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Lawrence D. Weiss Ph.D., M.S.  
Editor, AHPR

## Interview with Senator Bettye Davis



*Senator Bettye Davis is Chair of the Senate Health, Education, and Social Services Committee and a member of the Alaska Senate Bipartisan Working Group. She is also a member of the Alaska Health Strategies Planning Council. In this interview she comments on a wide range of topics. For example, she gives her candid assessment of the legislators and the committees that have been obstacles to the passage of good health policy. She discusses the precarious benefits of working with the Bipartisan Working Group, and comments on the future of SB 160 Mandatory Universal Health Care. She also discusses her past and future as a legislator, among many other topics. This interview was conducted October 1, 2007, and has been edited for clarity and length.*

**AHPR:** From the vantage point of your long and distinguished career, has healthcare as a public policy issue in Alaska changed much in the last three decades?

**Senator Davis:** No it hasn't.

**AHPR:** Really?

**Senator Davis:** That's the problem. It has not changed that much. Very little work that I think needs to be done has been done. I am so pleased to see that [in] the last session we seem to be moving more towards some of the points that I'd like to see covered in health care and health policy--not simply because I'm chair of the committee this past session and hope to be next year also. I served six years also on the House side. I came in in a year when the Democrats were in the majority, so my first two years on the House side the Democrats were in control and that's the only chance that I've ever had to be in the majority. I served six years on the House side and I left in 1996. I ran for state Senate--didn't win. Came back in 2000, and won. I have been serving in the Senate since 2000, and this is my first chance to chair any major standing committee since I have been elected to the state Senate or the House.

**AHPR:** And how long have you been chair of this committee?

**Senator Davis:** Just the one year. [I was] elected last year. It's a two-year term, and if everything holds with the working group that I am in, I will also chair it in January--till the end of the session.

**AHPR:** Earlier I was asking you if health as a policy issue has changed much in the last three decades.

**Senator Davis:** I can't really speak as for what happened in Juneau except for the time that I was there. I do know there was not much being done. Most of my time at the local level has to do with education. Even though I was a nurse social worker, I was on the school board for nine years, I served on State Board of Education for two years, and so most of my time was spent in education and social services--not necessarily just health itself--but I haven't seen that many changes since I've been there. When I went there back in the 1980s--you know, we were in pretty good shape those first two years--but then they began to cut the budget because oil prices went down so low. They cut education, and they cut health services, they cut everything that

they could. They were so worried about what they were going to do with Medicaid because it was just blowing out of proportion, so they were doing everything they could do to cut back, and not necessarily given the money that needs to be provided.

It is just only within the last couple of years have we really been giving money back to education, and now we have the education task force, which has made some really good recommendations. I started off pushing for early funding of education way back when I was on the school board. I thought that was a good thing to run on because it wasn't happening, so I came there in 1990 thinking, "This is a good time to push that issue." I came back in the minority, which means you don't chair anything and you don't have a real say. You do all you can because there's a role for majority and minority, but you can do more when you are in the majority in the sense of convincing people to look at the things that you think are important and move on them. Many times many good bills that we offered as Democrats were ignored simply because we were in the minority, and you did good to get maybe one or two bills through or get an amendment in here or there.

You did everything you could to represent your constituents, and I think I did a good job at that but I always felt I could have done more had I been in the majority role, but my constituents seem to think, "Well, you've been doing a great job. We appreciate what you do." You kind of feel like, "Oh, I wish I could do more." Even now, where I am now, I wish I could do more because they sure haven't done things exactly the way I want to do.

Just, for example, what happened with SCHIP, Denali KidCare Plus--they had cut it back--because it was a wonderful program. During that time Governor Knowles was there we were doing quite well. It got cut back under Murkowski. It took us until just last year to bring it back up to the 175% [of federal poverty level for eligibility], which is not very much because some states have gone up past 250% or 300% above the poverty level. Here we are just struggling, and we wouldn't have gotten that except the fact that there was a bill that was pushed out there, and I am a cosponsor of that bill for health care for all children. I knew that Bill would not get through under the present legislature. This is Senator Bill Wielechowski's bill [\[SB 87\]](#).

He pushed the bill out there for health care for all children, so we had those three bills that were out there. We had my bill [\[SB 27\]](#) bringing it back up to 200%, which didn't go, and at first they were going to pass that bill. It was sitting up in finance for weeks and weeks and weeks and weeks and nobody would do anything with it. It was a bill on our side and they decided not to push that bill. In the end, on a compromise, they said, "maybe we will consider the 175%." It passed the Senate, and the thing was to get it heard on the House side. In the final moments before the session ended, it did get heard, but they took out the adult [and seniors] portion of that, and that pregnant women and children part stayed in. That was better than nothing at all, so you make your compromises, and the bill passed and the governor did sign it.

And you know where we are now. This federal government--the House and Senate both--have passed the bill [State Children's Health Insurance Program, SCHIP] because it's time for it to be reauthorized. Authorization is supposed to be the 30th [of September 2007]. The bill has probably shown up at the president's desk. He said he would veto it. They have a veto proof on the Senate side but they don't have it on the House side. So they need at least 15 more people to say, "Yeah, we will override it" for anything to happen, but if that bill were passed, that would be leading us in the direction that I think we should be going. Here at the state level [our job] is to make sure at least, if we are not going to be doing anything else, we should make sure that we have health care for all our children. That would bring in an additional 9 million people across the United States, if that bill [is] signed by the president.

**AHPR:** What would be the consequences for Denali KidCare or Alaska children if the president either doesn't veto the bill or it's vetoed and then overridden?

**Senator Davis:** It's possible that it wouldn't do anything to make us any worse off if he doesn't sign it because he claims he wants to get a group together and come up with a compromise--not go the full portion that they're asking for, but give a portion of that, so anything over and above would be in our favor. How much it would give us, I don't know. The department would have to figure all that out once the money has been decided how much that it is. He is not saying that

he's going to take money. But there are some things that they are talking about, that you have got to have 90% approval of all the people that are eligible for it, in order to qualify for certain things. It's a whole lot of things that we don't really know how it's going to work, so we have got to wait and see what is going to happen.

You know, all the major health policy groups are right there pushing it and hoping that everything is going to work out. The Democrats have done a real great job pushing that to the forefront because you've got not only that, but you've got No Child Left Behind out there also for reauthorization. So they have their work cut out for them. I feel that in the end we're going to come out better. We will reauthorize it and we will have some more money in there, but how much, who knows?

Regarding health policy per se, we haven't really done very much because we were busy cutting and now we are just trying to make up.

***"...I never thought I would see myself in the room with six Republicans on the Senate side working with the nine of us, and we did. We didn't agree on everything, but we were willing to compromise, we were willing to listen, and that's all I've ever asked for."***

**AHPR:** And talking about working together, you are a member of the Alaska Senate Bipartisan Working Group. How would you characterize the working group's views on health policy reform in Alaska, and how might that play out in the coming session or two?

**Senator Davis:** If you are just sticking to health, like I said, we were instrumental in getting SCHIP passed, and Denali KidCare. We did do that, and it pushed from the Senate side over to the House, so I would say that the working group did very well. We might have done better if we were strictly a Republican majority or a Democratic majority. If we would have been a majority Democrats, I believe that we could have gotten a higher percentage, but at least we got something because we have been pushing for the higher percent as a minority but haven't gotten anything, so 175% is better than nothing at all. I feel that we did a good job on that.

I couldn't believe my six years on the House side. First of all, you've got more members and they do more talking, and they are always working on something, and they've got everything going. On the Senate side you don't speak that much on the floor. They pretty much have their mind made up about what they are going to do. I felt that on the Senate side--and many of the constituents come in and they felt--that it is so cold over here. We can't get anything done. Last year it was a different thing altogether. Why? Simply because we were working together.

The one reason I wanted to run for the Senate [was] because it used to be that they would split the leadership because you usually just about had 10/10 or 9/11. You were so close that you could split the leadership and everybody worked together. But then it started going downhill. When I came there in 2000, we had five Democrats out of the 20. We have worked our way up to nine, so I was pleasantly surprised when they said we were going to be able to put this group together because I never thought I would see myself in the room with six Republicans on the Senate side working with the nine of us, and we did. We didn't agree on everything, but we were willing to compromise, we were willing to listen, and that's all I've ever asked for. Just give me a shot at it. If it's a good thing it doesn't matter if it's a Republican or a Democrat. Listen and try to do what's in the best interests of their constituents. And I felt we did that last year.

**AHPR:** Do you feel the working group will hold together for the coming session?

**Senator Davis:** From the work we did last year, it's possible it could hold together, but then there are all these other things out there. You've got people now that are pushing once more saying that some of your people need to come out of certain positions that they are holding because they are now being investigated and might be indicted. I don't know what this is going to hold for us. We have one person that's the head of [Legislative Council]. He also is Rules chair, which controls all the bills. Even last year when we came together, the minority, the five Republicans, did not want him to hold that position, but we felt that it was an okay position for him to hold--we kept him there.

Will we be able to do it this time? Will it cause us to break down? If he has to be removed from that, you know, you have to decide who it's going to be. Is it going to be a Republican? Is it going to be a Democrat? Are we going to agree on it? It could break us down. There are always those out there that want to break it apart. They were not successful last year. If we stick together the way we did last year, they won't be able to do it next year. We've only got to hold together for 90 days since we only have a 90 day session, but we might have to stay together longer depending on how we get our work done, because if we don't finish in October [with] what we're going to do with our oil taxes, it's got to be picked up in January, which means we'll probably run more than 90 days in order to get done.

There are some things we have to do. We have to have education done by the middle of March, and that's a good thing. I have been pushing for that ever since I've been there. I'll be glad to see that they will know how much funding they are going to have right up front, and not have to send out the pink slips, and not have to guess about how much the funding is going to be. So it is possible we could still hold together. We have met very little since we have been out of session. We are getting ready to have a meeting I think on the 11th. It will be the first day we've come together since the one-day special session. We have been having committee hearings in various things that we are doing, but not coming together as a working group. It is possible that we could hold.

**AHPR:** It sounds like it has been a very positive relationship.

**Senator Davis:** It has, and not only am I saying that between the 15 of us, the public is seeing the difference. That lets you know that something is right. You come in and you're feeling good about it. When they come to my office, and I'm in the minority, I can't make very much difference but I can push for the issues I believe in. They believe that I will carry the message for them, and they felt good about coming to my office, but I knew all along in the end that I was not going to be one of the deciding figures to say, "Yeah, this is the way it's going to be," but last year I did have some say in that and it made a difference.

**AHPR:** When you say that last year you had some say in that, is one of your major accomplishments the Denali KidCare bill?

**Senator Davis:** That's one of them, but the thing is to chair HESS itself was a major accomplishment for me because I have always pushed children's health issues, family issues, and all those kinds of things so that was the place I thought I needed to be. Over the last couple of years I had even stopped serving on the HESS committee because I felt it was a waste of my time. I did serve on the Finance part of it, but not the HESS committee itself, because anything you push through, if they didn't want it to go, it wasn't going anywhere and it didn't happen. All the cuts were being done and I felt I could do better serving somewhere else. So for those two years, which is one session, I didn't serve on HESS. Then pleasantly, like I said, we came back last year and had the working group, and I was able to come back.

***"Do you know why it worked this time? Because it wasn't just the Democrats running over there trying to bring a few of them to us, it was them coming to us, and us together saying maybe we can do something here."***

**AHPR:** From your perspective, why did the working group suddenly coalesce? What made it possible last year, and not, for example, the year before?

**Senator Davis:** There was really no way it was going to happen before we had the nine [Democratic Senators] for sure. [Earlier] we had eight people, and there was nobody interested in doing a coalition at that time. I didn't even think that it would happen last year, and I sure was not instrumental in making it happen, because when they actually came together I wasn't even in the state. And as I was getting the calls saying that it was a possibility, you know, you hear these things, because we have tried to put them together before, and they fall apart before you get to Juneau. I figured this was another one of those times that we are trying, and it would probably fall apart, but it didn't.

Do you know why it worked this time? Because it wasn't just the Democrats running over there trying to bring a few of them to us, it was them coming to us, and us together saying maybe we can do something here. There was a certain one of them who was very much interested in it, and instrumental in making it happen. It took some Republicans working with some Democrats to do it, not just Democrats coming over and saying, "Why don't you come over here with us and be a part of us?" They really did it to themselves if you want the truth. The only reason that I believe it happened is that there were two people that wanted to be president; they couldn't agree who it was going to be. Both of them wanted it really bad, and so an offer came up and, you know, that's the way it happened. Had that not been the case, we would have been just where we were. Yeah, give us so many positions and you can be president! That's the way it happened.

**AHPR:** During the last session you were the prime sponsor or cosponsor of nearly two dozen health-related bills ranging from funding nonprofit providers to provide health care to the uninsured, to doubling the number of Alaska students who could participate in WWAMI [the acronym stands for "Washington, Wyoming, Alaska, Montana and Idaho"], the regional medical school program. Are there two or three of these bills which you deemed particularly important, and if so, why?

**Senator Davis:** Every bill that you just named there was important to me. First of all, you were talking about the WWAMI program. I have been trying to get more students into that program for years, but we haven't been able to do it. The recommendations have been made, and you need to give us 20 more. Give us 10, or five was better than nothing, so I see that as an accomplishment. I see no reason why we couldn't have our own school of medicine. I believe that we could. They are taking undergraduate work here, but we would only have one residency program.

That's another thing that I think would be helpful: if we had more hospitals involved in the residency program because when they come back to do their training here, they might stay. We only have Providence, we don't even have it at the Native Hospital, we don't have it at Regional, and we don't have it up in Fairbanks. That is something I'm going to be meeting [about] with the people at Regional. I don't know if they're interested in it, but I would sure like to think that they might be interested in it, and maybe something could be worked out that they could have a residency program. If not, then at the Native Hospital or wherever we can do it. There are professors at the University that feel that we could have our own program. Are we willing to do it?

Now we are looking at health care. The governor has her [Alaska Health Care Strategies Planning] Council. We are looking at health issues more than we ever have. We have had the Health Caucus, but that was a minority-led caucus. People just sort of [think] this is giving them something to do, and nothing really came out of it. We did get that compact that came out last year, that we were able to pass. It was just a joint resolution saying that we need to do more toward prevention and health care. That's a start, so with the Council and the recommendations that they are going to make, maybe prevention and early intervention and all that will come into play because we are going to give short-term goals and move it on up toward long-term goals.

Are we ready for universal healthcare? No! Yet there is a bill out there that is similar to a bill that has been introduced in other states. We haven't had a real hearing on it. We had a public hearing here, but you couldn't pass it until you go back to Juneau and it will come up again, but there is no way that we are going to pass that bill in 90 days. It is going to be around for a while. There is no way that bill will pass both houses and have everything in place. Look at the Massachusetts model. Even though it's been passed, they are still having problems. It is not all together yet; California hasn't got theirs [together yet].

There is one thing that we know now--states are picking it up because the federal government is not doing their part yet, so we have to look at some of these models. That is just one of the things that we are moving forward on. I would like to see us moving forward and having an interest, but we are not going to get anywhere until we educate the public saying, "Come in and join with us. These are the things we want." Sure, we've got a lot of uninsured people, some by choice though, others because they can't help but to be uninsured. They can't pay for it, and

there are those that have it but can't pay the co-pay, or buy the medicine that they need, so there's work to be done and I see we're moving in that direction.

**AHPR:** Talking about moving in that direction, you are on the Governor's Health Care Strategies Planning Council.

**Senator Davis:** I am on that simply because I chair HESS, and so she did put the HESS chairs on the committee. We are not voting members of the Council, but we can [be influential]. I have been providing them bills that we introduce, and sharing information, and hoping they will go the right way. It is good that we are there, and I have staff there and we are taking notes and hoping that we are going to come up with real good recommendations to the governor when that time comes in January.

**AHPR:** Can you give me some assessment about how you think the Governor's Health Care Strategies Planning Council is going, and what do you think it's end product will be? Do you have any idea yet?

**Senator Davis:** It is kind of hard to say. We have had those three meetings, going into the fourth meeting. We haven't had public input yet. I think there's only going to be one time when they're going to do that. When you really look at it, can those people really make all the decisions that need to be made in health policy? No, they can't. They have all this material and they're working really hard, but people are not satisfied about who's on it, [some people think] it should have been so many more people on there, so this is just the beginning. It is going to have to be an ongoing Council looking at it. But I think what it's going to do is at least get us on the path. First of all, you've got the governor at the top saying, "We are going to do something about it." That's good, that's better than pushing it up that way and then she's not ready for it. She says she's interested.

First of all, we need to look at what we have, and there are some components that we are going to keep--Medicaid, Medicare. They are there for a reason, and Medicare is one of the best-run programs the government has. That would be a good model for us. It is very low overhead. It is not like Medicaid because every state does their own thing with Medicaid. I don't understand our system and I've served six years on the House side and seven years over here, and I still don't know all the things that we have. We are employing a lot of people, nonprofits and other public service agencies to do our work, and you've got all these things out there, but I don't know that system well enough to know, have we done everything that we need? No! No, because we have been worried more about cutting then worried about making it work, and now even [with] the nonprofits that want to help us out and the community health centers--we do not put one dime into them at the state level, we don't give one penny.

**AHPR:** I noticed you were a prime sponsor of a bill to do just that.

**Senator Davis:** I have an appropriation [for Community Health Centers] in there from last year, because the governor didn't get it into her budget. I don't serve on Finance, but I felt strongly enough about it to put the bill in. I tried to get it into the capital budget, but we didn't get it there. I am hoping now that with all the exposure that they're getting, the governor is going to put it in her budget. Hopefully she's going to put some funding for it, and the appropriation for it is already there.

***"[Considering] all the money that we have, I am more interested in doing what's in the best interests of our people... Well, if that's all we're going to worry about, we don't need to be there!"***

**AHPR:** It seems like it might be more efficient to do direct funding of a nonprofit provider like you're suggesting than talk about health insurance which...

**Senator Davis:** That has got to be part of the mix, and that's already there and it's working. That's a low cost model and we ought to be doing something about it. The federal government is looking at, "Oh yeah, we are going to start cutting back," but other states are giving money to theirs, why can't we? [Considering] all the money that we have, I am more interested in doing

what's in the best interests of our people. I don't want to be one out there talking about "I'm going to save your permanent fund, and I won't touch this unless I come back." No, we can't touch the principle of the permanent fund, but we can't even use the interest earnings. We can, but we don't have the mind to do it. Everybody is worried about, "Oh, I won't get reelected." Well, if that's all we're going to worry about, we don't need to be there! But it is, because once they did put it out there and the people said, "No, leave it alone. We don't want you to do that," we haven't had the guts to try to do it again.

I wasn't there when they did that, but now they don't even want to do that. But some people are recommending that she use some of it. At some point we are going to have to get to that. We said we were saving the permanent fund itself for future generations. Well, a lot of generations passed since we started it. And the services needed for children--they are not going to stay children forever. We need to take care of these children while they are children--in the school, in health, in all the areas that we need to do.

The one thing I really feel good about when I was on the minority side [is that] I chaired what they called the Children's Caucus. At that time the Children's Caucus was really a Children's Caucus in the system. We followed every bill that was of importance to children and families, and we pushed for the funding that they needed. It worked very well. Over the last few years the Republicans took it over and it's been chaired. They have some meaningful meetings but they don't really concentrate on the children themselves. I always think that I would like to see us go back towards it. I tried to push some of the women towards seeing if they wanted to be co-chairs of the Children's Caucus last year.

It really didn't get off the ground that much, but the one thing I was able to do that I have been trying to do since I got down there is to have a women's caucus, but I've never been able to get the women to come together as Republicans and Democrats and say, "We're going to come together because there are some issues we can work on as a block regardless of whether we are Democrats or Republicans." Last year I was able to bring them together. We are down to 13. We had more, but 13 is better than none at all, and we do have a caucus now and I think it's going to hold next year and maybe will be able to endure some of those things and push it. I am hoping I can pick up an intern, and if I do I'm going to have an intern that will work strictly with the Children's Caucus to help push some of the medical bills through, some of the education bills through, the things that we need to do to make services better for our families and children. I am looking forward because they never have enough interns so you don't know if you are going to get one or not, but if I am fortunate enough to get one, that is where I'm going to use that position next year.

**AHPR:** I have heard you and perhaps one or two other legislators say that Alaska is not ready for single-payer or universal access to health care. Would you please explain to me why that seems to be a common feeling among progressive legislators in Alaska?

**Senator Davis:** When you say progressive legislators, well, you've got Hollis who has that bill out there. At the hearing you saw these conservative groups testifying, pretty much saying that's the way to go. I can see moving in that direction because that might be when the Clintons were there, trying to push health care. You see what happened, and when we had our own Jim Duncan who was pushing single-payer and all that back through the years. He was in the majority there for a while and then no longer. It didn't go anywhere. That's why I say the Bill that we have out there, there's only one, and I'm looking for other bills to come forward. I really don't know what they're working on because we haven't seen the pre-file bills, but so far that's the only major bill going in that direction. We don't have but 90 days. It might move from one committee to another committee, but it will definitely not be able to pass the House and Senate--not that I'm going to try to hold it up but there are so many unanswered questions that even the department is not able to give us the fiscal notes on the bill right now itself.

There are those that are saying, "That's the way to go." Even some of the unions are supporting it. There are others that might not support it. There are insurance companies that said it might work, but once we get into it we don't know what's going to come out of that. Is it something that needs to be happening? Yes, we need to be looking at it and we need to be looking at other models too. But I think when you are talking about what's going to come out of the [House], I

don't think they are going to say, "We want you to do this and use that bill as the model to get it done." I think what they are going to do is take incremental steps, saying, "We did look at our system to see what we could improve on, and Medicaid and Medicare, [and] what we can do to ensure more children." They might even push for making sure that we can insure all children, regardless. I don't know if they're going to do that but it's a possibility. That's a first step.

They might push something saying that we are going to do more for intervention and prevention. In the end it saves money, but you have got to educate the public about it. You've got all these things that have got to be done and bring all these people aboard so [you could do] early intervention, insure children, make our Medicare system better, Medicaid better, make sure that all those people that are not enrolled get enrolled, make it easy to happen, and be more supportive to some of the nonprofit groups. There are all kinds of recommendations that the Council can make that will not cost us a lot of money but could get us way above where we are now. So I am not saying, "Oh no, that can't happen," but it is not going to happen right away, but it will move it in a direction. The governor is new. She's just in there nine months or so and she's got three years to try to push some other policy issues through. I feel that there are going to be some good recommendations out of it, but will they have all the answers? No they will not.

***"They [bills] will get to Finance, they will make it out of HESS, make it out of Labor and Commerce, and make it out of the major judiciary, all those committees, and where do they go and die? Not in Rules, but in Finance!"***

**AHPR:** During the next few years, what do you think the big health policy debates will be? Do you think these debates will result ultimately in significant health care reform in Alaska?

**Senator Davis:** If we keep going in the direction that we're going now last year and what seems to be coming up in the next session, yes. We will be going in the right direction because it seems to be that it is not just a few legislators. It seems like all of us are interested in it at this point. The governor seems to be interested. The public is buying into it more saying, "We've got to do something!"

I am meeting today with this group, and they are interested in children's health care. They are pushing hard to make sure that Denali KidCare gets some additional money into it, and more people are going out there to be involved. You can't just leave it up to the six of us to get the work done. I think over the next few years you'll see a big change in health policy in the right direction. I really do believe that. She [the governor] is going to be there another three years and I think next year is an election year. You've got half of the Senate running. We are going to pick up some new people that I think will come in saying they are willing to follow that model.

We are also doing some other things. They had for the first time on the Senate side, which I have pushed for the whole time I was there, an Education Committee. Here we have health, education, and social services all in one committee. Some of the most powerful areas that we need to be dealing in, and you've got it in one committee. So this year they did a special committee on education. I've been asking that we have one on education, and then we came up with the task force, so that's moving in the right direction. They tell me that the House is going to bring back their special committee on education. That's good, so all that's moving in the right direction. Health and Social Services will probably always be together, and that doesn't mean that the education bills couldn't come through HESS, but at least you would have another group of people that are going to be looking at it also.

We just do business different because Finance has its role because they handle the money. Not only do they handle the money, we have some major bills that need to be passed. They will get to Finance, they will make it out of HESS, make it out of Labor and Commerce, and make it out of the major judiciary, all those committees, and where do they go and die? Not in Rules, but in Finance! They don't look at how good the bill is, they are talking about how much it costs. So they are going to hold back, "because we don't have the money to do that." It doesn't make any difference how good the bill is. You've got these seven folks up there who are going to control what we do in health care, education, and everything else, and that's just the way I say it's organized at this point, and it's got to be changed! It [should not be] done that way: that you are just going to leave it up to the Finance Committee to decide which bills will pass and not pass.

Go back and look at where all those major bills at you are talking about that didn't get passed and see where they are. They are in finance, not in rules.

Did you hear about that bill, the baby surrender [[HB 29 Safe Haven for Infants](#)]? All this talk about baby surrender right now, I've been pushing that baby surrender bill myself, and Gara. We are Democrats and we have never been able to get that bill through until we turned that bill loose and let it go to a Republican person and just go on it as a cosponsor. Then, when it finally came over to us, it was almost at the end of the session, but they are saying that the reason the bill didn't pass is because it is stuck over there in Rules because Cowdery wouldn't let it out, because she [Rep. Gabrielle LeDoux] didn't vote the way he wanted her to vote, or something like that. That might be true, but I'm not going to get into that argument because I don't know about that, but one thing I know is it didn't get there until the final minutes of the session. Besides that, the bill is still good and it's going to pass as soon as we get back down there. There are those now saying at least pick it up when we have the special session. I don't know if that's going to happen, but for sure it will get picked up in January and it will pass, but nobody seemed concerned about it when we were trying to get baby surrender in there. All these years and now all of a sudden it comes out they're saying they're holding it there in Rules and wouldn't let the bill go. But to be fair about it, it was very close to the end of the session when it got there.

Somebody's bills have to lay there, and then one thing about it, if I am going to have a bill to stay in Rules, I would want it to stay that year rather than next year because they die and have to start all over again, but it won't. It will go in January. That could be one of the first bills we have on the floor if they want [it] to be. I'll do everything I can to push for that bill to come forward. We have been wanting that bill for years. Every state in the union has it except us, so we are way off base. It's going to be interesting next year. I think we're going to have a good year. I am looking forward to it.

**AHPR:** I appreciate your passion on these issues. You have addressed this in part but I would like to ask you outright. What are your priorities for the coming legislative session?

**Senator Davis:** The main thing is hoping that the working group will hold so that we can continue the work that we have already started, at least to the end of the session. And of course my other interest is going to be health policy. I think we can make some big changes and make a difference there. I am looking forward to the recommendations coming from the education task force, and they are asking that another committee be formed in order to continue the work in that light. They are all my issues now. I am right here to the point now, where my second term is just about over, and I have to decide if I'm going to run or not run. If we keep going in the light that were going, and the things that I think are going to happen, it is a good time for me to hang around, because I have been pushing some of these issues for years, even before I got to the State House, just serving on the Board of Education and also the School Board, pushing these same issues that we are dealing with, finally coming to the forefront. It's a good time to be in the State House or the State Senate.

**AHPR:** I really appreciate your optimism.

**Senator Davis:** I could be off base but that's just the way I feel about it because I see changes taking place. It takes all of us, not just a few people leading the way and letting everything go by the wayside. We seem to be moving more in that direction. I don't think next year's election is going to make it worse; I think it's going to make it better.

**AHPR:** let me return if I may to the governor's Health Strategies Planning Council. It seems to me that there is a noticeable absence of any health planning body at the state level that's permanent. I think many other states have some sort of a state health commission, or some state planning body. Ours is very temporary. They only meet six or seven times and then it's done. I wonder if you could comment on whether you think it would be a good idea if the state had a more permanent health planning body.

**Senator Davis:** I think for sure we need that, and I do think that's probably going to be one of the recommendations coming from the Strategies Council. I think they already know that that's something that needs to happen. I can't say that's going to happen because they haven't sat

down and talked about all the things they're going to recommend yet, but that would be one of the things that I would recommend, and I believe it will come to the forefront, and we do need that. We do have a small population, but we do need that.

**AHPR:** Finally, is there anything else you would like to say to the Alaska Health Policy Review readership?

**Senator Davis:** I appreciate the fact that you did interview me. There are many issues that are very near and dear to my heart that I could talk about for a long period of time, but I do like the direction the [Alaska Health] Policy Review is going in, and I hope you will be quite successful. Not only will you inform legislators, because we do need to be informed and educated, [but] for the public it's easy reading, it's good reading, and it's valuable.

**AHPR:** Thank you.

**Senator Davis:** And I appreciate the fact that you have it and I hope we will all be able to support you by taking subscriptions to the Review.

***"[What is] needed [is] for people to come in with the attitude that they want to do what is in the best interest of the state and not necessarily for their own personal gain. To see that we are moving in that direction makes me feel good."***

**AHPR:** Any other closing statements that you would like to make?

**Senator Davis:** I'm glad to see that you are involved in this and I hope that you will continue to keep in touch with legislators as well as the Council to see which direction they are heading in. It's needed for people to come in with the attitude that they want to do what is in the best interest of the state and not necessarily for their own personal gain. To see that we are moving in that direction makes me feel good.

One of the things that happened when I came on was that people said, "You know, you are going to be in the minority," and I said, "Oh, that's not a problem. I was born a minority!" It's not a problem. I've never had a problem getting to where I am at this point and I think I'll be okay, but I will share this with you: one of the worst positions that I ever have been in is being in the minority in politics because they do put you in a box, the way we do it. If you are not in the majority you can't chair anything, and you are going to always have the lower numbers, and you are not always going to be listened to. It hasn't always been that way, but I can see now where it is kind of revolving and we are coming back to a place where I think Republicans and Democrats can work better together, and that is in our best interest. I hope we keep going in that direction.

**AHPR:** Thank you very much for your contributions to health policy in Alaska over the years, and thanks so much for taking the time to do the interview. I appreciate it very much.

**Senator Davis:** You are quite welcome. I was wondering when you were going to ask me for an interview... [Laughter all around]

**AHPR:** Well I did, and now I'm really glad I did.

--AHPR--

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## Update: SB 160 Mandatory Universal Health Care

### Introduction

On September 10, 2007, the Senate Health, Education, and Social Services (HESS), and Labor & Commerce (L&C) committees held a hearing on SB 160 Mandatory Universal Health Care. SB 160, sponsored by Senator Hollis French, proposes that all Alaskans acquire affordable health insurance. SB 160 is the only bill before the Legislature that attempts such an expansive change to the Alaska health care system and represents a major departure from current policy. September's hearing was the first and only one on the bill so far, and set the stage for further discussion when the Legislature returns to Juneau in January.

The meeting, led by Senator Bettye Davis, Chair of HESS, and Senator Johnny Ellis, Chair of L&C, also included Senators French, Bundy, Gatto, and Cowdery, with Representative Wilson calling in. Senator French gave an overview of the main components of SB 160 and explained his reasoning behind the bill.

The testimony before the Committee included several recurring themes and topics in the health care debate: patient categories as defined by how people currently pay for their health care, problems that are associated with changing health care and health insurance systems, and a general consensus that the system needs to change.

### Bill Presentation

Senator French explained that SB 160 is neither a government-run health care nor a single-payer system, two commonly referenced alternatives to the current health care system. According to the senator, about 100,000 Alaskans currently have no health insurance. Of those, approximately 60,000 are employed with no employer provided health care.

He explained that his bill is modeled after the Massachusetts state health plan, and that it would require all Alaskans to obtain a health insurance policy at a competitive cost. SB 160 contains three main components to counter the problem of uninsured Alaskans: the creation of the Alaska Health Care Board, the Alaska Health Fund, and the Health Care Clearinghouse.

The Health Care Board would be operated out of the Department of Health and Social Services (DHSS), and it would define essential health care services and certify private plans which meet the basic criteria. The Alaska Health Care Fund would assist Alaskans to purchase insurance by providing vouchers, based on need, to make it affordable. The Alaska Health Clearinghouse would provide information about health insurance products and will oversee the transfer of vouchers from the fund to an insurance provider selected by the individual.

Senator French referred to a chart that divided uninsured Alaskans into three groups and explained how the plan would affect each group. Alaskans whose income is below 100 % FPL, and who do not qualify for Medicaid, would receive a voucher to pay for health insurance. Alaskans whose income is between 100 and 300 % FPL would be issued a voucher that will pay a portion of the cost of the policy based on a sliding scale system. The remainder of the cost would be out-of-pocket.

Alaskans whose income is above 300% FPL would be on their own to buy a policy, but they could draw from a beneficiary fund deposited by employers. Senator French finished his presentation with a brief overview of his web site, which includes a calculator based on the Massachusetts health care plan, to help individuals figure out their expected monthly out-of-pocket policy costs.

Senator French took questions from the committee members. Responding to comments from Senator Con Bunde, he stated that members of the Health Care Board would be similar to the Board of Regents; that rationing of services is not expected because the bill is not socialized

medicine or single payer; and that healthy lifestyles should be rewarded.

Senator Cowdery asked for an explanation for the increase in medical care costs. "I wish I could give you a short answer," Senator French responded. "I just was this afternoon studying a recent ISER (Institute of Social and Economic Research) report on the high cost of medical care in the state of Alaska, and they could not pin it down. So, far be it from me to come in here and give you a twenty second answer on what it is." He continued, "I think you are onto something, I think it is the high cost of drugs and the high cost of medical care. We do enjoy some of the best medical care in the world, and we pay for it."

### **Testimony: National Experts**

Michael Tannen, director of Health and Welfare Studies at the Cato Institute, was the first national expert on health care to testify on SB 160. After talking briefly about his personal views on health care reform, he expressed his support for the principle behind SB 160. Mr. Tannen then strongly cautioned against a fully government-run system, citing a 2005 Canadian Supreme Court decision that struck down a part of the Canadian health care system policy that affected about 800,000 people on the waiting list that would live in chronic pain and/or die before being treated.

Mr. Tannen continued, saying that he had serious concerns about the proposed employer mandate in the bill. Employers are typically indifferent to the "kind" of compensation they provide and do not care how it is divided up. He said that employers pay a certain amount per worker, and if that amount increases without accompanying increased employee productivity, then employers will have to find other ways of reducing costs, such as lowering wages or the amount paid into retirement funds. Ultimately, Mr. Tannen warned, the increased cost to the employer will be borne by the employee. Later speakers would also raise this point.

Mr. Tannen also expressed concerns about the individual mandate. Requiring everyone to get health insurance is a violation of privacy rights, and that enforcing an individual mandate would not be easy--inevitably requiring a new series of regulations. While the Health Care Board would define what essential health care services are, Mr. Tannen guaranteed that special interest groups would demand inclusion into that category. He said that the cost of that health care product would rise and that either the subsidy would need to be increased, or premiums would need to be capped--and capping premiums would lead to rationing care.

Another issue raised by Mr. Tannen was the expansion the subsidy level to 300% FPL because, in Alaska, that amounts to an income of roughly \$62,000 for a family of four, essentially expanding welfare to the middle class. He also said that the Health Care Board would act as a giant regulatory agency and add to the costs of insurance. He used some the Massachusetts board's regulatory decisions as examples: the requirement that all policies provide prescription drug benefits and the prohibition from offering high cost deductibles--which Mr. Tannen said are the kinds of policies people should really be buying.

Mr. Tannen concluded his testimony by saying that while states should be concerned about health insurance costs, most of what state governments can do would make the problems worse. He believes the problems needed to be addressed in Washington, D.C., where changes to the federal tax code and antitrust laws can be made. He suggested that Alaska do the following: repeal mandates rather than add them, allow associated groups to band together to get benefits usually only available to large employers, and try to bring down the cost of insurance. He said that the reason most people do not have health insurance is because they can not afford it and that the mandates and other regulations make health care policies even more expensive.

Answering questions from the committee members, Mr. Tannen asserted that about 50 percent of a person's lifetime health expenses occur in the last year of life. When asked how pre-existing conditions should be handled, he responded by recommending taking the small group of medically uninsurable out of the general pool and subsidizing them under a separate plan. He also suggests that adopting the approach that the purpose of health insurance is to spread out catastrophic health care costs--as opposed to providing routine, low-cost care-- would make premiums affordable for the young and healthy.

The current tax code, Mr. Tannen also said, rewards first-dollar insurance coverage and penalizes people who pay out-of-pocket. Health savings plans, he finished, are a way of equalizing the tax burden.

Next to testify was Edmund F. Haislmaier, senior research fellow at the Center for Health Policy Studies, the Heritage Foundation. He explained that the basic concept of SB 160 is to shift from a payer-centered system to a consumer-centered system. This, Mr. Haislmaier said, places the consumer in control rather than the employer, which is the typical hierarchy of a payer-centered system. There are two reasons a state might look to a consumer-centered system, he said: first, it changes the incentives because everyone would be working for the consumer; second, it introduces the concept of value, which is the relationship between cost and benefit.

"If you read, as I do, many of the discussions or studies, or participate in these programs, you very rarely hear the word 'value.' But value, I believe, is what is really key here, because value is the relationship between that cost and that benefit. And value is inherently subjective; it is inherently in the eye of the beholder, so I cannot make a value decision for you in purchasing a car for you or purchasing clothing for you. You may have a different equation than I do. And you most certainly will. It is very difficult for me to understand, and certainly to say--let's just randomly pick all the people at the front of the room--well, I'm going to make a decision for you as to the best value in your medical care. That would be impossible with eight. How are you going to do it with eight hundred?"

The easiest way to control cost, Mr. Haislmaier noted, is to not treat people, but this does not deliver value; the second easiest way is to cut payments to the provider, but that does not produce value.

Mr. Haislmaier said that the most important reason to move to a consumer-based system is to create incentives, and to reward doctors or insurance companies who provide value. He went on to explain that a consumer-centered system better reflects the economic realities of today. People no longer work for the same company their entire professional lives, and Alaska has a wide variety of seasonal and part-time labor options. This is a dynamic part of the economy that legislators should encourage, and a system of insurance that moves with the person encourages this economic vitality.

"When you look at the national data on the uninsured over time, you find that very few of these people are constantly uninsured," Mr. Haislmaier explained. "When you then look at that by income, the people who were predominantly covered, even though they had some experience with being uninsured over four years, the ones of those who were above 200 percent poverty [level], that's about forty-one percent nationally. And so the message to lawmakers is if you got the insurance to stick to the people instead of the jobs--and this will vary depending on your state--but plus-or-minus forty percent of your problem might simply go away. If people stop losing insurance, we stop creating a lot of new, uninsured people. That seems intuitively obvious, but we have been beating on this problem without thinking about it longitudinally for a long time."

There were several points in the Massachusetts plan that Mr. Haislmaier urged SB 160 not to follow: do not regulate employers; remember that the low-income premium support is a defined amount of money; and health plan standards should at least be set to comply with federal law. He added that creating a hybrid of a group market and an individual market would be the best approach for reshaping the insurance market.

Mr. Haislmaier told the committee that the first three goals of the Massachusetts plan were to make insurance more affordable for the middle class, to make insurance easier to get, and to subsidize the program with money that was already going to hospitals but with no accountability. This approach addressed mandates last, he said. He outlined several insurance issues, such as his concerns about community ratings and his preference for age-adjusted ratings with an accompanying risk transfer pool to address concerns that insurers have about getting stuck with a disproportionate share of certain illnesses or conditions. By simply creating the ability for people to choose, the market dynamic changes from seller-driven to buyer-driven. This basic change creates market demand because the consumer makes the choice about which plan to

pick and which provider to go to for treatment.

Mr. Haislmaier's final piece of advice was to forget about creating an ideal system at first. Instead, he said, put the information out there and invite interested entities to suggest improvements.

### **Testimony: Alaska Perspectives**

Jeff Ranf, president of the Alaska Association of Health Underwriters (AAHU) and Broker, Wallace Group Services, disagreed with Mr. Tannen, and said that states can provide solutions to the health care problem. He said the AAHU agree that monitoring insurers will bring forth quality and affordable products, and believe the Alaska Health Care Board is a crucial element for the success of SB 160. But, he cautioned, the board would need to have the authority to make hard decisions and solid recommendations, and should include employers, providers, federally funded program officials, public health officials, state chamber officials, and executive branch members. The board must also have a clear and concise agenda and be capable of making unbiased decisions based on the true needs of the state.

The uninsured population is just one part of the health care problem, he said, and many other factors are in play. Once we understand what is driving the costs, determining what it will cost to insure the uninsured will be easier. Funding will remain the largest concern, and he does not believe that passage of SB 160 will result in lower premiums. However, he believes that if premium increases can become more moderate instead of the current steady 15 percent per year increase, it will be a huge step in the right direction.

Mr. Ranf said currently people who do not have insurance but who want treatment go to emergency rooms. The cost for this is high, but providing insurance to the uninsured will not be cheap, either. He said that the reason health care is so expensive is because we as a nation are not healthy.

Karlene Jackson, Commissioner for the Department of Health and Social Services (DHSS), said that while DHSS could not comment yet on the points of the bill, they were preparing a fiscal analysis based on the fiscal note that accompanied the bill text. She added that she did think that once the Governor's Health Strategies Council concluded in January, that their ideas for short and long-term solutions would be beneficial to any bills being considered by the legislature. She expected future conversations to happen when those analyses are complete.

Ms. Jackson said that the Department is not too reliant on federal funding, but that Congress's continuing debate about the State Child Health Insurance Program (SCHIP) would certainly affect SB 160. She also stressed that the Committee make sure that access is more than just an insurance card--that it is genuine access to health care for Alaskans. Finally, she asked that the Health Care Board be based on the Alaska Mental Health Trust Authority, and not be placed as a division of DHSS.

Dr. Jay Butler, Chief Medical Officer for DHSS, had two comments: first, that he had not heard what perspective a physician might bring to the discussion; and second, that it would probably be impossible to reduce costs to Alaskans unless prevention is addressed. Dr. Butler said that there is no easy solution to the problem of the shortage of health care providers in Alaska, but he mentioned that current data suggest that physicians practice close to where they completed their residencies; Alaska currently only has one residency program.

Duane Heyman, executive director of Commonwealth North Alaska Healthcare Roundtable, urged the committee to keep two points in mind: first, "do no harm" by making the necessary reforms, but being careful not to jeopardize those who already have adequate health care; second, by making the real long-term goal to make Alaskans healthier, not just to get them insurance coverage. Mr. Heyman said that while the Roundtable favors universal health care, there are many factors to consider, and stressed once again that prevention is ultimately the best way to stem the high costs of health care.

Laile Fairbairn, managing partner of Snow City Café in Anchorage, and one of her employees,

Jesse Collins, offered personal testimonials about the human cost of being a small business and unable to afford to provide employees with health insurance. Ms. Fairbairn related a story about an employee who was diagnosed with cancer and how Snow City, unable to afford the premiums with the Café's income, resorted to fundraising to help the employee pay for treatment. Ms. Fairbairn said that while the restaurant grew in popularity and became more profitable, she was unable to find an insurance plan because of the employee's pre-existing condition. She said that Snow City developed a small pool from employee's wages that can be used to help employee's pay for health care.

Mr. Collins told the committee that he had aged out of Denali KidCare, the state insurance program for children under age 18, but that as a diabetic, he could not get coverage with a private insurance company. He said that Snow City has done as much as they can for him, but that he still needs help. Ms. Fairbairn said that Snow City would be happy to pay a percentage of its payroll to help fund the proposed program, and she believed that the program was an incredible opportunity for the state.

Joel Gilbertson, regional director for Strategic Development and Administration for Providence Health Systems, expanded on an issue raised earlier: emergency room use by uninsured people. He noted that Providence had over 70,000 emergency room visits last year, "and a large portion of those individuals coming in are self-pay, or uninsured, and that is growing. Our self-pay volume at Providence has been predictable for some period of time--and that's how we refer to people who do not have health insurance. But that's grown broadly. We have looked at, just from '06 to '07, we are seeing trends rapidly increasing. I can not tell you what is happening in the marketplace. What we know is on an annual basis, and certainly something over the last twenty-four months has really expedited that, but a large number of individuals coming in [are] unable to pay for their health care services. They'll still get the care, it is just not in the most efficient manner possible."

Mr. Gilbertson said that while he did not have specific numbers for the emergency department, about seven percent of all hospital patients are self-pay. He added that this year Providence is running at about nine percent, and that each percentage point increase represents about \$9 million in uncompensated care to the system. Those who are unable to pay still get care, he said, but it is not the most expedient manner.

Mr. Gilbertson said that there were three basic groups of patients: those with no insurance, those with a government benefit like Medicaid or Denali KidCare, and those with commercial insurance. He said that while the first two groups are growing, the third group is shrinking, but the cost of the health care system is constantly being pushed into that third group. The system is not sustainable, he said.

He agreed with Ms. Jackson that focusing on access is key when discussing health care reform, but if there is no provider willing to provide care, or if there is no provider willing to accept the insurance, then the coverage is not worth too much. He added that state-specific plans need to focus on cost control as much as access and coverage expansion. He said that there is no central database to see if a person actually has insurance or not, and added that Providence lists the total amount of uncompensated care and internally divides it up as either charity care or bad debt.

Patrick Higgins, human resources director for North Star Behavioral Health Systems, first reiterated Mr. Gilbertson's remarks about the three groups of individuals within the health care system. He noted that those who self-pay often delay seeking care until the problem grows worse, at which point it invariably costs more. He then cautioned that the impact of insurance for employers went beyond small businesses: as more and more employers drop their health insurance plans, the insurance pools shrink even smaller, which drives up the cost. Mr. Higgins said that when cost estimates for SB 160 are done, he hopes the cost of insurance to state and local employees and the growing numbers in Medicaid are taken into account.

Karen Rhoades, owner and operator of Northern Living Centers, said that she is a stakeholder in this issue on several levels: she is a health care provider, and employer, and a working Alaskan without health insurance. She urged the Committee not to be afraid of a mandate, but suggested

that it be capped. Ms. Rhoades also said that people will be more willing to pay into a program if the cost is reasonable, and said that if the state is going to make it impossible to be competitive then it has an obligation to help her as a health care provider.

Wayne Stevens, president of the Alaska Chamber of Commerce, said that the problem is that consumers want the "Cadillac" of health care, not just the basic services plus catastrophic coverage. Clearly, he said, health care issues force businesses to make tough decisions about how to provide benefits to employees while remaining competitive in the market, and that the fundamental problems are cost, quality, and management. Mr. Stevens urged the Committee to look at all the issues, and to pay special attention to Health Savings Accounts as a way to restore market discipline, and added that fixing health care would require an aggressive public/private partnership, and that the legislature must make sure out-year costs do not increase unchecked.

Vince Beltrami, executive president of Alaska AFL-CIO, said that while nearly all of the affiliated members of Alaska AFL-CIO had some sort of health insurance, the organization also speaks on behalf of other working Alaskans who are either without a union or are without basic health insurance. Mr. Beltrami said that while he was a trustee on the IBEW NECA Health and Welfare Plan, he saw double-digit increases in premiums with decreasing benefits, and he said that recent statistics show that elderly retiring Anchorage couples will need \$200,000 in savings to pay for their most basic medical needs. Mr. Beltrami added that he believed the biggest need at the moment is to de-politicize the issue of health care, and that regardless of which side of the aisle a person sits on, health care issues are killing everyone.

Pat Senner, MS, RN, ANP, on behalf of the Alaska Nurses Association, offered what she called a radical suggestion to helping solve the health care problem: reward people for living a healthy lifestyle. She noted that a problem with SB 160 is that only two of the eleven Health Board members would be direct consumers, and that all other members would have a vested interest in the health care system. She said the Health Care Board would need to have a better mix or be given less power. Ms. Senner said it was not clear if active and retired state employees, Medicaid, and Denali KidCare would be merged into the program, but if they were, it would represent about one-fourth of the state's population. She also mentioned that nurses are not mentioned in the provider category, even though they provide about 850,000 patient visits per year. She also suggested that committee members contract with primary health care providers to address the issue of billing, and she reiterated her request that nurses be included.

### **Closing Remarks**

Chair Ellis asked Mr. Tannen and Mr. Haislmaier if either of them wanted to respond to the testimonies given.

Mr. Tannen issued a word of caution about the discussion of uncompensated care: there must be a differentiation when talking about the charges versus the actual cost incurred by the hospital, as costs are not the same as uncompensated care. He also cautioned about focusing too much on preventative care because, while certainly good for the individual, it does not save money. He also agreed with Mr. Haislmaier that an employer mandated system would be too problematic. Finally, he urged caution in using the argument that people who do not have health insurance cost everybody money.

Mr. Haislmaier presented data related to the use of emergency rooms by categories of patients. According to his national data, the Medicaid population uses emergency rooms at twice the rate of the uninsured and elderly, and five times the rate of the privately insured. He explained that when states are faced with a budget crisis they have three options: they can throw people off the rolls, they can cut the benefits, or they can pay the providers less. None of those are good solutions, but paying the providers less is the least ugly, he said. If the solution used is that providers are paid less and they get to the point that they will not accept or can not afford to accept those patients, those patients go to the emergency room. If this is what a state is doing, he said, then the state has to ask itself if it is really saving money in its Medicaid program by doing this.

Mr. Haislmaier added that the Federal Employee Health Benefits Program is the closest thing there is to a consumer choice market. That system has consistently turned in cost control better than large employee plans even when adjusted for benefits.

Chair Ellis said that public testimony would be taken at subsequent hearings, and he welcomed all written testimony. He thanked all the presenters and several of the committee members expressed that the hearing was very helpful. With that, Chair Ellis adjourned the meeting.

--AHPR--

## Interview with Jerome List

*Dr. Jerome List DDS, MD, is the Alaska Medical Director of Mountain-Pacific Quality Health Foundation. The Foundation is one of the organizations mandated by Congress to monitor the quality of the Medicare program. In this interview Dr. List discusses a range of issues such as why Alaskan health care providers may refuse to see Medicare patients, why hospitals might have reimbursements withheld, and how Medicare issues intersect with state and municipal health policy issues in Alaska. Dr. List may be reached by email at [jlist@akqio.sdps.org](mailto:jlist@akqio.sdps.org), and by phone at 907.561.3202. The Foundation website is [www.mpqhf.org](http://www.mpqhf.org). Note that this interview has been edited for clarity and length.*

**AHPR:** Please tell us about your professional history and your current position with Mountain-Pacific Quality Health Foundation.

**Dr. List:** I am a private practice Ear, Nose and Throat surgeon. I came up here as a medical student and as a locum tenens--which is basically covering somebody else's office--until 1993 when I moved up here permanently. My training is a little bit diverse in that I finished dental school before I went to medical school. I have done some international work. I finished dental school in Costa Rica and I did a residency in oral surgery at the Pavlov Medical Institute in Russia--Soviet Union at that time.

I am very pro community-oriented. I think professionals need to fulfill commitments towards their communities, so I have spent a lot of time with community issues since I have been in Alaska, and probably will continue doing that. One of the reasons I was employed by Mountain-Pacific is partly because of my technology orientation. My medical office is a paperless office and I have promoted technology in the state of Alaska for a long time. I am currently the president of the Alaska Electronic Health Record Alliance, which is a grass-roots physician movement to try to promote electronic health records for all physicians in the state of Alaska.

**AHPR:** What is Mountain-Pacific Quality Health Foundation?

**Dr. List:** I will start out by explaining that a QIO (Quality Improvement Organization) is basically an organization that is mandated by Congress to monitor the quality of the Medicare program. Because this is a monitoring program, it is done outside of the Medicare program and it is a hired process through a third-party company. In the case of the state of Alaska, the contract is held with Medicare by a company called Mountain-Pacific Quality Health Foundation. That company has been doing this type of work for many, many years in Montana, where the home office is [located]. There are actually four states that are together: Wyoming, Montana, Alaska and Hawaii. I am the medical director for the Alaska office.

When we say "monitoring quality for the Medicare program," we refer to a whole variety of issues depending on the scope of work. Medicare has three-year cycles called "scopes of work," and there are certain emphases on certain areas. Those areas cover nursing home care, home health care issues, hospital issues, and some outpatient issues. One of the strong issues for the eighth scope of work--which is what we are in right now--is promoting technology for the medical field. My background is probably one of the reasons I was awarded the directorship for the state of Alaska--because of my strong tendency towards using technology and promoting technology for the community.

**AHPR:** How big is the organization here in Alaska?

**Dr. List:** It is a small office, relatively speaking. The company, I believe, has a total of 120 employees throughout the four states--somewhere in that neighborhood. In Alaska we have six or seven full-time employees. There are several parts to the contract. There is a Medicaid portion to the contract because the federal government also subsidizes the Medicaid program. We do not have control over the Medicaid portion, only the Medicare part of that. There is another company; it was actually our successor in Alaska, called Qualis. They are out of Seattle and they are responsible for the Medicaid portion of the contract.

**AHPR:** Who do you work with in Alaska--organizations, not necessarily individuals--and what is the nature of your involvement with them?

**Dr. List:** Essentially, I work with anybody who has anything to do with Medicare recipients: hospitals, private doctors, clinics, nursing homes, home health organizations. We still do peer reviews, so sometimes we will actually do some peer review cases from out of state because of neutrality, especially in smaller communities. If you have a town of three practitioners, you do not want one of the practitioners in the town doing the peer review for the other two. So sometimes things will come from out of state for us to review, but most of my contacts and interactions have to do with those groups that I mentioned--hospitals, nursing homes, physicians. There is no one single week where I do exactly the same thing. It really depends on what the demands are for that week, and again, my job is mostly to interface with physicians.

**AHPR:** Would this be physicians that see Medicare patients? If some facility or physician does not see Medicaid patients, would you have any involvement with them?

**Dr. List:** Relatively little. For instance, we have fairly little to do with pediatricians because Medicare recipients amongst the pediatric community are fairly small.

***"A lot of physicians are not very enthusiastic because this is being "shoved down their throats" or "is being promoted by the federal government," when in reality, all of these programs are based on medical scientific information."***

**AHPR:** Would a physician or a hospital hire you? What is the nature of the relationship?

**Dr. List:** No, I am hired by Mountain-Pacific, and my job is to come into the hospitals and help them with their quality improvement programs. You are probably aware of some of the quality issues that are being promoted at the hospital level. There are essentially two groups. One is called SCIP, or Surgical Care Improvement Program, and the other one is called ACM, or Appropriate Care Measures, which have to do with certain parameters pertaining to congestive heart failure, myocardial infarction or heart attack, pneumonia, community-acquired pneumonia, and what have you. There are certain guidelines that are being established and these hospitals are being asked to comply with this. As a matter of fact, the information regarding these programs is now being aggregated and posted on a public web site where any citizen can watch that, and that is [hospitalcompare.org](http://hospitalcompare.org). Any citizen can look at those parameters and there are very good explanations on the web site as to what some of those parameters mean.

A lot of the problems that we have had [involve] incorrect reporting or convincing physicians that we need to document [for example] the administration of aspirin when a patient comes into the emergency room with an acute myocardial infarction, or with a heart attack. That is an important parameter. There has been a lot of education and a lot of promotion to try to get physicians to endorse these programs. These programs of quality, actually, affect everybody in the hospital. We need to be, I think, repetitively going to these hospitals to show people the importance of this.

A lot of physicians are not very enthusiastic because this is being "shoved down their throats" or "is being promoted by the federal government," when in reality, all of these programs are based on medical scientific information. It is not just the government saying, "Well, we think it would be a good idea to do this."

I believe there are eighteen or nineteen different agencies who are actually bound together in

trying to get these medically, scientifically-based pieces of information to set up these programs [including] CDC (Center for Disease Control), CMS (Centers for Medicare and Medicaid Services), and so on and so forth.

**AHPR:** Can a hospital or physicians group refuse to see you or refuse to participate?

**Dr. List:** Very much indeed. It is a voluntary thing. I do not know of a hospital or of a physician group that does not believe in improving quality, but sometimes they do not see us as an ally in trying to promote that. Again, because some of these parameters are promoted by the federal government, sometimes there will be a little reluctance to think that that really is good. As a physician, basically the complaints that I often hear are [about] decreasing reimbursement and increased regulation. It is an algorithm--some groups are negative toward that. It is my job to let them know that no, it is not necessarily something that the government wants. That is the way health care is going and we feel that we should continue to improve quality of health. Quality of health is very difficult to measure, yet I think we need to start somewhere and start promoting this.

Obviously, I think now with the public reporting, that is some pressure from the outside because patients can look at that information and say, "Well, I am not going to this hospital because they do not have very good ratings on there." I would still caution people at this early date [that] I do not think the data is as reliable as I would like to see it; however, it is getting better all the time and I think that hospitals are starting to understand that this is important, and the reporting tools are, perhaps not perfect at this point in time, but we are moving in that direction.

**AHPR:** Does Mountain-Pacific interface in any way or any potential way with state policy? I ask because Medicare is entirely a federal program. Is there any possible or actual relationship between what the state can do to interface?

**Dr. List:** That is kind of a broad question but I think there are a number of public health issues that are going to cross paths here. One thing that might come to my mind for instance, is the issue of the stroke prevention program--basically educating folks around this state to look out for certain signs for an impending cerebral vascular accident, or stroke, and get those patients into the hospital as soon as possible where there are some medications called TPA, which if administered in the first ninety minutes of the stroke, greatly improve the outcomes of that stroke. But that requires a lot of coordination with a number of different agencies, so there are a number of issues where we need to interact very directly. Nursing home care for instance, even though the recipients may be Medicare, the state has responsibility for monitoring the quality, the inspections, and so on and so forth. They are reviewed so some of the interactions that we may have with the nursing home care may help them. When the state reviews those facilities we are in good favor. If we help them but [if] we are not in compliance with the state that is not going to do them very much good.

**AHPR:** There is a lot of anecdotal information about physicians and other providers refusing to see patients who are insured under Medicare.

**Dr. List:** I think it is more than anecdotal and it is not hard to understand why. What happened in Alaska was that for the years 2005 and 2006, Senator Stevens was able to get a special dispensation for reimbursement for physicians seeing Medicare patients. That program ended at the end of 2006. Now, around the country, physicians were very unhappy about a four percent drop in reimbursement that Medicare was going through nationwide. In Alaska, we had a 54% drop in reimbursement because that program went away. Unfortunately, that triggered a lot of physicians ceasing to see Medicare patients.

Even though things were not exactly where I would like to have seen them, after the turn of the year in 2007, things got very much worse, and so physicians stopped seeing Medicare recipients for a variety of reasons, but basically reimbursement was a very strong one. You simply cannot afford to pay your overhead if you are seeing Medicare patients and of course, that is probably more of a problem in the primary care area where practices sometimes had a large volume of Medicare patients. In my practice--I have not looked at the numbers exactly--but probably six or seven percent of my patients are Medicare--maybe more. So I can afford to

absorb that but if it was the majority of my practice, I can not pay my overhead. I simply can not live with that. So the real crisis is perhaps more in the primary care area, getting people in to see physicians in the primary care area. I do not have numbers but I know it is a real problem.

***"There may be some other groups, but I think physicians are the only group in the United States that are required by federal law to work for free."***

**AHPR:** Is there any policy at the state level that could in some way improve this situation? For example, I understand that in some states--in order to practice medicine in that state--you have to guarantee to see some share of Medicare patients.

**Dr. List:** In Massachusetts, [they] actually attached the license to an obligation towards seeing Medicare patients, and I do not think any physician in this country has ever thought that is a good idea. That has been in place for a long time. I think you are going to develop a real negative feel from physicians. I am not entirely sure that policy-wise, that that is really going to be an effective way of doing that. I think for a majority of physicians that that is not a particularly effective way of doing it, you know, forcing people to see patients at a loss. As a matter of fact--I say that with some amount of resentment--and I want to qualify that: I am a very community-oriented person. I am more than glad to work for free. As a matter of fact, I am a founding member of Anchorage Project Access, which is basically an organization designed towards getting physicians to donate their time. So I donate a lot of time.

But in the federal arena there is this law or series of laws called EMTALA (Emergency Medical Treatment & Labor Act) and basically the federal government requires me to take calls in the emergency room and requires me to see patients who have no way of paying. Yet, again, they make no form of reimbursing me, so far as I know. There may be some other groups, but I think physicians are the only group in the United States that are required by federal law to work for free. The federal government says, "You will work for free because you will be under high level of penalty if you do not see these patients in the emergency room. You will work for free," and there is no provision whatsoever to reimburse. Now all the patients that you see when you are on call in the emergency room are not necessarily no-pay patients, but some of those may be Medicaid or Medicare or what have you, but if it is a non-paying patient, then basically you will see them for free.

**AHPR:** In terms of the providers not seeing Medicare patients here in Alaska, what would fix that?

**Dr. List:** Well, there has been a lot of discussion. I remember a number of years ago, actually I was president of the Alaska State Medical Association at that time, and this issue about Medicare recipient access to care has been a long standing problem. I met with the head for the Centers for Medicare and Medicaid Services federal representative for the state of Alaska and we had a breakfast and the key item around that meeting was access to care. So we are going to sit down, I am the president of the Alaska State Medical Association; she is the regional representative for CMS. She is concerned about access to care so we are going to have a breakfast and see if we can hammer something out. And as we are sitting down to breakfast, she said, "You know, I am very interested in this topic but I just want you to know that I have no control over the reimbursement issues for Medicare recipients. That is all mandated by Congress and I have no control over that." And I said, "There is little that we are going to be able to talk about. I may not agree with the physicians in the state of Alaska but I am here at this table today representing them and I can not ask them to work and to provide services at a level that they can not pay their overhead expenses. I can absorb that in my practice but I am representing the physicians in the state of Alaska."

My personal idea, and again I am not a high-level economist, but the thing that I have thought of which makes sense to me, is that if physicians could be given a tax credit for the patients that they see, then no money would actually be exchanged but there would be an incentive for those physicians to be able to see those patients. It is not like the state is paying them, or the federal government is paying them anything additional above and beyond the established fees for Medicare, but it would give them some incentive to be able to do that. I am sure the IRS would not be happy about that, but essentially no money would be flowing from anybody's pocket and

that would certainly be an incentive for them.

There was a group of physicians who met with Senator Stevens. I was not invited to that meeting--that was about six months ago--[they were] trying to bring up some ideas. I think the core recommendation [that] was made to Senator Stevens at that time was to allow balanced billing. In other words, to allow the patients to pay the difference for what Medicare does not. I do not know really what has happened with that. I will have to say Senator Stevens has been very interested in this issue. Senator Lisa Murkowski has also met with a group of physicians--I am going to say this spring--in trying to get some ideas on how to deal with this. So it is not that there has not been some attention, but I have not seen specific solutions that would really work for this.

In all honesty, this program that Senator Stevens has, I think in good faith, tried to incentivate by increasing the reimbursement for the state of Alaska, which was a trial program for two years, in the end was probably more damaging than beneficial because when that 54% drop in reimbursement came about, physicians just stopped seeing Medicare patients. I mean it was a disaster, at the end of the two years I think the situation was worse than where it was when we started with that reimbursement. I think those were lessons learned and I think the intent was good.

We still have not resolved the problem; we still have not even come close to resolving the problem. As a leader in the community, it is hard for me to ask physicians to see patients for [free]. I ask them to see patients for free for the Anchorage Project Access but I can not ask them to see [patients who are sponsored by] a government program at a loss. I can only represent them and echo and carry on their voice, but I can not speak for them.

***"So, what happens to these thousands of patients who can not find a doctor to see them or who will not see them or whatever? Where do they go when their blood pressure starts getting sky high, or they have a headache, or their congestive heart failure gets out of control? Well, they go to the emergency room. That is a very expensive and ineffective way of dealing with health care..."***

**AHPR:** It sounds like, at the level of state policy, there is really nothing that can be done to help resolve this issue.

**Dr. List:** This is a federal program but the bottom line is that these folks live here in Alaska and some of the resources that they require essentially put a drain on some of the resources of the state. So, what happens to these thousands of patients who can not find a doctor to see them or who will not see them or whatever? Where do they go when their blood pressure starts getting sky high, or they have a headache, or their congestive heart failure gets out of control? Well, they go to the emergency room. That is a very expensive and ineffective way of dealing with health care and that is where this shifts over. I am sure that some of the resources are picked up by the state for instance; the hospital probably winds up losing money on that--so it does affect [the state]. I have not seen a lot of state involvement in that issue.

And is it their obligation to do that? I do not really know the answer to that. I still think that the state should perhaps help out a little bit more in thinking about that. They have got their hands pretty full with the Medicaid budget right now, but Medicare, that is entirely federally [funded]. So they have not had a lot to do with that. Having said that, I mean they are still citizens of the state of Alaska, who live in Alaska and have health care needs. I am not sure that I have thought out exactly how the state should interface with them, but I do think that by virtue of the fact that they do drain some state resources, perhaps indirectly or otherwise, that the state should probably have a little bit more involvement in that.

**AHPR:** In the last legislative session there was a bill so that the state would give the Community Health Center, at least the one here in Anchorage--I can not remember the details of the bill--a couple of million dollars to help facilitate them seeing patients. From what I understand they do see Medicare patients, so that might be one way that the state could have direct involvement in helping to resolve that issue.

**Dr. List:** Absolutely, and again it is just a shifting of cost to somebody, and that is why I struggle with the comment, "We want to talk about access but we can not talk about reimbursement." Unfortunately, somebody winds up picking up that bill because those people require health care and some of them will get some of it through the emergency room, which is more expensive, more ineffective, and does not have good follow-up, and it is just not a good way to get health care. So resources are being, I think, misused, that could be put to better [use]. That is where agencies need to talk to each other, where groups need to work together to be able to get some resolution to these problems. But they are interagency problems and often these agencies do not go out of their boundaries very well.

**AHPR:** Does Mountain-Pacific have anything to do with discovering or addressing Medicare billing fraud?

**Dr. List:** We are not involved in that directly. That usually goes to the OIG (Office of Inspector General).

**AHPR:** Does Mountain-Pacific in Alaska have anything to do with the reduction of health disparities? I noticed that nationally this is an issue that some of the quality improvement organizations get involved in. For example, minorities may have higher rates of diabetes than non-minorities. That is one way of looking at health disparities. Then there are access questions. Access is a lot more difficult in the bush than on the road system.

**Dr. List:** Absolutely. One program that comes to mind very specifically when you talk about this is a program [where] we are trying to measure what is called "cultural competency," mostly for providers. We are encouraging them to take some educational modules. The way that some of the programs work is that they develop these cultural competency modules and then we go out and try to promote physicians to take these modules and get credit for them and then register for them. Is that really the most effective way? I am not sure; I mean these things are difficult to deal with.

Probably one of our strongest supporters for that has actually been the family practice residency here in Anchorage because they are very diverse, they are very culturally sensitive, and they have promoted that very well. So they have helped us a lot [to] promote issues of dealing with the different cultural things that we have here. Access to care, again, has not been a specific topic that we have talked about--for anybody--I mean, and still understanding the target of our program is the Medicare recipients, so those are the folks we are looking at most closely. But unfortunately, access is not something we are looking at.

**AHPR:** it is not part of your contract?

**Dr. List:** It is not part of our contract. Again, whether I am wearing the Mountain-Pacific hat or not, it is still one of the prime issues I am looking at. I just think you can not measure quality if you are not providing health care. I still think that is the center piece of tasks that I need to be doing.

**AHPR:** Does Mountain-Pacific have any plans to become involved with Medicaid in Alaska as for example, the foundation has in Montana?

**Dr. List:** Some of that is a little bit of confidential information, but we had actually applied for the contract for Medicaid and there is some higher level dispute as to who is going to have the contract awarded to them. So I am not privileged to talk a whole lot more about that, except to say, yes, we are interested. No, currently we do not have the contract for Medicaid; that is run by Qualis. I am not sure what is going to happen in the future with that. It is probably out of my hands; I am not going to make that decision but we are interested in obtaining the Medicaid program contract for Alaska.

**AHPR:** If that were to happen, then it seems to me you would have more direct involvement with state policy issues because that Medicaid is a program that is heavily influenced by state decisions.

**Dr. List:** I would think so and again, I will have to apologize because we have not been involved with that program to date even though our sister-states have had that involvement. I have looked at a couple of things as to what that contract would look like and what our obligations would do, but I agree, I think we would have a lot more direct involvement with the state if that were to be the case. No question about that. Dr. Malter in Juneau is currently the Medicaid medical director and we have talked occasionally at meetings saying that if this contract does come to be, I will be on the phone with him a lot.

**AHPR:** What are some of the emerging issues and future plans for Mountain-Pacific? Perhaps Medicaid might be in there. Anything else?

**Dr. List:** We are close to finishing out our scope of work, so Medicaid may be dictating some of the main issues. I think the emerging issue continues to be promoting quality. These quality measures that we are talking about are being measured in hospitals. I think we will continue to expand. We are going to need to continue our support, our promotion of these issues. I would still like the issues of access to health care to have a higher [priority]--again, that is just my personal perspective--but I would like access to health care to be much more emphasized than it has been in the past. We have to meet and fulfill certain basic contractual requirements to be able to maintain our contract, so some of the directions may be, in fact, determined by Medicare. We do not know a whole lot about the next scope of work, which will come into play next year, but certainly, some of the direction will be predicated by Medicare [administrators].

***"If we feel that, in our reviews--again, some of the things we do are peer reviews--we periodically monitor charts in the hospital for quality issues--and if issues come out and the hospitals are not compliant, we have the power to withhold reimbursement of those hospitals."***

**AHPR:** Is there any aspect of the work that Mountain-Pacific does that might lead to, or result in sanctions against health care facilities or providers?

**Dr. List:** Well, actually, even though we are kind of the good will promoter of health care quality for the state of Alaska, we do actually have some power. If we feel that, in our reviews--again, some of the things we do are peer reviews--we periodically monitor charts in the hospital for quality issues--and if issues come out and the hospitals are not compliant, we have the power to withhold reimbursement of those hospitals. I do not like to talk about that because I am promoting quality health care; I am not trying to act as the police. I am not going to act as somebody that has a big club. Perhaps a lot of folks do not even think of it, of us having that power. Again, I would like for quality to be a positive thing. I would like for it not to be a negative thing, especially at the hospital level. Most hospitals are not interested in getting into that kind of an adversarial [situation]. They understand very clearly that the viability of the hospital depends on reimbursement. Every hospital has a fair number of Medicare patients. Yes, we do have the power. The ultimate power is to withhold reimbursement if they are not in compliance. It is not something I talk about much in public, but we do have the ability to do that.

**AHPR:** Is there anything else you would like to tell the AHPR readership? Any final comments?

**Dr. List:** Perhaps just expand a little bit of my philosophical thoughts. This is not specific for Mountain-Pacific, but just as a community person. I think agencies that are involved with health care, and agencies that are not involved--because health care affects everybody in the community--need to work more closely together. I think this compartmentalization of agencies is just very, very difficult for the ultimate goal, which is to improve access to health care and to improve [the] quality of health care.

**AHPR:** Are you talking about state agencies or federal agencies?

**Dr. List:** Both. All agencies and I am talking about municipalities because health care affects everybody. How much involvement does a municipality have in health care? Well, they have been supportive of the Anchorage Project Access, but I think that they should be. As I mentioned earlier, the problem with access to care for Medicare patients affects everybody in our community, so I think we should be more tightly integrated in trying to help those people. I think

the disjointed health care system leads to high expenses, to the inefficiency of care, [and] that if we could improve some of those things we would certainly provide better health care for our citizens and reduce costs. Then of course, my ultimate passion is the utilization of technology to improve health care, which has been more difficult and more challenging than you might imagine. It is very, very difficult.

***"You may have heard of this term, called "pay for performance," which is basically where Medicare is going to incentivate physicians who have good quality measures..."***

**AHPR:** Is it difficult because of custom and habit by individuals, or is it difficult because of the technological issues themselves?

**Dr. List:** I think it is difficult because of customs and habits of individuals. A case in point, I could just quote some of the things when I talk to physicians about adopting electronic health record systems, even though the president of the United States has mandated that: "Gee, I have been practicing nephrology for twenty-five years and I have done just fine without it. Why should I change?" "Gee, I am going to retire in three years, why am I going to burden myself with this?" Well, I think that some of the programs that we are [looking at] for quality are based on being able to review some of our clinical measures, and what we are finding is that physicians want to do good and we are trained to do that--and there are bad apples in every basket--but essentially physicians want to practice good medicine.

What we are finding is that if you have an electronic system, that you can go back and review some of those parameters, you might find out that our quality parameters are not as good as we may have thought they were. I think an electronic health record is a lot more than just keeping charts out of the office. It is a way of promoting quality. It goes hand in hand with that, but there is a big resistance from physicians. Physicians will say, "You know, I have done it this way for many years." Physicians will say, "You know, with the number of Medicare patients, I can not even pay my overhead, how am I going to spend another twenty, thirty, forty thousand dollars on an electronic health record and decrease the productivity in my office on top of that, so that I can learn a new system?" There is a lot of resistance. There is a lot of reluctance from physicians.

You may have heard of this term, called "pay for performance," which is basically where Medicare is going to incentivate physicians who have good quality measures, and essentially it is going to be almost impossible to report or generate a report on those quality health measures unless you have electronic health records. So it is kind of a Catch-22 thing. In the early days I was under the impression that the "pay for performance" initiative was actually an initiative to promote technology because it is very difficult or almost impossible to report on those parameters unless you have some technology. There is a lot of discussion going on around the country in the arena of "pay for performance." I think it is acceptable to incentivate for quality.

The biggest problem that I see [with] "pay for performance" [is that] very sick, non-compliant patients are going to make [physicians'] numbers look bad. Physicians are going to shy away from seeing the sicker, more needy patients. That is one of my big concerns right now--that [physicians will] just stay away because [it] is going to make their numbers look bad even though they are supposed to be statistically adjusted numbers for the co-morbidities and the other levels of illness that the patients have. But I am so concerned about that issue. I think it is going to disincentivate physicians to see the patients who need [the] most health care.

**AHPR:** And might this "pay for performance" also exacerbate the current problem of providers often not seeing Medicare patients at all?

**Dr. List:** I think they are kind of different issues, as best as I can tell, because "pay for performance" is going to be spread out through a lot of other areas. Typically, what happens is when Medicare establishes a new trend or a new way of doing things, insurance companies start picking up on that so even though Medicare may be promoting the "pay for performance" program, you can bet that once this is up and going that insurance companies are going to follow suit. It will trickle down a lot farther than the reimbursement issues. I think insurance companies would like to adopt the reimbursement schemes of Medicare but they simply cannot

do that.

**AHPR:** Thank you, Dr. List, for taking the time to interview with Alaska Health Policy Review.

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## Money and Influence in Alaska Health Policy

This list of Alaskan lobbyists and their employers was compiled using the 2006 Subject Year End Summary from the Alaska Public Offices Commission. As of this writing, October 4, 2007, no 2007 Subject Year End Summary was available. Lobbyists have much greater access to legislators and influence on health policy than the average citizen, and the state regulates them very carefully because of this. Keeping track of who has this power - and on behalf of whom they are using that access and influence - is a necessary and important part of the health care debate in Alaska.

Names on this list were compiled based on certain subject headings as designated by APOC: only subjects with an obvious, direct health care connection were used, including "Health Care," "Pharmaceuticals," and general psychiatric or psychological issues.

<b>Name</b>	<b>Employer</b>	<b>Fee</b>	<b>Total Payments*</b>
Anderson Group	FMH/Denali Center	\$65,000	\$65,000
Betit, Rod	ASH&NHA	\$26,000	\$26,000
Bickford, Frank	American Academy of Ophthalmology	\$60,000	\$60,000
Bitney, John	Catholic Community Services	\$14,000	\$14,000
Bullock, Geoff	AK Physicians and Surgeons, Inc.	\$25,000	\$28,140
Carter, Patrick	GlaxoSmithKline	\$36,000	\$36,000
	Schering Plough-External Affairs	\$5,000	\$5,250
Evans, Robert	HealthSouth-AK Surgery Center	\$60,000	\$60,000
Fink, Linda	ASH&NHA	\$18,576	\$18,576
Ford, Michael	AK Native Health Board	\$57,479	\$58,050
Fuhs, Paul	AK Open Imaging Center, LLC	\$40,000	\$40,000
Fuller, Joseph	AstraZeneca Pharmaceuticals LP	\$1,963	\$6,102
George, John	AFLAC	\$15,050	\$15,300
Gillespie, Raymond	North Star Behavioral Health Systems	\$80,000	\$80,536
Gruening, Clark	AK Psychiatric Association	\$18,250	\$21,639
Hickey, Mark	American Cancer Society, Greatwest	\$25,000	\$31,290
Hughes, Shelley	AK Primary Care Association	\$7,980	\$8,707
Kelly, Tim	AK. St. Medical Association	\$36,000	\$39,486
Kito, Jr., Sam	AK Optometric	\$42,000	\$42,747
	Eli Lilly & Co.	\$48,000	\$60,106
Kubley, Don	Mat-Su Regional Medical Center	\$60,000	\$60,463
	Medco Health	\$11,122	\$11,122

Laubacher, Cynthia	Solutions, Inc.		
Lehmann, Waltraut	Premera Blue Cross Blue Shield of Alaska	\$252	\$252
Legislative Consultants	First Health Services Corp.	\$60,000	\$60,000
	Providence Health System in AK	\$60,000	\$60,000
Logan, Jeff	AK Chiropractic Society	\$15,000	\$15,000
Luby, Pat	AARP	\$105,749	\$112,175
McRae, Jack	Premera Blue Cross Blue Shield of Alaska	\$1,386	\$2,852
Miller, Charlie	AK Regional Hospital	\$54,000	\$56,284
	Psychiatric Solutions, Inc.	\$22,500	\$22,913
Mulder, Eldon	Geneva Woods Pharmacy	\$40,000	\$40,000
	Providence Health System in AK	\$60,000	\$60,000
	Wyeth	\$10,000	\$10,000
Munson, Myra	Yukon-Kuskokwim Health Corp.	\$0	\$0
Parish, David	American Heart Association	\$20,000	\$20,250
Patton Boggs, LLC	1-800-CONTACTS, Inc.	\$0	\$0
Reed, Ashley	AK Spine Institute	\$50,000	\$50,000
Reinwald, Jerry	Blue Cross Blue Shield of AK	\$63,000	\$63,000
Richards, Paul	Advanced Medical Centers of AK	\$0	\$0
	PHRMA, Inc.	\$31,000	\$32,038
Robinson, Caren	AK Pharmacists Association	\$15,000	\$15,000
Schlatter, John	TAP Pharmaceuticals	\$9,000	\$9,000
Stoops, Reed	Aetna	\$50,000	\$50,250
	America's Health Insurance Plans (AHIP)	\$15,000	\$16,750
Walsh, John	AK Psychological Association	\$8,000	\$8,250

\*Includes reimbursement expenses but does not include Schedule B expenses

--AHPR--

## Health Policy Calendar

October 15, 2007-- <a href="#">Alaska Health Care Strategies</a>	<p>What: general meeting</p> <p>When: 1-5 PM</p> <p>Where: Alaska Native Tribal Health Consortium Office Building, 4000 Ambassador Drive,</p>
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<a href="#">Planning Council</a>	<p>Anchorage</p> <p>Other information: call-in: 1-800-315-6338 Code: 7800</p>
<p>October 18, 2007 -- <a href="#">Presidential Candidates Forum: Health Care 2008</a></p>	<p>Who: Sen. Hilary Rodham Clinton (D-NY)</p> <p>What: Live webcast</p> <p>When: 2 PM ET</p> <p>Other Information: organized by the Federation of American Hospitals and Families USA</p>
<p>October 25, 2007 -- <a href="#">Presidential Candidates Forum: Health Care 2008</a></p>	<p>Who: Rep. Dennis Kucinich (D-OH)</p> <p>What: Live webcast</p> <p>When: 8:30 AM ET</p> <p>Other Information: organized by the Federation of American Hospitals and Families USA</p>
<p>October 25, 2007 -- <a href="#">Presidential Candidates Forum: Health Care 2008</a></p>	<p>Who: Sen. Joseph Biden (D-DE)</p> <p>What: Live webcast</p> <p>When: 11:30 AM ET</p> <p>Other Information: organized by the Federation of American Hospitals and Families USA</p>
<p>October 31, 2007 -- <a href="#">Presidential Candidates Forum: Health Care 2008</a></p>	<p>Who: Sen. John McCain (R-AZ)</p> <p>What: Live webcast</p> <p>When: 11 AM ET</p> <p>Other Information: organized by the Federation of American Hospitals and Families USA</p>
<p>November 1, 2007 -- <a href="#">Presidential Candidates Forum: Health Care 2008</a></p>	<p>Who: Sen. Christopher Dodd (D-CT)</p> <p>What: Live webcast</p> <p>When: 11 AM ET</p> <p>Other Information: organized by the Federation of American Hospitals and Families USA</p>
<p>November 7, 2007 -- <a href="#">Presidential Candidates</a></p>	<p>Who: Sen. Sam Brownback (R-KS)</p> <p>What: Live webcast</p>

<a href="#">Forum: Health Care 2008</a>	When: 10 AM ET  Other Information: organized by the Federation of American Hospitals and Families USA
November 12, 2007 -- <a href="#">Alaska Health Care Strategies Planning Council</a>	What: general meeting  When: 1-5 PM  Where: Alaska Native Tribal Health Consortium Office Building, 4000 Ambassador Drive, Anchorage  Other information: call-in: 1-800-315-6338 Code: 7800
December 3, 2007 -- <a href="#">Alaska Health Care Strategies Planning Council</a>	What: general meeting, open for public comments  When: 1-5 PM  Where: Sheraton Anchorage Hotel, 401 E. Sixth Avenue, room TBA  Other information: call-in: 1-800-315-6338 Code: 7800
December 3-5, 2007 -- <a href="#">Alaska Public Health Association (ALPHA) summit</a>  December 6-7 -- post-summit	What: annual summit meeting  When: all day  Where: Sheraton Anchorage Hotel, 401 E. Sixth Avenue, room TBA  Other information: summit title -- "Making Alaska Healthy: Individuals, Communities, Policies, and the Environment"

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