ALASKA STATE LEGISLATURE
SENATE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE
August 3, 2010
9:02 a.m.

MEMBERS PRESENT

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

MEMBERS ABSENT

All members present

OTHER LEGISLATORS PRESENT

Representative Wes Keller
Representative Paul Seaton
Representative Sharon Cissna

COMMITTEE CALENDAR

PATIENT PROTECTION AND AFFORDABLE CARE ACT

- HEARD

DENALI KID CARE (SB 13)

- HEARD

PREVIOUS COMMITTEE ACTION

No previous action to record.

WITNESS REGISTER

DEBORAH ERICKSON, Executive Director
Alaska Health Care Commission
POSITION STATEMENT: Spoke to workforce and public health provisions related to the Patient Protection and Affordable Care Act.

JUDITH BENDERSKY, Health Program Manager
Medicare Information Office

Division of Senior and Disability Services
Department of Health and Social Services (DHSS)
Anchorage, AK
POSITION STATEMENT: Provided information about Medicare as it related to the Patient Protection and Affordable Care Act.

LINDA HALL, Director
Division of Insurance
Anchorage, AK
POSITION STATEMENT: Provided information about insurance as it relates to the Patient Protection and Affordable Care Act.

RACHEL PETRO, Deputy Commissioner, Department of Administration
POSITION STATEMENT: *

PATRICK SHIER, Director
Division of Retirement and Benefits
Department of Administration
POSITION STATEMENT: Delivered a presentation entitled PPACA Provisions Impacting the State of Alaska as an Employer.

JON SHERWOOD, Medical Assistance Administrator
Department of Health and Social Services
Juneau, AK
POSITION STATEMENT: Provided information related to the impact of the Patient Protection and Affordable Care Act on the State of Alaska.

JON SHERWOOD, Medical Assistance Administrator
Department of Health and Social Services (DHSS)
Juneau, AK
POSITION STATEMENT: Provided information about the Medicaid program as it relates to Denali Kid Care.

STACIE KRALY, Chief Assistant Attorney General
Department of Law (DOL)
Juneau, AK
POSITION STATEMENT: Answered questions about the instructions from the governor to conduct a comprehensive review of the options available under the Medicaid program relative to the veto of SB 13.

RANDI SWEET
United Way of Anchorage (UWA)
POSITION STATEMENT: Testified in support of increasing the federal poverty level limit to qualify for Denali Kid Care.

DAVID MASUO, representing himself
POSITION STATEMENT: Testified in support of increasing the federal poverty level limit to qualify for Denali Kid Care.

ACTION NARRATIVE

9:02:38 AM
CHAIR BETTYE DAVIS called the Senate Health and Social Services Standing Committee meeting to order at 9:02 a.m. Present at the call to order were Senators Paskvan, Ellis, Dyson and Davis.

Patient Protection and Affordable Care Act

9:04:40 AM
CHAIR DAVIS announced the first order of business was to hear an overview of the federal health care bill, the Patient Protection and Affordable Care Act ("Affordable Care Act").

SENATOR PASKVAN expressed hope that the review would identify the sections of the federal legislation that are important to Alaska and the timeline for implementation. He understands that there are mandates and opportunities and he is interested in knowing the timelines that are applicable to each. In particular he'd like to know what grants are available to the state for the various components of the federal health care law and what information the Legislature will need to receive in order to effectively take advantage of the opportunities.

SENATOR ELLIS related that he recently attended a conference that was sponsored by the National Conference of State Legislatures and principally funded by the Annie E. Casey Foundation. He offered to pass along the information that he received to this committee and perhaps the finance committees because Medicaid is a growing component of every state budget and it's a common complaint among legislators. According to the staff at the Annie E. Casey Foundation, the federal legislation put a lot of money on the table and many states applied for those federal dollars to help fund their Medicaid budgets. Other states opted to sue the federal government and some were just holding back. What is absolutely clear is that once the money's gone, it's gone.

9:07:27 AM
SENATOR ELLIS expressed interest in knowing if the State of Alaska is making use of the available opportunities to help fund or refinance its Medicaid budget, if it's in a holding pattern, or if the administration has decided to reject the money.

9:10:16 AM
DEBORAH ERICKSON, Executive Director, Alaska Health Care Commission, apologized for Commissioner Hogan that he wasn't available today. She said she was asked to speak to specific workforce and public health provisions, but she would first provide some context for the rest of today's presentations. She related that an interagency team has been meeting periodically to ensure that state agencies are identifying mandatory provisions in the federal law, looking at the options, looking at the legal considerations and making decisions about implementation. Representatives from the agencies will be speaking to these particular provisions. Mr. Sherwood will speak to the specific Medicaid provisions; Deputy Commissioner Petro and Retirement and Benefits Director Patrick Shirer will speak to the requirements for the state as an employer under this new law; Division of Insurance Director Hall will talk about the private insurance market reforms under the law and where the state stands with respect to compliance.

MS ERICKSON directed attention to the PowerPoint that she intended to present today and explained that while she did not plan to provide an overview of the health care law as she had in a presentation at the end of the session last year, she would lay out the major components of the Affordable Care Act. This includes the changes to the private health insurance market; changes to Medicaid and Medicare; provisions related to prevention and strengthening public health and population-based health; a series of health care workforce development provisions related to transparency and strengthening fraud, waste, and abuse provisions; the new act entitled The Class Act that is embedded in the law and creates a new long term care insurance program; and new taxes and fees that help to finance the changes that the new law imposes.

9:13:08 AM
MS ERICKSON noted that there are many different interrelated pieces to this new law and she regularly comes across provisions that contain mistakes. Understand, she said, that the first nine titles of the Affordable Care Act are the basis of the basic law, but Title 10 of the Affordable Care Act actually makes amendments to Titles 1-10 and then the Health Care and Education Reconciliation Act again makes amendments. A consolidated version that reflects all the changes to the law came out of one of the congressional committees and DHSS has posted that on their website. She said she's mentioning this to ensure that it's understood that they are looking at the current amended

version of the law. She said it's also important for the public to understand the distinction between authorizations and appropriations and that the new law authorized many new programs and reauthorized some old programs, but not all of the provisions include the appropriations. While it appears that there may be another funding opportunity, Congress must first appropriate the funds to support it.

9:15:26 AM
MS ERICKSON highlighted the apparent conflicts in some of the effective dates and explained that she has been maintaining a master spreadsheet for the interagency team showing the effective dates of provisions in the law, but some of the other spreadsheets are from the program folks who are working on implementation and these identify when the state will have to take action. Those dates aren't necessarily the same as when the provision in the law takes effect. Obviously, she summarized, it's important to understand what an effective date means in terms of whether that's when the law takes effect or if there's a different date by which the state government of some other federal agency might have to take some particular action.

MS. ERICKSON emphasized that the details on how the law is implemented are coming out daily. She referenced slide 4 to illustrate how quickly things change. Late last Friday the information she submitted for this presentation indicated that DHSS was aware of at least 25 new funding opportunities that had been released - grant guidances, grant RFP that had been released by the federal government. Literally minutes after she sent the information an email came in from the federal government advertising a new opportunity that had become available. Over the weekend she heard about a grant that had been awarded to an organization in the state and she didn't even know that that funding opportunity was available. It was an existing program that had been reauthorized under the Affordable Care Act, but it wasn't on any federal lists of opportunities under the Affordable Care Act. So while the PowerPoint lists 25, she knows that at least 27 funding opportunities have been released. Similarly, the information she sent last Friday lists 8 regulation packages and she now knows that at least 10 have been released. One came out later on Friday and she wasn't aware of the other, which came out in May, and it wasn't on any U.S. Department of Health and Human Services list.

9:17:49 AM
MS ERICKSON said that at least one new federal office has been established and a few more are authorized under the new law. The

most significant is the Office of Consumer Information and Insurance Oversight, which was created right after the law passed. That's the office within the U.S. Office of Health and Human Services that's overseeing all the changes related to private insurance market reforms and also some of the new insurance programs - like the temporary high risk pool and the insurance exchanges. A number of new councils/committees/commissions were also formed under the Affordable Care Act and she's aware of 3 that are already functioning. 1) The National Prevention Health Promotion and Public Health Council convened and has already released a preliminary report on the status of public health nationwide; 2) A committee specifically to review criteria for federal designations for health professional shortage areas and medically underserved areas has been created to advise the federal government on new regulations they plan to adopt related to those designations; and 3) A Plan Advisory Board to guide the development of regulations and other guidance related to the grants that will come out in a couple of years to support the nonprofit member-operated insurance companies that are created under the Act.

9:20:27 AM
One of the many mandates for the Secretary for the Department of Health and Human Services was to create a website for the public specifically on insurance opportunities and options and other issues related to health care and health care reform. It was posted on July 1; www.healthcare.gov includes state-by-state information. While this was a requirement for the federal government and would appear as though state government would have no role, the state insurance division actually had a staff member assigned for a full week to compile some of the basic information for the federal government. The website also has information and links to the state Medicaid program so the state Medicaid staff has to be involved to ensure that the information is accurate and complete. That's an example of just one area where state government is involved even though there isn't a mandate in the law for the state to participate directly. She noted that the website contains information specific to Alaska and a summary of the federal implementation of the new law.

9:22:13 AM
MS ERICKSON referenced slide five and explained that the interagency team that she's mentioned is entitled the Alaska PPACA Impact Team. This group came together initially to ensure a coordinated approach across agencies in an effort to

understand and identify areas where state government needs to comply with the law.
Consultation with the Department of Law (DOL) has been particularly important in understanding the interface between the lawsuit to which the state government is a plaintiff and applications for any of the federal funding opportunities and if there is any special legal disclaimer language that needs to be included with the grant applications. She affirmed that they have been consistent in identifying what that is and including it. They are also looking at the potential risks and potential benefits to state government when considering and operating grants and these new programs.

The members of the team are largely present today. Patrick Shirer, the director of the Division of Retirement and Benefits, is representing the Department of Administration (DOA) looking specifically at the requirements for the state as an employer; Linda Hall, the director of the Division of Insurance, is representing the Department of Commerce, Community and Economic Development; deputy commissioner Bill Streur and deputy commissioner Patrick Hefley, and the chief medical officer Doctor Hurlbert have been representing Department of Health and Social Services (DHSS) on the team.

While Dr. Hurlbert wasn't present due to a family obligation, she assured the members that he would be happy to speak to the committee about any issues related to health care reform generally and how it impacts the state and anything related to population-based health improvement. Mr. Streur is representing the state today at a one day meeting in Minnesota by the U.S. Department of Health and Human Services on the health insurance changes. She said that Ms. Hall is taking the lead today on the issues related to the health insurance exchange. She noted that as that moves forward she will need to work closely with DHSS, specifically the Medicaid agency, because of the requirements that Medicaid enrollment and eligibility be integrated into the health insurance exchange.

9:26:30 AM
SENATOR PASKVAN said he made a request in early June for information regarding this and was told that there would be meetings under executive privilege, but that a report would be issued by the end of June. He said he hadn't received it and questioned when it might be issued.

MS ERICKSON apologized that an expectation was created for the production of a report. She said at one point this committee

envisioned that a preliminary report on the impact of the new law could be produced in short order. This past month a draft report was provided to the governor's office and the information that's being provided today is a summary of what's been provided to the governor's office to date. The resources that have thus far been required to understand what's involved in implementation of this new law have overwhelmed this interagency team more than was anticipated. Because things are changing on a daily basis with respect to this new law, she said she can't commit to when a comprehensive and consolidated report might come out from state government.

9:29:21 AM
CHAIR DAVIS said at some point there has to be a plan that's laid out and once that's submitted to the governor, the Legislature should have access to it. She asked how many people make up the interagency team.

MS ERICKSON replied this group met once for 45 minutes via teleconference in the past 4 weeks. Before that when they were trying to develop a consolidated list and identify the areas where they needed to be coordinating, like the legal waiver language she mentioned previously, they were meeting via teleconference on a weekly basis for 45 minutes to an hour. The official members include the people she listed earlier and Stacie Kraly representing the Department of Law and Kelly White representing the Office of Management and Budget. In addition, some agencies have had their assistant attorneys general participate including assistant AG Ann Johnson, who supports the Department of Administration and the Division of Retirement and Benefits. Mr. Sherwood, who is representing Medicaid, has been convening an intradepartmental staff team that came together to identify the issues within the DHSS on a programmatic level that shouldn't take the time of the other division directors and deputy commissioners. Mr. Sherwood has been sitting in on the meetings more recently. Because of the scope of the impact on DHSS, Commissioner Hogan has made a point of participating in these meetings regularly. A couple of people from the governor's office have been sitting in as well.

9:33:02 AM
CHAIR DAVIS questioned why the Department of Education and Early Development (DEED) isn't involved because money is earmarked for DEED for health clinics and [indisc] in particular.

MS ERICKSON explained that initially the decision was to limit it to those agencies that would have multiple programs or

impacts. They've identified a number of departments that will be impacted and the Department of Labor and Workforce Development (DOLWD) has already applied for one grant under the Affordable Care Act to support statewide health workforce development planning. And they are in the process of applying for another grant opportunity specific to developing health professional occupation opportunities for low income people and Temporary Assistance for Needy Families (TANF) recipients. There was never an intention to bring every agency to the table that might have some opportunity because it wouldn't be a good use of their time.

REPRESENTATIVE WES KELLER asked the interagency team to generally track how the various divisions and departments respond to these funding opportunities.

CHAIR DAVIS interjected to recognize the next speaker.

JUDITH BENDERSKY, Health Program Manager, Medicare Information Office, Division of Senior and Disability Services, Department of Health and Social Services (DHSS), reported that her office is funded through the centers for Medicare and Medicaid and the Administration on Aging to provide one-on-one counseling to people as they turn 65 and become eligible for Medicare and to do public outreach helping Alaskans navigate Medicare.

She noted that Mr. Obermeyer provided some points in the Affordable Care Act for her to address with respect to impact on the state. She said she doesn't see many specific points that the state needs to create new policy or regulations around, but she would touch on a few. One provision in Section 3110 that was to be effective March 2010 may impact dual eligibility - people on Medicaid and Medicare. It's a special enrollment period for disabled tri-care beneficiaries; those are people who are receiving health insurance benefits through the military will automatically become enrolled in Medicare Part A and Part B effective the 25th month of receiving Social Security disability benefits. That's a minor tweak in the Affordable Care Act that makes a needed fix in Medicare so that tri-care beneficiaries receive the same enrollment period as other disabled beneficiaries. There are a number of points like that, but they have no specific impact on the State of Alaska and anything the state has to do in terms of response.

9:39:42 AM
MS. BENDERSKY said the largest impact that the Affordable Care Act has on Medicare beneficiaries is to reduce and close the

coverage gap known as "the donut hole." This gap in prescription coverage impacts about 12,000 people in Alaska and now they'll pay less out of pocket to get prescriptions. She mentioned that Medicaid is impacted by the Affordable Care Act so it will have to align its payment policies to accommodate benefit changes in the Medicare program. It also means that there will be more people eligible for Medicaid in the future. At some point Mr. Sherwood will address that in greater detail. She offered to address specifics the committee may have.

9:42:15 AM
CHAIR DAVIS found no questions and asked Ms. Erikson to respond to Representative Keller's question.

MS ERICKSON said she recently started a spreadsheet that lists the grant opportunities and some information about the deadlines and dates and specific proposal information. That information is summarized in the PowerPoint. She offered to provide the committee with copies of the spreadsheet.

CHAIR DAVIS said she would like that.

MS ERICKSON directed attention to slide 6 and explained that state governments are responsible for implementing the requirements imposed on employers and will be responsible for implementing the Medicaid expansion requirements. There also are a series of programs that state government may participate in including the high risk pool, early retirees reinsurance program, the health insurance exchange, the insurance market reforms - a series of service delivery and payment reforms that are made through changes to Medicare and Medicaid so those changes that are made through Medicaid and are presented as state options will be considered. Also included are public health and preventions programs and the workforce development program. She said these are general areas of options and opportunities for the state and she will defer explanation of them to the other presenters.

9:45:28 AM
MS. ERICKSON said she imagines that the needed statutory and regulatory changes for implementation will be made prior to 2014, which is the date that the Medicaid expansion takes effect.

SENATOR PASKVAN recalled reading that in mid July Alaska signed a contract with the federal government related to the high risk pool. He asked what the state contractually obligated itself to

do and what the policy choices were for coming to the decision to sign or not to sign that contract.

CHAIR DAVIS said that will be taken up by the Division of Insurance. She asked Ms. Erickson to continue.

MS ERICKSON said she anticipates that Director Hall will address the issues of the health insurance exchange and the insurance market reforms and be able to answer detailed questions. She acknowledged that the committee had specifically asked about the general areas that might require state legislation and those are the three main areas she would anticipate.

Continuing with the presentation, she said the next several slides contain lists of grants or contracts for which state agencies are either in the process of developing applications or have already applied. The high risk pool is in place and she believes that it's a contract with the Alaska Comprehensive Health Insurance Association (ACHIA). State government was involved in supporting and negotiating for that and Director Hall will address that further.

The temporary reinsurance program for early retirees is an application that the Department of Administration (DOA) submitted and those department officials will explain that in greater detail.

A number of programs in this new law focus on maternal and child health so the first several bullets on slide 8 are about two programs. The Personal Responsibility Education Grant focuses on adolescent health and safety issues; DHSS applied for that grant in early June. The Maternal, Infant, and Early Childhood Home Visitation Home Visitation is a new program created under the bill. It's significant in that there was a requirement for all states to participate in phase 1 grants in order to continue to receive their maternal and child health block grants. The state submitted an application for phase 1 funding and received $584,000 several weeks later. This first phase grant expands a requirement under the maternal and child health block grant that all states conduct every 5 years a needs assessment related to maternal and child health issues and resources in the state. The scope of that assessment was expanded significantly and the phase 1 grant supports the expansion of that data collection/needs assessment effort.

Support for pregnant and parenting teens is another new grant opportunity. The Council for Domestic Violence and Sexual

Assault under the Department of Public Safety (DPS) developed an application for that program and she assumes it was sent in by the deadline, which was yesterday.

9:50:28 AM
One workforce planning and development grant is available for each state and provides strategic planning funds. For states that have a strategic plan in place, implementation funds are available. The Alaska Workforce Investment Board submitted an application on July 19 for the planning funds. They have been working with a statewide coalition that produced a strategic plan. She believes that they envision using these funds to apply for a workforce development implementation grant.

In a couple of days an application is due for health professions for low income individuals and TANF recipients. She reiterated that the Alaska Workforce Investment Board under the Department of Labor is working with their partners on that.

Two grant applications that were submitted last Friday include aging and disability resource centers and a small grant opportunity - Medicare part D outreach for about $60,000. Ms. Bendersky's office provides the outreach support work to Medicare recipients with information about part D, specifically the pharmacy benefit under Medicare.

There's also funding available that the Division of Public Health within DHSS will pursue related to that division's background check program in order to participate in a national background check program. She noted that Alaska was a pilot program state, but she isn't sure how it expands or continues the state's participation in that program. Nonetheless, DHSS is applying and that application is due August 9.

She referenced the new National Public Health Prevention and Health Promotion Council and noted that a new program was created under the Affordable Care Act and $500 million was appropriated in the first federal fiscal year for that. A new process is being pilot tested moving towards developing an accreditation program for state and local government public health agencies. In the future all state and local government agencies will have an opportunity to become accredited as a state or local government public health agency. Performance standards and performance measurement plans are being put in place related to that new accreditation process.

9:53:36 AM

MS. ERICKSON offered her understanding that the first grant related more generally to strengthening the public health infrastructure is meant to support states in developing their performance management systems for public health. And it's intended to support states in moving towards that accreditation process.

A new grant that she learned about just yesterday and that DHSS is applying for is an existing grant program - public health laboratory and epidemiology capacity support. The Division of Public Health has received a grant under that program for a number of years, but it's been reauthorized and expanded under the Affordable Care Act with the new National Public Health Fund. She learned yesterday that the state Division of Public Health is in the process of developing an application for that program and the application is due August 27.

Slide 11 lists some of the grant programs. The first two came out in the last week or 10 days and are related to health insurance funding opportunities. Last Thursday the federal government announced they were releasing the grant guidance for health insurance exchange planning for each state. Those applications are due on September 1. Last week she learned about the grant opportunities to develop offices of health insurance consumer information and assistance in states and/or a health insurance ombudsman office or program. Director Hall will provide more detailed information about what is included in those grant opportunities and what the state's considerations are related to risks and benefits and the possibility of applying for those two programs.

9:56:32 AM
MS. ERICKSON said another opportunity that was released recently is the Money Follows the Person Rebalancing Demonstration Project. That's a Medicaid funding opportunity and those applications aren't due until January.

She said she wanted to point out several things related to State of Alaska government officials being involved. She noted that earlier she mentioned the new committee to review criteria for designation of health professional shortage areas and medically underserved areas and it was an honor that two Alaskans were appointed to this new committee, but it's also potentially a real benefit to the State of Alaska and Alaskans. Issues related to measuring and understanding medical access in remote areas of Alaska will be considered in this. Alice Rarig who is a planner with DHSS has been actively involved in seeking these

designations in the past is a member of this committee now and Sally Smith who is the chair of the board for the Bristol Bay Area Health Corporation and is a member of the national Indian Health Board have both been appointed to this committee. The Division of Insurance is also actively involved and Linda Hall can speak to any questions with regard to the National Association of Insurance Commissioners involvement, but that association is actually named in the Affordable Care Act in some places as a partner with the federal government to help come up with some of the new federal regulations related to the private insurance market reforms as well as the development of some of these new programs - like the health insurance exchanges. That association is made up of members from state insurance divisions and departments. Staff from the Alaska Division of Insurance are actively involved in some of those work groups in helping to participate in development of some of those federal guidelines.

A new federal taskforce created under the Affordable Care Act is specifically looking at improving access to health care in Alaska. This was an amendment that was proposed by Senator Begich and is included in Title 10. The members were appointed about a week ago and it has a deadline of September 23. The taskforce has had one teleconference and will be in Alaska next week for a week. The slide lists the members representing the different federal agencies involved. During the week they'll conduct site visits and she understands that they'll break into 2 groups and will each go to 2 or 3 different communities. A week from tomorrow, Wednesday, everyone will convene in Anchorage for a meeting.

9:59:55 AM
MS. ERICKSON said she's only talked briefly with Senator Begich's office and with Susan Johnson who is the Region 10 director in Seattle for the U.S. Department of Health and Human Services about this. She suggested that if members want more information they go to her at this point. The health care commission will be interested in seeing the findings that this taskforce will produce in their report. According to the law the taskforce expires with the production of the report that is due to Congress on September 23.

Another important aspect of the law is that the Indian Health Care Improvement Act was reauthorized under the Affordable Care Act after having sunsetted essentially 10 years ago. To her knowledge the State of Alaska isn't directly participating, but the Alaska tribal health system has been actively involved working on the reauthorization and is now working to ensure that

the different tribal health organizations statewide understand the implications.

MS. ERICKSON said she's communicated periodically with staff from the University of Alaska and has looked at the various opportunities available for workforce development, specifically for colleges and universities.

She continued to say that the committee will hear from the Department of Administration and the Medicaid program the extent to which state agencies have preliminarily identified potential future costs to state government as well as some funding opportunities. She said she noted earlier the three main areas where they anticipate there might be changes required to state law related to implementing private market insurance reforms and the health insurance exchange and changes to the Medicaid program. There are numerous policy and programmatic changes that state agencies already have to make. The committee will hear from other presenters too, including the new employer obligations. She said they continue to try to understand how the flexibility of state government is being impacted with all the new federal rules and how the state's role in this new health care delivery system might change. For example, considering the potential changes through the Medicaid program to organization and payment mechanisms for health care.

10:03:15 AM
MS. ERICKSON noted that the committee asked her to wrap up with an update on the status of the Health Care Commission and the potential role for that commission in understanding the impacts of the Affordable Care Act and developing recommendations for moving forward. She directed attention to slide 16, which is relates to the commission. It had been established by Governor Palin and it met for the calendar year 2009. Representative Keller participated as a commission member representing the House of Representatives on the initial commission. SB 172 established the Alaska Health Care Commission in statute and transitioned the existing voting members to the new commission and added four more seats. Currently the board has five vacancies and the governor's office of boards and commissions has interviewed over 20 applicants. She anticipates that the governor will make those appointments in the next week or so and that the commission will meet twice in the fall for a day and a half each time. The new commission will continue the established practice of holding a public hearing as part of each meeting. The primary concern of the commission this past year was related to the cost of healthcare in Alaska. She noted that Dr.

Hurlbert, who is chair of the commission, reminds anybody who will listen that paying attention to the cost of health care in the state should be one of the highest priorities of any official in state government. If not checked, the cost of care translated through the Medicaid program will continue to consume more and more of the state's budget and potentially impact other programs.

10:06:00 AM

At the beginning of the first year the Health Care Commission decided it was not interested in identifying and responding to any new policy option or opportunity that came along in developing a response. It was more related to more potential federal and state legislation. They didn't want to be seen as the policy analysis and impact analysis body because they were formed to develop their own recommendation rather than to evaluate others. She said she doesn't believe that the commission has the capacity, resources, or time to do a comprehensive impact analysis of the entire Affordable Care Act and she doesn't believe that they will see that as their mission. That being said, the commission identified it their first year report the importance of understanding that if federal health care reform passed, what the implications for the state were related to how it might change the health care environment in this state. She admitted that it's going to be a challenge and Dr. Hurlbert has expressed concern that if the commission spends all its time studying the Affordable Care Act that they're not going to get anything else done and won't be able to make any sort of impact on the issue related to health care cost control. With that in mind, she anticipates that the commission might look at the Affordable Care Act from the perspective of the changes that they might be making recommendations about and making sure that they're integrating into any recommendations related to health care cost control both opportunities that might be available through the Affordable Care Act and other changes that are being made by the Affordable Care Act that will impact in some way the delivery of health care in this state and the cost of health care in this state. She acknowledged that she is in part speculating and that it's important to get the new members appointed and convene the group and see what direction they want to take. Hopefully that will be sooner rather than later.

10:08:18 AM

CHAIR DAVIS remarked that she didn't know that the intent of the bill was to bring all the members of the temporary commission along to the permanent commission and then add 5 new positions.

She observed that many of the names listed might not be in the Legislature come next January.

MS ERICKSON explained that SB 172 included a transition clause that automatically appointed the existing voting members of the commission to the new commission. Legislators are not voting members. Under the former commission that was established under Administrative Order 246, there were 7 voting members. Six of the voting members have indicated an interest in continuing with the commission and she anticipates that Governor Parnell will reappoint them automatically. The commission has 3 ex officio or nonvoting members: Senator Donald Olson was the representative from the Senate and she believes he will be appointed to continue; Representative Wes Keller was the representative from the state House and Speaker Chennault has already reappointed him to the new commission; and Linda Hall was initially in the seat appointed by the governor to represent the Administration. She can't speculate who might fill that seat on the new commission, but she assumes that will be announced when the new members are appointed to the five vacant voting seats.

10:11:13 AM
CHAIR DAVIS said the information has been helpful but at the end of this session she isn't sure she'll have all the information she's looking for. For example, she would like to know how much money the state has received in grants through the Affordable Care Act; how many opportunities the state has refused to apply for; and what those are because they apparently haven't applied for everything that's available to the state. She asked the members if they needed additional information.

REPRESENTATIVE KELLER said he's eager to receive the spreadsheet Ms. Erickson offered to provide, but the question he asked was answered in the PowerPoint.

SENATOR DYSON commented that he suspects that the elephant in room that hasn't been discussed is the governor's veto of increasing the limit for Denali Kid Care due to the abortion issue.

CHAIR DAVIS said that issue will be addressed this afternoon.

SENATOR DYSON asked Ms. Erickson if she knows of any grants and funding streams that the Administration has decided not to pursue.

MS ERICKSON replied she's aware of one that's related to health insurance rate review and she would defer to Ms. Hall to explain the rationale for that.

10:14:12 AM
LINDA HALL, Director, Division of Insurance, said she will try to address the questions that came up during Ms. Erickson's presentation. She continued to say that many of the provisions of the Affordable Care Act that have become effective are related to insurance. She informed the committee that in the presentation she is using a cut down version of a document from the National Association of Insurance Commissioners (NAIC) that is being used around the country and she will address Alaska's position relative to that. She will not discuss things to the level of detail that is in the PowerPoint, but she will touch on each point because there's a lot to deal with market reform and what that means to the state. As Ms. Erickson stated, the National Association of Insurance Commissioners has a large role in the implementation and establishing regulations for the Affordable Care Act. Katie Campbell who is the DHSS health actuary is active in a number of those committees. On average she and Ms. Campbell participate in 5 teleconference meetings a week on these various provisions as well as attending meetings.

MS. HALL informed the committee that today she would address the major areas of consumer assistance grants; health insurance rate review, which is grant money she did not apply for; the high risk pool and what they did with that and why; the web portal, which is minor; health insurance market reforms, which she believes are much of the stimulus for all of this to prohibit the rescissions and exclusions that have been a problem in the health insurance world for a long time; and the health insurance exchange that isn't effective until 2014. Many of these reforms are being implemented gradually with the outcome to be the insurance exchange.

10:17:24 AM
She displayed a slide depicting a spreadsheet and explained that it has a column that shows what action the division is taking and the effective dates and a column for a group of things called market reform. She noted that annual lifetime limits are one of the market reforms and as of September 23 they will transition from lifetime limits on health insurance policies to annual limits. She pointed to the blue section, which reflects the transition, and remarked that some people but not many reach either the annual or their lifetime limit. Rescissions, which are part of the market reforms that are effective September 23,

can be made for only two reasons - fraud or intentional misrepresentation. A policy cannot be canceled because an individual got sick.

MS. HALL explained that when she talks about reviewing coverage forms for compliance those are coverage changes. The division approves and keeps on file all policy forms and today they receive 98 percent of their filings through the NAIC electronic system. This means that an insurance company can go on line, file a coverage forms and select the states they file it for. This makes the forms more consistent from state to state. She said they will see a number of those forms filed between now and September 23 and they will look similar to most other states. So in their form review the division will watch to make sure that provisions that are in health insurance policies today are changed to reflect these mandatory coverage changes.

10:20:15 AM
MS. HALL noted that she was specifically asked to address preventative coverage and said that one benefit to consumers is that there will be mandatory coverage for preventative services without cost sharing, but there will limits to the services that are considered preventative. Also, there will be an annual review of who recommended the preventative services be offered.

The extension of adult dependent care is part of the September 23 market reform that has received a lot of media coverage. It extends coverage to adult children up to age 26.

Preexisting condition exclusions will no longer be allowed in policies for children under age 19. In 2014 there will no longer be preexisting exclusions in any policy. The appeals process is part of the market reform. That means that if a claim is denied, the consumer policy holder has the ability to appeal that decision. These are usually disputes about whether it is or is not medically necessary. There are two types of appeals processes. An internal review is internal to the insurance company staff and an external review is one that must comply with the minimum NAIC model Act including review by an independent outside source with specialty qualification. While both types of review are in statute, the NAIC model has not been implemented because it requires the Division of Insurance to administer the program and they didn't want to insert themselves in that process. The external review is probably an area that will need legislative changes.

10:24:01 AM

Patient Protection is another part of the market reform. It allows the policyholder to designate the primary care provider, emergencies services do not need prior authorization, and it allows a female patient to receive obstetric or gynecological care from a participating provider without a referral. She described these as provisions that allow an individual to see his/her own doctor.

MS. HALL referenced three bullet points at the bottom of slide 2 and said this particular provision is how premium dollars will be allocated - how much is for clinical or provider services. There's a provision for activities that improve health care quality and there's a third expense category. The first two must be clinical services and activities that improve health care quality. In the small group and individual market, 80 percent of premium dollar has to be spent in this area and in the large group market it's 85 percent. There's a huge debate about what a provider is, what a clinical service is, and what an activity is that improves health care quality. The remaining 15 or 20 percent is the only part of the premium dollar that insurance companies will have for administration, commissions to agents, and the various expenses that they have.

These expenses are likely to exceed the allocation. Maine, for example, has already asked for a waiver because their current state law allows a 35 percent administrative margin. If an insurance company does not meet the 80 or 85 percent, they must rebate the excess to the policy holder. She noted that it may be necessary to make a statutory change in the definition of rebate because that term currently references an illegal activity. Ms. Hall emphasized that this is a real tightening on how insurance money can be spent and an attempt to ensure that it's spent on actual health care.

10:27:38 AM

Health Insurance Consumer Assistance Office or an Ombudsman is another grant opportunity. While $30 million is available for divisions and departments of insurance to set up and operate consumer assistance programs, the Alaska Division of Insurance is still evaluating if it wants to apply for funds because it already has a Section of Consumer Services that currently performs most of these tasks. She said she isn't sure that an additional person is needed to do these tasks, but they're evaluating other things they may be able to provide with the money. She explained that the problem with federal grants is that the money lasts for just a year, but a function and position were created and then it becomes a state funding

obligation. They're trying to figure out how to keep that money in ways that are effective without creating obligations going forward. Assisting consumers with enrollment and plans and resolving problems with obtaining subsidies really will not come into being until the exchanges are operational. Today the division occasionally assists a consumer with applications or where to go to apply for insurance, but they're not really involved with enrollment per se. So 2 of the 5 functions of this position wouldn't be applicable until 2014.

MS. HALL said the title of the next area is Ensuring Consumers Get Value for Their Dollar, but this was actually the rate review part of the Act and she recommended Alaska not apply for the grant. $250 million in grants is to be awarded over a 5-year period and that money could be used both to do a rate review program and to establish medical reimbursement data centers.

The first round of grants was $51 million so each state could apply for $1 million, but they had to apply for the full amount. Alaska is small and has 10 health insurance companies who write business in the state. There is no domestic health insurer in the state but they do review rates. The division reviewed what it might do with $1 million and could have put together a plan to enhance the data collection systems…

SENATOR DYSON interjected to ask if this money could be used to put the unfinished drug registry program in place.

10:32:34 AM
Ms. HALL replied that's not her understanding. There were very strict limitations on what the money could be used for; just $50,000 of the $1 million could be used for the data centers. It had to do with insurance rates.

SENATOR DYSON acknowledged that his question was misplaced. He then referenced an earlier subject related to preexisting conditions and asked if there's a provision that would allow some judgment or discrimination based on behavior-related conditions that are preexisting.

MS. HALL answered she isn't aware of any exceptions.

SENATOR DYSON asked if the new law provides incentives or help to manage situations where people with chronic and very expensive health problems won't cooperate with the best treatment.

MS. HALL replied she isn't aware of any penalty but there certainly is an awareness of preventative services and the management of chronic illnesses. She noted that the last estimate she saw indicated that chronic disease takes up 75 percent of all health care costs.

10:35:54 AM
SENATOR DYSON asked if the insurance companies are authorized to work on that issue.

MS. HALL replied she believes they are authorized and that can be included in the things they'll pay for under medical expense.

SENATOR DYSON posed a hypothetical example of a person with adult onset type II diabetes who isn't compliant in tending to his/her health care. He asked if the insurance company can do something to encourage that person to take care of him/herself, both for their own health and the sake of the costs involved.

MS. HALL replied she believes they can but they don't have to.

She again mentioned the $1 million rate review grant and clarified that the rationale for not applying didn't relate to the lawsuit; it was due to a philosophical stance she took.

10:39:11 AM
MS. HALL said the next topic is the Temporary High Risk Pools. She explained that this was optional for the state, through a nonprofit entity or the federal government and either 21 or 28 states opted to operate their own in various ways. Alaska has a high risk pool through the Alaska Comprehensive Health Insurance Association (ACHIA). To make it clear that it's totally separate she said they named it the Alaska Federally Qualified High Risk Pool. It's all federal money but there is a premium tax offset that's been in place for 3-4 years.

She explained that they did risk and benefit analyses to make the decision to make this recommendation and they looked at ACHIA that has a third party administrator and an established network and is familiar with the high risk individual in Alaska. The system is already established to deal with those individuals. The risks were that if the money ran out the state might be liable for that money. The original allocation of the $5 billion was done the same basic way the Children's Health Insurance Programs (CHIP) are done. Alaska's portion of that allocation was $13 million. The state doesn't get that as a pot of money to draw from; it's set up on a reimbursement basis.

There's a 10 percent limit of the cost of the program to do the administration so the actual contract was signed by the executive director of ACHIA. They are the nonprofit entity who can contract to operate this federally qualified high risk pool. It's temporary because of preexisting conditions. Once the exchange is in effect in 2014 that's the point at which all preexisting exclusions go away. Thus, individuals who are unable to obtain insurance today through the normal private market will be able to do so through the exchanges. At that point there will no longer be a need for a high risk pool - either this temporary one or ACHIA.

Current statutes allow ACHIA to go forward with this and barring some unforeseen circumstance the state would not have any obligation at the end. The application that the individuals sign clearly says that this is a federal program that's done with federal money and when the federal money runs out the program ends. To highlight the high cost of health care she warned that the $13 million will give coverage for only 100-105 individuals based on the experience in the current high risk pool about what it costs to provide medical care for individuals. Some states have lower costs; Illinois' projections, for example, indicate it would cost about $47,000 per individual as opposed to the $130,000 cost per individual in Alaska.

SENATOR PASKVAN asked why there's such a difference in cost between states.

10:46:44 AM

MS. HALL replied it reflects the cost to provide health care in Alaska. She doesn't want to speculate on why it costs so much more, but Alaska does have the highest health care costs in the nation.

SENATOR PASKVAN asked if it's related to hospital charges or doctor charges. He assumes it isn't prescription costs.

MS. HALL replied it's every element of the health care system including prescription costs.

SENATOR DYSON opined that Senator Paskvan has highlighted a key problem that this committee at some point ought to pursue. He mentioned contributing factors including physician's costs, transport costs, the requirement for hospitals to treat individuals regardless of their ability to pay, and the resulting cost shifting that hospitals do to help pay for those

unrecovered costs. He asked the chair to consider this for future committee work.

CHAIR DAVIS announced that Senator Thomas joined the meeting via teleconference.

SENATOR ELLIS asked if she wouldn't be better able to answer the questions about why health care costs in Alaska are so high if she had applied for the rate review grant and therefore had the money to study all the contributing elements. He said he understands the small market here and that carriers can write more business in a single Lower 48 city than the entire state of Alaska and he knows that she is obligated to maintain a healthy market and to keep the 10 carriers that routinely threaten to leave. Other states are trying to find out about all the elements that contribute to the cost of care in their states and he finds it striking that Alaska didn't apply for the grant that would help to answer those questions. He asked if she could offer a better explanation for not applying for the money because the committee is confronted with a lack of information and understanding of the true costs of care and coverage in the state and it's been very frustrating to the members of this committee on both sides of the aisle.

10:52:55 AM
MS. HALL explained that the Division of Insurance already does rate reviews looking at the elements and claim costs and they feel that they have existing rate standards and resources to do the kind of rate review that is required to look at those elements. She elaborated that the Division of Insurance currently collects an insurer's report of charges by CPT codes [current procedural terminology codes] so they already have that kind of information to use. When they do a review they look at claim costs and where the increases are. She noted that Senator Ellis mentioned transportation costs and those have dramatically increased.

The data collection is a different issue. She reiterated her understanding that a restriction on the $1 million for rate review was that only $50,000 could be spent on a data collection center. That's a very limited amount to truly have a data collection center. Yes they could have hired a consultant to do the work, but she doesn't believe it would cost the full $1 million. That was the problem because states weren't allowed to apply for less than the full amount. While they could have used some of the money she and others didn't feel they could use it all because of the federal sideboards restricting the use.

10:55:32 AM
SENATOR ELLIS encouraged her to consider asking the Legislature for the money that she thinks is needed to answer these recurring questions.

MS. HALL replied she would consider that. She added that she is also seriously considering asking the Legislature for greater statutory rate authority oversight. Part of the current limitation is that they have general rating standards and the ability to ask for actuarial justification in the event of a complaint, but she only has the ability to do prior rate approval for Premera. She doesn't have the authority to do prior rate approval for the other 9 companies that write health insurance in the state.

SENATOR ELLIS summarized that she can review the rates under current statutory authority but she doesn't have any kind of hammer to get the insurance companies to justify the rates they're charging.

MS. HALL said that as the result of a complaint she can ask for the actuarial justification, but she can't do that prior to the rate being used. She explained that Premera files a rate with the division with all the actuarial justification, but they can't use that rate until it's been approved and the division goes through a fairly lengthy and complex process before it gives approval. But she only has that ability with Premera; she does not have that ability with any of the other 9 insurers that write business in the state.

SENATOR ELLIS said he looks forward to the discussion and the proposal from the administration.

10:58:32 AM
SENATOR PASKVAN summarized that she believes that someone in her position would be appropriate to do some consumer protection for those rate applications

MS. HALL said absolutely.

SENATOR PASKVAN asked what percentage of Alaskans are uninsured and how that compares to other states.

MS. HALL replied about 18 percent of Alaskans are truly uninsured and that's not all that different from other states. Uninsured rates are higher in some southern states and others

are single digit. She acknowledged that she hasn't made comparisons in awhile and perhaps someone from HSS could provide a better answer.

Moving on to the Web Portal topic, Ms. Hall confirmed that while it was a federal requirement every state was required to provide information for it to start. We did, but it took significant Division of Insurance resources to try to interpret and implement those requirements.

She mentioned the topic Preservation of Right to Maintain Existing Coverage and explained that these are the grandfather provisions. Any coverage in place on March 23 2110 can stay in place unless they have changes, but the federal guidelines indicate that those changes don't necessarily have to be significant to lose grandfathering status. It can include things like a change in the contribution amounts.

11:02:55 AM
The topic Affordable Choices of Health Plans relates to the exchanges that will be effective January 1, 2014. States that are going to do an exchange must have the plan in process by January 1, 2013 so that the Department of Health and Human Services knows the state is actually going forward. This is an option and the division will go through an evaluation procedure to determine if they want to manage an exchange as a state or join with other states and have a regional exchange or let the federal government do the exchange. There's a grant opportunity for $1 million per state to fund a study of whether or not to do the exchange. The applications are due by September 10 and there are a number of workshops ongoing to provide information. Mr. Streur is attending a meeting today, division staff attended a 2-day meeting in Washington D.C. last week, and she is going to a 5-hour meeting in Seattle as part of the NAIC meeting next week. There's a lot of discussion nationwide about exchanges and the division is also getting solicitations from companies claiming to be exchange experts. That will be the next thing we're doing, she said.

SENATOR DYSON mentioned a conversation they had several years ago about giving people the option of purchasing health care insurance from purveyors that don't reside in the state. He asked if that relates to exchanges.

MS. HALL answered no; all policies can be sold through the exchange. Premera can sell through exchange or out of exchange as long as the plans are qualified. The idea is to bring in more

companies that want to sell through exchange but it can be the same companies that sell in the state today.

SENATOR DYSON clarified that his point was that it could also be companies that don't sell in the state today. He recalls that her reservation was that it doesn't allow her office to ensure quality control because services purchased from a provider that isn't here may or may not be very good. He asked if there is some criteria for joining the exchange and if she has confidence in that process.

MS. HALL replied there are criteria. The policies being sold are more standardized and have 4 levels of benefits: platinum, gold silver, and bronze. They have to be qualifying plans and the companies have to be licensed in Alaska to sell through the exchange.

SENATOR DYSON asked if they would be under her purview.

MS. HALL said that's correct. The state of domicile is still the primary regulator - and that's true today. Her concerns have been making sure that a particular company follows Alaska consumer protection laws. For example, Alaska has a fairly strong patient bill of rights that is absent in other states and she wants to be able to enforce that. She believes that standards can be built in under these exchanges to provide appropriate consumer protections.

CHAIR DAVIS asked her to speak to the issue of insuring and reinsuring early retirees age 50-64.

11:07:03 AM
MS. HALL said she believes that the Department of Administration will address that part.

CHAIR DAVIS asked if coverage for preexisting conditions in children is currently in effect.

MS. HALL replied it will be in effect September 23. She added that it's part of that group of market reforms that become effective on that date.

CHAIR DAVIS asked if she anticipates any problems in that area.

MS. HALL answered no.

CHAIR DAVIS asked about insurance companies dropping clients before a certain period of time or not picking them up if their policy expired.

MS. HALL said no; some states have reported insurance companies no longer writing in the individual market, but she hasn't seen that in Alaska and she isn't anticipating any problem.

CHAIR DAVIS asked if it related to the age extension.

MS. HALL said yes, but probably more with the preexisting condition. The age extension probably isn't an issue in Alaska because some of the companies already provide coverage until age 24 or 25.

CHAIR DAVIS asked if she's saying that when that goes into effect the state is ready to go and there's no need to wait until the next benefit year.

MS. HALL replied some of the things go into effect with the plan year so if somebody's plan year was August the ability to do it should have gone into effect then. They wouldn't need to wait until August 2011.

REPRESENTATIVE KELLER asked if these grants are specifically for DHSS or should the Legislature be looking at the grant for the Office of Health Insurance Consumer Information and Assistance of Ombudsman Office since there's already a unique ombudsman system within the Legislature.

MS. HALL said the grant proposal that's currently available isn't just for the Division of Insurance but that office has to do those fairly defined things. She added that since those services are for the most part provided already, she would not want to duplicate the services or have two different departments doing the same thing.

REPRESENTATIVE KELLER suggested she keep the thought in mind and he appreciates that she doesn't want to duplicate services or create something that would leave a hole once the money goes away.

11:11:05 AM
SENATOR THOMAS asked if there are any requirements or emphasis on managed care for the high risk pool. He opined that it would be helpful for people who have a variety of diseases and don't take care of themselves.

MS. HALL said no. There are provisions that allow payment in the medical services part of a premium, but there are no mandates requiring people to take good care of themselves.

CHAIR DAVIS added that the new federal Act has a preventative model and it has provision that might address some of those issues. Getting people into the system early helps to keep them from becoming chronic.

SENATOR THOMAS asked Ms. Hall if she has the staff to write the grant applications and implement the new programs.

MS. HALL said she and 2 staff have done most of the work. She explained that the Division of Insurance is a receipts-based agency so they have never been involved in grant writing. People in other departments who do have experience with grant writing have offered assistance and she believes they'll get there, but it is a stretch of their resources. They talked about hiring but finding someone with the depth of knowledge to be useful didn't seem practical. She restated her belief that they can do the job that's needed. Responding to a further question she said the short answer is that it will work.

11:15:45 AM
RACHEL PETRO, Deputy Commissioner, Department of Administration informed the committee that she and Mr. Shier will talk about the state as an employer with the nuances that the state is a self-ensured employer and it administers the Alaska Care Retiree Health Plan that covers public retirees statewide. In both instances the new law applies differently compared to Alaskans in general. She and Mr. Shier will walk through the provisions they are aware of and where things are today. They provided a FAQ handout on one of the most talked about provisions in the new law - the dependent care extension to age 26. That is posted on the website as well as information on a variety of provisions. As new information comes in it is posted so that active members and retirees have access to that information. It changes frequently.

11:19:41 AM
MS. PETRO continued to explain that people expected the new law to impact all plans the same way, but it does not. In June DOA received clarifying regulations indicating that the dependent care extension provision does not apply to the retiree plan. Because they get new information all the time, they are being

circumspect about what they communicate because they don't want to raise expectations that can't be met.

PATRICK SHIER, Director, Division of Retirement and Benefits, Department of Administration directed attention to the spreadsheet entitled PPACA PROVISIONS IMPACTING THE STATE OF ALASKA AS AN EMPLOYER and expressed his intent to walk through it top to bottom. He explained that the State of Alaska is an employer and it also administers the Public Employees Retirement System, the Teachers Retirement System, and the Judges Retirement System. He will proceed in that context.

One of the first issues is for break time and locations to be made available for nursing mothers. This is a mandatory issue and policies and procedures for that are in place. As an employer the State of Alaska already had such provisions in place, but not in writing so it wasn't difficult to put them in writing.

11:23:10 AM
Temporary reinsurance for early retirees is the next item. It was the desire of law makers to stop what they view as the decline in the number of retiree plans that were actually paying for health care people who retire before they're eligible for Medicare. One graph showed that it was high 20 percent headed to mid 20 percent. This program is temporary and $5 billion was set aside for it. Policy statements from the federal government indicate that there is no intent to extend it. As fiduciaries for PERS, TRS, and JRS DOA felt they should apply, because the state's plans do cover medical expenses for early retirees and the plan pays 100 percent of those costs. The application was submitted on July 3 and it will likely be months before they know if the application is approved. To date they don't have the format for submitting periodic applications they'll be required to make for actual reimbursement of funds. Those applications will be data that substantiates eligibility and asks for reimbursement for a percentage of the claims as they're eligible.

Elimination of annual and lifetime limits is marked as complete because the employee plan already did not have lifetime limits. There are a number of provisions in the new law where the state employee health plan already met or exceeded the requirement.

Extension of dependent coverage up to 26 is mandatory for the employee plan. The regulations stipulate that the first plan renewal after September 23 is the first time when plans must

implement the provision. It can be done earlier. They are on schedule to implement that change and there will be an open enrolment period to bring family members on who are eligible.

Prohibition of preexisting condition exclusion is a provision that must be implemented no later than the first plan renewal after September 23, 2010. They are on schedule to do that. There is a preexisting condition exclusion in the current active employee plan and the retiree plan, but they were not used.

11:27:32 AM
Class Act - long term care insurance program is optional. They have not examined that provision for implementation; a self-funded long term care program is already in place for retirees in PERS, TRS, and JRS. A number of retirees select that and pay monthly premium on an ongoing basis. About half of the retirees choose not to take that benefit. Given that, they did not look further at the option employer program. The long-term care insurance program is destined to be fully participant funded and not an employee benefit. The employer's role would be limited to payroll deduction service.

Reported value of health care benefits on W-2s is the next item. Commissioner Kreitzer directed the Division of Finance to start reporting the value of health care benefits on pay stubs. The process for capturing that value was already available and the Division of Finance has said that the subcontractor that provides the software to produce W-2s will be ready to implement this January 1.

11:30:02 AM
There are provisions affecting health savings accounts, flexible spending accounts, and health reimbursement arrangements. Under the active plan they will be ready to notify individuals effective January 1. Over the counter medications will no longer be eligible as qualified reimbursements for the flexible spending accounts. That's the device currently used for state employees to set aside money for health care benefits.

SENATOR DYSON asked what the limits are on what state employees can do with health savings accounts and how many are subject to the bargaining unit agreement.

MR. SHIER replied that since the state currently uses only flexible savings accounts that is the area on which they've focused their analysis. It reduces the amount of money that can be contributed to an FSA. He hasn't looked at the details for

health savings accounts or health reimbursement arrangements so he can't answer the question in the detail it needs. For example, the retiree health program in the new defined contribution retirement plans are health reimbursement arrangements and they want to make sure they fully understand that going forward as well. He offered to provide the information at a later time.

SENATOR DYSON asked if they'd be subject to bargaining unit agreements.

MR. SHIER said he can't speak to what savings arrangements they're operating individually. For the Alaska Care Plan, which are the exempts and the the supervisory unit, those provisions are tied up in collective bargaining and they would expect that to be a topic of discussion by the health benefits evaluation committee and in other venues.

SENATOR DYSON asked if the new federal Act supersedes bargaining unit agreements particularly those with their own health programs.

MS. PETRO said they have not analyzed the health trust and the applicability to PPACA to their trust. Under the new law Alaska Care employees with flexible spending accounts will only be able to put away $2500 per year instead of the current $5000 per year. While this doesn't impact the employer or the provider of the benefit, it will impact employees.

11:34:07 AM
SENATOR DYSON said he and the other members of the committee would enjoy being updated when the analysis is complete.

REPRESENTATIVE KELLER observed that the FSA program as a reform element and important cost control for health care in Alaska and asked if she can do anything to challenge this change.

MS. PETRO replied they're not focused on challenging the law; they're scrambling to make sure they're in compliance. It is an interesting question and they're limited in what they can do, but they'd be happy to have a conversation.

REPRESENTATIVE KELLER said legislators have to decide whether or not to continue with reform efforts or sit back and see what comes down the pike.

11:36:31 AM

MR. SHIER continued his presentation. The uniform notice of coverage and other things like the effective dates have not been fully analyzed by the division in terms of its duties as administrator of the Alaska Care Benefit package for active employees and retirees. He said he'd just name the rest and point out that they are future effective dates and will be analyzed to comply as needed. These include: increasing FICA taxes on earned income (employer has no role here); employee notices regarding an exchange; mental health and substance use disorder services included in essential benefits package (they don't have a clear view of what the group assigned to arrive at the essential benefits package will produce); reporting to the IRS of health insurance coverage (this is a future requirement); employer mandate to provide coverage and penalties for employers offering coverage that is not sufficient (they have identified some issues with meeting the requirements with temporary or seasonal employees); free choice vouchers (related to whether the state is contributing enough for individuals to secure health insurance at some minimum level); excise tax on high cost employer sponsored health coverage - Cadillac tax that has a 2018 effective date (this will affect some individuals in both the active and retiree health plan and the taxes will likely be borne by the State of Alaska in the Alaska Care active plan and the trust fund for the retiree plans which is a concern).

11:39:32 AM
The last item on the spreadsheet is the State of Alaska as employer - employee and retiree plans are assessed a tax of up to $2. (They haven't seen the regulations on that but they're estimating the impact will be about $160,000 per year.)

11:41:00 AM
JON SHERWOOD, Medical Assistance Administrator, Department of Health and Social Services directed attention to his handout that is entitled Summary of Medicaid Requirements Included in PPACA. He said he did not intend to describe each provision in depth. The federal health care legislation has and will continue to have a substantial impact on state Medicaid programs and Alaska is no exception. Many provisions in the law address Medicaid but not all will have a significant effect on Alaska. Other provisions like the Class Act and efforts to improve the community health system may have indirect impact.

Providing some framework, he explained that some of the provisions are about the federal health legislation attempt to push toward universal coverage and providing a role for Medicaid to fill in that push. The legislation was broader than that

attempting to improve the overall health care delivery system, promoting prevention, and program integrity. Many of the things he will describe cover a broad range of areas and will have something for Medicare, something for private insurance, and something for Medicaid. He emphasized that their analysis is ongoing and that new policy regulations arrive daily. While the effective dates are listed, not all are the practical effective dates. Sometimes they're the date that the federal authority can move forward to issue guidance. Our date will be when they give guidance on what to do and in some cases we will have wait for regulations or further clarification before we act, Mr. Sherwood said.

MR. SHERWOOD said the maintenance of effort provision prevents states from reducing Medicaid eligibility standards until the mandated health insurance provisions of the law become effective. It's a longer period for children.

The Medicaid budget at the state level will be less flexible moving forward in terms of choices to implement cost containment strategies. Eligibility has historically been one of the less used strategies, but it has been implemented in the past.

The universal coverage provision is the centerpiece for Medicaid in the law. Beginning in 2014 a new Medicaid category of eligibility is created for legal residents under age 65. The income standard is 133 percent of poverty with a mandatory 5 percent disregard so it's essentially 138 percent of poverty. For this group the state-specific income disregards would not apply. The most significant in Alaska is the permanent fund hold harmless disregard. The state Medicaid office has used provisions of federal law to exempt the permanent fund dividend in order to comply with state statute. This is an area that will need analysis to determine the real impact. If more people have to be moved into a hold-harmless program, it would come out of the dividend payment pool. Right now the impact is unclear, but this coverage group has no asset test and is unique in Medicaid. It represents a radical break from existing Medicaid eligibility because it's not categorical in nature. The other eligibility categories require the individual to be aged, blind, disabled, a child, pregnant, or a caretaker relative of a dependent child. Putting the pieces together - people over 65 are Medicare eligible and there are special low-income Medicare savings provisions in Medicaid that assist low-income Medicare recipients. There are existing Medicaid categories and this brings in the pool of able bodied childless adult who don't fit into the current medical assistance framework. This category

does require steps to ensure that an individual did not already fit into another Medicaid category.

11:49:45 AM
Virtually everybody in the Chronic & Acute Medical Assistance (CAMA) program would probably be covered by this group in Medicaid. This program provides drug assistance for people with certain chronic conditions who do not fall under Medicaid. Based on current data this will probably add about 30,000 people to the program. This will have a substantial impact on the program but it would be relatively straightforward and they'd do more of what they're currently doing.

Referencing the bottom of page 2 he pointed out that one provision of the new law requires the use of a new definition of income called modified adjust growth income (MAGI). This shifts income counting rules from longstanding principles developed specifically for low income entitlement programs to rules based on the federal tax code. This makes a lot of sense when you're trying to integrate a seamless transition from Medicaid to the health insurance exchanges. It provides a more commonly understood framework for doing eligibility determinations for the arcane rules of Medicaid, but it's a radical change for the way the state Medicaid office has to do business.

At the system level this means training staff and receiving guidance to answer literally hundreds of unanswered questions. For example, a lot of the tax policy isn't written to make a monthly income determination. It will be a big challenge to be on schedule to implement this in 2014. To date they don't have any needed guidance and it's unclear when it will be forthcoming.

11:52:30 AM
SENATOR DYSON asked what the following statement means: "States will be prohibited from applying any asset or resource test for purposes of determining eligibility."

MR. SHERWOOD replied it does not matter how much money or property you have. The state Medicaid office looks at your income as defined and it's usually money you're receiving in a particular time period. Now they do a monthly income determination looking at the money they expect an individual to receive in the future month.

SENATOR DYSON asked if a multimillionaire's other assets would disqualify him/her even if his/her definable income flow qualified him/her.

MR. SHERWOOD replied the simple answer is a tentative yes. The way income is actually defined may be more complicated than that, but he can conceive of situations where people could qualify.

REPRESENTATIVE KELLER asked for confirmation that 30,000 new people coming into the system is just a best guess.

MR. SHERWOOD agreed it is a best guess at this point in time, but they will be refining that estimate going forward based on a variety of circumstances. The number of people who will elect to use the exchange rather than Medicaid, for example.

REPRESENTATIVE KELLER observed that it's clear that the number is going up so some budget will go up.

11:55:38 AM
MR. SHERWOOD said he'll provide numbers at the end of the presentation. Continuing, he said he expects this change in the modified gross adjusted income calculation to be the biggest single change in Medicaid eligibility that he's seen in his 30-year career. It's not clear what kind of radical modification of the eligibility system might be required to seamlessly interface with the health insurance exchange.

Referencing the top of page 2 he said another mandated change is coverage of all kids ages 6-19 up to 133 percent of poverty. We've already made this change, he said, but a portion of that population is covered under the Medicaid CHIP expansion. Right now it looks like 3,700 kids will move from the CHIP Medicaid, for with the state receives a higher match, to the regular Medicaid. In addition, the kids who age out of foster care while on Medicaid continue to be eligible up to age 26. Mr. Sherwood described this as a parallel provision to the one that allows children to remain on their parents' health insurance until age 26. The summary indicates that the CHIP authorization is extended and some of the language anticipates further extension. He noted that there will also be enhanced funding for CHIP.

There are other changes to the eligibility process. Presumptive eligibility for hospitals would allow hospitals to make preliminary eligibility determinations. Presumptive eligibility is valid for a certain period of time until the state can make

its own determination. Administratively these are very cumbersome to manage because it entails taking eligibility from outside sources in order to enter it into your system to pay claims. Follow up is then required. The law mandates some spousal impoverishment protection that Alaska currently uses. They will continue to monitor this.

11:59:39 AM
The next provisions cover a range of health information that imposes standards or requirements on Medicaid including enrollment simplification, health information technology, and standards and protocol. They will try to keep up with these as the guidance comes out. This ends the CHIP enrollment performance bonus effective in 2013 and it's difficult to estimate the impact. The federal government still hasn't provided clarification about how they should account for spending the bonus money they already received.

The state's CMS agency is keeping up with all areas of guidance it needs for both the Medicaid program and the Medicare program. The bulk of the health care reform requirements fell under that agency's purview.

The descriptions of the mandated services are mostly minimal impacts on Alaska because they're already doing it or something similar. This includes things like tobacco cessation and payment for free-standing birthing centers.

12:02:53 PM
The provision on home and community-based services requires the federal government to issue regulations setting standards for long term care systems. Until they see those requirements it's hard to know the impact, but the federal government's track record in this area hasn't been great. The fear is that they'll be subject to micromanagement and a lack of flexibility.

Starting next July they have to figure out a way not to pay for health care acquired conditions. The statute appears to be a little broader than hospitals and they're still looking for clarifications to ensure that everybody is included that's appropriate. At the national level, the disproportionate share of hospital payments will be reduced and the assumption is that hospitals will serve fewer uninsured people. They don't anticipate that it will impact Alaska's current use of these federal funds because the state has never used its full allocation.

Page 6 lists a number of fraud, waste, and abuse provisions. Some have analyses pending under the description, but that doesn't mean they aren't thinking about and working on them.

SENATOR DYSON asked to be updated going forward and said he hopes to see Alaska's fraud investigation and screening enhanced.

12:06:07 PM
Referencing the bottom of page 6, Mr. Sherwood said some of these issues are significant. The Medicaid prescription drug rebate system has changed. Currently there are mandatory rebates that drug companies have to provide for the Medicaid program. And some states have negotiated additional rebates from drug companies for giving certain preferences in their coverage policy. Essentially, the federal government has increased the mandatory mandate and they keep the extra money from that. That will likely decrease the state's supplemental rebates because drug companies likely wouldn't want to pay much of a supplement if they were paying more in the mandatory rebate. On Thursday the federal government will hold a meeting addressing in greater detail how this will be implemented.

12:08:10 PM
MR. SHERWOOD said phasing out the donut hole in Medicare part D doesn't have a direct impact on Medicaid but it's an issue his office continues to monitor. When the State of Alaska implemented Medicare part D it was required to make claw-back payments to help offset the cost of Medicare part D for people who have dual eligibility. Prior to Medicare part D the state provided the drug coverage for "dual eligibles." Generally states feel that part of that was to pay for things that were uniquely provided to the dual eligibles and if the donut hole closes and becomes something that is available to all Medicare recipients then maybe Medicaid shouldn't have to pay so much. Part of what the state pays for in the claw-back payments is the fact that dual eligibles are not subject to the donut hole. They have special provisions including lower co-payments and they're not subject to the donut hole. If that becomes a broad-based benefit the question is if states should have to pay as much in their claw-back payments, but nothing in the law specifically addresses that.

The class act will be a voluntary, self-sustaining, long-term care insurance system. Medicaid is a major payer of long-term care insurance so that will have some potential effect. They will have to figure out how Medicaid will interact with class

act benefits. Also, Medicaid gets some new responsibilities in terms of oversight of the home and community-based service system. These are things that sound wise on paper but it's not clear what those responsibilities really mean or how much effort it will take to keep up with them.

Significant federal money will go into the expansion of community health centers. They play an important role in providing health care in many areas of Alaska so this could have direct impact, both increasing access and increasing the work load as CHSs typically bill Medicaid as one source of income. As access is expanded costs may go up in the Medicaid program.

Page 8 describes grants and options for Medicaid that are made available through the new law. They'll need to look at the funding opportunities, figure out what they mean, and determine how relevant they might be to Alaska. There's an option to provide family planning services to low income individuals under Medicaid as a stand-alone service group not the full range of services. A number of states do it through demonstration waivers but that's not necessary. It's generally seen as a health promotion, cost management proposal as Medicaid agencies typically cover low-income pregnancies and health care for low-income children.

12:13:56 PM
The early expansion option relates to the new big category of working adults, childless adults, low-income adults he mentioned earlier. States have the option to expand earlier. As previously mentioned the Medicaid program spends money through the CAMA program on a subset of folks who would be covered here. Another significant area where Medicaid spends money would be their grants for behavioral health services. Many behavioral health service recipients would fit into this group so there might be opportunities for refinancing here. The analysis for this has just begun.

It's taken a lot of work to identify and understand the mandatory changes and while they will continue to examine the opportunities presented by these options but it's a work in progress and there will be challenges. Adding staff still requires time to bring them up to speed with the programs. Another option they'll be looking at is providing health homes to enrollees for chronic conditions. They will be looking for guidance to see if this option fits. The opportunity for a demonstration project to allow payment to private institutions

for mental disease is likely not an option because Alaska doesn't have a qualifying institution.

12:17:08 PM
The preliminary budget impact of the expansion for adults to 133 percent of poverty - effectively 138 percent with the mandatory 5 percent disregard - shows a savings for being able to absorb CAMA into this group. It also shows a projected savings for the increase in federal funds for CHIP. It's a short-term increase over 4 years and it phases in and out over that period. The impact of the drug rebate will increase Medicaid's costs by $7.5 million. The net cost to the state is projected to vary through the 7-year period from about $65 million up to about $18 million by the end of the period. The fluctuation is based on the CHIP increase and also that there is no cost to the state the first 3 years because the federal government pays 100 percent of the cost of expansion. In 2017 Medicaid begins to pay a percentage and it's substantially higher than the regular federal medical assistance percentage (FMAP). Overall it will bring in substantial federal funds to the Medicaid program; by 2020 it will be over $190 million.

12:20:07 PM
REPRESENTATIVE KELLER asked if the changes in the expenditures include the administrative costs.

MR. SHERWOOD answered no; it's just the changes in the benefits.

SENATOR PASKVAN referenced the comment on page five that says Alaska does not have a reporting requirement for health care, acquired infections, or conditions. He asked if there is a recommendation that Alaska have a reporting requirement, if there is a model state to look to, and if that's a good step toward consumer protection.

MR. SHERWOOD offered to provide the information later. He added that in his tenure hospital reporting has been controversial because of the administrative burden to the facility versus the benefit to the state.

12:22:44 PM
CHAIR DAVIS recessed the meeting until 1:30 p.m.

DENALI KID CARE (SB 13)

1:37:34 PM

CHAIR DAVIS reconvened the meeting at 1:37 p.m. [The business before the committee was to hear a presentation on Denali Kid Care.]

1:38:17 PM
JON SHERWOOD, Medical Assistance Administrator, Department of Health and Social Services (DHSS) said that after the governor vetoed SB 13 a number of questions came up about other options under Medicaid or CHIP to expand coverage without raising the same abortion issues.

The answer is yes there are other options to expand coverage. Under CHIP an expansion would indirectly include pregnant women under the coverage of unborn children as well as expanding coverage of children of pregnant women under the Medicaid program. However, it doesn't obviously provide a different result with respect to abortion. He explained that under Medicaid and CHIP federal law, most abortion coverage is already excluded through the Hyde amendment that limits abortion to cases of rape, incest, or jeopardy of the life of the mother. But under Alaska case law, if the state provides medically necessary services to pregnant women it must include coverage of medically necessary abortions. Alaska courts have found that a lack of federal funding or a specific appropriation to pay for abortions is not a legitimate basis for the state not to pay for abortions. Essentially, if the state operates a Medicaid or a CHIP program that provides health care services to pregnant women, medically necessary abortions have to be included under that coverage. The difficulty is that there is no statutory definition for "medically necessary."

1:41:26 PM
MR. SHERWOOD said that any time you take a new approach to coverage, it opens the possibility to re-litigate the issues and you may come to a different conclusion. Also, there may be alternatives that aren't as obvious. He said he wants the committee to be aware that the governor instructed the Department of Law to analyze all possible options including looking at other states that have limited coverage of abortion services. This will take at least 3 months.

CHAIR DAVIS announced that Senator Dyson had rejoined the committee and a quorum was present.

REPRESENTATIVE CISSNA observed that she has seen the terminology "abortion" also used in cases of miscarriage and she wonders if that figures into what happened [with respect to the veto of SB

13.] Both are the end of a pregnancy but in one case it's beyond the woman's control. She asked if this is a possibility.

MR. SHERWOOD said he is not an expert on medical terminology, but when they talk about coverage for abortion, it is specifically about a procedure that is not a follow up to miscarriage or a naturally terminated pregnancy. His understanding is that those necessary procedures are coded differently than for those services that they pay for from state general funds under court order. He asked if he'd answered her question.

1:46:58 PM
REPRESENTATIVE CISSNA replied maybe we need a doctor for this.

MR. SHERWOOD said you might need a doctor to parse out the different procedures that are provided in different situations and for different causes. He offered to provide more clarity in a follow up.

CHAIR DAVIS asked if his statement that they code various procedures differently is accurate because her understanding is that abortions or other various procedures like giving pills to prevent a pregnancy are all coded together. She asked if that's true.

MR. SHERWOOD said the staff who oversee medical claims have said that the statistics they developed were coded using codes that applied only to Medicaid's coverage of therapeutic abortions - not to procedures that would be a follow up to a miscarriage. Because he isn't an expert on coding he said he wasn't comfortable elaborating.

CHAIR DAVIS said she would like it clarified in writing how many codes are used.

MR. SHERWOOD said he can provide a list of the codes that go in this category. He clarified that in addition to codes for different procedures, there are codes for health care services that support a therapeutic abortion that may get included when they set aside money around their expenditures on abortion.

1:50:48 PM
CHAIR DAVIS asked if he had ideas on how the committee might be able to look at what other states do in terms of abortion compared to the Denali Kid Care program to see if another system might help Alaska look at a new way for doing procedures.

MR. SHERWOOD said the governor has asked the Department of Law (DOL) to do that analysis. His understanding is that a lot of what works in a particular state depends on the provisions in the state constitution, which is why DOL has been charged with the task.

CHAIR DAVIS recognized that Senator Thomas and Representative Seaton were participating via teleconference.

SENATOR DYSON asked if there is a way to withhold benefits from someone who has behavioral problems and over a long period of time refuses to deal with that.

MR. SHERWOOD said his understanding is that the only way a covered service might be withhold from an individual is if they were found to be incompetent and that is outside the scope of the Medicaid program. In those cases a referral would be made to either Adult Protective Services or Child Protective Services.

SENATOR DYSON said he assumes that nothing in the new federal law adds incentives or penalties for that.

MR. SHERWOOD replied he isn't aware of anything in the Medicaid program, but there are incentives to encourage preventative care.

1:54:18 PM
SENATOR DYSON asked if anything in the new law enhances the ability to eliminate the misuse of pain medications.

MR. SHERWOOD replied he doesn't know of anything in regards to Medicaid. He offered to follow up to find out if he's overlooked anything.

SENATOR DYSON said his question was prompted by a pharmacist's comment about abuse of the system with respect to Oxycontin. He's also told that some professionals are notorious for writing promiscuous prescriptions for psychoactive pain medication.

MR. SHERWOOD said there are a number of controls over those medications in the Medicaid program including prior authorization and a point of sale system to identify attempts to fill a prescription multiple times. It's an area of concern and they are constantly on the lookout for ways to improve oversight, he said.

SENATOR DYSON asked if the point of sale system is in place and working.

MR. SHERWOOD replied it is in place for Medicaid transactions.

SENATOR DYSON asked about non Medicaid transactions.

MR. SHERWOOD said he can't speak to other payers, but the Board of Pharmacy has received a grant to develop a database for these kinds of drugs. He said he didn't know the progress.

1:57:41 PM
CHAIR DAVIS asked if he'd like to speak to not having a definition for "medically necessary" and if perhaps it should be in statute so everyone is on the same page when using the terminology.

MR. SHERWOOD responded that's part of the legal analysis that DOL is doing.

CHAIR DAVIS asked Ms. Kraly if she'd like to enhance anything Mr. Sherwood said.

STACIE KRALY, Chief Assistant Attorney General, Department of Law (DOL) explained that DOL has been instructed by the governor's office to do a comprehensive review of the options available under the Medicaid program related to the expansion of services as well as the coverage exclusions such as the use of state general fund money for abortion services. Part of that evaluation will be to look at each state program to see how each one deals with these issues but the analysis will rest on an evaluation of each state's constitution and how it relates to this state's constitution.

In addition, she said, DOL will conduct a comprehensive review of the definition of "medical necessity." Medicaid services and most other health care services are predicated on a determination that the service is medically necessary. Part of the analysis will be to look at the states that do and that don't have a definition and then they'll look at whether the definitions are global or limited to specific services such as reproductive services. They'll also evaluate how and if a definition would be medically appropriate in the state of Alaska in terms of the state consideration, case law, and other things. One consideration is that when a definition of medical necessity is created, it would apply to all services in the Medicaid program, not just reproductive services.

2:01:35 PM
MS. KRALY said DOL decided to wait until after this meeting to roll up their sleeves and get started in case there are further instructions, but they intend to report to the governor as quickly as possible.

SENATOR PASKVAN wondered if there's a definition for "medical necessity" in the medical profession as opposed to the legal profession.

MS. KRALY said the distinction will be a consideration. The problem she and others in her office have is that Medicare is administering a medically-based program but it's managed through statutes and regulations so a medical definition has to dovetail into a legal framework.

SENATOR PASKVAN said he'd like to know if the analysis distinguishes between a medical definition of medical necessity and legislative definitions of medical necessity on a nationwide basis. The American Medical Association, the American Pediatric Association and others may weigh in on the issue.

MS. KRALY said she made note of that.

SENATOR DYSON said a half dozen reports have been done about the things that are done for "medical necessity" and evidence indicates that it's been used by some as a real loophole. Whose definition of how big a loophole has driven folks like himself who have reservations about the promiscuous use of abortion to be concerned. There's a long history of people trying to wrestle through this issue on both levels, he said.

REPRESENTATIVE KELLER asked what is different this time about what the governor has instructed DOL to do versus what's been done before.

MS. KRALY said the difference is that the question has been raised in the context of the veto of SB 13 and the issue is a bit more comprehensive. If you define medical necessity you define it for all purposes as to the Medicaid program so DOL needs to evaluate whether it's possible to narrow the definition for different types of procedures. They will also look at how other states have dealt with the issue of public funding for abortion services in light of the Hyde Amendment and specific state constitutions. Part of that will be to evaluate how states have progressed subsequent to passing legislation.

2:08:14 PM
MS. KRALY said what they've been asked to do will take considerable time and resource allocation is an issue. She will be the primary attorney working on this and she'll balance it with the myriad of other time-sensitive health, safety, and welfare issues that take priority over a research project.

CHAIR DAVIS referenced the increase in CHIP funding and observed that it might be feasible to bring in all uninsured children with the new money from the federal government.

MR. SHERWOOD said the money he talked about this morning is a special time-limited enhanced match rate that would reduce the requirement to provide a state match. So a bargain may be had for awhile, but barring any change in federal law they'd go back to the regular match rate beginning in 2020.

2:12:31 PM
CHAIR DAVIS asked if he had ideas on how to change the program next year to keep the same thing from happening next year.

MR. SHERWOOD said he believes that the driving force behind the Department of Law review is to look at options that may satisfy the concerns of the governor and at the same time address the intent of SB 13, to expand coverage for pregnant women and children. It would be premature to comment on specifics.

CHAIR DAVIS asked if it would be premature for him to give an opinion about the ideas that Mr. Obermeyer presented to him about how some states are handling their programs.

MR. SHERWOOD said they did review that memo and he did outline a number of different options that are available under CHIP for expanding coverage for the pregnant women option or the unborn child option. Their preliminary analysis is that neither option gets around the issues raised by Alaska Supreme Court decisions. Neither would be a secure solution to avoid the issue of covering abortion.

2:16:02 PM
SENATOR PASKVAN asked what other areas of medicine she's looking into that the definition of medical necessity would apply to.

MS. KRALY explained that as they look at how other states define medically necessary services they'll analyze whether or not other states' definition is limited to reproductive services or

if it's more of a global definition. She continued to say that if they can agree on a definition of medical necessity, it will have to apply across the entire program so the question is whether or not it's over inclusive or under inclusive. She doesn't want to create unintended consequences for the Medicaid program going forward and lawsuits for the state. She asked if that answered his question.

2:19:06 PM
SENATOR PASKVAN replied it piggybacks on his earlier question about other organizations that may have defined medical necessity within a particular field. He said he's trying to determine how much latitude the definition gives the practitioner compared to the politician. It'll be a lot of work for you, he added.

MS. KRALY agreed it will be complicated.

CHAIR DAVIS noted that Mr. Sherwood said that the governor asked the Department of Law to begin working this about a month ago. She asked if that means they will be finished by November.

MR. SHERWOOD said he became aware of the request within the last month, but he would defer to Ms. Kraly as to when the analysis will be finished.

MS. KRALY said her office received the request from the governor within the last ten days and at that time she estimated it would take 3 months to do a comprehensive analysis and then it will be the governor's prerogative whether or not to release the information. While she can't promise that it will be finished by November, she does hope that her part will be completed.

2:21:53 PM
CHAIR DAVIS said she'd like the information before she presents a bill again next session so there wouldn't be any misunderstanding and it would have a better chance of being signed into law. But she understands that she's saying that it's privileged communication and that the governor may or may not release the information.

MS. KRALY said that's correct. They'll have to wait and see how that plays out, but she believes that the governor's office is eager to find a solution to this issue. That's why DOL was asked to look into this and hopefully come up with recommendations for statutory changes, new legislation, and/or a regulatory process to achieve a different result than what happened recently.

2:24:30 PM
MR. SHERWOOD clarified that DHSS did not attempt to deceive anyone or withhold information, but they did fail to ensure that the governor's office adequately understood the implications of the Supreme Court cases.

RANDI SWEET, United Way of Anchorage (UWA) stated that the United Way of Anchorage has and continues to support the increase of coverage for Denali Kid Care. Kids who don't get a healthy start have more difficulty succeeding in school and in the long run the community suffers. Families that are struggling to survive should not have to choose between housing or food or healthcare. Nor should they face bankruptcy because of medical bills. Increasing coverage is a relatively small investment for the state, but it will improve the lives of 1,300 children and 225 pregnant women. Increasing coverage is the right thing to do and a sound community investment. She concluded saying that United Way of Anchorage will continue to work with the governor and the Legislature to find a solution to increase the Denali Kid Care coverage.

2:29:25 PM
DAVID MASUO, representing himself, said he began working for the Division of Public Assistance in 1989 because he wanted to help people. In 1999 he was one of the first workers to be hired for Denali Kid Care. At that time the income guideline was based on 200 percent of the federal poverty level. For people that had insurance, it was 150 percent of the federal poverty level. He expressed his personal feeling that the percentage is unfair to children because all children should be covered.

In 1998 Governor Knowles saw the CHIP program in another state and directed DHSS to develop a similar program within 6 months. Mr. Sherwood was in charge of policy and had the responsibility of establishing the rules. Denali Kid Care was a fantastic program, he said. It allowed the state to pay less for health care if a child met the CHIP income level as opposed to the Medicaid income level, but Medicaid was the basic payer.

MR. MASUO related that U.S. Senator Frank Murkowski told him that Denali Kid Care was a wonderful program and he'd never touch it, but within 6 months of becoming governor he froze the program and dropped the income level from 200 percent of the federal poverty level, which hurt a lot of kids. When he was a state employee he couldn't say much but now that he's retired he can openly state that he's an advocate for Denali Kid Care.

He explained that Medicaid does not pay for abortions, but it does pay for all procedures up to the termination of pregnancy based on an abortion. It also pays for care for 2 months after the pregnancy ends. He said that while he doesn't like the idea of abortion, he doesn't believe that he or any other man has the right to tell a woman that she can't have one.

MR. MASUO said it hurt when SB 13 was vetoed and he told the governor that the information he received was wrong. Even when the procedure is medically necessary a physician has to jump through more hoops than you can imagine because Medicaid is reluctant to pay even in that circumstance. In fact, the state pays for the procedure, but not the pre care or the post care. In conclusion Mr. Masuo said he made a special trip to Anchorage today specifically to speak in support of Denali Kid Care.

2:44:25 PM
SENATOR DYSON asked how the Legislature should decide what the optimum income level is for a family to receive coverage under Denali Kid Care.

MR. MASUO replied he doesn't know what the limit should be, but his personal feeling is that every child should be given the option for Denali Kid Care because preventative care is much less costly than after the fact care.

SENATOR DYSON said this program is designed for kids whose parents can't afford minimum medical care, but there has to be a rational process to determine what the optimum income level should be.

MR. MASUO suggested matching whichever state has the highest level. For example, if Minnesota has 300 percent, Alaska should as well.

SENATOR DYSON commented that presupposes that Minnesota has a process that even you with all your experience can't figure out. He added that he rejects the premise that you can't stand up for a group unless you're a part of it because many of the advances in human rights around the world have been made by people who were loathe to fight for the rights of others who were different than they were.

2:51:27 PM

SENATOR PASKVAN asked him to estimate the number of Alaskan kids that would not get appropriate medical care if the qualifying level were 200-250 percent.

MR. MASUO replied he doesn't know the numbers, but when the level was 200 percent they got a good group of kids and at 250 percent they would have gotten an even larger group. He said he would like the notion of insurance to be removed because it's a hindrance to parents that have purchased it. He cited an example.

2:55:03 PM
CHAIR DAVIS described Denali Kid Care as a wonderful and proven program and said she would like to move forward from the 175 percent level. For 4 years she's introduced legislation to raise the income level to 200 percent of the poverty level percent and when it passed the income level was reduced to 175 percent and that's where it stands today. She said she plans to introduce the legislation again next year and hopes to work out the differences. At this point Alaska is near the bottom and is one of just three states that have a standard that is less than 200 percent. We need to do everything possible to provide insurance for those 30,000 uninsured Alaskan children who could qualify for this program, she said.

SENATOR PASKVAN asked if there is any way to analyze how many kids are not receiving appropriate medical care.

MR. SHERWOOD said the biggest stumbling block is getting information about people's income if their care isn't compensated.

2:59:10 PM
SENATOR PASKVAN said he's just trying to figure out how to analyze how many kids aren't getting care at a particular income level.

MR. SHERWOOD offered to do a demographic analysis to estimate the number of kids that will fall within the different income brackets.

CHAIR DAVIS thanked everyone who participated and said the committee will continue to work to find resolution to this problem. She added that it is indeed a problem when a state like this can't cover its uninsured children because the state is certainly capable of doing so.

3:02:22 PM

There being no further business to come before the committee, Chair Davis adjourned the Senate Health and Social Services Standing Committee hearing at 3:02 p.m.