ALASKA STATE LEGISLATURE
JOINT MEETING
HOUSE STATE AFFAIRS STANDING COMMITTEE
HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE
May 11, 2017
3:08 p.m.

MEMBERS PRESENT

HOUSE STATE AFFAIRS STANDING COMMITTEE

Representative Jonathan Kreiss-Tomkins, Chair
Representative Adam Wool
Representative Chris Birch
Representative DeLena Johnson

HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE

Representative Ivy Spohnholz, Chair
Representative Sam Kito
Representative Geran Tarr
Representative David Eastman
Representative Jennifer Johnston
Representative Colleen Sullivan-Leonard
Representative Dan Saddler (alternate)

MEMBERS ABSENT

HOUSE STATE AFFAIRS STANDING COMMITTEE

Representative Gabrielle LeDoux, Vice Chair
Representative Chris Tuck
Representative Gary Knopp
Representative Andy Josephson (alternate)
Representative Chuck Kopp (alternate)

HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE

Representative Bryce Edgmon, Vice Chair
Representative Matt Claman (alternate)

OTHER LEGISLATORS PRESENT

Representative Harriet Drummond

COMMITTEE CALENDAR

PRESENTATION: BECKY HULTBERG~ AK STATE HOSPITAL & NURSING HOME ASSOC.

- HEARD

PRESENTATION: GINA BOSNAKIS~ BOSNAKIS & ASSOCIATES~ AND JEFF RANFF~ AK ASSOC. OF HEALTH UNDERWRITERS

- HEARD

PRESENTATION: TOM CHARD~ ALASKA BEHAVIORAL HEALTH ASSOC.

- HEARD

PRESENTATION: KYLE MIRKA~ ALASKANS FOR SUSTAINABLE HEALTHCARE COSTS

- HEARD

PREVIOUS COMMITTEE ACTION

No previous action to record

WITNESS REGISTER

BECKY HULTBERG, President/CEO
Alaska State Hospital and Nursing Home Association (ASHNHA)
Juneau, Alaska
POSITION STATEMENT: Presented an overview of the Alaska State Hospital and Nursing Home Association.

GINA BOSNAKIS
Gina Bosnakis and Associates
Anchorage, Alaska
POSITION STATEMENT: Presented an overview of the Alaska Association of Health Underwriters.

JEFF RANF, Member
Alaska Association of Health Underwriters
Anchorage, Alaska
POSITION STATEMENT: Testified during discussions regarding medical cost transparency.

TOM CHARD, Executive Director
Alaska Behavioral Health Association
Juneau, Alaska

POSITION STATEMENT: Presented a PowerPoint overview about sustainable health care costs.

KYLE MIRKA
Alaskans for Sustainable Healthcare Costs Coalition
Anchorage, Alaska
POSITION STATEMENT: Presented a PowerPoint overview of the Alaskans for Sustainable Healthcare Costs.

ACTION NARRATIVE

3:08:31 PM

CHAIR JONATHAN KREISS-TOMKINS called the joint meeting of the House State Affairs Standing Committee and the House Health and Social Services Standing Committee to order at 3:08 p.m. Representatives Wool, Birch, Johnson, Kreiss-Tomkins, Eastman, Saddler (alternate), Johnston, Sullivan-Leonard, Tarr, Kito, and Spohnholz were present at the call to order. Also in attendance was Representative Harriet Drummond.

3:11:09 PM

CHAIR SPOHNHOLZ said that she and Chair Kreiss-Tomkins had been in discussion regarding ways to address the cost and price of health care in the state, as the state paid for the health care of its employees and retirees. She added that the state also had to manage the Medicare and Medicaid budgets. She pointed out that the State of Alaska had health care costs which exceeded those in the Lower 48. She stated that they wanted to expand the conversation and get some facts and information out regarding health care price transparency.

PRESENTATION: BECKY HULTBERG, AK STATE HOSPITAL & NURSING HOME ASSOC.

3:14:38 PM

CHAIR KREISS-TOMKINS announced that the first order of business would be a presentation by Becky Hultberg, Alaska State Hospital and Nursing Home Association.

3:14:46 PM

BECKY HULTBERG, President/CEO, Alaska State Hospital and Nursing Home Association (ASHNHA), reported that the Alaska State Hospital and Nursing Home Association was the member

organization for the hospitals and skilled nurses' facilities in Alaska, which included the community hospitals, emergency rooms, and nursing homes. ASHNHA treated the underserved and marginalized, those with insurance and those without insurance. She emphasized that it was critically important to recognize that behind the dollars were real people with real lives. She stated that when talking about hospitals it was easy to only think about the large centers in larger areas, but it was important to remember the small, unaffiliated hospitals that operated on very thin margins and were having difficulty with growing costs and falling revenue. She explained that the reimbursement environment was becoming more challenging, as hospitals take all patients regardless of the ability to pay. She pointed out that a high percentage of the payer mix was government, specifically Medicare and Medicaid, which already reimbursed less than the cost of care, and with a 5 percent Medicaid reduction starting on July 1, 2017. She declared that there was unprecedented uncertainty at the state and federal level, as the American Health Care Act would force a reduction of almost $1.5 billion in Medicaid reimbursement on Alaska hospitals, as well as an additional $500 million for treating the uninsured over the next ten years. She pointed to the current fiscal challenges. She expressed caution for simple answers to very complex problems, as cultural, economic, and structural reasons influenced the health care market, different than normal markets. She pointed out that if this was an easy problem to solve, there would not be "this vigorous national debate." She reported that there were ten different factors affecting health care costs. She directed attention to employer sponsored health care and the tax treatment of health care, noting that people get tax breaks for buying health insurance, which incentivizes benefit plans that drive costs up. She reported that most people with insurance got it through their jobs and the amount that employers paid for coverage was tax deductible for the company and tax exempt for the worker. This encouraged more expensive health plans with richer benefits, as these rich plans meant higher utilization of services and higher costs. She moved on to third party payment, which incentivized people to consume more care than otherwise needed. She said that, as low deductibles or small co-payments encouraged people to use health care at a higher rate, driving up costs, many private sector employers were moving toward high deductible coverage to align incentives and slow premium growth. She moved on to the fee for service system, which rewarded the volume of procedures, doing more instead of being efficient, and incentivized over-treatment. She stated that, as most insurers, including Medicare, paid providers separately for each task,

service, or treatment, the volume of service instead of outcomes was incentivized. In this fee for service system, the economic incentives to providers and payers were not aligned. She stated another factor, the high cost of prescription drugs from federal policies which constrained normal market forces, as prescription drugs were often one of the fastest growing components of a health plan. She noted that this was one aspect of the health insurance system that could be addressed through smart, market-based reform. She reported that the high use of new medical technology, new drugs, and new services in the United States comes at a high cost as they often cost more than what was replaced. She emphasized that the United States had higher provider rates than other industrialized, more heavily regulated countries, even though generalizations about rates were difficult and it did not capture the complexity. She reported that an aging population needed more medical care and the overall costs were rising. She relayed that the unhealthy lifestyles in the US, which led to high rates of obesity and chronic conditions, forced higher payment by everyone. She pointed to high administrative costs, which included the costs of insurance, billing, processing, regulations, and insurance broker fees. She offered an example of the 21,582 pages of hospital guidance from the Centers of Medicare and Medicaid Services. She emphasized that the industry was already overregulated at all levels, with more local and federal proposals poised to add to this. She declared that "regulation equals cost." She shared that culture and expectations of health care made the system more expensive, as we expected to not have to wait, even as waiting lists were not uncommon in other countries. She reported that much of our health care expense came in the last month of life, and that too often interventions added to suffering and only prolonged life at a terrible cost. She declared that these were hard issues, and that she was not making any value judgements. However, she pointed out that some of the cost discussion was related to significant ethical and deeply personal components that had to be acknowledged. She pointed out that these societal choices had an impact on health care costs. She stated that providers had "to be at the table as true partners" for any discussions regarding growing health care costs while maintaining access to critical health care services. She reported that the factors were much more complex than merely pointing fingers at providers for health care costs and were driven by systems and decisions not often thought about and possibly taken for granted. She declared that the question would be for whether the public was willing to listen, to do the work, to have the difficult conversations, and to engage in the shared sacrifice that would

be necessary for reform. She stated that this would require spending the time learning and then having real conversations, with a commitment to deep and long-term engagement. She shared her realization, after a long career in health care, that this was a huge challenge. She pointed out that hospitals were the community safety net, with thousands of dedicated employees who spent their careers helping things go right. She emphasized that, although health care reform was hard, complex, and required sacrifice, it was the most important thing to do and was worth the commitment.

3:25:36 PM

CHAIR KREISS-TOMKINS expressed his support to ensure that providers had a voice in the health care discussions.

3:26:37 PM

REPRESENTATIVE JOHNSTON acknowledged that the public sector had driven up a lot of the health care costs. She directed attention to the increased use of the emergency rooms since Medicaid expansion and asked if that was the case in Alaska.

MS. HULTBERG replied that there was not enough recent data, although there was an emergency room project being undertaken to tie the emergency rooms together through an electronic information exchange system. This would provide a better care linkage to providers in the community and was based on the seven best practices developed in the State of Washington. She reported that this program saw Medicaid visits drop by about 10 percent in Washington. She acknowledged that a challenge from Medicaid expansion had been that this initial access to care had instituted an increase for use of the emergency rooms, even as this was not always the appropriate place. She added that the hospitals were trying to address this at the front end.

REPRESENTATIVE JOHNSTON asked about the drop in uncompensated care in emergency rooms prior to Medicaid expansion.

MS. HULTBERG replied that the anecdotal reasons were for an increase to the numbers of people newly insured on the individual market through the health exchange.

3:29:48 PM

REPRESENTATIVE TARR stated that Ms. Hultberg was making a case for a single payer [insurance program]. She referenced the tax

breaks which encouraged higher spending and lower deductibles which encouraged more use and asked how those behaviors were substantiated.

MS. HULTBERG offered to provide direction toward some economic studies which demonstrated evidence to support the correlation with these two factors as a part of the growing cost escalation in health care. She explained the origin of employer-based health care as being post-World War II when wage controls had prevented any raise in wages, so health care benefits were offered.

REPRESENTATIVE TARR asked if there was any conversation regarding the current federally prohibited deductibles on Medicaid.

MS. HULTBERG reported that the new Centers for Medicare and Medicaid Services administrator was the architect of the "Healthy Indiana Plan," which "pushed the envelope" in terms of Medicaid plans by creating health savings accounts. She offered her belief that there could be an increase of incentives to apply these principles to the Medicaid population. She stated that, however, this was a challenge because this population had few resources and it was necessary to ensure access to care.

3:32:15 PM

CHAIR KREISS-TOMKINS asked about market-based reforms to contain the cost increases for pharmaceutical drugs.

MS. HULTBERG said that a few key elements included allowing Medicare to negotiate drug prices just as they set health care rates. She pointed out how long it took to get patent protections and how long those patent protections lasted. She spoke about the "orphan" drugs which were developed for very targeted conditions, hence were not economic to develop. Even so, these orphan drugs could be used for "a whole host of other things where there's a large population" even though these orphan drugs had very long patent protections. She opined that these and other smart market-based reforms could have an impact on drug costs.

3:33:33 PM

CHAIR SPOHNHOLZ asked about strategies regarding the high use of new medical technology, even as research often showed this was

not the best practice, and about the impact of unhealthy lifestyles on health care.

MS. HULTBERG replied that it was a difficult and complex question for how to get people to take better care of themselves. She opined that it was necessary to not let medical technology proliferate as it had, as this use was going to be covered and would continue to drive the cost upward. She offered her belief that the bigger message was for a way to align the incentives for providers, to do more stuff to more people, with payers, to receive high quality and low-cost care. She stated that the incentive should be for the objective and not for the revenue.

CHAIR SPOHNHOLZ observed that a realignment of compensation would resolve many problems. She asked if there should be more proactive compensation for nutritionists and personal trainers to offer support for a healthy lifestyle.

MS. HULTBERG reported that discussions with primary care physicians indicated that many chronic conditions were caused by lifestyle factors and were very challenging to manage. She suggested that it was not a good use of time for a primary care physician to be the nutritional counselor or the social worker. She declared that it was possible for a primary care-based system to have reimbursement payment for all these professional services.

3:38:33 PM]

REPRESENTATIVE WOOL asked the reason behind her statement that more people having insurance and more people using health care would make things more expensive.

MS. HULTBERG explained that in a system where the patient was not responsible for the overall cost of the service, they would utilize services at a higher rate. She said that the question was for how to manage that utilization so that health care resources were being appropriately and necessarily used. She pointed to an economic function that people consume more when something does not cost much. She asked how that could be managed to avoid unnecessary utilization and emphasized that Alaska State Hospital and Nursing Home Association advocated for access to coverage.

REPRESENTATIVE WOOL asked at what point something was determined to not be new technology, and if so, why was it still so

expensive. He offered an example of an MRI, and asked why that was still so expensive, even though this was not new technology. He asked if this was partially due to a fee for service structure.

MS. HULTBERG opined that the fee for service system did play a role in the proliferation and cost of these services, although it was most likely not the only cause. She stated that "we have a very advanced medical system, we have the latest technology, people come to the United States from all over the world because of the technology advances that we've made in our health care system." She declared, "that is a good thing" because those advances were lifesaving, although they had a very high cost. She opined that it was necessary to recognize and understand that the technology advances that brought dramatic improvement in health also cost a lot of money. She added that it was necessary to use the most effective and lowest cost technology possible.

MS. HULTBERG, in response, said that there were always new advances in technologies and she pointed to the increased use of specific technologies in the United States compared to the rest of the world.

3:42:40 PM

REPRESENTATIVE SULLIVAN-LEONARD asked for feedback from those discussions with the Alaska congressional delegation regarding any changes to the Patient Protection and Affordable Care Act.

MS. HULTBERG reported that the two Alaska Senators were "in a listen and learn mode" and that their respective staff were researching any effects on Alaska.

3:44:50 PM

REPRESENTATIVE BIRCH offered his belief that "you can't really manage what you can't measure." He shared some figures from a report in the Anchorage newspaper for the profits by Providence Alaska Medical Center last year. He asked if she had any reports for gross dollars billed, write-offs against that, and then the actual cost of delivery.

MS. HULTBERG said that she did not have any hospital by hospital data and suggested that he review the Medicare cost reports, even though these were "pretty complex to interpret." She declared that measurement was difficult in health care because

different systems counted different things in different ways. She acknowledged that this information would be helpful, although it was difficult to find. She stated that hospital costs were one piece in the overall spend for health care, cautioning that the numbers from one hospital did not necessarily translate to the entire industry.

REPRESENTATIVE BIRCH reflected on an education environment with average dollars per student as a measure and asked if this compared to a similar metric for healthcare.

3:49:01 PM

REPRESENTATIVE SADDLER asked about any effect of the philosophical or legal background for which health care was provided, and if this affected pricing. He listed various views of health care in the United States: a service available for a fee; a hybrid social and business obligation; a moral obligation with profit being reprehensible; and a basic human right that government should do what it can to provide. He asked about the philosophical expectation behind health care pricing and the business model.

MS. HULTBERG replied that he had "hit on one of the factors that makes health care unique, and not like a normal market." She said that opinions were different. She stated that, at a macro level, we want healthcare to function as a normal market economic system. She reported that the Emergency Medical Treatment & Labor Act (EMTALA) ensured that everyone had access to care through an emergency room. She stated that these issues had not yet been addressed from a cultural standpoint. She declared that there was both a moral and a market aspect, emphasizing that health care was a complex conversation about economics as well as an ethical, moral discussion about personal care.

REPRESENTATIVE SADDLER asked if it was necessary to make that decision before making decisions about a price system to address these expectations.

MS. HULTBERG said that there were still things to make the system function more efficiently and effectively within the construct of the current framework. She said, to a certain degree, the determinations for health care as a right or as a market were going to be made at the federal level. She declared that the state could think about a better way to align

incentives, manage care, and target areas with high costs from end of life care and chronic conditions.

3:53:22 PM

REPRESENTATIVE JOHNSON asked which targeted reforms would curb Medicaid fraud and abuse.

MS. HULTBERG opined that although there were some high-profile examples of Medicaid fraud, she did not believe that Medicaid fraud would "move the needle that much on cost." She suggested to target high risk providers. She said that, although there was not a lot of Medicaid fraud in the hospital world, the compliance burden and the cost burden to survive the many audits and to ensure the appropriate reporting was huge. She was not sure that the balance had been struck, and she questioned that an increase of audits would "find a lot more money in our Medicaid program." She reported that additional layering of regulatory systems would only add cost to the providers, so instead it would be more beneficial to do a better job of targeting.

REPRESENTATIVE JOHNSON asked how to define the fine line for over-use or over-prescribing instead of actual fraud.

MS. HULTBERG offered her belief that it was necessary for payers and providers to work together to align incentives to change the economic model. She stated that high quality, reasonable cost care was the end goal for both groups in the economic system. She added that utilization reviews were another strategy to pursue.

PRESENTATION: GINA BOSNAKIS, BOSNAKIS & ASSOCIATES, AND JEFF RANFF, AK ASSOC. OF HEALTH UNDERWRITERS

3:57:03 PM

CHAIR KREISS-TOMKINS announced that the next order of business would be a presentation by Bosnakis and Associates.

3:57:39 PM

GINA BOSNAKIS, Gina Bosnakis and Associates, reported that she had a small employee benefits firm. She said that she worked with employers for the best fit for their health insurance needs and budgets and that she worked daily with employees. She said that employers were paying on average over $14,000 annually per

employee. She reported that when a surgeon or facility was out of network, the employee would have to pay more than the anticipated 20 percent. She declared that insurance technology was very confusing. She reported that an out of network provider cost the employee a deductible plus 40 - 60 percent or more, versus the 20 percent owed if they were in network, as well as any charges that were considered over reasonable. She declared that transparency would be a good step in the right direction to better allow patients to determine the cost ahead of time. She said that it was necessary to obtain the procedure code and the names of all the providers for a patient to determine the cost. She said that a lot of factors contributed to having the highest health care costs in the country, so that anything which could assist Alaskans to lower those costs was positive. She offered an example of the cost for a total hip replacement in Anchorage, $23,200, whereas in Seattle, the same procedure was $11,700. She acknowledged that, although the industry was heavily regulated, transparency would be a big help for patients.

4:01:20 PM

JEFF RANF, Member, Alaska Association of Health Underwriters, stated that many Alaska medical providers simply did not have to be transparent, and often found reasons for not being required to post their price data for consumers. He declared that every other industry produced cost data prior to work and services being performed and that it was time for the Alaska medical industry to come into line with the rest of the country. He emphasized that he was not implying that this was a simple problem with simple solutions, but instead that it was a complicated, decades old issue. If this was easy, it would have been addressed and resolved long ago. He stated that it was imperative to address why medical cost transparency was so important as it focused on the consumer, not on the insurer. He pointed out that it was the consumer who paid the bill balance beyond the insurance coverage because the provider did not offer full disclosure and the insurance company was not clear for the coverages. He pointed out that the providers were not required to be contracted with the insurance companies, so the consumer needed to be educated to the workings of the system. He noted that the providers did not readily provide a cost sheet to the consumer. He reported that, in Alaska, as many providers did not agree with the reimbursement schedule from the insurance company and then did not contract with them, the consumer ended up paying. He offered the question for whether medical transparency would control costs. He declared that cost was a

separate issue and that only specific legislation to address pricing would ultimately control cost. He reported that many states had that legislation, which was often referred to as managed care. He added that transparency, as a pro-active first step in understanding medical pricing, placed the consumer in a more traditional consumer role to receive care and services and agree with the provider and insurer for the share of the cost. He identified this transaction as being more open for the consumer. He expressed his "sincere desire" that the state enact legislation for how to best protect the consumer. He expressed his agreement with Ms. Hultberg that physicians and provider groups needed to be at the table to resolve this problem in the current free market system.

4:06:54 PM

REPRESENTATIVE SULLIVAN-LEONARD asked why a hip replacement in Anchorage was so much more expensive than this same procedure in Seattle.

MS. BOSNAKIS stated that there were many reasons, and she offered her belief that the biggest culprit in the cost of care in Alaska versus the rest of the United States was the regulation through the Division of Insurance called the "80th percentile." She said that it was complicated but that it meant that 8 out of 10 submissions with the same procedure code in a region would determine the usual and customary charges. However, if there was only one specialist in a more remote area, they would set their own charges, and the insurance companies would have to pay that rate. She said that this would "not be dealt with easily."

4:08:57 PM

REPRESENTATIVE WOOL referenced a study which indicated that the United States was the only developed country without price controls on health care. He asked why a CT scan was so expensive when the technology had been around for a long time and was used all over the world.

MR. RANF, in response, stated that there was not any price control in Alaska as there was not any managed care legislation. He offered his belief that managed care was not legal in Alaska. He explained that groups of physicians or providers could not come together to form a collective to provide services and negotiate the prices with the claims payers. Consequently, the 80th percentile tended to drive up the prices as physicians

could raise their fees and the price increases would go up unabated with no upper limit. He pointed out that in the State of Washington, there was regulation which did not allow prices to go up unabated, and there was an upper limit.

4:11:34 PM

CHAIR SPOHNHOLZ asked for further explanation to his statement that managed care was not legal in the State of Alaska.

MR. RANF offered his belief that legislation had been passed several decades ago and that people had reported that it was not legal for provider groups to come together and negotiate pricing with the claims payers. He offered to research a more in-depth response.

4:13:01 PM

CHAIR KREISS-TOMKINS asked if the passage of the Anchorage municipal ordinance on price transparency had resulted in any changes to pricing or market behavior.

MS. BOSNAKIS replied that, as this was recent legislation, it was too early to determine any effects. She offered her belief that it would take at least a year, and reported that this municipal ordinance had "a much heavier hand than anything that we've looked at on a state level." She declared that this transparency for procedure codes and the names of the providers was the only way to "step into this easily."

MR. RANF stated that this had been discussed at the association level and there was currently not any indication for market change. He expressed agreement that "time is going to tell" although he opined that there could be "a fair amount of pushback from the provider community." He stated that the consumer had to oversee the decisions for their health care, which he opined was currently very difficult for the everyday consumer.

4:15:39 PM

REPRESENTATIVE SADDLER asked about the effect of the certificate of need requirement for high cost medical technology and health care services.

MR. RANF replied that the certificate of need was a controversial statute. He offered his belief that it had

virtually no effect on provider groups applying and receiving approval, and he offered an example from Montana which had determined that this was driving up costs. He offered his belief that it had not done anything to control costs.

PRESENTATION: TOM CHARD, ALASKA BEHAVIORAL HEALTH ASSOC.

CHAIR KREISS-TOMKINS announced that the final order of business would be a PowerPoint presentation about sustainable health care costs.

4:18:17 PM

TOM CHARD, Executive Director, Alaska Behavioral Health Association, explained that the Alaska Behavioral Health Association was a member driven non-profit for mental health and substance abuse treatment providers in Alaska. He pointed out that, on slide 2, that there were many different types of behavioral health provider services in Alaska. He referenced Senate Bill 74, which made the private for-profit providers much more able to provide behavioral health services, and to hopefully be able to bill Medicaid for these services. He pointed out that the prison system, the school classrooms, homeless shelters, foster families, law enforcement and domestic violence shelters were also behavioral health providers. He reported that much of the behavioral health budget cut savings in the Department of Health and Social Services budget subsequently "show up [as expenses] in Corrections or Education or other places." He shared that there was a membership survey in 2015, prior to Medicaid expansion, to get a "rough check on what was going on." He noted that at that time Medicaid comprised about 50 percent of revenue for its member providers, grants comprised about 20 percent, and private pay comprised about 15 percent, along with a myriad of other revenue sources. After Medicaid expansion, the portion of Medicaid revenue had grown while the grants were shrinking. He pointed out that a provider that had multiple sources of revenue also had multiple reporting and system requirements.

4:22:05 PM

MR. CHARD shared a brief breakdown of expenses for behavioral health providers in the state, noting that wages and benefits were the two highest cost drivers. He reported that these had grown to about 75 percent, even though they did not have any fancy new technology. He said that this cost was for counselors and clinicians providing the service. He reported that this

sampling found that, in 2015, 20 percent of the organizations were operating in the red and that 70 percent of the providers were in the red during a $100,000 pay cycle, which he declared a crisis level. He expressed his shock and referenced the report findings of an independent consultant hired by the Division of Behavioral Health, which concluded that more than 75 percent had fiscal health which was vulnerable and at-risk and were running operating deficits. He noted that this was still the current state of the behavioral health provider system. He added that part of the problem was a need for reimbursement rates to be increased, and although Medicaid expansion saved the state a lot of money, the reimbursement rate to providers did not cover the cost of care. He offered the belief that an investment in behavioral health services would reflect a cost savings across the budget. He encouraged the committee to consider this problem from a provider and a patient perspective, asking what were the main cost drivers. He declared that promoting earlier intervention, group and family engagement, and holistic health care were all general points. He pointed to the 11 efficiencies to reduce the administrative burden which had been studied in a joint investigation with the department and the providers. He added that reductions of uncertainty and support of work force development initiatives were important, as well as examination of appropriate scopes of practice by practitioners. He declared that removal of the Federal Institute for Mental Disease exclusion would also help, and examination of the Alaska Health Care Authority opportunity to include State of Alaska grantees would help bring down the costs.

PRESENTATION: KYLE MIRKA, ALASKANS FOR SUSTAINABLE HEALTHCARE COSTS MEMBER

4:28:34 PM

KYLE MIRKA, Alaskans for Sustainable Healthcare Costs Coalition, directed attention to slide 2, and stated that the coalition consisted of employers concerned with the current health care environment in Alaska and was working with Alaskans to understand and find solutions about the drivers affecting rising health care costs. He stated that Alaska had the highest healthcare costs in the United States, which continued to rise faster than anywhere else. He noted that employers paid most of the cost burden, even though they did not have the cohesive platform to address this increasing strain on the bottom line. He moved on to slide 3, sharing that the coalition was striving to educate employers and break down the barriers of individual businesses while discussing the issues affecting all of them.

He shared a desire for an influence over the 80th percentile rule, which he recognized as a main driver for the skyrocketing increase of health care costs in Alaska. He directed attention to slide 4 and listed a few facts, which included that Alaska had the highest cost of health care in the United States, and the medical consumer price index reflected a 4 percent increase annually in Anchorage compared to a 2.2 percent increase in Seattle. He declared that cost transparency was critical in Alaska. He stated that remote locations, small populations, and the high cost of certain goods and services were not enough reason for these high costs. He reported that the cost of medical professional services in Alaska averaged 400 percent of the Medicare reimbursement rate, which had already been adjusted to the state. He declared that the 80th percentile regulations which set the usual and customary rates contributed a 3 - 5 percent annual inflation to the cost of health care services. He addressed slide 5, which outlined some of the specific stories and the significant issues with health care. He pointed to slide 6, which called attention to the fact that these cost drivers were affecting everyone, whether it was retail, nonprofit, or construction. He said that slide 7 showed two interesting newspaper articles about the cost of health care, and that slide 8 showed that costs were going up, and employees out of pocket expenses were increasing. He spoke about medical tourism, a great thing for the state as it offered substantial savings for out-of-state travel, although leaving the state could be a challenge. He expressed a desire to, instead, get the in-state costs under control. He moved on to slide 9 and slide number 10, which listed medivac as a very expensive service and would require state assistance to reduce those air ambulance costs. He read from slide 11 and spoke about the adverse impact of the 80th percentile on the employer premiums. He declared that this was now a consumer penalty as providers could raise their fees at will. He addressed the last slide and offered his belief that transparency would empower the consumer to shop around and make informed decisions on healthcare.

4:36:57 PM

REPRESENTATIVE JOHNSTON expressed her agreement that the 80th Percentile was driving up the healthcare cost, suggesting that a state agency set the price instead.

MR. MIRKA, in response, said that he would be encouraged by this approach. He expressed his desire that the market would allow the setting of the price, but that the 80th percentile went against this as it allowed providers to charge whatever they

liked. He opined that a maximum allowable charge would be "a path towards getting costs under control."

4:38:48 PM

REPRESENTATIVE TARR asked for his reaction to the changes and proposals in Washington D.C., specifically to block grant programs.

MR. MIRKA acknowledged that he had been following this, although there were so many unknowns. He reiterated that the State of Alaska had a very unique problem, and he did not believe that the Patient Protection and Affordable Care Act was responsible for these rising health care costs. He opined that the conversations in Washington D.C. would not have a significant impact on what Alaska was already experiencing.

4:40:45 PM

CHAIR KREISS-TOMKINS asked that he speak to the medivac cost in Alaska and what Montana had done to control those costs.

MR. MIRKA declared that medivac was more expensive in Alaska than other locations and it would be preferable to have it subject to state regulations instead of federal regulations.

4:41:59 PM

CHAIR SPOHNHOLZ asked for examples to an earlier comment that investments in behavioral health care would reduce overall healthcare cost.

4:42:25 PM

MR. CHARD replied that emergency departments were flooded by people with undiagnosed and untreated mental health and substance abuse issues. He pointed out that a lot of this emergency room work was case management and social work in a very expensive setting. He offered his belief that investments in community behavioral health in a less restrictive environment was "far cheaper and would keep the emergency departments and some of the higher acute settings from having to work on these cases." He pointed out that the professionals in these settings were more expensive.

CHAIR SPOHNHOLZ offered her belief that this might tie in well with the emergency department data base system that Alaska State Hospital and Nursing Home Association was currently piloting.

MR. CHARD added that the Alaska Behavioral Health Association had just started talks with Alaska State Hospital and Nursing Home Association to ensure that the primary care provider for an individual had contact information included in the data base.

4:44:46 PM

REPRESENTATIVE WOOL asked Mr. Mirka about the difference in cost for rotator cuff surgery, $87,000 in Anchorage and $17,000 in Seattle. He asked if the price controls in the State of Washington were strong, and whether other states had similar controls.

MR. MIRKA offered his belief that, although the general percentage of cost differentials for services and procedures did vary, the primary driver for these cost differentials was the 80th percentile rule.

4:46:29 PM

REPRESENTATIVE BIRCH mused about the obligations for day surgery facilities on whether to accept emergency care patients and asked how this obligation was distinguished.

4:47:35 PM

MS. HULTBERG replied that it had to do with the Emergency Medical Treatment and Labor Act, a federal statute which determined that when you operated an emergency room or hospital, you had to treat people through that setting regardless of their ability to pay. She added that this federal statute was predicated on licensing and whether Medicare and Medicaid were accepted.

4:48:35 PM

REPRESENTATIVE SADDLER asked about the Alaskans for Sustainable Healthcare Costs Coalition membership, and the legal obligation of Medicare and Medicaid to cover behavioral health.

4:49:08 PM

MR. MIRKA reported that the coalition had no discrimination for its membership and that many members would come on a periodic basis.

REPRESENTATIVE SADDLER noted that there were not any members listed on the coalition website.

4:49:44 PM

REPRESENTATIVE JOHNSON expressed her appreciation for the representation from private industry, as health care costs had a significant impact on them.

4:50:40 PM

REPRESENTATIVE SADDLER repeated his question for the membership of Alaskans for Sustainable Healthcare Costs Coalition.

4:51:04 PM

MR. MIRKA listed his two businesses in Anchorage, as well as Denali Federal Credit Union, Northwest Auto, and Valley Concrete as members.

4:51:51 PM

REPRESENTATIVE JOHNSTON reflected that mental health support was grant and private insurance based prior to Medicaid expansion. She asked for an estimate to the administrative cost of making this transition to Medicaid based compared to the previously grant based costs. She expressed her concern for the outcome should this become "unraveled."

4:52:45 PM

MR. CHARD explained that his association membership included mental health and substance abuse treatment providers. He said that the mental health treatment providers had were primarily been grant based and had already made the transition to Medicaid, whereas the substance abuse treatment providers were now making the transition. He acknowledged that the substance abuse treatment providers had a large challenge and were hiring "extra back office folks to do the Medicaid billing and compliance." He added that different quality assurance programs were being put in place to meet the Medicaid standards. He added that it was necessary to review the mission of the clinic, as Medicaid had a medical necessity framework. He pointed out

that many of the substance abuse providers had a holistic care approach, which was sometimes "hard to fit into that medical necessity box." He said the cost to transition depended heavily on the current capacity as well as the anticipated volume.

REPRESENTATIVE JOHNSTON said that this should be followed as it would become part of the policy discussion.

4:55:32 PM

REPRESENTATIVE WOOL referenced an earlier comment that Medicaid expansion was causing some to lose more money as it did not suitably reimburse many businesses. He noted that people released from prison were now eligible for Medicaid expansion and behavioral health counseling. He asked for verification that more use of this service created greater loss and whether this was a result of the 80th percentile regulation. He asked for an update to "the 16-bed situation."

4:56:25 PM

MR. CHARD replied that Medicaid offered an array of services, and he offered an example of the cost to make a pizza and the maximum that could be charged, which was less than the cost to make the pizza. He noted that the Department of Health and Social Services was very aware of the potential increase in use and was working to correct the issue. He stated that the Institute of Mental Deficiency was a throwback to the 1960s when the Social Security Act first created the Medicaid program. As they did not want to build community hospitals, the number of beds had been capped at 16 beds. With Medicaid expansion, large substance abuse providers not previously under that rule were not able to bill Medicaid. He said that the congressional delegation was working to correct this problem.

4:58:04 PM

REPRESENTATIVE SADDLER asked about the legal underpinning for coverage to behavioral health under Medicaid, and whether this expansion would bring prosperity to the behavioral health community.

MR. CHARD acknowledged that, although there were a few growing pains that needed to be fixed, more people were getting the necessary treatment, and that was a good thing. He expressed agreement that the Patient Protection and Affordable Care Act "double down on some parity legislation that was previous to it"

as the act had made mental health and substance abuse treatment services part of the essential health benefits package which required that both Medicaid and private insurance programs have those services as part of the minimum plan. He noted that there had been congressional discussions for the Patient Protection and Affordable Care Act which questioned whether mental health and substance abuse should be part of the minimum plans, and he offered his understanding that states would have the option to waive those requirements. He stated his belief that this "would a bad thing for the State of Alaska." He reiterated that investment in mental health and substance abuse treatment services was keeping costs down, and removal of this access to treatment would directly impact prisons, law enforcement, and classrooms.

5:00:19 PM

REPRESENTATIVE EASTMAN offered his assumption that as more people were getting treatment, more people were being diagnosed, and he asked about the remaining gap for those remaining to be diagnosed.

MR. CHARD replied that the national surveys on drug use and health provided state by state estimates on the need for mental health and substance abuse treatment services. He offered to research and respond to the question.

5:01:31 PM

ADJOURNMENT

There being no further business before the committee, the House Health and Social Services Standing Committee and House State Affairs Standing Committee joint meeting was adjourned at 5:01 p.m.