ALASKA STATE LEGISLATURE
ADMINISTRATIVE REGULATION REVIEW COMMITTEE
Eagle River, Alaska
October 29, 2013
12:03 p.m.

MEMBERS PRESENT

Representative Lora Reinbold, Chair
Senator Cathy Giessel, Vice Chair
Representative Mike Hawker
Representative Geran Tarr

MEMBERS ABSENT

Senator Gary Stevens
Senator Hollis French

COMMITTEE CALENDAR

PRESENTATION: AFFORDABLE CARE ACT

- HEARD

PRESENTATION: REGULATIONS FOR HEALTH INFORMATION EXCHANGES

- HEARD

PRESENTATION: DEPARTMENT OF HEALTH AND SOCIAL SERVICES ASSISTED LIVING HOME RATE CHANGES

- HEARD

PREVIOUS COMMITTEE ACTION

No previous action to record

WITNESS REGISTER

JYLL K. GREEN, Advanced Nurse Practitioner (ANP)
myHealth Clinic
Anchorage, Alaska
POSITION STATEMENT: Testified during discussion of the Affordable Care Act.

TYANN BOLLING, Enroll Alaska
Northrim Benefits Group, LLC.

Anchorage, Alaska
POSITION STATEMENT: Testified during the hearing on the Affordable Care Act.

ROSS TANNER, M.D.
Diabetes & Lipid Clinic of Alaska
Anchorage, Alaska
POSITION STATEMENT: Stated his position on healthcare during the discussion of the Affordable Care Act.

BRANDON CLARK, Health Care Policy Expert
FrogueClark LLC
Washington, D.C.
POSITION STATEMENT: Explained details of the Affordable Care Act.

THOMAS HENDRIX, Ph.D., RN, Nurse, Educator
Anchorage, Alaska
POSITION STATEMENT: Testified about waivers during the discussion of the Affordable Care Act.

EVAN FEINBERG, President
Generation Opportunity
Washington, D.C.
POSITION STATEMENT: Testified during the discussion of the Affordable Care Act.

JOE RIGGS, Registered Agent
Alaska Healthcare Strategies, LLC
Anchorage, Alaska
POSITION STATEMENT: Testified during the discussion of the Affordable Care Act.

WILLIAM J. STREUR, Commissioner
Office of the Commissioner
Department of Health & Social Services (DHSS)
Juneau, Alaska
POSITION STATEMENT: Testified during the discussion of the Affordable Care Act.

DR. RANCIN (ph), Dentist
Anchorage, Alaska
POSITION STATEMENT: Testified during the discussion of the Affordable Care Act.

JOSHUA DECKER, Interim Executive Director

American Civil Liberties Union of Alaska (ACLU of Alaska)
Anchorage, Alaska
POSITION STATEMENT: Testified during the discussion of the Affordable Care Act.

SHERRY METTLER, Past President
Assisted Living Association of Alaska;
Past President
Assisted Living Professionals of Alaska
Anchorage, Alaska
POSITION STATEMENT: Testified during the discussion of the proposed changes to the Assisted Living Home (ALC) rate changes.

AMY ONEY, President and Owner
Mama's Assisted Living Homes
Anchorage, Alaska
POSITION STATEMENT: Provided a PowerPoint presentation during the discussion of the proposed rate changes for assisted living homes.

ROBERT NASH, Owner
Riverside Assisted Living, LLC
Soldotna, Alaska
POSITION STATEMENT: Testified during the discussion of the proposed rate changes for assisted living homes.

LYNN VAZQUEZ
Juneau, Alaska
POSITION STATEMENT: Testified during the discussion on the proposed rate changes for assisted living homes.

JASON HOOLEY, Special Assistant
Office of the Commissioner
Department of Health and Social Services (DHSS)
Juneau, Alaska
POSITION STATEMENT: Testified and answered questions during the discussion on the proposed rate changes for assisted living homes.

JARED KOSIN, Executive Director
Rate Review
Division of Health Care Services
Department of Health and Social Services (DHSS)
Anchorage, Alaska

POSITION STATEMENT: Testified and answered questions during the discussion on the proposed rate changes for assisted living homes.

ACTION NARRATIVE

12:03:01 PM

CHAIR LORA REINBOLD called the Administrative Regulation Review Committee meeting to order at 12:03 p.m. Representatives Hawker and Reinbold and Senator Giessel were present at the call to order. Representative Tarr arrived as the meeting was in progress.

Presentation: Affordable Care Act

12:05:26 PM

CHAIR REINBOLD announced that the first order of business was the discussion of the Affordable Care Act (ACA).

CHAIR REINBOLD related that the Administrative Regulation Review Committee had been hearing people around the state talk about the ACA and its impacts on Alaska and Alaskans. She said the program is in its twenty-ninth day and problems have arisen, such as Federal Exchange glitches within its reported 500 million lines of code. She remarked that according to The New York Times, that is "more than Apple OSX, Windows XP, Facebook, Linux, and Google Chrome web browsers combined." She offered her understanding that millions of people potentially may not be able to keep their current insurance. For example, she stated:

> Already, Kaiser Health reports that Florida Blue is terminating about 300 policies - about 80 percent of its individual policies in the state; Kaiser Permanente, in California, has sent notices to 160,000 people - about half its individual business in the state; Highmark, in Pittsburgh, is dropping about 20 percent of its ... customers; ... Independent Blue Cross, the major insurer in Philadelphia, is dropping about 45 percent; Blue Shield of California sent roughly 119,000 cancellation notices in mid-September - about 60 percent of its individual businesses.

CHAIR REINBOLD said the new plan is "being proposed to offer broader benefits," and that in many cases increased benefits

lead to higher costs. She emphasized the importance of nurses and physicians' assistants (PAs) in providing patient care.

12:07:41 PM

[Due to technical difficulty, the sound was not recorded for less than 30 seconds; however, no testimony was lost.]

12:08:28 PM

JYLL K. GREEN, Advanced Nurse Practitioner (ANP), myHealth Clinic, stated that [the Affordable Care Act] is brought up by her patients five or six times a day, and she opined that "the education of the public in Alaska has been poor at best." She indicated that [myHealth Clinic] printed out a one-page reference to the healthcare.gov web site, and she expressed amazement that so many of her uninsured or underinsured clients are unaware of that source for information. She said she knows other states have provided information for their residents, but opined that Alaska as a whole has done a poor job of getting the word out to Alaskans as to how to navigate the new law.

MS. GREEN said she wants to believe that the goal of the ACA is to increase patient access to health care, improve health care outcome, and restrain escalating health care costs; however, she said she thinks there are underlying agenda threatening the effectiveness of the law. She stated, "A lot of people want to talk about insurance companies making money off of this, and while that may be kind of off to the side and the stock prices may or may not have risen, I don't think I should say more on the positive side of what the law could do for us and what we need to do to get the vision that it's trying to create." She said she does not feel that the current plans in place are helping to achieve the goals of the ACA. Further, she stated that as a small business owner, she is unsure how she is supposed to implement and afford all the changes effected through the Act. She said that with 8,000 people under the care of her practice, she does not think it is fiscally feasible to implement a lot of the changes recommended to obtain a healthier population.

MS. GREEN said the patient-centered medical home is one concept that has been brought up repeatedly in the discussion of how to help reach some of the goals of the ACA. She remarked, "But if I move through those steps to achieve that certification, I just don't know if could stay fiscally or mentally sane while I implement those."

12:11:33 PM

MS. GREEN said myHealth Clinic and the hospital try to create a meaningful relationship with a goal toward getting patients to be involved in their own personal health care, thereby reducing some of the testing that is done, and she questioned how caregivers can continue in those efforts under the Act. She further questioned how patients can afford the ACA. She related a story about a patient who was upset that she had to go to a web site to access a plan that could cost $5,000. When Ms. Green told the patient that it could cost $12,000-$13,000 for the plan, the patient asked how she could afford that when she is retired and not yet eligible for Medicare. Ms. Green stated her understanding that in order for the Act to work, everyone has to be afforded the opportunity to have health insurance, and to offset some of those costs, it will be necessary for healthy people to enroll in the system. She said she thinks the goal is to provide health care for all without doing so via a single payer plan or massive taxation for everybody. She said her patients who are healthy and have chosen to pay out of pocket for years are upset. She said she provides health insurance to her staff, at a cost $1,000 a month and with no tax benefit. She said her staff can insure their families for only an additional $50 a month, because "a lot of them kind of fall into the other 40 percent of the tax bracket." She stated, "The problem with that is ... when they look at it, they have to spend $750 a month for this plan, if they qualify for the tax credit, yes, they will probably get half of that back in tax credits at the end of year, but none of them have the fiscal ability to pay that $750 a month up front. They can afford the $350 a month; they just can't afford the ... $750." She said tax credits are great, but they do not help with immediate, out-of-pocket costs.

MS. GREEN said she has patients who are uninsured and patients who are underinsured; the latter have maximum deductibles, which become her problem. She related that in a year's time, she has written off nearly a quarter million dollars in bad debt. She stated, "I don't know that getting their new silver plan with this higher deductible ... is going to ... get that first $1,000 deductible ... paid." She indicated that medium to high deductible plans will result in her having to cover the cost, not the patient. She questioned how she could turn anyone away because he/she was unable to pay a high deductible.

MS. GREEN stated that there is nothing in the federal plan that is going to help her keep her doors open. She said now she is facing markedly increased costs to provide quality care, with the threat that major insurers will come back and give her the highest reimbursement rate if she can get all her patients healthy. She said that comes at a huge cost to her practice. She said she has increased her support staff by one and a half persons per provider, at huge cost, to take care of the extra forms and other requirements.

12:16:04 PM

MS. GREEN expressed uncertainty that there is a lot of data available to support all the primary care measures for preventative health care. She stated, "I don't know that I can stand around forever and say, 'You really need to eat healthy,' and then have anybody buy into that if there's a donut in the room. You know, I don't think that we have the ability to really take care of ourselves and be personally accountable for our health. It's a great concept; I don't know what it's going to get people to do so." She gave an example of a patient whose treatments have reached a cost far above his ability to pay. She opined that the ACA will bankrupt the lower and middle classes. It isn't sustainable. I am worried about nurse practitioners in particular. She said there are two insurance companies that have created some road blocks for nurse practitioners. I need to see my patients as primary care providers. She said United Health Care has sent letters to the recipients saying that nurse practitioners fall into a gray area and will now be listed as specialists and not listed under primary care guide. She said the co-pay increased from $20 to $30 for patients to see her, and all calls to rectify the situation have "not come to fruition." She mentioned Section 27.06 of the Act and said in order to have a level playing field, "these kinds of things need to be addressed." She said Aetna sees her as specialized, so patients are "penalized for coming to see us." She offered her understanding that health economists repeatedly have proven nurse practitioners can help patients achieve a health care goal in a more cost-effective manner. She surmised that is probably because [nurse practitioners] spend more time [with a patient] in one office visit than a physician has time to spend. She said she has taken Medicare and Medicaid patients and there is a reimbursement disparity. She explained she has yet to see that her Medicare wellness exams differ in any way from that of a physician.

12:18:57 PM

SENATOR GIESSEL asked Ms. Green to talk more about her clinic's certification.

12:19:05 PM

MS. GREEN responded as follows:

> There is ... a whole group in the United States focused on patient-centered medical homes. (indisc.) They're very informative; they always leave me kind of excited (indisc.) primary care. The goals of patients in our medical home is to hopefully -- they've proven thus far, Blue Cross is currently engaged with several clinics in the Lower 48 to do studies to see if they could reduce health care expenditure. And guess what? The answer is absolutely it can. But within that medical home concept, you really are asking the patient to buy into the system. They have to accept a certain level of accountability. A certain percentage of the patients - actually 50 percent - needs to be involved in your patient portal. If they want to communicate with me, they're not clogging my phone lines; they're having a direct conversation with me via a secure messaging portal. It's ... just a way of engaging them in their health care; having some behavioral health specialists, services on site, health coach on site, to hopeful -- and do some meaningful use of directives, like tracking outcome, tracking how often are you getting blood pressure checked on your hypertensive patients. It's a way to track health care, make it more meaningful, make it more thorough, and make it high quality - hopefully to reduce health disparities and make people healthier, I think is the general goal. It's just the expense of this application to institute the plan. While I envision, as the altruistic health care provider in me, economics aside, say that's actually a really great idea. I think we could actually achieve some great things in health care if we implement this plan. We're moving forward to do that. I think I've had the visions of a seven-year commitment business and we started with DHR, we upgraded our EHR (indisc. - coughing) to track our data better. These all come at huge, huge expense, of course. So, we're working on that, but there's no ... nothing in there that they

have to afford to implement this medical call. There are some grants for nonprofit facilities, the for profits. They're kind of (indisc. - voice trailing off)

12:21:15 PM

CHAIR REINBOLD asked Ms. Green what the legislature could do to support her.

MS. GREEN suggested leveling the playing field for both nurse practitioners and physicians' assistants to allow them to be more involved in "the front lines of primary care." She mentioned Medicare patients, diabetics, and home health.

12:23:54 PM

TYANN BOLLING, Enroll Alaska, Northrim Benefits Group, LLC., echoed the previous testifier's statement that there has been little done in terms of educating people on the impacts of the ACA and explaining how individuals can get into a health care policy with a government subsidy offsetting the cost of the premium if they fall between 100-400 percent of the federal poverty level. She said Alaska did not establish its own state-run marketplace as other states have done; therefore, federal money did not come to Alaska. She indicated that [Enroll Alaska] took on the role of getting information out to Alaskans across the state. Rural Alaska agents work in most major hospitals, as well as in most Wal-Mart and Sam's Club stores in the state, to provide individuals with the ability to understand and enroll in a health insurance policy that is right for them and their families.

MS. BOLLING reported that currently Enroll Alaska has had to suspend enrollment, because the federal (indisc.) market place has an inaccurate subsidy calculation for Alaska. Enroll Alaska issued a press release and has worked with the media to get the word out about the suspension, because Enroll Alaska does not want people to enroll into a health insurance plan that is calculating their subsidy incorrectly. She explained that currently Alaska subsidy is calculated lower than it should be. Enroll Alaska believes that the federal poverty levels voted into the federal facilitated market place for the State of Alaska are inaccurate. She said Alaska's cost of living is higher than in the Lower 48. She said Enroll Alaska's worked with Susan Johnson (ph), the Region 10 director of Health and Human services, to get information up to Washington D.C. to

correct the error. She said once Enroll Alaska is satisfied that that glitch, as well as other major glitches in the market place, have been resolved, it can resume enrolling individuals and providing outreach to Alaskans.

MS. BOLLING said Alaskans are confused as to what the ACA means to them as individuals, what the tax (indisc.) penalty means, why they are being forced to buy health insurance, what insurance policy they need to have for their families and for themselves, how much it all will cost, whether they qualify for a tax subsidy, and what it means to their business and to their family. Enroll Alaska was established to assist individuals with those questions while enrolling them in the right plan. She said many Alaskans are receiving notices from their current insurance companies that their policies will be cancelled starting December 31 [2013]. She said Alaskans are not happy about that, because they were told by the Obama Administration that if they liked their health care plan, they could keep it. She said that is not true, because the current health care policies do not meet the regulations and requirements of the ACA. Individuals whose policies are being cancelled have to purchase new ones that will begin on January 1. She said Enroll Alaska believes that these people need help and need to be given insurance information by a licensed health insurance agent - not an abrogator or an assistor - on making the right choice for them and their families.

MS. BOLLING said many people applying for insurance have never had it before; therefore, they will not readily understand topics such as premiums, deductibles, health savings accounts, and catastrophic versus premium insurance policies or understand the impact they would have. She emphasized the importance of having licensed insurance agents enroll individuals into health insurance and having a broker manage the policies. She stated concern that people who are not health insurance agents are being allowed to enroll people into health insurance plans. She opined that that is a failure of the law that has not been addressed.

12:31:11 PM

MS. BOLLING, in response to Senator Giessel, explained that North Rim Benefits, LLC, is an insurance broker focused on group health benefits across Alaska for businesses for over 30 years. Enroll Alaska, she continued, is a division of North Rim Benefits, LLC, and was established to focus on the individual market place, which was not a necessity before passage of the

ACA. Enroll Alaska saw both the need to enroll people and to educate them through presentations and educational outreach events. She said Enroll Alaska also provides information to organizations, health care facilitators, physicians, financial administrators, and corporate heads of hospitals. She offered her understanding that Alaskans are angry about the federal mandate and the misconceptions surrounding it, and Enroll Alaska, as an Alaska-based company, has an interest in helping Alaskans through the process. In response to a follow-up question, she said commissions are built into insurance premiums; they have been for years. She said Enroll Alaska receives a commission from the insurance carrier. She added that there is no cost to the individual for going to Enroll Alaska.

12:34:13 PM

CHAIR REINBOLD emphasized that the ACA is a federal law, not a law passed in Alaska.

12:35:05 PM

MS. BOLLING, in response to the chair, said Enroll Alaska has a health insurance portal that will "layer on top of the federally facilitated market place to quote individuals and to pull information based upon what's loaded in there." She said individuals have to be enrolled into the healthcare.gov web site. She indicated that the President misspoke; there is not a process by which to enroll individuals over the phone. She explained that when a person calls, the person helping him/her over the phone still has to enter the information via the healthcare.gov web site. She remarked that Enroll Alaska has not "gone down the path of going through a paper process," because it does not "have confidence in what that would look like." She opined that it is not right to ask an Alaskan to send information off to "some place in Kentucky," just to be sent more paperwork for selecting coverage, which then has to be sent back to the Lower 48. She said Enroll Alaska does not know all that happens in the process, and she said representatives at healthcare.gov cannot give those answers.

MS. BOLLING, in response to a follow-up question, said Enroll Alaska has enrolled three individuals, but must now go back and work with those individuals to ensure that their subsidy gets corrected, because the calculation was wrong. She said the estimation was that at this point Enroll Alaska would have enrolled about 4,000 people; it has a backlog of over 1,700

individuals that are wanting to be enrolled, but cannot do so because healthcare.gov does not work. She explained that she uses the terms "the market place" and "healthcare.gov" interchangeably. She stated, "Whether you like the law or not, there is a great benefit for many Alaskans who fall within the federal poverty level to be able to afford health insurance. They receive a subsidy; it offsets the cost of their premiums; and therefore, they have health insurance at a reasonable rate for them. However, they cannot enroll them, because the market place doesn't function and the subsidy calculator's off."

12:39:06 PM

CHAIR REINBOLD encouraged people to send written testimony to her office. She stated, "Basically, we're just going to be used as a platform for Alaskans to speak their mind on any different level."

MS. BOLLING said Enroll Alaska is doing everything it can to explain the delay.

CHAIR REINBOLD said Congressman Young and U.S. Senators Begich and Murkowski are the only ones who have the power to do something and the committee will bring those concerns to them. She opined that using antiquated technology is a disservice to the people.

12:42:12 PM

ROSS TANNER, M.D., Diabetes & Lipid Clinic of Alaska, related that he is the immediate past president of the State Medical Association, has spent time talking with Alaska's constituents in Washington, D.C., is currently on the faculty of three different medical schools, and teaches medical students. He mentioned a concern medical students have that they may not be able to pay off their loans.

DR. TANNER opined that what the country really needs is the reformation and delivery of health care in a fiscally conservative manner. He added, "And I don't think that this bill really has anything to do with that. It is about expanding services to 37-50 million people, depending on the estimates you're looking at." He said he thinks everyone should have healthcare and access to physicians and providers. He remarked upon the implications on the economy, such as military preparedness and the workforce. He noted that the U.S. has many health issues, including childhood obesity.

12:44:16 PM

DR. TANNER stated that his perspective on healthcare is threefold: as a taxpayer, a patient, and a physician. He said he suspects his taxes will be increased. He mentioned a $55,000 tax related to the ACA, which he said will be levied on him because of his level of income. He said as a patient, he is "almost sure" he is going to get less for his money. As a physician, he said that in the last few years, he has seen a metamorphosis of the bureaucracy of practicing medicine. He stated that may not have been brought on specifically by the ACA, but "if they can't get the web site down, then I'm sure they're not going to get ... these other exchanges down, as well." Dr. Tanner said 55 percent of healthcare in the U.S. is some sort of state or federal subsidy, such as Medicare, Medicaid, or Tricare, and he estimated that 25-35 million people do not have healthcare coverage; therefore, he said he believes that a smaller percentage of people are getting health care either through their employer or on their own. Dr. Tanner said that under the ACA, healthcare plans initiated after March 2010 - when the Act was signed into law - are extinguished. He opined that this is a passive aggressive way to get people into the exchange.

DR. TANNER said personally he thinks having tax waivers for professionals, particularly congressmen and their staff, is inappropriate. He said citizens were told that their taxes would not increase, they would get more healthcare, they would get it more efficiently, and the tax savings would come from a reduction in healthcare fraud. He remarked upon the existence of fraudulent behavior.

12:47:25 PM

DR TANNER asked, "Why would I take a Medicare patient?" He continued as follows:

> I'm going to get paid 30 cents on the dollar, and I have a waiting list of people who are going to pay me full ... benefit. Why would I do this? Because it's my responsibility to take care of people, that's my responsibility. So, my own personal way of doing business is that if 6 to 8 percent of our population in Anchorage is Medicare, that's what I'll do; I'll do my part. But if you get into 10-15 percent of your practice being Medicare, it's not going to be

sustainable over a long period of time. You're going to lose money, and as overhead goes up and reimbursements go down, that's going to be our problem.

And I would say to this committee: I think there's going to be an intent by insurance companies to change the way usual and customary rates are calculated in our state, and there's going to be an attempt to pay doctors less, because as premiums go up -- and if you talk to the ... insurance companies, there are the two that are participating, the one I talked to is Blue Cross, is that their actuarial data is flawed, because they don't know how many people are going to actually be in the exchanges. So, if we have a bunch of young, healthy people getting in it, and they're going to pay $600 a month for their premium, which is the average price - $646 or whatever it is - ... if they're going to fine me 1 percent of my income, and say you make $50,000 a year, then that's going to $500, that's going to be what I'm going to be fined or taxed - whatever word you want to use - on their insurance, it's going to be cheaper for them to still pay out of pocket and still pay the fine, until next year, then it's 2 percent; the year after that it's 2.5 percent. So, I think ... the insurance companies, they're not going to lose money. If they collect a million dollars in premiums, and they pay out 2 million dollars in services, guess what's going to happen? They're going to go to the insurance commissioner, and they're going to try to figure out how they're going to be able to increase the premiums, because they're not going to go broke. The oil companies aren't going to go broke; the insurance companies [aren't] going to go broke.

So, what are they going to do? They're going to try to pay me less. Are they going to try to increase my bureaucracy? Every prescription I write, if it's not a generic drug, I've got to write a preauthorization; I've got to get people to go to the facility they need to go to, because ... if I send them to one facility and they're ... not approved, now Blue Cross has made that's my fault, ... and it's the patient's responsibility to pay, because they did not go to the facility that maybe they were uninformed and they didn't know where they were supposed to go to or maybe

> it changed or maybe they didn't read the fifteen-page document of disclaimers that they were sent ... by the insurance company.

DR. TANNER said he figures that because [the federal government] has spent four years on a web site to accommodate the ACA and implement federal exchanges and has not gotten it right, "it's going to be really, really painful ... for the next twelve to eighteen months." He suggested that the state, through the help of the insurance commissioner, could protect how physicians and mid-levels get reimbursed and look at how the usual and customary amount is calculated and ensure it does not keep getting reduced.

12:50:50 PM

DR. TANNER regarding mandating insurance said he has patients who do not want to work until they are 65 and are concerned about being able to pay their rising healthcare costs if they do quit working. He said he thinks premiums will go up. He said he does not think an increase in healthy people in the system will drive the cost down, because "you're going to have to manage the money that you have, and I don't think they do a very good job at that, unless it's their money."

DR. TANNER said a couple years ago the Accountable Care Organization (ACO) was started under the ACA. He explained that the concept of the ACO is to have a group of physicians and providers that group together to "take risks for that group." He said he has an exclusive diabetic practice and has patients who are compliant and those who are not. He said there is a payment model that is "pay for performance," wherein a physician gets paid when patient care meets certain criteria and the patient meets certain demographics. He posited that this system is problematic, because it questions his integrity. He explained, "If I'm going to get paid more, [then] that suggests that I'm going to take better care of you if you're my patient. I should take better care of you no matter what, because you're my patient and that's what you expect of me."

DR. TANNER continued as follows:

> The other thing [about] the Affordable Care Organization is that as you're taking risks in that group - and let's say there's a million dollars goes ... in that pool and there's 15 doctors in it - and it takes $500,000 to take care of those patients, then

> that $500,000 can be disseminated equally based on workload in those groups of physicians. This is the same thing that happened in the '90s with capitation, the same thing that happened [with] HMOs: the businesses couldn't run it, so now they're going to display that financial risk to the physicians.
>
> So, what happens if it costs $2 million dollars to take care of those patients and there's a million dollars in the pool? Nobody knows what's going to happen with that. But this is the ACO model, to me - taking risks for patients that may not necessarily want to quit smoking, ... exercise, do the things they need to do - somehow it's going to come at my ... cost.

DR. TANNER questioned why that should be the case when he is doing what he should be doing to the best of his ability. He said he has practiced for 23 years and is dedicated to his profession. He said he tracks his own outcome data and can see that his numbers are better than what is expected at the national level, but risk pools mean screening of patients depending on how they perform.

12:54:33 PM

DR. TANNER talked about the addition of more primary care physicians. He said the government has come up with the idea of patients having a medical home with primary care physicians and nurse practitioners so they avoid going to the emergency room or hospital, but he said that is the way it happens now for his patients. He added, "But how many times are people told to go some other place when they don't have a medical home? It happens a lot, because they can't find a primary care physician." He related that last year, for the first time in the U.S., the number of medical graduates was bigger than the number of residency "slots." So, now there are graduates with $200-300,000 in school loan debt with no place to get trained in residency. So, if federal money does not go into training physicians, this imbalance will not be addressed. He said he uses nurse practitioners and physicians' assistants, but stated his belief that they do not replace physicians.

DR. TANNER stated that as a specialist, he should know more than a primary care provider. He opined that it is inappropriate to put a nurse practitioner, who is paid less, in a position to handle "all the responsibility to handle all the complications."

He said his nurse practitioner and PA do not facilitate his making more money; they facilitate his taking better care of his patients. He emphasized that he could not practice without a nurse practitioner or a PA. He talked about the differences between people who have earned the title of doctor after 12 years of training as compared to two to three years. He mentioned a pharmacist with a doctorate who may have been mistaken for a physician by a customer. He reemphasized the issue of funding sufficient residency slots to support the numbers of medical students graduating, especially to accommodate greater numbers of people insured who need to find a medical home.

12:59:19 PM

DR. TANNER stated that he is okay with an insurance company telling him what is not covered under a plan, but not telling him how to practice medicine. He said he thinks this will be an increasing burden on physicians. Insurance companies make decisions that are not always in accordance with the standards of care, and that is something that is a state-level problem, he said.

1:00:54 PM

DR. TANNER, regarding the Cadillac tax, talked about a change in 2018 wherein a patient whose benefits supersede what is considered the norm will be taxed 40 percent on the difference. He said medication that costs the patient only $10 "costs somebody something." He said in 2018, everybody is going to have more taxes. He surmised the reason the ACA is being staggered in its implementation from 2010 to 2020 is because "the system couldn't take it all at one time." He predicted that with the 2014 mandate being delayed for businesses to 2015, premiums and taxes will rise and fragmentation of healthcare will worsen. He said Alaska is still the best place in the country to practice, but it has deteriorated over the last two to four years because of federal impact.

1:02:36 PM

SENATOR GIESSEL referred to Dr. Tanner's comments about insurance companies' involvement in his practice of medicine - telling him what he can and cannot prescribe. She said she is aware of the cost of the Medicare system, and she indicated the reason to adhere to a list of prescription drugs is that they tend to be generic; however, some diabetics and mental health

patients do not respond to generic drugs. She said, "It's a careful balance."

1:03:16 PM

DR. TANNER concurred, but made the distinction between the art and the science of medicine. He said Blue Cross recently advocated a concept called "choosing wisely," which relates to "10 areas of waste." For example, he said, Vitamin D levels should not be ordered on every Alaskan. He said "we're" spending lots of money, for example, for fiscal remuneration or [in response to] litigation. He talked about the complexity of memorizing phone menus for pharmacies, let alone a list of preferred drugs. He said he has been prescribing long enough that all the current generic drugs were brand name drugs when he started his practice, and he questioned why, if they were good enough then as brand names, they are not good enough now as generic drugs. He emphasized the savings in using generic drugs, but reiterated that he would not compromise care just to save money. He questioned why he has to prove, when writing a prescription, that the patient has failed three other drugs. He continued:

> Like with Medicaid, ... if they just write "medically necessary" it's approved. Well doctors and nurse practitioners have a way around it: just write medically necessary on everything. Well, it's all medically necessary; it's a prescription. If it wasn't medically necessary, I wouldn't write a prescription for it; I'd say, "Go buy Tylenol over the counter." So, I think, where you create laws and mandates and regulations, people are going to find a way to circumvent that to where you have less work in your office, because the last thing I want is two nurses coming to me every day saying, "Do you know how many authorizations I did today?" I think, "I know, but I can't practice without being able to do that."

DR. TANNER said he gets reports from the insurance companies showing how many generic drugs and brand name drugs he has prescribed. He said unfortunately, patients who come to a diabetes specialty clinic have already been on all the generic drugs and are entrusting him to not only manage their disease but also address complications. He said there are currently 28 million diabetics and 65 million pre-diabetics in the U.S., and the cost of care will increase, because of the numbers of children at abnormal weight, which he called "diabetic

wannabes." He said many smokers take their Lipitor to maintain their cholesterol, but they will die early anyway because they continue to smoke. He said it is his job to educate his patients that "it's about how you're eating, how you're moving, and the medications that complement that." It takes time to do that. He said, "If I get paid less, I'm going to have less time for patients." He posited that he can be more impactful by teaching holistic health care, which he said he has been doing long before the government told him to do it. He said his practice manages about 4,000 diabetics and sees 6 to 10 people a day. He said approximately 6 to 10 people a year go to the cardiologist to have intervention done. He opined that that speaks for itself and said, "I think we do a pretty good job at what we're supposed to be doing." He said it is insulting to question a physician who has gone through years of school, training, and fellowship, and has taken licensing exams, on what he/she is doing. He said he never imagined while going through school that he would be spending more time addressing bureaucracy than taking care of patients. He concluded, "The overweight, smoking truck driver is easy compared to the federal government."

1:08:17 PM

SENATOR GIESSEL said she would ask Commissioner Stuart to affirm that simply writing medically necessary on a prescription is no longer effective. She noted that she works in a homeless clinic and writes very few prescriptions, because most of her clients cannot afford the cost of filling one.

1:09:05 PM

CHAIR REINBOLD restated her willingness to listen and voice to the federal government. She said she is sorry Dr. Tanner has a $50,000 tax.

DR. TANNER remarked that that is in addition to his other tax. He commented that everyone wants someone to take care of them who genuinely cares about them. He urged, "I would recommend everybody just ... vote for people that are helping us." He said, "When I don't like coming to work anymore, I'm done."

CHAIR REINBOLD said that scares her.

DR. TANNER related that he knows 18 physicians in his city who are quitting by the end of the year, and more than half of them are primary care doctors.

1:10:40 PM

CHAIR REINBOLD said, "And these statistics were provided before ... the Obamacare vote, which our vote was the (indisc.) vote in Alaska to make this law." She said the thought that "this is affecting us at such a local level" is alarming.

1:12:14 PM

BRANDON CLARK, Health Care Policy Expert, FrogueClark LLC, related his work history on Washington D.C.'s Capitol Hill, including being in charge of the Republican efforts for about 85 percent of the jurisdiction of the Affordable Care Act legislation, and "working the initial parts of the implementation" once the Act was passed. He said he started a consulting firm, which handled the [Patient Protection and Affordable Care Act (PPACA)] implementation team for the State of Georgia, using "level 1 HHS funds." He said he has testified to the State of Kentucky and done significant work in the State of Georgia, as well as a few other states, as well as doing work in Washington D.C. on PPOC implementation. He noted that he would give a PowerPoint presentation to the joint committee.

1:14:59 PM

MR. CLARK noted multiple names have been given to the legislation, including PPACA, the Affordable Care Act, and Obamacare. He said the legislation has implementation dates through 2020. He said no Congress can restrict the action of future Congress. He stated that federal and state elections over the next decade will produce significant shifts in the White House, Congress, the gubernatorial seats, and state legislatures, and he predicted that all those institutions will have significant impact on how this law is implemented, both by statute and regulation. He explained that the amount of discretion in the legislation could lead to significant problems, because later generations would be able to change it by regulation.

MR. CLARK said many people have concerns about the American Health Benefit Exchange (AHBE), commonly called "the Exchange," and the enrollment through healthcare.gov and the toll-free phone number; however, he stated that one of the more significant changes is going to be in Medicaid. He said the Congressional Budget Office predicts that at one particular time, there will be 84 million individuals enrolled in the

Medicaid program. By 2022, there will be up to 134 million individuals in the Medicaid program, well over one-third of the U.S. population, for a 48-year welfare program which pays doctors on average 66 percent of Medicare rates. He said the shift toward Medicaid is of concern to providers. In contrast, [the Congressional Office of Management & Budget] projects that only 26 million will be enrolled in an exchange in 2022, whereas four times more people will be enrolled in Medicaid than in an exchange plan.

1:19:06 PM

MR. CLARK related that the ACA legislation was projected to outlay $938 billion in federal-only funds for the purpose of reducing the uninsured by 32 million Americans by the end of the initial 10-year budget window, 2019, with an additional 16 million Medicaid enrollees, at a cost of $441 billion to the federal government and significant cost to the states. Total Medicaid enrollment under the initial projection was going to exceed 93 million Americans by 2019. He said the actuary in the Obama Administration projected closer to 25 million Medicaid enrollees. Mr. Clark said it is important to keep in mind that that is above the already unsustainable growth of the Medicaid program. He said another projection was 29 million getting private health insurance through state- or federally-run exchanges and millions dropping or losing access to current coverage in employer-sponsored or individual health insurance markets. Mr. Clark said this goes against the President's statement that people who like their health insurance plans will be able to keep it. He said there are already millions who are seeing their health insurance changing; they have received notices that their coverage will not be available by next year. Mr. Clark relayed that he has already received a letter telling him to be prepared for a significant increase in the cost of his health insurance premiums.

1:21:17 PM

MR. CLARK said moving into 2013, the Congressional budget projection shows an increase from $938 billion to a ten-year cost of $1.329 to $1.33 trillion - a $200 billion increase from two years prior. As 2014 approaches, so do more years with an outlay of a significant amount of funds to do premium assistance, cover out of pocket maximums, and enroll more people in Medicaid; therefore, a higher percentage of those years in the ten-year window are actually where the outlays of significant funds are occurring. He continued:

> We are also seeing again 84 million people, at any given time in the Medicaid program, and they're also projecting $93 billion in outlays, less for Medicaid, because of the [U.S.] Supreme Court decision in the summer of 2012 that makes Medicaid expansion optional to the states, and seeing a reduced number of Americans receiving down to 26 million in the AHBEs.

1:22:47 PM

MR. CLARK provided information regarding the background of the Congressional legislation relating to the ACA to illustrate the complexity of blending legislation between the Senate and House. He stated, "We've seen over 20,000 pages of regulations needed; we've also seen over 1,500 waivers." He indicated that there is no statutory authorization for the waivers that were given to health insurance plans and organizations. He said, "There are many provisions where the law says certain things need to happen that were actually just delayed or ignored by the Administration, including the one-year delay of the employer mandates, which ... was pushed back ... on July 1, for a full year."

MR. CLARK proffered that one of the interesting parts about "this growth," and one of the things that leads to a significant amount of uncertainty with the Obamacare legislation is that the spending growth is significantly outpacing the revenue growth. He said when the legislation was passed, there were almost four full years of taxes in the legislation before major spending started, which he said is what enabled it to be considered "budget neutral." Nearing 2014, the spending is outpacing the revenue growth. He said he knows several people who are concerned about the medical device tax of 2.3 percent, which will be passed on to the consumer. If that is delayed or removed, the Congressional Budget Office thinks that will "remove ... $30 billion more of revenue, over ten years, from the legislation."

MR. CLARK stated that there have been significant problems with healthcare.gov. He imparted that he has tried for the last 29 days to sign on and find out how much more the exchange would cost. He said he has not been successful. Conversely, he described having successfully signed up for ehealthinsurance.com in 2010, in less than 2 hours, while watching television. He said if individuals want to have a health plan by January 1, 2014, they have until December 15th, 2013, to select and enroll

in the plan and submit their first premium payment. He said the likelihood of people being able to select a plan by that deadline seems less and less likely. He reviewed that the penalty in 2014 for an individual not having federally approved health insurance will be to pay 1 percent of his/her income, as a penalty tax to the Internal Revenue Service (IRS), up to the full cost of a "bronze" health insurance plan. He said he thinks some individuals will be paying the penalty, which will have an adverse effect on them, and still they will not be able to enroll in health insurance coverage. He said then Senator Obama, when running against then Senator Clinton for [the Democratic nomination] for Presidency, criticized Senator Clinton's plan for having an individual mandate, because it would be bad for individuals, and "then signed legislation into law that would actually implement over $50 billion in ... penalty taxes that would collected from individuals who ... fail to enroll ... ."

1:30:22 PM

MR. CLARK stated that, in order to make the $938 million outlay budget neutral, the ACA cut $575 billion from the Medicare program - over a half trillion dollars - in the 2010-2019 budget window. He quoted the Office of the Actuary as saying that roughly 15 percent of all Medicare Part A providers would be unprofitable within 10 years, as a result of the cuts. He said he thinks this makes a lot of experts look at those [cuts] and determine that they are unsustainable and increases the problem of expenditures outpacing revenue.

MR. CLARK put forth another issue leading to considerable concern, the use of modified adjusted gross income for eligibility calculations. He said a state participating in the Medicaid expansion has to increase its Medicaid eligibility level to 138 percent of the federal poverty level. He continued:

> But that's measured using modified adjusted gross income, ... which includes a significant number of business deductions, farm deductions, so you can have people making well above a state median household income who ... go in thinking that they are going to receive ... private health insurance coverage - something similar to their existing ... plan - and find themselves enrolled in ... the Medicaid program, which, again, is a 48-year-old, highly inefficient

Welfare program that I myself would not want to be enrolled in.

MR. CLARK said, "We offered numerous amendments on the Republican side to put members of Congress ... into the Medicaid program, since the vast majority of people gaining coverage would be through Medicaid, and none of those amendments passed, because it didn't seem like any of the members of Congress wanted to see themselves or their families in the Medicaid program," though millions of Americans will lose their private health insurance coverage and end up in the Medicaid program, which has significantly longer wait times to see a physicians and lower reimbursements to providers in the vast majority of the states. Mr. Clark reiterated that, on the national average, Medicaid pays 66 percent of what Medicare pays, which is not enough to cover a provider's costs.

MR. CLARK said the individual penalty will be problematic, and he said he does not know if that will be implemented because of its being so politically unpopular. He said some people - with modified gross income and not receiving as many subsidies as they would like - may choose to pay a penalty, because the health insurance plans are guaranteed issue and use modified community ratings, meaning there really is no penalty for not signing up, and the cost of a family plan, according to IRS regulations, may well exceed $20,000; therefore, paying a penalty of less than 10 percent of that amount may seem like a better option. He said the employer mandate option already has been delayed one year and "seems to be unworkable." Regarding the individual mandate penalty, he said the Department of Health and Human Services has never worked or exchanged information with the IRS, and he does not see that as something that is workable. He suggested that employers may consider a $2,000 per employee penalty as being less expensive than paying for the bulk of a $16,000 health insurance plan; a lot of employers may opt to drop coverage and put their employees into the exchange or, more likely, onto the Medicaid program. He explained that an employer that has a significant number of employees above 400 percent of the poverty level and a significant number of employees in Medicaid does not pay that $2,000 penalty for those employees. A large employer with many employees on Medicaid may choose to drop coverage for those employees, because the employer does not pay a penalty for those individuals.

1:36:11 PM

CHAIR REINBOLD said Senator Grassley, from Iowa, proposed an amendment regarding an exemption for Congressmen and Senators. She asked Mr. Clark to explain briefly why that amendment was not adopted.

MR. CLARK responded:

> There was a provision that was included in the mark-up ... of the Senate Finance Committee to put members of Congress and their staff into Obamacare should it pass. There were those regulations, even though the statute ... is very clear in that they should go into the exchanges, that the Obama Administration actually is saying that members of ... Congress and their staff no longer have to go in to the exchanges. Should that actually be implemented that it would be -- I don't ... think that would actually happen, just because members of Congress want to treat themselves separately and special. ... It is a violation of the statute to do ... that, and, you know, that was one of the provisions that the Republicans in the House kept putting forward is to actually implement that provision as included in the legislation.

MR. CLARK, in response to the chair, continued:

> To keep them subject to and go into the exchanges was the intent of the ... legislation, and I actually think it would be a lot of the lower level Congressional staff ending up in -- it's quite possible that if have a family, they could end up actually in the D.C. Medicaid program.

CHAIR REINBOLD asked Mr. Clark to confirm he is saying that the Republicans kept bringing forth amendments to ensure that Congressional men and women were on the same plan as the rest of America.

MR. CLARK answered that is correct.

CHAIR REINBOLD asked Mr. Clark if he would agree that it is an accurate statement to say that the elderly should be concerned about the impact of the $250 billion cut to part D and the $575 billion cut to Medicare.

MR. CLARK answered yes. He said most of the cuts are to part A Medicare, and projections from the Office of the Actuary showed

that "you could see up to 50 percent of everyone enrolled in a Medicare Part C or a Medicare advantage losing access to their current plan."

CHAIR REINBOLD said, "So, this is going to have significant impact on our elderly population?"

MR. CLARK said, "Absolutely."

CHAIR REINBOLD noted that many states are not doing Medicaid expansion, and said Alaska is "still on the fence." She asked what the total figure would be if the entire U.S. does Medicaid expansion. Further, she asked Mr. Clark if, considering the $17 trillion debt and the $55 trillion liability, he thinks the federal government can be counted on to keep up its end of the Medicaid exchanges if Alaska accepts the exchanges.

MR. CLARK said both the original CBO projections and Centers for Medicare and Medicaid Services [CMS] actuarial projections show over 93 million Americans on Medicaid by 2019. He said he thinks that number is low. He continued:

> We took testimony from the director of the Congressional Budget Office in a close-door hearing, because the Democrats wouldn't let us have a public hearing .... I think their numbers were significantly lower than what the reality would be, because they said there's a[n] "accepted social norm for employers to provide coverage"; however, we've seen significant evidence to the contrary, that a lot of employers are going to be dropping coverage, especially employers with a lot of low income employees, because they do not have to pay a penalty at all if they drop an employee who ... ends up enrolling in Medicaid. So, ... there's only cost providing health insurance for these low-income employees, and there's no penalty, so it's all gain and really no loss.

CHAIR REINBOLD questioned the motivation for employers to keep their insurance, based on some of the data that Mr. Clark provided.

MR. CLARK said when the legislation was changed with H.R. 4872, the mandatory federal poverty floor for Medicaid was raised from 133 percent to 138 percent in order to get more Americans on the Medicaid program, because it was $5,000 less expensive to get a person on Medicaid than on a private health insurance plan. He

said, "The legislation is designed to enroll as many people as possible into Medicaid." In response to a follow-up question, he said he would not trust the federal government to be a reliable partner. He surmised that "they will put it back down to the regular FMAP rate of 50/50 instead of 90/10." He said Alaska pays a 50/50 share for all its previously eligible Medicaid enrollees. He said there will be millions of previously eligible people going into Medicaid because their employers dropped their coverage, and "the states won't receive the 90/10 match for them either." He suggested the best resource for all this information may be at the web site of the Congressional Budget Office: cbo.gov.

1:47:16 PM

THOMAS HENDRIX, Ph.D., RN, Nurse, Educator, said he would talk about waivers. He stated that in a nation of men, people choose which laws to follow, while in a nation of laws, people follow the laws. He defined a waiver as exempting a single person from a law everyone else has to follow. He said it is normal for waivers to be created to address unintended consequences in laws; however, he stated that "these unintended consequences were quite predictable." He said "you" must either think the President and law makers are either "naïve or "something else," and he said he thinks it is the latter. He said the goal was to "keep it under a trillion dollars," to save money, and to allow people to keep their existing policies. He said the logical consequences of the legislation could not be true; therefore, waivers are given. Each waiver given takes away coverage from someone else. He noted that Chair Reinbold had said there was a [$55 trillion] and said it is actually about $80 trillion "if you add everything, not just the health care patients." He indicated that the finances of future generations are being affected.

1:51:55 PM

DR. HENDRIX said one waiver is the "medical loss ratio." He said this is when an insurance company sells a product, collects premiums, pays part of that money out for health care, uses some of the money to cover their costs, and ends up with the rest in profit. He talked about people "churning" on and off of policies as they come and go in the work force. He said it is much easier to keep administrative costs low when an employee stays with a company for 30 years. He said churning makes it much more difficult to "keep that 80/20 rule." He questioned what would have happened if the 80/20 rule had been enforced.

He asked, "Well, how many more uninsured people would there be right now before the 2012 election and before the 2014 election?"

DR. HENDRIX opined that "people knew exactly what they wanted it to be." He said, "They sold it one way, and then they gave the waiver so that we wouldn't be confronted with who knows how many tens of thousands of unemployed people who couldn't make the 80/20 rule." He said insurance companies' state what coverage is listed, but have a lifetime maximum. The companies base coverage on how much it costs to pay for the care and what the likelihood of medical event happening. He indicated that the cost of insurance will be less expensive when there is a maximum set, because that maximum helps the actuary. Under the ACA, insurance companies can no longer impose lifetime limits; therefore, the premiums of the less expensive plans skyrocket. He said that cannot happen, because then employers would drop low-paid employees from coverage.

1:56:04 PM

DR. HENDRIX, regarding the employer mandate, posited that it is predictable that setting a 30-hour and 50-employee exception will result in employers looking for ways to get their employees working under 30 hours and to hire less than 50 employees. He indicated that the year waiver delayed that from happening. He said an employer who signs up for insurance while under the waiver can do so on December 20, 2013, and keep that insurance until 12/20/2014. He noted that the employer mandate was July 21. Regarding the individual mandate, Dr. Hendrix indicated that the following categories qualify: religious objectors, health care sharers, illegal aliens, inmates, the impoverished, members of an Indian tribe, or someone suffering a hardship. He said he thinks "Indian tribe" is poorly worded and needs amending, and he said he is not sure "suffering a hardship" has yet been defined. He stated, "If Obamacare moves forward the way it's going to ... move forward, we're going to end up with hospital-run systems, huge health care systems with large patient populations, and small practice is going to slowly (indisc.) get insured; it won't be able to survive."

1:58:56 PM

CHAIR REINBOLD offered her understanding that there are 1,500 waivers.

DR. HENDRIX said he has heard there are 1,800 waivers to special groups, individuals, firms, or unions. In response to a question, he referred to a list, and he named the following 12 out of 20 largest companies in America that got "a break": ConocoPhillips Alaska, Inc., GE, GM, Bank of America, Ford Motor Company, Hewlett Packard, AT&T, JP Morgan, Citi Group, Horizon, AIG, and IBM. He said they are all highly unionized. He predicted that "the little guy," without a lot of waivers, will be "crushed by this."

CHAIR REINBOLD observed that there were more exemptions, including the USCW Allied Trust. She asked Dr. Hendrix if he would share his perspective.

DR. HENDRIX responded that he found information on waivers for unions, but clarified that he is not trying to say "that's all there was." He mentioned generous compensation packages, which included health benefits through retirement as part of their compensation packages. He offered his understanding that Congress realized that under the ACA, the mandate, and the Cadillac plan, these policies would be in jeopardy. He stated his assumption that the President knew that, as well. He said [Congress] allocated $5 billion. He offered his understanding that by March, $4.73 billion had been spent reimbursing these companies. He mentioned the following unions that were given an exemption: Allied Trade, Health and Welfare, IBEW, Asbestos Workers, Local Welfare Plumbers, Pipefitters, Welfare (indisc.), USCW, and Local 227. He stated that the pattern he saw was "big businesses and big money." He said it is difficult to find out this information without going "three, four, or five clicks into these web sites." In response to a question, he said HHS.gov is a source for information.

CHAIR REINBOLD offered her understanding that there are 729 companies and unions with ACA exemptions listed on freepublic.com.

2:04:01 PM

DR. HENDRIX stated that he thinks "they" know exactly what they are doing, and "this" is about the destruction of private insurance. He said young, healthy individuals are being told to buy a policy they do not think they need, for ten times what it costs now, with a $5,000 deductible, and they are not going to buy it. He said, "And then we're going to put a bunch of sick people in, and in insurance theory it's called a Dutch fund; it's going to start with you." He said insurance companies are

being told they have to cover everyone, even those who instead of paying into the insurance system during their healthy years, sit back and pay the fine and then get a catastrophic illness and "just knock on the door." He compared that to waiting until his house catches fire and then getting fire insurance at that time. He reiterated that insurance companies will be put out of business. He said he wants leaders to call politicians out for telling them something they know is not true.

CHAIR REINBOLD talked about difficulty in getting through to offices when looking for information.

DR. HENDRIX clarified that he does not want to hear future politicians running for office and saying, "Oh, gee, I had no idea that was going to happen."

2:07:13 PM

The committee took an at-ease from 2:07 p.m. to 2:22 p.m.

2:21:53 PM

CHAIR REINBOLD reviewed what the committee had heard thus far.

2:23:15 PM

EVAN FEINBERG, President, Generation Opportunity, stated, "Generation Opportunity is an organization that empowers young people to fight for their economic freedom and their future prosperity." He said it is a grass roots organization that represents millions. He related that he is 29 years of age and worked on Capitol Hill during the ACA debate. He said he is a former staffer of Senator Tom Coburn of Oklahoma, for whom he handled health care policy. Subsequently, he was a staff director for Senator Rand Paul's subcommittee on the Health, Education, Labor, and Pensions Committee in the Senate, where he said he continues to "fight the implementation of the law ... ."

MR. FEINBERG opined that the ACA is set up to steal from young Americans in "a vain attempt to offer universal health insurance." He stated that the ACA is predicated on notion that young, healthy adults will sign up for the exchanges and pay more than their fair share for health care in order to provide health insurance for more people. He related that the Congressional Budget Office projects that in order for the ACA to work, 2.7 million of the 7 million that register must be young, healthy individuals. Mr. Feinberg said 96 percent of the

uninsured youth in America do not have a chronic condition or pre-existing disease or anything else that would drive up the cost of their health care; therefore, they have options for affordable health insurance already, without the ACA in place. Under the ACA, premiums for young people are expected to increase "by 260 percent - well over three times as much ... ." He said when that happens, it makes it impossible for young people to buy the insurance, and the money is being spent not on the young, but on health insurance for older, sicker Americans.

MR. FEINBERG suggested looking at the cost for premiums in Anchorage, Alaska, before and after the ACA. He said the average premium for the lowest plan prior to the Act cost $79; a similar plan under the Act, at the bronze level, with a $5,000 deductible, costs $254. He emphasized the significance of the increase. He said a mandate forces young people to sign on to an exchange that is not a good deal. He said celebrities, such as Jennifer Hudson and Amy Poehler, are being used to "sell this bad deal to young Americans." Mr. Feinberg stated that the new spending over the next ten years is primarily money borrowed from that of his and his son's generations. Further, he said even after getting young people to sign up, there will still be 30 million uninsured Americans.

MR. FEINBERG said college students are losing coverage. He said a "government accountability office" report showed that 600,000 young people currently receiving insurance through their college or university - primarily low-income students - are going to be kicked off of their insurance plans because of the mandates and requirements of the ACA. He listed the following ways America's youth are hurting under the current economy: the effective youth unemployment rate is 16 percent; one-third of individuals 18-34 years of age have been "forced to move back in with their parents"; and 43.6 percent of youth ages 18-29 are working fulltime. He stated that the ACA makes it expensive for employers to hire employees who work over 30 hours a week. He concluded by positing that it is a difficult time to be paying three to four times for health insurance.

2:29:03 PM

CHAIR REINBOLD mentioned an Internet article that states, "Even President Obama is afraid of creepy Uncle Sam." She asked Mr. Feinberg if he would like to expound on that subject.

MR. FEINBERG said Generation Opportunity has a campaign in progress to encourage young people to make the best possible

health care decision during the open enrollment period, to opt out of government insurance and choose private insurance. He said people are referring to the Generation Opportunity's campaign as "the creepy Uncle Sam campaign." He said the group has generated three web videos, which have received a total of 3.1 million views on YouTube. The videos show Uncle Sam changed from a symbol that protects freedom to one that "oversteps the limitations on government and gets involved in young people's health care." Mr. Feinberg expressed the group's privacy concern that there will be a "massive federal data hub collecting health care data and personal financial information on young Americans for the purpose of trying to get them to sign up for health care or make decisions the government wants them to." He characterized the group's campaigns as "creative and fun," and encouraged watching the newest video put out this week for Halloween.

CHAIR REINBOLD relayed that Mr. Feinberg had given her a tour of his office in Washington, D.C. She said she thinks the aforementioned videos alarm viewers to the impacts of the ACA on America's youth. She encouraged people to watch them on generationopportunity.org. She stated, "You were on the front line back there in Washington, D.C., and got to see this sausage being made; and some sausage has a lot of fat in it." She stated that this law is creating alarm across the nation. She said she thinks that "if their web site is any indication of what this law is going to become," then Americans have cause for concern.

2:32:09 PM

REPRESENTATIVE TARR asked Mr. Feinberg to talk about the source of Generation Opportunity's funding; in particular, she asked what percentage of the organization's total funding was sourced by the Koch Brothers. She explained she was asking in the interest of "being fair about any organizational bias you might have."

CHAIR REINBOLD told Mr. Feinberg he could choose not to answer that question, which she opined was not pertinent to the hearing.

MR. FEINBERG responded that Generation Opportunity has "a variety of donors, both large and small," and a lot of the donors request anonymity, which he said he can understand "in an era where the IRS is going after political opponents of the President." He said he encourages donors to disclose their

affiliation with the organization, but respects the confidentiality of those donors who ask for it. He emphasized that Generation Opportunity is focused on what is best for young people, and those who support it care about the economic prosperity of the next generation.

REPRESENTATIVE TARR stated, "Well, for the record, as an official activity..."

CHAIR REINBOLD told Representative Tarr that she had not yet recognized her to speak. She added, "I think that question has been answered."

REPRESENTATIVE TARR said, "I have another comment. This is an official business meeting of the Alaska State Legislature, and there are materials that are passed here that are not factual, and this organization has some..."

CHAIR REINBOLD interjected that she has an objection, and she reminded Representative Tarr that she is the chair of the joint committee.

REPRESENTATIVE TARR responded that as a member of the joint committee, she is allowed to make a comment for the official record.

CHAIR REINBOLD said, "When I recognize you."

REPRESENTATIVE TARR stated, "I would like it to be part of the official record that this is an organization that is heavily funded by the Koch Brothers, with a particular organizational bias."

2:34:40 PM

SENATOR GIESSEL proffered that the information [Mr. Feinberg] shared with the committee, regarding Generation Opportunity, has been substantiated by the Institute of Social and Economic Research (ISER) and "other organizations that do unbiased, nonpartisan research."

2:36:13 PM

CHAIR REINBOLD reminded members that they are allowed to speak only when recognized by the chair, and anyone speaking without being recognized is out of order. She then thanked Mr. Feinberg for taking time to testify and to care about and study that

which impacts youth. She emphasized that the ACA is "a living document" comprised of 2,700 pages and 20,000 pages of regulations thus far. She said there are many issues of which the legislature should be aware.

2:36:49 PM

JOE RIGGS, Registered Agent, Alaska Healthcare Strategies, LLC, said he has represented both large and small manufacturers of medical devices for the past five years. He related that because of his exposure to the medical field since the age of 13, he is familiar with how changes get adopted throughout the system. He shared that his background is in economics and finance. Mr. Riggs stated his purpose before the joint committee is to talk about medical device tax, which he said will affect Alaska, even though the state does not have major medical device manufacturers. He said the 2.3 percent excise tax that was originally placed on any medical device, from artificial hearts to toothbrushes, was given a retail exemption by regulators in 2012, so that anything that can be purchased by a retail consumer in a store or pharmacy, for example, is now exempt from the tax. However, he indicated there is now a cost involved with proving a device's retail status.

MR. RIGGS said it is important to remember that the 2.3 percent excise tax is on gross profit, which means for a company with a 10 percent profit margin, the 2.3 percent tax would drop the company's profit margin down approximately 23 percent. He noted most companies, after expenses, "follow the profits back to research and development." He said there has already been a "cross boards cut" in research and development and a 50 percent cut in adventure capital for new start-ups and products. He said "the big 10" have done quite a number of layoffs already, and he mentioned some of the company names along with the number of employees that have been let go from each - that number ranging between 440 and 1,000. He said Alaska is not feeling the pinch of the layoffs right now. He related that in 2011, there were over 16,000 device manufacturers in the U.S., over 13,000 of which had 50 or fewer employees. He said, "This is where the impact will be the worst." He opined that this issue is not being sufficiently addressed.

MR. RIGGS said the first thing a firm will do to adapt to a tax of this magnitude is cut [its own] costs through layoffs, reduce research and development, and shift the cost of the extra tax to the consumer. A number of companies are listing the 2.3 percent excise tax on their customers' statements. He indicated that

companies doing with business with Alaska have, in general, three-year contracts; therefore, the prices will likely go up when the contracts end. Alaska will see that increase.

2:41:50 PM

MR. RIGGS said the smaller firms are the ones that take the risks, as they might have a single product or idea. Like most start-up businesses, they have a lot of costs put into research and development and inventory. So, if a company makes a 2.3 percent profit on a product, the excise tax will take away any profit that would have come from that. A rational business person would consider that and "slow it down" or perhaps not put out as innovative a product. The larger companies have continued to do research and development, but have cut 20-30 percent of that budget. Big companies don't usually come out with "the big game-changing products." It's the small businesses that may be going out of business.

MR. RIGGS, regarding the lifestyle of a product, offered the example of a company called Aridian, which produced a product for a problem wherein pain killers slow down a patient's breathing, and some patients are more sensitive to others. In the past, a higher nurse to patient ratio made it more likely that someone would discover a patient's breathing was slowing, but automation and a decline in the nurse to patient ratio meant that some people "started to slip through and have some bad episodes." He said one man came up with an idea of monitoring a person's breath by measuring the amount of carbon dioxide expended, which gives a lot of information to a doctor. The equipment used for this measurement can set off an alarm if a patient quits breathing, therefore allowing help to arrive before the situation becomes irreversible. In over five years, this product has become the standard of care across the country for any patient who is on a narcotic pump or pain killer in the hospital. The federal government has made it mandatory in all its institutions, as well. Mr. Riggs questioned whether that product would have been made if the excise tax had been in existence.

2:45:41 PM

SENATOR GIESSEL pointed out that the data regarding a patient's breathing goes to the nurses in the hospital, not the doctor. She said what Mr. Riggs is describing about "the tax suppressing innovation, you know, that applies to independent practitioners as well." She said when Ms. Green began her independent

practice, she "worked for two years for free." She said that is what it takes to start and build up a practice, and adding taxes will result in less and less community clinics. She questioned what would happen during a big disaster without those clinics.

MR. RIGGS said his spouse is a physician, and he indicated that it took nine years of his support in the medical field to help her start her practice.

2:47:05 PM

MR. RIGGS, in response to the chair, reiterated that retail devices, such as toothbrushes and bandages have been exempted. Examples of that which is not exempted range from orthopedic devices to tools to video monitors. Regarding the 2.3 percent excise tax, he said, "One can imagine that a product that has been around for ... a number of years probably doesn't have much of a profit margin."

CHAIR REINBOLD said she is from Eagle River, which does not have a big corporation; therefore, this issue concerns her. She mentioned the importance of mom and pop businesses for teenagers entering the workforce.

2:51:02 PM

WILLIAM J. STREUR, Commissioner, Department of Health & Social Services (DHSS), stated that some prefer to call the law "Obamacare," but he calls it the ACA, because this tends to "depersonalize it," because "it's endemic of what happened on a Congressional level." He said President Obama "couldn't have done it alone" and "we need to be aware of that." He continued as follows:

> When the [U.S.] Supreme Court decision came down, it became the law of the land, but the State of Alaska, along with the other states, was offered the opportunity to say "just say no" to Medicaid expansion. Although it's been stated in any number of national and state journals that the governor has said no, he has not said no. He has said maybe/maybe not, and he's given me the opportunity to do the deep dive and try to show him the good, the bad, and the ugly. And I say the good, the bad, and the ugly, because you want all three sides.

So, I've been spending a fair amount of time reading, looking at data that we have, internal and external, to look at where the savings might be, to where the costs might be, to where the liability might be, to the what ifs. You know, what if Congress turns over? And the 90 percent to 100 percent of funding goes to the 50 percent in the traditional (indisc.) That's where the rest of our Medicaid participation (indisc.) is generally at. We get a little amount with Denali Kid Care; we get a little higher amount for certain IT projects, but straight Medicaid, as we know it, is about 50 percent federal mandate and federally funded. It's a big part of the budget; it's $1.6 billion with a "b." "And yet when I came on, it was about $1.2 billion. with a "b", and ... over seven years we've had some substantial increases. I'm happy to say over the last two years we've been virtually flat. In fact, 2013, I was able to return $25 million in federal funds, which nicely paid for the governor's supplemental of $24.7 million. So, we were able to get some wins and we got those wins through being innovative and working closely with our provider community.

COMMISSIONER STREUR stated that one of the issues he addresses is generic medication. He said [the state] saves a million dollars for every percentage point it is able to increase generic medication through the Medicaid program. He said historically, the numbers were going in the wrong direction, from 74 to 72 to 68 to 65 percent, but there has been a large run of new "bling-bling drugs," which affects the numbers. He said he approached the medical community for help, which he indicated has been successful. He said there have been two years of "flat spending," but said he thinks there will be climbs in Medicaid spending. He said, "So, when we're looking at Medicaid expansion, that's got to be factored into that." He said he has been working in the last few days to put together recommendations for the governor.

2:56:28 PM

COMMISSIONER STREUR identified one question as whether there is enough bandwidth; that is whether there are providers who will pick up the load since a Medicaid expansion would result in an increase of 25 percent. Although there is no knowledge as to what the health insurance exchange is going to receive in terms of additional insureds, there are 137,000 uninsured people in

Alaska. If, say, 60 percent of the people avail themselves of the health insurance exchange, that would amount to about 90,000 people. With regard to the study that discusses [the need for] 4,000 new providers, Commissioner Streur stressed that the state can't obtain providers now and thus he questioned what will be different under the health insurance exchange, particularly since every other state in the nation will be facing similar problems.

COMMISSIONER STREUR then expressed concern with placing more bodies in the nation's already broken health care system. He informed the committee that the U.S. is the highest cost nation in the world for health care, no matter if it's per capita or population basis. Alaska is one of the two highest cost states for health care in the nation, which some argue is because of the cost of living. Commissioner Streur expressed the need to control back such that care is returned to primary care practitioners, which include doctors, nurses, nurse practitioners, or physicians' assistants. If Medicaid expansion occurs and the ACA and health insurance exchange is embraced, he questioned whether providers will step up. He related that a study from the hospital association reports there are $200 million in write offs at hospitals each year. He doubted that [hospitals] would be willing to reduce their rates by $200 million if insurance coverage is increased for individuals. With regard to whether there would be better care, Commissioner Streur opined that will only happen when care is returned to primary care providers. He also expressed the need for better managed care and questioned whether more/less prior authorizations should be reviewed or whether rates should be reevaluated. He highlighted that Brandon Clark's paper relates the national average for Medicaid payments is 66 percent of Medicare, while Alaska is 140 percent of Medicare. He noted that Alaska can thank U.S. Senator Stevens for the bump in the Medicare rates. Commissioner Streur acknowledged there's a lot of room to talk about rates, but noted that [the department] has been able to provide a robust health care plan to the needy in Alaska. With regard to the notion that Medicaid should be expanded to 130 percent of the poverty level in order to cover the extra children, he pointed out that children are currently covered up to 175 percent of Medicaid.

3:03:09 PM

COMMISSIONER STREUR then related that he and Representative Hawker have struggled over the years with the amount of grant money for behavioral health and senior disability services, [the

need] for which continues to grow exponentially. Under a Medicaid expansion, he questioned how many individuals would not be covered under Medicaid. He further questioned whether there is an offset and if so, what it would be. About $60 million in general funds (GF) is spent on behavioral health. These are what he is considering when preparing the paper for the governor, he said. He emphasized that he has to present a balanced [approach] for Alaskans. He expressed concern that there is donut hole, even with the Affordable Care Act, for those below 100 percent of the poverty level who are not eligible for the exchange and thus they cannot receive reimbursement. He opined that the belief was that Medicaid would be mandatory, and thus this group would not be of concern. However, that is not the case. Although those between 100-138 percent can go on the exchange, file, and be covered, they have to front the premiums for 12 months until they can claim it on their taxes. Those slightly above 200 percent of the poverty level will receive 100 percent reimbursement of their insurance premiums. He clarified that without the expansion, those below 100 percent of the poverty level won't be eligible. He noted that this group is largely made up of childless adults.

3:05:28 PM

COMMISSIONER STREUR, in conclusion, told the committee that he hopes to meet with Governor Parnell and provide an overview in the near future.

3:06:52 PM

CHAIR REINBOLD thanked the commissioner for keeping [the DHSS budget] flat, particularly since the state's budget has been growing on average at 6.5 percent a year for the last 10 years or so, which is unsustainable. She then inquired as to how many people are currently enrolled in Medicaid.

COMMISSIONER STREUR specified that about 151,000 people are enrolled in Medicaid of which about 137,000 actually use the benefit.

CHAIR REINBOLD opined that Denali Kid Care was a huge expansion of Medicaid, and then related her understanding from those in the room that Denali Kid Care was expanded in 1998 under the Knowles Administration. She then inquired as to the annual cost per patient.

COMMISSIONER STREUR answered that the annual cost per patient is $11,000-$13,000.

CHAIR REINBOLD referred to a University of Virginia study that found the outcomes of patients on Medicaid with restricted formularies, restricted access to certain physicians, and restrictions to certain procedures were not as good. She asked whether that is the case in Alaska, where there is a good program with a good reimbursement rate. She further asked whether any research has been done regarding the outcomes of patients compared to the private sector or in-house [services].

COMMISSIONER STREUR answered that there has been very little research done on that. In terms of the Medicaid in Alaska, Commissioner Streur didn't believe one could afford to buy a policy as good as what Medicaid in Alaska offers, although it's very costly for the state.

CHAIR REINBOLD questioned whether [Medicaid in Alaska] is sustainable, particularly with declining state revenues. She then asked whether Commissioner Streur could provide any solutions in terms of the future in Alaska.

COMMISSIONER STREUR reiterated his belief that care should be returned to primary care providers otherwise the trend will not be reversed.

CHAIR REINBOLD asked whether Commissioner Streur believes the ACA will help that.

COMMISSIONER STREUR responded that he didn't know because he didn't believe the ACA is concerned about quality of care but rather is concerned about access to insurance. He pointed out that the ACA isn't bringing providers in the mix as good counsel and [has an awkward funding structure]. Commissioner Streur opined that the ACA, in its present form, isn't going to do much to improve the quality of care, although it will improve access to care. He reiterated the need to find balance. He then highlighted the sticker shock that is occurring. For instance, Oregon developed its own health care exchange for $240 million and it's limping along.

3:13:45 PM

SENATOR GIESSEL agreed with Commissioner Streur that Alaska's Medicaid program is great. In fact, she said she has known patients to move to Alaska because of its generous Medicaid

program. She then recalled that Commissioner Streur said there were 137,000 uninsured Alaskans. She also recalled reading a report from Mark Foster, an economist with ISER, that said the uninsured numbers may not be accurate because those who qualify for Alaska Native health care are included as uninsured because that's not considered insurance. Therefore, the uninsured numbers are distorted, she opined.

COMMISSIONER STREUR explained that he uses that number because it comes from ISER and others. However, he said that Senator Giessel's concern about the numbers is "spot on." He then informed the committee that the 137,000 uninsured also include certain veterans who are eligible for Veterans' Affairs (VA) benefits. Since the uninsured number includes covered people, he said he used it mainly for illustration purposes. He noted that the tribal health care organizations in Alaska will argue that they don't have insurance while the federal government says they do. Therefore, the number of [true uninsured] is considerably lower than [137,000].

3:18:06 PM

DR. RANCIN (ph) informed the committee that in 2009 a group of individuals in Anchorage formed the Municipal Taxpayers League which involved itself with local Anchorage issues, but also addressed some statewide issues such as Obamacare. The group contacted the Dittman group who developed two surveys, one of which went out to the public at-large, about 400 people throughout the state, and another survey that went out to health care providers. He noted that the questions on the surveys were similar regarding health care reform and provided the information as widely as possible, including the media, legislators, and the congressional delegation. He specified that the offices of U.S. Representative Don Young and U.S. Senator Lisa Murkowski were anxious to obtain the information, while the office of U.S. Senator Begich seemed to stonewall attempts at receiving the information prior to the congressional vote. Referring to the survey provided to the public at-large, he related that the public was generally against the survey 55 percent to 42 percent. The healthcare providers were in stronger opposition than the public at-large such that 80 percent opposed it and 10 percent supported it.

3:26:10 PM

CHAIR REINBOLD, referring to this Alaska statewide health survey, pointed out that about 400 registered voters were asked

to participate in the survey. These registered voters were opposed to a national health care system and the vast majority of respondents expressed concern with the health care reform plan being proposed [in 2009]. With regard to question 3 60 percent of respondents felt that the quality of health care was going to become worse [under the proposed health care plan]. With the limited information at the time, 64 percent of respondents felt that the cost of health care will increase. The survey found that 82 percent of respondents felt that government is spending too much. She opined that respondents would be even more alarmed today in light of the true costs.

3:28:49 PM

SENATOR GIESSEL inquired as to what kind of provider Dr. Rancin is.

DR. RANCIN answered that he is a dentist.

SENATOR GIESSEL pointed out that the two surveys are sponsored by two different groups. The first survey says it's sponsored by the Municipal Taxpayers League while the second survey specifies that it is sponsored by Alaska Family Medical Care.

DR. RANCIN informed the committee that both surveys were funded by the [Municipal Taxpayers League]. The survey of the 400 [public at-large respondents] was performed completely by Dittman whereas the other survey utilized some medical people to help get the survey out to medical practitioners.

SENATOR GIESSEL noted that Dittman is always very clear that it tries to match the demographics of the sample to that of the state, which is likely why the general [public at-large] survey is more accurate as opposed to the more limited distribution of the second survey.

DR. RANCIN informed the committee that the second survey was distributed fairly widespread throughout the state, including Wasilla, Fairbanks, Soldotna, Anchorage, and the Bush.

3:31:12 PM

CHAIR REINBOLD pointed out that the second survey was among medical professions that included 114 physicians, 41 dentists, 9 pharmacies, 21 nurses. She then highlighted that the second survey had some similar results to that of the first, including that 84 percent opposed a nationalized health care system in the

U.S. Furthermore, 89 percent were in some opposition to the proposed Obamacare.

3:32:59 PM

The committee took an at-ease from 3:32 p.m. to 3:42 p.m.

Presentation: Regulations for Health Information Exchanges

3:42:19 PM

CHAIR REINBOLD announced the committee would next hear testimony regarding a new regulation for the health information exchanges that can be found in the Alaska Administrative Code (AAC) 7 AAC 166. She explained that in the aforementioned regulation a public sector member will be nominated.

3:43:18 PM

JOSHUA DECKER, Interim Executive Director, American Civil Liberties Union of Alaska (ACLU of Alaska), stated that the main thrust of the health information exchange is a good idea as it's an electronic database that allows patients to have their medical records electronically stored and accessed. However, there are some problems with the health information exchange, which precipitated a meeting between the ACLU of Alaska and the Department of Health and Social Services (DHSS). Although DHSS listened to the concerns of ACLU of Alaska and was responsive, three main concerns remain. The statute that governs the broad strokes of the exchange, AS 18.23.310(c)(1) states that the exchange should be opt-out instead of opt-in. Therefore, if patients are silent, their records are automatically incorporated into the exchange. The exchange is currently on-line in the Fairbanks area and will soon be statewide. Currently, in order for a patient to opt-out of the exchange he/she has to go to their provider's office, fill out the paperwork, and the paperwork has to be processed. Mr. Decker offered what he considered a more simple solution, particularly in light of the privacy concerns; the solution would be such that the state would assume patients who are silent do not want their records to be part of the exchange. Therefore, it would be an opt-in as opposed to an opt-out exchange.

MR. DECKER moved on to the second concern of the ACLU of Alaska, which is the gap between the statute and the proposed regulations. The statute, AS 18.23.310, says the health information exchange can only be used for treatment and billing.

The problem is the proposed regulations, 7 AAC 166.040(e)(1)(b)(5), would allow the use of individual medical records for treatment and billing as well as for "any reporting purpose under 45 CFR 164". He explained that 45 CFR 164 is the Code of Federal Regulations regarding the Health Information Privacy and Portability Act (HIPPA), which addresses medical records. The concern, he related, is that 45 CFR 164.512 allows medical records to be used in a number of concerning ways. For instance, 45 CFR 164.512 allows medical records to be used by any company or organization regulated by the Federal Drug Administration (FDA), which could include drug companies, to engage in "post market surveillance." Therefore, drug companies would be allowed to call patients to follow-up on their marketing. The ACLU of Alaska, he related, doesn't believe that's a central way for Alaskan's private medical records to be used. Under 45 CFR 164.512, Title 45, would allow health records as part of the health information exchange to be used for law enforcement purposes. Mr. Decker opined that in Alaska, a state that values individual privacy, law enforcement should not be able to simply write a letter to gain access to an individual's private medical records. Under 45 CFR 164.512(k)(2), the private medical records of individuals would be allowed to be used for national security and intelligence gathering operations. As currently proposed, the DHSS regulations would allow the aforementioned to happen.

MR. DECKER then informed the committee that the computers of the contractor running the exchange, the Alaska eHealth Network (AeHN), had its computers audited this year. The auditors' concluded that "the controls around Internet access are likely insufficient" and further stated that "some machines have been observed sending traffic to a location in Russia that could be indicators of compromise". The auditors' also said, "The anti-virus engine deployed by AeHN may not be effective in the technical (indisc.)." Mr. Decker opined that organizations that are going to hold the personal and private health records of Alaskans should have robust security.

3:50:48 PM

SENATOR GIESSEL inquired as to whether ACLU of Alaska will testify before the DHSS regarding its concerns with the proposed regulations.

MR. DECKER confirmed that the ACLU of Alaska will submit written testimony to the department and would be happy to submit it to DHSS.

SENATOR GIESSEL commented that Mr. Decker's concerns are similar to those surrounding the prescription monitoring program for controlled substances. She noted her appreciation for Mr. Decker's concerns and expressed hope they would be presented to DHSS.

CHAIR REINBOLD pointed out that many of Mr. Decker's concerns seem to be with the CFR, which are federal regulations that are adopted by the state by reference. She expressed the desire to be informed with regard to the responsiveness of DHSS to ACLU of Alaska's concerns.

MR. DECKER pointed out that adoption of the CFR is not mandatory and the regulations could be structured to say that the records will only be used for billing and treatment as narrowly defined in the CFR.

3:53:51 PM

The committee took an at-ease from 3:53 p.m. to 3:56 p.m.

Presentation: Department of Health and Social Services Assisted Living Home Rate Changes

3:56:03 PM

CHAIR REINBOLD announced that the last part of the hearing would be a presentation regarding the proposed changes to the Assisted Living Home (ALC) rate changes to the Alaska Administrative Code (AAC) 7 AAC 145 and 7 AAC 160.

3:57:35 PM

SHERRY METTLER, Past President, Assisted Living Association of Alaska; Past President, Assisted Living Professionals of Alaska, related her prior experience with assisted living homes, including that she currently serves as a consultant to various assisted living homes, but she has also operated assisted living homes for over ten years. She said she is testifying today with respect to proposed regulations for assisted living homes.

AMY ONEY, President and Owner, Mama's Assisted Living Homes, introduced herself. She stated that Mama's Assisted Living Homes has been in business since 2002.

3:59:07 PM

MS. METTLER then began her presentation by providing a brief history of assisted living home regulatory changes and rates. When assisted living homes began sometime prior to 2002, a regulatory structure rate was established at approximately $70-78. In 2001, Senate Bill 73 was introduced, which became law in April 2002 and increased the amount for assisted living homes by an additional $70. However, the department retained 42 percent of the $70, she said. In order to receive its portion, assisted living homes were required to submit a cost-based reimbursement, which became a negotiated rate, although the current term used in the proposed regulations is a hold-harmless rate. At the time the hold-harmless rate was higher for most of the assisted living homes than the previous rate in 2011. In 2004, a freeze was placed on the rate. She elaborated that in 2002, cost-based reimbursements were supposed to be reviewed annually by the department to ensure that the assisted living homes performed according to their projected costs and to allow for renegotiated rates. However, "That never happened," she said. Instead, in 2004, the rates were frozen and assisted living homes could no longer renegotiate terms.

MS. METTLER advised the state also made changes which allowed the [Division of] Alaska Pioneer Homes (Pioneer Homes) to serve Medicaid waiver clients. In short, the changes pertained only to Medicaid waiver rates since the private sector facilities were not restricted, she said. Ms. Mettler reiterated that once rates were frozen, the private sector could no longer negotiate rates. In approximately 2006 or 2007, the Pioneer Homes raised rates for its medical personnel, including the registered nurses although the private sector was not allowed to do so. In 2005, a policy shift also had occurred, shifting from an intermediate model to a medical model. Instead of [assisted living homes] using the social model they then fell under the medical model. Subsequently, their clients shifted from intermediate care to nursing home level of care. She pointed out hold harmless rates have not increased since 2002.

4:03:29 PM

MS. METTLER briefly referred to handouts [previously distributed to members] that she said provides additional background information, including a reference to a 2008 letter [not specifically identified]. In 2009, the assisted living home owners worked with the department in an attempt to change the rates. In 2011 the department adopted new rates by regulation. Currently, assisted living homes are in danger of losing hold

harmless rates when new regulations become effective on January 1, 2014. She offered her belief that assisted living homes wouldn't have had any issue with the regulatory changes except that the new rates for assisted living care are based on the financial statements of a small number - only 76 of the 680 assisted living homes in Alaska. She referred to a handout she had just distributed. She explained that the rates are broken out by the number of beds, "under 5," "6-16," and "17 and above." Prior to this, Pioneer Homes fell under the "17 and above" category; however, under the new regulations, the Pioneer Homes are separate and distinct. She referred to the first column in the handout that read, "5 or fewer beds" and to the second column that read, "T2031," which includes a daily rate. It appears the department randomly selected rates ranging from $65.81 to over $205, based on the audited financial statements supplied by the department, she stated. It also appears that consideration was not given to the models or to the individuals who work in homes and whose employers pay wages and insurance. She then referred to another packet [no title provided]. She expressed concern with respect to the methodology used to calculate and interpret the rates that personnel costs and wages were not considered in some instances, in particular, with respect to the hold harmless rates. She indicated that she just closed two assisted living homes [Soldotna Day Centers] - a 16-bed facility and a 4-bed facility - because she felt she could not operate under the new rates. As of 2002, the rate for her assisted living homes was $216.64 [per day], but was scheduled to be reduced to $130 [per day] under the proposed regulations. Therefore, the hold harmless provision is especially important to her, she said. She expressed her ongoing frustration over the prospect of trying to care for people under low rates, such as the $65 per day rate. She also felt it was unfair to lump assisted living homes together by bed size. She preferred that the department base its rates on business models to determine more sustainable and accurate rates.

MS. METTLER turned to slide 4, which shows the proposed rates effective July 1, 2013 and on July 1, 2014. Under the new rates, private industry home rates are reduced by 7 to 19 percent while at the same time; the rates for the Pioneer Homes will increase by 229 percent. She said, "Something's wrong with this picture. It has to be." She said the crux of the issue is that adopting the new rates, combined with eliminating hold harmless rates, will put many assisted living homes out of business. She urged the committee to provide assistance in determining the true cost of providing assisted living care to clients. She also urged members to prohibit dismantling the

hold harmless rates, which become effective date January 1, 2014 under the proposed regulatory changes.

4:12:09 PM

MS. ONEY informed the committee that she has four assisted living homes with five residents in each. Under the proposed regulation changes, the assisted living rates for her facility will be set at $205 per day. Her assisted living homes are not considered a single big facility since they are in four separate locations, noting she had consolidated her four homes into one at the recommendation of the department. Additionally, she did so to reduce the overhead necessary to maintain four limited liability companies (LLCs). Her total rate, based on four homes with five residents in each at $205 per day, would equal $1,496,500, which represents the cost of doing business, she said. The proposed rate changes would decrease her rate to $124.81 per day for a total annual income reduction of $911,000, which would be approximately $500,000 less. She said, "I have absolutely no way to cut that kind of expense and still care for my residents." Furthermore, she said doesn't have a personal slush fund to draw funds, although she has worked to streamline her operation.

MS. ONEY compared rates for assisted living care using the proposed rates, such that someone who isn't insolvent would be charged $541 a day, but someone in a group home would be charged $310.63 per day for the same care. At the same time, the Pioneer Home rates for respite care costs are $350-$455 per day, although temporary care charges would be $282.11 per day. Still, her eligible rate would be set at $124.81 per day under the new rates. She translated the "per minute rate" at $1.30, which for 15 minutes totals $5.64. She compared these charges to personal care attendant (PCA) care fees and concluded those rates would be 434 percent higher than her assisted living care facility rates. She added that respite care patients would be charged 226 percent more than her group residential care rate.

4:17:11 PM

MS. ONEY turned to the [the Division of Alaska] Pioneer Homes. She emphasized that the Pioneer Homes should provide [the committee with] a great cost model since the state is in full control over the type of care residents receive and the legislature has total access to their costs. However, the department has shifted the rates for Pioneer Homes outside the ones for assisted living homes. She predicted that if the

Pioneer Homes had been left in the same category the effect would be that her rates would have increased by an average daily rate of $286. She detailed some of the onerous administrative requirements [under the proposed regulations] that assisted living homes must comply with, including additional training requirements plus an increased standard of care. She characterized it as being similar to walking into Wal-Mart and asking for directions to Gucci designer items. Meanwhile, the legislature's best tool for cost comparison, the Alaska Pioneer Homes has been removed. She recalled previous testimony before the House Finance Committee by the division indicated residential care exceeds $12,000, but Pioneer Home residents are only charged $6,000 per month. The overall effect has been that people who can afford good private care have migrated to the Pioneer Homes. After all, who wouldn't want to receive double the benefit, she asked. She referred to detailed rates on the next slide that indicate the Pioneer Homes have 169,317 units multiplied by a $554.55 rate, for a total of $60,031,342. Comparatively, if their rates were similar to hers, at $124.81 the total cost of care would be $21,332,000. According to the department's figures, she concluded the state has overpaid $38 million for people who receive care in the Pioneer Homes.

4:21:06 PM

MS. ONEY argued that if the Pioneer Homes operated under her current rate, the state would still save $25 million. She contemplated the effect of her homes closing on January 1, 2014 or on July 1, 2014, if the hold harmless rates are maintained. For one thing, her assisted living homes are duly licensed so she is also qualified to care for older adults, adults with disabilities, and those with mental health issues. Referring to the next slide, she pointed out that Anchorage has 13 assisted living homes, with a total of 17 assisted living homes in Alaska. She predicted this will only increase as Alaskans age. At the same time, the Pioneer Homes are not licensed and cannot accommodate her assisted living home population, she said. Ms. Oney turned to identify her staff person, Elizabeth, who has been with her for the entire 11 years she has operated. She identified other members of her staff, who also have served her facilities from 8 to 10 years. She expressed concern for their livelihood. She identified what she believes assisted living homes need. First, the assisted living homes need the ability to address and maintain the hold harmless rates, which are scheduled to expire on January 1, 2014, prior to the new rates being implemented.

4:24:00 PM

MS. ONEY expressed concern that she will lose $492 per day if the hold harmless rates are abandoned. Meanwhile, the notice of closure requirement is set at 90 days, but she has less than 30 days remaining before the proposed regulations go into effect. However, at this point she hasn't obtained a clear answer with respect to the department's intentions on the proposed regulations for rate changes. She expressed her frustration at being stuck in a difficult situation since she doesn't want to give staff and residents notice when she is unsure of the department's stance. She said, "I need some help and I need some answers. I need someone to be willing to step up in the department." She characterized the department's lack of decision-making ability as putting assisted living homes in an impossible situation.

4:26:20 PM

MS. ONEY recommended a task force be assigned to discuss ideas. She anticipated assisted living homes will have to comply with additional regulations for licensing and Medicaid. She would like the state to identify benchmarks for quality of care expectations and to identify what it can afford. She recalled her prior committee service, which leads her to believe that when all the parties sit at the table sustainable solutions can be worked out by the end of session. She related that Vermont has also conducted a feasibility study on assisted living care facilities. She wondered whether the department had run feasible economic models and if so, whether closed homes were removed from the calculations. She also would like adequate notice in order to have an appropriate wind-down for her facilities. She concluded by saying she takes pride in the quality of care she provides clients at her assisted living homes. However, if that isn't what the state wants, she'd just like the dialogue to happen in a "grown-up" way.

MS. METTLER asked the committee to give other people an opportunity to testify.

4:30:26 PM

CHAIR REINBOLD thanked Ms. Oney for caring for the elder Alaskans. She pointed out that Alaska has a growing aging population and no one seems to understand the magnitude of the expenses. She mentioned that she introduced HB 140, which did not pass. Her bill would force the department to consider how

statutory and regulatory changes affect municipalities and the private sector. She emphasized HB 140 remains one of her priorities. She emphasized that some regulations adversely affect our communities and should be addressed on a state, federal, and local level.

4:33:04 PM

REPRESENTATIVE TARR related her understanding of the issue. She understood the hold harmless provisions are working but will be eliminated on December 31, 2013, followed by a lag period, with new regulations becoming effective on July 1, 2014. However, issues have arisen with the proposed rate reductions for assisted living homes. She further understood that the Pioneer Home rates are based on a level of care provided basis, so lower needs clients can be charged less. She asked whether the rates should be adjusted based on a tiered level of care.

MS. METTLER agreed that could be an option, which is one she has suggested in prior years. She suggested that the department seems to be trying to eliminate dual licensing, rather than to create tiered licenses. She stressed this as one reason a task force approach is important. She suggested the department consider other factors, including patient acuity. She recognized the benefits of having residents at different abilities and ages since people help one another. She urged members not to limit the Pioneer Homes strictly to the elderly since that type of care tends to isolate people.

4:36:36 PM

SENATOR GIESSEL asked for the location of the other 17 licensed homes.

MS. ONEY offered her belief the assisted living homes were scattered throughout the state, with one in Kodiak or Fairbanks. She clarified that the total includes the nine assisted living homes in Anchorage.

MS. METTLER, in response to Senator Giessel, answered that one assisted living home is in Kenai and Fairbanks. She pointed out some homes are dual-licensed.

CHAIR REINBOLD reiterated the importance of putting the power back into the hands of the legislature instead of the bureaucracy since it isn't held as accountable.

4:38:51 PM

ROBERT NASH, Owner, Riverside Assisted Living, LLC, stated that his 96-bed facilities were recently licensed and opened. In 2011, the rates were increased, but at the time the rates were too low for facilities to break even, let alone achieve any profits. He said when rates were increased he invested $7 million in Soldotna to build a beautiful assisted living home on the Kenai River. Basically, the proposed rate reduction from $155 to $122 per day represents reductions for facilities ranging anywhere from $40,000 to $80-90,000 per month. He predicted that if the proposal passes Alaska will have a mass crisis without places for Ms. Oney's clients to go. "Alaska will be in a crisis mode. One of the things we've already done is to purchase property in Kenai, Alaska to build another large facility. Kenai and Soldotna did not have one facility over 17 beds. Not one. And there's a tremendous need down there," he said. In fact, the Pioneer Homes in Ketchikan, Sitka, Juneau, and Palmer currently experience a three to five year waiting list. Furthermore, seniors represent the fastest growing population in Alaska so [the number of seniors] will be doubled in five years. He cautioned that investors currently shy away from Alaska since it lacks stability. He offered his belief that the private sector must fill this need. He reiterated that he did not believe he could open another facility in Kenai since it won't be possible to stay in business [under the proposed regulations].

MR. NASH said he is accountant by profession and reiterated the department's methodology is flawed. He cautioned the grouping used. In fact, his home is as large as the local Pioneer Home. He characterized the situation as being similar to the state being the referee and the rule maker. Under this model, the state will lose $38 million per year. The Medicaid waiver almost requires a nursing home degree of care. He stressed that the state saves a lot of money by allowing the private sector to provide more homes and fill the void. He emphasized that it costs $14,000 to $16,000 [per month] to put people in nursing homes. He compared that to costs in Boise, Idaho, as well. He suggested the group hoped to talk to the governor during the post-comment period. He suggested a long-term solution would be to stabilize rates by having the Office of Rate Review work with private people - using audited financial statements to identify fair rates. He acknowledged that he did not like competing against the Pioneer Homes - the rule maker. He offered his belief that some solutions could be achieved. He expressed his disappointment that the legislature did not have the power [to

negate the regulations], noting other firms don't have a desire to compete in Alaska.

4:44:52 PM

MR. NASH also expressed his disappointment that the director has not been listening. He predicted an imminent crisis related to assisted living homes. He asked to go on record to provide facts, especially if a lot of seniors are displaced [due to the proposed changes.]

CHAIR REINBOLD stated the purpose of hearings so both sides can be heard. She indicated the department has also been hearing the testimony and the committee will follow up as this regulation moves forward.

4:46:59 PM

LYNN VAZQUEZ stated she has a relative who has been receiving [assisted living home] services. Consequently, she has visited over 20 assisted living homes. She referred to page 2 of a handout [not identified], noting a big discrepancy exists between the proposed compensation for the Pioneer Homes and the private sector assisted living homes. She did not think the level of care has been considered. She has also visited Mama's Assisted Living. In her estimation, some of the clients could go into a nursing home due to their needs. However, the proposed rates do not take level of care into consideration. She contrasted the private home care with the care offered by the Pioneer Homes since some of the Pioneer Home residents are ambulatory, cognizant, and self-sufficient, although she believed some clients also need a higher level of care. Again, the proposed regulations do not recognize the difference. She referred to [page] 11 of the handout, and suggested there isn't any reason not to form a task force to examine the issues. She cautioned that unintended consequences of the proposed regulations may crush the private sector. She said it isn't easy to find a good assisted living home. Members might not realize how critical the services are to the people they serve unless they have personally visited these facilities. She reiterated the importance of reviewing the proposed regulations. She pointed out the difference between services needed for personal care assistant (PCA) to services in assisted living homes. She stressed that [assisted living homes] may be the most cost effective method of delivery. In her view, the Pioneer Home should provide care for those who need nursing home levels of care, but also provide care for those who can take

care of themselves, including those who walk around, go on dates, and feed themselves. On the other hand, homes such as Mama's Assisted Living homes provide care for the nearly bedridden elderly. She pointed to her professional background, expertise, and credentials. She said she has a Juris Doctorate from Cornell University and a Master of Business Administration (MBA) in health care services administration. She has worked for the Division of Public Assistance for many years in the Commissioner's office of DHSS. She added other supportive roles she has served in the field. She characterized her status as being "very well versed" on the subject of assisted living home care. She emphasized that she, too, would like to see the department form a task force to address the issues prior to taking action that could render significant harm. She predicted that the state could save money both from the financial standpoint, and from the managerial perspective.

4:52:48 PM

JASON HOOLEY, Special Assistant, Office of the Commissioner, Department of Health and Social Services (DHSS), said he appreciated today's testimony. The department considers itself accountable to the legislature, the governor, and most of all to the people of Alaska regarding actions, decisions, and regulations before the committee today. He offered to work with Commissioner Streur on the issues as presented today.

4:54:33 PM

JARED KOSIN, Executive Director, Rate Review, Division of Health Care Services, Department of Health and Social Services (DHSS), stated the regulations at issue came from his office. First, he said the department is listening, it will continue to do so, and he also takes these issues very seriously. He advised members he assumed his position in January of last year, and that he and his wife are residents of Eagle River having relocated to Alaska from Denver, Colorado. He stated he is an attorney, with an MBA. He also said he has a tremendous respect for legislatures and has spent time working for majority leaders and speakers in two different states. He further stated that he takes his job seriously when writing regulations and releasing bonds. He noted the regulations at issue have a public comment period until November 1. Thus the department is limited in its response today, but he indicated he appreciated the comments. He has specifically urged Ms. Mettler to submit her comments so they can be considered as part of the public comment on the proposed regulations. He acknowledged the decisions being made

are big ones. The proposed rate changes are not made "out of the blue" but date back to 2011.

4:56:18 PM

MR. KOSIN said in 2011 [federal] regulations came into effect that called for the new cost based rate to take effect on or after January 1, 2014. The regulations also provided for the expiration of the hold harmless rate. The decisions and proposed changes in regulation really stem from those changes. He related that he continues to meet with people on the proposed regulations. For example, he met with about 50 providers at an Association of Developmental Disabilities meeting today. He acknowledged the process can be frustrating, but again, he is restricted in what he can do today, although he assured members he is listening to the comments.

4:57:39 PM

CHAIR REINBOLD said she appreciated having his comments on the record. She said she will consider adding a provision requiring disclosure in HB 130 so people can pinpoint the person responsible for writing any regulations. She elaborated on accountability and stressed the importance of knowing the elderly will be cared for in the future.

4:59:43 PM

SENATOR GIESSEL asked for clarification on how long after the November 1 public comment period that the department will need to respond to the proposed regulation changes.

MR. KOSIN answered the deadline for the proposed regulations will be on or after 1/1/2014; however, the department is very sensitive to the hold harmless rate. Of the 332 entities that provide waiver services subject to the rate, 38 relate to the hold harmless rate, which he estimated is worth approximately $10 million in the system of payment. He agreed the rates will expire on 12/31/13 if the department does not take some regulatory action. He indicated the department will try to be very fast in responding after the November 1 public comment date.

5:01:19 PM

SENATOR GIESSEL related her understanding of the department's actions once the public comment period ends. She further

understood the department would re-write regulations, which would then be subject to another 30-day public comment period. She asked whether that would be the process.

MR. KOSIN answered no. He explained the process, such that the department would make a decision based on the comments, which would go forward to the Lt. Governor for filing without the requirement for additional public notice.

SENATOR GIESSEL asked for further clarification. She asked for further clarification on the process. She asked whether the process is that the regulations will go into effect 60 days after the Lt. Governor signs them.

MR. KOSIN answered that the department would want the hold harmless provision to go to the Lt. Governor by December 31, 2013. He predicted that action could happen pretty quickly.

5:03:08 PM

CHAIR REINBOLD asked to place on record that AS 44.62.710-800 is under negotiated rule making, in which discussions can occur between the department and the stakeholders. She hoped that a path would be available so Alaska's elderly can be cared for appropriately.

5:03:40 PM

ADJOURNMENT

There being no further business before the committee, the Administrative Regulation Review Committee meeting was adjourned at 5:04 p.m.