

**ALASKA STATE LEGISLATURE
ADMINISTRATIVE REGULATION REVIEW COMMITTEE**

Kenai, Alaska
July 23, 2013
10:03 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 Kurt Olson
Representative Paul Seaton (via teleconference)
Senator Peter Micciche

COMMITTEE CALENDAR

AFFORDABLE CARE ACT: PRESENTATION AND DISCUSSION ON THE EFFECT
THE FEDERAL LAW WILL HAVE ON ALASKA AND ALASKANS

- HEARD

PREVIOUS COMMITTEE ACTION

No previous action to record

WITNESS REGISTER

MIKE NAVARRE, Mayor
Kenai Peninsula Borough
Soldotna, Alaska

POSITION STATEMENT: Discussed the complexities of health care during the presentation on the effect the Patient Protection and Affordable Care Act will have on Alaska and Alaskans.

STORMY BROWN, Director
Human Resources
Kenai Peninsula Borough

Kenai, Alaska

POSITION STATEMENT: Testified during the presentation on the effect the Patient Protection and Affordable Care Act will have on Alaska and Alaskans.

AMANDA AMAKI, Staff
Senator Lisa Murkowski
United States Congress
Washington, D.C.

POSITION STATEMENT: Testified during the presentation on the effect the Patient Protection and Affordable Care Act will have on Alaska and Alaskans.

J. NELS ANDERSON, M.D.
Central Peninsula Hospital (CPH);
Mayor
City of Soldotna
Soldotna, Alaska

POSITION STATEMENT: Described how the Patient Protection and Affordable Care Act would affect physicians.

STACEY KRALEY, Chief Assistant Attorney;
General-Statewide Section Supervisor
Human Services Section
Civil Division (Juneau)
Department of Law (DOL)
Juneau, Alaska

POSITION STATEMENT: Provided comments on the underlying litigation and U.S. Supreme Court decision issued last June that led to the determination that the Patient Protection and Affordable Care Act was valid.

RICK DAVIS, CEO
Central Peninsula Hospital (CPH)
Soldotna, Alaska

POSITION STATEMENT: Testified during the presentation on the effect the Patient Protection and Affordable Care Act will have on Alaska and Alaskans.

ACTION NARRATIVE

[10:03:10 AM](#)

CHAIR LORA REINBOLD called the Administrative Regulation Review Committee meeting to order at 10:03 a.m. Senator Giessel, Senator French (via teleconference), and Representatives Tarr and Reinbold were present at the call to order.

Affordable Healthcare Act: Presentation and discussion on the effect the Federal Law will have on Alaska and Alaskans

10:05:11 AM

CHAIR REINBOLD announced that the only order of business would be the Affordable Care Act: Presentation and discussion on the effect the Federal Law will have on Alaska and Alaskans.

CHAIR REINBOLD said the committee would be holding several hearings across the state to discuss the Patient Protection and Affordable Care Act (ACA), also known as "Obamacare." She offered her understanding that regulations that might be imposed are still being written at a federal level: 10,000 pages so far, with a possible 50,000 pages by the end of the implementation of the Act.

10:06:04 AM

MIKE NAVARRE, Mayor, Kenai Peninsula Borough, stated that he would discuss the complexities of health care in general. He said it is next to impossible to find solutions to the issue of health care costs and coverage "for a resident." He explained that one of the reasons he returned to politics after a hiatus was because he got on the [Central Peninsula Hospital (CPH)] Board and recognized how incredibly fast health care costs have grown in the last 12 years. He relayed that when he left his former office as mayor in 1999, the gross revenues for CPH were \$33 million, and now they approach \$200 million, partly because health care costs have been growing far greater than the rate of inflation, and also because the CPH has expanded its services. He remarked that costs are much higher than that today.

MAYOR NAVARRE imparted that when he was in the Alaska State Legislature years ago, he was on a Health Care Task Force, which was created because the insurance for health care for the State of Alaska had grown from just under \$100 million to over \$120 million. He indicated that because of the work of the task force, Aetna, Inc., did not increase costs for two years, which Mayor Navarre said he interpreted to mean that Aetna was overcharging the state in the first place. He said a second task force on which he served focused on the growing cost of health care and how to meet the needs of Alaska's citizens. He said those involved included health care providers, union members, state Representatives and Senators, and people in the administration. The focus was on the importance of health care

and a search for ways to combat its rising cost. He said one idea at the time was to take the money from the Permanent Fund Dividend and put it into the state's health care system, but that plan "did not fly." He suggested part of the reason that that plan was not accepted was because there was, and still is, no focus on what was driving the cost of health care. He stated, "Until you can fix what's driving the cost of health care, you just can't throw more money at it."

[10:09:44 AM](#)

MAYOR NAVARRE mentioned studies done by the University of Alaska Anchorage's Institute of Social and Economic Research (ISER), which show that over \$10 billion a year is being spent on health care in Alaska. He continued as follows:

In this country, we used to focus on working together to find solutions. If we were going to - in this state - spend in excess of \$10 or \$15 billion a year on health care, would we have the system we have today? ... I think the answer is no. And I think that's what we need to look at in the country and in this state is not where we are, but where should we be?

MAYOR NAVARRE said there are many interests that will be affected by the ACA and the politics surrounding it, including providers and hospitals, and some access to care will be hurt by it. He said 65 percent of health care costs in the country are being paid for by government, including federal and state government through Medicaid and Medicare, and insurance for public employees. Mayor Navarre said as an employer, the Kenai Peninsula Borough has a good health insurance plan for its employees and negotiates to ensure it can maintain flexibility in the face of changes coming from the ACA and avoid getting caught in "the Cadillac health care system." He said the Kenai Peninsula Borough owns two hospitals - South Peninsula Hospital and Central Peninsula Hospital - and has a vested interest in [the ACA], because revenues to both hospitals will be impacted "one way or another." He said there is a lot of uncompensated care. He said one thing about Medicaid expansion is that it doesn't change the dollars going into health care; it just provides an opportunity to be compensated for it rather than having to share it among the payers in the system. He said he spoke with Alaska's Congressional delegation to try to figure out a way to do a demonstration project on the Kenai Peninsula to try to show "what health care should look like over time."

He posited that the Kenai Peninsula Borough would be a good place to do that because there are two hospitals, it is "a closed environment for health care," and there are many good providers. He said nobody really understands who pays for health care and how to figure out a bill. He imparted how much trouble his father had trying to figure out health care bills when sick and doing what many people do, which is to wait until the point a bill is about to go to a collection service before finally being able to figure out how much is owed, because there are often "multiple bills that say different things."

[10:14:04 AM](#)

MAYOR NAVARRE opined that one goal of the Act not yet accomplished - simplification in the health care system to allow transparency in fees charged and health care coverage - should be a goal of Alaska and the whole country. He said hospitals should be allowed to charge only the cost of care; but if they did, they would be penalized, because hospitals "only get paid a portion of that." He characterized the system as "goofy" and "complex." He remarked that his comments were more of a diatribe on the health care system in general rather than on the ACA specifically. He said he thinks the Act was driven by the increase in the cost of health care and what is being paid out by the federal government, and said it is necessary to find ways to control the costs. He said special interests will be impacted by a reduction in the compensation for health care - many negatively.

[10:16:08 AM](#)

STORMY BROWN, Director, Human Resources, Kenai Peninsula Borough, indicated that the Kenai Peninsula Borough employs 300 people and has about 800 "covered lives." The borough has established health care plans, and recently delved into its health plan with its union to try to avoid the aforementioned Cadillac tax. She stated, "We have very few of those employees that are 30-40 hours that are going to change their benefit; we had already benefitted them at 75 percent ... if they wanted it." Ms. Brown said one effect she has seen [as a result of the Act] has to do with the borough's bargaining process. She explained that the delay of the employer mandate, announced in July, "was already too late for a lot of employers and employer decisions." She indicated that spouses and children of employees are affected. She continued:

We put things into our contract that redefined a full-time employee around what was the law, and so now it's in the contract, but there's a delay of a year. So, we are going to pay, in that sense; we're going to pay full-time benefits to employees who, under our definition, wouldn't have been, but we were working under ... the understanding of what the law would be on January 1.

MS. BROWN said employers are doing what they are supposed to do. She indicated that [the Act] does not change what employers do from day to day but people "don't really know for sure what's on the other side of it." She said she thinks some people are making money claiming to be experts on the ACA, claiming that the sky is or is not falling; however, she said, "We don't really know until we're in it." She described the situation as "laying the track while we're on the train." Ms. Brown said that from a larger perspective, the borough cares not just about its employees, but also about how its citizens are going to manage under [the Act].

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MS. BROWN, in response to the chair, described the location and types of borough employees.

[10:21:26 AM](#)

MAYOR NAVARRE stated that "as a private sector employer also," [the borough] is under the threshold for the employer mandate of full-time employees. He related that the borough employs many part-time employees in the "quick-service restaurant business," but it cannot afford to provide insurance for all those part-time employees, because the cost is prohibitive.

[10:22:14 AM](#)

SENATOR GIESSEL asked Mayor Navarre if he knows of small businesses reducing their employees' hours in order to avoid paying benefits.

[10:22:20 AM](#)

MAYOR NAVARRE said he does not know any directly, but suspects "there would be people doing that." Further, he predicted that some companies may split into two, in order to stay below a mandate level, if the impact of the Act becomes onerous.

10:24:03 AM

AMANDA AMAKI, Staff, Senator Lisa Murkowski, United States Congress, stated that she addresses health care issues on behalf of U.S. Senator Murkowski. She relayed that she has read the ACA, which she estimated to comprise 20,000 pages of regulations in its unfinished state. She said that according to the Government Accountability Office (GAO), the October 1 deadline - the time at which the exchanges need to be in place and enrollment is to begin - is very likely not on schedule, which is a concern, given that Alaska is one of the states in which the federal government is going to be instituting the exchanges.

MS. AMAKI suggested it would be helpful to talk about ACA issues covered by the media. She relayed the latest news was the July 2 postponement of the employer mandate, which was done through a U.S. Treasury Department blog post, rather than through a press release or statement, while President Barack Obama was on a 20-hour flight from Africa with the entire group of White House correspondents. She opined that that was an awkward method by which to make an announcement. She said the mandate was listed for businesses, not individuals; therefore, individuals would face a penalty for not having health insurance, but businesses have been given a reprieve for a year. She said although this is most likely welcome news for employers, it treats employers and individuals differently.

MS. AMAKI talked about the 40-hour work week now becoming the 30-hour work week; under the Act, 30 hours a week is considered full time. She offered her understanding that The Wall Street Journal wrote about "49ers" as employers who keep the number of employees under 50 and "29ers" as the number of hours that some workers will be [reduced to] working in order not to be classified as full-time employees under the Act. She said hourly workers making the lowest wage potentially will be "hit with 11 hours less of employment." She said she does not believe the Administration, nor any Democrat or Republican, thinks that is good policy for America. She related that there are restaurant chain operators, which have said they will have to reduce the number of hours their current part-time employees work. Ms. Amaki said the Congressional Budget Office has stated that approximately 8 million people will stand to lose the employer-sponsored coverage they have currently. She said Ben Bernanke, the chairman of the Federal Reserve System, stated during a July 17 House Committee on Financial Services hearing that feedback received through commentary at the Federal Open

Market Committee is that employers are hiring part-time employees in order to avoid the federal mandate. She said it is a concern that has "risen to the level of really being a factor" in employment economics.

MS. AMAKI said the May 13, 2013, Gallop Poll showed small businesses are taking certain actions, such as holding off hiring, pulling back plans on growing their businesses, and cutting employee hours. She said U.S. Senator Susan Collins of Maine has introduced legislation with Senator Donnelly, a Democrat from Indiana, which would change the definition of full-time employee back to 40 hours. She said Senator Murkowski is a co-sponsor. Ms. Amaki related that the labor unions have come out in full force against the ACA, which she said is interesting given their position in helping President Obama get re-elected and their support for the health care law in general.

MS. AMAKI said the consequences of the Act are adverse to the unions. She mentioned a letter, which was sent in July by James P. Hoffa, the general president of the International Brotherhood of Teamsters; Joseph T. Hansen, the president of the United Food & Commercial Workers International Union (UFCW); and D. Taylor, the president of Unite Here, which represents the food service, gaming, and hotels. She said the letter states that the health care laws will destroy the foundation of the 40-hour work week, which is the backbone of the American middle class, and that the employer mandate incentives are shifting workers to part-time status. The letter directly asks President Obama to "fix this problem." It talks about how multi-employer Taft-Hartley plans are arranged between the labor unions and industry. She said [the unions] believe that although they are helping to contribute to the health care law and the subsidies in the form of a Cadillac tax paid on the plans, in the form of the additional tax that employees are going to have to pay for the health insurance premiums - "an additional tax on top of that" - they are not eligible for any of those subsidies. She said the union leaders also believe that the Act is creating a disincentive for them to have more work hours and potentially is making it less attractive to be in a union, because unions arrange the benefits for their members, so if the benefits pushed for are not going to exist, then employers say, "We'll pay the penalty and put you in the exchange." She stated, "That's a disillusion of the entire structure of how unions help to support their members with regards to their health benefits."

MS. AMAKI mentioned another letter from Terry O'Sullivan, general president of the Laborers' International Union of North

America (LiONA!), regarding a tax on insurers that members of unions are going to have to pay, without being eligible for subsidies in the health care exchange. She said the United Union of Roofers, Waterproofers, and Allied Workers sent a letter withdrawing its support. She related that in May, the United Food and Commercial Workers International Union wrote in The Hill regarding its concerns related to the ACA. She stated that if she were President, she would be concerned about the number of recent feedback about the health care law as it pertains to labor unions, given the amount of support the unions have had for the law and the President.

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MS. AMAKI said a GAO report came out in June, which stated that the exchanges are not on schedule and are not likely to be, because 85 percent of required program activities have not been completed, federal and state base exchange court functions have not been completed, and the United States Department of Health and Human Services (HHS) has yet to complete critical steps regarding credits and cost-sharing subsidies. She indicated that yesterday CNBC LLC reported in an on-line article that only 11 percent of doctors believe that the exchanges will be available for their patients, and 70-80 percent of doctors were not familiar with the impact that policies from state exchanges would have on their businesses, the contracted rates with payers, patient coverage regarding cancellation policies and grace periods, and claims processing. As someone who has worked as both billing and office manager in a medical office, Ms. Amaki stated that a lot of patients go to their doctors' offices to get answers concerning health insurance, and with so much unknown about the law, it is concerning that doctors do not know how the exchanges are going to work and how claims will be processed.

MS. AMAKI said there is a new investment tax, at 3.8 percent, for those earning \$200,000 as an individual or filing \$250,000 jointly. She remarked, "Which, by the way, if between 200 and 250, jointly filing, you may be better off not jointly filing, because then it would actually be 400 when you would hit these threshold amounts." Ms. Amaki clarified that, for example, an engineer and a fire fighter could have combined earnings of over \$250,000, and for any type of investment income they would be subject to an additional 3.8 percent [tax]. She said, "We're not talking about millionaires; we're talking about people who have regular jobs, but they may have some ... small investment" She said that tax is going to raise \$123 billion over 10

years "for the health care law." She related that there is a .09 percent increase under the Act for those earning \$200,000 or filing \$250,000 jointly, "so, a total of 2.35 percent." She continued as follows:

So, two working professionals, each earning 125, if they exceed that ... they would be paying an additional .09 percent in payroll tax. That is going to raise \$86.8 billion over 10 years to pay for the law.

MS. AMAKI said there is no longer eligibility for tax-preferred purchases through the health savings accounts and flexible spending accounts unless you have a prescription, which she said will raise the cost of health care, because in order for a person to use a flexible spending account, he/she will have to visit a doctor in order to get a prescription. She stated, "That's going to raise \$5 billion over 10 years for the health care law."

MS. AMAKI said a 2.3 percent medical device tax went into effect the beginning of 2013, which exempts items retailing for less than \$100, but would tax items such as crutches, braces, or an implanted device. That tax will raise \$20 billion over 10 years.

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MS. AMAKI said there is a cap of \$2,500 on flexible spending accounts. She reminisced that members of the U.S. Senate used to be able to put as much as they wanted into their flexible spending accounts in anticipation of any major medical procedures. She said some use flexible spending accounts to pay for the care of a special needs child, and \$2,500 does not go far in that regard, nor does it cover much for those with conditions that require further treatment. She opined that the cap was arbitrarily set, because there is "no reason policy should not be set to encourage savings." She said [the cap] will raise \$13 billion over 10 years, solely for the purpose of raising revenue to "pay for the health care law." Ms. Amaki said there is a 10 percent "suntan" tax, which went into effect in 2011. She explained it taxes indoor tanning and would raise \$2.7 billion over 10 years. She said, "It's just a tax to raise money for the health care law."

MS. AMAKI continued as follows:

... When you have high health ... care bills in general, you can expense that so long as it exceeds 7.5 percent of your adjusted gross income. Under the health care law, they raised that threshold to 10 percent of adjusted gross income. So, they basically made it more difficult to ... claim that deduction; you have to spend more in health care in order to do that.

MS. AMAKI said there is an individual mandate, which is 1 percent of a person's income or \$95 - the higher of the two - in 2014 if the person does not purchase health insurance. That goes up to 2.5 percent or \$695 by 2016. She said an individual - working a low-paying, hourly wage job - who does not get health insurance, could be subject to paying \$695. Ms. Amaki relayed that the employer mandate tax is on employers with 50 or more employees. She said if those employers do not provide health insurance to their employees, they will either have to pay a penalty or provide the government mandated health insurance benefits. She said the penalty is \$2,000 or \$3,000, "depending on what they do." Ms. Amaki stated that the Cadillac tax would raise \$32 billion on plans that are considered "Cadillac health plans." She stated, "This is probably the scariest for Alaskans, given that the threshold amount is only \$10,200 or \$27,500 for a family." She continued as follows:

So, ... if the value of your insurance is \$5,000 - meaning the employer [sic] contributes \$2,000, the employer [sic] contributes the remainder - that's the value of the plan. The Cadillac tax says if your plan exceeds what we consider a Cadillac tax - \$10,200 for a plan - then you're going to pay a 40 percent tax on top of that. So, based on that Alaska State employees' benefit plan this year, the lowest pure benefit available to an individual on ... the economy plan, which has a \$500 deductible, ... would have a tax of \$2,800, because it exceeds the \$10,200 threshold. For the mid- and highest-level plans available to the Alaska State employees, the taxes would be \$3,033 and \$5,894.40, respectively. So, based on today's numbers for Alaska State employees, they're going to be subject to this tax. Now, granted this tax doesn't go into effect for another five years, but it still is worth noting that just based on today's numbers for an individual policy for an Alaska State employee, the tax is going to be there.

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MS. AMAKI said the [ACA] has \$716 billion in Medicare cuts. She said, "We already know that Medicare is struggling, and to create a new entitlement on the back of Medicare is probably not economically sound, but I guess that's for my generation to worry about." She related that ISER has conducted a study of how Alaska Medicare beneficiaries will be hurt by cuts in general and by federal health care reform. She said the studies were done before the health care law went into effect, so they are dated, but she opined that a study is not necessary to show that cuts in Medicare are not helpful for Alaskans or seniors. She mentioned a Wall Street Journal article, dated July 21, entitled, A CEO's-Eye View of ObamaCare, written by [Andrew Puzder], CEO of CKE Restaurants, which is the parent company of Carl's Junior and Hardee's Restaurants. The article relays that those restaurants: have 21,000 employees; pay 60 percent of the benefit given to the 60 percent of the general managers who sign up; and have only about 6 percent of entry-level workers sign up. The reasons many of the entry-level workers gave for not signing up include they are not concerned about illness or injury, they get insurance through a spouse or parent, and "emergency room care is free." She said under the health care law, a person can get insurance whenever the need arises, which she said is "pretty exemplary of how young people think." Ms. Amaki stated, "As you all know, this law hinges on young people signing up for health insurance, and if you have young people saying, 'Well, I can sign up when I get sick or I need it,' then that's ... very indicative of where we're going with this health care law." She reiterated that "the penalty" is \$95 or 1 percent of a person's household income, up to \$695 or 2.5 percent of a person's household income, by 2016. She said a general manager working at a Carl's Junior or Hardee's is paid in the \$50,000 range; therefore, the penalty for a manager would be \$500 in 2014 and \$1,250 by 2016. Ms. Amaki questioned why any of the lower-level employees would buy health insurance, which would cost a contribution amount of \$2,000-\$3,000 to the plan offered by CKE Restaurants, when that cost is three to four times greater than the buying health insurance at the time of need. She illustrated that for the young crew level workers, the penalty in 2014 would be \$115, rising to \$695 by 2016, and their contribution for insurance would be \$1,091.55.

10:49:52 AM

MS. AMAKI said an American Broadcasting Company (ABC)/Washington Post poll reflects that in 2010, moderate to conservative

Democrats' support of the ACA was at 74 percent, and the poll indicated that by 2013, that support dropped to 46 percent. Further, she relayed, the poll reflected that Democrats in general supported the Act by 68 percent in 2012 and by 58 percent in 2013. The public in general was shown as being 47 percent in support of the Act and 47 percent opposed. Ms. Amaki said she thinks there is growing concern about how the ACA will affect the economy, how exchanges will be implemented, and why employers are getting a reprieve when individuals are not.

[10:50:57 AM](#)

CHAIR REINBOLD said Ms. Amaki's presentation was enlightening, and she asked her to send a copy of it electronically to her office.

[10:52:02 AM](#)

CHAIR REINBOLD read a question from Representative Seaton as follows:

Is there an estimate to whether Alaska will be further relegated into last place on a share of income from federal funds as a portion of our total budget with our state choices under Obamacare?

[10:52:13 AM](#)

MS. AMAKI answered that she does not know. She asked for clarification if the aforementioned estimate pertains to Alaska's share of [federal] income.

CHAIR REINBOLD ascertained that Representative Seaton was available to respond via teleconference.

[10:52:30 AM](#)

REPRESENTATIVE SEATON clarified that he wants to know whether the state choices made under the plan would have an impact on the percentage of income to Alaska.

MS. AMAKI confirmed she would have to look up the answer to that question.

[10:53:22 AM](#)

SENATOR FRENCH asked Ms. Amaki to expand on the issue of custom Medicare under the ACA.

MS. AMAKI said the Act cuts \$716 billion from various programs in Medicare, and she offered to provide a chart showing exactly what is impacted. She added that Medicare Advantage is one area where there are cuts.

SENATOR FRENCH said he would like that information provided to the committee.

MS. AMAKI said, "Sure, and that's from the CDL."

[10:54:54 AM](#)

REPRESENTATIVE TARR asked Ms. Amaki if she could talk about the savings that would come from the ACA in contrast with the taxes she already discussed, because she said her understanding is that "if everything lines up it should be revenue neutral."

MS. AMAKI replied that there are various measures in place to "help with cost reduction," such as cuts to the Medicare program, which she said will be "seen as ... helping to make savings." She said the Independent Payment Advisory Board (IPAB) is supposed to make cuts to programs. She remarked that unelected bureaucrats would be appointed to the board to make those decisions. She said there are programs that would provide more residency incentives for primary care, which hopefully will "help with some of the Nation's problems with getting access to primary care." She opined that is a good thing, although not a cost saver. She said there are provisions that will see reductions in revenue, but at the cost of patient access to care and cuts to Medicare.

[10:56:57 AM](#)

CHAIR REINBOLD related that an elderly couple called her to say they were alarmed when they were told they had to fill out a 63-page questionnaire, on which they must record all their financial information or be fined with a huge penalty. She said her on-line research confirmed that this form was being given to elderly people to fill out, but that since then "they've tried to reduce it to about half a page." She said the couple who contacted her felt that the form was incredibly invasive and out of line.

MS. AMAKI indicated that [the form] asks whether the person filling it out is registered to vote, which she questioned as to relevancy. She credited the Administration for recognizing the lengthiness of the questionnaire and trimming it down. She said the form had a lot of questions on it that "didn't seem right," such as questions about income and justification requested from Native Americans as to their Native status. She said the ACA requests a lot of information from people. She said dozens of new Internal Revenue Service (IRS) employees are being hired, because the IRS plays a large role in the enforcement of the Act. She said when federal dollars are given to people to buy health insurance, the government tries to get as much information as possible to ensure it is providing the right amount of subsidy per individual. Ms. Amaki posited that the problem is that with the delay of the employer mandate "we're now basically on an honor system." She compared it to dropping off a donation to the Salvation Army and deciding how much it is worth. She said, "There is no way to check that data when the employers don't have to report." She stated, "It just gives another level of scrutiny of your information by the IRS." She opined that it is all part of a larger problem.

CHAIR REINBOLD encouraged Ms. Amaki to send any other information she has to the committee.

[11:01:54 AM](#)

J. NELS ANDERSON, M.D., Central Peninsula Hospital (CPH); Mayor, City of Soldotna, said he received a call from legislative staff member Jim Pound to come testify about how the ACA has affected physicians financially. He said he has strong opinions about the Act because of patients that are dying because they are not covered with or cannot get insurance and do not have the funds to pay for care. He opined that the Act has "killed discussion on meaningful reform, which would allow people to actually get coverage." He said even after the Act is fully implemented, there will be approximately 20 million people uncovered, about 30 million with only partial coverage, and half the bankruptcies will continue to be caused by people not having adequate medical insurance. He added, "More than half of those have, supposedly, health care coverage - have insurance - we just don't have the system that I'm very happy with as far as that. So, you understand where my prejudices are."

[11:03:58 AM](#)

DR. ANDERSON credited the late Representative Ted Stevens for Alaska's having the highest Medicaid reimbursements. He said the state has the highest Medicare reimbursements and resource-based relative value scale (RBRVS) multipliers. The only other places in the country that come close are San Francisco County and San Jose, in California. He said he has delivered babies of many Medicaid patients and gets paid handsomely for doing so. He said the effects of the ACA are merely speculations. The rules for the insurance exchange and the basic coverage have not yet been established, and until they are no one knows what is going to happen, he said. He remarked that every article under an Internet search for "Obamacare" will be negative, while the results for a search for the "Affordable Health Care Act" will be more balanced between support and opposition to the particular aspects of the Act.

DR. ANDERSON said the Act improves coverage for children, because they cannot be denied for preexisting conditions. Insurers are prohibited from discriminating against adults for preexisting conditions, and young adults can stay on their parents' plan until the age of 26. Insurance companies are prohibited from rescinding coverage, from limiting lifetime insurance coverage, and from having annual limits on insurance coverage. He said, "They're also affixing the Medicare Part B (indisc. - rustling papers) doughnut hole." He said physicians will benefit because they get paid for some of these services. Dr. Anderson said the Act: provides scholarships and loans for those going into primary care and for nurses; increases Medicaid payments to physicians by 10 percent; gives a 1.5 percent bonus for physicians for quality reporting on Medicare; and provides coverage for preventive health care services and personalized prevention plans, such as counseling, which have not previously existed. He said theoretically if people have counseling and preventative care "they may be able to cut down costs"; however, he noted that when Richard Lamm was governor of Colorado, he argued that smoker's should be thanked for killing themselves, which reduces the population, thereby reducing health care costs. He remarked that he has never been able to find Mayor Lamb's data. He stated, "The fact is we're all going to die of something sometime, and we're all going to need the system." He said currently the average Medicare recipient uses between \$250,000 and \$400,000 in his/her lifetime, which Dr. Anderson ventured no single person can "save and account for." He said the Act also provides coverage for non-patient planning and review. For example, a family with an elderly person who is sick would be covered to talk with someone about a plan of action. He said that has never existed before.

11:08:27 AM

DR. ANDERSON relayed that the Act is supposed to provide for administrative simplification. Dr. Anderson said family care physicians currently spend 30 percent of their income attempting to collect what they charge for their services. He asked the committee to try to name any other business that does that. He said he has three people in his office who do nothing but try to collect from the multiple insurance companies whose main goal is to make a profit, not to provide care for people. He opined that insurance is "the wrong way to go" and the Act "will just add billions more in terms of profits to the insurance company." He said administrative simplification would be helpful, but there is no way of knowing if that will actually result from the Act.

11:09:23 AM

DR. ANDERSON talked about the negative aspects of the Act; a topic, which he said is covered by "the Heritage Foundation's web site" or "papers." First: "The rules and regulations will drive doctors out of practice." He said there are now 12,000 pages of regulations written on the Act, and it is unknown how many more pages will be written and "how this will affect it." He said everybody is worried about both intended and unintended consequences of the regulations that are written. Second: "The ACA will drive physicians to be employed by hospitals, and employed physicians see fewer patients." Dr. Anderson confirmed that employed physicians see about 15 percent fewer patients than they do when working in private practice. However, he said he thinks that has little to do with the Act. He explained that in 2005, about half of physicians were in private practice and that number is down to 33 percent - prior to the Act taking affect. He said students coming out of medical school do not want to run a business, so most are opting to be employed rather than starting a private practice.

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DR. ANDERSON said another concern is: "There are not enough doctors to see the new patients." Dr. Anderson said his cynical side thinks "those doctors who are marginal now and can't fill their schedules will be able to fill them." He said that by 2021, of the 95,000 to 120,000 new physicians, about 15 percent are "probably going to be caused by the ACA," while the other 85 percent "are caused by Baby Boomers like me aging and the

increase in population." He said in 1997, Congress cut back substantially on the amount of funds that were provided for training of new doctors. He said medical training is expensive and is not something that is going to be taken on by private enterprise. Dr. Anderson said the Act provides some extra funds, especially for primary care providers and their training, "so it begins to reverse that a little bit, but we're still way behind." He stated, "In my view, that has very little to do with the ... Act, it's mostly to do with decisions we've made in the past."

DR. ANDERSON posited that if people have to have health care and there are not enough physicians and the argument is that "we can't afford it," then "as of right now we sort of let those people stay out there and die." He said he does not think people really appreciate that. Dr. Anderson set up an example wherein a person is 45, owns a private business, gets Diabetes, and must pay for medication until he/she is eligible for Medicare at age 65. He indicated that before the Act was passed, Senator Murkowski held a public hearing and heard from parents without health insurance who were spending an incredible amount of money on medical care for their asthmatic daughter but could not buy insurance for the child. He offered his understanding that Senator Murkowski was "frustrated and flustered because she had trouble understanding why this child couldn't be seen." Dr. Anderson said he sees many similar examples in his practice, where patients tell him that they have to choose between paying for medication or food, and they choose to eat. He remarked that someone in a car accident would be taken to the emergency room and treated, but those dying from chronic disease processes are not being treated, and he said he finds that "extremely bothersome."

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DR. ANDERSON said the perception by the majority of doctors is that the ACA will have a negative impact on their practices. He said he thinks that depends on how the question is asked. Before the Act was passed, a survey showed that more than 70 percent of physicians preferred a single payer system. He said there is disagreement about how that single payer system should run; however, about five hundred billion dollars a year could be saved by going to a single payer system from the current system, which uses 35 major insurance companies and 12,000 minor insurance companies. Dr. Anderson opined that that makes sense. He stated, "All of us have reason, when government intervenes in things, to be worried about those consequences and what will

happen." However, he said he does not think the changes mentioned by the previous speaker, regarding people's support for a system, reflect much of anything; he said he thinks "it reflects the fact that nobody knows exactly what's going on, including most of us."

DR. ANDERSON put forth another consideration: Medicaid rates are lower than private insurance, and because there will be some people who switch to Medicaid, doctors will get paid less per patient. In response, he said he has not found that to be a problem in Alaska, because he said he thinks Medicaid pays exceptionally well. He stated another consideration: The Independent Advisory Board will control Medicare expenditures or make decisions without physician input, and the prospects of proposed fees without recourse to scientific evaluation is a serious issue. He concurred with that. He said most evaluations show that up to 70 percent of x-rays and radiological procedures and 50 percent or more of heart surgeries in the country are unnecessary. He offered an example. He said in a system where the focus is not on what is cost effective and useful, physicians are encouraged to do what makes a profit. He said it does not make sense that he gets paid more for performing a 15-minutes C-Section with no office overhead cost than he does working a full day in his office and paying staff.

DR. ANDERSON indicated [the Act] may result in positive effects for primary care but negatively impact specialists. He said studies show that to run a medical care system effectively there should be 80 percent primary care providers and 20 percent specialists; however, the U.S. has 80 percent specialists and 20 percent primary care providers. He said, "Specialists create their own needs; if they don't have them, they'll figure out things to do so that they can get paid." He said the percentage of people in primary care needs to increase so that the field of medicine can be run more cost effectively.

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REPRESENTATIVE OLSON asked Dr. Anderson if he has suggestions for ways to increase the number of primary care physicians in Alaska, particularly in larger towns.

DR. ANDERSON said financial incentives work, but bringing a doctor up to Alaska does not always work unless he/she wants to be here. He suggested getting more Native Alaskans into the medical field to hopefully have them return to their villages,

although he said it is not possible to control who stays in Alaska and who leaves.

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REPRESENTATIVE TARR asked for Dr. Anderson's thoughts on expanding the scope of practice for nurse practitioners and others who are not physicians but would be categorized as primary care providers.

DR. ANDERSON responded that the Act does provide funds for "increasing nursing for nurse practitioners and things." He said he thinks there is no question that extended providers need to be used to "help manage a lot of the initial problems," and that doing so is cost effective. He said Alaska's nurse practitioners have "a free hand to do whatever they want," and he said he does not disagree with that.

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SENATOR MICCICHE commented that it is difficult to support the idea that the Act will solve problems and bring down the cost of insuring individuals. He asked Dr. Anderson to describe how "we" got "in this situation" and whether he sees solutions for Alaska.

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DR. ANDERSON reiterated his concern with [the Act] is that it has killed any meaningful reform. He said in 2002, a bill was before Congress that said states could "take their funds and do what they wanted with them, as long as they provided coverage for about the same number of patients that was already being covered for under federal funds." He said the same bill was proposed a couple years ago. He opined that until there is a law that allows states to innovate, "we're going to be in trouble." Dr. Anderson relayed that he lived under the Canadian system, where each province had its own system and learned from each other's mistakes what things worked. He said he thinks the same needs to happen in the U.S. He mentioned Joe Jarvis, who runs a health insurance exchange in Utah and is a Republican and advocate of the single payer system. He related that Mr. Jarvis said the State of Utah spends \$15 billion on health care, two-thirds of which is paid for by the government, and also indicated that he could provide health care for everyone in Utah for the \$10 billion without the presence of private insurance; the insurance companies are taking \$5 billion out of Utah. Dr.

Anderson expressed concern that taking a trillion dollars out of the system to move a single payer system would cause a lot of people to lose jobs. For example: the people in hospital administration who do billing; the people he hires in his office to do billing; all the people working for the insurance company "fighting not to pay us for what we do." He said Representative Olson is helping him with a bill which proposes at least a partial solution to mal practice issues in the state and would save money. He said he personally would like mal practice to go to a worker's compensation-type [system] or to use a system used in other countries where health care court judges are utilized to look at the system and decide whether a patient has been harmed and what his/her compensation should be.

[11:31:30 AM](#)

The committee [took an at-ease] from 11:31 a.m. to 11:43 a.m.

[11:43:52 AM](#)

CHAIR REINBOLD brought the Administrative Regulation Review Committee meeting back to order.

[11:44:10 AM](#)

STACEY KRALEY, Chief Assistant Attorney;;, General-Statewide Section Supervisor, Human Services Section, Civil Division (Juneau), Department of Law (DOL), specified that while she could give a short summary of the litigation and decision related to the ACA, she was not in the position to comment on any current impacts on the implementation of the Act. She questioned whether, in light of the chair's stated purpose of the meeting, her comments would be helpful, or whether the chair would rather have her yield to Mr. Mills and the public to talk about implementation issues.

CHAIR REINBOLD indicated that Ms. Kraleley's information was pertinent to the discussion.

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MS. KRALEY reviewed that last June, the U.S. Supreme Court ruled that the ACA was, "through various judicial alliances," valid and was going to be the law of land. She said there were three major components to the underlying litigations. One was whether or not the law could be challenged under the Anti-Injunction Act, a federal law, which precludes any litigation related to

enforcement of a tax until the tax is actually levied. She said there was a theory in the underlying litigation that the case was not right for judicial determination, because the tax component of the Act would not be implemented until 2014; however, the U.S. Supreme Court rejected that argument, saying that the matter was not a tax, but a penalty, and therefore the Anti-Injunction Act did not apply. The second provision was the individual mandate, which was challenged in the underlying case, in which the State of Alaska participated, under the theory that the individual mandate violated the commerce clause, because the Act was trying to regulate inactivity rather than activity by penalizing individuals for not participating in health care as opposed to regulating individuals who do participate. She said the U.S. Supreme Court ruled that the Act was unconstitutional as to the commerce clause, and that the clause did not apply, because the Act was regulating inactivity versus activity; however, the court then ruled that the Act, under the individual mandate, was still permissible, because it was a valid exercise in Congressional authority to tax. She said this was an interesting outcome, because there was not a lot of briefing, argument, or focus on the taxing clause provision of the arguments; the vast majority of briefing, argument, and underlying cases dealt with the attack on the commerce clause. In the end, she said, the court ruled that while it wasn't a valid exercise under the commerce clause, the Act's individual mandate components were a valid exercise of Congressional authority under the taxing power. Finally, she said, the remaining provision of the Act that was challenged in the litigation was the Medicaid expansion, which was ultimately found valid, but with some limitations. She mentioned an "original theory" that the Act required the states to engage in a Medicaid expansion that would increase the numbers of individuals eligible for Medicaid to childless adults, which is not a current category of coverage, and who are individuals with income up to 133 percent of the federal poverty guidelines. At that point, she said, states, including the State of Alaska, objected that the Medicaid expansion was basically coercive in nature, because if the states did not agree to include the Medicaid expansion, they were at risk of losing 100 percent of their money from the federal government. The U.S. Supreme Court ruled that it was indeed coercive, but that the provision that required an all or nothing proponent or outcome under the Medicaid expansion could be severed. So the court said that rather than having the expansion be a mandatory component of the Act, states are now in a position to determine whether or not they want to expand to that Medicaid population or not. If they chose to expand, they would have all the benefits of federal

participation and matching dollars in order to expand that population, but if they choose not to expand, the remainder of the Medicaid dollars would not be impacted. She concluded, "That is a very brief summary of the three major components of the Supreme Court decision and how we got to the point now where they are implementing the underlying provisions of the Affordable Care Act."

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CHAIR REINBOLD asked Ms. Kralely if it is legal for the President of the United States to delay part of the law on his own.

MS. KRALEY answered that she has not looked into the Presidential authority in that context.

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RICK DAVIS, CEO, Central Peninsula Hospital (CPH), remarked that CPH is a 49-bed facility, which is owned by the borough. As a disclaimer, he stated that he thinks health care is too expensive, uncoordinated, lacking in pricing transparency, and unsustainable in the long run. He referred to the patient Dr. Anderson had mentioned who had open heart surgery while on vacation, and estimated that that probably resulted in a half a million dollars paid for by "the system," because there is no coordination of care. He recollected that Mayor Navarre had suggested a better job could be done in "coordinating the care of our members here on the peninsula." He said, "We're kind of the perfect little model for something like the Accountable Care Organization model that's been talked about. Whether or not those actually ... become a mandate or not, I guess nobody knows." He opined that those system-wide problems are what the Act is meant to address, although he said he does not think it will make those changes directly. He ventured that indirectly, the Act might force better relationships between patients and doctors. Mr. Davis said primary care doctors make a lot less than specialists. Someone who goes through eight years of medical school may make \$200,000 to \$300,000 annually; whereas someone who continues with a residency could make \$800,000 to \$1 million. He added, "I think you could find a lot of people to help finance that last two years if they could get a cut of the next twenty years at that kind of income." He said the structure of the system encourages lots of specialists and a lot of procedures.

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MR. DAVIS said the Central Peninsula Hospital (CPH) is well aware that measurement, delivery, and reimbursement methods of health care change rapidly. He reported that CPH is currently the top hospital in the state in terms of its ability to take full advantage of value-based purchasing, which he explained is a combination of reimbursement for quality outcome and patient satisfaction, as opposed to the current volume-based reimbursement. He said the hospital associations in Washington were at the table when reform negotiations took place. He said in the end, hospitals across the country supported \$155 billion in cuts to Medicare payments over ten years, "in order to help pay for the legislation," along with certain guarantees that more people would be covered. He explained the reason "we" supported that is because "we're mandated to provide emergency care to anyone who walks into our emergency room, regardless of ability to pay."

MR. DAVIS noted that Ms. Kralely had talked about the Medicaid expansion as being "one of the challenges that was successful to [the] Affordable [Health] Care Act." He said Medicaid expansion became optional for the states. The individual mandate will occur, with exchanges "going live" in less than 70 days. The hospital has accepted that \$150 billion cut, with the reassurance that people would be covered. He said some people are going to be covered through the mandate, but he reiterated that the Medicaid expansion is an option for each state, so "that could leave a pretty big hole in the covered patients who are still going to come to the emergency department, and we're still going to care for them."

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MR. DAVIS relayed that Enroll Alaska, a new subsidiary of North Rim Bank, is a private enterprise company that was started to help enroll eligible members who "now don't have insurance" into the new coverage. Mr. Davis offered his understanding that for Alaskans, that coverage would be provided through the exchange by Moda Health and Premiera Blue Cross. Enroll Alaska is asking hospitals in Alaska to allow it to set up enrollment specialists in the hospitals to help new members when the new mandate comes into play.

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MR. DAVIS said in addition to reform, cuts in health care happen every time there is a fiscal crisis in Washington, D.C. He

indicated that the next [fiscal crisis] will be in response to raising the debt ceiling "in about a month." He said he suspects hospitals will be part of that discussion. Mr. Davis said CPH was hurt badly on January 1, 2013. He talked about a reinstatement just before midnight, on the last day of 2012, which saved doctors from a 21 percent cut. Hospitals did not take a huge cut overall; however, rural hospitals took "a pretty big cut." He said the cut that day, along with a couple other cuts made about that same time, were about a \$2.1 million hit to CPH. He said currently there is a bill being considered in Washington, D.C., that would permanently fix the sustainable growth rate (SGR), of which Dr. Anderson spoke. He described SGR as a flawed formula from 1997, which is used to determine Medicare fees paid to physicians. He said, "If Congress does not override the formula by the end of December, physicians will face a 25 percent reduction in Medicare fees." He indicated that Congress has overridden that formula for the last 16 years, but "at some point ... that might go away." Mr. Davis said CPH's concern over that is twofold: first, hospitals will be targeted to pay for the fix; and second, if the fix does not occur, physicians will stop taking Medicare patients. Either way, he said, the hospital loses.

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MR. DAVIS stated that reform is not the only change occurring in health care; health care policy as a whole continues to be at the forefront due, for example, to economic concerns, transparency, and growing state and federal budgets. As a result, he said, it will become increasingly difficult to manage a hospital or physician practice, because of constantly evolving conditions. He said CPH is one of two hospitals on the Kenai Peninsula owned by the borough. As a small facility, it must address issues one at a time and try to do what is best for the community, which is financially "on the hook."

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MR. DAVIS said currently there is a patient in CPH that requires a procedure that must be done at an academic center; however, no facility in the Lower 48 will take the patient, because she has no medical coverage and her condition is not life-threatening. Mr. Davis said to date CPH has absorbed over \$1 million in medical costs for the woman, who does not qualify for Medicare or Medicaid and cannot afford insurance. He stated, "We would very much like to see everyone have some type of coverage."

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SENATOR MICCICHE offered his understanding that hospitals are required to give emergency care only to those who need acute care, but said he assumes that Mr. Davis' example shows that hospitals are required to treat a person who comes to the emergency room for any reason.

MR. DAVIS responded that for every patient that walks into the emergency department, the hospital is required to do a medical screening, stabilize the person, and release the person once stabilized or admit him/her if needed. He explained that the patient to which he previously referred had surgery, but is languishing and needs more complex surgery. He said a person who goes to a general practitioner or cardiologist with complaints of chest pain but no money to pay will likely not be seen. The same person with the same complaint who goes to the hospital will be told to stay home, eat better, and exercise, but when he/she has a heart attack, the hospital will provide care and a surgeon and have to cover the \$250,000 cost. Those uncovered costs trickle down to other patients. If the patient had been able to afford the cardiologist, he/she may have avoided having to have heart surgery.

SENATOR MICCICHE asked how the ACA would help municipalities with "some of those costs."

MR. DAVIS answered that as more people get coverage, that will help lower health care costs overall, because having coverage allows a person to get better primary care, which means earlier intervention. He indicated that the Act potentially could drive communities to a system that is responsible for the entire community; therefore, every member in that community would be working on getting each other healthy.

12:10:58 PM

REPRESENTATIVE TARR asked Mr. Davis if he is referring to the medical home model.

MR. DAVIS answered yes.

REPRESENTATIVE TARR mentioned that two facilities were opened in Anchorage, Alaska, just for Medicare patients. She said she was under the impression that "moving towards that model was the way to go," but questioned whether that would have a negative impact on hospitals that would lose those patients.

MR. DAVIS answered not really. He explained that CPH does not particularly want Medicare patients to come into its emergency department, because more chronic conditions are better dealt with in a physician's office.

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CHAIR REINBOLD said she had received a question from someone. She continued as follows:

In the case of a patient who comes to the emergency room today ... but right now they can't pay, so you may need to spread the cost amongst ... other patients or take a loss: Under the Affordable ... Care Act, will you receive something and will it reduce the cost to other patients and do you believe the Affordable [Health] Care Act is the right solution for today?

MR. DAVIS answered as follows:

... It won't increase what they pay unless Medicaid expansion is put in place and they're able to get Medicaid, or if they are participating in the ... insurance exchange. If they're in the insurance exchange we'll be able to get something; if ... Medicaid is expanded to the point where that person would then be eligible for Medicaid, we would get something. Where that saves money for the members of the Kenai Peninsula Borough is it reduces that cost shifting, because it's kind of ... not really a zero-sum game. I mean, we have to buy new equipment, we have to pay our employees, we have to maintain a certain level of ... revenue. So, however that revenue gets cut, ... we either decrease services or try to get the revenue from another source. And so, that's what the cost-shifting is all about. And this ... should help reduce that cost-shifting. Whether the Affordable Care Act is the right answer or not, I don't guess I'm qualified to have an opinion on that. I'm just trying to ... play the hand we're dealt

MR. DAVIS indicated that in an article he read, Senator McCain made arguments to the effect that the Act was here to stay. Mr. Davis ventured the Act could be repealed, but said right now it looks like it's "on its way" and CPH is doing its best to be ready for it.

[AN UNIDENTIFIED SPEAKER] made a remark regarding viewing testifiers as experts.

CHAIR REINBOLD said that with so many pages and more still to come, she cannot imagine being an expert on the ACA.

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REPRESENTATIVE TARR offered her understanding that the premise behind "this" is that the more people who are covered, the lower the cost would be. She recollected that during its last meeting, the committee had heard from [Premera Blue Cross Blue Shield of Alaska] that "it's going to be a bit of a roller coaster until things sort of even out." She asked Mr. Davis if he has a timeline in which he thinks "that will happen." She asked him how he is projecting finances.

MR. DAVIS responded that CPH is budgeting for an annual drop in its reimbursement rates for Medicare and budgeting Medicaid as it is now. He said the fiscal year 2013 (FY 13) just ended, and he said he thinks CPH did \$18.6 million in uncompensated care; \$9.8 [million] of bad debt; and \$8.6-\$8.8 [million] of charity care. He said the \$18 million has to be made up for in other ways, "to the extent that those people would have some means of paying ... is what we're trying to ... get to."

12:17:12 PM

REPRESENTATIVE OLSON asked Mr. Davis if he perceives the hospital will ultimately get into a situation where it is buying retail and selling wholesale - getting more people, but making increasingly less money.

MR. DAVIS answered that is exactly what CPH is expecting. He relayed that he used to be a cattle buyer who said, "I lose a little money on every transaction, but I make up for it on volume."

REPRESENTATIVE OLSON said that is his greatest concern for all.

MR. DAVIS said CPH understands that the reimbursement per member is going to drop, and would like to increase some of the covered members to offset some of that and continue its mission.

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CHAIR REINBOLD asked Mr. Davis if he finds it alarming that the young may buy coverage only when they need it.

MR. DAVIS offered his understanding that Mr. Davis of Premera Blue Cross Blue Shield of Alaska talked about that at the last meeting. He said it is not so much a problem for CPH as it is for Premera Blue Cross Blue Shield of Alaska, because the insurance company will be the one to face that problem.

REPRESENTATIVE OLSON, having spoken with Mr. Davis of Premera Blue Cross Blue Shield of Alaska after that meeting, offered his understanding that Mr. Davis' primary concern is that he has "lost all his underwriting tools." He continued:

[He] can't discriminate: ... It's not based on age; it's not based on health; it's not based on life mechanisms that people may have control over - choice; but all of a sudden they have a condition that needs to be treated. They could go in, they could find out pre-existing conditions on something that may have been substantially of their making, get fixed, and drop off.

REPRESENTATIVE OLSON gave an example of someone who signed on for the highest monthly premium of \$1,000, had a hip replaced, dropped off insurance, and wrote a thank you, stating his/her intent to repeat the process for the other hip the following year. Representative Olson surmised that for two hip replacements, the person paid \$2,000, while the state probably paid \$40,000 to \$50,000.

CHAIR REINBOLD added that Premera Blue Cross Blue Shield of Alaska is "running on 1 percent profit margin," so "this" could really affect the company.

12:22:00 PM

CHAIR REINBOLD opened public testimony for the Kenai Peninsula area.

CHAIR REINBOLD, after ascertaining that no one wished to testify, closed public testimony for the Kenai Peninsula. She specified that although the opportunity to testify orally had ended, the committee would continue to accept written testimony from Alaskans across the state until about October 15, 2013.

12:24:53 PM

ADJOURNMENT

There being no further business before the committee, the Administrative Regulation Review Committee meeting was adjourned at 12:25 p.m.