

ALASKA STATE LEGISLATURE
HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE

March 20, 2012

3:03 p.m.

MEMBERS PRESENT

Representative Wes Keller, Chair
Representative Alan Dick, Vice Chair
Representative Bob Herron
Representative Paul Seaton
Representative Charisse Millett

MEMBERS ABSENT

Representative Beth Kerttula
Representative Bob Miller

OTHER LEGISLATORS PRESENT

Senator Cathy Giessel

COMMITTEE CALENDAR

PRESENTATION: THE FEDERAL HEALTH LAW AND ALASKA: WHAT YOU NEED TO KNOW.

- HEARD

OVERVIEW: HEALTH CARE

- HEARD

PREVIOUS COMMITTEE ACTION

No previous action to record

WITNESS REGISTER

CHRISTIE HERRERA, Director
Health and Human Services Task Force
American Legislative Exchange Council (ALEC)
Washington, DC

POSITION STATEMENT: Presented a PowerPoint titled, "The Federal Health Law and Alaska: What you need to know."

WILLIAM STREUR, Commissioner

Office of the Commissioner
Department of Health and Social Services (DHSS)
Juneau, Alaska

POSITION STATEMENT: Presented a PowerPoint titled "Health Care and Fiscal Sustainability" and answered questions.

BECKY HULTBERG, Commissioner
Office of the Commissioner
Department of Administration (DOA)
Juneau, Alaska

POSITION STATEMENT: Presented a PowerPoint titled "Health Care and Fiscal Sustainability" and answered questions.

ACTION NARRATIVE

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CHAIR WES KELLER called the House Health and Social Services Standing Committee meeting to order at 3:03 p.m. Representatives Keller, Seaton, and Dick were present at the call to order. Representatives Herron and Millett arrived as the meeting was in progress.

Presentation: The Federal Health Law and Alaska: What you need to know.

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CHAIR KELLER announced that the first order of business would be a presentation on "The Federal Health Law and Alaska: What you need to know." He offered his belief that the rising costs of health care were a "huge threat to us, and its spooky." He noted that although anyone could go to an emergency room, that cost was not sustainable. He reported that ALEC (American Legislative Exchange Council) wrote model legislation for health care.

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CHRISTIE HERRERA, Director, Health and Human Services Task Force, American Legislative Exchange Council (ALEC), said that she was going to explain how the PPACA (Patient Protection and Affordable Care Act) would affect Alaska. She displayed slide 2, "An Overview," explaining that she would address the individual and employer mandates, the expansion of Medicaid, and the health insurance exchanges. Moving on to slide 3, "PPACA's

Individual Mandate," she defined the individual mandate as a federal requirement that you purchase health insurance, and stated that individuals who did not comply would be fined the greater of \$95 or 1 percent of their annual income, increasing to 2.5 percent of income in 2016. She reported that individuals with insurance which did not meet "minimum essential coverage" criteria would also be subject to fines. She opined that the penalties were not strict enough and, as the supply of health insurance had not increased enough to meet the demand, there had not been resolution to the "free rider" problem. She reported that emergency room usage in Massachusetts increased by 17 percent after its health insurance mandate went into effect. She pointed out that the U.S. Supreme Court would hear six hours of oral argument on this federal health care law. She shared that 14 states had passed the "Health Care Freedom Act" which prohibited an individual mandate, and she noted that 67 percent of Americans disapproved of the individual mandate.

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CHAIR KELLER, offering his belief that the individual mandate was "the heart of ObamaCare," declared that there was no incentive to pre-purchase insurance with an individual mandate, as insurance could be purchased at any time and had to cover every pre-existing condition for an individual.

MS. HERRERA suggested that individuals with pre-existing conditions could be taken care of through measures other than the individual mandate, including purchase of insurance through state high risk pools, extra subsidies to purchase health insurance, and buying into a state Medicaid program. She moved on to slide 4, "PPACA's Employer Mandate," which stated that any business with more than 50 employees had to provide government defined benefits, or pay a fine. She declared that states would also be subject to this employer mandate.

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MS. HERRERA, moving on to what she declared to be the second leg of the PPACA stool, slide 5, "PPACA = Skyrocketing Medicaid Enrollment," said that states would be required to extend Medicaid to anyone earning up to 133 percent of the federal poverty level, the equivalent of an income of \$30,000 for a family of four. She directed attention to the map on slide 5, and said that 15 states would have increases to the Medicaid roles by 30 percent, while 9 states would experience increases of 40 percent.

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REPRESENTATIVE SEATON posed that, as the State of Alaska was currently extending Medicaid coverage for 150 percent of the federal poverty level, what would be the affect for the aforementioned coverage of 133 percent.

MS. HERRERA, in response, said that it would be necessary for Alaska to apply for a federal waiver for matching funds to any funding over the 133 percent coverage.

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MS. HERRERA moved on to slide 6, "Tightening Budgets," a map of the United States which showed the state by state percentages of state budgets spent on Medicaid in FY 2010. She reported that, although the average state spending on Medicaid was 17 percent, Alaska only spent 6 percent of its budget on Medicaid, the fourth lowest Medicaid budget in the U.S. She offered her belief that PPACA would increase the Medicaid budget, which could result in budget cuts to other programs.

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MS. HERRERA reviewed slide 7, "The Problem with Federal Funding," and acknowledged that federal funding would pay 100 percent of the Medicaid expansion costs until FY 2020, with 90 percent funding after that. She said that although this would be paid through taxes, it would not cover everyone. She reported that, nationally, 25 percent of the uninsured were eligible for Medicaid but had not yet enrolled; however, if they did apply, there would not be additional federal funding. She guesstimated that this could cost about \$70 million in Medicaid expansion costs through 2020.

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MS. HERRERA, directing attention to slide 8, "PPACA = More Crowded ERs," shared that many people had suggested a need for the individual mandate in PPACA in order to relieve the congestion in emergency rooms. She offered her belief that Medicaid recipients were most often the users of emergency rooms for non-emergency care, which she attributed to the scarcity of physicians for Medicaid patients due to the low reimbursement rates to doctors from Medicaid. She directed attention to a study about the frequent users of emergency rooms, more than

four visits annually for non-emergency care, and reported that 67 percent of those patients were Medicaid or Medicare recipients. She reflected on the difficulties of finding a physician, even with Medicaid coverage.

MS. HERRERA spoke about slide 9, "PPACA = Poor Health Outcomes," which listed various studies for the lower quality of care and the difficulties for access of care for Medicaid patients.

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MS. HERRERA identified slide 10, "Exchanges: In Theory," and defined a health care exchange as a neutral health insurance market place for the buyer to use the pre-tax, defined contributions from an employer toward the purchase of a personal health insurance policy. This would allow the patient to maintain policy coverage with the same health insurance carrier, regardless of job situation.

MS. HERRERA reviewed slide 11, "Exchanges: In Practice," and noted that there were private health insurance exchanges, including e-health insurance.com, which gave the buyer a list of health care options available. She summarized that the PPACA health insurance exchange would subsidize the individual mandate for the purchase of health insurance and would impose price controls and standardize benefits. She offered her belief that this could restrict choices for coverage and could limit innovation by health insurers. She declared the Massachusetts's Health Connector to be a model for the PPACA model. This plan determined that only plans of "high quality" and "good value" could be sold. She shared that the annual operating cost for the Massachusetts exchange was more than \$40 million, but that since its inception in 2006, the annual premiums for a family had only increased by \$2500. She presented that the Utah Health Exchange model had also provided a list of health care options, and that it had provided coverage for 5,500 people.

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MS. HERRERA, providing slide 12, "Federal Exchange = State Exchange," shared that many states looked to implement state health insurance exchanges in lieu of a federal solution. She offered her belief that many factors pointed to the formation of a federal health insurance exchange which would be operated, administered, and paid by the states. She noted that a state health insurance exchange had to be approved by the Department of Health and Human Services using federal rules and standards.

She confirmed that federal subsidies would be proffered to the state exchanges.

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MS. HERRERA indicated slide 13, "How PPACA Controls State Exchanges," which listed the federal regulations on the state exchanges, including the benefits, the plans offered, and the preferred providers. She explained slide 14, "The Threat of a Federal Exchange?" She opined that, although there was not any current funding for federal exchanges, Congress had previously funded the exchanges. She noted that PPACA did not mention the offer of any subsidies to a federal exchange.

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CHAIR KELLER asked if states were creating health insurance exchanges.

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MS. HERRERA said that 15 states had enacted legislation for the health insurance exchanges, and she opined that the Department of Health and Human Services (DHHS) had changed the time table for compliance.

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MS. HERRERA assessed slide 15, "The Threat of a Federal Exchange?" She referred to a recent report from DHHS that \$1 billion had been granted to states for health insurance exchanges, with an additional \$150 million for a federal exchange for coordination of benefits, eligibility, subsidies, and premiums. She reflected that even more funding could be necessary.

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MS. HERRERA introduced slide 16, "State Exchanges Can Strengthen PPACA," and reported that the federal court judge in Florida had refused to stop implementation of PPACA because eight of the plaintiff states would continue to implement it regardless of the ruling. She explained that the federal government had argued that the exchanges were critical as they would be used to determine support for the individual mandate in PPACA.

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MS. HERRERA, referring to the aforementioned \$1 billion federal grant to states, explained that this funding would expire in 2015. She offered examples of ways states could increase revenue for funding, including user fees, provider taxes, sin taxes, naming rights, and reallocation of other funding, slide 17, "State Exchanges Can Be Costly."

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MS. HERRERA presented slide 18, "Other Considerations," and spoke about other initial concerns for the health exchanges, which included early adopter risks, technological snafus, high costs, and other unanswered questions.

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MS. HERRERA analyzed the U.S. map on slide 19, "Exchange Implementation in the States," which depicted that 17 states had enacted legislation for an exchange, 11 had established Exchange planning, and 10 had not taken any action to this point.

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MS. HERRERA relayed that slide 20, "Exchange Grants in the States," depicted the use of exchange grants throughout the states. She pointed out that every state, except Alaska, had accepted the \$1 million planning grant. She shared that 26 states had already accepted money to establish an exchange, with 4 states refusing the exchange grants.

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MS. HERRERA introduced slide 21, "Action Stalled in 2/3 of Exchange States," and assessed the progress of the health exchanges in 15 states: West Virginia, Rhode Island, and three others were "pretty far along;" California had signed its exchange into law; Colorado, Illinois, Indiana, North Carolina, and Virginia had either enacted the exchange or its intent.

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MS. HERRERA moved on to slide 22, "More States are Reconsidering." Referring to the aforementioned 11 states that had established Exchange planning, she reported that Alabama, Mississippi, and Arkansas had determined to start an Exchange,

while North Dakota had passed legislation for an exchange but then voted against its establishment.

Overview: Health Care

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CHAIR KELLER announced that the final order of business would be an overview of health care.

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WILLIAM STREUR, Commissioner, Office of the Commissioner, Department of Health and Social Services (DHSS), presenting a PowerPoint titled "Health Care and Fiscal Sustainability," said that the health care issues in the State of Alaska were not strictly related to Medicaid, or state employees, but to everyone. He referred to slide 2, "By 2037, health insurance will swallow your entire paycheck," and noted that, by 2037, at the current rate of inflation, the cost of health care would swallow the entire household paycheck.

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BECKY HULTBERG, Commissioner, Office of the Commissioner, Department of Administration, directing attention to the PowerPoint titled "Health Care and Fiscal Sustainability," announced slide 3, "Why are we here?" and explained that this was "a bigger picture of health care than if you would just look at Medicaid or one of our plans, or even two of our plans." She reported that Alaska spent money on health care plans for active employees, retirees, Medicaid, inmates, state employees who were members of union health trusts, and state workers' compensation claims.

COMMISSIONER HULTBERG offered slide 4, "State Budget: 2001 - 2010," as a context for the remainder of the presentation. She noted that state spending for capital and operating budgets had doubled in that time, an annual rate of growth of 7.5 percent, which included an annual CPI (Consumer Price Index) rate of 2.6 percent. She declared that there were growing wants and needs for state general fund dollars.

COMMISSIONER HULTBERG directed attention to slide 5, "State Revenue," which stated that oil revenue had subsidized Alaska, slide 6, "State oil production: 2001 - 2010," which graphed the annual 5 percent decline of oil production in Alaska, and slide

7, "State Health Care Spend: 2001 - 2011," which showed that health care spending had doubled in the last decade, an annual increase of 8 percent, whereas annual inflation was only 2.6 percent.

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COMMISSIONER HULTBERG summarized slide 8, "State health care spend," which plotted the amounts spent for health care to the aforementioned plans, and estimated that 25 percent of the \$2 billion health care dollars were paid by the State of Alaska.

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COMMISSIONER HULTBERG indicated slide 9, "Where does our current path lead?" She declared that, should the increase in health care cost continue at a 9 percent rate, it would double to \$4 billion by 2020. She pointed out that this did not include an anticipated increase in Medicaid or a boom in the state retiree plan population.

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COMMISSIONER STREUR clarified that slide 10, "Challenge: Medicaid" did not reflect any increase to Medicaid cost under PPAPC. He stated that the projected cost increase was founded on the current growth history while implementing some recent program changes. He declared "we are trying to bend that curve."

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COMMISSIONER STREUR, furnishing slide 11, "AK DHSS 10- year plan operating budget," projected the FY2013 Department of Health and Social Services (DHSS) budget to be \$2.6 billion, the largest department budget in the state. He projected that, in FY2022, the DHSS budget would be \$6.6 billion. He said that although the cost of PPACA to Alaska was unknown, there was a projection for 35,000 new enrollees in the state, at a cost of between \$6600 and \$17,000 per recipient. He shared that the non-service related costs for increasing the Medicaid enrollees was also unknown. He observed that the population of Alaska was aging, and that public assistance could be increasing.

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COMMISSIONER STREUR reviewed slide 12, "Medicaid direct services Beneficiaries and expenditures," and noted that there was a continual increase to the number of enrollees, and the subsequent cost, for Medicaid. He reported that there was more access and utilization of health care.

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COMMISSIONER HULTBERG called attention to slide 13, "Challenge: PERS/TRS," which charted the projected growth for the retirement system. She declared this to be the largest plan managed by the Department of Administration (DOA). She noted that, as the retirement system was growing, it was a difficult plan to manage; as most health plans were dynamic in response to a changing market, the Alaska retirement plan was safeguarded by the diminishment clause in the Alaska State Constitution, and consequently, changes were rare and often contested in court.

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COMMISSIONER HULTBERG selected slide 14, "Retiree medical expense growth," which depicted two areas, other than population growth, that influenced medical expense growth. She noted that the medical cost per member had increased 5.4 percent in the prior year. She expressed concern that there had been a 4.3 percent decrease in utilization of services, but an increase of 10 percent in provider costs. She stated that utilization would not decrease indefinitely; therefore, it was imperative that provider costs not increase at this same rate.

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COMMISSIONER STREUR considered slide 15, "Controlled growth in Medicaid," and indicated that the options were limited to control Medicaid growth. He noted that the state was restricted in making any changes to eligibility for Medicaid. He reported that utilization controls, such as pharmacy and chronic care management, could be focused upon for controlling costs, whereas the federal government was focused on compliance/ anti-fraud. He declared that the opportunity for innovations in service delivery, including chronic care management, adequate pricing, generic medications, bundling of services, and patient centered medical home, could change health care delivery in Alaska. He offered his belief that new technology in and between hospitals, and between states, was still not fully operational for optimum service.

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CHAIR KELLER asked if there was any good news.

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COMMISSIONER STREUR replied that, as the status quo was not acceptable, hard choices were necessary for smarter ways to deliver health care.

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REPRESENTATIVE MILLETT asked for specific examples of choices for smarter health care delivery.

COMMISSIONER STREUR asked that he respond to this later in the presentation.

COMMISSIONER STREUR, directing attention back to slide 15, declared that it was necessary to maximize revenue, and he intoned, "right care, right time, right place, right amount of money." He advised that DHSS had a lot of room for improvement in health care delivery.

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COMMISSIONER STREUR moved on to slide 16, "State policy actions implemented in FY 2011 and adopted for FY 2012." He said that states were taking different measures to better provide health care, including adjustment of provider payments, increased primary care focus "at the front door, where they should have been all the time," increased eligibility, reviews of benefits, and initiatives to provide long term care in a more strategic manner.

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COMMISSIONER STREUR, reflecting on slide 17, "Medicaid Services," said that it was tough to determine whether services would be mandatory or optional. Addressing optional services, he declared that the reduction or elimination of transportation services would affect the 60 percent of the state population which was off the road system. He noted that inpatient psychiatry for patients under 21 years of age was very important. He stated that health care in Alaska was a good package, but not a super generous package.

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COMMISSIONER HULTBERG presented slide 18, "Controlled growth in AlaskaCare" and explained the costs associated with each plan. She indicated the AlaskaCare retiree plan, and said that any plan changes to retirees had to be a net benefit to the retirees, or be offset by enhancements. She stated that this had to be managed the same as any other health plan, taking into consideration the many changing variables in health care. She opined that preventive care should be covered in this plan, but that it was not.

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COMMISSIONER HULTBERG, in response to Representative Seaton, said that comprehensive changes could be made to the whole plan, or the state could either offer a side by side plan for selection of various coverages, or a package of benefits to purchase. She opined that, although most retirees would not select a package to purchase, the state was going to explore all three options with the goal to provide a health plan with the best quality care foremost. She questioned whether the current plan promoted wellness and health. She declared a need to manage the plan in a sustainable way because of the significant impacts to the state's long term fiscal situation.

REPRESENTATIVE SEATON asked if a package of health care options was available on a pilot plan basis, in order to review its efficacy, yet not require a full plan amendment.

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COMMISSIONER HULTBERG replied that the concept had been discussed, but that DOA had not yet spoken with the Department of Law.

REPRESENTATIVE SEATON expressed his concern for the necessity of to have a program in place for a while, before you could determine its effectiveness.

COMMISSIONER HULTBERG stated her agreement with this option. She opined that the likelihood of an optional package for purchase would be selected by those already taking pro-active measures for health. She expressed the need to enlist retirees who were not actively managing their own health. She declared that the challenge was not only to make the plan available, but

to ensure that there was an incentive for those who did not seek preventive care to now do it.

REPRESENTATIVE SEATON suggested that "a real good deal" could sometimes motivate more effectively than a mandated plan change.

COMMISSIONER HULTBERG reported that some plans, in jurisdictions other than Alaska, actually paid their members to participate in primary care.

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CHAIR KELLER declared that it was necessary to come up with ideas.

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COMMISSIONER HULTBERG, returning attention to slide 18, discussed the AlaskaCare active plan, which covered about 6200 state employees, and stated that, other than eligibility, the DOA had many options to make adjustments to the plan for any changes in cost or quality. She moved on to Union Trusts, and stated that the majority of State of Alaska employees were in this category. She reported that this payment was negotiated, based on the premium cost for AlaskaCare members. She stated that the State of Alaska did not provide the coverage for Union Trusts, and that limited the controls placed on the plan. She discussed Political subdivisions, which were PERS/TRS retirees inherited into the retiree plan. She declared this to be significant, as encouragement for wellness and healthy behaviors while active employees resulted in healthier retirees; however, as the State of Alaska did not manage the health care plans for political subdivisions, there was no control of the wellness plans, yet the state had to then inherit this group as retirees.

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COMMISSIONER HULTBERG, in response to Representative Seaton, explained that the asterisks on slide 18 denoted areas which allowed controls of the variable, though "not necessarily straightforward." She noted that the diminishment clause for the AlaskaCare retiree plan and the premiums for the Union Trusts both allowed limited controls.

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COMMISSIONER STREUR called attention to slide 19, "Payment comparisons," comparing the costs of Medicaid and Medicare in Alaska to other plans throughout the Pacific Northwest, including Washington, North Dakota, and Idaho. Noting that the cost of Alaska Commercial Mean payments for high level, complex office visits was far more than the cost in other states, he clarified that it was difficult to pinpoint because the various insurance payment systems often bundled rates. He reported that the Medicaid population could be more difficult to manage, because of missed appointments, non-compliance with doctor orders, and other concerns; hence, Alaska Medicaid maintained "ready and open access to care." He pointed out that Alaska payment for obstetrical care was good.

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COMMISSIONER HULTBERG moved on to slide 20, "Payment comparisons: by procedure," which compared costs of physician fees between the Seattle area and the Anchorage area. Although these procedures had significant cost differentials, she reported that there were other procedures with even greater discrepancies. She stated this to be a core area of cost drivers which needed to be addressed. Even though Alaska was deemed to be more expensive, this cost variance for compensation was problematic.

CHAIR KELLER suggested the necessity for patient incentives, and "empowering the market forces to be able again to have an effect."

COMMISSIONER HULTBERG considered slide 21, "The hidden cost of health care," and stated that, as health care costs grew at a greater rate than other services, it was crowding out other state investments, such as roads, public safety, and schools. She declared the necessity of maintaining a healthy balance among the state's obligations.

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COMMISSIONER STREUR directed attention to slide 23, "Innovations in service delivery/payment," stating that, although he would speak about Medicaid, much of it also applied to commercial health care. He opined that patient centered medical home was bringing patient care management back into the primary care arena, which he called "effective steering for right care, right time, right place." He applauded the DHSS relationship with its tribal health partners, declaring them to be innovative leaders.

He declared that the Alaska Medicaid program benefited from this relationship, as every tribal member who received care in a tribal facility was reimbursed at 100 percent from the federal government, saving Alaska's general fund dollars. He emphasized the difficulty for care in rural areas, and he lauded the tribal health program for filling in this void. He offered his belief that Medicaid services also needed to be bundled, as this most often resulted in lower rates. He declared that better integration of behavioral health and primary care services was a necessity for better treatment. He spoke about pay for performance and centers of excellence, the need to review what worked and then only pay for that. He explained that more observation during utilization reviews would control which provided services were offered. He stated "the closer to home we are, the better we are" and he touted the benefits of community based long term care. He affirmed the need for better management of chronic care and disease states to ensure effective programs that guaranteed the proper care, in order to decrease the number of emergency room visits. He established the necessity for maximizing the Medicare reimbursement by better managing those who were dual eligible.

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COMMISSIONER HULTBERG, addressing slide 24, "Innovations in service delivery /payment," stated that AlaskaCare was seeking low cost alternatives and, as the State of Alaska paid about 25 percent of the total health care expenditures in the state, better leverage with collective purchasing power. She shared considerations for the option of expanded travel benefits, as well as the creation of Centers of Excellence for bundled health care services. She reported that an employee wellness program was being developed. She indicated that DOA would continue to aggressively pursue contractual discounts, following its success with this in FY2011. She endorsed to align contracting strategies around innovative care for delivery models. She expressed her goal of the provider community bringing forward lower cost innovative ideas for care improvement. She declared that the State of Alaska was working to develop a comprehensive health management strategy that optimally managed health for quality and cost.

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COMMISSIONER HULTBERG summarized slide 25, "The State's approach," stating that the challenge was to lower the rate of growth for health care spending to a sustainable level, which,

she surmised, was at, or slightly above, the rate of inflation. She stated a desire to work cooperatively with the providers, the stakeholders, and the legislature for creative solutions to high-quality, cost-effective health care delivery in Alaska.

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REPRESENTATIVE MILLETT asked when preventative health care plans for retirees would be implemented.

COMMISSIONER HULTBERG, in response, relayed that this would possibly be addressed later in the year.

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REPRESENTATIVE SEATON asked whether the lack of occupational licensing for paraprofessionals prevented programs from being implemented.

COMMISSIONER STREUR expressed agreement, offering the tribal partnership as a good example. He noted that a community health aide was the entry contact who meted out and scheduled service to the necessary level of care. He declared that too much insistence was placed on seeing a physician, when other professionals were sufficient in the majority of cases. He allowed that the health industry was seriously reviewing the roles of these adjunct staff.

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REPRESENTATIVE SEATON emphasized that the health industry had never suggested a lower level of health care contact, illustrated by the failure of various naturopath bills introduced in the Alaska State Legislature. He opined that it would be necessary for DHSS to implement this change.

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COMMISSIONER STREUR replied that there was not any choice but to partner with the providers for a more efficient, more effective way to provide health care. He shared that a long list of providers had requested discussion about this topic.

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REPRESENTATIVE MILLETT shared that it would take re-education of patients to break with medical inclinations, as well. She

lauded the tribal health care program for its education of patients to a better understanding of the necessary care level.

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COMMISSIONER STREUR expressed his agreement with the need for the state to provide better patient education to understand the various levels of health care delivery. He praised the Canadian health care system for its scheduling to health care need, noting that the Canadians had a better mortality rate than the U.S.

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CHAIR KELLER suggested a need for the elimination of the confusion for the budget review process. He expressed concern "that we can't pay for the sickest and the neediest because of the utter turmoil, because everything had been turned on its head." He declared that it was difficult for the legislature to recognize the needs and where the money was going, and then look for the "places where we can make a difference." He suggested a presentation to the providers sharing that DHSS and the legislature were working together to better understand the budget and review process.

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COMMISSIONER HULTBERG said that the legislature had more visibility regarding Medicaid than the other areas in the budget. She reported that DOA did not have a health care line item in the budget because health care costs were built into personnel costs; consequently, there was not specific visibility around employee and retiree health care cost. She pointed to the magnitude of overall spending as a more comprehensive picture of the health care demands on the state. She agreed that Medicaid was "the lion's share," and would most likely become a greater percentage of health care spending. She offered her belief that it was necessary to review all the areas of health care spending, even though these areas were not as visible as Medicaid. She offered for DOA to give health care presentations about costs and cost management.

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MS. HERRERA, in response to Chair Keller, declared her agreement with all the solutions offered by DOA and DHSS, although she was ambivalent regarding pay for performance for Medicaid doctors.

She reported that nationally almost 50 percent of doctors did not accept new Medicaid patients. Directing attention to the testimony that doctors did not quickly accept new health technology, she opined that the addition of pay for performance might further limit access to care. She expressed agreement with the suggestions for utilization review for radiology and prescription drugs. She noted that it was necessary to balance access for care with cost; that home and community based care would trigger a federal match; that managed care had to be done "the right way", opining that fee for service contracts with one company were not the solution; and that occupational licensing would ensure that patients could connect with providers of necessary services, even those not accepted by the "medical cartels." She reported on an agreement for occupational license reciprocity, when charity care was also offered, between Tennessee and Illinois.

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REPRESENTATIVE SEATON, referencing an article regarding salaried positions, declared a need for adequate salary and motivation. He suggested pilot programs for salaried medical personnel in order to allow them to focus solely on medicine. Directing attention to an earlier reference by Ms. Herrera about an increase in medical premiums of \$2500 in Massachusetts from 2006 - 2011, he declared that his health care premium for private insurance, notwithstanding an increase to his deductible amounts, had risen that much in one year, much less than the referenced Massachusetts increase for five years. He offered his belief that the health exchange could dramatically slow the increase of insurance premiums.

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ADJOURNMENT

There being no further business before the committee, the House Health and Social Services Standing Committee meeting was adjourned at 4:52 p.m.