ALASKA STATE LEGISLATURE
HOUSE LABOR AND COMMERCE STANDING COMMITTEE
January 29, 2016
3:19 p.m.

MEMBERS PRESENT

Representative Kurt Olson, Chair
Representative Shelley Hughes, Vice Chair
Representative Jim Colver
Representative Gabrielle LeDoux
Representative Cathy Tilton
Representative Andy Josephson
Representative Sam Kito

MEMBERS ABSENT

Representative Mike Chenault (alternate)

COMMITTEE CALENDAR

HOUSE BILL NO. 159
"An Act exempting certain health care agreements from regulation as insurance."

- HEARD & HELD

OVERVIEW: DIVISION OF INSURANCE - DEPARTMENT OF COMMERCE~ COMMUNITY & ECONOMIC DEVELOPMENT

- HEARD

PREVIOUS COMMITTEE ACTION

BILL: HB 159
SHORT TITLE: HEALTH CARE RETAINER; INSURANCE EXEMPT
SPONSOR(s): REPRESENTATIVE(s) KELLER

03/23/15	(H)	READ THE FIRST TIME - REFERRALS
03/23/15	(H)	L&C
04/15/15	(H)	L&C AT 3:15 PM BARNES 124
04/15/15	(H)	Heard & Held
04/15/15	(H)	MINUTE(L&C)
01/29/16	(H)	L&C AT 3:15 PM BARNES 124

WITNESS REGISTER

KEN TRUITT, Staff
Representative Wes Keller
Alaska State Legislature
Juneau, Alaska
POSITION STATEMENT: Speaking on behalf of Representative Keller, sponsor of HB 159, presented the bill and the change made by the proposed committee substitute.

LORI WING-HEIER, Director
Anchorage Office
Division of Insurance
Department of Commerce, Community & Economic Development
Anchorage, Alaska
POSITION STATEMENT: Speaking on behalf of the Division of Insurance, expressed the division's concerns with HB 159.

DOUG NICHOLSON, D.O.
Unalaska, Alaska
POSITION STATEMENT: Testified in favor of HB 159.

CHARLES MCKEE
Anchorage, Alaska
POSITION STATEMENT: Provided comments that were not on topic with the published agenda.

LORI WING-HEIER, Director
Anchorage Office
Division of Insurance
Department of Commerce, Community & Economic Development
Anchorage, Alaska
POSITION STATEMENT: Presented an update on action against Moda Health Plans Inc.; and provided a PowerPoint presentation entitled, "Division of Insurance - Healthcare Insurance, dated 1/29/16."

ACTION NARRATIVE

3:19:25 PM

CHAIR KURT OLSON called the House Labor and Commerce Standing Committee meeting to order at 3:19 p.m. Representatives Olson, Colver, Tilton, Kito, Josephson, Hughes, and LeDoux were present at the call to order.

HB 159-HEALTH CARE RETAINER; INSURANCE EXEMPT

3:20:01 PM

CHAIR OLSON announced that the first order of business would be HOUSE BILL NO. 159, "An Act exempting certain health care agreements from regulation as insurance."

3:20:34 PM

REPRESENTATIVE HUGHES moved to adopt the proposed committee substitute (CS) for HB 159, labeled 29-LS0256\H as the working document. There being no objection, Version H was before the committee.

3:21:02 PM

KEN TRUITT, Staff, Representative Wes Keller, Alaska State Legislature, speaking on behalf of Representative Keller, sponsor, said he would present HB 159 and the change made by the proposed CS. The bill seeks to amend the insurance code by creating an exemption in the code for direct primary care practice groups for physicians and other health care providers, so they may contract directly with patients. Without an exemption, said contract would fall within the definition of insurance, thus the purpose of the bill is to "create space" so these contracts can occur without the regulatory oversight related to an insurance product. Mr. Truitt expressed the sponsor's belief that such a contract allows for a relationship between a physician and patient. Additional benefits from HB 159 are reducing the cost of health care and providing greater access to care. For example, one in three physician retirees are primary care physicians and only one in six recent graduates from medical school specialize in primary care. The bill may convince primary care physicians to delay retirement. He directed attention to the original version of HB 159, labeled 29-LS0256\W, page 1, beginning on line 4, which read in part:

> (k) Notwithstanding another provision of this title to the contrary, this title does not apply to the solicitation, negotiation, formation, terms, or other action or matter relating to an agreement that
>
> (1) is a contract between a health care provider and an individual patient or the patient's representative in which the health care provider agrees to provide routine health care services to the individual patient for a fee during a specific period;
>
> (2) is in writing;
>
> (3) is signed by the health care provider or the agent

of the health care provider and by the individual patient or the representative of the individual patient;

(4) allows the health care provider or the individual patient to terminate the agreement by giving written notice to the other party to the agreement;

(5) describes the specific routine health care services that the agreement covers;

(6) specifies the fee to be paid by the individual patient under the agreement;

(7) specifies the period during which the agreement applies;

(8) prominently states in writing that the agreement is not health insurance; and

(9) prohibits the health care provider, but not the individual patient, from billing an insurer or other person for the services provided under the agreement.

(*l*) In (k) of this section,

(1) "health care" means care, treatment, service, or procedure to maintain, diagnose, detect, manage, or promote an individual's physical or mental condition;

(2) "health care provider" means a person who is licensed, registered, or otherwise authorized under AS 08 to provide health care services or an individual who is an employee of the person and acting within the course and scope of employment;

(3) "routine health care services" includes

(A) screening, assessment, diagnosis, and treatment for the purpose of promoting health or the detection and management of disease or injury;

(B) the dispensing of medical supplies and prescription drugs from a health care provider's office or facility;

(C) laboratory work, including routine blood screening or routine pathology screening, performed by a laboratory that

(i) is associated with the health care provider that is a party to the agreement described in (k) of this section; or

(ii) if not associated with the health care provider that is a party to the agreement described in (k) of this section, has entered into an agreement with the health care provider that is a party to the agreement described in (k) of this section to provide the laboratory work without charging a fee to the patient for the laboratory work.

MR. TRUITT said aforementioned subsection (k) is the exemption amending AS 21.03.021. Following that, paragraph (1) sets out the contract relationship between the physician and the patient. Continuing to page 2, he said paragraphs (2) through (9) are the elements required for a written contract, and beginning on line 10, new subsection (l), paragraphs (1) through (3), define health care, health care providers, and routine health care services. He pointed out that "routine health care services" is the phrase in the bill that is used to describe the direct primary care relationship. Further on page 2, beginning on line 24, subparagraph (C) [text previously provided], begins the definition of laboratory services, of which the second half of the definition, beginning on line 28, sub-paragraph (ii), has been removed by the proposed CS. The reason a portion of the definition was removed is that the definition required that the cost of laboratory services - at a laboratory with which a physician does not have a relationship - is to be covered by the physician or a physician's group, and not the patient. Mr. Truitt said the bill is modeled closely after legislation passed last year in Michigan, which provides a balance of freedom for physicians and patients, and offers parameters without undue regulatory oversight.

3:26:36 PM

REPRESENTATIVE LEDOUX asked how "concierge medicine" differs from HB 159.

MR. TRUITT explained that concierge practice is identified with celebrity care, wherein a patient pays a physician or a physician group "multiple thousands of dollars," through a contract for access, and the physician or physician group bills insurance in addition to the contract. However, HB 159 differs in that the monthly fee is for patient expenses. He directed attention to Version W, page 2, line 8, paragraph (9) [text previously provided] that the physician or physician group is not allowed to bill insurance, but the patient can seek reimbursement for care that is covered by the patient's insurance.

REPRESENTATIVE LEDOUX questioned why a patient would not prefer the physician to bill insurance because the process described in HB 159 lacks paperwork, and the information required by the insurance company - such as billing codes - is unavailable. She then offered an example.

MR. TRUITT acknowledged that the provision addressed by Representative LeDoux is new in the bill in 2015, and he was unsure as to the exact answer, except to opine "that's between the physician and the patient, and then the patient and the insurance company."

3:30:34 PM

CHAIR OLSON suggested that HB 159 allows the patient to buy prepaid access, and concierge care includes house calls - with a higher cost - and access. He added that concierge care providers have fewer patients.

REPRESENTATIVE KITO surmised a physician with a small- to medium-sized practice who signs a contract with many patients would amortize their care over the monthly fees; however, he questioned whether a participating individual who develops a serious condition would be adequately covered, and if there is an assurance that a small practice could "handle that cost." Further, he expressed his concern that a clinic - as a small insurer - would be able to refuse to accept certain patients for care in order to keep their risk low and thus put more pressure on the "regular" insurance market.

MR. TRUITT observed that even without HB 159, both of the above described circumstances exist and are already concerns for the practice of medicine and the regulation of insurance. He was unsure as to whether a regular insurance market exists for private individuals in Alaska; in other states, the type of practice being discussed typically works in conjunction with high-deductible, catastrophic insurance products and is viewed as a secondary insurance, and in fact, qualifies as a secondary insurance product under the Patient Protection and Affordable Care Act of 2010 (ACA).

3:33:44 PM

REPRESENTATIVE HUGHES related her previous concern about "taking the cream of the crop patients"; however, she was told that physicians desire to see a variety of patients and experience the challenges and rewards of treating patients with chronic conditions. Also, she pointed out, all of the care the physician could provide is in the contract thus specialty care, such as care for cancer, would not be covered.

REPRESENTATIVE JOSEPHSON directed attention to the bill on page 2, line 18, [text previously provided], defining routine health

care services, including screening, assessment, and diagnosis. He asked whether the CS restricts some of the lab work that is eligible in the monthly fee.

MR. TRUITT clarified that on line 18 the word "includes" is typically interpreted to mean "includes, but is not limited to." The CS does not prohibit certain laboratory work because what follows in subparagraphs (A), (B), and (C), are the conditions that must be covered under routine health care services. For example, a large physician group that could absorb lab fees could include those in the contract.

3:37:08 PM

REPRESENTATIVE JOSEPHSON suggested that if a patient were referred and his/her previous treatment lacked coding - or paperwork - the patient would not be admitted for subsequent care.

MR. TRUITT expressed his understanding that the bill does not exempt a provider from their recordkeeping responsibilities under the "physician practice act." Routinely, coding and billing records are handled by administrative staff who are familiar with insurance codes, and who transfer the treatment information from a physician into codes. He opined recordkeeping will remain the same as it is a standard of practice.

REPRESENTATIVE JOSEPHSON directed attention to page 2, line 19, [text previously provided] which states that routine health care services includes treatment. Without any limitations on treatment, he observed that the contracts between physician and patient would get pretty long and complicated.

MR. TRUITT agreed, and noted that in December, the health law committee of the Alaska Bar Association began addressing this matter.

3:40:55 PM

REPRESENTATIVE LEDOUX inquired as to how a patient can bill an insurer because they are paying for routine, everyday treatment; she posed an example of a patient who is treated for various ailments, "because they could come in all the time under this, and they've paid for everything, they've paid for everything under one, big, lump, sum." On the other hand, in the realm of concierge care, a patient pays [only] for access and every

specific treatment could be billed to the insurance company by the physician or the patient.

MR. TRUITT suggested that a contract may list options that are provided, with additional charges, and also could specify services for which a patient may seek reimbursement.

REPRESENTATIVE LEDOUX stated that the contracts allowed by HB 159 do not work as comprehensive insurance unless coupled with an insurance policy for services that are not routine. She acknowledged that contracts could work well as long as a patient had another type of insurance, such as catastrophic insurance. Representative LeDoux asked what deductible amounts are available for catastrophic insurance.

3:46:24 PM

CHAIR OLSON asked members to defer their questions for the insurance industry.

REPRESENTATIVE HUGHES commented that new business models need time to succeed and the insurance industry will respond if the model is well-received and saves money.

REPRESENTATIVE KITO returned attention to page 2, line 18, paragraph (3), sub paragraphs (B) and (C) regarding prescription drugs and laboratory work included in routine health services when they are available at the providers' facility. When those services are not available at the providers' facility, the patient would go to a regular pharmacy and pay retail; he expressed concern that a provider may provide limited prescription drugs and laboratory work thus forcing a patient to pay more.

MR. TRUITT stated that the aforementioned circumstance exists now; in fact, the bill attempts to alleviate needs and he has not heard about that problem since the application of this practice model 10 years ago.

REPRESENTATIVE KITO inquired as to the target market for the exemption created by HB 159.

MR. TRUITT said the target market is an individual who does not work for a large employer or government, or who may be a sole proprietor and who is required to have an insurance product under ACA.

3:50:41 PM

REPRESENTATIVE LEDOUX asked whether the [policy created by the exemption], without a catastrophic insurance policy, meets the ACA mandate.

MR. TRUITT was unsure, and said he would provide an answer to that question.

REPRESENTATIVE JOSEPHSON advised that either party can terminate the agreement by giving written notice, which is not consistent with ACA.

MR. TRUITT offered that in other states, contracts work in conjunction with catastrophic insurance plans.

REPRESENTATIVE HUGHES addressed Representative Josephson's response, saying that insurance through an employer could be terminated along with the employee's job, and that employee would then be "within the federal law or outside the federal law."

3:52:17 PM

LORI WING-HEIER, Director, Anchorage Office, Division of Insurance, Department of Commerce, Community & Economic Development (DCCED), acknowledged that the health care industry is in need of innovative ideas that will bring affordable health care to Alaskans and throughout the nation. However, the division has concerns about the bill because the division does not regard health care agreements as a secondary insurance product, but instead as access to medical care provided by physicians' clinics. She said the division has been contacted by physicians' clinics in Anchorage and Fairbanks that cannot make money based on the current fee schedules, and HB 159 would allow clinics to maintain their patient volume and level of care. Ms. Wing-Heier gave an example of a patient who was notified by his/her clinic that it does not accept Medicare, however, if the patient has a retainer agreement, the clinic would accept Medicare coverage; therefore, the contract for a monthly or annual fee would be paying for access to care. An additional concern is whether insurance can be billed for care not totally outside of the contract, and then billed to an ACA qualified - or grandfathered - health plan. She restated that the contract is not an insurance product, and "a bill just cannot be generated to then bill the insurance company." Ms. Wing-Heier said the division recognizes that there is a health

care crisis, and seeks to keep costs down thus is concerned about billing for services that are part of a contract between a patient and a provider. The division has no doubt that HB 159, as written, does not create a qualified ACA health plan. She remarked as follows:

> But could it go outside, and we could say it is not an insurance product? We think we could, but we would like to see it with some constraints. The State of Washington ... asks that they be registered with a two-, it's a very simple, two-page registration and it allows for consumers then to register complaints, and then it asks that we report back to the legislature, of complaints received. It's a simple process, we think we could do it, so that you know if these are being successful within the state or not.

3:56:25 PM

REPRESENTATIVE LEDOUX said her understanding is that even if patients who qualify for Medicare want to see their primary care physician, and offer to pay the shortfall, the extra payment is prohibited if the physician provides care to other Medicare patients.

MS. WING-HEIER said the division does not regulate Medicare and is unable to advise consumers in this regard.

REPRESENTATIVE LEDOUX assumed a doctor who has other Medicare patients can enter into an agreement created by HB 159 with one who qualifies for Medicare. The doctor then collects the monthly agreement fee and also bills Medicare for reimbursement.

MS. WING-HEIER said physicians seek agreements which include the ability to treat their patients who now qualify for Medicare, and also collect fees from contracts with those patients.

CHAIR OLSON restated his request that members defer their questions to the insurance industry.

REPRESENTATIVE HUGHES asked whether a physician would be prevented from having, within his/her patient load, a group of patients with contracts for direct primary care and also a group of patients who are traditionally billing insurance.

4:00:01 PM

MS. WING-HEIER said there is no reason a physician cannot see Medicare patients and others. In further response to Representative Hughes, she pointed out that a patient with a high deductible under an ACA individual plan may benefit from a retainer agreement.

REPRESENTATIVE HUGHES returned attention to the aforementioned registration in Washington and questioned whether that function would already be the responsibility of the State Medical Board, DCCED.

MS. WING-HEIER was unsure whether the State Medical Board's responsibilities would be a duplication of this process. She restated that because these contracts look like an insurance product to consumers, consumers direct questions to the division. Washington's retainer agreement bill contains a provision for registration through the division of insurance, and not through its licensing board.

CHAIR OLSON speculated that in areas with a large population, day surgery clinics and diagnostic centers will be the next group to offer contracts. He expressed his hope that alternatives will grow.

REPRESENTATIVE JOSEPHSON cautioned that contracts will cause many disputes between physicians and patients on the extent of treatment. He asked, "What does it mean to say, 'I've treated you,' what does it mean to say, 'I've diagnosed you, or I've assessed you'?"

4:03:56 PM

MS. WING-HEIER stated that the division questions the following:

> Can the clinic sustain the treatment diagnosis? At what point does it go from what I would consider primary care, to taking someone through a full-blown cancer diagnosis .... Our conclusion has been that it depends on how the contract is written, not so much the statute, and that it would be to find in the contract itself as to ... the extent of the treatment you would receive under the contract you signed with your physician.

MR. TRUITT advised that Washington was the second state to enact pertinent legislation; published data from the State of Washington's division of insurance indicated that in fiscal year

2014, there were 8,558 patients within the state who were "members of these types of organizations" and no complaints of disputes have been received.

REPRESENTATIVE LEDOUX asked whether there was data from Washington on patients who are seeing specialists as opposed to general practitioners; she suggested primary care physicians may have an incentive to refer patients to a specialist earlier.

MS. WING-HEIER has heard that patients with agreements seek primary care sooner in order to get a referral, and proper medical treatment, on a timely basis.

4:07:51 PM

CHAIR OLSON opened public testimony on HB 159.

DOUG NICHOLSON, D.O., said he is a 64-year-old family practice doctor working at the Iliuliuk family health center in Unalaska. Dr. Nicholson explained that the current model of medical practice is a volume-based model that generates a certain amount of revenue related to the number of patients treated; however, in a direct pay care model, clinics may have a limited amount of patients and can see patients on the same day, over Skype, or via a video screen for visits that do not require an in-person examination. He said he was unsure how much longer he could continue a volume-based practice, but in a relationship model, with a smaller group of patients, he may continue for 10-15 years. Dr. Nicholson visited a direct care pay model in Kansas and was told it was successful; there was flexibility in treating patients and in billing. The direct care model also works best for those who have high deductibles and catastrophic health care, but it is not designed for the uninsured. It is also designed for small employers who may pay a portion of the direct care fee. He opined health care for most people is at the primary care level. In Unalaska, health care charges are in the 90th percentile in costs, and a patient may have a $300 bill for a 10-15 minute visit; the direct care model allows a physician to charge for "what you're actually doing." He gave examples of low cost medication and of other advantages to direct pay care, such as more decisions made between the doctor and the patient.

4:13:26 PM

CHARLES MCKEE provided comments that were not on topic with the published agenda.

4:15:19 PM

CHAIR OLSON, after ascertaining no one else wished to testify, closed public testimony on HB 159.

[HB 159 was held over.]

4:15:37 PM

The committee took an at ease from 4:15 p.m. to 4:17 p.m.

OVERVIEW: DIVISION OF INSURANCE - Department of Commerce, Community & Economic Development

4:18:41 PM

CHAIR OLSON announced that the final order of business would be a presentation by the director of the Division of Insurance, Department of Commerce, Community & Economic Development (DCCED).

4:18:51 PM

LORI WING-HEIER, Director, Anchorage Office, Division of Insurance, DCCED, stated that since her presentation was scheduled there has been a dramatic change related to insurance in the state, which she will address. She provided a PowerPoint presentation entitled, "Division of Insurance-Healthcare Insurance," dated 1/19/16. Ms. Wing-Heier said the mission of the division of insurance is to protect consumers in Alaska, and the division's recent action against Moda Health Plan, Inc., was to do so. The division has a statutory responsibility to review rates, rules, and forms, and to determine whether rates are excessive, inadequate, or unfairly discriminatory. She explained that excessive rates are not those that affect one's budget, but are justified by whether they support the pool of individuals insured and the claims thereof; inadequate rates are "almost the opposite"; and to determine whether a rate is unfairly discriminatory is to ensure that any rate difference is allowable, such as higher rates charged for tobacco users [slide 2]. Slide 3 was a list of common acronyms which was provided for reference purposes. She continued to update the committee, noting that the Patient Protection and Affordable Care Act of 2010 (ACA) was enacted 3/23/10, and under the terms of the Act, insurance plans in effect at that time remain in effect and are called grandfathered plans. In 2013, a decision was made that

plans purchased after 3/23/10, and before 1/1/14, are considered non-grandfathered, and must be rewritten to comply with ACA. Therefore, at this time the division is reviewing three segments of insurance plans: grandfathered plans written prior to 3/23/10; non-grandfathered plans written between 3/23/10 and 1/1/14, which will transition in 2016 or 2017; and plans written after 1/1/14 [slide 4]. Ms. Wing-Heier said there have been rate increases: in 2014, Premera's average increase was 37.2 percent and Moda's average increase was 27.4 percent; in 2015, Premera's average increase was 38.7 percent and Moda's average increase was 39.6 percent [slide 5]. She stressed that included in the division's task of protecting consumers is to review the solvency of the companies, the size and health of the insured pool, and "the simple math of going back into what does, [what] are the rates, and what [it is] going take to support that pool." There is no doubt that more people have started to enroll; however, in 2016 Assurant is out of the marketplace and their clients would have enrolled in Premera or Moda. Recently, it appeared that the number of enrollees has been split between Premera and Moda, although in 2015, Moda had a significant share of the market due to its lower rates. Ms. Wing-Heier said, "Even with the rate increases, the health of the pool has led to significant financial distress for [Moda] and the result [was] the order that was issued this week." Aetna and Assurant have left the market and Celtic Health Plan has not written business, although they have been approved by the Centers for Medicare and Medicaid Services (CMS). She expressed her hope that Celtic and Aetna, after its merger, may come back to the market in Alaska, but a statute is in place that prevents Aetna's reentry for five years [slides 6, 7, and 8].

4:26:39 PM

CHAIR OLSON questioned whether the change in statute can be accomplished without legislation.

MS. WING-HEIER was unsure. She said the division will determine whether a change can be made through regulation, if Aetna seeks to reenter the market after its merger.

CHAIR OLSON urged the division to pursue making a change through regulation, if at all possible.

MS. WING-HEIER assured the committee the division is working hard to bring insurance competition back to Alaska. She returned attention to slide 7, and relayed that at one point in one individual market there were over $44 million in losses

which, when divided by the number of enrollees, equaled over $6,000 per member, not including the cost of adjudicating claims and claims management. Potential drivers of premiums in 2017, based on [Milliman Healthcare Reform Briefing Paper December 2015], are: health care costs, including the cost of prescription drugs, and utilization, sought at emergency rooms and not from primary care providers; changes to essential health benefits, which may affect rates; additional data, which may stabilize the market in Alaska; continued migration of insurers, which is incorporating non-grandfathered plans into the individual market; insurers merging and exiting markets nationwide, as are Aetna and Assurant in Alaska; ongoing uncertainty in court cases and upcoming elections; reinsurance; risk corridor; risk adjustment; and changes in fees and taxes in ACA [slide 9].

4:31:46 PM

MS. WING-HEIER advised that potential cost drivers in Alaska - in addition to having one provider - are: the cost of health care, which is among the highest in the nation and thereby affects rates; and limited providers and challenges with provider networks, because many residents are rural and Alaska has a small population.

REPRESENTATIVE JOSEPHSON returned attention to slide 5 and noted Alaska had rate increases of 38 percent and 39 percent; he inquired as to the national average of rate increases in the individual marketplace.

MS. WING-HEIER said she would provide that information.

CHAIR OLSON added that the University of Oregon workers' compensation comparison of five states illustrated a disparity of cost between Alaska and other states.

REPRESENTATIVE JOSEPHSON asked what the average Alaskan spends for health care in the individual marketplace.

MS. WING-HEIER was unsure because of premium tax credits and the many plans that are available; for example, there were two insurers, three tiers, multiple plans within tiers, different pricing, and three regions within the state. She knows of plans that cost $1,800 per month, per person, and others that cost $500 per month, per person, before subsidies. In 2015, Alaska was the highest in rate increases; in 2016, other states are making similar rate increases to keep the carriers solvent.

4:35:18 PM

REPRESENTATIVE HUGHES returned attention to slide 10 entitled, "Alaska - Potential Cost Drivers" and asked whether the division tracks the number of providers in Alaska, and how that compares with rate increases. She expressed her understanding that increasing the ratio of primary care providers to population serves to lower health care costs and health insurance rates.

MS. WING-HEIER agreed that there is a shortage of primary care physicians in Alaska, which causes residents to go to emergency rooms for care. She returned to the list of potential cost drivers [slide 10]. The individual market is expected to remain at between 20,000 and 22,000, but - reflected by the adverse loss experience, it is not a healthy pool - she said, "... not buying insurance and paying the penalty to the [Internal Revenue Service (IRS)], are the healthy ones; somehow we need to get those to buy insurance too, and we're struggling with that, because of the premiums."

REPRESENTATIVE KITO recalled before the enactment of ACA, it was anticipated that Alaska had approximately 27,000 uninsured residents; he asked whether the division believes the number of uninsured residents is still around 28,000, and the number between 22,000 and 28,000 is the number of residents in the healthy population.

4:38:19 PM

MS. WING-HEIER said, "I would think right now that probably ... there's probably five or six thousand that we're not getting to." Returning to slide 10, she advised that national cost drivers do impact Alaska, but the most impact is local. Continuing on the topic of potential cost drivers, Ms. Wing-Heier stated that for 2017, CMS has issued over 100 revisions to the plan affecting deductibles, filing data, uniform modifications, re-certifications, riders, network adequacy, the certification process, and more. She restated the additional potential cost drivers: medical trends are increasing; reinsurance and risk corridor; transitional or non-grandfathered plans will enter the market and increase enrollees; mergers and acquisitions will tighten the market, but may provide additional choices in Alaska [slide 11]. In response to Representative Hughes, she explained that medical costs have been relatively flat but are now increasing, which affects the overall cost of

insurance. In response to Chair Olson, she said the trend also affects the cost of prescription drugs.

MS. WING-HEIER presented slide 12 entitled, "The Three Rs," and explained that risk adjustment, reinsurance, and risk corridor were mechanisms in ACA that were meant to stabilize the market between all insurers, until the effects of the Act were known. Risk adjustment was devised so that companies with "bad" losses from certain coded claims would receive money from those with "good" losses. However, the mechanism is working backwards; for example, a company like Moda is having to pay Premera, even though the purpose of risk adjustment was to protect a company with a lesser rate and higher claims. The risk adjustment mechanism is currently under review. Reinsurance is a three-year program that sunsets this year, thus insurance companies will have to buy commercial reinsurance, which could impact rates. Risk corridor is a program that took a certain percentage of profit from profitable insurance companies, again to stabilize the market for the first three years; however, losses were higher than anticipated and companies only received 12.6 percent of their losses [slide 12].

REPRESENTATIVE JOSEPHSON asked whether 12.6 percent was the insurance companies' profit.

MS. WING-HEIER gave an example of an insurance company that expected to receive 100 percent of $50 million from the federal government through the risk corridor program, but actually received 12.6 percent of $50 million.

[There followed a brief discussion of other mechanisms.]

4:45:43 PM

MS. WING-HEIER informed the committee that in 2017, ACA Section 1332 permits states to apply for a State Innovation Waiver which she characterized as a "huge step, a scary step." Colorado, Minnesota, Hawaii, and Massachusetts are exploring the possibilities of the waiver, and Vermont tried and failed. The waiver allows the state, by itself, to provide the same benefits to consumers as does ACA, rather than participate at the federal level. The state must garner legislative approval to apply for the waiver; further, the waiver is subject to approval by CMS [slide 13].

REPRESENTATIVE JOSEPHSON stated, "What you're speaking of here ... is more, more than just the state taking control of the

individual market, it's the whole shooting match, it's sort of taking the entire bill."

MS. WING-HEIER said that's correct. She provided a list of the requirements for the state to obtain a waiver including, provide coverage at least as broad as that of ACA with the same "out-of-pocket, cannot increase the federal deficit, and submit business plans. She said the state would be taking the risk that if it fails, the state would take on the obligation, which is a big undertaking [slide 14].

4:47:16 PM

CHAIR OLSON asked how many positions would need to be added to the division to do so.

MS. WING-HEIER opined the division would need to establish an organization similar to the Alaska Permanent Fund Corporation, or an organization outside of the state. The money paid out in premium tax credits would come to the state as a block grant, which would be disbursed back to citizens for premium tax credits, based on premiums charged by the state, and there are other possibilities; however, the division will see how successful other states are after 1/17/16.

REPRESENTATIVE LEDOUX asked how much this option would cost, and whether the state would function as an insurance company.

MS. WING-HEIER said the division has not considered the cost because the organization would have to be a stand-alone entity. In further response to Representative LeDoux, she acknowledged that all options should be explored, but cautioned that, based on known losses, without a pool of enrollees in the individual market larger than 22,000 it would be a gamble. She suggested that enrolling all of the state employees would create a bigger pool, and there is a question of what other groups to bring in. She also questioned "who's going to administer it and how does it pay for itself?"

REPRESENTATIVE JOSEPHSON observed that of approximately 730,000 Alaskans, about 22,000 have been added to the individual market, about 20,000 have been added through Medicaid expansion, and some have other coverage. He asked for the number who are left uninsured.

MS. WING-HEIER advised that the division has estimated about 16 percent of the population may be insured [in a state plan]

because federal employees would not enroll, nor would beneficiaries of the Indian Health Service (IHS), Medicaid, or Medicare. She said, "We just don't know if the number is big enough to make it work." However, the division will watch the activities in other states, especially Hawaii which has demographics similar to Alaska's. She turned to other solutions such as regional exchanges, although at this time sales are not allowed across state lines. Also, it may be possible to combine small and individual groups to spread the risk, but that would not make small group constituents happy.

4:52:54 PM

REPRESENTATIVE KITO surmised regional exchanges are limited by insurance laws rather than ACA; he asked whether other states or regions have considered selling products across state lines.

MS. WING-HEIER said there is much discussion in this regard among the National Association of Insurance Commissioners, particularly by those from small states.

REPRESENTATIVE HUGHES asked whether state or federal laws disallow sales across state lines.

MS. WING-HEIER said both. In response to Chair Olson, she advised that state employees are not impacted by the decision on Moda. Although the state insurance card indicates Moda, the dental plan is actually Oregon Dental - which is under the same parent company - but is not Moda Health Plan Inc., against which an order has been issued.

CO-CHAIR OLSON suggested the division email state dental plan enrollees informing them in this matter.

REPRESENTATIVE HUGHES asked for suggestions as to how to bring health care insurance rates and health care costs down in Alaska and nationally.

MS. WING-HEIER stated that the division is provided information from all of the parties to this issue and sees a disparity in medical rates that cannot be justified; although the medical community is a source of pride for Alaska, the cost of medical care is inexplicable when compared with other states. She questioned why medical procedures in Anchorage cost up to seven times the cost of the same procedure in Seattle, and urged that the providers - not necessarily small clinics - recognize that the cost of health care is becoming unaffordable. When the division receives a filing, although the rates have already been

negotiated, it is unknown why a hospital or clinic charges what it does. She said, "And I think that's the missing piece of the puzzle."

4:57:42 PM

CHAIR OLSON recalled previous testimony from the Department of Labor & Workforce Development that health care providers justify what they charge in order to "pick up the difference between what Medicaid will pay and what their costs are ... and it's not illegal I might add."

[There followed a brief discussion about medivac costs in Alaska.]

REPRESENTATIVE JOSEPHSON pointed out that unknown medical costs are hard on consumers and providers are reluctant to discuss rates.

5:00:08 PM

ADJOURNMENT

There being no further business before the committee, the House Labor and Commerce Standing Committee meeting was adjourned at 5:00 p.m.