who are employable and looking for work, and about 40 percent are children.

Slide 6
Another way to look at this is that 84 percent of Alaska's uninsured are in working families, compared to 76 percent in the nation as a whole.

1:29:01 PM
Slide 7

Underinsurance is another problem. The Commonwealth Fund has defined the “underinsured” as people who have health coverage that does not adequately protect them from high medical expenses.

It is hard to know which comes first, ill health or bankruptcy, but they often go together. High deductibles can result in postponed care. Many people have some care but cannot afford the co-pay or the deductibles and choose not to get care until and unless they feel they have to. Benefit limitations can result in high out-of-pocket costs. And, she reiterated, coverage doesn't necessarily mean access. It can be a matter of geography; it can be the provider Medicare acceptance issue or shortages of providers that mean there are no people available to provide services. She cited the example of dentists in some rural areas who have to spend all of their time on emergency treatments rather than prevention because there are too few providers to do both.

Slide 8
MS. RARIG advised that there is a great deal of data available on the department’s website from a two year federally funded state planning grant to look at the uninsured. There is information from a household survey; an employer survey; “key informant” interviews; an economic analysis; and an overview of what other states are doing. The web address is: http://www.hss.state.ak.us/dph/healthplanning/planningGrant/default.htm.

Slide 9
Regarding expenditures for health services, two years ago the Institute for Social and Economic Research (ISER) at University of Alaska Anchorage (UAA) wrote a carefully prepared summary of the state’s health expenditures and arrived at the total of $5.3 billion for 2005. About $1 billion of that from individuals’ out-of-pocket and premium costs; a little less than $1 billion from businesses for health insurance or direct services for their employees; about $.5 billion from local governments; $.8 billion from state government and $2 billion from the federal government. At an average annual increase of 8.5 percent, which has been the average for the past 20 years, Alaska would be at about $6.3 billion now; however the increase has accelerated to about 12 percent annually over the last six years, which would put the total at about $7 billion for 2009. She noted that the ISER study is also available online at http://iser.uaa.alaska.edu/Home/ResearchAreas/health care.htm.

Slide 10
MS. RARIG introduced a graph by Neal Gilbertsen, [PhD, Economist, Department of Labor and Workforce Development, Research and Analysis Section] on Per Capita Health Care Expenditures, which represents what Alaska and the U.S. per capita health expenditures are as a percent of per capita income. Nationally, the percentage has increased from 13 to 16 percent of per capita income, while Alaska has gone from paying 11 percent to 19 percent. This is partly due to that fact that per capita income in the state has remained fairly steady at about $33,000 per year in constant dollars while income in the rest of the country has been going up.

Slide 11
She discussed access to care in terms of what is available for primary care, hospitals and other facilities, workforce and reimbursement. There are 24 hospitals across the state, of which 11 are "critical access" hospitals with fewer than 25 beds in communities where their existence might be threatened without a reimbursement structure that provides an economic advantage. There are veterans' clinics now in Anchorage and in Juneau. Alaska also has 26 community health center organizations serving people in 141 different sites. Three or four of those are frontier "extended stay" clinics, which are able to provide services overnight or for a longer time; they are working with Medicare and Medicaid payers on an acceptable reimbursement structure for those. There are also nursing homes, pioneer homes, assisted living and residential psych treatment facilities. The department is very concerned about the community-based programs and levels of care and has been focusing a lot of attention on improving the capacity for prevention and community-based services to keep people close to home.

1:35:31 PM
MS. RARIG touched briefly on the matter of workforce shortages, saying that there is a lot of anxiety and some real shortages in physician numbers, mid-level providers, dentists, nurses, pharmacists and behavioral health workers. There are also some paraprofessional positions for which Alaska has spotty shortages; often it is the distribution rather than absolute number that is a concern. There is national competition for every warm body that works in health care because there is a national shortage.

Criteria for enrollment in public programs, such as the citizenship documentation requirement, has made it difficult in some cases for people to enroll in Denali Kid Care and Medicaid.

MS. RARIG offered several maps [Slides 12-14] to illustrate the geographical disbursement of various types of medical facilities.

- Community Health Centers are well distributed across the state.
- Hospitals tend to be in the larger population centers in Southeast, Anchorage, Mat-Su, Kenai and Kodiak except for the important regional hospitals in Nome, Kotzebue, Barrow and Dillingham.
- There are many Public Health nursing centers from which nurses itinerate to other communities; but the distances between the villages and the regional centers sometimes are great and the challenges of Alaska weather can be substantial.

Slide 15
Health Status Considerations in Alaska are slightly different form those in the rest of the country in that only about six percent of the state's population is 65 or older as compared with 13 percent in the rest of the country. It is significant however, that services do have to be available for that aging population.

Behavioral health is a major focus in the department, reducing the number of children with severe emotional disorders who end up going to outside residential psych treatment centers. The "Bring the Kids Home" project has been effective in keeping kids in state.

Alaska is doing fairly well at reducing mortality rates for some of the chronic diseases such as cancer and heart disease, but not so well yet with diabetes and suicide. In the area of lifestyle choices and "built environment" improvements, both the Division of Public Health and the department are focusing on continuing to bring down mortality rates and morbidity.

Slides 16-17
MS. RARIG said that a household survey conducted a couple of years ago enabled them to identify the fact that about 12 percent of Alaskans consider self-employment their primary place of work, which was not known previously. About 1/2 of the

respondents were in private for-profit enterprises, about 1/4 in government, 1/8 in not-for-profits and 1/8 self-employed.

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Slide 18
Self employed people are less likely to have insurance coverage than others; but 7 in 10 had coverage under someone else's policy or under a public program. Government covers about 98 percent of their employees. Private sector employers cover about 87 percent of their employees and the self-employed are about 71 percent covered by something.

Slide 19
Alaska has more upper-income people without insurance coverage than the rest of the country. This may be due in part to the fact that access to services isn't as good here.

Slide 20
Alaska has about 11,000 small firms and only about 300 large firms, those with 100 or more people. The jobs are mostly in the large firms; so the number of people covered in the small firms is fewer than 50,000. Over 150,000 work for those larger enterprises. The larger firms are much more likely to offer insurance to dependents as well as employees and waiting times are generally shorter for the larger firms.

Slides 21-29
Alaska has the most seasonal private sector economy in the nation. There is a 25 percent increase every year from the January base to July. That is 21 percent higher than the national average. The greatest variation occurs in Bristol Bay where there is an 1100 percent increase annually.

The annual seasonal variation in employment is predictable and consistent. While many seasonal workers are non-resident, many more are Alaskans. Seasonal employment contributes to problems in obtaining and retaining health insurance; most insured workers are full-time employees. Seasonal workers seldom have sufficient tenure to be eligible to enroll in employer-based programs. The July employment captures peak enrollment; but many enrolled will lose employment-based insurance or suffer gaps in coverage when employment declines to seasonal lows.

MS. RARIG stressed that some jobs have more than one person in them in the course of a quarter and some people have multiple jobs; so one needs to distinguish between jobs and people when thinking about insurance coverage.

1:48:44 PM
In conclusion, Ms. Rarig reiterated that Alaska does have a strong seasonal economy with a mixed labor pool, a lot of self-employment and small firms, which means that there are big challenges in terms of the current employer-based insurance models.

She encouraged the committee to think about whether the goal of any reform is affordable and accessible care, affordable insurance or a blend of both; about what are the target populations; and about the underinsured. The current system rests on 200,000 jobs covering about 400,000 people, public programs that cover 150,000 to 175,000 and about 100,000 uninsured.

1:51:20 PM

What You Need to Know: Health Reform in Alaska

MR. BETIT introduced Enrique Martinez-Vidal, saying that his background was important to the Alaska Health Assurance Advocacy Team (AHAAT), which is behind this presentation. AHAAT is made up of providers, the business community, consumers and other interested parties who are trying to understand what makes sense for Alaska. Mr. Martinez-Vidal is the vice president of AcademyHealth, which is one of the premier health-policy institutes in the country. He is also the director of the Robert Wood-Johnson [State] Coverages Initiatives, which is what he has been working with the Department of Health on. He has been around the country helping individual states try to understand the data and what they need to do.

1:52:48 PM
ENRIQUE MARTINEZ-VIDAL, Vice President, AcademyHealth; Director, State Coverages Initiatives, said health reform is not just coverage and access. When states think about coverage and access, the first thing that comes to mind is how much it will cost, which leads immediately to cost-containment strategies. They have also been thinking about quality improvement and improvement to systems such as the delivery and payment systems; so it is cost, quality and access that states are trying to deal with all at the same time.

AcademyHealth is a community of health services researchers, policy makers and policy analysts. Their mission is to work to get research and information into the hands of policy makers so

they can make better decisions and to talk with policy makers to find out what kind of information they really need to make those decisions.

Slides 1-3
State Coverage Initiatives is an initiative of the Robert Woods-Johnson Foundation that works with state officials to provide information as well as direct technical assistance to work on health reforms.

MR. MARTINEZ-VIDAL began with an overview of his presentation. He said it will provide a brief background of what is happening to health coverage across the county; what is driving state reform and what is going on in other states at this time.

Slide 4
Two maps are color coded to show the distribution of uninsured adults 18-64 over two time-periods. These illustrate the decreasing trend in employer-sponsored insurance over time, which is causing the number of uninsured to increase.

Slides 5-6
MR. MARTINEZ-VIDALpointed out that the uninsured have a wide range of incomes. He agreed with Ms. Rarig that Alaska's distribution has a larger number of uninsured at the higher income levels than does the lower 48. The important thing about that programmatically is that the uninsured are not a monolithic population, which means there are different solutions for the differing populations.

Slide 7
In 1987 it took just over 7 percent of the median family income to purchase medical insurance coverage; now it takes over 20 percent to buy that same policy.

The U.S. map on slide 8 illustrates the variation in health system quality across the country.

Slide 9
He touched on the drivers of state health reform, which are high levels of uninsured, decreasing employer-sponsored insurance programs and increasingly unaffordable health care costs and insurance premiums. A lot of research points to the need for [health insurance] coverage for an effective, efficient health care system; many problems are due to the fragmentation in our existing system.

2:00:48 PM
Slide 10
MR. MARTINEZ-VIDAL offered a list of key policy and design issues, which are covered individually on slides 11 through 16. He returned to the idea that different populations require different solutions, but clarified that there are three major groups to be considered when looking at the uninsured.

- There are those who have very few resources to bring to the private insurance market and who end up in public programs like SCHIP. This population needs a 100 percent subsidy. He suggested that there is some layering possible on top of that; perhaps some people would need to use the public program delivery system but could help contribute to it. Some states have sliding scale subsidies for those over a certain income level.
- The middle group is those who can bring some resources to the private sector solution. These are the working poor, lower income people who just can't afford to direct 20 percent of their income to purchasing an insurance policy. States are trying to provide some sort of subsidy to the premium through reinsurance, tax credits, direct premium assistance, vouchers and other methods.
- The third group is those who have sufficient resources to participate in the market but choose not to. As Ms. Rarig mentioned, there might be very viable economic reasons not to do that; but if they are outside the system, they are not contributing to the risk pool, and many times these people are healthier than the other groups.

He asserted that there are only two ways to deal with the issue of voluntary non-participation: mandate insurance coverage as Massachusetts has done, or encourage voluntary participation through education, outreach and simplifying the enrollment process.

2:04:10 PM
"Who will pay?" and "Who will benefit?" Most states that have moved ahead with reform have really tried to bring people "into the fold" in terms of paying for any expansions and reforms. It comes under the rubric of shared responsibility. Some states believe there is enough money in the system and the problem is waste and over-utilization. A lot of research supports that view, indicating that about 1/3 of expenses in the health care system aren't necessary. However, redistribution becomes very difficult politically. Maine tried to do it but was hit with law suits and had real political problems. The bottom line is, if

redistributing the money in the system isn't possible, the state has to find a new form of revenue.

Should Health Insurance Coverage be required, and is that enforceable? Massachusetts is doing it through the state income tax system. The Baucus [Health Reform] Plan includes a mandate that would be enforced through the federal tax system. Some people feel ideologically that such a mandate impinges on their personal freedoms. There are also administrative issues that have to be resolved to make this happen; but the biggest issue in terms of whether this will work or not is economic. If the government is going to require that people buy insurance, it will either have to subsidize the middle and low income groups that simply can't afford it, or increase the eligibility levels for public programs, which costs money.

That leads to the question of what is affordable coverage. It is related to benefit design, to subsidies perhaps, and to that individual mandate. If the state is going to mandate coverage, it has to determine what is affordable. It is generally agreed that the premiums, co-pays and out-of-pocket costs should be related to income and the ability to pay.

MR. MARTINEZ-VIDAL continued that benefit design comes down to not only the cost of the coverage, but the value of the benefit plan. Many states have tried allowing carriers to sell mandate-free policies and found that no one wants them because they don't offer a good value for the money. There are other ways to approach the problem; for example, Minnesota is trying to do benefits design based on evidence of what works. Indiana is looking at consumer-driven health plans in their public programs. Tennessee is putting forth policies on "first dollar" benefits... front-loading the benefits with primary care and preventive services. Rhode Island is trying to design their plan based on changing consumers' behavior, getting them to take advantage of primary care, prevention and chronic care management.

He explained that the delivery system includes cost-containment, quality improvement and systems redesign and stressed that there is no "silver bullet" in terms of what's going to work. States cannot do just one of these things; they generally have to do all of them over time. The problem is that many of these things have short-term costs but long-term benefits, which becomes problematic for funding.

2:10:10 PM

One thing that many states are trying to do is promote the idea of a “medical home” also called the “chronic care management model” or “primary care case management”. Covered on slides 17-20, this gets into redesign of the delivery system by focusing on creating a centralized, coordinated way to deliver care. The principals were developed by leading physicians’ groups; The American Academy of Family Physicians; The American College of Physicians; and The American Osteopathic Association. They are:

- A primary care physician who has a personal relationship with the patient
- A team approach to provide...
- Comprehensive patient care
- Coordination of services through the primary care physician
- Improved quality and safety
- Expanded access, (which is a big complaint in insurance circles)
- Reimbursement/payment for the added value

MR. MARTINEZ-VIDAL pointed to studies of the health care systems in the U.S. and other countries, which have shown that high access to primary care correlates with low health care spending. The U.S. is among the countries with the poorest access to primary care and has the highest per capita spending.

At this time, 31 states have implemented advanced medical homes in their Medicaid programs and a number of other states are working across different payers trying to bring their private sector insurance carriers on board. The big problem is that Medicare is not at the table on these pilot projects. AcademyHealth is working with the federal government, not only to get Medicare to do pilot projects, but to allow them to participate in state pilots. Many states are using their community medical centers as medical homes because they have the infrastructure in place and are already functioning in much the same way.

2:15:02 PM
Slides 22-50
Most states are taking a pragmatic approach to health reform. They don’t propose a single-payer plan or purely market-driven plan, but something in the middle. A successful plan will look at how to build on existing systems, how to improve existing systems and how to take advantage of and redesign the current delivery systems.

2:16:04 PM

Maine, Massachusetts and Vermont have been most successful, at least at the time of enacting comprehensive reforms. They all have the building blocks of public program expansions and subsidies for low income consumers.

Massachusetts is the only state with an individual mandate. Both Massachusetts and Vermont do have employer requirements but they are minimal; putting too onerous a requirement on employers can trigger the federal ERISA issue.

What these three states illustrate is that actual reform is possible. All three worked in a bi-partisan manner and had Democratic legislatures and Republican governors when their reforms were enacted.

MR. MARTINEZ-VIDAL highlighted Massachusetts' "Pillars of the Reform." These include a Section 125 plan requirement, an administrative mechanism that allows their premiums to come out of employees' checks on a pre-tax basis. Surprisingly, he said, a number of employers don't have that in place; so just putting that requirement in place could save 1/3 of the premium for many people.

Massachusetts merged their small group and individual insurance markets, which was easier in Massachusetts than it would be in many states because the two groups had the same rating rules. They also raised the dependent age up to 25 so young adults can stay on their parents' insurance policies. (That is becoming known as the "slacker law.")

Another thing Massachusetts has done and that many states are interested in, is a purchasing mechanism called the "Connector," which really helps to make their private market function more efficiently and more competitively. It provides more consumer-friendly information to people shopping for insurance, allowing them to compare participating insurers' costs and benefits. It has been referred to as the "Travelocity of health insurance."

2:20:17 PM
Massachusetts' efforts have been amazingly successful. Within 18 to 20 months they actually reduced the numbers of uninsured by 2/3. Almost 40 percent of those are getting no state subsidies; they are doing it all through private coverage. They have seen no "crowd-out," which is when a public program siphons people out of the private market. In fact, non-group premiums are down over 40 percent and membership in the individual market has grown over 50 percent. Only about 1-2 percent of the population

has been exempted from the mandate. He clarified that, if a state is going to have a mandate, it needs to provide a "relief valve" for those it can't quite afford to subsidize and for whom they don't have affordable benefits available.

Vermont's "Blueprint for Healthy Vermont" is really delivery and payment system redesign. This is a top-to-bottom comprehensive effort to get everyone involved: the policy makers, the payers, the hospitals and physicians, the communities, the families and the individual.

2:22:27 PM
MR. MARTINEZ-VIDAL mentioned that California proposed a huge reform, which failed. They tried to do access, cost and quality reforms all at the same time and it may be that the change was just too big. Unlike Massachusetts, which had been building their public programs for years and had only about eight percent uninsured to begin with, California did not have the building blocks in place and started with about 15-18 percent of their population uninsured.

2:24:12 PM
Kansas' 2008 legislative plan is looking at cost, quality, access, transparency issues, implementation of medical homes, prevention and wellness. He pointed out that they are really trying to do aggressive outreach and enrollment of those children who are currently eligible for their public programs.

2:25:27 PM
New Mexico accomplished a higher enrollment in existing plans but was not able to get their reform through the legislature in 2008. They were able to pass funding for the "eligible but not enrolled" during the special session.

Pennsylvania is attempting to address affordability, access and quality. They are now doing a chronic care management program and working on health information exchange technology through an executive order.

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In terms of substantial reforms that have occurred, MR. MARTINEZ-VIDAL noted that Indiana is trying to do some consumer-directed "HSA" (Health Savings Accounts) within their Medicaid program that are linked with high-deductable insurance plans. This is very controversial and has not been in place long enough for anyone to know what the impact will be.

Iowa had a big task force that has come back with some broad recommendations including public program expansions; Section 125; dependent coverage up to 25; and a medical homes initiative.

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Maryland did both public program expansions and SCHIP parents, and will phase in childless adults as money is available. They are also providing subsidies to their small employers (2-9 employees) through the Small Business Health Coverage Act. In order to qualify for the subsidy, an employer must put a Section 125 plan in place and offer a wellness program to encourage healthy behaviors and life-style choices among their employees.

2:28:40 PM
The big story out of Minnesota is that they are on the cutting edge of payment reform and delivery system redesign. They are not only working on medical homes (what they refer to as "health care homes"), but are trying to integrate some of their public health programs into the delivery system.

2:30:00 PM
MR. MARTINEZ-VIDAL touched very briefly on activities in other states including:

- Slide 36 - New Jersey: Phase one mandate is "Kids First." Phase two will bring a full mandate, Section 125, subsidies etc.
- Slide 37 – Washington is working on public program expansions and a partnership that is like a connector.
- Slide 38-40 - Wisconsin really tried to simplify their "Badger Care Plus" programs, which are their public programs. This gets to the issue of their eligible but not enrolled by streamlining the application process, reducing the eligibility rules, investing a lot in outreach and hiring additional staff to process enrollment.
- Slide 42 - HealthFirst Connecticut Authority Recommendations
- Slide 43 – Kansas 2009 Health Reform Priorities – Health Policy Authority
- Slide 44 - Ohio State Coverage Initiatives Recommendations are in the governor's office now
- Slide 45 - Blueprint for Oklahoma – Draft Report
- Slide 46 - Oregon Health Fund Board Report
- Slide 47 - Utah Legislative Health System Reform task force
- Slide 49 - Rhode Island ('07): Their HealthPact benefit design is fashioned around five wellness initiatives, in exchange for which consumers' deductable is reduced

substantially (from $5,000 to $750). People haven't taken it up very readily, so the state is still not sure how successful it will be.

- Slide 50 - Cover Tennessee ('07) is a portable product that has a maximum benefit amount of $25,000 and puts all of the benefits up front.

2:37:25 PM
MR. MARTINEZ-VIDAL said that shortages in the health care workforce are a major problem here and in many states. Slides 51–58 define that issue and what some states are doing to address it. He asserted that states do have a strong influence on the development and practice of the health workforce, but recognized that it is becoming increasingly difficult [to maintain sufficient healthcare workers] as the population ages. There is going to be a greater demand for long-term care, home health care and other community-based services.

It comes back to delivery system redesign. A lot of research and discussion has indicated that what is needed now is a different sort of workforce, more physician "extenders," more nurse practitioners and other physician support people.

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One obstacle to progress in this area is that there is no central coordinating mechanism or data collection point for monitoring and planning for the health workforce. Decision-making is splintered across various state agencies.

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Massachusetts did pass another big reform in August 2008 to strengthen the primary care infrastructure, including an affordable housing pilot for health care workers.

Oregon is looking at action steps that include expanding schools' capacity in order to teach more health care students.

2:41:52 PM
MR. MARTINEZ-VIDAL spent a few moments on state quality reporting activities [slides 59-66], noting that most states provide public reporting in terms of health plans, hospitals, nursing homes and ambulatory care settings. Most of the time, reporting serves two purposes: to drive consumer choice and to drive internal quality improvement. The biggest move lately is to report on health care acquired infections.

Some issues related to "report cards" are:

- Where does the data come from?
- What level is the reporting at?
- Displaying the data could pose a problem because the data may be good but it doesn't always mean a lot without consumer information around it to make it usable.

MR. MARTINEZ-VIDAL suggested that some common principals of good performance reporting are to bring together a committee of interested parties to understand the data issues; pilot the reporting programs before going to full implementation in order to iron out the bugs; and try to reduce duplication of efforts by using data that is already available from other sources.

2:46:46 PM
Many of the recommendations that have been discussed were made by temporary task forces. Some state health policy commissions and authorities are more permanent; slides 67-76 cover the makeup of some of these.

2:49:17 PM
In his experience, Mr. Martinez-Vidal said, he has found the permanent bodies to be more effective because health care reform isn't a one-time fix. He cautioned that creating such a body brings up another set of problems such as where to put it; how it will be funded; what the governance structure will look like; and, more important, what its duties will be. In some states the commission actually runs the public programs.

2:52:01 PM
MR. MARTINEZ-VIDAL highlighted the lessons learned in state reform efforts so far:

- Successful comprehensive reforms are built on previous efforts. The successful states have spent years trying to get to a point where they could make that comprehensive leap.
- The needed ingredients are leadership, opportunity, the readiness to act, and persistence. Bi-partisan leadership is absolutely essential to make it work.

2:53:44 PM
- There are no free solutions. This is not to say that states should not invest in long-term solutions to find the cost-drivers; but in the short-term, many of these solutions will cost money up front.

2:54:21 PM
- It is hard to get agreement on what aspects of health care reform to address first; but it is clear that comprehensive

reforms need sequencing. Sequential or incremental reforms have a vision; it means laying the building blocks to reach the ultimate goal.

2:56:07 PM
Every state has different economic ability and different needs. That variability is creating a dilemma for federal reform. A federal reform might have 50 different impacts, so any federal efforts at reform will have to take that into consideration.

2:58:37 PM
MR. MARTINEZ-VIDAL ended with the final thought that everyone has a different idea of what they want change to look like; and if it doesn't help him or her personally, status quo is the second choice. AcademyHealth and the states are working to make the second choice reform based on a compromise rather than status quo.

2:59:26 PM
MR. BETIT thanked Mr. Martinez-Vidal for his presentation. He said Alaska needs to get a handle on what is going on, what the data reveals about different populations, and how to address costs; but he feels the country is on the cusp of change with a president who wants to move forward. The governor has created a health care commission; but it is new and still being developed in legislation.

The question, he said, is "Why should we act?" The answer is that only about 20 percent of small businesses and individuals are paying for health care each year. When costs are rising, a simple price adjustment won't cover it because federal programs deflect the price increase so more of it falls on the back of that 20 percent. Alaska needs some thoughtful body to navigate through all of that and decide what the state's next steps should be; so pursuing a commission this session makes sense.

3:05:08 PM
REPRESENTATIVE GARDNER noticed that there were only two references to the Certificate of Need (CON) in this presentation and asked Mr. Martinez-Vidal if he thinks the CON helps control health care costs.

3:06:49 PM
MR. MARTINEZ-VIDAL answered that it varies across states, depending on how it is structured and what the state's needs are. He admitted that he doesn't often work with states on the issue because it is so political, but said his experience has

been that, while it can be used as a lever to try to control costs, many times it is not very successful.

Maryland has started including in the underlying state health plan that informs the Certificate of Need awards some broader ideas rather than straight-up need. They were able to use the state health plan and Certificate of Need process to do more interesting things such as adding patient safety measures. For example, an agreement to incorporate patient safety measures in a new emergency room might be one of the criteria used in deciding whether to grant a Certificate of Need. Or perhaps a hospital that wants to offer a particular service for which there is already enough access, would be granted a CON if it agreed to provide those services to an underserved population.

So, if the state doesn't want to battle over whether or not to keep the CON, they might want to start using it in a more creative way. He reiterated that, in general it hasn't been very successful in controlling costs.

3:10:36 PM
REPRESENTATIVE HERRON commented that Senator Davis and her co-chair have worked a great deal on this issue. The remarkable thing about all of this is that so little has changed. He asked Mr. Martinez-Vidal what the legislature should do during this session to capitalize on health care reform efforts currently under discussion at the federal level.

MR. MARTINEZ-VIDAL answered that the two big things on the table now at the federal level are the State Children's Health Insurance Program (SCHIP) reauthorization and the stimulus package; something will happen in next month on those. Reauthorization is an opportunity. The discussion is about what level states are going to be allowed to take the income eligibility level to. Right now it is at 200 percent of the federal poverty level; but it looks as if congress may allow it to go to 300 percent without a waiver. With the stimulus package, there is a lot of money in it for health information technology that he is afraid will be squandered because people don't know what to do with it. He feels the state should really think about how to capitalize on that. The technology underpins the delivery system redesign, the quality reporting, and payment system reforms.

3:14:19 PM
SENATOR PASKVAN asked what Mr. Martinez-Vidal's thoughts are regarding mandatory overtime and the issue of nurse retention.

MR. MARTINEZ-VIDAL said some states have been using the prohibition of mandatory overtime as a way to retain nurses. That also has a down-side; it means hiring more nurses to cover the hours. California tried it and had issues with less well-trained nurses on staff; but it does seem to have encouraged more nurses to stay.

3:15:36 PM
SENATOR THOMAS asked Mr. Martinez-Vidal, regarding the sequential nature of planning, if he has gathered statistics on what incremental steps have been most successful to begin building toward reform. He commented that even developing a vision is difficult when the goal is so vast.

3:16:43 PM
MR. MARTINEZ-VIDAL responded that the vision most people can agree on is pretty broad: universal coverage, better quality and low cost. What has been successful is to incrementally push up public program eligibility and enrollment first. States have to address that lowest tier of people who will never be in the private financing sector, then look at how to subsidize the next tier. The whole issue of chronic care management, prevention and wellness is critical to health care reform and goes upstream to the cost-drivers in the system. He stressed that 80 percent of costs in the system are driven by the 20 percent of people with chronic conditions, many of which are preventable.

3:19:03 PM
MR. BETIT commented on Senator Thomas' question "Where do you go from here." He said that ASHNHA has worked on that this year with Mr. Martinez-Vidal's help and have produced "Guiding Principles for Health Care Reform 2009" which identifies four principles to guide what they think Alaskans would want to see in a sequential set of steps. He encouraged the committee to review it and see if it resonates with them.

CHAIR DAVIS commented that Alaska has a lot of building blocks already in place and said she was pleased to hear that they can build upon those to get to the bigger goal. Denali Kid Care is one program they can strengthen this year to help Alaska's children and is one step toward health care for all of Alaska's citizens. A bill is being introduced in both houses for the governor's commission on health care reform and that is another step. She is hopeful that they can accomplish a lot in this 90 days and that they can continue to build on the blocks they have

in place. She also noted that Senator French has introduced a bill based on the Massachusetts plan.

3:22:28 PM
CHAIR DAVIS adjourned the meeting at 3:22:28 PM.