ALASKA STATE LEGISLATURE
ADMINISTRATIVE REGULATION REVIEW COMMITTEE
Anchorage, Alaska
June 25, 2013
10:04 a.m.

MEMBERS PRESENT

Representative Lora Reinbold, Chair
Senator Cathy Giessel, Vice Chair
Representative Geran Tarr
Senator Hollis French

MEMBERS ABSENT

Representative Mike Hawker
Senator Gary Stevens

OTHER LEGISLATORS PRESENT

Representative Shelley Hughes (via teleconference)

COMMITTEE CALENDAR

IMPACTS OF THE AFFORDABLE CARE ACT ON ALASKA

- HEARD

PREVIOUS COMMITTEE ACTION

No previous action to record

WITNESS REGISTER

DEBORAH ERICKSON, Executive Director
Alaska Health Care Commission
Department of Health and Social Services (DHSS)
Anchorage, Alaska
POSITION STATEMENT: Presented during the discussion of the Impacts of the Affordable Care Act on Alaska.

SENATOR FRED DYSON
Alaska State Legislature
Juneau, Alaska
POSITION STATEMENT: Asked questions during the presentation on the Impacts of the Affordable Care Act on Alaska

REPRESENTATIVE WES KELLER
Alaska State Legislature
Juneau, Alaska
POSITION STATEMENT: Testified during the presentation on Impacts of the Affordable Care Act on Alaska.

BRET KOLB, Director
Division of Insurance (DOI); Anchorage Office
Department of Commerce, Community & Economic Development (DCCED)
Anchorage, Alaska
POSITION STATEMENT: Presented during the discussion of the Impacts of the Affordable Care Act on Alaska.

REPRESENTATIVE KURT OLSON
Alaska State Legislature
Juneau, Alaska
POSITION STATEMENT: Testified during the discussion of the Impacts of the Affordable Care Act on Alaska.

JEFF DAVIS, President
Premera Blue Cross, Blue Shield of Alaska
Anchorage, Alaska
POSITION STATEMENT: Presented during the discussion of the Impacts of the Affordable Care Act on Alaska.

ILONA FARR, M.D.
Alaska Family Medical Care
Anchorage, Alaska
POSITION STATEMENT: Testified during the discussion of the Impacts of the Affordable Care Act on Alaska.

ACTION NARRATIVE

10:04:10 AM

CHAIR LORA REINBOLD called the Administrative Regulation Review Committee meeting to order at 10:04 a.m. Representatives Tarr and Reinbold and Senators French and Giessel were present at the call to order. Also in attendance was Representative Shelley Hughes (via teleconference).

Impacts of the Affordable Care Act on Alaska

10:07:10 AM

CHAIR REINBOLD announced that the only order of business would be a presentation regarding the impact on Alaska of the federal

Patient Protection and Affordable Care Act (PPAACA) also known as the Affordable Care Act (ACA).

10:08:20 AM

DEBORAH ERICKSON, Executive Director, Alaska Health Care Commission, Department of Health and Social Services (DHSS), offered to explain key provisions of the Affordable Care Act (ACA), briefly outline the ACA's projected impact on Alaska, and to address the legal challenges and political realities with respect to implementing the act on both the state and federal levels [slide 2]. She explained that the ACA is based on two federal laws with several amendments. The ACA's structure consists of 10 titles, although most of the media coverage has been focused on health insurance system changes [slide 3]. It's important to note that numerous provisions in the Act address many other aspects of the healthcare delivery system, including workforce development, prevention and public health, and fraud and abuse.

MS. ERICKSON stated the main goal of the federal law is to drive or address increased health insurance coverage for Americans. The federal law attempts to provide insurance coverage through various strategies, including provisions that reform the way the insurance market operates, such that individuals and businesses must carry or offer health insurance or pay a penalty [slide 4]. The ACA also has created a health insurance exchange, which is referred to as the health insurance "marketplace." The federal law was intended to require states to expand their eligibility for Medicaid programs, which is now an option. She acknowledged that her presentation would be "a mile wide and an inch deep" since there is significant ground to cover. She offered to provide information on some new rules for the private insurance market, including that there is now a prohibition on excluding certain preexisting conditions [slide 5]. For example, if someone with diabetes applied for an insurance plan, that person may previously have been prohibited from participating in an insurance plan; however, under the ACA, insurance companies have been prohibited from excluding patients with preexisting conditions soon after the law passed in 2010. Additionally, she indicated this prohibition will take effect in 2014 for adults. The ACA also contains significant restrictions regarding the proportion of premium dollars insurance companies are allowed to spend on costs other than medical claims. Further, the ACA provides new rules with respect to how premium rates are set. Additionally, some changes are not really reforms, but are new programs or additional activities related to the health

insurance market. For example, a temporary high-risk health insurance pool has been created for adults, which is meant to bridge the period from 2010 - when the law passed - and 2014, when the prohibition on preexisting exclusions will take effect [slide 6].

10:13:26 AM

MS. ERICKSON said the ACA created new non-profit organizations supported by loans and grants from the federal government meant to be consumer-operated plans, which essentially will create new insurance plans for states. Additionally, the ACA insurance market reforms include multi-state health plans and health choice compacts for state insurance commissioners to work across state lines. These compacts will essentially equalize or "share" regulations and facilitate cross-state insurance plans. In addition, funds have been made available for states to increase their capacity to review health plan premiums and provide state consumer-assistance programs. She turned to individual mandates, which require individuals to either have a qualified health plan or pay a penalty [slide 7]. She indicated this requirement is scheduled to take effect in January 2014, with a penalty for those who do not have a qualified health plan of $95 per year, per individual, or 1 percent of the household income, whichever is greater. She advised members that the tax penalty will be phased-up until 2016 at $695 per year, per person, or 2.5 percent of the household income. She reported that after 2016, the amount will be adjusted based on inflation.

MS. ERICKSON outlined exemptions for the individual insurance mandate, including financial hardship, religion, American Indian and Alaska Natives, or those who can prove that the lowest cost option will be greater than 8 percent of their family's income [slide 7]. She turned to individual subsidies, which for low-income individuals come in the form of both premium support or advance tax credits made available through the health insurance exchange or marketplace [slide 8]. These tax credits would apply to individuals with incomes between 133 percent and 400 percent of the federal poverty level. She directed attention to the 2013 Federal Poverty Level (FPL) guidelines for Alaska, noting that Alaska and Hawaii have higher thresholds for the federal poverty level than most other states.

10:16:30 AM

MS. ERICKSON pointed out that to qualify for an individual premium an employee must be an employee of a firm that offers

minimal essential coverage - deemed to meet the federal threshold - such that the employee's share does not exceed 9.5 percent of their income. If an employee has an option to purchase a qualified health plan from his/her employer and it meets the other [ACA] conditions, then the employee will not qualify for an FPL premium through the exchange. She noted that subsidies are provided on a sliding scale based upon income, which would mean the level of subsidy eligibility that individuals and families qualify for is based on an economic sliding scale. Of course, those at a higher level will receive fewer funds. Furthermore, she said that the amount of the subsidy will be capped based on the second lowest-level cost plan at the "silver level." The plan caps the maximum amount based on actuarial values at different levels, such as bronze, silver, and gold with 60 percent being the lowest level.

10:18:26 AM

MS. ERICKSON turned to employer mandates and subsidies, and with regard to requirements, explained that businesses with 50 or more full-time equivalent employees are required to provide minimal coverage or be subject to a tax penalty [slide 9]. She said it's important to understand that under this mandate an employer would only be required to pay the penalty if one of their employees receives a subsidy through the exchange. The penalties will differ depending on whether the employer offers coverage, but an employee qualifies for a subsidy - and obtains a subsidy - through the exchange. She directed attention to the example on the slide that indicates if an employer does not offer coverage, the employer would be required to pay $2,000 per full-time equivalent (FTE), with the first 30 FTE's excluded. For example, an employer with 100 FTE's that met this condition would pay - with 30 exclusions - $140,000 in tax penalties. In the event an employer offers coverage but an employee does qualify for a subsidy through the exchange the payment structure would differ, with the penalty at $3,000 per subsidized employee, which is capped at the higher level, as outlined in committee members' handouts.

MS. ERICKSON noted that very small employers are able to qualify for a tax credit if they provide coverage for their employees. Beginning in 2014, businesses with 25 or fewer FTEs, with average annual wages of $50,000 or less would be eligible for a tax credit of up to 50 percent of the employer's contribution to the employees' premiums. The health insurance exchange would create electronic marketplaces for purchasing insurance in every state [slide 10]. Thus, each of the 50 states must have a

health insurance marketplace. The ACA initially provided funding for state governments to create their own state-based exchanges with provisions to allow states to partner to create a multi-state exchange; however, there was also a provision for states to opt-out of establishing their own exchanges. In instances in which states opted out, the U.S. Department of Health and Human Services (USDHSS) would create an exchange for them.

10:21:40 AM

MS. ERICKSON reported enrollment will begin on October 1, 2013, and changes will take effect for health plan benefit years beginning January 1, 2014. Again, beginning October 1, 2013, people can begin enrolling in health plans in each of the 50 states. Also important to keep in mind is that the threshold differs depending on the provisions. For example, the employer requirement threshold to provide employee health benefits is 50 FTE employees, but the threshold for employers receiving a tax credit is 25 employees and the threshold to participate in the initial health exchange is based on 100 employees or less. Therefore, firms with more than 100 employees would not be eligible to purchase insurance through the exchange or offer the insurance to their employees until 2017. Beginning in 2017, any size employer would be able to participate in purchasing insurance through the electronic marketplace.

MS. ERICKSON also pointed out that the federal law requires health insurance exchanges to be self-sustaining by 2015. In the first year the federal government will be supporting implementation of the exchanges, but starting in 2015 the self-sustainability requirement will begin. For example, in 2015, the health insurance exchange might need to charge insurance plans a fee to participate or to charge consumers to purchase.

10:24:17 AM

MS. ERICKSON highlighted that the Medicaid expansion was initially intended as a requirement for state governments to expand eligibility for everyone up to 133 percent of the federal poverty level (FPL) [slide 11]. However, various reports describe the eligibility level at 138 percent of the FPL. She explained one requirement for determining eligibility is that states must apply a 5 percent income disregard when determining eligibility, effectively rendering the threshold at 138 percent. Also, until 2017, the federal government will fully fund the state's portion, at which time the state's share will phase in,

which she believed would be at 2 percent and reach a maximum of 10 percent by 2020.

MS. ERICKSON assumed members knew that a year ago the U.S. Supreme Court ruled it was overly coercive on the part of the federal government to require states to participate in the expansion as a condition of continuing the entire Medicaid program. Therefore, it's now optional for states to participate in the Medicaid expansion. Since that ruling, U.S. Department of Health and Human Services (U.S. DHHS) Secretary Kathleen Sebelius has issued guidelines to state Medicaid programs. Some states are testing the flexibility of the law, including requesting 100 percent expansions, which Secretary Sebelius has indicated would not be permitted; however, the deadline for states to make expansion decisions has not yet been established. Furthermore, U.S. DHHS Secretary Sebelius noted one option states will have will be to discontinue the Medicaid expansion at a later date.

10:26:45 AM

MS. ERICKSON pointed out a couple of key points related to changes to Medicaid, which are not tied to the Medicaid expansion, including changes for eligibility determinations. In 2014, regardless of whether the states expand their Medicaid programs, there will be a significant change in the methodology for determining program eligibility and all state Medicaid programs will be required to coordinate eligibility determination with the health insurance exchange through the marketplace.

10:27:34 AM

MS. ERICKSON, moving beyond changes to health insurance coverage, offered to cover other provisions of the ACA that are intended to change the way healthcare is paid and delivered [slide 12]. Referring to [slide 12], she indicated that a series of provisions have been made to change payment for healthcare away from a fee for service model to other models that focus on outcomes and the value of healthcare. She pointed out a number of demonstration pilot programs are specifically authorized in the federal law. Additionally, the federal Center for Medicare and Medicaid Innovation in the U.S. DHHS was created to implement the federal goal of how healthcare is provided. This means some new programs will be implemented that were not specifically authorized under the ACA to reach the federal goal.

MS. ERICKSON said most of the programs listed provide additional payments, such as the Federally Qualified Health Center Advanced Primary Care Provider Demonstration project, noting the Anchorage Neighborhood Health Center is participating in that program. She highlighted that these services are intended to fund support for patient-centered medical homes or more advanced primary care service delivery for Medicare patients served through federally-qualified health centers. Additionally, in 2012, provisions affecting hospitals include the Medicare hospital readmission reduction program, which penalizes hospitals for exceeding a certain threshold for readmission within 30 days of patient service by reducing their level of Medicare payments. Another provision took effect in 2012 that will tie payment levels to hospitals meeting certain quality metrics. In 2011, one provision became effective that will prohibit payments for services provided in healthcare facilities for conditions required as a result of the treatment. For example, when someone is hospitalized for a procedure and later contracts an infection as a result of the procedure, the Center for Medicare and Medicaid Innovation will prohibit payment for the services required to treat the infection.

10:32:05 AM

MS. ERICKSON turned to other key provisions [slide 13]. She explained that 32 provisions address fraud prevention. For example, the Medicare Recovery Audit Control Program (RACP), which currently contracts with auditors to audit organizations to recover payments that were made inappropriately, will be expanded to state Medicaid programs. Additionally, all state Medicaid programs are currently implementing the recovery audit programs, as well. Also, a number of programs, such as the emergency medical services for children - in effect for 20 years - have been reauthorized and funded under the ACA. Thus, an entire title specifically addresses prevention and public health. While some programs have been in existence, the ACA also creates a new prevention and public health fund intended to fund public health and prevention programs. Another title has been devoted to workplace development; however, little funds were appropriated to implement the program, although some components were funded. In Alaska, for example, the Department of Labor & Workforce Development (DLWD) received a small grant several years ago to develop a statewide healthcare workforce development plan. The program collaborated with the Alaska Health Workforce Coalition to develop a plan using funding under this provision. She stated that the Alaska National Health

Service Corps was significantly expanded, which has resulted in an increase in personnel serving in underserved sites in Alaska.

10:34:36 AM

MS. ERICKSON pointed out an expansion of the federal government's role in implementing protections for seniors, such that the Elder Justice Act was authorized under the ACA. She mentioned that the Indian Health Care Improvement Act was reauthorized, plus it has been permanently authorized under the ACA, thereby significantly impacting the tribal health system in rural Alaska. Further, the ACA has instituted a number of new Internal Revenue Service (IRS) requirements for providers and hospitals. For example, nonprofit hospitals will be required to conduct community health needs assessments every three years and must create an organizational strategic plan based upon that assessment.

MS. ERICKSON explained that a number of provisions are designed to address increased home and community-based services and supports for long-term care, which is being done to help facilitate a move away from facility-based nursing home care. Referring to her presentation, she mentioned an entire title has been devoted to identify and create new revenue streams to help the ACA support itself, as well as to identify other cost savings [slide 14]. The Congressional Budget Office determined that the overall effect of the ACA will be a budgetary cost-savings. In this regard, a series of new taxes will be implemented, including a new sales tax on indoor tanning and a "Cadillac" tax, which will apply to "very rich" health plans. Additionally, some of the payment reforms will lead to reductions for Medicare budget and other federal program. She pointed to a list of fees and taxes scheduled to take effect under Title 9 of the Act [slide 15].

MS. ERICKSON stated that the Health Care Commission contracted with the University of Alaska's Institute of Social and Economic Research (UAA-ISER) after the law passed to obtain a high-level assessment of the overall impact of the ACA, which predates the U.S. Supreme Court ruling and assumes a Medicaid expansion; however, it does analyze how healthcare spending might be expected to change [slide 16]. The ISER estimated the impact would be an increase in overall spending in the state by $289 million, assuming that Medicaid expansion. The ISER also estimated increased healthcare spending for federal, state, and individual households.

10:38:42 AM

MS. ERICKSON said based on the models the increased insurance coverage, including the Medicaid expansion, represents an overall increase of 53,000 Alaskans. The slide shows the distribution by changes in type of coverage. The U.S. Supreme Court ruling upheld the state's challenge - Alaska was 1 of 26 states who participated in the lawsuit that questioned the constitutionality of the law; however, the U.S. Supreme Court upheld that the individual mandate requiring individuals to purchase health insurance or pay a penalty was constitutional. [slide 17]. She noted that states have a role in determining "how" not "if" provisions are being implemented - depending on the extent the state is participating [slide 18].

MS. ERICKSON stated that in recent months federal government funding reductions - the tightening of the belt - has had an impact on the ACA. For example, one of the provisions that would have created a national long-term care insurance program was repealed under what she characterized as the "fiscal cliff deal," through political negotiations [slide 19]. Additionally, nearly $2 billion was cut from the program that would have provided loans for the consumer-oriented and operated health-plan programs. Further, she related that a number of provisions were impacted in the sequester that took effect in March 2013. To date, she relayed, there have been billions of dollars awarded by the federal government in grants, as well as over 10,000 pages of regulations promulgated [slide 20]. A number of new offices, boards, committees, and councils have been formed. Referring to slide 21, entitled "State Implementation To-Date", she reported that 17 states are planning to operate their own state-based exchanges, with the remainder defaulting to the federal government. There are provisions for states that choose to allow the federal government to operate their exchange to participate more actively in consumer assistance and rate reviews. Additionally, seven states will participate in a partnership exchange. She indicated that the Medicaid expansion decisions do not have any deadlines, but the earliest date is 2014. She reported that as of June 20, 2013, 24 states have decided to expand their Medicaid programs in 2014 and 21 states have decided not to implement the expansion at this point; there are a few states in which the debate is still ongoing.

MS. ERICKSON directed attention to slide 23, entitled "Timeline" to the major provisions that will take effect on January 1, 2014.

10:42:32 AM

SENATOR FRED DYSON, Alaska State Legislature, asked for the impact of the ACA on the union health trust and if the rules will be different for government employees.

MS. ERICKSON offered to provide that information at a later date, but noted that there is a change in the level of the health savings account, which is the level that individuals can contribute to a health-savings account in order to be able to receive a tax savings under the Act. For the most part, state governments are not exempt as employers, but the insurance rules vary. She offered her understanding that the main type of plan is grandfathered and is not necessarily fully required to comply with all provisions of the Act, such as for retiree plans. However, she indicated that the Department of Administration (DOA) could better answer that specific question. In further response to Senator Dyson, she related her understanding is that the definition of a grandfathered health plan isn't tied to whether the plan is a government or union plan, but she deferred to the Division of Insurance or Jeff Davis, Premera, to respond.

REPRESENTATIVE WES KELLER, Alaska State Legislature, asked for the timeline for other key programs, including the Quality Measurement & Improvement program and the Recovery Audit Contractor program (RCAP). He surmised it may already be in place since the DHSS contracted with an auditor. He recalled that the audit required the state to pay back a huge dollar figure as an adjustment, which he deemed was "quite blatant."

MS. ERICKSON explained that most of the fraud and abuse provisions took effect in 2011, including the state Medicaid RCAP. Again, she deferred specific questions to the DHSS and surmised that others could better address how the programs are working and how well they align with other fraud and abuse programs already in place in state law.

10:46:50 AM

SENATOR FRENCH referred to slide 8 and asked, in the absence of a Medicaid expansion, where the uninsured people who fall between 100 and 133 percent of the federal poverty level will go for an insurance policy. He asked for clarification on whether they would go to the exchange with a 100 percent voucher or if something else would occur.

MS. ERICKSON offered her understanding that it would depend on the cost of the plan versus the person's income level, and thus the affordability question arises. This group would not necessarily be subject to a tax penalty for not having insurance if they could demonstrate financial hardship or if the lowest cost option exceeds 8 percent of their income. To hone in and answer the question, she responded that this group would be able to buy a plan through the insurance exchange provided they could afford to do so.

SENATOR FRENCH understood the ACA envisioned this group becoming Medicaid recipients through the Medicaid expansion. He recalled the U.S. Supreme Court indicated it was an option. Thus it seemed to him there would be a bit of a gap for those people at the 100 percent to 133 percent of the federal poverty guideline for Alaska.

MS. ERICKSON concurred that the Act envisioned that the aforementioned gap would be covered under the Medicaid program.

10:48:51 AM

CHAIR REINBOLD, referring to slide 7, asked whether the individual tax penalty of 2 percent household income for years 2015 and 2016 would be in pre-tax dollars.

MS. ERICKSON answered she was unsure of the IRS rules at this time, although she offered to research that issue further.

CHAIR REINBOLD indicated that since it is 2 percent or greater, it could result in a big impact. She then referred to slide 9, and asked whether the penalty for employers assessed at $2,000 per subsidized employee would be applied annually.

MS. ERICKSON answered yes. In further response to a question, she agreed the first 30 employees are excluded.

10:50:14 AM

REPRESENTATIVE TARR noted that some assumptions have been made that businesses would choose the penalty since it would be financially advantageous to do so. She said it seemed that might be the case. For example, an employer with 70 employees would potentially have a $140,000 penalty. She surmised that since insurance could easily range from $800 to $1,000 per employee per month, it could be significantly less expensive to

take the penalty. She asked where members could obtain more information for evaluation purposes.

MS. ERICKSON suggested that some information on that issue specifically might be provided by other testifiers since they have more information on employer impacts. Additionally, a number of larger organizations have been working with employee benefits consultants to provide detailed analysis.

10:51:42 AM

The committee took an at-ease from 10:51 a.m. to 10:52 a.m.

CHAIR REINBOLD advised members that the federal government is still in the process of drafting regulations.

10:56:13 AM

BRET KOLB, Director, Division of Insurance (DOI); Anchorage Office, Department of Commerce, Community & Economic Development (DCCED), referring to the ACA, remarked that the primary challenge the division faces is attempting to review over 10,000 and eventually 20,000 pages of regulations. Even with the amount of information available, many of the basic questions have not been answered. He highlighted that the biggest concern is the cost to consumers, small businesses, and the impact on the insurance industry [slide 1]. He advised members that the Division of Insurance has not performed a formal study of the cost to individuals; however, the division has been tracking various studies to become knowledgeable about the impacts for them going forward. He referred to an implementation timeline provided by the National Association of Insurance Commissioners [slide 2]. As previously mentioned, the decision has been made that it was in the best interest of the state to select a federally-facilitated exchange also known as a marketplace. In fact, the exchanges stand out as the significant change that will take effect in 2013. Most people are interested in the impact of the marketplace on themselves or their families. He pointed out that October 1 is the date when open enrollment is scheduled to begin, but many other things underlie that date. He stated that rates would still be filed with the division under the ACA and the marketplace. In fact, the division would continue to review the insurance rates. He reported that insurers interested in participating in the exchange must apply by July 31, 2013. He informed members the DOI is on track to complete the reviews for the insurers and submit them to the federal government.

10:59:19 AM

MR. KOLB stated the second concern relates to the review and approval by the DHHS for plans that will be offered in the federally-facilitated marketplace. He indicated he has heard that by early September the federal government will make determinations as to which companies have been approved to be offered on the marketplace. The third and largest hurdle will be to create the marketplace, which is sometimes considered as a portal or web access site. The portal will provide access to the marketplace for consumers to shop and determine which policy or plan may be best for them. In fact, in order to accommodate open enrollment by October 1, 2013, the portal must be up and available by that date. He reiterated that this is what's being created by the federal government for the federally-facilitated marketplace. The marketplace would only cover some of the high-level items of coordination between the states, federal agencies, and insurance companies, but all of these activities are being done in preparation of meeting deadlines.

MR. KOLB turned to the question of the cost to the consumer [slide 4]. He noted that according to a report produced by the U.S. House and Energy Commerce Committee, just released in May 2013, the members of the Energy and Commerce Committee sent letters to 17 of the largest insurers - health insurance companies - requesting their analysis of the impact of the ACA's policies, mandates, taxes, and fees on health insurance premiums. He referenced the source of the information, which is available on the U.S. House, Energy, and Commerce Committee's website, which is [http://energycommerce.house.gov/rate-shock]. Referring to slide 5, entitled, "Individual Marketplace Components of 2014 Rate Impact", he explained that many of the components are in ranges or estimates. The full-year data will not be made available for the rate-making process until the 2016 plan year. In fact, it may take several years before enough information has filtered through to provide a full year's worth of data for anyone to review. Estimates will likely be refined and tightened up as the 2016 plan year approaches, but currently only broad estimates are available.

MR. KOLB pointed out that the mission of the Division of Insurance is to regulate the insurance industry to protect consumers. Specifically, the division is very aware of its mission and how the division impacts consumers. In 2012 alone, the individual market provided coverage for over 13,500 Alaskans in the state. Some of these individuals or families may qualify

for subsidies after January 2014 or may be served by plans in the federally-facilitated marketplace. So regardless of where an individual obtains coverage, research seems to indicate the cost of individual insurance is going to rise.

11:03:36 AM

MR. KOLB stated that benefits, cost sharing, and guaranteed issues are all factored in and outlined on slide 5. He referred to a "rate shock" chart and explained that this reviews the impact on individual markets for a young healthy male [slide 6]. Again, this report was provided to the U.S. House, Energy, and Commerce Committee, but it illustrates a projected increase of 180 percent. However, there is not any subtraction for subsidies and it is possible individuals might qualify for subsidies. Thus, the example might need to be adjusted to take into account the average subsidy, which he has heard may be around 40 percent. Still, he characterized the impact as being huge and the result is this will impact people trying to purchase insurance.

11:04:27 AM

MR. KOLB discussed the cost to small businesses [slides 7-8]. In 2012 alone, the small group market covered approximately 17,000 Alaskans. Referring to a chart similar to the one for individuals, he identified the headings: small group (SG) fully insured, large group (LG) fully insured, and administrative services only (ASO) - the Employee Retirement Income Security Act (ERISA) types of arrangements. In 2014, the SG would be significantly impacted, thus, he would primarily focus on this group. Since the 1990s Alaska has required guaranteed issue in the small group market. In addition, the group health market tends to have richer benefits available than the individual market and that those two things taken together will result in a smaller increase on the overall cost. He predicted the impact to the small group market will likely be less than the impact to the individual market. He anticipated that some employers will attempt to take on some of the risk themselves. He noted that he has heard that some employers, even small employers, are considering self-funding in order to avoid some costs under the ACA, in particular, to meet some of the mandates.

MR. KOLB stated that division will be monitoring increases in stop-loss insurance, which is the insurance that backs up this type of self-risk. In 2015, employers will be required to report health coverage to the IRS. He recalled tax credits were

discussed in the earlier presentation, which he will not discuss. He pointed out administrative factors that small employers will be subject to which cannot yet be taken into the overall calculation and cost.

MR. KOLB turned to the cost to insurers [slide 10]. He explained that insurance companies are businesses, which will continue to incur additional costs associated with the ACA compliance. For example, this would include both costs associated with creating and pricing new plans, as well as the many different taxes and fees previously discussed. As with other businesses, the cost of the business is factored in and in the case of insurance, the costs will be passed on in the form of a premium increase. Since January 1, 2012, insurers writing health insurance in Alaska have been required to file their rates with the division. These rates are reviewed and by statutes, cannot be approved if they are excessive, inadequate, or unfairly discriminatory. He concluded that numerous new ACA taxes will impact consumers and the division is currently reviewing rates.

11:08:01 AM

MR. KOLB reported that Alaska has been deemed by the federal government as an effective rate review state. Therefore, the federal government will rely on Alaska's review of rates for purposes of determining whether a rate increase is reasonable. The federal authority must only disclose unreasonable rate increases or possibly not allow sale on a federally-facilitated marketplace. Technically, the federal government does not have "disapproval" authority. Furthermore, with regard to forms, the federal agencies have indicated they will rely on the division with respect to compliance for mandates in Alaska, as well as for components of the federal mandates.

MR. KOLB said that to date, no specific ACA statutes or regulations have been adopted in Alaska. Again, the authority to review rates currently exists so the division will continue to review rates as it has in the past. Referring to estimated pricing impacts, he said it doesn't matter whether it is the individual market, the small group market, or the large group market, since all groups will be impacted. However, the ACA will also provide benefits and access for some people, but he offered his belief that it will undoubtedly add cost to health insurance and to the population as a whole. Everyone buying insurance will be touched by this in some manner, he opined.

11:10:03 AM

MR. KOLB, in closing, provided the committee with some sources that have performed studies and directed attention to the division's website, which now contains links to ACA resources as a repository to obtain information.

11:11:01 AM

CHAIR REINBOLD, on behalf of Representative Saddler's office, asked for the impact of the ACA on specific diagnoses for conditions such as autism.

MR. KOLB explained that one of the components of the ACA is the essential health benefits, and one which must be included is coverage for mental healthcare. He pointed out that autism benefits fall under that coverage. Therefore, as of January 1, 2014, plans are required to have essential health benefits, and thereby will offer coverage for autism.

11:11:56 AM

REPRESENTATIVE KURT OLSON, Alaska State Legislature, referred to slide 8 of his presentation. He asked for clarification on The Patient-Centered Outcomes Research Institute (PCORI), which is listed under taxes and fees.

MR. KOLB answered that PCORI is part of the funding mechanism that refers to effectiveness research.

REPRESENTATIVE OLSON asked who is responsible to make sure commissions and fees are not bundled, for example, brokers could charge fees and also receive a seating commission from companies for placing the reinsurance.

MR. KOLB answered that the current licensing falls under the purview of the division so as people gain commissions, the division will be reviewing the activity. However, he clarified that navigators - those assisting someone else in the process - are not eligible for commissions.

REPRESENTATIVE OLSON asked whether navigators will be licensed by the division.

MR. KOLB answered that the division does not anticipate adding licensing responsibility for navigators since they are being identified by the federal government to work through the

federally-facilitated marketplace. At this point he did not envision any additional licensure responsibility for navigators.

11:14:16 AM

SENATOR FRENCH offered his understanding that the ACA has provisions that allow states to pool insurance. For example, Alaska could pool insurance with another state with a larger population. He asked what research the division has done to determine any options the state has for pooling, for example, for states with similar issues including Idaho or Montana.

MR. KOLB acknowledged pooling is conceptually available, but to date he's not heard of many states seeking to pool; however, a state would want to take on the risk of the new state. For example, Idaho would want to have the medical cost and risk Alaska has pooled in with their costs and risks. However, in many instances, it might result in a worse situation. These states also encounter regulation of insurance at their state level. State regulations and programs also differ, such that one state may regulate one thing and the other state might mandate benefits in a different manner. Certainly, Alaska would like someone to take on its risk, but to date it has not happened.

The committee took an at-ease from 11:16 a.m. to 11:18 a.m.

11:18:36 AM

JEFF DAVIS, President, Premera Blue Cross, Blue Shield of Alaska (Premera) began his presentation. He offered to focus on context and impact since it is important to understand the context in which all of this is happening. He said that healthcare as it existed in March 2010 was unsustainable and costs have continued to rise [slide 1]. He highlighted the elements of the crisis, pointing out the graph depicts all non-interest spending including social security, which is flat, but adding in health spending presents a different picture [slide 3]. Additionally, once interest on the debt is added in it gets to be "pretty scary" and by 2014 will be the equivalent of 35 percent of the gross domestic product (GDP). The amount would be totally unsustainable by 2080. He identified the underlying base problem, which is that healthcare costs are rising faster than GDP and as costs continue to rise consume more of the GPD. He spoke to the rapidly escalating situation. In 1982, when he was in graduate school eight percent of GDP was for healthcare, but by 2013 has risen to 18 percent.

MR. DAVIS said healthcare spending in Alaska is significantly higher than in other parts of the country. In fact, Ward Hurlburt, M.D; Deputy Director, Department of Health and Social Services; Chair of the Alaska Health Care Commission indicated the U.S has the highest healthcare costs in the world and Alaska has the third highest in the nation. Therefore, Alaskans are paying the third highest healthcare costs in the world.

MR. DAVIS compared Alaska's spending to other markets, in terms of small group premiums. Alaska's small group premiums are $650 per person per month, which is $2,600 for a family of four [slide 4]. For reference, in Washington [state] the premiums are approximately half the cost. Thus, Alaska's employers and individuals are being crushed under the financial burden. He said it is not likely that the ACA will fix the problem. He indicated the ACA would initially apply to groups of 2-50 persons, although some implications will occur for larger groups [slide 5].

11:21:46 AM

MR. DAVIS said the major implications from an insurance perspective happen on January 1, 2014. He explained that guarantee issue and no preexisting condition waiting periods go together, which means is that anyone coming to an insurer, regardless of health condition must be given a policy without any waiting periods for preexisting conditions. He offered his belief that this will have a significant impact on health insurance costs. He characterized this as being similar to someone purchasing homeowners' fire insurance after his/her house has burned down or a person needs coronary bypass surgery and then purchases healthcare insurance after the surgery. Essentially, beginning January 1, 2014, an insurance company must provide for immediate coverage and he predicted the effect of the mandatory coverage will increase insurance rates.

MR. DAVIS said that federal subsidies in the healthcare exchange for individuals will begin on January 1, 2014, which also represents a "really big" market change. Somewhat hidden in the midst of the reform is the minimum essential benefit package, which requires a minimum actuarial value of 60 percent. In fact, a 60 percent plan is a richer plan than most people purchase today. For example, if one were to compare it to car insurance, a party who has a deductible of $1,000 but wants $100 deductible would expect the policy will be more expensive. He offered his belief that the minimum essential benefit package

will increase insurance costs the most. He pointed out about 11,000 pages of regulations have been promulgated to date.

MR. DAVIS emphasized that these changes are market-changing forces and of course no one knows for certain what will happen. He characterized the ACA as being on a roller coaster. For example, companies were required to file rates on April 30, 2013 for 2014 without knowing the population. Further, in April 2014, companies must file rates for 2015, without yet knowing much about enrollees. He ventured that by 2015-2016, the companies ought to know the population enrolled and a "new normal" will emerge.

11:26:04 AM

MR. DAVIS said individual insurance costs and prices will depend on several factors, such as the person, his/her age, what type of current plan, if any, and whether the person is eligible for any federal subsidy. He advised that Premera's actuaries believe the average impact for individuals will be between 21 and 79 percent. For example, a 50-year-old with a fairly rich healthcare plan today, paid out-of-pocket at 399 percent of federal poverty, will likely pay significantly less out-of-pocket for the plan in 2014 due to the federal subsidy. However, a "20-something" with a high deductible plan today, at 401 percent of federal poverty could face rates that have doubled. However, the range of impact for individuals depends on substantial information, although the range of impact for small groups would likely have less impact, as Mr. Kolb mentioned; however, some impacts will occur.

MR. DAVIS estimated that about half of the 10,000 individuals Alaskans would be "grandfathered in" because they have not made any significant changes to their coverage since March 23, 2010. Those who are "grandfathered in" would have an option to keep their plan and represents the group that will be largely sheltered. In fact, about half of the groups Premera covers will be "grandfathered in" and will have an option to wait to see what happens. He assured committee members that Premera has been trying to shelter its members from the effects of the Act. He turned to the health insurance dollar [slide 6]. He mentioned substantial information has been formulated during the debate that indicates healthcare costs are estimated at 40 percent administrative costs with 30 percent profit. Having said that, he questioned what business could operate under that model since businesses with those costs and profits would not operate for long.

11:29:30 AM

MR. DAVIS reported that in 2012, for every dollar Premera received - based on approximately 1.7 million people receiving coverage, primarily in Washington and Alaska - it spent six cents on administration. He pointed out that Premera is a taxable non-profit company and currently has a profit of one percent. He advised members that this one percent profit gets reinvested in the company to build reserves to provide for future needs of its clients and to build the capability of the company. He further reported that Premera has hired an additional 245 people to its traditional 3,000 staff to implement aspects of the Act, which represents a huge impact on Premera. Healthcare consumes 91 percent of all of the dollars, he said.

MR. DAVIS indicated that the U.S. still has a problem in that the Act reforms insurance but not healthcare itself. He discussed where the healthcare money goes [slide 7]. The Division of Insurance approves rates, whose standards are adequate but not excessive. This provides Alaskans with consumer protection. Studies point to 30-40 percent of all health care in the U.S. as being considered waste, he asserted, and he offered examples of [fraudulent practices]. He estimated that the U.S. spends $3 trillion on healthcare so therefore about $1 trillion represents waste. This represents the area in which Premera believes opportunities exist to reduce waste by improving quality [slide 8]. He suggested that this can be done by engaging and empowering consumers and rewarding them for being educated. He indicated "choosing wisely" is a model from the medical associations, who point out 5-10 standards, for example, for obstetrical care or asthma. He indicated these standards are found on the consumer reports' website as well. Essentially, if 30 percent is waste, as a consumer he would want to avoid doing things that contribute to waste and become educated how not to do so. He pointed out that Premera works on cost transparency and uses integrated health management.

MR. DAVIS turned to what employers are doing about costs [slide 9]. He stated that the focus is on personal health status improvement. Approximately 75 percent of the cost of healthcare is spent on chronic disease and a third of that is related to lifestyle-related choices, including exercise and food choices.

MR. DAVIS stated that high deductible plans reduce people's willingness to just buy things "willy-nilly" and to research

options. He said that consumers who buy their own plans consume about 30 percent less in claims with no difference in health status. He further said that employers have been working on cost transparency and hold worksite clinics to help integrate wellness and reduce workers' compensation, to improve health status with significant reductions in consumption of services. He pointed out that employers are also interested in medical tourism, which he said would not be debated today unless the committee wishes to do so.

MR. DAVIS turned to the delivery system transformation [slide 10]. He stated that more needs to be done to empower primary care. He suggested that paying primary care physicians more and putting them in charge of their patients can be very effective in reducing waste; however to do so, the doctors need tools, including data. He said that Premera has created "Global Outcomes Contracts" but he believed this effort needs to be provider-led with carrier support.

11:34:20 AM

MR. DAVIS summarized that the current healthcare system is unsustainable and the ACA won't fix it [slide 11]. According to an article in Forbes ["Rate Shock: In California, Obamacare To Increase Individual Health Insurance Premiums By 64-146 percent" dated 5/30/2013], California anticipates a 64-146 percent impact to implement the ACA, whereas Washington estimates a 34-80 percent impact. He reported some statistics from Oregon and Washington, with respect to the federally-facilitated marketplace, including that Oregon has allocated $300 million in federal dollars and has delivered 50 percent of the requirements for the exchange, with 50 percent in draft form; and Washington has spent $150 million in federal dollars and has delivered 25 percent of the requirements, with 40 percent in draft form. In Alaska, zero percent of the requirements have been met, 30 percent are in draft form, and 70 percent have not yet been received. He was unsure of how it would all work out, but said Premera Blue Cross will do what it needs to do for its clients.

CHAIR REINBOLD relayed that she was impressed and alarmed by the information he'd provided.

REPRESENTATIVE KELLER said he has been outraged by the ACA, in particular, as it relates to preexisting conditions. He asked how Mr. Davis's company is going to change as a result. He further asked whether the company is moving more towards healthcare management. He predicted that insurance will no

longer be insurance as it is known today. He also asked Mr. Davis to predict what Premera Blue Cross would look like in five years.

MR. DAVIS indicated that his company will be performing "pre-funding" rather than insurance services. As mentioned last week, two things make something an insurable event. One, it is not a desirable event. Second, it is not predictable to the individual. However, once a person has already been diagnosed with something it would fall under "receiving care," and becomes predictable to the person. Thus Premera would not be "risk selectors" but would function as "risk managers." He said that Premera's mission is to create a sustainable health care environment which would translate into "all hands on deck and nothing 'is' off the table." Certainly, Premera would be making changes, adding his belief that everyone has a role to play in reducing healthcare costs, for example, choosing to lose weight. He pointed out his diverse roles, including that he serves as a health insurance executive, a health care commission member, an individual, and as a father.

MR. DAVIS said that Premera has focused on what it can do in integrated health management to help primary care physicians become empowered, and to help employees and employers in terms of worksite wellness. Certainly, the risks will happen, and the company can't control them, but it can work to reduce overall health care costs.

MR. DAVIS reported that actuarial science around wellness shows that reducing the body mass index (BMI) by a meaningful amount translates into health care expenditure reductions almost immediately, within a matter of months. Thus, employers understand wellness as a strategy and really embrace that aspect, including the recognition that a healthy workforce is a more productive one.

11:41:02 AM

REPRESENTATIVE TARR recalled testimony that it is difficult to determine the cost of individual coverage since it is an uncertain population. She said the [committee] has seen estimates that identified who would be covered under Medicaid expansion. She asked whether there would be more certainty if the state had selected Medicaid expansion since Premera could exclude a certain number of Alaskans, which would whittle down the number of new individuals that would be covered. Additionally, she recalled the ACA did not require companies,

such as Premera, to participate or offer a plan through the federal exchange. She questioned if it is so cost prohibitive why Premera would participate and offer a plan through the federal exchange. It made sense to her that an economic decision would be made on the part of Premera and she asked for clarification on these points.

MR. DAVIS, with respect to reasons Premera would participate, answered that Premera believes if it did not act, that an individual insurance market would not be available in Alaska. The Premera board has been committed to create a sustainable health care situation and without coverage, the market would go in the opposite direction. Fortunately, Premera believes it has sufficient reserves to carry it through the uncertain times. With respect to the uncertainty to new entrants into the marketplace, he offered his belief that most of these people are currently uninsured, so nothing is known about them in terms of risk factors. He estimated that approximately 120,000 Alaskans are uninsured. The state predicts that in 2014 approximately 44,000 people will be covered under the exchange, which will increase in 2017 to 66,000. He said Premera does not believe that Medicaid expansion would really be a part of it since either the expansion would occur or the group would not be eligible for subsidies; therefore, not many would fall into the affordable insurance situation.

SENATOR FRENCH opined that Premera is one of the outstanding companies operating in the healthcare arena. He commended Premera for its low administrative costs. He turned to insurance pooling, noting that Washington has substantially lower healthcare costs than Alaska does. He pointed out it would be to Alaska's advantage to pool with Washington. He suggested that policymakers should be exploring this aggressively.

MR. DAVIS attempted to clarify that the one percent profit is achieved over its 1.8 million members. He predicted that Premera will receive a rebate because profits were greater than expected. In terms of a state compact, he responded that he has grimaced when he's heard about it. Since Premera has worked in Alaska since 1952, the company must make costs work in Alaska. If Premera must compete with someone based on Washington's costs, it would be difficult. For example, the federal employee plan averages prices across Alaska. Further, compacts have problems, since the costs are different in different locales. He said the Alaska Health Care Commission explored some of the reasons for higher costs and information is on its website.

While it would be advantageous for Alaska to pool, it would not be benefit Washington until Alaska can bring down its healthcare costs. The concept behind the state compact is that somehow there is extraordinary profit or waste in the insurance marketplace that would be driven out by an across-state competition; however, for Premera, which is a company without a lot of waste in administrative costs or profit, it is all about healthcare. He identified the main issue is that healthcare simply costs more in Alaska than in Washington, so it's hard to imagine how this can be a "win-win."

11:48:12 AM

REPRESENTATIVE TARR asked whether Premera has considered expanding its healthcare practice for healthcare providers as a means to reduce costs.

MR. DAVIS responded that Premera's work with primary care is not an expansion of licensure, but works to the extent of licensure. He said Premera believes that the primary care physician is in the best place to evaluate a patient holistically. Premera's focus has been to consider paying primary care physicians more to reduce waste and improve quality.

11:49:15 AM

REPRESENTATIVE OLSON questioned how it would work if Premera is prevented from underwriting older people with health care issues and the premiums are being doubled for clients in their 20s and 30s, which is the group that is typically the "gold standard" for the industry.

MR. DAVIS answered that the individual mandate was intended to keep everyone in the marketplace, but he has two sons and he wondered how to encourage them to understand the value of staying in the system. Again, some people will be subsidy eligible, others will pay significantly more. He predicted that health insurance premiums will have to go up and will be extremely costly. While the process will evolve over time, he predicted it will be extremely costly.

The committee took an at-ease from 11:51 a.m. to 11:55 a.m.

CHAIR REINBOLD introduced her sister.

11:56:18 AM

ILONA FARR, M.D., Alaska Family Medical Care, after mentioning she is the head of a group of 16 family practice private practitioners, explained that substantial impact will occur in Alaska due to the implementation of the ACA. She acknowledged other changes are due to rules adopted under former President George W. Bush's administration with some changes due to the stimulus bill. She offered her belief that many of the changes do not affect government agencies as much as the changes affect physicians in private practice.

DR. FARR said she started working in health care in 1997 with the late U.S. Senator Ted Stevens to try to impact federal regulations. At the time, the federal government attempted to increase the documentation for physicians. She figured out she would need to write 180,000 words per year to meet the documentation. While the regulations were kept at bay for some time, they are now in place. She predicted it will dramatically increase provider costs since more needs to be documented. She said other rules and regulations have occurred, decreased reimbursement from Medicare and Medicaid, relative to costs. She reported that Medicare reimbursements on claims were at 34 percent and Medicaid at 80 percent. She also said her practice breaks even with Medicaid and loses money on Medicare, but it takes six paying patients to offset the losses from one Medicare patient.

DR. FARR stated in 2008 the Bush administration mandated ICD-10 codes [the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD)], which are due to start in October 2014. According to various studies the estimated cost to implement the codes ranges $1.5 to $8.3 billion with providers facing a minimum expense of $83,000 for private practitioners up to $2.7 million for large clinics [slide 2]. She estimated the medical classification list will increase from 10,000 codes to 140,000 alphabetical and numeric codes. She further estimated that 36 percent of the codes will correspond to the new codes. Therefore each physician will need to use the new system or have coders do this. She predicted it would be cost prohibitive for many physicians, taking an additional five minutes for each patient, which increase her fees by $50. Some places estimate more physician time; however, she estimated it would add 1.5 hours to her day under the new system.

11:59:36 AM

DR. FARR related some people think the impact of the changes will be more drastic than the housing bubble. Further this will come at a time when the country has a shortage of medical providers.
11:59:50

DR. FARR said the federal ACA/Stimulus bills entail several pieces of legislation [slide 3]. The Independent Payment Advisory Board, or IPAB, will define fees for providers after examining fees for five years. Therefore, the state will not know the impact of this for several years. She identified the Agency for Healthcare Research and Quality's (AHRQ) as a federal program that provide patient and physician educational materials, but looks at studies and is making recommendations to the Federal Coordinating Council for Comparative Effectiveness Research (FCCCER) committee, who will help determine which services should be provided as physicians. She expressed concern that some of the boards and committees are using older research and it may slow down the progress being made in health care.

DR. FARR expressed further concern that the process may interfere with the physician and patient interactions. For example, in her practice, 50 percent of breast cancer patients were diagnosed before the age of 50. According to the task force guidelines, she should not be performing mammograms on her patients before they reach 50; however, that would mean half of her patients would potentially have died.

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DR. FARR indicated that breast and cervical cancer rates are much higher in Alaska. Again, she stated she has concerns about the federal government setting rules and regulations. She offered her belief that these decisions should be made between the individual patients and their providers. She stated that there have been over 159 committees, and 20,000 new rules and regulations. She emphasized the difficulty in trying to keep up. She reiterated it would be virtually impossible to keep up with the enormity of the proposed changes.

DR. FARR identified 18 different audits the federal government can impose, including Medicare RAC audits, which are audits paid on commission and auditors can extrapolate findings over the whole practice. These audit practices have tremendous negative implications for practitioners. She offered her belief that the majority of the audits are conducted by "fly by night"

operations. Most people in private practice are not committing the fraud on the scale being discussed at the national level. She hoped the Medicaid audits at the state level can be influenced so it will not drive practitioners away from taking Medicaid patients. Additionally, her practice must comply with 75 Healthcare Effectiveness Data and Information Set (HEDIS) quality measures and the National Committee for Quality Assurance (NCQA) [which is an independent 501(c) (3) non-profit organization]. She noted her practice sends bills to 120 different entities and potentially any one of the companies could request an audit. She pointed out audits and documentation take away significant time from her practice and patients.

DR. FARR turned to Medicaid [slide 4]. She noted that the biggest study done by the University of Virginia found Medicaid surgical patients are 97 percent more likely to die than surgical patients with private health insurance and 13 percent more likely to die than those without insurance. She stated that one reason for this is due to the limited formula. Medicaid patients generally receive less time with providers, in particular, since the providers typically earn little or lose money with Medicaid patients so doctors generally tend to restrict visits with those patients. Further, there are limits on services, decreased reimbursement, increased audits, and more rules and regulations with Medicaid patients plus the preauthorization takes time. She reiterated her concerns, noting that between 26 and 40 percent of physicians nationwide are not taking Medicaid patients due to the governmental restrictions and interference with their medical practices. She noted that in the past physicians often took charity cases; however, Medicaid and Medicare have restricted the amount of charity care physicians can perform. She encouraged members to visit U.S. Senator Tom Coburn's website, M.D., for information.

DR. FARR also encouraged members to visit the University of Virginia's study. She expressed considerable concern about the proposed expansion of Medicaid due to the potential decrease in the quality of health care in Alaska.

DR. FARR turned to the ACA [slide 5]. She highlighted some positives of implementing ACA, including the Alaska Native Tribal Health Consortium (ANTHC) funding and coverage for children up until the ages of 26.

12:06:47 PM

DR. FARR said she found coverage of preexisting conditions to be a "mixed bag." In some ways coverage of preexisting conditions is good for patients, but in other ways it will drive up private insurance premiums. She predicted that people will buy insurance when they are ill and then drop it. She recalled Mr. Bush's prior testimony on ACHIA, in which people drop the program once they receive services. She anticipated the effect of ACA will increase insurance costs. She pointed out there would be a 40 percent tax on the insurance premiums estimated to effect 100 percent of the private Alaska market by 2018. Additionally, it will eliminate health savings accounts. She offered her support for HSA's since the patient actually sees the cost of services and are much more likely to shop wisely. Indiana conducted a study, and actually subsidized some of the health savings accounts for specific individuals. She reported taxes will increase from $95 or 2.5 percent of income for businesses. She indicated that she hasn't been able to figure out what services to provide her employees even though she would like to comply. In fact, it will take small businesses time to sort through.

DR. FARR stated that the marketplace exchanges will start in October 2013. At this time, she was only aware of two providers, Premera Blue Cross and ODS Health Plan, Inc. [now Moda Health), who will participate. She reported that the application form instructions consist of 20 pages for individuals and 65 pages for companies.

DR. FARR offered her understanding of how this will affect patients [slide 6]. She predicted that insurance premiums will increase. One provision she is seeing in her practice is non-coverage of spouses. She said employees are suffering cutback in employment hours and some insurance companies are "pulling out of the market" and taxes are increasing. She recapped that 18 new taxes will help pay for the ACA. She was unsure of whether some provisions of the Act that may or may not have been repealed, or that might be repealed in the future.

12:10:21 PM

DR. FARR, according to a survey conducted by the Physicians Foundation in 2012, sent out e-mails to 600,000 physicians, and received 13,500 responses. She characterized the survey as "being fairly accurate". She said the survey indicated 60 percent of physicians would retire now if they could afford it, that 26 percent would not take Medicaid. However, Alaska has one of the better Medicaid reimbursement systems and is the

highest or second highest in the state [slide 7]. She reported that 52 percent of physicians have limited access to Medicare patients due to low reimbursement rates, while 50 percent of physicians plan to cut back on patients, work part-time, switch to concierge medicine or reduce patient access to services. The more paperwork and preauthorization takes physicians away from their patients. In fact, the more paperwork that physicians must fill out would be reducing patient access

DR. FARR again said that providers now spend over 22 percent of their time on non-clinical paperwork. However, she noted her time is actually closer to 25 percent. She reported that 59 percent of physicians indicated the passage of the ACA has made them less positive of the future of healthcare, 47 percent have significant concerns about EMR. Most physicians in primary care felt that electronic health records decrease the number of patients they can see. She summarized that basically, physicians are experiencing increased workload, decreased reimbursement, including 16 percent fewer patients than in 20018. As mentioned previously, preauthorization and audits take physicians away from patients.

12:13:09 PM

DR. FARR reported that she conducted an informal survey of 400 physicians in Anchorage in 2008. At that time, 67 percent of providers planned to opt out of Medicare/Medicaid if ACA was enacted. She characterized this survey as a "telling" survey that indicated the level of concern about federal regulations going into effect. Further, a 2013 survey by Merritt Hawkins just released this month indicates - nationwide - 60 percent of facilities are short of primary care physicians, which is a significant problem. The American Association of Medical Colleges recently released a study that showed a nationwide shortage of providers of over 91,000 by 2020. She predicted that there will be a tremendous shortage of providers. She said 57 percent of providers are choosing to be employed through larger entities to help them through the transition. She estimated that approximately 33 percent of physicians are in private practice, in part, due to the increased cost, increased regulations, and student loan debt. She reported that in the 1950s, 75 percent of medical doctors belonged to the American Medical Association (AMA), which is now reduced to 15 percent. She mentioned this since people think the AMA represent all physicians. She surmised that 10 percent of the AMA's membership dropped once it supported the ACA.

12:16:26 PM

DR. FARR touched on potential solutions [slide 9]. She suggested that health savings account (HSA) systems should be allowed for all ages. First, she emphasized the importance of the HSAs, which she thought should be birth to death account and part of the Medicare options. Second, she supported legislation before the Congress such as U.S. Senator Coburn's bill on patient choice. She said he is 1 of 17 physicians in the Congress. She also supported U.S. Senator Lisa Murkowski's Medicare bill, which would allow patients whose physicians have opted out to receive Medicare reimbursements for some out-of-pocket expenses. Third, she supported having fewer rules and regulations. She indicated additional documentation or requirements add to the costs. Fourth, she offered her belief that educational and not punitive audits are needed. Fifth, she supported concierge medicine. Basically, this would allow a patient to pay a physician a monthly amount to be a patient. It gives providers financial certainly, which could help rural providers. She pointed out that liability reform is always an issue. Finally, she supported the Washington, Wyoming, Alaska, Montana, and Idaho program (WWAMI) program, and increasing resident slots since it helps students attend medical school.

DR. FARR concluded by reminding members that mandates for physicians takes them away from patient care. She emphasized that the amount of time patients spend with providers impacts outcomes.

12:18:45 PM

SENATOR DYSON asked whether it's true that the liability laws are among the best in the nation. He indicated several physicians he knows are concerned about the security of meeting the Health Insurance Portability and Accountability Act of 1996 (HIPPA) requirements due to electronic records.

DR. FARR answered that both are valid points. With respect to the security of electronic health records, she said she has shared the concerns and does not use electronic records except to scan in chart notes in PDF file formats. She acknowledged that the information is stored on servers or in "clouds" and physicians don't have any control over the record. She reported that HIPPA allowed 2 million entities access to electronic health records.

SENATOR DYSON asked about the liability.

DR. FARR answered yes; but she believes the courts have reversed some of the liability provisions, although she was uncertain of the details.

SENATOR DYSON asked how the legislature could fix the liability issues.

DR. FARR recalled that the Alaska State Medical Association has been focused on this issue. She offered to put Senator Dyson in touch with one of the association members.

SENATOR GIESSEL commended Dr. Farr as a practicing physician with the most knowledge on the ACA. She noted that providers other than doctors provide healthcare services, including nurse practitioners, nurse midwives, and naturopaths, who focus on wellness. According to Alaska Health Care Commission, Milliman Client Report [Physician Payment Rates in Alaska and. Comparison States] pointed out doctors are charging very high fees. She asked what physicians are doing to address the astronomical charges. She questioned that staff and supply charges causes Alaska's health care costs to be twice or four times as much as other states in the Pacific Northwest.

DR. FARR indicated that some specialties charge more than other places; however, she recalled primary care rates were at 127 percent, which she thought was pretty consistent with other service industries. She was unsure what the cost drivers were, but some technology will reduce costs, such as patients having the ability to monitor lab work and other tests. She predicted "a whole revolution" will actually bring healthcare costs down considerably if the devices meet federal approval. She agreed the rules and regulations apply not only to physicians but other healthcare providers.

12:24:00 PM

REPRESENTATIVE KELLER recalled a physician's testimony before the Alaska Health Care Commission who said the only way he could envision surviving was "concierge" medicine. He asked for a definition and further direction for the legislature.

DR. FARR opined that [concierge medicine] would help; however, she has heard "mixed reviews" on this. She recalled previous insurance commissioners questioned implementing this in Alaska since Alaska pre-collects and is considered an insurance entity. She said she thinks it's important to work with the insurance

companies since basic care is provided in "our offices." She suggested that the attorney general should research that issue, since it may help retain primary care physicians. She noted some places are using concierge services, such that the patient comes in and pays a $2,500 lump sum for a physical, which entitles the patient to four free visits the rest of the year instead of charging a monthly fee. She added that she would like to see the legislature work on the issue. Further, she suggested that health care freedom bill would help. This would allow any patient or provider to make a decision on services. For example, in Canada a patient cannot pay for an individual service, but this should be allowed in the U.S.

REPRESENTATIVE KELLER appreciated her taking time from her practice to testify.

DR. FARR estimated it cost her $800 to participate in this committee hearing.

REPRESENTATIVE TARR related her understanding that the medical home model that has been implemented at Anchorage Neighborhood Health Center is the direction the [medical community] is taking. She questioned whether, in terms of private individual providers, there was general agreement that the state is moving away from that model. As the medical home model is integrated more fully, she asked whether some of the issues will be resolved and if this is more of a transition period since her impression was that primary care providers would not have their own offices.

DR. FARR acknowledged this has been the trend although she totally disagrees with it. She said she has been the medical home for her patients for many years and is able to totally focus on her patients. She pointed out the Alaska Academy of Family Practice has had several presentations on the medical home models. She identified the problem as one that it takes so much time away from the individual provider since the provider is supervising all of the other services. She pointed out that overhead increases since the physician is overseeing other services. She recalled testimony from a Colorado provider who said he/she is now performing Botox and dermatology treatments for patients. She offered her belief that she is trained to treat diabetes and hypertension, but not esthetician services, which she would object to doing. In fact, she predicted the medical home model would increase costs. Instead, she believes the focus should be on primary care physicians and allowing them to work best, whether in a private office, an established

clinic, or at the Alaska Native Medical Center. She concluded that the model does not work in her practice since she is the medical home and she essentially provides concierge medicine although she is not in that fee model.

DR. FARR suggested Mr. Davis could provide testimony on Alaska Comprehensive Health Insurance Association (ACHIA).

CHAIR REINBOLD opened public testimony and noted that the committee would accept comments through October 1, 2013.

12:31:27 PM

MR. DAVIS recalled the comments Dr. Farr referred to are ones he made at the Alaska Health Care Commission recently. He noted that he has the privilege of being the chair of the Alaska Comprehensive Health Insurance Association (ACHIA) also known as the high-risk pool. With the passage of the ACA, the federal government created a Pre-Existing Condition Insurance Plan (PCIPs). Governor Parnell asked ACHIA to set up and administer the federal preexisting condition pool alongside the ACHIA plan - with a firewall between them. The ACHIA began doing this July 2011, but it will go away as of December 31, 2013. He explained that the preexisting pools are stop gap measures anticipating guarantee issue and no preexisting condition exclusions in 2014. In essence this allows someone who has been uninsured for six months to come into the federal pool with no preexisting conditions exclusions, limitations, or waiting periods. He reported that the plan has had 40 patients at any one time, which he characterized as being a churning enrollment since people move in and out of the plan. He offered an example of a patient who acquired the preexisting insurance just for a particular service, a total knee replacement, for $250,000, paid premiums for three months and then dropped her coverage. He reported that she paid approximately $3,000 in premiums for the service. He characterized her as "a house on fire" type of patient. He recalled the Forbes article mentioned a patient in Washington [state] in the 1990s who said she had enrolled in the health plan during pregnancy, but dropped out once the baby was born. That patient commended the service and indicated she would be back if she gets pregnant again. This illustrates what Premera Blue Cross anticipates will happen under the new rules. The Premera Blue Cross actuarials refer to this as "jumping and dumping" since the patient jumps in when he/she needs service and dumps it when the service is no longer needed. He recalled Representative Olson mentioning that this will create financial

pressure upwards on rates and it is yet to be seen how that will play out.

12:34:46 PM

REPRESENTATIVE TARR asked whether an opportunity exists to make changes to how the pool will be applied.

MR. DAVIS offered his belief that this will evolve over time, for example, some rules could be placed with respect to the ability to "jump in" and "jump out" provisions. It may allow people to "jump in" during open enrollment, but if coverage is dropped the person must be out for a set time, perhaps two years to discourage people from the aforementioned behavior. He predicted the ACA rules will evolve over the next 10-15 years.

12:36:26 PM

CHAIR REINBOLD indicated that the committee's work on this issue would be ongoing.

12:37:48 PM

ADJOURNMENT

There being no further business before the committee, the Administrative Regulation Review Committee meeting was adjourned at 12:38 p.m.