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7 **80TH PERCENTILE PM SESSION A HEARING**
8 **Q=Lori Wing-Heier**
9 **Q1=Woman**
10 **Q2=Anna Latham**
11 **A=Chuck Ossenkop**
12 **A1=Dr. Annie Zink**
13 **A2=Roald Helgesen**
14 **A3= Ilona Farr**
15 **A4=Jim Thompson**
16 **A5=Bruce Kiessling**
17 **A6= Different Women**
18 **A7=Different Men**
19 **A8=Sarah Bailey**
20 **A9=Chuck Idophine**
21 **A10=Different Men**
22
23
24 Q: It's approximately 5:30 on January 6th and we are conducting or continuing
25 the hearing that we started this morning. It's a public scoping that we're
26 asking for comments on the 80th Percentile Regulation. We are live in Juneau,
27 Alaska. We are live in the Atwood building in Anchorage. And we are also
28 taking public comments, uh, over the phone. This morning we talked a little
29 bit about what the 80th Percentile is as opposed to the - the eightieth- 80
30 percent of billing. If anyone would like to have that discussion again, I'm
31 certainly happy to do it. But if not, we can go right into public comments.
32 Certainly up - up to the audience if you'd like to have a discussion again.
33 Because there has been some confusion about what the 80th Percentile is as
34 opposed to 80 percent of one's medical bills. We also have copies, we're
35 having more brought down of what the presentation is, the PowerPoint that we
36 gave this morning. And a, um, we've received many comments, letters of
37 support and letters of opposition to the 80th Percentile. And we have copies
38 down here for everyone and we're bringing down more. They will be
39 available in Juneau and we will have them online. (Betsy) can download them
40 Monday morning to PDF. So, with that being said, I'd like to open the hearing
41 and...
42
43 Woman: Where we got to do - start.
44
45 Q: Okay. We're going to start in Anchorage. And I've got Chuck Ossenkop?

46
47 A: Yes.
48
49 Q: Chuck, would you like to start?
50
51
52 A: Sure. Thank you. I guess...
53
54 ((Crosstalk))
55
56 Q: Is that okay?
57
58 A: Absolutely.
59
60 Q: All right. Thank you, Chuck.
61
62 A: Do I need this mic? I don't think I need this microphone do I?
63
64 Woman: Not unless someone...
65
66 A: Okay. Um, now my comments are directed more for health, uh, more to help
67 with the healthcare costs for businesses, not necessarily the percentile rule that
68 office is tied in and (that is). Um, again my names Chuck Ossenkop. Uh, I, uh,
69 own a business called Northwest Auto Parts in Anchorage. And it's all
70 business in Anchorage since 1955. And I purchase - purchased the business in
71 1981. The business had a healthcare plan at that time with Blue Cross and, uh,
72 while looking at the expenditures on buying the business, and whether or not
73 we could maintain that plan, it became apparent that the plan did make sense.
74 It provided coverage to help protect current employees, providing an incentive
75 for prospective employees to work with the company. And it was affordable.
76 Even though it had no deductible and no co-pay, it was 100% employer paid.
77 Boy, have things changed in 35 years. Uh, we now have a plan that is a
78 catastrophic health issued plan. It has a very high deductible. We do not
79 provide an H-R. We do provide and HRA to help with deductible costs. Our
80 copay is split 60% employer, 40% employee. We have structured the plan this
81 way so we can afford to carry a plan at all. Rates have skyrocketed on an
82 annual basis- most often at double digit rates. Um, in terms of operating
83 expenses, one of our major line items after payroll expense has changed
84 substantially. You have entered the cost, we have a little control over. And
85 since we do have an HRA plan to help with the deductibles, we have a
86 difficult time budgeting expenditures for the year. We cross our fingers and
87 hope for the best. And it's not a normal business expenditure line item. Now
88 why do we keep the plan at all? We have many valuable long-term employees
89 whose income is sufficiently high to preclude them from getting credits on the
90 exchange. The result would be a major hit to their disposable income if we

91 were to drop that plan. We cannot afford to lose these folks, their access to our
92 country, our company and it's not fair for them to share the - the burden of the
93 cost. On the other hand, we have entry level employees that, uh, might be
94 better off in the exchange if they can get sufficient exchange credits. The
95 result is the lower paid employees are forced to our plan and they're the folks
96 that can at least afford to carry the burden. The process creates what we feel is
97 a lose - lose proposition for the company and our employees, the costs are
98 extraordinarily compared to the cost when we first bought the business. And
99 the benefit reduced. From our point of view, we are getting close to a point
100 where we can no longer sustain the cost of our healthcare plan. Um, we, uh,
101 we - many of our employees they see the cost and the limitations. But quite
102 often, uh, those create a lot of discomfort toward our company. They don't
103 understand why we can't better control our costs. The problem is not with our
104 attitude toward our employees but with the cost structure that is fiscally
105 burdened to all concerned. We simply can't do better. We realize that this
106 problem is complex and there is not a simple solution. However, we
107 encourage any efforts to break the problem into this component parts and start
108 to apply solutions to those parts. And I believe this rule would be one of those
109 parts. And we would love to see it looked at and talked about. At this point,
110 anything but the status quo should help. And I thank you for your time.
111
112 Q1: Thank you. Next on the list is - was it (Carol)? Okay. The recent one on that.
113 Uh, Annie (Bass). I'm sorry, Annie's not, I'm sorry. Yeah.
114
115 ((Crosstalk))
116
117 Q1: I'm sorry.
118
119 A1: Hello, I'm Dr. Zink. Um, and I'm a board-certified emergency physician
120 trained in emergency medicine and practicing at MatSu Regional Hospital for
121 the past eight years. I've been caring for emergency patients during that time.
122 And I'm currently speaking on behalf of the American College of Emergency
123 Physicians Alaska Chapter. So, it's a chapter that covers about 80% of the
124 emergency physicians in the state. And we cover both very rural and rural -
125 well very, uh, urban areas making emergency staff network for our hospital
126 system 24 hours a day, seven days a week, 355 days a year. I have the honor
127 of working with many of you over the past year in (accrue) of SB 74 in an
128 attempt to improve the values and qualities of healthcare for hardworking
129 people in Alaska as just mentioned. So, thank you Madame director for this
130 opportunity to speak today on both the - both Alaska (ASEP) Chapter and in
131 support of other hundreds of physicians whose patient care is provided
132 entirely within the hospital setting. The six million reflects the collaboration
133 of numerous physicians from around the state and reflects some of the
134 comments that were made earlier today. You have already heard from
135 emergency physicians and additional letters have been submitted for those

136 who cannot testify in person. And at the front line as providers, a failed
137 healthcare policy, emergency physicians feel as that a cost shifting could
138 happen and as a result patients can be hurt by the removal of the 80th
139 Percentile regulations, unequally and unfairly burdening these patients in an
140 emergency when we're there to care for them. Also, as mentioned, other states
141 have now implemented similar regulations such as Newark and Connecticut
142 which have used the 80th Percentile of all charges as a consumer protection
143 issue to prevent (not) billing and control - control cost. Connecticut, July 21,
144 July 1, 2015 surprised billing legislation uses the same 80th Percentile rule
145 and is thought to be a best practices protection bill for emergency care in this
146 country. We support the mission of the Division of Insurance to protect
147 Alaska's consumer while encouraging the growth of strong competitive
148 marketplace for all Alaskans. We particularly support the division's interest in
149 the matter before us to (repute) surprised billings when insurance companies
150 have elected gap in coverage. Such as when patients are either billed for a
151 large deductible or out of network balanced billing. This has been a growing
152 problem, both nationally as well as locally. The number of people enrolled in
153 low premiums, high deductible plans have increased by 40% in the last six
154 years according to the CDC. Nearly one in four Americans registered voters
155 report that their medical conditions got worse because they didn't go to
156 emergency departments and figured that the health care- health insurance
157 companies would not cover their costs. Also, nearly one in five Americans or
158 19% said they went to or contacted either their primary care office or urgent
159 care or specialty care and were sent directly to emergency departments
160 because they need a higher level of care than that the facility could offer.
161 Think about the last time you called your pharmacy or your doctor's office out
162 of - after hours and how many times have you heard the words, "If this is a
163 medical emergency, please call 911." These patients should not be worried
164 about a med- a medical emergency creating a financial crisis in their time of
165 greatest need. My oath and my moral and legal obligation is that to my
166 patient. If mother presents in the emergency department with her child unable
167 to breathe, I do not ask what insurance she has. I care for her. When a 50-
168 year-old male presents ch- emergency department with chest pains, I work
169 them up for chest pain. Regardless of their ability to pay if they are drunk, if
170 they are sober, if they are pleasant to work with, if they try to give me a black
171 eye. This is not a fair market system. This is a safety help net system. This is
172 what we have been trained to do, what I took an oath to do, and what I love to
173 do. And also, what the federal law and (to) required us to do. The nature of
174 evaluation is based on a patient's perception of emergency. We cannot turn
175 patient's pa- we cannot turn patients away asking for a prior authorization for
176 them to seek if they were actually in network. We see everybody. We treat
177 everybody. But to keep those doors open and to have adequate specialty
178 backup, we must be able to be fairly compensated and must be able to have
179 the legal ability to fairly negotiate with insurance companies. Fair payment is
180 a patient protection issue. This is why we feel compelled to speak out on any

181 intent to eliminate the 80th Percentile rule. Insurance companies have solely
182 been driving a wedge between patients and providers. And this is one more
183 attempt to do so. Most Alaskans do not realize how fragile and thin our
184 medical network really is in time - until they need it in time of care. We have
185 minimal plastic surgery coverage as we've talked about earlier today in
186 Anchorage. We have no burn units in the state. Sometimes we have no
187 masque facial coverage. We have no cardiology evaluation or ability in
188 Juneau. We have no neurosurgery coverage in Mat-Su Regional Fairbanks,
189 and in Juneau. And in just these past few weeks, there were no inpatient beds
190 anywhere in South Central Alaska. Every patient that needed a hospital had -
191 bed had to be board in the emergency department. Every hospital and
192 diversion, these patients had been boarding for longer and longer times
193 waiting inpatient beds or trying to quote, "Jury rig," a less than ideal system
194 where patients are sent out often to return to the emergency department in a
195 few hours to a few days. We board patients for days. Sometimes weeks in the
196 emergency department because of a lack of psychiatric care. We lack
197 intensive care coverage at the - in the valley which it recently left us looking
198 to transfer some of our sick, uh, some of our sickest patients to Seattle six
199 critical hours away. Transfers are not only expensive but they are dangerous
200 despite our amazing flight crews. Boarding in the emergency department has
201 been shown to increase mortality. We believe that the 80th Percentile rule has
202 helped to fill its intended purpose. To provide Alaska's patients with high
203 quality health care and allowing us to recruit and retain capable physicians,
204 practice, and live in Alaska. However, that job is not yet done. The physicians
205 who are called often go above and beyond finishing their multiple scope of
206 practice to care for a community when no one else is available. I spend hours
207 every shift making phone calls negotiating, looking for specialists who will
208 care for acute medical emergencies. And this is with the protection of the 80th
209 Percentile Rule. When I wake up a specialist in the middle of the night, asking
210 him to comfort an injured or sick patient regardless - they come regardless of
211 their insurance. I want the consultants to be ensured that at least with insured
212 patients they will have fair compensation for their work. A patient shouldn't
213 have to worry if we call a specialist within network, or if their network
214 hospital is under (burt) or worry about being taken to a hospital when they
215 could be prove- when their care could be provided locally. Removing the 80th
216 Percentile rule without whether some clear protection for pa- fair payment
217 would result in a loss in a safety net and proletarian state. This would shift
218 cost to patients and potentially increase total costs of increased transfer.
219 Delayed stabilizing care and potential result in unavoidable suffering and
220 death. This is not cost sh- this is cost shifting. This is not a cost savings
221 measure. We use the last of emergency physicians to get that insurance is
222 expensive. In the state, and the state is in a financial crisis. We share your goal
223 of protecting patients and trying to save patients and assist in money. We have
224 heard moving testimony about the cost of healthcare. We have those
225 conversations every single day with our patients. We, um, like many people

226 here are also employers and provide health insurance. We see those costs. But
227 we are also patients, and we are parents of little patients. The devastating
228 needs by the child that has cancer is quickly followed by the question, "How
229 will I ever pay for this?" The cure that share with a mother of a 5-year-old
230 who came to the emergency department with a breast map feeding through her
231 chest wall as she was too afraid of the health care costs are real. Then, the
232 anger that we do not have a better system for her to access care early so she
233 can live to see her child grow is also real. These are the stories of the patients
234 that fill my days at work and we are committed to finding solutions with
235 everyone in this room. Patient, provider, insurers, and the government. We
236 share your same goals protecting patients and trying to save a patient and
237 assist in money. We have taken proactive approaches to reducing low to the
238 emergency department visits, decreasing opiate prescription, and proving care
239 coordination and producing financial savings to our involvement with
240 legislature with SB 74, the emergent department coordination project.
241 Washington State used similar methods and saved Medicare 33.6 million
242 dollars in one year. And we hope to have the same (pro-ration) savings. We
243 care about the costs and the efficiency is delivered and it - and delivering
244 effective and it - and on timely emergent care. With these changes, we can
245 affect system based changes and these systems can be realized on both the
246 private and track market as well as the public. There has been testimony on
247 the high cost of healthcare and there has been some significant misdirection in
248 this testimony. We would encourage everyone to look at the care - the Fair
249 Health Consumer Database created after a lawsuit where insurance companies
250 were doc- manipulating charges and determining what is usual and customary.
251 As mentioned before, the 99285 or what is that - service a (deal) for the most
252 critical patients that come into emergency per- someone having a heart attack
253 or a bad accident. In emergency care if you look at the fair health database,
254 the 80th Percentile for Anchorage or an emergency physician bill was $1,021.
255 Yet also it's $1,120. Dallas, Texas, it was $1,488. Miami, $1,793 and New
256 Orleans was almost 200 - $2,000. This was countered earlier today by calling
257 these in network costs of $300. This is not comparing apples to apples. This,
258 um, that sufficient in then my (salient) bill that's different. And again, by
259 removing the 80th Percent, we will not be saving, we will be shifting costs.
260 That additional costs in Washington State then gets billed to that pro- to that
261 patient. We believe the emergency care in Alaska is less expensive than any -
262 many other parts of the country because local competition and strengthen
263 independently locally owned emergency groups who live and vest here in the
264 community, rather than being run by large investor owned staffing
265 organizations. Also, Alaska's existing fair payment allows us to keep charges
266 down because health plans have to pay fairly. With the payment standard is
267 our to- is not publicly available, permissible, and forcible transparently
268 derived or equally be in ne- be manipulated by health insurance insurers and
269 the discriminate - and the detriment of patients and provider. Who share the
270 concerns of the department, the insurance companies and the public of

271 extreme billing practices? But emergency pro- providers are setting fair
272 nationally competitive prices and these are the only prices we can directly
273 comment on. We've also seen locally where increased competition with
274 specialists has resulted in in network providers and decreased costs. Where
275 extreme billing practices are found, individual or large groups can be
276 investigated. However, broadly addressing that is by limiting the 80th
277 Percentile rule will have profound and unintended consequences on the health
278 system as it takes - (somebody) seeking that. We note that in 2015, the A-R
279 reports showed a full two-thirds of all health insurance c- lives covered in
280 Alaska were controlled by just two insureds, Premera and Aetna. Changing or
281 eliminating the 80th Percentile rule would certainly benefit these health plans
282 without specifically benefiting the majority of Alaska patients, who under the
283 current rule have no balanced bill today because emergency providers charge
284 below the 80th - the 80th, uh, Percentile. We also do not know what will
285 happen with the federal level and if the federal - if Affordable Health Care Act
286 were reversed, the state 80th Percentile rule will be taken away and balanced
287 billing, insurance companies can set whatever price they wish. We can
288 support a ban on balanced billing if the 80th Percentile Rule is kept in place as
289 this would s- support fair pa- fair payment without placing patients in the
290 middle. If the Division Insurance decides to reverse, um, the Alaskan
291 administrative code to eliminate or reduce the 80th Percentile Rule and re- in
292 order to preserve a safety net, all it's (tall) obligator provider including on-call
293 specialists must be exempt from out of - any out of network balance billing
294 rule. Although again, it puts the patient in the middle - in the middle. We then
295 also submitted additional testimony about hoping to protect Alaska Section
296 AS1 at 21, uh, 54 dash 020 which recognizes assignment as benefits to the
297 healthcare provider and I have additional testimony in my letter to that. We
298 would like to encourage the commissioner to lo- also look at having the
299 insurance companies be responsible for collecting their high deductible and
300 take physicians and hospitals out of this middle. This would simplify and
301 increase the transparency of billing practices and again save the system
302 money. Merchants secure and access to a lot that's solely improving and are
303 sick of patients or well care for within our system, are eliminating the aid for
304 central role and putting all the power in insurance company's hands will take
305 us back decades and leave rotations without the coverage where they most
306 need it. We ask this in defense of our numerous patients who live in this wild
307 and wonderful state. Patients who should be able to access basic emergent and
308 lifesaving care in our closest facility without the fear of financial ruin or
309 significant transport away from their community. In summary, we as Alaska
310 Emergency physicians, uh, all the way ask the following. Consider that
311 emergency physicians are providing - are - are pro- physicians in Alaska see
312 are competitive nationally. Recognize that removing the 80th Percentile rules
313 is not necessarily results from cost savings but costs shifts and could increase
314 the process of billing - billing in emergency medicine. Preserve the 80th
315 Percentile rule and allow this to fully mature, competition transparency and

316 sim- in the marketplace will drive down costs, not reducing and in - insurance
317 industry responsibility to pay. Recognize that we still have a fragile limited
318 healthcare network in Alaska and removing the 80th Percentile Rule puts us at
319 risk. We can support a ban on billing - billing as mentioned, strictly if it's r-
320 um, if it's similar to Connecticut 80th Percentile Rule. Maintain statute A-F,
321 uh, 2154021 and require insurance companies bill. Thank you for considering
322 this. Thank you for sitting through this lengthy testimony. We ask for the
323 opportunity to work with the division and a legislature to ensure that any
324 revisions to the state law does not compromise access to quality emergency
325 care (program).
326
327 Q: At this time, I'm going to go to the phone. Is there anyone online who would
328 like to testify at this time? All right. Is there anyone online who would like to
329 testify? Is there anyone in Juneau? Okay.
330
331 Man: No, it's not.
332
333 Q: Okay. We will continue in Anchorage. And next - Roald did you want to
334 testify?
335
336 A2: Thank you. Good evening. My name is Roald Helgesen . And I'm with the
337 Alaska Native Tribal Health Consortium. The Alaska Native Tribal Health
338 Consortium in the statewide tribal health organization that co-manages the
339 Alaska Native Medical Center in Anchorage along with the South-Central
340 Foundation. The Consortium has well over 2,800 employees and we provide
341 healthcare to nearly 160,000 Alaska Native people. In addition to serving our
342 tribal members, we also provide access to for health services to Department of
343 Defense, uh, staff and veterans across the state that would not otherwise have
344 access to these needed health services. The Alaska Administrative Code
345 26.110 or also known as the 80th Percentile rule is important to the
346 Consortium. Because the Alaskan Native Medical Center is an out of network
347 provider with the largest provided insurer doing business in Alaska. The
348 largest challenge for health providers in our state today is a single company
349 that controls the majority of the insurance market. Such market dominance by
350 one insurer can make it impossible for fi- for providers to get a fair contract.
351 You heard the percentages earlier today of the market share of the different
352 insurers in how market plays. We don't have a contract today with the largest
353 insurer because we felt we couldn't get a fair contract. We've also heard some
354 of the dramatic examples of charges and differences between Alaska and
355 lower 48. And I appreciate doctors making some comments on those
356 differences. What is real and what is perceived. But we haven't heard is how
357 some of us are getting paid in Alaska. For us, after the insurer seemingly
358 arbitrary deduction amount for what is called patient responsibility, and
359 determination of an allowed amount, we end up receiving less than half of
360 what would be that 80th percentile what the amount should be. Our problem is

361 the rule doesn't have enough teeth to protect us in this current environment.
362 Eliminating or lowering the 80th Percentile Rule to a smaller number would
363 mean in fact that we get paid even less as a not for profit healthcare
364 organization. Without the 80th Percentile Rule, we have little to no protection
365 from large insurance companies paying us pennies on the dollar for services
366 that we provide to their insured individuals. Allowing this would greatly
367 impair our ability to provide the care of - to the people that need it most. It is
368 critical that to Division of Insurance fully evaluate the potential impact of
369 removing the rule on providers, payers, and above all patients before taking
370 any action. The rationale for implementing the 80th Percentile Rule was based
371 on curtailing the abusive practices of insurers, leaving patients with a
372 significant and unforeseen financial liability after receiving needed medical
373 services. From this perspective, the rule plays an essential role as a consumer
374 protection as a safeguard. ANTHC fully supports this state and partnering
375 with healthcare stakeholders to control costs and provide more efficient access
376 as well as effective access to care for Alaskans. Without an equitable and
377 transparent out of network reimbursement formula to replace the 80th
378 Percentile Rule currently in place, Alaska risks removing the most important
379 protection patients and providers have against arbitrary financial liability by
380 insurers. And further diminishing the already strained resources available for
381 care for our people. ANTHC looks forward to continuing dialogue among
382 providers, payers, and patients to address this issue. Thank you for the
383 opportunity to present this evening.
384
385 Q1: Next is Dr. Farr. (Marnie), co- and move out there and move that - well -
386 yeah.
387
388 A3: Hi, so I'm Ilona Farr, family practice doc here. Grew up here in Alaska and
389 my children are here. And I really want to stay here. But I'm really concerned
390 if this rule is repealed. And I have a solo practice family practice staff that
391 went through the (whammy) program and have been in practice for 30 years
392 and will not be able to stay in business, because of what the insurance
393 companies are doing to us. It's also going to be very difficult for my patients
394 to - because they'll have more payments that they have to make. So, their
395 prices will increase and right now in my office, um, we just got our - our, um,
396 Blue Cross, um, statement of how much it was going to cost. It's going to cost
397 $18,848 for one staff member per year for the insurance company to pay for
398 pennies. And so, small businesses like myself where you have that amount of
399 money going out before the insurance companies even pay a penny, it's going
400 to be a tremendous burden because that's almost more than a lot of people
401 make up here. So, I have a lot of concerns because of this because if we get
402 rid of this rule, the insurance companies can basically set whatever rate they
403 want to. And I will be forced to take it and it will also right now I'm a
404 preferred provider for both Aetna and Blue Cross. And if they low- lower their
405 reimbursement rates, I will not be able to stay in business. And I will be

406 forced to drop them which will increase the cost to my patients because they
407 will no longer get the en- the, you know, the discounts that I provide to them
408 because of being in - in that work provider. So, I'm extremely concerned
409 about this. Um, our rates again went up 36% this year. And I'm not sure why
410 because I thought with the bailout and stuff like that, through the legislature,
411 that the rates would stay lower. But they are increasing dramatically every
412 year. Um, so I just talked to two of my colleagues this week. Um, one of
413 them, um, closed her practice because of the increased cost and decreased
414 reimbursement. 'Cause she was paying for I-T people and a lot of business
415 people, more to keep her practice going. And she was getting paid by the
416 insurance company, Medicare and Medicaid. And a second one just told me
417 today that she was closing her practice for the same reason. So, I'm extremely
418 concerned because I want to live here in Alaska. I want to grow old here in
419 Alaska here with my children, my grandchildren and all of my family
420 members. And I'm extremely concerned if there won't be primary care
421 physicians or if specialty physicians to be able to take care of me or my
422 patients in my old age. And I think getting grid of this 80th Percentile Rule
423 will have a tremendous negative impact both on patients in terms of increased
424 costs. And those of us that really want to stay here in this primary care
425 physicians and also some of the specialists that, um, would not get reimbursed
426 appropriately by insurance companies. So, that's my testimony. I did fax a
427 letter in earlier. And if you guys just have any questions for me?
428
429 Q: Yeah but I do appreciate your testimony.
430
431 A3: Okay. Thank you. And should I give this to you?
432
433 Q: Yeah, if you faxed it in, I'm sure you - and you probably have it now.
434
435 ((Crosstalk))
436
437 Q: Okay. All right. Let's go on. On the phone is there anyone online who wants
438 to provide testimony to this public scoping hearing on the 80th Percentile?
439 Anna, do you have anyone in Juneau?
440
441 Q2: Yes.
442
443 A4: Yes, we do.
444
445 Q2: We do.
446
447 Q: All right. We'll go to Juneau for public comments.
448
449 A4: Hi, my name is, uh, Jim Thompson. I'm an emergency room physician in
450 Juneau. I've been practicing medicine in Alaska for I hate to say it but 42

451 years. Um, and I'm concerned that this rule may be eliminated or
452 downgraded, uh, so that our reimbursement will decrease. Um, we are getting
453 m- pinched more and more. We don't know what Medicaid, uh, what's going
454 to happen to Medicaid, uh, in the - in the next, uh, coming year or two. Um,
455 I'm concerned that after reimbursement declines, that we're going to have less
456 ability to hire, uh, fully trained, uh, American medical school graduates for
457 our hospital. Um, and we'll end up with four medical graduates like they are
458 all around the country. Um, also, uh, we're getting, uh, more and more, uh,
459 pressure from a Native reimbursement in their - it's segued everything over
460 into, uh, Medicaid as much as possible. And so, that's concerning. Um so, uh,
461 we've, you know, under EMTALA, we're mandated to do a medical screening
462 exam on everybody that shows up regardless of whether or not we get paid.
463 And if you look at our reimbursement in Juneau for the last six months, um,
464 we get reimbursed less than 1% of what we bill, uh, for patients that do not
465 have some Medicare, Medicaid, or insurance. And now we see a hit with
466 Medicaid coming up, uh, f- possible E-O decline in that reimbursement. And
467 then we get another hit with a- insurance, it's going to be, uh, devastating for
468 the whole system. So, and it's just - it's kind of a house of cards. Um, and it's
469 - it's cost shifting. I mean there's no question about that. And, um, one other
470 thing is if we use - lose this 80 Percent Rule and it decreases, uh,
471 reimbursement for say specialty services, we're going to end up having more,
472 um, Medivac situations. Right now, it's $72,000 to Seattle and $102,000 to
473 Anchorage for one patient. And so even if you could keep say ten of them
474 here, that's close to a million bucks. So, anyways, I just want to put in my two
475 cents worth and, um, hopefully the reimbursement situation as it is now will
476 stand. We'll have to see.
477
478 A2: Thank you for your testimony Dr. Thompson. Thanks. That's all we have for
479 Juneau right now.
480
481 Q: Okay. I don't think we have anyone else. Is there anyone in Juneau? Or in
482 Anchorage that wants to testify? Let me check the phone lines again and
483 'cause I know you - is there anyone on the phone that wants to testify at this
484 time? The floor is yours sir.
485
486 ((Crosstalk))
487
488 A5: Hi, I'm Bruce Kiessling, a physician in Anchorage. Been a physician for 44
489 years, 42 in Anchorage. And, uh, to be direct to the issue, I think the, uh, there
490 are enough compelling reasons to leave it as it is. At least for six months, um,
491 and have another hearing because it's so much fun. Um, or maybe in a year.
492 Um, and the reason for that is, uh, because there - it's a very polluted
493 environment. And I think that, um, well the problem with the medical care and
494 the cost of medical care has been, I mean, I sat through the entire morning
495 session. And now this evening to hear, uh, what was being said. And what I

496 heard was a lot of well-intended, uh, folks, um, trying to describe the elephant.
497 I mean we all know the metaphor of said people, uh, blind people, um, trying
498 to describe the elephant and everyone has a different perspective. I have to,
499 uh, I have to say that I'm amazed at how many on how caring and how many
500 patient's radiologists care for. Just never knew that that was the case. Uh,
501 quite like it was, uh, represented. Um, I do think that there are three to five
502 million dollars a year, uh - uh, incomes probably paid off their, uh, student
503 loans and that there can be some changes here. There need to be some
504 changes. Those of you who know that, um, I have on - on my group is the
505 largest primary care group in Alaska. We see 60,000 patients a year. I get to
506 see the results. Uh, and I get to see the - the care that's being done. We get our
507 patients to the A team. First of all, let's talk about insurance. Insurance itself
508 is a misnomer. It's a delayed payment plan period. You have fire insurance
509 and no expectation of having your business catch on fire. So, the actuarial risk
510 can be built into a very reasonable premium. But N equals Y for those of you
511 who have done any statistics. Meaning we all get to die. And most of us
512 unfortunately will suffer before we die. And we will need to be treated. So,
513 the delayed payment plan needs to be kept in mind because we, uh - uh, are
514 very sincere and genuine and lamenting the suffering of our patients. But
515 somebody has to pay for it and that's really what this is all about. I think, um,
516 you know, there was an - it was an elephant presentation from the emergency
517 room di- I'm sorry, I forgot your name. I will tell you that 90% of the people
518 in the room didn't understand. I understood it. But I'm in the business. Um,
519 clearly the 18th per- uh, 80th, uh, Percentile didn't solve the problems that
520 you - the litany of problems. And so, the assertion is they're getting rid of the
521 80th Percentile will only make it worse. Well that's debatable. But there's no
522 question it will make Blue Cross stronger which we don't necessarily need at
523 this point in time. The crux issue is you need to listen to my podcast. I've been
524 broadcasting for 30 years. I've been talking to people about the number one
525 problem. 30% of medical care has to do with utilization. Cost equals
526 utilization times rates. Okay. Rates are a finite number and everybody likes to
527 hang their hat on because it's a bean counter. And bean counters can say,
528 "Well we're going to pay you $100 or we're going to pay you $500." And
529 then they're - or we're going to calculate it as cost ut- utilization times rate.
530 Well utilization hurts people. Cost, you know, are costly to people.
531 Utilization, inappropriate utilization can really hurt people. So, I was surprised
532 that that - that Charles, uh, Wohlforth hasn't been to either one of these
533 sessions. Because he is (certified). Those of you who have been reading his
534 articles. I admire that. And I have teed off on that. Unfortunately, Charles like
535 most journalists who have an agenda, um, follow the (Sheila Toomey) rule
536 that truth is so limiting. And he doesn't get his facts straight. The problem is -
537 is severe enough without having to exaggerate. And I hope to be able to touch,
538 although I was hoping to be able to talk to him here. 'Cause I want him to
539 keep stirring the pot. He needs to. And so, on September 11 when he talked
540 about the monopolies in town and we're talking about not wanting Blue Cross

541 to be a bigger monopoly. What he talked about monopolies, uh, for instance
542 the orthopedic room. On September 13th, I teed off on that and gave specific
543 examples of people who go to the orthopedic group and don't get to the
544 orthopedics. Who are seen by unmentored, unsupervised P-A's who are
545 instructed and incentivized to incite and drain their insurance. Now that's
546 harsh words. They could, you know, really make a claim against me except I
547 have evidence of it. And so, when I got back from that pod - podcast, and we
548 ran it on my radio, uh, program, I had a colleague for me as you might expect.
549 Dr. Powell, Eli Powell who's part of my A team. Primary care associates have
550 designated A team. And we send people too. Eli Powell is exceptional okay?
551 So, Eli is present in the room because Bruce we need to talk. I said, "I suppose
552 we do." So, he came over. And I thought that Eli that your group wants - that
553 wants - expects some form of an apology. Okay well they're pretty upset. And
554 I said, "Well you know there is an apology that needs to be given here. It's
555 your egregious rates. You need to apologize to the community for now
556 forming this monopoly you and (AFA), so that you can get whatever rates you
557 want." Now Eli, I've been here for 44 years except for two. I remember what
558 it was like to go to Virginia Mason. We can do that. And my patients, our
559 patients on any elective procedure we give them the option of going outside.
560 And many of them do and they get excellent care and some instances much
561 better care. It's ridiculous when you have a, um, monopoly of the Alaska
562 Heart Association to get charged $120, $180,000 for a procedure you can get
563 in the lower 48 very - very competently. At UCFF, or at Cleveland Clinic for
564 $40,000 or $30,000. How about, uh, a simple thing like a colonoscopy? Up
565 here it's $8,000 to $12,000. Well that's ridiculous. In the low- in - in Seattle,
566 you can get an excellent colonoscopy for $1,200 to $1,600. Now you can pay
567 for that and, um, and you know and the insurances are now, um, at least
568 allowing some of that medical truism. What it thought back in the 70s, not
569 having the sub-specialists, um, actually the specialists. Not having the
570 neurosurgeons, not having a lot of the services that we have today. No, it was
571 not. But we need to instruct and the insurance companies need to take the, uh,
572 the bull by the horns and talk to their clients about becoming informed
573 consumers. Back in the day. I started my first business when I was 18. When I
574 came to Alaska in the '70s, the tide was right and for everything. I had a
575 construction company. I had an underground utility company. I owned all the
576 Taco Bells at one time. I was a businessman as well as a physician. Then I got
577 married and things changed. And I devoted myself entirely to, uh, the medical
578 practice and primary care associates. But I used to race motorcycles. A little
579 bit of a gear head. And I carried 'em around in my old pickup. You go to an
580 auto parts store, like it's Northwest. Okay. What do you want for your shocks?
581 You try to sell me some Bilstein's for my, you know, 20-year-old truck and
582 I'm going to say, "Bilstein's, those go for the high end - high maintenance
583 Mercedes, what do you think I'm driving? I want those $50 Monroe's." I'm
584 not fearful. I'm not in pain. My family is not in jeopardy. I'm modestly
585 informed and I make an informed decision. A person can make a very decent

586 livelihood by simply being a patient advocate in the situation. And I tell
587 people, having negotiated the largest payment for wrongful death in an
588 emergency room in the State of Alaska, I tell people, "When you go to
589 emergency room, you need to have an advocate with you." It was a death from
590 a person who went in for the migraine. And when you go into the emergency
591 room with a catastrophic problem, you get a lot of attention. When you go in
592 with something else, you need to have an advocate in the room. I think even
593 the emergency room doc would admit that having somebody in the room
594 when the emergency doctors not there, is a good idea. And when treatment
595 options are given, that's it's a reasonable thing to do. This person was not put
596 on a monitor and, uh, received an overdose. You need to advocate for
597 yourself. You need to line up your ducks before your family has a crisis and
598 before you have a need to en- engage the system. You need to do your
599 homework ahead of time. And that's the role of a primary care physician and
600 that's where, you know, in my particular field, I'm a dinosaur and I'll - I'll -
601 what we provide is going to be gone in another five years. That's a separate
602 topic, listen to my podcast. Just spool up, he's like a radio podcast. I go
603 through this all the time. And next week, I'm going to go into detail of what's
604 the rest of the story of what was, uh, of what's going on, uh, today and what I
605 think, um, is a better idea. 30% waste though, we need to get the utilization.
606 We need to - our doctors are over standing. We need to call out these out
607 vibes. Just a couple more examples. Why would a neurosurgeon have to
608 advertise for a second opinion? Did you hear all those advertisements? Isn't
609 that a little strange? It's because he doesn't get first opinions. In other words,
610 the doctors in the community don't refer to him. That comes back to the A
611 team. Same list name dropping, but Elton John asked me to take care of him
612 when he came to town, his group. It's because I knew who the A team was. I
613 said, "Will you give me free tickets to the concert?" He said, "No, but you
614 don't have to wait in line. Charge me for your services." So, I bought 30
615 tickets to the Elton John Concert. And I called up the A team. The
616 neurosurgeon, the orthopedic surgeon the anestheologist, EMT, the whole
617 range. And I said, for instance, my, uh, um, A team surgeon, (Roland Garr).
618 "(Roland), are you going to the concert?" "Well I'm not going to stand in
619 line." Well, you know, the line as you remember it was taken care of in seven
620 minutes. "So, good news (Roland), I have tickets for you and (Christy). Bad
621 news is you gotta be on call for me. I don't want any surprises when these
622 folks are in town. So, I know who the A team is." And we, uh, and we were
623 able to make a diagnosis that had been missed at two other facilities. Good
624 facilities. And it was all about because of the rush and because of triage. And
625 because of the doctors didn't listen to the patient. But the point is, I know who
626 the A team is. So, when we have a patient who needs to see, um, uh, needs to
627 have their knee operated on, I will tell 'em, "There's - there's like a - about
628 three A team people for knees." So, I said, "You can go to (Eli) and (Eli) is
629 going to give you a good result. But he's going to charge an arm and a leg for
630 your knee. But you're going to get a good result." Well the insurance

631 companies need to talk to the - the - the - their client and employers need to
632 talk to their employees. When - when I see patients and they say - I say, "Why
633 did you, uh - uh, let this happen?" "Well the insurance pays for it." And I said,
634 "No, you pay for it. We all pay for it. You have to get engaged as a consumer.
635 You have to, um, to feel it, that's really coming out of your pocket because it
636 will come out of your pocket eventually. So, you need to - you need to have
637 that engagement be- to get rid of that 30% of overutilization." I recently had a
638 really sad case and this is the last example I'm going to give. A 52-year-old
639 gentleman who had two, uh, unfortunately two, um, answers and they became
640 metastatic. And when I says metastatic, they - it's hardly a square inch of his
641 bone that didn't involve tumor. Now what happened to the group that take -
642 wi- uh, with the care from the group that he was seeing. In a period of 14
643 days, after confirmed metastatic disease, no cure for this, all right, he received
644 nine. Count them, nine $2,000 to $3,000 imaging studies. For what? He knew
645 what he had. There was no reason for this. Except as a business plan and
646 that's the crux of the issue. Too many of the outliers. In fact, when I talk about
647 an outlier, the outlier physicians in this community have put a business plan in
648 front of a patient care plan. It is that simple. And so, you need to know who
649 the A team is and for instance, if I want somebody to see (Eli), or (Jeff
650 Moore), another A team member, I'm going to call - I'm going to pick up the
651 phone and say, "I want this patient to see them." I don't want him to go to the
652 mid-level clinic. Okay. I employ mid-levels but my mid-levels are mentored
653 on a daily basis. I was the first group to hire mid-levels. But the m- but the
654 model of proper mid-level care for patients is that they are supervised and
655 mentored by physicians on a regular basis and that's their apprenticeship.
656 That's how they learn. And I will stack my mid-level that work at primary
657 care associates for anything over two or three years with any of the physicians
658 in town at a primary care level in general. 'Cause they know what they don't
659 know. And the most dangerous thing about a mid-level is not knowing what
660 they don't know and then they begin to triage. And they order all these tests.
661 And then they have post-relationships with referrals where they get the, uh,
662 you know, a fruit basket or more than a fruit basket for Christmas because of
663 the referral time. Well the role of the primary care provider is whether they're
664 a mid-level or a physician that's actually treat the patient. So, you need to
665 know how to navigate the system. That's the issue. We need to deal with the
666 overutilization and we need to identify those folks who clearly have a business
667 plan in front of a patient care plan. Now football fans, last one. I told you last
668 one is last one. But this one really is the last one. How about that (anti-diluvia)
669 football player that was on the airway for so many years? (Larry Tonga).
670 Okay. What does he know about spine care? He was the advi- he was the - he
671 was the mouthpiece for the Alaska Spine Institute. All right. Well I - I - I've
672 fished with (Larry), he's a great guy. But he doesn't know squat about you
673 know what are the indications. The final, uh, the - the absolutely thing that's
674 broken for me was I heard on my radio program before my, uh, I heard on the
675 radio station before I started my radio program. One of their, uh,

676 advertisement, (Larry Tonga) said, "You got back pain, you get an MRI. You
677 got back pain, you get an MRI. And you go to so and so." I said, "That's it."
678 So, I called up, uh, the Alaska Spine Institute and I said, "You get that guy off
679 the airway or every fricken week I'm going to tell 6,000 of my closest friends
680 what a ridiculous thing it is - this is. It violates all the rules of how you
681 manage, uh, back pain and direct consumer marketing has followed the
682 footpath so badly," it was gone. It was gone the next week. So, you need to
683 know how to navigate. So, the problem is not the 80th percentile. That needs
684 to be put on hold. It is - it is horrible the - the prices that are being charged as
685 a small businessman. And I have 130 employees. I understand what you're
686 talking about. It needs to change but not in this way yet. We need to instruct
687 our employees and we need to have our insurance companies also so that have
688 - review these bills. And ask the right questions. Other than that, I don't have
689 an opinion.
690
691 Q: Okay. All right. I'm going to go back to Juneau. Do we have anybody in
692 Juneau? Okay.
693
694 Man: No, we don't.
695
696 Q: On - through the phone, is there anybody on the phone that wants to testify at
697 this time? Or provide public comment I should say. It's not testifying. All
698 right. In the Anchorage, uh, office, we've had some people join. Is there
699 anybody that wants to provide any comments in the Anchorage, (hear it).
700 Okay. We don't have anybody signing in. Let me hear - we'll deal with till
701 7:30. As we said we will keep the doors open till 7:30. We'll keep the lines
702 open till 7:30. Uh, both in Juneau and in Anchorage, the doors will be open till
703 7:30 to allow people to come in to testify. It's cold, it's winter, keep working -
704 be working or what have you be - that's out to allow people that were working
705 to get off work and come in. So, we will keep going till 7:30 as we agreed
706 then. That gives us about another hour. You're free to stay. Um, we will - so
707 you know we will have all the letters, uh, in a PDF on the website. There are
708 packets of what we received so far. We will also have this transcribed and
709 available, um, we'll put it on our website at some point too so that you can
710 hear all the public comments that were made. What - what brought this whole
711 thing up now was see, as you know, we have and H-B 374 and as we end
712 there, part of the profits are going through H-B 374 with the cost of insurance
713 and frankly its front and center. And in that of course probably, uh, it's the
714 cape of was the 80th Percentile. And in doing that, there were suggestions of
715 what do we do with the 80th Percentile. And you can tell by the testimony -
716 there's two things. And what we decided was to basically have this hearing,
717 and to let people talk about the good, the bad, the ugly. Well in a matter of just
718 of this - the 80th Percentile. So, that we do not have a plan right now. There is
719 nothing in place where we are - you're going to see Monday where we're
720 going to advertise it, we're repealing the 80th Percentile and we're amending

721 it. But our intent is to look at what people think the insurance - the insurance
722 community, the medical provider community, and the public, you know, the
723 employers and to take it to the administration. And with the in - put in front of
724 the administration and possibly there have been legislators on the line. They
725 may have a different view. But to then come up with a plan as to what should
726 we do because there's certainly two camps and possibly three if you look at
727 how the employers wanted them. That we see it as a consumer protection, but
728 we also understand that there is definitely a side that says that this is going to
729 cost them. And it's hard to measure. So, we wanted to hear from more than
730 just one side or one and a half side as to how this was impacting their industry
731 so to speak. And the only way we can do it was to have a public hearing. And
732 to allow people and the groups, the industry to provide comments and
733 testimony.
734
735 A6: What I thought was interesting was I am secretary treasurer of the personnel
736 and (what) society, head of (coverage) of 17 different divisions. And whatever
737 the chair of the family practice department over the last three and a half so and
738 then we'll add mine N-A-F-C, I heard about this from none of those
739 organizations. I read a blog last night at midnight on the internet and that's
740 how I heard about it. And that's something that's dramatically going to affect
741 those of us in primary care. And that's why I was a little bit concerned
742 because I don't know how many providers, physicians, other people in the
743 community, small business and etcetera, that this will impact and knew about
744 the appearance. And I know you, you know, published them before, you
745 know, that. But the...
746
747 Q: And we did try to let trade groups that I know of, that I...
748
749 ((Crosstalk))
750
751 Q: ...was one that we know of and need.
752
753 A6: I saw a letter in there. But they didn't let the - the people know.
754
755 Q: That - that I don't know about but we did try to be - the groups that interacted
756 with in - in Juneau just on one bill or another but I - and I don't know all the
757 trade groups on either side. But the ones that I know of now so that they - they
758 could do an outreach on your (al)- and such of the independent agents are o-
759 and the health and directors that were here. And, that these health workers are
760 going to the state hospital. But in as many as I know of that I'm interacting
761 with. But admittedly, it's not all and - and that there is issue of yeah how do
762 we - I thought this - this...
763
764 ((Crosstalk))
765

766 Q: We try to get the notice out and it's hard.
767
768 A6: And it's very...
769
770 Q: It's hard, I mean, certainly if I - I would give you my business card and if you
771 will email me, I will see that it's when this goes forward, whatever it is, that I
772 need to email you directly as - as we try to, uh, different industry groups,
773 organizations. But it is sometimes hard to make sure that we're getting the
774 word out there. And as much as we can to get the input that we want. Sir...
775
776 Man: Will there be a, uh, a summary of the meetings and all the testimony available
777 for most?
778
779 Q: That's what we're hoping to do. It's when we - we will have - we're going to
780 have it transcribed, the hearings. And then try to put together somewhat of a
781 summary. But the hearings we will have them transcribed and we will post
782 them.
783
784 Man: Okay. That one - that...
785
786 Q: That everyone has talked, we will have it typed up basically.
787
788 Man: Okay.
789
790 Q: And that will be available on our website.
791
792 Man: Okay. And you would...
793
794 Q: Yes. It will probably take them close to a week to transcribe it. But we will
795 have it available.
796
797 Man: Okay.
798
799 Q: As - as well as all the public comments and public comments all was here
800 tonight. But we will have all the letters that we've received and emails that
801 we've received pro or con, it will all be available on our website.
802
803 A7: Starting off with question, this is a little off the topic. But, you know, with
804 what they're considering in the US Congress right now, this repealable Obama
805 Care, where that's going to go and I have no idea. Um, you do - we don't - the
806 - the problem with Prudential and Medicaid funding in the future, um, what
807 things are we going to be able to do here in Alaska if we caught down to make
808 sure that primary care stays in business with adequate reimbursement because
809 we are kind of today in the lowest cost for medical care here. I'm just really
810 concerned about what's going to happen, especially if we repeal this

811 regulation now, you know, if Obama Care is repealed, what is that going to
812 mean for Alaska?
813
814
815 Q: Well what I can tell you, just because I found out this afternoon, just in kind
816 of a - a side note. Uh, I don't know where, but I know I was invited to, um,
817 Senator Murkowski next Saturday, not tomorrow but a week from now is
818 having a business hearing on the repeal of or what it should - the replacement
819 of the Affordable Care Act should be on I believe - so it's the 14th from 1:00
820 to 4:00. I don't know where but she sent me an email today and asked me to
821 be there. Um, so, I think she wants to hear from Alaska of what - what they
822 think of repealing or replacing of what it should look like. Um, so if - if that
823 helps, that's probably - I don't - I just know she's having a listening session.
824 That's as much as I know about it. And I - and she didn't tell me where the
825 email, just that it's going to happen, um, and she's trying to schedule it for
826 next Saturday. We're struggling too. We're in the middle of - we just
827 submitted our innovation waiver to fund our re-insurance program. You know
828 we have tried to look at the Affordable Care Act in going down one path,
829 we're concerned now with how that path is going to change. Uh, but our goal
830 as we keep trying to tell ourselves is still to find a way to provide affordable
831 insurance product to consumers in Alaska so they can seek healthcare. Now,
832 the cost of healthcare itself is somewhat of a different topic that we have to
833 address as a group. I've heard them here tonight but I - and this morning that I
834 have not heard before. So, obviously, there's a disconnect. Uh, between what
835 you - what you hear from perhaps in the paper, perhaps what we've heard
836 from insurers, what we've heard from consumers. And then what we're
837 hearing from providers. I mean it's just - we're hearing a lot in this - in this
838 hearing or this - which is being testified. I think that at some point we're going
839 to have to have some meetings of focus groups to figure out what will work in
840 Alaska. Because no one wants to run a medical group out of it. I think that,
841 you know, I've been up here over 30 years myself in - in Anchorage in
842 medical. And there's different issues. And if you're in Fairbanks or you're in
843 Southeast Alaska. But, you know, we've watched the medical community
844 grow. Providence was just a tiny building. And nobody wants to see it go
845 backwards. So, how would we get to a point that we can keep the current
846 medical community and have certainty and have the specialists and such but
847 you're talking utilize them correctly. But the other thing, you know, add the
848 services and the providers that we want and not have to go outside for simply
849 cost. But to have that. And I don't know that I have the answer. But I can tell
850 you that hearings like this. Of course, the governor addressed the 74 and
851 created healthcare authority. And it's gone through phase one or about to enter
852 phase two and - and sit on it, but it's not necessarily my project. That's,
853 Commissioner (Fisher) and (Emily Ricci) are working that. And you know
854 they're looking for ideas too. Um, often we statewide address healthcare and
855 over utilization and just the, you know, if we all band together someone's

856 stuck not necessarily single care, that's kind of a (dirty) to work with people.
857 But I mean if there were ways to impact pharmaceutical. All right. If there
858 were ways that we can use the power of - of the number for that we all
859 participate even though we had our own plan or have this or that. But you
860 know there is - or something to comfort that we stood all around to say okay,
861 we all support that. Can you bring down the cost overall? And that's what the
862 studies about. Um, and seeing what we can do, what other healthcare
863 authorities have been successful at and the lower forty eight. And to
864 implement them and you know in Alaska. Because we are somewhat of a
865 personal (pay) here. But I mean obviously the, um, right or wrong, what you
866 believe or not, we've been thrown somewhat of a curveball and, um, in
867 Washington and in the fact that we're all waiting to see what's going to
868 happen. Someone will tell you they're not going to do anything. Some are
869 telling me well on January 20th, it's - it's out. And we - we don't know any
870 more than probably you sitting in this room. There's no more insight.
871
872 A7: Of course not. I'm just sitting here going on now of the (unintelligible), um,
873 we are telling the - as an advocate, help with the discharge that when people
874 are discharged well interact, you know, giving us their surgery to have and
875 knock it off in 30 days. And remember the table. And through a process of
876 upon this - this stuff. Uh, and, uh, you know, we're instructably to help
877 coordinate that care coordination and this directly that's, um, a huge, uh,
878 service or limitation. The whole issue really is that we, um, have a move in -
879 in my records which is (calls) to entire - my call line, my number call line is lit
880 all physicians have to pass this (brisk) and of that being here. That's where it
881 sums. And this is the penalty for (caring) and it's on, you know, and
882 everything. Um, I've called that to be they're not phenomenal but, um, I
883 understand that had an officer there he'd be A's and everything and
884 (unintelligible) in anyway.
885
886 Q: Well and (Moda) is still here as United Health Care and others are here. But
887 that there are other insurers out there as to...
888
889 A7: But no - oh yeah, it'd have to, uh - uh - uh, mark it down. Yeah. You know, I
890 helped all the time on, uh, when in fact in the '80's when Blue Cross was
891 predominant. And they - in part bring ACHIA was brought to and a less
892 provided (enemy). And Blue Cross (unintelligible) period that reality factual
893 itself had been there. But in 42, 44 years, he's seen a lot of stuff going on, at
894 least - here's the idea, that you know if this, um, the other thing though is the
895 workman's comp. Uh, that task force - you familiar with that?
896
897 Q: A little bit.
898
899 A7: Okay. Well...
900

901 Q: It's not - it's not under 1021.
902
903 A7: Okay.
904
905 Q: But it's that way.
906
907 A7: One more topic. Uh, during your technician (unintelligible) he and his project
908 with it was, uh, (Marianne Toll) and my colleague getting a single and they -
909 well changed for the workman's comp. And more towards the, um, R-V-U
910 status and - and a working in progress is that then, uh, primary care and - and
911 getting a little bit better deal and seeing a specialist and, uh, particularly work
912 or - or, uh, dealing the pain. But I mean if it's and they're egregiously
913 overcharging it and its brought down to semi-overcharging, gets up and you f-
914 um, but again it comes back to where people are going to go when you lower
915 the bo- well the detective was said earlier this morning was how are we going
916 to recruit. People are going to leave. Well you know I sat next to this pain doc
917 we had in one of the meetings. And I said, "Well you know we got a lot of
918 pain doctor. Well I just wonder and he makes so much money." And (forever).
919 Right, you know, I was down in Florida and one made multiple - multiple -
920 multiple, uh, (unintelligible). I - I - I'm not a typical gonna be those people
921 that recruiting more at any time. Now we've got a real problem here and it's
922 really - it's the doc together and you can imagine the, um, also I guess some of
923 the podcasts for here and want to call it up. But it's you know it's factual. And
924 we're talking about - but before doing these - and but also, uh, I'm afraid of,
925 uh, the different information there were we talked about a colleague when he
926 talks to patient care because we all in (unintelligible) we have all these things
927 going through there. But we're talking about a patient care plan versus a
928 business plan and a business plan from here, that includes report and we - we
929 need to readily keep the profession. We - and now we really do. And I'm not
930 sure how to do that. But when (Charles Wohlforth), you know, Ch- you know
931 started doing his thing and with that we learned more, okay, and to get all
932 this...
933
934 Woman: That's for - two questions are we going to bring back ACHIA from here? I
935 don't know if that's part of the plan. That the thing is you know it was into
936 unemployment status and no new jobs that where we want the security,
937 whether it's $6,800 last year and (16) upwards into 18,000 a year.
938
939 A7: Yeah, money range.
940
941 Woman: We have - well 7,500 but then you look and you extrapolate and you said
942 anywhere from 7,500 to 18,000 if we on - with that single (passion). I mean
943 that's going to have a tremendous impact because these are working people
944 with insurance. And that's going to have a tremendous impact I think on
945 insurance premiums and stuff too 'cause you're going to have a smaller tool

946 against individuals that are actually paying premiums to cover more - more
947 (life).
948
949 Q: Well yes and no. Um, I - I look at it two ways.
950
951 Woman: Correct.
952
953 Q: If you come out of let's say, uh, (Conoco) Be- the - the - their (officers).
954
955 Woman: Right.
956
957 Q: And you had their benefits. And all of a sudden, you're - you're looking at
958 paying COBRA or you're losing COBRA and what's your opinions?
959 Individual market. Maybe we'll just draw. Maybe a short-term thing but I may
960 go from $20,000 to $27,000.
961
962 Woman: Okay.
963
964 Q: Or $40,000 because we lost 7,500 jobs and these people who had insurance,
965 let's just now has to have insurance and they only get COBRA for so long.
966 For COBRA's expensive and - and actually the individ- the individual market
967 is - had it - I don't know what they're paying for COBRA. But - but at some
968 point, they have to switch from COBRA to the individual market. And not get
969 by (unintelligible). So, there's a chance that the individual market can grow
970 until the economy rebounds.
971
972 A6: But (Marianne) was saying that there - the - if you, um, repeal Obama that you
973 - which is, um, in the (care) report, the only standard that didn't grow while
974 the rest was that healthcare.
975
976 Q: Yeah.
977
978 A6: Um, services which - which is the thing. But it - but it has to then you know in
979 respect to its grown. So...
980
981 Q: And as for your question about ACHIA, ACHIA has never got in here. It's
982 always been there.
983
984 A6: Mm-hm.
985
986 Q: Uh, partially because we don't have the markets for the medical supplements,
987 Medicaid (lump). Um, and it was kind of exhibiting, we said it was what we
988 use for vehicles for the reinsurance pool.
989
990 A6: Mm-hm.

991
992 Q: Now, with what changes in Washington, if you read some of the Republican
993 plans, it could very well be coming. Uh, (Iris Fullihan), or it's - it's - we just -
994 we don't know. But our legislation and what all state - our legislation was
995 never taken out. So, we're waiting to see what would happen and we'll
996 respond you know and to - what steps forward and one was coming out of
997 (DC) and what's best for (that too).
998
999 A6: Okay. You know when we do around to them, nobody - I'm unclear maybe.
1000 And so, when this doesn't - with for them, they're even when we doctor,
1001 you're like a (unintelligible) and more importantly really. I don't think but
1002 you know so (unintelligible).
1003
1004 Q: I would ask is there anybody on the phone that wanted to testify? I'm just
1005 checking while we're still here. Okay.
1006
1007 A6: And that would be the question. That was me - there has been that ACHIA
1008 offer form, uh, conversation recently on it.
1009
1010 Q: Yeah.
1011
1012 A6: It was a great one in November, specifically that was cost...
1013
1014 Q: Yes.
1015
1016 A6: You know all different payment providers. And it seems as though that was
1017 there with a (unintelligible) and that wasn't brought up or is that once in a
1018 lengthy con- or conversation. And now it feels as though what was during the
1019 spring, a public hearing was announced and high standard (unintelligible)
1020 standard of public views or what not and pubic was or - or of residence. And
1021 be it those other - well that's, um, we don't have (exhibit three) covered
1022 (unintelligible) conversations. 'Cause I don't know how long this were (lying)
1023 and why that wasn't discussed there. Or one from the conversations that were
1024 done.
1025
1026 Q: Well it - the one we had in November was as far as S-B 74. And we were
1027 talking Medicaid's design.
1028
1029 A6: That's the one, the - in November, wasn't it? I think it's back in April or...
1030
1031 Q: Right.
1032
1033 A6: It was a separate one and it was in our report that was held at the, um...
1034
1035 ((Crosstalk))

1036
1037 A6: And was the name on the (unintelligible). And it was over generalized
1038 healthcare provide. And they had panels and (Jen) and we broke down in
1039 another and percent of actual profit to see basically on the issue of we - and
1040 where the other components and what the accepted responsibility and we
1041 could had a conversation with them on it. So, this was acceptable. So again, I -
1042 I don't know, I'm just kind of curious on that to determine 'cause I don't...
1043
1044 Q: I don't have an answer for that. Or - or of a...
1045
1046 ((Crosstalk))
1047
1048 Q: I - I don't on the line.
1049
1050 A6: Okay.
1051
1052 Q: Then, um, put it together at that time.
1053
1054 A6: But there still made (refers) on it. And...
1055
1056 ((Crosstalk))
1057
1058 Q: Mm-hm.
1059
1060 A6: Can you imagine? But, um, this scheduling on question on the phone was...
1061
1062 Q: Absolutely.
1063
1064 A6: Uh, yes.
1065
1066 Q: Absolutely.
1067
1068 A6: And one of the things, I mean, due to disabilities and (higher) there is more.
1069 And what I was paying for is that told me is to inherently the cost of your
1070 employer so they can (beat) and by the way, we're in a fair position. Don't
1071 just I'll tell you this is something or had a whole bunch of tests done or don't
1072 just be - but also for the baby makers position, about where no based on the
1073 cost and maybe making that - that really is another relator to this - this whole -
1074 the whole profit (carriage). There's all these moving parts and these are just
1075 one piece, there also is probably (you know left) here.
1076
1077 Woman: Our concern is...
1078
1079 ((Crosstalk))
1080

1081 Woman: And someone from (unintelligible).
1082
1083 ((Crosstalk))
1084
1085 Woman: Engage in a lot of these other comments. And I don't want them. I want to try
1086 to dissolve because really of the lesser things that we get. That's really what
1087 we're talking about.
1088
1089 ((Crosstalk))
1090
1091 A6: I think.
1092
1093 Q: Yeah.
1094
1095 A6: Well all be said, it hasn't been any easier okay. We always say weeks to here.
1096 You know why Friday night I'm getting heart palpitations, you know, I'm you
1097 know don't freak out calling you know the patients in your (unintelligible).
1098 Might be (unintelligible). But that's...
1099
1100 ((Crosstalk))
1101
1102 A6: What I'm saying is maybe there is a way that I can go to get an MRI done that
1103 doesn't cost me $8,000. And the other thing is - the other thing that we heard,
1104 that I - I heard a lawyer say that when - when a membership, well now that
1105 you have high deductible plan, um, people have hadn't been paid for just out
1106 of their pockets. Right, maybe I have a $4,000 deductible upfront. But I heard
1107 people say, "Well if you walk in and say okay, and - and he's got a solution to
1108 things that we have insurance." It pays this much. But you know I like
1109 (unintelligible) MRI and $900 not - not being settled for $4,000. Okay. So,
1110 that is capital. So, get some cost transparency so that we know all this (true
1111 over) and maybe I - maybe I want to go that 18 doctor. Maybe 18 doctor, I'm
1112 not saying it is - it isn't. But you know maybe it's worth paying anymore.
1113
1114 A7: Well they - they don't charge more than, uh, than being - being...
1115
1116 A6: Yeah, I didn't mean, it's just...
1117
1118 A7: Yeah.
1119
1120 A6: ...a different.
1121
1122 A7: But you know I don't understand like man, uh, got this colonoscopy.
1123
1124 A6: Yeah.
1125

1126 A7: Well a colonoscopy is going to be positive for details and possibly to vital too,
1127 all with approval, 16% of the time. Well now a virtual colonoscopy you're
1128 going to get like on time, when I had some stomach problems, I mean, you
1129 know, where you go - and I probably just got six weeks ago. It cost me $800,
1130 you know, (unintelligible).
1131
1132 Woman: And with that it six times that you go, um...
1133
1134 A7 Well I mean that's - that's all...
1135
1136 ((Crosstalk))
1137
1138 A7: Yeah that's after they had cancer. Still on the street...
1139
1140 A6: Oh, this is perfect, records to prevent. That you know...
1141
1142 A7: Oh...
1143
1144 A6: ...so that we can get more people in...
1145
1146 A7: Okay. But we - we can't - we - we don't want to have examples.
1147
1148 A6: No...
1149
1150 ((Crosstalk))
1151
1152 A7: Um, so anyway the, um, the education. You - you have - you have Blue Cross
1153 got more involved. By the way, it raised the (prompts) more to manager,
1154 they've locked up more time in the office than its - it's a partial and
1155 (unintelligible). We know that and the approval marks on that is their business
1156 plan is to, um, metal their losses and you know and after they so (be) and start
1157 running. They were not just in years ago. In less than ten years, in
1158 (unintelligible) they provide (health) back to and then - these are (fast). And
1159 the kick - kick back of their back in...
1160
1161 ((Crosstalk))
1162
1163 A6: The other thing is I mean really we - we - and they're usually paid on a cost
1164 for that page. And they're willing to do that closure on it.
1165
1166 ((Crosstalk))
1167
1168 Woman: That's an by the way. And it's got to be tried. We have to comply with that
1169 and that's in separate program. Wasn't it like the 13?
1170

1171 Woman: Sure.
1172
1173 Woman: It had nothing to do with that.
1174
1175 Woman: So, we don't have to bypass...
1176
1177 ((Crosstalk))
1178
1179 Woman: Buying it.
1180
1181 A6: You got to get - the legislation going down, these are May, 2015 and you got
1182 to get there. By maybe during here, and you had - you had a great (year).
1183
1184 ((Crosstalk))
1185
1186 A7: You know I've got people that do it, you know, I've...
1187
1188 A6: But that's a legislative thing. So, and - and actually all employers are paying
1189 fees to - for that. You have to fax and directly that - that program.
1190
1191 Woman: Especially just caught (unintelligible) there.
1192
1193 Q: Is Sarah - can you talk about the vaccine assessment program?
1194
1195 ((Crosstalk))
1196
1197 Q: Which seems to be the conversation right now.
1198
1199 A8: Sure. I can't - I can't hear exactly what - what the conversation has been. So...
1200
1201 Q: Uh, Dr. Farr and (Henderson) has been talking about the vaccine assessment
1202 program and do physicians have to buy from a vaccine assessment program.
1203 Sarah sits on the board but she represents, um...
1204
1205 A8: Right. So, the answer to that is no. However there are definite downsides if
1206 you don't purchasefrom the state, uh, for lack of a better term depot of
1207 vaccines. There are different requirements for reporting and - and - and so if -
1208 if you - if you want to not be penalized, I suppose in the payment from the
1209 insurer, then you would want to be purchasing from in the state program.
1210 Because the way the assessment works, the insurance companies are paying
1211 for the vaccinations ahead of time. And then they would be reimbursing based
1212 on the assessed or the cost of the vaccinations, um, from the - from the depot.
1213 The - the reduced cost.
1214
1215 A6: So essentially Sarah when (Henderson) from g- so essentially though we

1216 won't pay twice because our - we're already paying for the - the payers -
1217 payers and so funded employers are already paying for the vaccine. So, we -
1218 we wouldn't - we'd get a - a bill charge that come - come through. We
1219 wouldn't pay that too, it - it's the way I think we - we are communicating that.
1220
1221 A8: Okay. So - so the bill, I - I'm sorry. Which bill charged and what - what is it
1222 for?
1223
1224 A6: So, it's in the, uh, it's remember the - the - the bill came through pretty
1225 quickly at the end of 2015? Right?
1226
1227 A8: Right.
1228
1229 A6: And so there might be - it might be such that you've got a catchup time here.
1230 But what I'm saying is we - you know everyone is pay- is supposed to be
1231 paying the assessments correct?
1232
1233
1234 A8: Right.
1235
1236 A6: Okay. Payor...
1237
1238 A8: There are some - some insurers and - and self-funded plans who have opted
1239 out.
1240
1241 A6: One. There is one. It's, uh, (Maritane). Okay. So - so we pay - we all pay the
1242 assessments including employers. And so, when you bill again for the vaccine,
1243 certain vac- whatever the category of vaccines are, we wouldn't pay again for
1244 that charge if we got - or we shouldn't be paying for that. Essentially, we're
1245 paying twice for the same vaccine. I think that's what you mean by paying
1246 ahead for the assessment.
1247
1248 A8: Right, the insurer for the plan...
1249
1250 A6: Our understanding is now we're paying - we're all paying assessments and so
1251 we're not supposed to be paying for the you know there - there is, um, an
1252 administrative charge.
1253
1254 A8: Right.
1255
1256 A6: Okay. That - that - the differences from the - the vaccine itself. You know
1257 what I mean?
1258
1259 Q: And that's why the same - that type of a program is something that, uh,
1260 healthcare authority is looking at as the powers of the large numbers, if we

1261 buy in bulk. Does it work out to be less expensive for everyone? Rather than
1262 small pockets buying here and there.
1263
1264 Woman: Yeah too many administrative things that we had to use. Finally, if I had to
1265 backtrack, I wonder first you have to get trained in data, knowing the
1266 (unintelligible) duty stats, they put in so many dog gone goals, regulations,
1267 how much training? I mean we had I think two days off, go through all this
1268 training. And then they told me there was going to be an additional like five or
1269 six things that we had to do. They test our refrigerator for a lost period of time
1270 before we could get vaccines. I can - stated back (cleaning), so I just got to the
1271 point where you know what? This is way too much time off. It's costing me
1272 thousands of dollars.
1273
1274 A6: You're not even going to get reimbursed for at any point in time. So, we went
1275 back to my - all the lots of vaccines where I could see e- exactly what I need. I
1276 have a ton of things that I want. And he - he billed me, insurance companies at
1277 cost. I mean not - no markup on the vaccine at all. And so, but I was just
1278 figured out how much I was assuming on those vaccines and they do
1279 thousands of dollars a year. So, it's to the point where I was thinking that they
1280 brought me vaccinations I think are vitally important rather than getting -
1281 losing so much money every year on this, by giving the information. But to
1282 me it was not worth already that I was having to losing by going through the
1283 vaccine system. I mean that's just - that's just one factor we're talking about
1284 insurance about one of the things is driving up healthcare costs, is you have so
1285 many regulatory burdens that we used to be able to just go and pick up the
1286 vaccines. We find how many - (you know) and its monitoring our refrigerators
1287 and that was it. And now there's so many - that you have to know and training
1288 and everything else that it's basically impossible for us to log private practices
1289 to be able to do that.
1290
1291 Q: But and Sarah is out next week because I - we had pretty - pretty significant -
1292 indication during sessions. So, I'm taking next week off. But why don't you
1293 try to hook up with her in a week or so.
1294
1295 Woman: Yeah.
1296
1297 Q: And talk to her about what you experienced with it. Because I don't think it
1298 should be quite that tough Sarah I'm not sure. But why don't you - she's in the
1299 Juneau office. So why don't you give her a call and talk to her about it.
1300
1301 Woman: Okay.
1302
1303 Q: Be- from your...
1304
1305 A8: Please do.

1306
1307 Q: ...estimation.
1308
1309 A8: Please. Please do because we haven't received as far as I know any sort of
1310 feedback like what are you are sharing.
1311
1312 Q: Yeah.
1313
1314 A8: So please contact me.
1315
1316 Woman: You know and...
1317
1318 Q: And just- be out next week. So, if you could call the week after and talk to her
1319 - and talk to her about it what you're going through with it.
1320
1321 A6: Or she can just call me in my office too.
1322
1323 Q: Okay.
1324
1325 A6: 562-4045.
1326
1327 Q: You should have it on your sign-in sheet.
1328
1329 A6: Yeah.
1330
1331 Q: And that's to Dr. Farr) - Sarah?
1332
1333
1334 A8: Okay. And Lori, if there's anyone else that from the audience that wants to
1335 speak, the (volume has) kind of been fading in and out. And we can hear those
1336 in the front row. But if anyone in the back row has comments, could you just
1337 pass the microphone - phone around just so we can hear the discussion?
1338
1339 Q: Sure, put the microphone on and I moved, uh, the - the...
1340
1341 A8: And yeah that helped.
1342
1343 Q: Hopefully so that helped a little bit. Is there anybody on the phone? We've
1344 had - I've heard...
1345
1346 A8: Thank you.
1347
1348 Q: ...some beeps on and off. Is there anybody on the phone who wanted to - who
1349 called in to give testimony? Okay. I'll take that as a no. And - and I take it
1350 there's - I recognize most of you in Juneau. So, I'm going to say that there's

1351 nobody in Juneau from your testimony.
1352
1353 Man: Do you have the actual (training) for us...
1354
1355 Q: Oh, absolutely until 7:30 sir.
1356
1357 Man: All right. Thank you.
1358
1359 Q: Till 7:30.
1360
1361 Man: Okay.
1362
1363 Q: Yes, sir. We do have a gentleman that's going to testify now. Please.
1364
1365 A9: Good evening. My name is, uh, (Chakri Inampudi). I'm a, uh, radiologist. An
1366 x-ray radiologist. I'm just gonna say, uh, I can say that based on my evidence,
1367 um, I came up here 14 years ago. And, um, perhaps, uh - uh, that was my -
1368 this is my first job. And contrary to some of the - from your comments we've
1369 heard, I didn't come up here for the money. I was the first of fellowship
1370 training eventually evolved in, um, as called and possible and, um, at that time
1371 and probably still is and only used as part of, um, (475), um, pursuant to
1372 (unintelligible). And my, uh, specialty, um, allows me to treat, um both
1373 vascular and, uh, oncologic and these on (for the). And, uh, I'm proud to state
1374 that, uh, myself and, uh - uh, two of my partners, uh, who will join me later,
1375 um, are the only ones, uh, that in the State of Alaska that go by, uh, care for,
1376 uh, rare treatment oncologic and (some) probably went to like when, uh, but,
1377 um, uh, very important. Uh, I prolong life in cancer patients and, uh, from -
1378 from conflicts in the vascular problem. So, there's an argument that, uh, if you
1379 are, um, narrowly providing a se- type of practice, that - that you have a
1380 monopoly, you can say that our taxes pay for monopoly. But the monopoly is
1381 not created by - by either - an entity. The monopoly is created by lack of you
1382 know, uh, service providers. It is - it's extremely difficult if referred to the
1383 state of collapse that people of - of that type of service that providing. But I'm
1384 also incredibly proud of our group and ourselves for not ever abusing that and
1385 not ever raising our prices, more than the consumer prices and since I've been
1386 here in the last 17 years. And, um, I think that it is important so that to - to
1387 know that not everybody abuses the system. And the 80/20 rule of its, uh, has
1388 been approved for us physicians such as myself, not in the ways you might
1389 think in terms of, uh, financial incentive. But it - it took away me sitting down
1390 with each and every patient and explaining to them how much the insurance is
1391 going to cover on. It could be a liver ablation, it could be an lung
1392 (stabilization). It could be a (senac stent). It could be a carotid stint, it could be
1393 a (neural) procedure and these are all the procedures that I do. And it's been
1394 an incredible barrage of - of - of cases that I deal with. And I speak to the
1395 patients. And I came up here in 1999. The first six years, I was - first of my

1396 first job. And it was so confusing to me to try to explain to these patients,
1397 okay, how much it's going to cost. And how much of your - how much is the
1398 hospital fee. And you know we did our best but it was completely animatic.
1399 Insurance companies, I firmly believe this, um, want to make this a very
1400 complex process. Once a process is complex, the - the consumer either gets
1401 frustrated or gives up. They have no choice. So, they made a complete lack of
1402 transparency before. Which actually is the one that drove the - this legislation.
1403 Very well, there is no, you know, what insurance company that is that, they
1404 say well my usual and customary for reading a chest x-ray is $10. But Blue
1405 Cross Blue Shields pays, my insurance customer for reading the check x-ray is
1406 $6. But the doctor's fee is $12. But the other doctors fee is $4. It's all over the
1407 place. It's 80/20 rule if we should not forget this, um, we could go on either
1408 side of the aisle. But the 80/20 rule they're instituted to protect the customer
1409 which is the patient. It wasn't meant for the doctor. It wasn't meant for the
1410 hospital. It was meant to protect the customer. What part of changing this rule
1411 is going to benefit that customer which is the patient? Well people will say
1412 well it's going to drive healthcare costs down. That's fantastic if that happens.
1413 Does anybody believe that changing the 80 per- 80/20 percent rule is going to
1414 bring down our interest premiums? Honestly, does anybody believe that that's
1415 going to happen? We have seen it. It's impossible. Insurance rates are never
1416 coming down regardless of what we do. That's what I believe and 'cause
1417 that's the life care decision. Insurance companies do not like care decisions.
1418 Doctors for life care decisions, nurse practitioners for life care decisions.
1419 Hospitals for life care decisions. Pharmaceutical companies do research that
1420 come out of this wonderful drug. Yet, device manufacturers are provided with
1421 care information. Insurance companies are middle - middle managers taking
1422 money from you know one segment of the population. Taking their cuts,
1423 brilliant subject and not the public organization. And then imposing their -
1424 whatever rules they want to impose through the background channels, their
1425 lobbying or whatever is happening on all the other states. But it's not going to
1426 trickle down to the consumer which it - which is - which is the patient. Yes,
1427 we have our (life), absolutely. For example, is forgiven, nobody can get either,
1428 and nobody should even defend it. But there is a way to - to - to take care of
1429 those (out) life. But - but bring it up punish the hundreds of doctors that
1430 working so hard to provide care in this community. This is a very hard
1431 community to recruit to. Doesn't matter, you don't have to be a doctor. It's a
1432 very hard community to recruit to do anything. And like manage it. I mean a
1433 truck driver, a plumber, this is a very hard community to recruit to. That's
1434 why when the plumber comes to my house and takes $120 an hour, I pay it.
1435 Because I know that it - it's minus 20 degrees outside and the poor guy is
1436 coming to - to fix the broken pipe. There is no way you can pay back $120 an
1437 hour to a plumber in California. I mean it just doesn't happen. So, why is it -
1438 hey, why are we paying more? Because it costs more to run a business in - in
1439 the State of Alaska. It costs more to recruit primary care physicians. It's none
1440 of my family care physicians, I mean, uh, I went to medical school right. I

1441 have a ton of medical lasted (all year), primary care physicians. None of them
1442 would hope to stay in Alaska. None of them. And you know we can always
1443 joke about you know re- you know the funny here and there, saying that oh I
1444 moved up here because of money and still my - I mean, it's not true on - on a -
1445 on a broader scale. Of course, there are exceptions always. And it's nice. And
1446 I joke about it, talk about the depression. But that is not the rule. The rule is it
1447 is incredibly hard to recruit for this. And one of the biggest attractions, uh, for
1448 - for recruiting physicians is I mean leave it on the - the - the income page for
1449 a second and same thing to that. Is the lack of headaches dealing with
1450 insurance in the State of Alaska? It's huge for physicians here. That is going
1451 to disappear. Once you take away this law, it's that the lack of transparency
1452 that was there before is going to come back down. Insurance companies are
1453 going to be all over the place in what they decide. The doctor should be paid.
1454 And - and that is only going to increase their bottom line. It is not going to
1455 reduce our, um, uh, the - the rates that they charge for the - for the customers.
1456 On which participation, uh, or the insurance. I give you one simple example
1457 why - why I believe that it's true. All right. They didn't even start. I actually
1458 did a simple Google search today. What is good, uh, and it's - it's available,
1459 anyone of you can Google search it. They - they, uh - uh, CMS would collect
1460 data and its incredible in-depth data of - of - of increase in - in, uh, in - in
1461 physician pay, hospital pay, uh, the manufacturer's pay, all pay - all - all the -
1462 all the healthcare expenses from 1995 to 2000 and - and 9. Data is there. It's
1463 on PDF charts. And - and it's by date. And - and what I know this is Alaska,
1464 uh, it's - it - it - it went up by, uh, 30%. The physician in - from 2000, uh,
1465 four, I looked at the 2004 because that's when the regulation came out. So,
1466 from 2004 till - till whatever 2010 or whatever, and that the physician, um,
1467 paid or - or the payments made to physicians went up by 30%. Our insured
1468 has quadrupled. Why? If - if physicians are the dry work of - of - of healthcare
1469 costs, how come our insurance did just go up by 30%? Why did it go up by
1470 400%? And where is all this cost coming from? An excellent reference was
1471 made earlier to utilization. Yes. 80/20 rule is not going to do anything to
1472 change utilization. Why? All the smart people in the room know it's the
1473 utilization that's driving the cost. The chain in 80/20 rule is not going to drive
1474 the utilization down. Which is what needs to happen. So, you know, don't
1475 repeal what's actually working. What's actually working for the physician and
1476 what's actually working for the patient. The only people that this is not
1477 working for is insurance company. And please do not let them use the - the -
1478 the outline examples of, you know, what (speaks) surgeons or more surgeries
1479 to - to influence and major change. I mean lets - I mean you know what we -
1480 we have an opportunity to talk about it. And I'll be glad to provide counsel
1481 alternative on - on how to you know deal with the outline. And - and this is
1482 still I think it goes to something that's outlining to - to becoming an in lying.
1483 Um, this process. And because I acquired, you know, just a couple of days ago
1484 that, um, you know, one of the big groups that we were referred to earlier, um,
1485 and actually, uh, you know, is in the - in network now. Starting January 1 or

1486 something like that.
1487
1488 A7: And I told you that.
1489
1490 ((Crosstalk))
1491
1492 Woman: They're in.
1493
1494 A10: They're in now? Yes. So, uh, yeah, I'm not a radio show speaker so I'm not
1495 comfortable dropping names. But, uh - uh, you can - you can always say good
1496 things to somebody, I think. Yeah.
1497
1498 A9: So anyway, this set - so that's good news, right? To - to change that com-
1499 from within without shattering what's working right now. And, uh, with that,
1500 I'd like to end my testimony.
1501
1502 Q: Thank you Doctor.
1503
1504 A7: Were you in the same question?
1505
1506 Man: Sure. And now drop everything and I already have.
1507
1508 A7: Well why drop it?
1509
1510 ((Crosstalk))
1511
1512 Man: Yes please.
1513
1514 A7: And one part of your statement you mentioned that the problem - we're not
1515 the problem.
1516
1517 Man: Yes sir
1518
1519 A7: What part of any of these industries is not the problem?
1520
1521 ((Crosstalk))
1522
1523 A9: Blue cr- Blue Cross Blue Shield is not the problem.
1524
1525 A7: No, that is not - that is not a good (unintelligible) insurance. Okay.
1526
1527 Man: Right I am - I am exempt, I am just wondering where you come up with an
1528 insurance company, the, uh, the problems?
1529
1530

1531 Q: They are organized, it's a not for a profit sir. They - they are. They're
1532 incorporated...
1533
1534 Man: And they have a...
1535
1536 Q: And if you'd like to address it.
1537
1538 A6: Not yet?
1539
1540 Man: Yes please. I - I'm just curious because...
1541
1542 A6: There are certain...
1543
1544 ((Crosstalk))
1545
1546 A9: It's a very - very good question. People should be aware of.
1547
1548 Q: The providence knows it.
1549
1550 A6: If I could stand up so...
1551
1552 Q: And you may - you may address those.
1553
1554 A6: There are for profit insurance companies that are non-prof- not - not for profit
1555 insurance companies. Premera is a not - non-profit insurance company.
1556
1557 Man: Okay.
1558
1559 A6: And so, we - we - our certificate - here's what our certificates are, it's 91 cents
1560 of every dollar that we collect pays claims. And of our administration creative
1561 overhead, we have somewhere between one-half to 2% of margin or profit
1562 margin. That's Premera. That's not necessarily every insurance company out
1563 there. There are for profit publicly traded administra- and that may be
1564 different. But for us that's the way it is.
1565
1566 Man: Net or gross?
1567
1568 A6: Net or gross on the...
1569
1570 Man: On the administrative profit?
1571
1572 A6: The - well even - it would be - I have to think about that.
1573
1574 Man: Your gr- right.
1575

1576 A6: So, I mean, just to put it in perspective, there are for profit Blue Cross
1577 Companies. Let me say that. So, and some because - at the state of reform,
1578 um, I was in a panel discussion and a, um, a pos- position got out and it was
1579 pretty - pretty animated. And I think he got us confused with (Anthem) Blue
1580 Cross. And started to spout all of this data about, um profits. And so - and of
1581 course we have lost money. We lost 40 million - 40 million - 41 million
1582 dollars last year, Premera did, because of the individual market. So, you
1583 know, even though we might - we're bringing in maybe 1-1/2 to 2%, that
1584 doesn't mean we're making money either.
1585
1586 Woman: And you got it going to the other way.
1587
1588 Man: Yeah, I need to say this...
1589
1590 A6: Well because we have good reserve. But we can't stay in this one forever like
1591 that.
1592
1593 Woman: And stay like that for sure.
1594
1595 Q: Well now the - if I can interject on that. The state has not helped Premera out
1596 at all yet. And it's not to help Premera out. The state will reimburse the - any
1597 insurance company, be it Premera, Moda, Aetna, or anybody who would come
1598 in of - for the high-risk claims. But they're reimbursing that. It is - I had to
1599 clarify this when I spoke at rotary a week or so ago. We are not - we are not
1600 giving them a grant or a loan or, uh, anything...
1601
1602 A6: It's not for profit.
1603
1604 Q: If - if - yeah, if they get it, um, a leukemia patient.
1605
1606 A6: Right.
1607
1608 Q: And they submit to me or to its actually ACHIA. If they submit to ACHIA a
1609 bill for $20,000 for treating that leukemia patient, then we pay them back for
1610 that leukemia patient. But it's not an upfront here is 55 million.
1611
1612 A6: Right.
1613
1614 Q: To...
1615
1616 A6: That would be for (2.7) percent tax and everything premium.
1617
1618 Q: Yes.
1619
1620 A6: And the state and what the 55 and all (be in), so, it's actually going for

1621 ACHIA. I didn't read the (available) all the way so I wasn't sure how...
1622
1623 Q: It - it's being offered through ACHIA. But this time instead of being a high-
1624 risk pool up front, it's a reinsurance behind and Premera is administering all
1625 the costs. So, technically your patients should never know that they are in that
1626 high-risk pool. They would always be dealing with Premera at this point.
1627 Hopefully we'll have other insurance companies at some point. But that they
1628 should never know that they are being reinsured, uh, through this program.
1629 (Kevin)?
1630
1631 A10: Just like Premera requested to go to pro- for profit. They must have - State of
1632 Washington goes to my direct and goes about the - I think the why and the
1633 (unintelligible).
1634
1635 Q: Uh, yeah that was a couple years ago. I'm not quite sure. There is a lot of
1636 crazy things but...
1637
1638 A10: And you remember why?
1639
1640 Q: No, I - I - I don't know. I don't remember why. I...
1641
1642 ((Crosstalk))
1643
1644 A10: Yeah you can't go from that - from that first of all with respect to them that's
1645 really went, you know, technically now. Um, but you can't go from the taxing
1646 now status to a vaccine status when you induce the tax up status you benefit
1647 from off the market. So, you have to pay a penalty. You have to - you have to
1648 upfront something and offer something and, uh, I think to great parity and
1649 that's where the negotiations come in. And where you install part of it. Your
1650 question...
1651
1652 Q: Okay. If I could just - just for one minute. Premera does pay tax.
1653
1654 A10: Um, well reserves over a million then is- issued too and...
1655
1656 Q: If...
1657
1658 A10: ...what happens with billion, they take money off it and they do that and so
1659 that separate source of (occupancy)...
1660
1661 A6: And it's also keeps it solvent so we can stay in business really for 41 million
1662 dollars.
1663
1664 A10 Oh okay. Okay. But like I - but like there's (threaten), you know, your
1665 (unintelligible) money. So, your question how do you stay solvent, I think -

1666 that's true and the margins here for you - and also, you - you're talking about
1667 being (unintelligible) why are we picking on the outliners because if we took
1668 all of the outliners and, uh, someone's position, how much would that save us
1669 when we are profitable about the hospitals and the hospitals, uh, so, you
1670 know, it was just being forced on us...
1671
1672 ((Crosstalk))
1673
1674 Q: I just want to make one correction for the record. Premera does pay premium
1675 tax like every other insurer in the state. So, they - why they are set up the way
1676 they are set up as far as their incorporated structure, they pay premium tax. As
1677 other insurance companies do just for the record.
1678
1679 A10: Well I have - the way when a tax exempt elsewhere how is...
1680
1681 Q: I - I can't tell you. I can't speak for other states. But I can tell you that they
1682 pay premiums tax in the State of Alaska. So, just for the record.
1683
1684 A10: After saying that - and where to (call), is that what type of premium, act like a
1685 paying, uh, they - they are culpable and they pay the (most). All of this
1686 happened if you were paying a dollar of your service.
1687
1688 Woman: Well he said (done).
1689
1690 A10: I don't care, I'm just saying. That you're not in business to lose money.
1691
1692 Woman: Correct.
1693
1694 Woman: Right.
1695
1696 A10: You're at the - at the...
1697
1698 ((Crosstalk))
1699
1700 A6: But we're not here to make repeat a net profit either. Or 14% year after year
1701 for making a profit. Um, for share on the (profit).
1702
1703 ((Crosstalk))
1704
1705 A10: To get back to your question of being transferred, if it were equitable, there
1706 wouldn't be a problem with me going back and, you know, back paying if it
1707 really was clear what they were paying the tax and pays, um, 'cause they're
1708 obviously not paying federal income tax.
1709
1710 Q: I can't speak to the federal. I can't speak to...

1711
1712 A10: So, they're not paying federal tax.
1713
1714 Q: I - all I can tell you is they pay premium tax in the State of Alaska. Other
1715 questions or com- is there anyone online that wanted to speak to the 80th
1716 Percentile for the public hearing? We have about ten more minutes till I'm
1717 going to close the hearing.
1718
1719 A10: Is there general consensus other than that?
1720
1721 Q: I think the general consensus is we have some work to do.
1722
1723 A10: Yeah.
1724
1725 Woman I guess sound as hearing at this time right now, we can complain over dinner,
1726 just a thought and I mean I'm just kind of curious what your biggest challenge
1727 is.
1728
1729 Q: Well I think right now our - our biggest challenge is, uh, waiting to see what
1730 comes out of (ACA), and are going to be able to respond to it or how it's
1731 going to impact us. You know, it's dealing with the unknown. And then how
1732 well it impacts Alaska and our consumers. If all things stay equal, we will -
1733 are pushing hard on our waiver in DC, because we think that our reinsurance
1734 program is sound. And we need to have it affirmatively funded. So, seeking
1735 that from DC is certainly a goal. And then if the message out of DC is to
1736 change the ACA, then it's to prioritize things that we think that you know
1737 keeping our reinsurance program, um, looking at the essential health benefits,
1738 would that benefit Alaskans. Uh, cost sharing. If we could change 'em to
1739 benefit Alaskans. Looking at what networking is. Looking at the Cadillac tax.
1740 Should that - could that go away permanently. Because that's an impact
1741 certainly on employers. Um, and just you know how could we change the
1742 Affordable Care Act so people still have access to healthcare, physicians are
1743 still compensated, insurance companies are still here to do business. But that it
1744 still works. Um, I mean obviously, the hallmark of the ACA is people with
1745 pre-existing conditions can get insurance and therefore they can get treatment.
1746 And but then how do you build off of that to have a viable insurance system
1747 where people can actually get healthcare but it is affordable. We've got a very
1748 small pool and we have some very sick people in it. And as it is right now, it's
1749 not working, because there's just not enough people to spread the cost over.
1750 So how can we manage it for Alaska, because this one size fits all hasn't
1751 necessarily worked for us. So, how can we manage it? How can we tweak it to
1752 best fit us?
1753
1754 A6: Yeah like when you had that 2.7% tax in ACHIA, we have pretty good
1755 balance then. I mean premiums went up, they weren't astronomically up. And

1756 it seemed like, you know, everybody - patients or and physicians were more
1757 content. You know ten years ago, I looked at the difference between the
1758 intentions and now between patient's insurers, providers, versus now and it's
1759 like everybody is - sells everybody else right now. And...
1760
1761 Q: But with ACHIA, you still had to be denied insurance. And it was still a list of
1762 qualifying diseases so to speak to be a member. And so, there were still people
1763 that did not have insurance.
1764
1765 A6: Right.
1766
1767 Q: And it...
1768
1769 A6: What about the 3,000 people what (then to) 600 or something?
1770
1771
1772 Q: Yeah.
1773
1774 A6: So really for a state that supplies, we had that backup for the...
1775
1776 Q: We did have a backup.
1777
1778 A6: ' Because I know several individuals that were on in - in the program.
1779
1780 Q: And if it was - I mean it was the cost of the insured, it was a cost to the state.
1781
1782 A6: It was a cost to the patient and the state.
1783
1784 Q: Absolute- it was expensive. It was not cheap. So it wasn't the perfect solution.
1785 And maybe what we go back to. But it - it had, um, it worked. But it wasn't
1786 perfect for everybody. And in taking out the pre-existing conditions, then you
1787 did have something that anybody could get insurance. And they didn't have a
1788 six-month waiting period and they didn't have to be denied coverage or go- go
1789 through that hoopla of being denied and having only a certain condition and to
1790 qualify. So, it - we're just - we're going to - we're in kind of a waiting game
1791 too as to see what - what happens in the next six months. But our end goal
1792 hasn't changed. It's defined a way to make this work. So, that it is affordable
1793 and to see that, you know, everybody can have - make a decent profit, you
1794 know, including the insurance companies and including the physicians. You
1795 know, there's should be a way that people get treatment. And then we have
1796 the right treatment for people, for our populations. People shouldn't have to
1797 go outside. But you know we - we've heard testimony from the, uh,
1798 emergency docs that too often it's - it's a great risk to have to be flown out.
1799 Um, to receive cardiac treatment and burns or such that if you don't have the
1800 treatment here. And even in bringing treatment from Southeast to Anchorage

1801 or Fairbanks, or rural communities to Anchorage, it's a risk. And to have to
1802 further take them to Seattle if we can do this right, hopefully we can you know
1803 provide the services here. But it - it's getting the - the costs so that we all
1804 agree, um, I - I don't think there's anybody that doesn't agree. It's always
1805 going to be more (status) here. Um, but it's just figuring out, um, I've heard
1806 more today on the cost from physicians and what it costs to recruit, retain,
1807 than I've heard in three years.
1808
1809 Man: I just had my training in Britain and it's, uh, over the holidays, uh, and
1810 gathering and it's included, um, you know, actually one of the things that of
1811 course that Donald Trump and Trump go (apparently), one of the things that I
1812 was aware of - of the stratification of insurance in Germany and France and
1813 you can get that there, they do distinguish within the employers and obviously
1814 that one type of insurance will get clean, you know, within a week or two.
1815 And of their type of insurance, you know, they get called away. And so,
1816 rationing like a (lay) is, um...
1817
1818 Q: Their system is not perfect.
1819
1820 Man: Yeah.
1821
1822 Q: And - and yet we tend to view it as though it is.
1823
1824 Man: Yeah.
1825
1826 Q: And then when you talk to somebody who's actually in it, it's - it's not
1827 perfect. I've got about four more minutes. I'm going to ask one more time if
1828 there's anybody on the line that wanted to give testimony. Or to provide
1829 public comment.
1830
1831 ((Crosstalk))
1832
1833 Woman: I just want to (unintelligible) both 7:30 and hearing no one and so it - so we
1834 (unintelligible).
1835
1836 Q: No problem.
1837
1838 Woman: Um, the reason I was thinking was this internal (unintelligible) that, you know
1839 she is really in the marketplace and get whatever insurance you want because
1840 - it's the - and how I do coverage, like have another (unintelligible) coverage
1841 and that's just for her. And that's not the case and much more on that. I have
1842 never imagined this stuff but I have never been so (sudden). Is that I have
1843 called there for the last few numerous times and got (borated) what he got on
1844 call and I'm like how to get help for my agent's call. And they're not able to
1845 call either. And always the reason that's - and that's what we had done

1846 together and have to sit down and just to let it go and (it's now without me
1847 and not) together. And I wanted to see but I'm not - (unintelligible) again
1848 around holiday or we can - one set of (problems) even in just in that worker,
1849 and it's not just city agents, not just the agency, not this way that they're in
1850 turn raise and that's for and together, like you know, when they're together
1851 and make sure that agent comes together. Make that happen. Um, and that's
1852 what set with (unintelligible).
1853
1854 Q: Well I thank you all for taking your time on Friday night and those on the
1855 phone and certainly back in Juneau that took time. And I think it's close
1856 enough to 7:30 that we can call this hearing. I - I'm going to assume we're
1857 probably going to regroup in some form to, uh, continue this conversation
1858 over the next year. And to, um, to - to talk about, you know, based on the
1859 testimony we've received what the next step is. But I thank you all for, uh
1860 coming this morning, coming this evening. Calling in and attending in Juneau.
1861 And with that, I'm going to call it at 7:30 on June - January 6 that the public
1862 scoping hearing is over. Thank you.
1863
1864
1865 The transcript has been reviewed with the audio recording submitted and it is an accurate
1866 transcription. However, there may be minor differences in wording and grammatic flow as a
1867 result of the transcription program. Efforts were made to correct the spelling of names. In
1868 addition, comments made by division staff have been slightly edited to improve clarity. Readers
1869 are encouraged to review the electronic audio tapes on the division's website.
1870
1871 Signed____