DRAFT MEETING MINUTES

COMMISSION ON HEALTHCARE AND HOSPITAL FUNDING

Meeting Date: November 10, 2015

Time: 10:00 a.m. – 2:00 p.m.

Location: Florida Gulf Coast University, WGCU TV Studio, 10501 FGCU Boulevard South, Fort Myers, Florida 33965

Members Present: Carlos Beruff, Chair; General Chip Diehl; Marili Cancio Johnson; Eugene Lamb, Jr.; and Dr. Ken Smith

Members Present via Telephone: Dr. Jason Rosenberg

Members Absent: Tom Kuntz, Vice Chair; Robert Spottswood; and Sam Seevers.

Executive Directors Present: Secretary Elizabeth Dudek, Agency for Health Care Administration

Interested Parties Present: Dr. Rett Alsbrook; Linda Christmann, LM Christmann Consulting; Peter Canglo, Lee Memorial Health System; Donna Clarke, Lee Memorial Health Systems Board; Therese Everly, Lee Memorial Health System; Dr. Lee Gross, Epiphany Health; Patrick Hale, Castlight Health; John Harries, Community Hospital; Robert Hawkes, Florida Gulf Coast University; Sally Jackson, Lee Memorial Health System; and Rich Rasmussen, Florida Hospital Association.

AHCA and DOH Staff Present: Nikole Helvey, Nathan Dunn, Mallory Deason

Media: Liz Freeman; Naples Daily News; Stephanie Susskind WINK News; Tom Lloyd, WINK News; Frank Gluck; Fort Myers News-Press.

Call to Order: Carlos Beruff, Chair, called the meeting to order at 10:00 a.m. and called the roll.

Review and Approval of Meeting Minutes: The minutes from the October 20, 2015 meeting of the Commission on Healthcare and Hospital Funding were approved with edits to clarify Commissioner Dr. Ken Smith from presenter Dr. Keith Smith.

Health Care Cost Institute

Dr. David Newman, Executive Director of the Health Care Cost Institute (HCCI) from Washington D.C., gave the commission a presentation on "Health Care Transparency and a New Era for Consumers in the US". HCCI is a non-profit, independent, non-partisan research institute dedicated to promoting research and information on the drivers of healthcare costs and utilization. It was founded in 2011 by Aetna, Humana, Kaiser Permanente, and United Healthcare; 4 of the largest commercial insurers in the US but independent of them. HCCI provides for research by holding claims, with allowed amounts, for more than 50 million Americans, from 2007 onward which they make available for academic, non-commercial research. To provide for better transparency, Guroo was created by the HCCI, with the goal of giving consumers information on the costs and quality of healthcare so they can make more informed choices about how they spend their healthcare dollars. Guroo is a consumer-focused website that provides national, state and local cost and quality information for common health conditions and services. The

website is free and accessible to everyone, regardless of whether they have insurance or who their insurer is. The cost estimates on guroo.com are developed using data which includes approximately 50 million American's claims data.

Dr. Newman reported that HCCI currently holds claims data on 50 million Americans. Among the types of claims held are administrative claims, including employer-sponsored insurance, individual insurance, and Medicare Managed care claims from all 50 states, and Washington D.C. The database is updated annually and is compliant with privacy and antitrust requirements. By the end of 2016, HCCI plans to hold claims from Medicare, Part A, Part B, and Part D, as well as claims from Medicaid and the Federal Children's Health Insurance Program.

Dr. Newman went on to report that HCCI does not engage in any commercial proprietary research for anyone. The data contributors do not gain access to the combined dataset. HCCI does not perform commercial proprietary research for the data contributors. All research is in the public domain and free. He stated that HCCI believes they are building out an essential part of the nation's health services research infrastructure.

Dr. Newman next discussed transparency. According to the West Health Policy Center/Rand Study, providing patients, physicians, employers and policymakers more information on healthcare prices could reduce U.S. healthcare spending by an estimated $100 billion over the next decade. HCCI appreciates that a properly functioning market for any good is dependent on "information" regarding prices and quality of goods offered to consumers. In the US, there are consumer advocates who believe that many of the problems with the US healthcare system are somehow a function of secrecy between employers (as purchasers), insurers, and providers and that these stakeholders' reluctance to reveal prices means that something bad must be taking place. However, research shows that price transparency can raise prices depending on local markets. Consumers need more than prices at CPT code level – episodes or bundles for complex services. Unless the payment models are changed, transparency tools are generally imperfect estimates. Generally, there is a low rate of consumer usage of price transparency tools.

Price transparency is important but not the silver bullet, only a subset of services is shoppable, discretionary, and schedulable. Good quality measures do not exist to encourage consumers to buy value. High levels of consumer engagement are required and sick consumers want to get better, not shop for a lower price. To encourage participation, consistent signals/incentives in US markets are required.

Dr. Newman set forth the following goals of a transparency initiative. First, create a common consumer experience that is the private sector equivalent to www.medicare.gov. Second, provide consumers with cost and quality information, regardless of insurance status at no cost. Third, give consumers a credible, accurate data source through an independent nonprofit. Fourth, improve markets by providing accurate information to consumers; and finally, offer industry-wide portal to employers.

Some of the benefits of transparency are that it achieves economies of scale with a single source of consumer education that also has deep data to inform education. Transparency initiatives can serve Medicaid and Medicare managed care populations. The initiatives can drive standards on quality and cost; more reliable reported values through use of bigger data, and attract new partners around integrated delivery and new payment models.

HCCI's approach to transparency is unique in that it is offered by an independent, non-profit open to non-commercial collaborations; provides access to unparalleled data set; transparency requires a lot of data. The initiatives have the ability to bring together diverse stakeholders to gain consensus serving a public, non-commercial mission.

Dr. Newman reviewed the key consumer features to the HCCI transparency initiative. First, it is free to all consumers, whether insured or uninsured. There is no registration, password or user identification required. It provides geographic-specific data at the national, regional, state and metropolitan areas. The data reflects actual costs as well as relevant quality content.

The transparency tool allows consumers to search by condition or treatment; see average prices paid for care, treatment and procedures with descriptive statistics, see treatment steps, see questions to ask a provider that will help guide to a quality outcome and print the results.

Assembling and analyzing data is not easy and not cheap, as there is a limit to the return on data – give thought to how you are going to use the data. In order to maximize the return on investment (ROI), take advantage of economies of scale and scope; partner with other states and other stakeholders to bring down costs; align methods.

Do not presume that if you build it, they will come; if you collect it, it can be used; if you analyze it, it will be useful; or that telling someone a result, will make it actionable or attractive. It is not that easy. Driving behavioral change on the part of consumers, providers, and institutions requires more. This is the most difficult part.

Privacy and data protection is critical and it goes beyond legal requirements (which go beyond HIPAA) because, citizens are correctly concerned about what you are doing with their data; perhaps more problematic is what licensees may be doing with the data. Data can inform decision-making and direct inquiry; however, it does not always provide clear guidance as to how to respond, particularly in complex systems. HCCI has been finding high growth in EDs, spending on children, the use of psychotropic drugs. Appropriate policy responses to these issues, are not necessarily clear.

Licensing data is not easy nor is it necessarily a money-maker. Real thought needs to be given to who gets the data and how they may use it; beyond what any statute says, how do you want the data used and what does the public expect.

Price Gouging/Public Comment

Secretary Dudek introduced Mr. Dixon. Mr. Dixon shared a story about an injury that his son received during a recent car accident. He said that they transported their son to the hospital themselves and were in an Emergency Department room rather quickly, and X-rayed rather quickly. Unfortunately the doctor took 3 hours to come into the room and tell them that the child's leg was broken. Once the bills began to arrive, Mr. Dixon was surprised at the different bills from the each of the different entities for the specific procedures or locale of treatment. He voiced that he didn't know of any other business where the costs don't have to be justified.

Commissioner General Chip Diehl noted that it would be interesting to look at the final bills to see what each entity is actually paid. Mr. Dixon said that the insurance companies were still sorting the costs and payments out.

Mr. Alan Voss also spoke to the commission about the rampant fraud in the entire healthcare system. Commissioner Marili Cancio Johnson stated that she had been given a more in-depth presentation in her office and she had suggested that Mr. Voss come to a commission meeting and present. Chair Beruff suggested that Mr. Voss come back to present, but to be on the agenda as an agenda item.

Mr. John Harris spoke to the commission regarding care and costs for inpatient and outpatient care. He stated that hospital inpatient care is only needed for certain cases. A lot of procedures can be performed outside of the hospital setting and costs are significantly less. His recommendation for lowering costs is to encourage patients to use outpatient centers.

Castlight Health

Mr. Patrick Hale told the commission that he is an Enterprise Healthcare Manager from Castlight Health. He spoke to the commission about transparency and the advantage a consumer has if they can see the exact, personalized and actionable pricing, a comprehensive insight into quality variation, an unbiased education tailored to search, with search perimeters fully personalized for each employee and provide an engaging & unified user experience. He gave an example of a large manufacturer who was spending too much in healthcare. The company partnered with an urgent care to provide healthcare at all hours. Castlight has also invested in telemedicine to provide healthcare outside of the provider's location.

Castlight offers key differentiators that lead to immediate, meaningful engagement. First they provide a hub for healthcare; only vendor to integrate medical, pharmaceutical, dental, behavioral health and other vendor information on web and mobile. Secondly, they provide uniquely robust data arrangements; only vendor with web services arrangements. Third, they have a best-in-class reporting infrastructure; only vendor with real-time employer dashboard and self-service reporting. Fourth, their proof points with the State of Texas ERS peers; only vendor with engagement and return on investment proof points among economic research service peers. The program can easily support 400,000 new members, with no scaling required.

Mr. Hale showed a graphic with numerous vendor organization relationships. As an example, Mr. Hale spoke of an employee who needed to have a back surgery. He showed the commission a graphic of the multiple tools available throughout a patient's treatment that keep all of the physicians and therapists in the loop. Mr. Hale said that what you see with claims data 6 months after the fact is that an employee received back surgery.

Mr. Hale reviewed some of the trends that Castlight has observed, such as the types of things women search for as opposed to what men search for to determine what marketing plan should be followed. He shared a story about Google tracking the flu based on the different searches coming from geographically different locations. Mr. Hale listed some of Castlight's public sector clients; they have over 60 Fortune 500 clients.

Direct Primary Care

Dr. Lee Gross, founder of Epiphany Health and President of Docs4PatientCare Foundation spoke to the commission about affordable direct primary care. In 2010 Dr. Gross began to use direct primary care in his practice. His patients would pay a monthly fee, like a membership, which covers all care provided by the physician. The membership includes comprehensive primary care and wellness services, as well as access to a steeply discounted network of labs, imaging, specialty care, physical therapy, and pharmacy access.

Dr. Gross listed some of the benefits to direct primary care. The expenses of guaranteed services are covered with first month's dues. The net revenue was realized with dues over remaining 11 months. The reduced overhead optimizes net revenue. He stated that a direct primary care model, like Epiphany, can be added to an existing practice. He noted that it is the third party disconnect from costs which makes healthcare so expensive. Dr. Gross listed several tests and procedures that are offered at extreme

discounts, or are covered under the patient's membership. The business has a price list available for every type of service.

Dr. Grows reviewed a hospital bill and compared the pricing to Epiphany's pricing. He showed a hospital bill totaling $19,723.27 and said that Epiphany could have provided all of the services the patient received at the hospital for $278.79. He stated that the difference in costs is the difference between the cost of care and the cost of coverage.

Next, Dr. Gross compared Epiphany's coverage to an insurance policy for a family of 4. Epiphany charges $135 per month to be treated by Epiphany, and an average insurance company charges $1,935 per month, for a savings of $21,600.

Dr. Gross closed by telling the commission that the Florida Legislature has filed legislation on direct primary care; House Bill 37 by Representative Costello and Senate Bill 132 by Senator Grimsley. He mentioned that the Washington State has a direct primary care pilot program with approximately 3,500 patients and the federal government is looking at a Medicare pilot program. These pilot programs with wrap around bundles with catastrophic insurance policies are allowed under the Affordable Care Act.

Chairman Beruff inquired how many visits were allowed annually with direct primary care. Dr. Gross responded that each patient can see the provider up to 25 times per year. Visits beyond 25 would cost the patient $25 per office visit.

Ultimately, legislation that will allow direct primary care membership as a benefit for public employees; create a direct primary care Medicaid pilot program; and expand availability of stop-loss coverage for self-funded health plans is what is needed. The legislation must clarify that direct primary care is not insurance. There are 13 states that have laws pertaining to direct primary care. There is pending federal legislation by Senator Cassidy that clarifies the tax determination for a direct primary care so it can be used with a health savings or health flex account. The legislation also includes a pilot program for Medicare participants participating in direct primary care.

Secretary Dudek asked why Florida legislation is necessary if it is already legal. Dr. Gross responded that in all 13 states, their Office of Insurance Regulation has challenged the legality of the practice. While every state that a challenge has occurred in, the state legislature has passed legislation to allow the direct primary care model. So while Epiphany does not doubt the legality of direct primary care, they don't want to end up in litigation.

Chairman Beruff asked if the patients pay one month at a time, or annually. Dr. Gross responded that 97% of the patients pay monthly which reduces the risk greatly. Commissioner General Chip Diehl asked for a listing of the 13 states that have passed legislation on direct primary care so that the commission could follow up and speak with the other states for their experiences. Commissioner Diehl asked when the legislation was passed in the other states. Dr. Gross replied that all had passed during the last year. He noted that he had assisted in passing the bill in the State of Michigan. Florida's pending legislation is loosely based on Michigan's bill.

Commissioner Marili Cancio Johnson asked about liability, and if the practice could make enough money to pay for a team of lawyers. Dr. Gross answered that that is why he is pushing for legislation rather than going to court to defend the practice of taking money from patients for treatment. In regards to medical malpractice liability, the risk is the same as any other physician. He noted that he does not personally work in hospitals, which greatly reduces the risk.

Dr. Smith stated that he has discussed this with other physicians who provide concierge medical services and that the physicians who are charging less for the care are actually making more than they would be if they were taking insurance. He noted that part of the problem in Florida with primary care, is that new physicians don't want to go into primary care because they won't make enough money to run a business, while paying back student loans. Dr. Smith asked what the difference was between direct primary care and concierge care. Dr. Gross responded that concierge practices charge the insurance companies as well as requiring the patient to pay for a membership.

Commissioner Johnson asked about prescriptions. Dr. Gross answered that Epiphany has worked with local "mom and pop" type pharmacies to get lower prices on medication. Epiphany has a computer application that lists the price of every medication, so the patient knows that they can afford it and take it before going to the pharmacy. Dr. Gross will print coupons for the patients to take to the most inexpensive pharmacy.

Dr. Smith asked Dr. Gross what the barriers were keeping physicians from getting into a direct primary care. Dr. Gross answered that the fear of the risk involved is what keeps physicians from following the direct primary care model.

Chairman Beruff stated that by increasing access to primary care, the savings are found by fewer emergency department visits, fewer hospitalizations, because the patient's health is being cared for before there is a crisis because of the preventive medicine primary care physicians provide. Commissioner Johnson agreed and thinks that because the state is self-insured, it should look at direct primary care to save money and improve healthcare.

Commissioner Diehl suggested the commission consider the amount of money a small business could save by purchasing the memberships for their employees as opposed to taking out health insurance. He said to think about how much more a small business owner could invest back into their business. Chairman Beruff stated that the small business owners could take the savings and invest it in 401K retirement plans for the employees, providing two benefits for the price of one.

Dr. Rosenberg stated that while transparency has a vital role to play, he would like someone to help him understand how transparency will result in different human behavior. What has been observed in the past with transparency tools is that they aren't used. The patients don't seem to understand the tool's value.

Dr. Gross responded that transparency in pricing will only work if there is a market push. Simply posting prices doesn't solve the problem. Once there is competition in the market, the value increases.

Secretary Dudek told the commission that to move towards direct primary care, the legislature would have to pass legislation, and the Agency would have to get a waiver from the federal government because the practice model is not what has been approved. She told the Commission that more background on other states with direct primary care would be gathered and provided at the next meeting.

Closing Remarks and Next steps

Secretary Dudek told the commission that the "price gouging" letters had been redacted and placed on the website in similar topic groupings. She will bring the commission information about Florida's Health flex program. She told the commission about the primary care grant program.

The next meeting of the Commission on Healthcare and Hospital Funding will be held on December 1, 2015 in Tallahassee.

Commissioner Diehl inquired if there would be any workshops before Christmas. Secretary Dudek told the commission that there would be 4 speakers at the next meeting. Chairman Beruff suggested that the next meeting has 2 hours set aside for a workshop. Commissioner Johnson pointed out that the legislature is already meeting and she doesn't know what is in the legislation and wants to be informed. She also asked about a Medicaid shortfall. Secretary Dudek stated that there is no shortfall this year. She explained that the Agency is currently working with hospitals to determine the best way to spend LIP money this year FY 16-17. Next year, FY 17-18, there will be no LIP money.

Adjourn

There being nothing further to discuss, the commission adjourned at 1:33 p.m.