

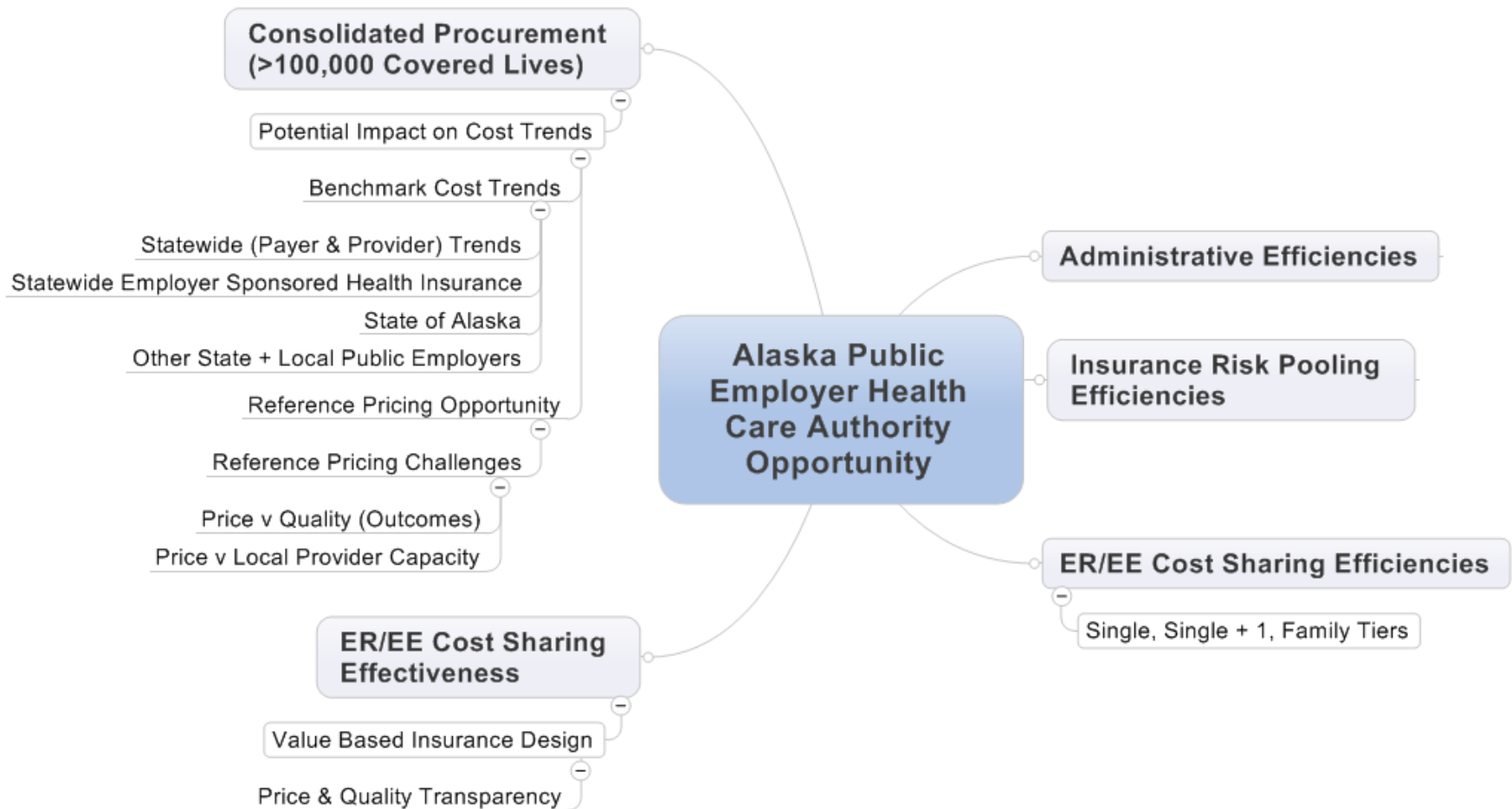
# Alaska Public Employer Health Care Authority

## Estimate of Potential Cost Savings

Developed for: State of Alaska Department of  
Administration, Webinar: September 13, 2017

Developed by: Mark A. Foster (MAFA)

# Topic Overview



Note: ER = Employer; EE = Employee

# Executive Summary

Potential Savings –

Figure 1

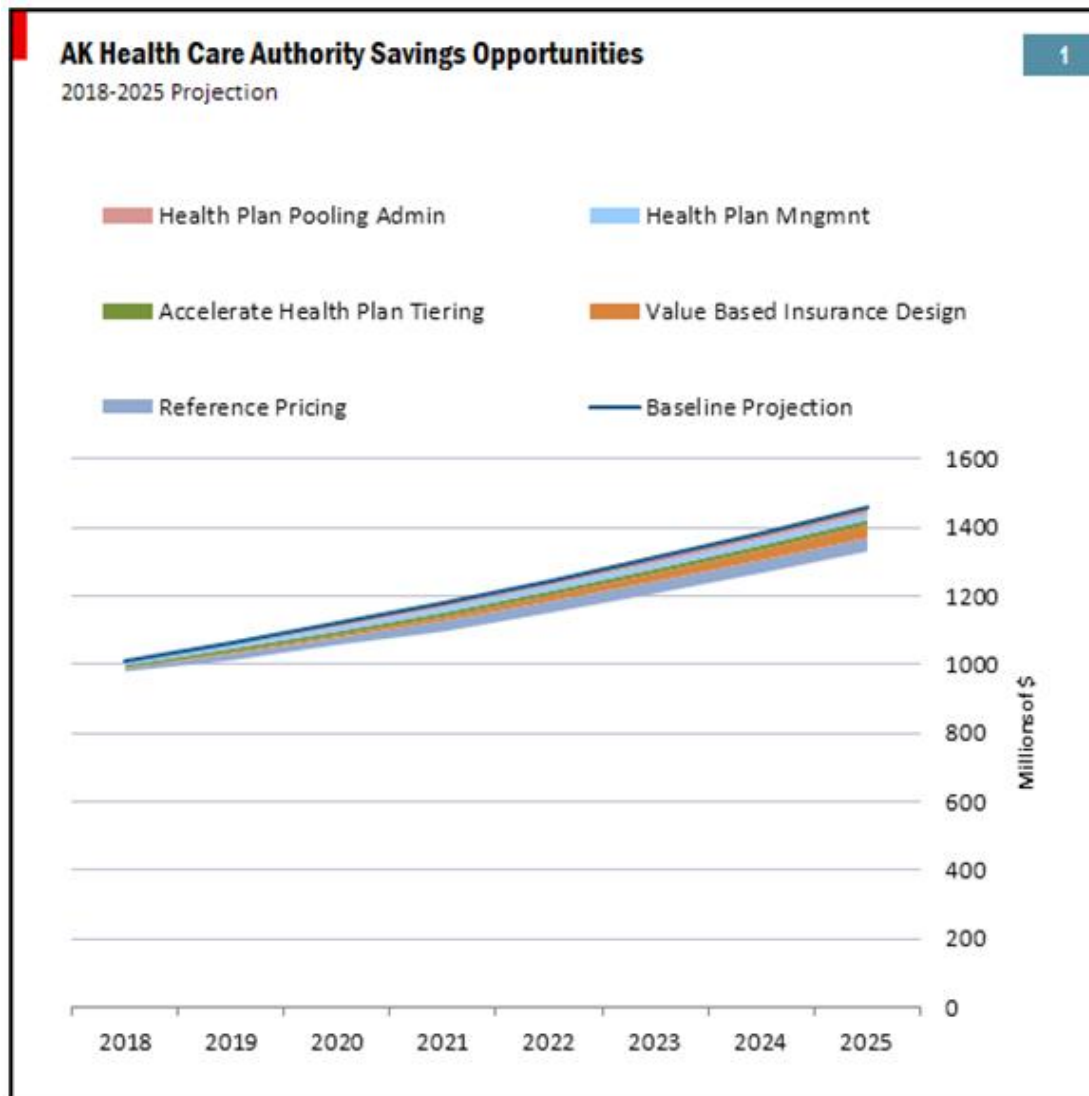
Savings grows to

~8.7% by 2025;

Aggregate

savings ~655 million

from 2018-2025



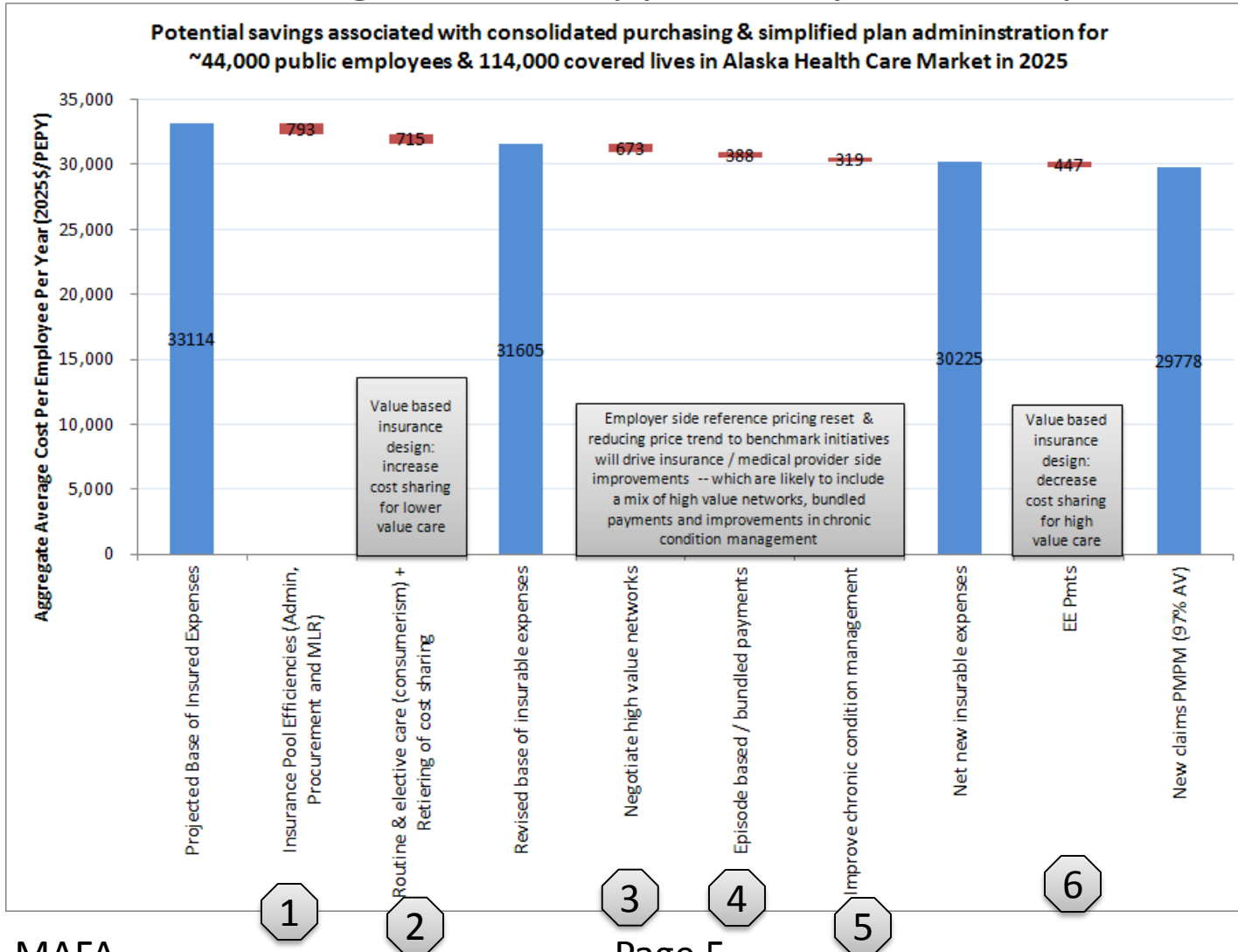
# Executive Summary

## Potential Savings – Table 2 (p. 12)

Line #	Alaska Health Care Authority - Summary of Potential Savings			2017	2018	2019	2020	2021	2022	2023	2024	2025	Cumulative Savings
1	Baseline Projection			millions \$	956.5	1,008.2	1,062.6	1,120.0	1,180.4	1,244.2	1,311.4	1,382.2	1,456.8
2	Baseline projection growth above 2017												1.52
Cumulative Savings v Baseline													
3	PRM	Health Plan Management	pct		0.9%	1.2%	1.2%	1.3%	1.3%	1.3%	1.3%	1.3%	1.3%
4	PRM	Health Plan Pooled Purchasing	pct		0.1%	0.4%	0.9%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%
5	MAFA	Reference Pricing	pct		0.9%	1.8%	1.9%	2.7%	2.7%	2.7%	2.7%	2.7%	2.7%
6	MAFA	Accelerate health plan tiering	pct		0.2%	0.5%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
7	MAFA	Value based insurance design	pct		0.2%	0.4%	0.6%	1.0%	1.4%	1.8%	2.2%	2.6%	2.6%
8		Savings v Baseline	pct		<u>2.3%</u>	<u>4.3%</u>	<u>5.6%</u>	<u>7.1%</u>	<u>7.5%</u>	<u>7.9%</u>	<u>8.3%</u>	<u>8.7%</u>	<u>8.7%</u>
9		Savings v Baseline	millions \$		<u>23.1</u>	<u>45.7</u>	<u>62.8</u>	<u>84.0</u>	<u>93.5</u>	<u>103.8</u>	<u>115.0</u>	<u>127.0</u>	\$655.0
10		Scenario 1 Projection	millions \$		<u>985.0</u>	<u>1,016.9</u>	<u>1,057.2</u>	<u>1,096.4</u>	<u>1,150.6</u>	<u>1,207.5</u>	<u>1,267.2</u>	<u>1,329.8</u>	
12		Scenario 1 growth above 2017											1.39
13		Reference Pricing Savings Estimate	pct		0.9%	1.8%	1.9%	2.7%	2.7%	2.7%	2.7%	2.7%	2.7%
14	MAFA	Price reset targeting reference pricing benchmarks	pct		1.1%	2.1%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
15	MAFA	+ Benchmark price trend reduction	pct					1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
16	MAFA	Offset by an increase in primary care utilization	pct		0.2%	0.4%	0.6%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%

# Executive Summary

## Potential Savings – 2025 Opportunity Summary, Fig 2, p. 18



# AK Health Care Authority Potential Savings

MAFA Table 2, Lines 3 & 4, based on PRM Coordinate Plan Admin & Pooled Purchasing Estimates

PRM, Phase 2 Report, Coordinated Plan Administration, p. 38

- 1) Reduce/eliminate claims fluctuation margins
- 2) Reduce administrative costs & fees
- 3) Reduce/eliminate “stop-loss” insurance
- 4) Reduce plan administration complexity of annual administrative tasks, e.g., rate development, plan communications, eliminate redundancies and inconsistencies in periodic billing and procurement
- 5) Savings =  $1.5\% \times \$1.192\text{B}/114,000$  members  $\approx$  \$157 pmpy

PRM, Phase 2 Report, Pooled Purchasing Function, p. 38

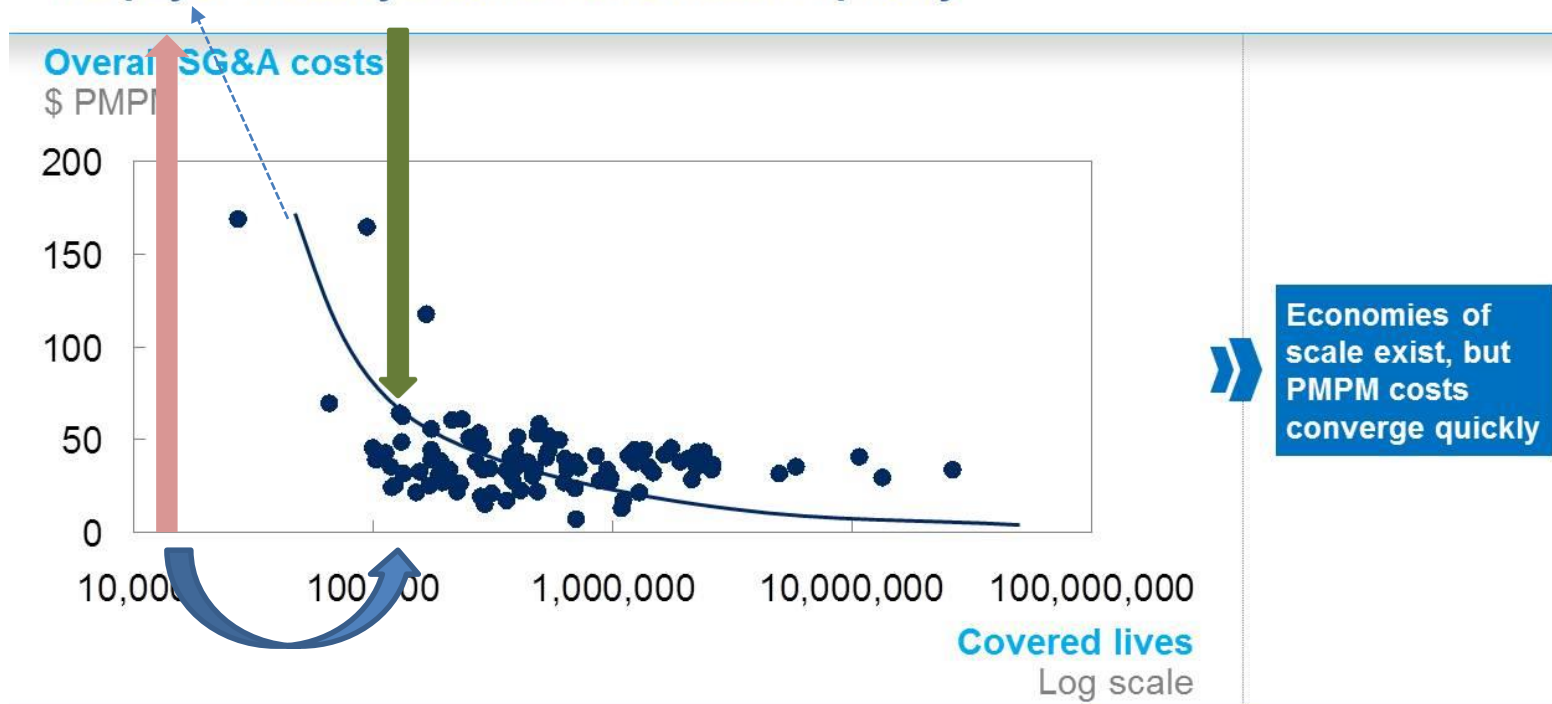
- 1) Carve out prescription drug benefit coverage
- 2) Travel benefit/centers of excellence consolidated contract
- 3) Savings =  $1.2\% \times \$1.192\text{B}/114,000$  members  $\approx$  \$125 pmpy

# AK Health Care Authority Potential Savings

PRM Coordinated Plan Administration savings estimate (Table 2, line 3) – appears reasonable compared to industry SG&A data

## Exhibit 1

The payor industry's scale curve flattens quickly



1 Commercial risk (large group, small group, and individual), Medicare, and Medicaid – top 100 players by premium.  
PMPM, per member per month; SG&A, sales, general, and administration.  
SOURCE: McKinsey Advanced Healthcare Analytics Payor Financial Database, McKinsey analysis

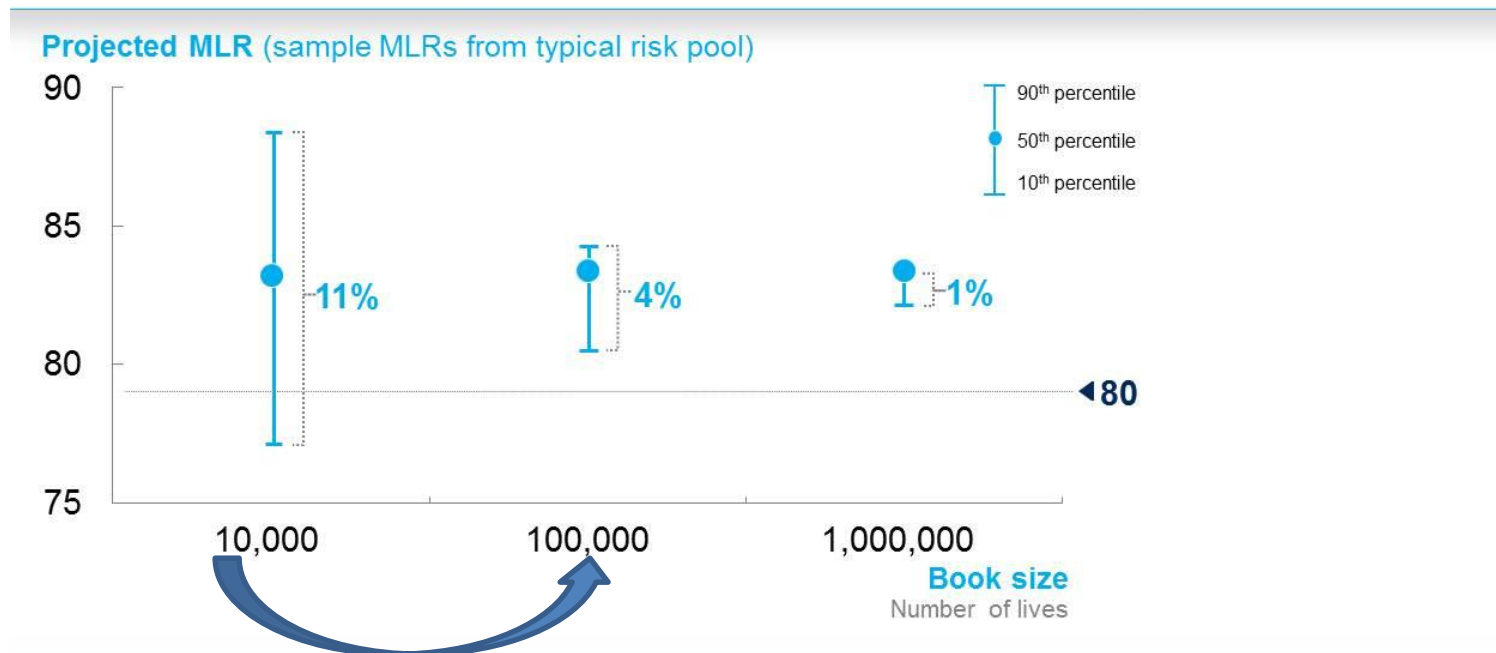
Source: "Bigger May Not Be Better: Does Scale Matter for Payors?", Shubham Singhal, Health Affairs Blog, November 15, 2013

# AK Health Care Authority Potential Savings

PRM Coordinated Plan Administration savings estimate (Table 2, line 3) – appears reasonable compared to industry data on volatility of medical loss ratio (and associated risk reserves / stop loss insurance premiums)

## Exhibit 5

Within a business line, scale could be important for managing volatility



MLR, medical loss ratio.

SOURCE: McKinsey Advanced Healthcare Analytics Roll Forward Model; data From Truven Health Analytics, Inc.

Source: "Bigger May Not Be Better: Does Scale Matter for Payors?", Shubham Singhal, Health Affairs Blog, November 15, 2013



# AK Health Care Authority Potential Savings

## Employer / Employee Cost Sharing Efficiencies – Single / Family Tiers

PRM, Phase 2 Report, Table 17 Modeled Savings from Adjusting the Spousal Contribution

- 13% savings on illustrative example that compares one AK health plan without tiers to two AK health plans with tiers

MAFA assumes that over time, the AK Health Care Authority will move toward multiple tiers across all State of Alaska, UA, local and school district plans that do not currently have multiple tiers to reduce cross-subsidization from single to family plans and incentivize households to find the most cost effective coverage for their families.

MAFA estimated pool savings of 1% associated with migration toward multiple tiers across all plans.

# AK Health Care Authority Potential Savings

Background: AK public employer health plans have lagged L48 in tiering & cost sharing (2013 PEW Compilation) -- while some progress has been made since 2013, more progress can be made in tiering and cost sharing to improve health plan efficiency

Average monthly premiums, employee contribution percentages by state, 2013							
State	Average Total Premium			Employee Only Premium vs. Avg Per Employee	Employee Plus Dependents Premium vs. Avg Per Employee	Avg. Employer Contribution Pct	Avg. Employee Contribution Pct
	Employee Only	Employee plus dependents	Per Employee				
U.S. Avg	\$570	\$1,233	\$959	(\$389)	\$274	84%	16%
AK	\$1,375	\$1,375	\$1,375	\$0	\$0	97%	3%
CO	\$446	\$1,027	\$733	(\$287)	\$294	83%	17%
HI	\$435	\$1,237	\$792	(\$357)	\$445	58%	42%
ID	\$458	\$1,063	\$860	(\$402)	\$203	90%	10%
MN	\$503	\$1,480	\$1,063	(\$560)	\$417	92%	8%
MT	\$712	\$890	\$809	(\$97)	\$81	91%	9%
ND	\$427	\$1,029	\$855	(\$428)	\$174	100%	0%
NV	\$631	\$1,111	\$840	(\$209)	\$271	82%	18%
OR	\$1,030	\$1,366	\$1,284	(\$254)	\$82	95%	5%
SD	\$496	\$675	\$580	(\$84)	\$95	85%	15%
UT	\$402	\$1,023	\$902	(\$500)	\$121	91%	9%
WA	\$536	\$1,187	\$889	(\$353)	\$298	85%	15%
WY	\$686	\$1,415	\$1,048	(\$362)	\$367	92%	8%
Comparison States Avg.				(\$324)	\$237	87%	13%

AK was only state in U.S. with one coverage tier for state employee plans identified in survey (2013).

Source: *State Employee Health Plan Spending: An examination of premiums, cost drivers, and policy approaches*, PEW Charitable Trusts / MacArthur Foundation, September 2014 Update; selected Western States excerpts from Table 1 State Health Plan Premiums, Employee Contribution Arrangements Vary (2013 data)

# AK Health Care Authority Potential Savings

## Employer / Employee Cost Sharing Effectiveness – Value Based Insurance Design

**“Value based insurance design”** aims to increase health care quality and manage costs by using financial incentives to promote cost efficient health care services and consumer choices. Health benefit plans can be designed to reduce barriers to maintaining and improving health. By covering preventive care, wellness visits and cost effective treatments such as medications to control blood pressure or diabetes at low to no cost, health plans may saving money by reducing future expensive medical procedures. Benefit plans may increase cost sharing for health choices that may be unnecessary or repetitive, or when the same outcome can be achieved at a lower cost. To decide what procedures are most effective and cost efficient, payers may use evidence-based data to design their health plans. [NCSL, 2016 update]

### Emerging success stories

- “The Impact of Increased Cost-sharing on Utilization of Low-Value Services: Evidence from the State of Oregon”, NBER Working Paper No. 22875, December 2016, Gruber, Maclean, Wright, Wilkinson, Volpp [Sleep studies, endoscopies, advanced imaging, back surgeries]
- Value-Based Design in Action: How Five Public Sector Employers are Managing Cost and Improving Health Using Value-Based Design, Center for Health Value Innovation (2009) [ME, counties & cities in WI, FL, OR, MI, KS]

AK Health Care Authority: Potential Savings over 7 year period, (2018 – 2025)

MAFA estimate of 2.6% savings at the end of 7 year period.

# AK Health Care Authority Potential Savings

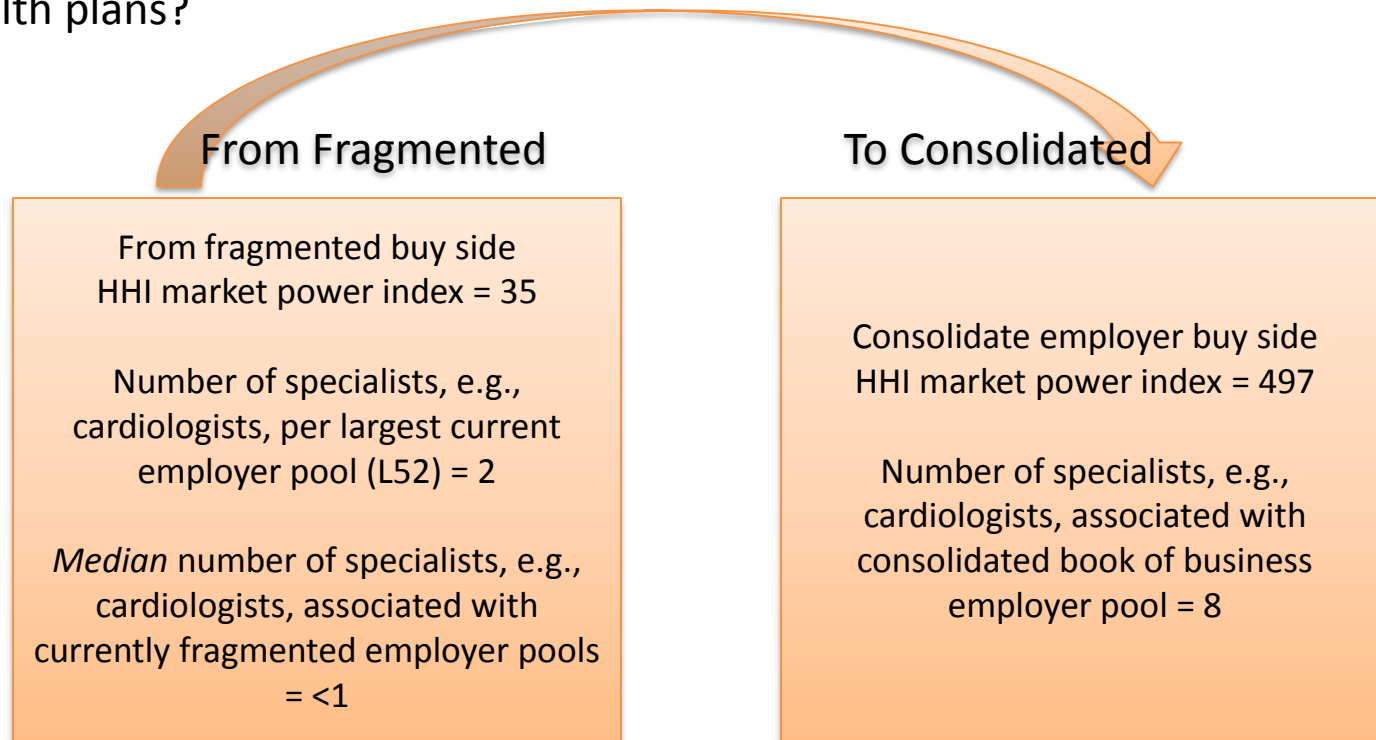
Consolidated Procurement (>100,000 covered lives)



# AK Health Care Authority Potential Savings

Consolidated Procurement Opportunity – What is the potential savings associated with consolidating purchasing power?

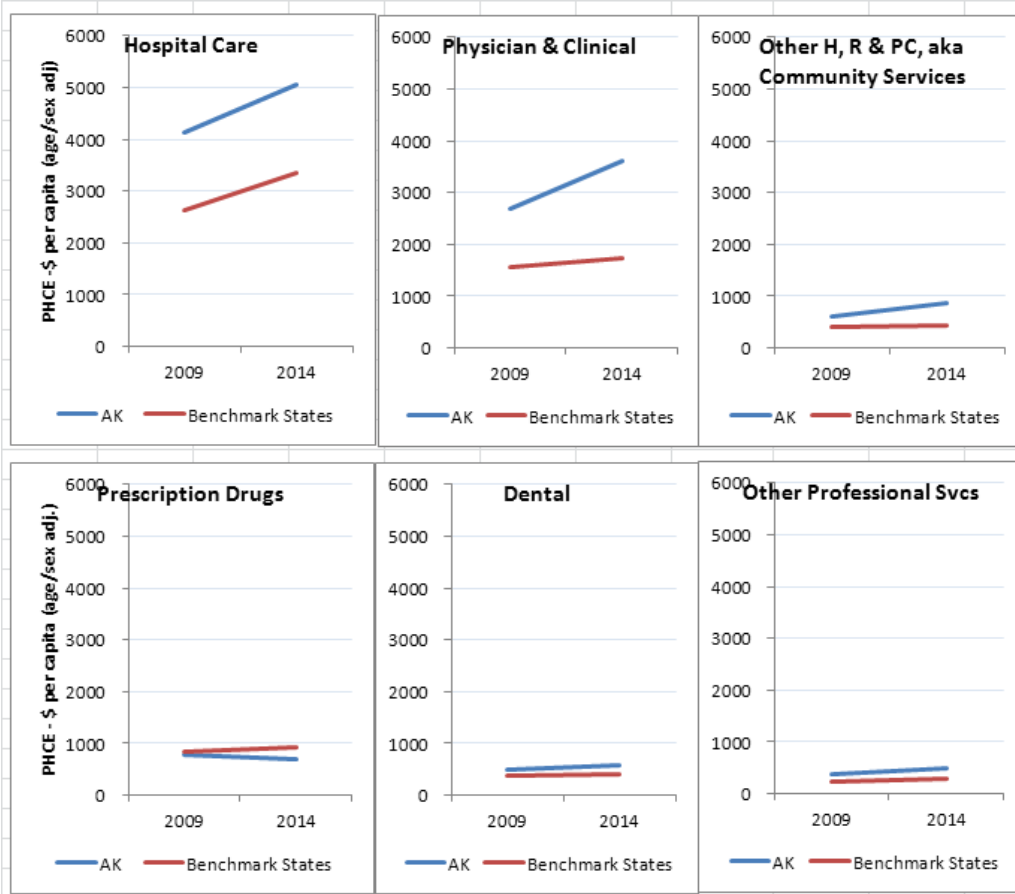
First, what is the magnitude of the market consolidation and resulting book of business associated with State, UA, local gov't and school district employer sponsored health plans?



HHI = Herfindahl Hirshfield Index of market concentration  
(sum of the squares of market share)

# AK Health Care Authority Potential Savings

What are the Key Cost Trends that buy-side consolidation can address –  
State Level Comparisons (CMS June 2017 release, 2009-2014 data ALL PAYERS, adj for age/gender)

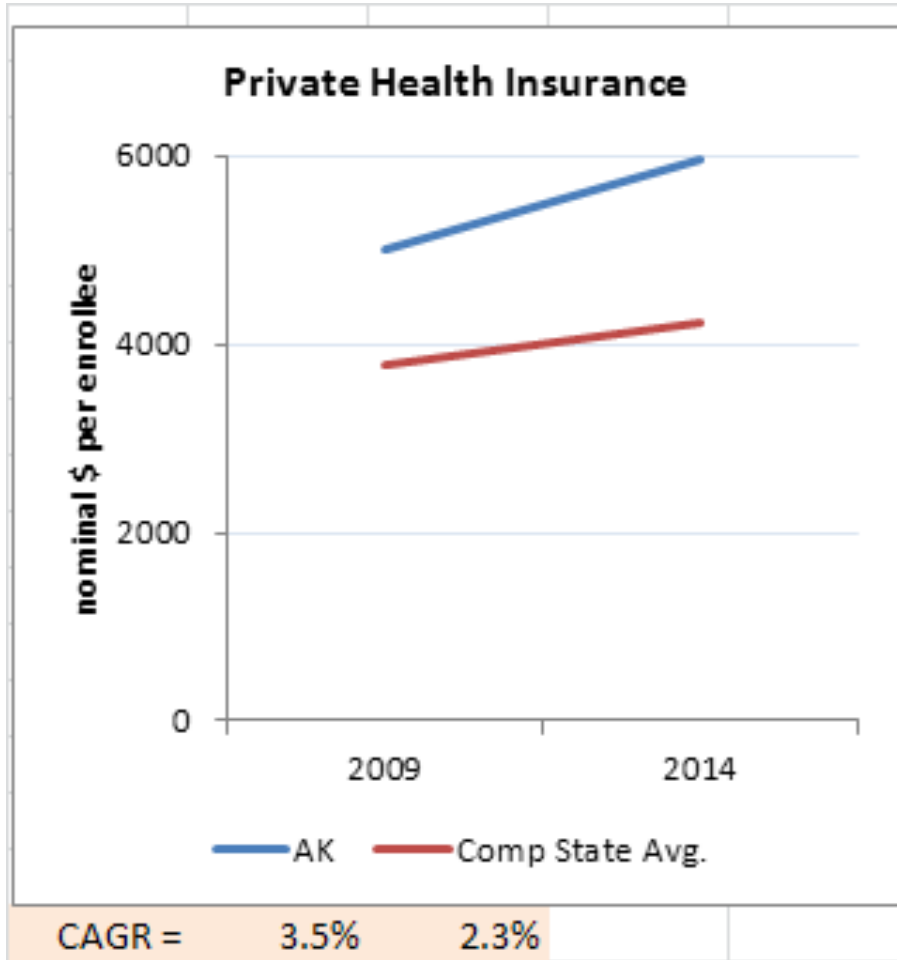


**Per capita personal health care expenditures by type (CMS, 2014)**  
*(Normalized for state age/sex demographic profiles)*

	Hospital Care (\$)	Physician & Clinical Services (\$)	Other Professional Services (\$)	Dental Services (\$)	Home Health Care (\$)	Prescription Drugs and Other Non-durable Medical Products (\$)	Durable Medical Products (\$)	Nursing Home Care (\$)	Other Health, Residential, and Personal Care (\$)	TOTAL (\$)
Far West, Rocky Mountains, Northern Plains, exclude CA										
<b>AK</b>	<b>5052</b>	<b>3608</b>	<b>498</b>	<b>581</b>	<b>209</b>	<b>686</b>	<b>149</b>	<b>219</b>	<b>854</b>	<b>11855</b>
CO	2799	1637	332	428	196	696	176	393	296	6953
HI	2784	1936	235	347	164	1190	171	353	175	7354
ID	3143	1371	312	402	184	824	154	379	396	7166
MN	3385	1766	271	405	526	959	135	870	587	8905
MT	3615	1610	294	376	147	840	160	530	410	7983
NV	2394	1886	275	352	235	973	151	246	252	6764
ND	4667	1785	271	448	75	1224	172	845	776	10264
OR	2890	1847	324	449	164	867	127	780	459	7908
SD	4516	1672	262	426	95	971	129	479	587	9137
UT	2771	1555	250	443	222	924	190	425	271	7050
WA	3106	2075	326	501	189	799	147	348	464	7954
WY	4111	1820	387	425	79	772	133	396	427	8551
<b>Benchmark Avg.</b>	<b>3349</b>	<b>1747</b>	<b>295</b>	<b>417</b>	<b>190</b>	<b>920</b>	<b>154</b>	<b>504</b>	<b>425</b>	<b>7999</b>
<b>AK / Benchmark Ratio</b>	<b>1.51</b>	<b>2.07</b>	<b>1.69</b>	<b>1.39</b>	<b>1.10</b>	<b>0.75</b>	<b>0.97</b>	<b>0.43</b>	<b>2.01</b>	<b>1.48</b>
<b>AK - Benchmark Difference (\$)</b>	<b>1703</b>	<b>1862</b>	<b>203</b>	<b>164</b>	<b>19</b>	<b>(234)</b>	<b>(5)</b>	<b>(285)</b>	<b>429</b>	<b>3856</b>
	hospitals	physicians	chiropractors						medicaid home & community based waivers	
	inpatient pharmacy	outpatient care centers	podiatrists						residential care facilities	
	hospital based nursing, home	lab services	optometrists						ambulance services	
	ancillary charges, resident physicians	Clinics/Veterans Affairs, Coast Guard, DOD, US INS.	physical/occupational therapists						school & worksite health, community centers	
	total "net" revenue		workers comp as predominant payer						senior citizen centers	

# AK Health Care Authority Potential Savings

State Level Comparisons (CMS June 2017 release, 2009-2014 nominal data); by Payer



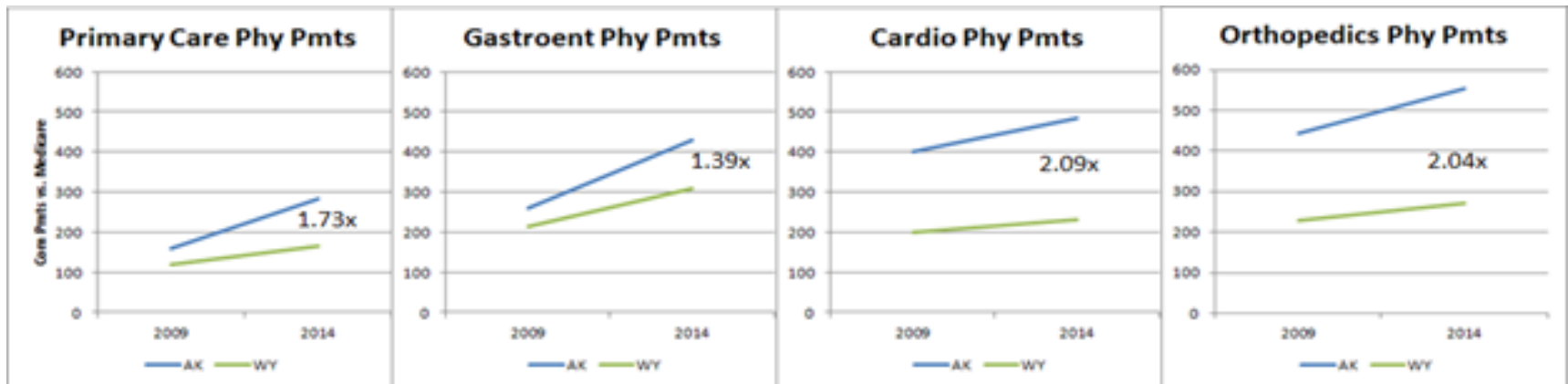
CMS (June 2017)		Private Insurance \$/enrollee		CAGR
		2009	2014	
737	AK	5012	5958	3.5%
5350	CO	3721	4623	4.4%
1416	HI	3636	4222	3.0%
1634	ID	3141	3560	2.5%
5453	MN	3834	4603	3.7%
1023	MT	3114	3882	4.5%
2833	NV	4108	3417	-3.6%
740	ND	3583	4410	4.2%
3968	OR	4069	4232	0.8%
853	SD	3553	4335	4.1%
2942	UT	3022	3657	3.9%
7054	WA	4034	4328	1.4%
584	WY	4190	4957	3.4%
Comp State Avg.		3768	4231	2.3%
	AK/Comp	1.330	1.408	1.2%
	AK/WA	1.242	1.377	2.3%

CAGR = compound annual growth rate

# AK Health Care Authority Potential Savings

Update Alaska Health Care Cost Commission Cost Driver Analysis (2011 Report on 2009 data) to the extent data is available (2014 ALL COMMERCIAL CLAIMS PAID) to identify areas amenable to mitigation with increased buy-side market share

1. Basic cost accounting framework: Cost = price \* utilization
2. Aggregate utilization of medical services has been below L48 benchmarks (after adjustments for age/gender distribution) for Alaska ALL COMMERCIAL CLAIMS (2009, 2014), STATE OF ALASKA EMPLOYEE POOLS (2009-2016), Selected Alaska SCHOOL DISTRICTS (2009-2016)
3. Alaska All Commercial Claims prices for medical procedures (net price paid after discounts) have been substantially above and increasing faster than other states [2011 Cost Driver Reports]
4. Alaska All Commercial Claims prices for medical procedures (net price paid after discounts) have continued to trend above other high cost states [MAFA review of All Commercial Claims paid prices 2009-2014]. See for example, physician payments clustered by specialty below:



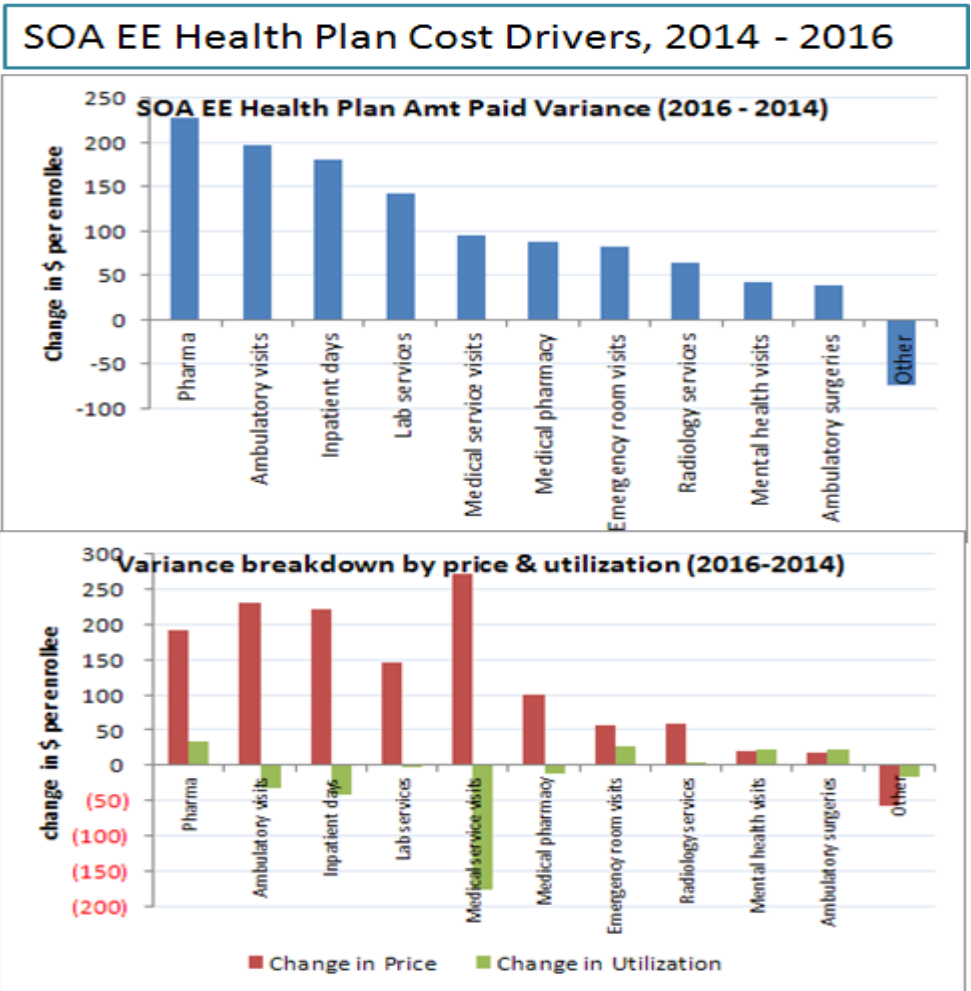


# AK Health Care Authority

## Potential Savings

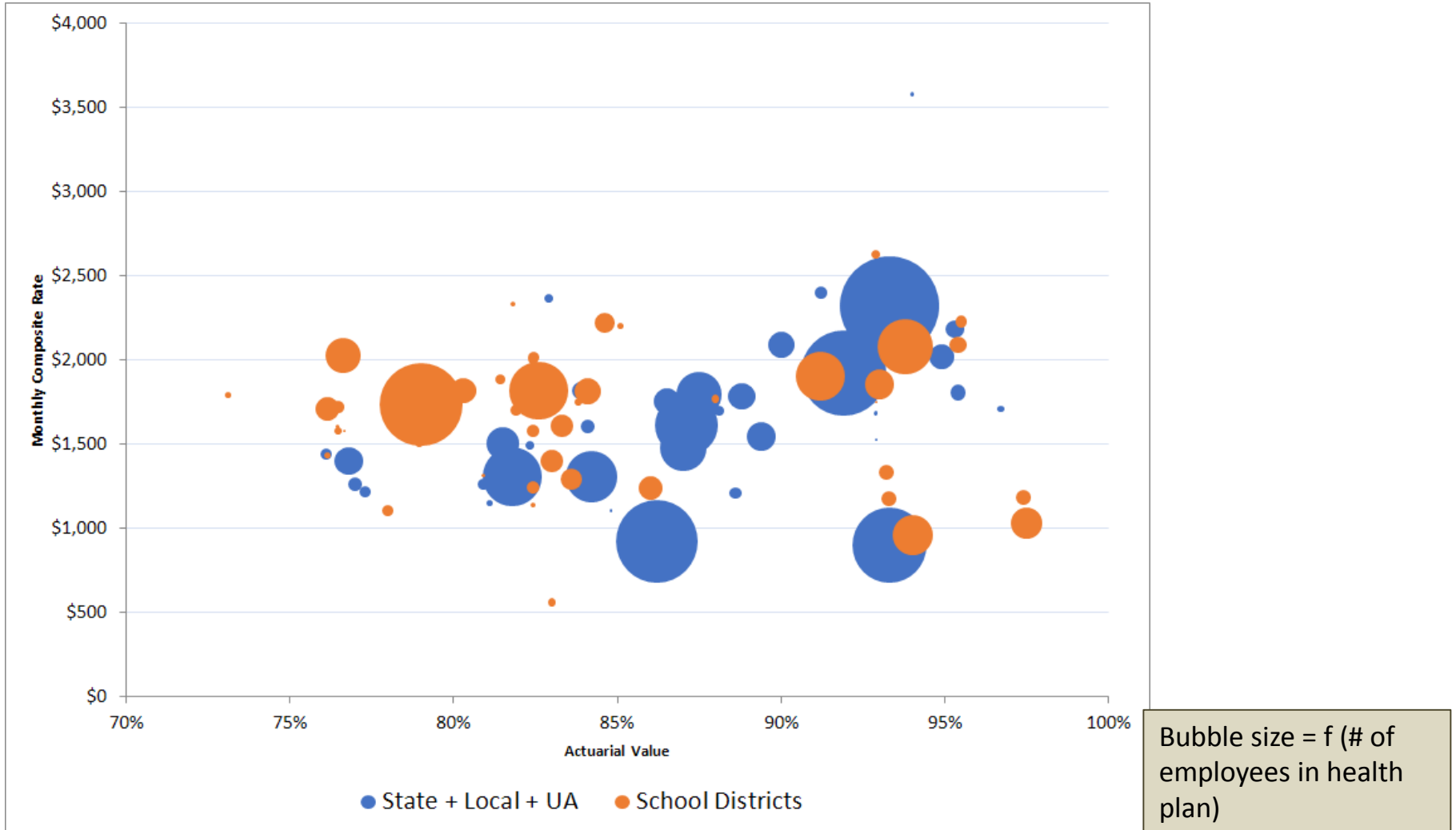
Extend State Public Employee [cost = price \* utilization] trend through 2016 and consider what cost drivers might be amendable to mitigation with increase in public employer buy-side market share.

Figure 16: State of Alaska Employee Health Plan Cost Drivers (Price / Utilization), 2014-2016



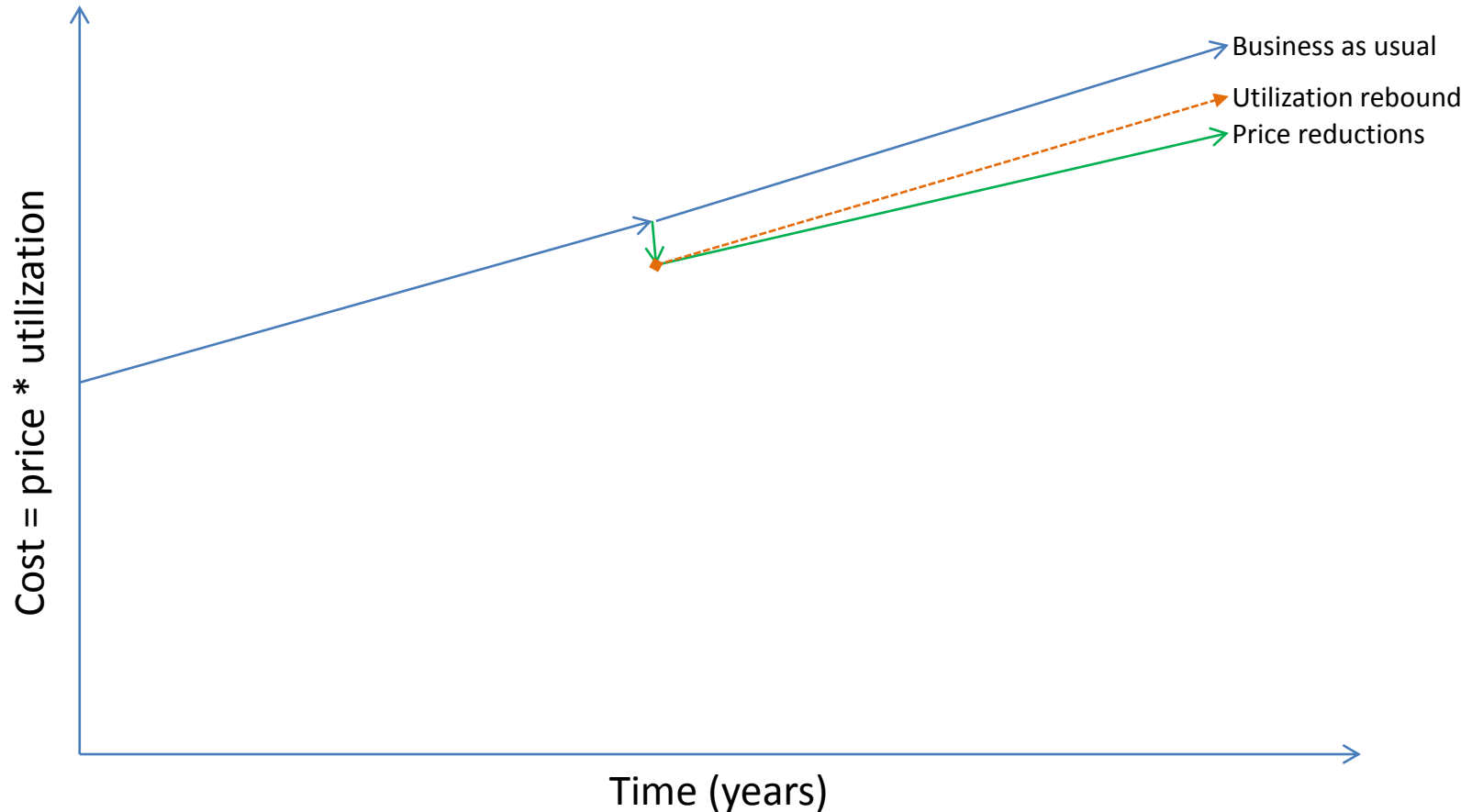
# AK Health Care Authority Potential Savings

AK Market Costs: State of Alaska + Other State & Local Public Employers



# AK Health Care Authority Potential Savings

What cost (price \* utilization) trends in public employer health plans might be amendable to mitigation by substantially increasing employer buy-side market share?  
PRICE.



# AK Health Care Authority Potential Savings

## Reference Pricing Challenges / Opportunities

Challenge 1: Price mitigation strategies are frequently associated with rebound in utilization

Nudge utilization rebound toward higher value care by accelerating migration toward measurement of value, e.g., health outcomes achieved per dollar spent (see <https://hbr.org/insight-center/innovating-for-value-in-health-care> , especially <https://hbr.org/2016/12/a-blueprint-for-measuring-health-care-outcomes> )

Challenge 2: Price mitigation strategies raise concerns around potential loss of quality

1. Measure and illuminate correlations between price/quality
2. Identify and monitor high value outcome measures

Illustrative examples

- International comparisons
- State & International comparisons
- Emerging health outcome metrics by care category (<http://www.ichom.org/medical-conditions> )

Challenge 3: Price mitigation strategies raise concerns around potential loss of access

- Identify and monitor high value access measures [local supply as proxy for access]

Illustrative examples

- AK specialists supply gains (fig 7, p. 32)
- AK dentists supply gains (fig 13, p. 51)
- Oak Street Health Medicare Clinic Model (<http://www.oakstreethealth.com/> )

# Summary

- Potential Savings Opportunity
  - Consolidate buy side market power (HHI+, BOB)
  - Focus on value; improving outcome per dollar invested
  - Estimate on the order of \$655 million over 7 years, approaching 9% savings vs. business as usual projection
- Implementation Challenges
  - Business as Usual Stakeholders
    - Employer / Employee groups
    - Health Insurance / Third Party Administrators
    - Medical Providers
  - Measure and manage outcomes per dollar invested and monitor cost / local capacity (access)