prm CONSULTING GROUP

Health Care Authority Feasibility Study

Phase I - Consolidated Purchasing Strategies

PREPARED FOR: STATE OF ALASKA DEPARTMENT OF ADMINISTRATION

JUNE 2017

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INTRODUCTION

The Alaska legislature passed Senate Bill 74 (S.B. 74) in April 2016, which among other issues established a series of provisions intended to fundamentally redesign Alaska's Medicaid program to increase quality and cost-effectiveness. S.B. 74 included a provision requiring the Department of Administration to procure a study to determine the feasibility of creating a Health Care Authority (HCA) to coordinate health care plans and consolidate purchasing effectiveness for all state employees, retired state employees, retired teachers, medical assistance recipients, University of Alaska employees, employees of state corporations, political subdivisions, school district employees, and other entities.

The State of Alaska is a central payer for health care in the state through its role in offering health insurance for state of Alaska employees and retirees, administering health care for Medicaid recipients, and the provision of funding to school districts, the University of Alaska, and other state corporations who in turn provide health insurance to their employees. The HCA study called for in S.B. 74, is the initial step in determining whether consolidating purchasing power under a HCA is feasible, realistic, and can serve as an effective avenue in developing a solution for the broader problems of health care costs and access to care needed by Alaska's citizens.

PRM Consulting Group ("PRM") was selected to conduct the study. This Phase I report provides the Department of Administration with the results of our Phase I analysis and evaluation of opportunities for coordinated purchasing strategies to improve cost effectiveness that could potentially be implemented without requiring employers or plan sponsors to change or modify their existing health care plan arrangements. The Phase II report evaluates the feasibility of coordinating health plan administration across various entities.

Following this introduction is an executive summary, which provides a synopsis of the results of a detailed survey conducted in September and October 2016 and an assessment of coordinated purchasing strategies that could be implemented with the current benefit plan structure (i.e. without the need to pool plan administration which will be examined in detail in the Phase II report to be issued in June).

As health care has its own lexicon of terms, the report includes a glossary in Appendix C with definitions for readers unfamiliar with the special meaning of certain health care terms.

EXECUTIVE SUMMARY

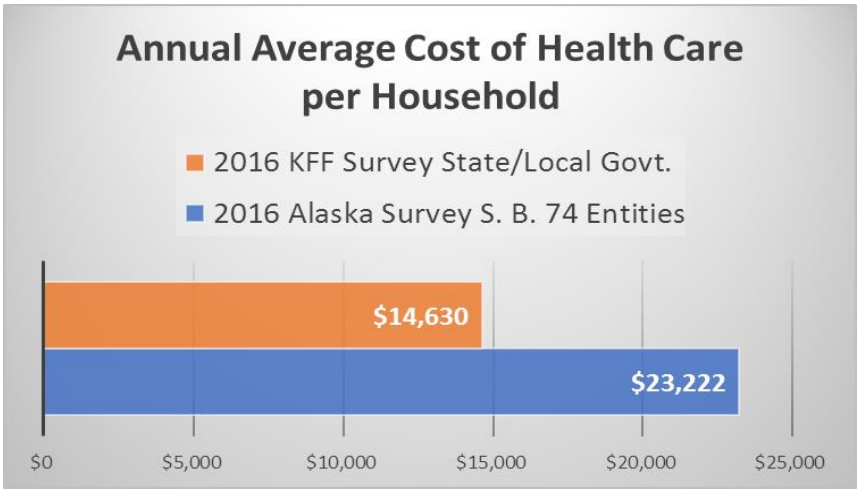
This Phase I report presents study observations and recommendations for potential purchasing strategies that do not require pooled plan design and coordinated plan administration. The Phase II report will address the advantages, challenges and feasibility of establishing a Health Care Authority that could coordinate and administer common plan designs as well as consolidate the purchasing of health care services across a large pool of public employees and other state funded entities.

KEY FINDINGS

1. Health Care Costs In Alaska Are Substantially Higher Than In Other States And The High Costs Are A Major Concern For Employers.

From the extensive interviews conducted for the study, supported by the data gathered from our survey of employers identified in S.B. 74 and other sources, the health care landscape in Alaska is found to have higher costs than observed in the rest of the U.S., a consequence due in part to Alaska's vast geography as well as limited competition among providers, low participation of specialists in provider networks, and higher cost of living. PRM compared the cost of medical coverage per household from the entities that provided data in the survey with the cost per household reported in the Kaiser Family Foundation (KFF) 2016 survey of State and Local Government employers. As shown in Figure 1, the composite cost in Alaska is 59% higher than the national survey results reported by KFF. Adjusting for regional price parities (Alaska is 5.7% above U.S. averages), the cost is still over 50% above national average.

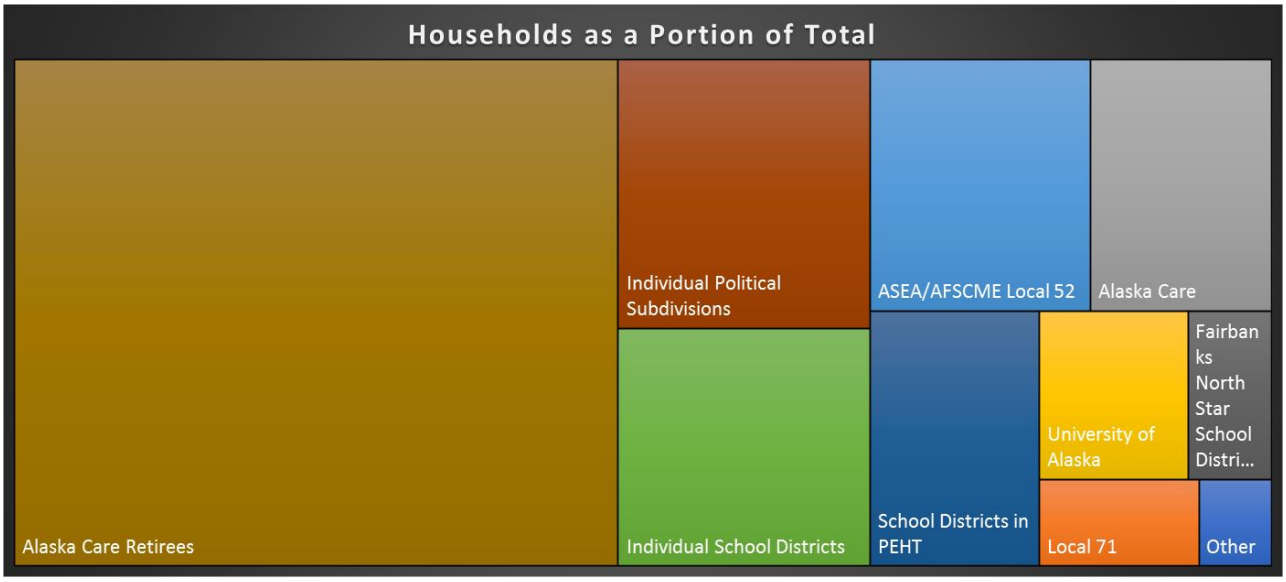
Figure 1 – Comparison of Alaska Health Plan Cost to National Survey Data



2. The Current Organizational Structure Already Has Significant Consolidation Among The Public Employer Plans

Figure 2 displays the share of employer health plans included in the study, where the area of each rectangle is proportional to the number of households in that group. It illustrates the current structure already has significant consolidation, as the AlaskaCare retiree plan covers a pool of most retirees from political subdivisions, school districts and the State. Furthermore, 18 school districts and 4 education associations participate in the Public Education Health Trust (PEHT). Fairbanks North Star Borough ("Fairbanks") manages the health care plan for both the Borough employees and K12 employees. In addition, the Health Care Cost Management Corporation of Alaska (HCCMCA) provides services to State of Alaska employees through the AlaskaCare employee health plan, union health trusts, multiple political subdivisions and a few school districts, including access to negotiated opportunities to decrease costs.

Figure 2 – Public Employer Health Plan Households



The data underlying the above graphic is shown in Table ES-1 below.

Table ES-1
Public Employer Health Plans

Entity	Number of Households	Percent of Total
AlaskaCare Retirees	41,628	48%
Individual Political Subdivisions	9,209	11%
ASEA/AFSCME Local 52	7,548	9%
Individual School Districts	8,124	9%
AlaskaCare Employees	6,176	7%
School Districts in PEHT	5,898	7%
University of Alaska	3,403	4%
Fairbanks North Star Borough & Schools	1,906	2%
Local 71	1,876	2%
Other		
PSEA	465	1%
State Corporations	291	0%
MMP	90	0%
Total	86,614	100%

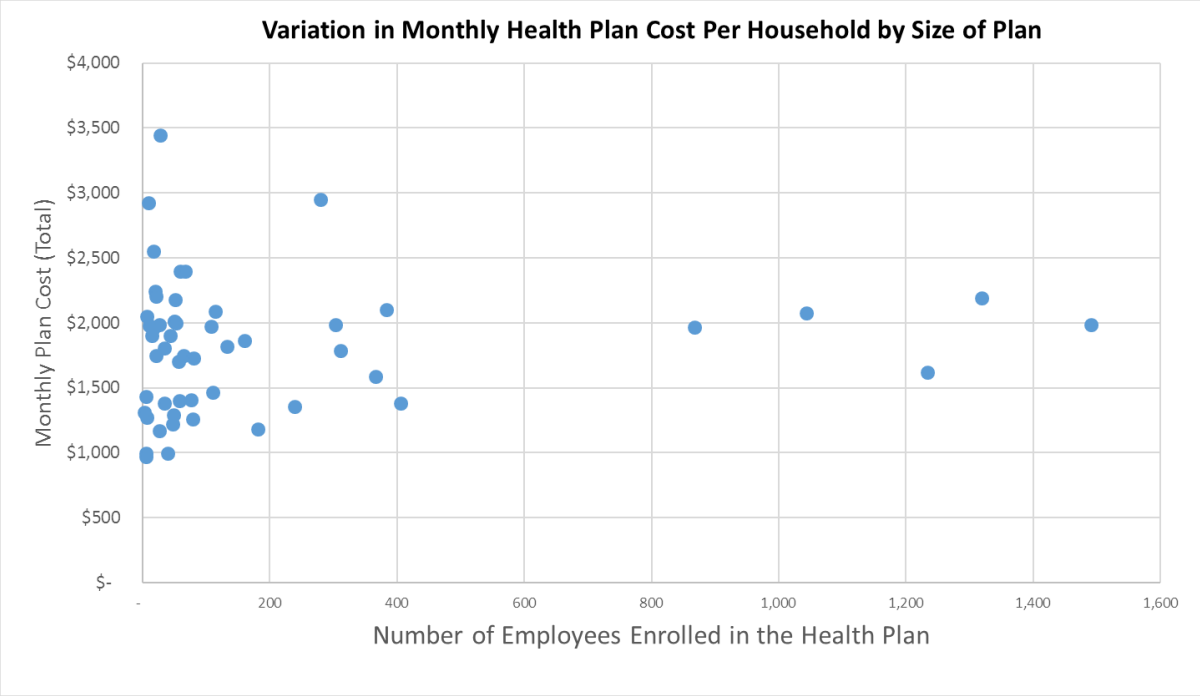
3. Wide Variation in Health Plan Costs

PRM's analysis of the survey data found a wide variation in costs by health care plan, especially for the smaller employers with fewer than 200 employees where the range from highest to lowest cost is over 3.5 to 1. For mid-size employers with between 200 and 500 employees the cost ranged from $1,400 per month to $3,000 per month. For the largest groups, each with more than 800 employees, the range in cost was narrower, with three of the five groups having monthly costs of about $2,000 per month.

Figure 3 below includes those entities that provided both enrollment and cost information. Due to scale, the figure does not include the cost for the AlaskaCare active plan, nor the costs for the other Alaska state employees whose funding cost is determined based on the AlaskaCare plan cost. Figure 3 shows the variation of health plan cost among the separate entities that are not coordinated under a single health plan and therefore does not include the retiree plan which covers both retirees not eligible for Medicare and those enrolled in Medicare. The cost shown is the total monthly health plan cost (i.e. including member premiums if required), and therefore does not include out-of-pocket costs from deductibles and coinsurance payments.

Neither the AlaskaCare plan nor the ASEA/AFSCME Local 52 plan (ASEA plan) are shown in Figure 3 below, due to scale, as each plan has over 6,000 households.

Figure 3 - 2016 Alaska HCA Feasibility Study Survey Data



In addition to a wide variation in health plan costs, the survey data also captured information showing a wide array of health care benefit designs employed by the various entities for the medical benefits with plan year deductibles ranging from $50 to $5,950. Pharmacy plan designs showed much smaller variability with the middle 50 percent of plans having very similar copays (between $10 and $13 for generic drugs, and between $20 to $30 for formulary brand drugs). Very few entities have carved out prescription drug coverage to be separately managed by a pharmacy benefit manager, with over 90% of employers having pharmacy included with the medical plan.

4. Cost Savings Opportunities

The survey analysis found that two insurance companies and their networks provide coverage to over 90 percent of the employer plans, and that in contrast to experience in the lower 48 states, a significant proportion of care is delivered by non-preferred providers. Given the lack of competing insurers with robust networks of competing providers, PRM found limited scope for substantial cost savings from pooled or consolidated purchasing through consolidation of insurers.

However, PRM can support a recommendation to establish a Health Care Authority as a system to manage the following three cost-savings opportunities that could be implemented without the individual employers having to revise or modify their existing health care plan designs or premium cost-sharing arrangements with their employees.

Table ES-2 lists the three strategies and indicates which of the entities would likely benefit from implementation of each strategy. The table also includes an estimate of the first-year aggregate savings for each strategy.

Table ES-2 Cost Savings Strategies and Estimated First-Year Savings			
	Employer Group Waiver Plan (EGWP)	Centers of Excellence / Travel Benefit	Pharmacy Benefit Carve-out
State Medical Assistance recipients	N/A		
State retirees	✓	✓	✓
State employees	✓	✓	✓
University of Alaska employees	✓	✓	✓
State Corporations	✓	✓	✓
School District employees	✓	✓	✓
Political subdivisions	✓	✓	✓
State of Alaska Workers' Compensation program	N/A	✓	✓
Expected 1st Year Saving	**$61,600,000**		
• **If some entities implemented**		**$2,900,000**	**$3,500,000**
• **If all entities implemented**		**$3,500,000**	**$8,000,000**

Employer Group Waiver Plan – 1st Year Savings Estimate $61.6 million

Figure 2 shows that all retirees are already consolidated in a single health plan covering retired employees from the Public Employees' Retirement System (PERS), Teachers' Retirement System (TRS), and the Judicial Retirement System (JRS). Currently, the AlaskaCare retiree health plan coordinates with Medicare Part D using the Retiree Drug Subsidy program. Adopting an Employer Group Waiver Plan (EGWP) should result in an additional $30 million in annual cash savings to the retiree health care trust, a reduction in the Actuarial Liability of approximately $847 million, and lowering the requirements for funding the benefits by reducing the Normal Cost (the cost of benefits accruing in each year) by $7 million. Based on the current retirement systems valuation census of approximately 44,400 employees, the average annual funding savings per employee would be about $1,350, or about $62 million in total across all entities. The development of the savings estimate is shown in Appendix B and the resulting cost savings by employer group are shown in Table 27 (page 47).

Centers of Excellence / Travel Benefit – 1st Year Savings Estimate of $2.9 to $3.5 million

The Centers of Excellence / Travel Benefit seeks to narrow the gap between cost and quality of care by steering members to the highest quality providers, both within and outside of Alaska, who have proven outcomes and predictable costs and savings. This service can be added to existing fully-insured or self-funded plan arrangements. The program is expected to save about $85 per employee per year on average in total health plan cost, by utilizing high-quality low-cost facilities for a range of rarely needed but typically high cost procedures, or about $3.5 million in aggregate, if all employers participated under a single contract. Savings would be smaller if the program were voluntary. The development of the savings is shown in Table 23 (page 34) and the cost savings by employer group are shown in Table 27 (page 48). The cost savings vary by employer group based on the type of arrangement each employer has in place currently for Centers of Excellence / Travel Benefits. In addition to the health plan cost savings, individual plan

participants who utilize the Travel Benefit will likely have reduced out-of-pocket costs. Services that are typically considered for Travel Benefit include surgical specialties such as bariatric, cancer care, cardiac, neurological, orthopedic, spinal, and vascular.

Pharmacy Benefit Carve-out -- 1st Year Savings Estimate of $3.5 to $8.0 million

Currently over 90 percent of the employers in the survey have the prescription drug benefit administered within the medical plan. By carving out the prescription drug benefit and pooling the plans to bid for a single pharmacy benefit manager we estimate that the aggregate pharmacy costs can be reduced by between 5% and 10%. The exact amount can only be determined through a competitive bidding process. However, based on experience with recent pharmacy coverage procurements the state should expect the employers collectively would be able to achieve savings of approximately $8.0 million annually, if all employers participated in a single contract. Savings would be smaller if not all eligible entities participated. The development of the cost savings by employer group are shown in the Table 27 (page 47). Cost savings vary by employer group based on the type of arrangement each employer has in place currently for pharmacy benefits including whether the employer already participates in a pharmacy purchasing coalition.

5. Recommendation to Establish a Health Care Authority to Implement the Above Strategies

Even the above savings will require a coordinated effort to contact each of the entities and secure their buy-in to the group purchasing arrangement before marketing and implementing the programs. Accordingly, we recommend that a Health Care Authority be established with the minimum staff level needed initially to accomplish the first-year tasks.

PHASE II

The Phase II report will address the advantages, challenges and feasibility of establishing a Health Care Authority that could coordinate and administer common plan designs as well as consolidate the purchasing of health care services across a large pool of public employees and other state funded entities.

BACKGROUND

Alaska's relatively small population and vast geography presents logistical and economic cost challenges for the provision of services including health care services. Three distinct health care networks have evolved to serve three generally separate markets: the Alaska Tribal Health System, Military Health System, including Veterans Affairs health facilities and Department of Defense Military Treatment Facilities; and the private healthcare system. About one in five Alaskans are eligible for services in through Tribal Health and a further 12% are covered by the military system compared to 2% and 5% respectively in the U.S. as a whole.[1]

Outside of the larger population centers, the lack of competition among health care providers in the private health care system has resulted in a greater reliance on fee-for-service reimbursements to health care providers than is found in other states which utilize a variety of managed care delivery networks. Another indication of the relative weakness of managed care delivery networks in Alaska is the absence of any Medicare Advantage products. That is in sharp contrast with the rest of the country. The Center for Medicare and Medicaid Services (CMS) has recently reported that 32% of all Medicare beneficiaries will be enrolled in Medicare Advantage programs in 2017, up from 24% in 2010. For the Alaska Medicaid population, none are currently enrolled in managed care organizations or programs, whereas nationwide more than 50% of Medicaid beneficiaries receive most or all their care from risk-based managed care organizations, and more than 70% receive some portion of their care from managed care organizations or programs.[2] See Appendix H in our Phase II Analysis (page 174) for a more comprehensive discussion of the issues presented by the competitive landscape for health care delivery in Alaska.

Using data from a variety of sources including summaries compiled by the Anchorage Economic Development Council on the size of the governmental workforce and other data gathered for the study, we estimate that the aggregate number of covered lives identified in S.B. 74 for this study is more than 40 percent of the State's population (currently estimated at 740,000). The State's Medicaid population alone represents about half the total population included in the Health Care Authority Feasibility Study.[3]

[1] Health Care in Alaska, Prepared for Alaska Health Care Commission by Section of Health Planning & Systems Development Division of Public Health, Alaska Department of Health & Social Services, April 14, 2014
[2] http://kff.org/data-collection/medicaid-managed-care-market-tracker/
[3] The Medicaid enrollment is individuals, that for the other groups is "households". On average 30% of these households elect employee only (or retiree only) coverage, so the minimum number of covered lives is 309,050, which is over 40% of the State's population of 740,000.

Table 1 Estimated Enrollment and 2016 State Medical Expenditures			
Employee Groups	**Estimated Enrollment**	**Medical Expenditures (Millions)**	**Source[4]**
Medicaid	162,750[5]	$1,695[6]	A
AlaskaCare Retirees	41,628	$504	B
State of Alaska Workers Compensation	N/A	$11	C
ASEA/AFSCME Local 52	7,548	$137	D
Local 71	1,876	$36	D
State Corporations	291	$6	D
PSEA	465	$10	E
MMP	90	$2	E
AlaskaCare Employees	6,176	$116	B
University of Alaska	3,403	$65	D
School Districts & Political Subdivisions			
Individual School Districts	8,124	$186	D
School Districts in PEHT	5,898	$139	D
Individual Political Subdivisions	9,209	$216	D
Fairbanks North Star Borough and School District	1,906	$47	D
Total	**249,364**	**$3,171**	

Table 1 shows estimates for the total annual health care expenditures in 2016 for the populations included in the Health Care Authority Feasibility Study is $3.2 billion. This cost is the aggregate State expenditure and does not include:

- Out-of-pocket costs incurred by plan participants
- Medicare expenditures for retirees enrolled in Medicare
- Employee premiums paid as a condition of participation.

This cost is borne by multiple payers, including the federal government which funds a portion of the Medicaid expenditures, state government, and local governments.

[4] A = Dept. of Health and Human Services; B = Dept. of Administration; C = Division of Risk Management; D = PRM Survey; E = PRM estimate F = Legislation – amount shown is for one year.
[5] Represents Medicaid covered lives
[6] Includes both state and federal funds - source: FINAL AUTH FY 2016

STUDY METHODOLOGY

The study began with an initial meeting with the Department of Administration to discuss the project, review the project plan, and obtain introductions to the various entities to be included in the analysis. PRM sought information on the current health care environment in Alaska, including details of how each of the populations identified in S.B. 74 obtains and manages its health care arrangements, as well as input from a broad range of organizations involved in the provision of health care in Alaska as well as other interested parties.

Organizations who were interviewed or who met with PRM were encouraged to provide their frank assessment of the current health care environment, what challenges they faced currently, and what opportunities they saw to improve cost effectiveness and quality of health care. PRM assured them that information obtained from in-person and phone interviews as well as follow up contacts would be held in confidence and not for attribution, and used only to inform each phase of this study.

Appendix A provides a list of the stakeholders and interested parties with whom PRM met or interviewed. We wish to acknowledge and thank the many organizations that participated in the survey and provided data for this study. A list of participating school districts and political subdivisions whose staff provided data is shown starting on page 52.

To capture information on the health care arrangements established by the municipal governments and school districts and other entities, a customized survey of current health plans for the covered entities was designed to enable PRM to provide:

- Analysis of survey and other data to assess the actuarial value of the benefit plans provided to employees (actuarial value is a commonly accepted method for determining the relative generosity of health care plan provisions).
- Analysis of the funding arrangement in place for the current benefit plans, including cost-sharing arrangements and employee contributions.

The survey provided participants with an opportunity to provide the following information:

- Premium information – the amounts paid for health insurance, including how much employees are required to pay and whether that amount varies depending on the size of the household.
- Plan design information - the features (i.e., deductibles, copays, coinsurance and any annual out-of-pocket limits) which indicate the amount plan participants are required to pay when receiving health care services.
- Funding arrangements – the arrangement which determines whether the health plan is structured as fully-insured, self-insured, or in some other manner.
- Network or insurance vendor information – the name of the health care vendor and whether medical, prescription drug, dental, and vision coverage is offered.
- Prescription drugs – whether prescription drugs are included in the medical plan or offered separately (i.e., through a pharmacy benefit manager or a coalition).

- Opt-out credits – whether financial incentives are offered for eligible participants to waive coverage.

The detailed questions in the on-line survey can be accessed at

http://www.surveygizmo.com/s3/3035918/AlaskaHCASurvey.

In addition to the on-line survey, PRM also collected data directly from several entities and departments. A summary of the data gathered is provided in the following section.

As with all surveys, there were limitations to the type of data that could be collected and the subsequent analysis performed on the submitted data. The survey was designed to canvas the employers with respect to the array of the types of health care arrangements expected to be in place among the various employers and obtain sufficient details of the health care plans to quantify material differences and commonalities. Information was captured as of September 2016, so for employers with seasonal workforces the information as of September may not have been representative of the costs in other months.

DATA GATHERED FOR THE STUDY

Data for the Health Care Authority Feasibility Study has been collected from a broad range of sources, including enrollment and claims utilization historical reports from Departments and individual entities.

Entity	Data Gathered
Department of Health and Human Services	Medicaid enrollment by benefit group (adult, disabled adult, child, disabled child, elderly). Total Medicaid enrollment was 162,750, or about 22% of Alaska's population. FY2016 projected expenditures of $1,695 million. PRM also obtained expenditures by major service category.
Division of Risk Insurance (Workers' Compensation)	Qualitative and quantitative data was obtained from a meeting with Department officials. An aggregate cost for health care coverage for State employees on Worker's Compensation of $11 million has been used as the baseline cost.
University of Alaska	In addition to current enrollment and plan design information, PRM gained insight into the University of Alaska's Joint Labor-Management Health Care Committee and its role in tracking quarterly plan experience and evaluating plan options.
ASEA Health Trust	The Trust provided enrollment and claims experience for FY2012 through FY2015 as data for FY2016 was not yet complete.
Department of Administration	Qualitative and quantitative data was obtained from a meeting with Department officials.

For entities that sponsor their own health care plans, detailed plan design, enrollment, coverage, cost and premium-sharing information has been collected using a combination of an on-line survey tool and electronic copies of plan documents and Collective Bargaining Agreements. The survey was launched the week of September 19th, and the survey data progress reports shown below reflects the information captured as of December 1, 2016.

An estimate of the total number of benefit eligible employees was developed by aggregating the number of employees participating in the State Retirement Systems (i.e. Teachers' Retirement System [TRS], Public Employees' Retirement System [PERS] and Judicial Retirement System and National Guard and Naval Militia Retirement System [JRS]), supplemented with an estimate of the number of employees in political jurisdictions that do not participate in the state retirement systems.

Table 2
Development of Estimate of Total Benefit Eligible Employees

Retirement System	Count of Benefit Eligible Employees	Source
TRS- Defined Benefit (DB)	5,502	TRS Actuarial Valuation as of June 30, 2015, page 42
TRS-Defined Contribution (DC)	4,095	TRS DC Actuarial Valuation as of June 30, 2015, page 23
PERS-DB	17,660	PERS Actuarial Valuation as of June 30, 2015, page 47
PERS-DC	17,098	PERS DC Actuarial Valuation as of June 30, 2015, page 32
JRS	76	http://doa.alaska.gov/drb/pdf/jrs/Alaska_rpt063014_JRS_FINAL.PDF, page 32
None	69	PRM estimate based on responses from political subdivisions not participating in PERS
Total	44,500	

Table 3 below shows that the data contained in the completed surveys represent over 83 percent of the total estimated number of benefit eligible employees. Accordingly, the data from completed surveys was found to be fully representative of the populations surveyed and sufficiently complete to be relied upon for the study.

Table 3
Comparison of Survey Data to Estimate of Total Benefit Eligible Employees

	Benefit Eligible Employees	Count of Employees from Completed Surveys	Percent Completed
Total	44,500	37,168	83.7%

Tables 4 and 5 below show the breakdown of survey participation by entity and region. While the total number of employees included in the completed survey was over 83 percent, the survey responses varied by region and by type of entity. Much effort was spent towards ensuring both large populated regions and smaller populated regions were well represented. The largest five of the seven regions (statewide omitted) by population have a much higher completion percentage than the entirety of the state. A breakdown of the total responses by region can be seen in Table 5.

Table 4 Survey Responses by Type of Employer				
Summary	Surveyed Entities	Completed	Not Complete	Percent Completed
State Employees & Retirees[7]	6	5	1[8]	83%
University of Alaska	1	1	0	100%
State Corporations	2	2	0	100%
School Districts	54	48	6	89%
Political Subdivisions	164	68	96	41%
Grand Total	227	124	103	55%

Table 5 shows the details on the surveys by region. The right two columns show the size of the civilian labor force by region and associated percentage of the total Alaska labor force. The northern region had the lowest completion rate, but also has the smallest share of the workforce. Therefore, even if all entities in that region had completed the survey information it would only have increased the aggregate data by 2%.

Table 5 Survey Responses by Region						
Regions	Surveyed Entities	Complete	Not Complete	Percent Completed	Civilian Labor Force[9]	
Anchorage	2	2	0	100%	155,765	43%
Gulf Coast Region	23	14	9	61%	38,973	11%
Interior Region	34	18	16	53%	53,174	15%
Mat-Su	5	5	0	100%	43,893	12%
Northern Region	39	12	27	31%	10,421	3%
Southeast Region	44	33	11	75%	38,384	11%
Southwest Region	71	32	39	45%	19,858	6%
Statewide	9	8	1	89%		
Grand Total	227	124	103	55%	360,468	100%

[7] Excludes Masters Mates and Pilots (MMP). Despite repeated attempts to contact them, MMP did not respond to our requests to participate and did not provide a contact name / person to receive the survey.
[8] Public Safety Employees Association (PSEA) did not complete the survey that was sent to them. Despite repeated attempts to contact them, PSEA did not participate as of 2/10/2017.
[9] Alaska Department of Labor and Workforce Development, Research and Analysis Section; and U.S. Bureau of Labor Statistics

Table 6 illustrates that responses were obtained from all entities with a reported population of over 30,000 (i.e., the densely-populated cities, towns, and municipalities) with lower response rates from smaller entities.

Table 6
Political Subdivisions by Population

Population Size Range	Surveyed Entities	Complete	Not Complete	Percent Completed
100,000 or above	1	1	0	100%
30,000 - 99,999	4	4	0	100%
5,000 - 29,999	12	8	4	67%
1,000 - 4,999	25	14	11	56%
0 - 999	122	41	81	34%
Grand Total	164	68	96	41%

Although Table 6 shows a 41 percent overall survey completion rate for the political subdivision entities, the percent of total population represented by the participating entities is significantly larger (approximately 85%). For example, the Municipality of Anchorage accounts for only 1 of the 164 entity responses (0.6%); however, the population of Anchorage is 38% of the statewide population.

ANALYSIS OF SURVEY DATA

COVERAGE TIERS

Coverage tiers refers to the size and composition of the household that is enrolled in or participating in the health care plan. As noted in a recent survey of state health plans and summarized in Table 7 below[10], most states use two or four tiers. However, many of the Alaska employers use a composite rate structure.

Table 7
State Health Plans by Coverage Tiers

Number of Tiers	Tier Structure	Number of States
Two tiers	employee only employee plus family	12
Three tiers	employee only employee plus one dependent employee plus two or more dependents	9
Four tiers	employee only employee plus spouse employee plus child(ren) employee plus spouse and child(ren)	23
Five tiers	employee only employee plus spouse employee plus child employee plus children employee plus family	1
Six tiers	employee only employee plus spouse employee plus child employee plus children employee plus spouse and child employee plus spouse and children	4

A composite rate will show the average cost "per household" without any knowledge or details about the size of the household. Employers that use tiered rates will typically set the rate for employee only coverage as the rate expected on a per employee basis, and that for employee plus family as the rate expected for a household that has two or more people. As some Alaska public plans use composite rates and others use tiered rates it makes it challenging to compare the costs on an apples to apples basis. The survey data showed almost two thirds of the employees were enrolled in plans that used composite rates.

COST OF COVERAGE

Table 8 shows the average annual total cost of medical coverage based on the information obtained from the survey. As many of the entities utilize a composite rate, where the same premium cost was provided for all coverage tiers, we

[10] August 2014 report from The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation – State Employee Health Plan Spending

have also compared the average composite rate with a composite rate developed from the Kaiser Family Foundation (KFF) survey assuming that 30% of the enrollment is for employee only coverage and 70% employee plus family coverage. This composite rate shows the costs in Alaska are 59% higher than the average costs reported in the KFF survey.

Table 8
Average Annual Total Cost of Medical Coverage

Coverage Tier	2016 Alaska Survey	2016 Kaiser Family Foundation Survey[11]	Ratio of Alaska Survey to KFF Survey
Employee only (excludes groups using composite rates)	$13,652	$6,435	212%
Employee & family (excludes groups using composite rates)	$27,323	$18,142	151%
Composite rate[12]	$23,222	$14,630	159%

TYPE OF BENEFIT PLAN

The most prevalent type of medical plan selected by employers are Preferred Provider Organizations (PPOs) and Point of Service (POS) plans followed by High Deductible Health Plans. Table 9 summarizes the percent of plan prevalence for Alaska and compares those percentages with the percentages reported in the 2016 Kaiser Family Foundation Employer Health Benefits Survey for State/Local Governments. We note that the KFF survey shows 11% of State / Local Government employees are enrolled in Health Maintenance Organizations (HMOs) whereas none of the Alaska entities indicated their prevalent plan was an HMO because they currently do not exist in the state.

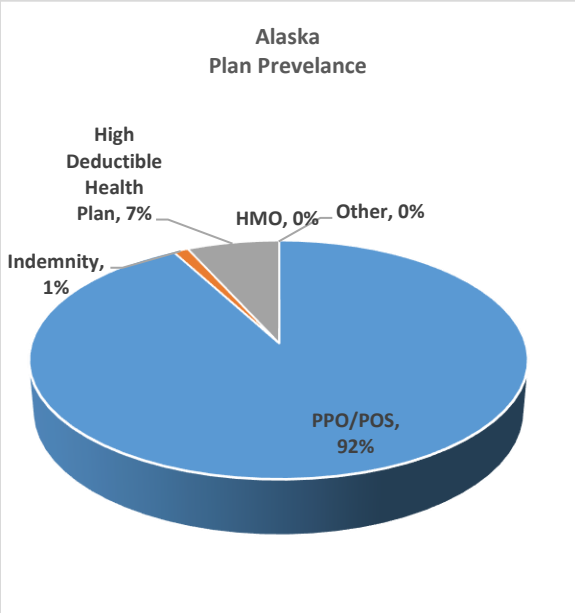
Table 9
Type of Medical Insurance Plan
(Based on the most prevalent plan)

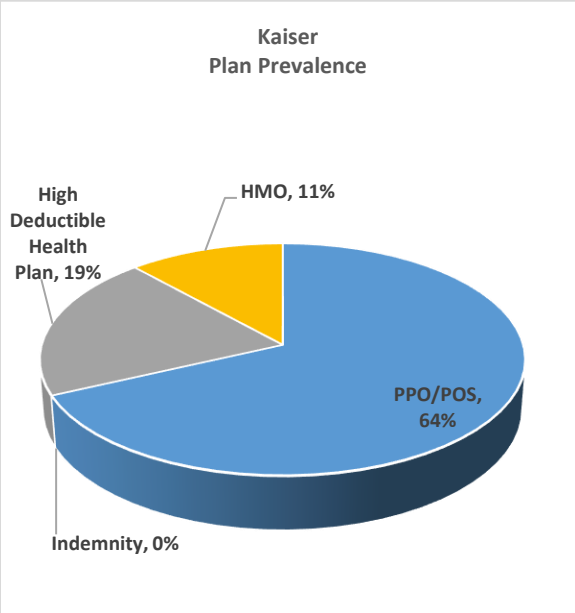
Type of Medical Insurance Plan	2016 Alaska Survey	2016 Kaiser Family Foundation Survey of State/Local Govt.
PPO/POS	92%	64%
High Deductible Health Plans	7%	19%
Indemnity	1%	<1%
HMO	0%	11%

[11] http://kff.org/health-costs/report/2016-employer-health-benefits-survey/

[12] KFF composite rate developed as the sum of 30% x employee only rate plus 70% x employee & family rate

One reason why no employers reported an HMO as their primary or most commonly selected plan is that employers did not contract with an HMO given the concern about their employees having sufficient access to specialists. HMOs usually operate with a closed panel of doctors and if an HMO does not include a full panel of doctors (including specialists) then care provided outside the HMO's contracted panel of doctors and facilities would not be covered by the plan, and instead the employee would bear the full burden of financial responsibility. This barrier would exist with other types of managed care models as well.





HIGH DEDUCTIBLE HEALTH PLANS

For employers who offer a high deductible health plan, 14 percent contribute dollars annually to a Health Reimbursement Account (HRA) and 5 percent contribute to a Health Savings Account (HSA). The contributions vary by plan (i.e., HRA and HSA) and coverage tier election (i.e., single or family coverage), and are illustrated in the chart below.

Table 10
High Deductible Health Plans

	HRA		HSA	
	Single	Family	Single	Family
Minimum Employer Contribution	$100	$100	$750	$1,000
Maximum Employer Contribution	$5,500	$10,900	$2,210	$2,210

PRESCRIPTION DRUG PLANS

Over 90 percent of employers who participated in the survey indicated that their prescription drug benefits are included as part of the medical plan with the same insurance vendor rather than having a separate Pharmacy Benefit Manager (PBM). With prescription drug costs increasing more rapidly than medical costs many employers are choosing to use a PBM to administer the prescription drug benefit. Competition among the leading national PBM companies is helping to deliver cost savings to employers that utilize PBMs compared to those employers that rely on their medical carrier to pass on discounts and rebates the carrier receives in their contracts with PBMs.

Table 11
Prescription Drug Plans - Alaska Survey Data

Prescription Drug Benefits are included in the Medical Plan	93%
Prescription Drug Benefits are separate from the Medical Plan	7%

FUNDING ARRANGEMENTS

As shown in Table 12, just under half of employers fully-insure their medical benefits. The group sizes for fully-insured funding arrangements range from 2 to 197. Employers who self-insure their medical plans are much larger with group size varying from 8 to 4,274. Employers who fully insure their health care coverage have the advantage of budget predictability on a month-to-month basis, but may be incurring higher costs over the longer term as the premiums include risk charges and any margin is retained by the insurer. Employers who self-insure may save money over the long term by avoiding these charges and can manage the cost exposure by purchasing stop-loss insurance.

Table 12
Medical Plan Funding Arrangement

Type of Funding Arrangement	Percent of Plans	Average Group Size
Fully-Insured	43%	34
Self-Insured	57%	414

EMPLOYEE CONTRIBUTION RATES[13]

The survey found that about 33 percent of all employees enrolled in a medical plan do not contribute toward the cost of medical premiums. Almost 70 percent of employees are enrolled in plans that utilize a composite rate structure whereas 30 percent apply different rates depending on the coverage tier (i.e., employee only, employee plus spouse, etc.). On average, employees enrolled in a composite rate structure pay $83 per month for "employee only" coverage whereas employees enrolled in medical plans with non-composite rate structures pay on average $112 per month. In addition, employees enrolled in "other-than-self" coverage (which ranges from "employee and spouse" to "employee

[13] The contribution rates analyzed were for employee health coverage and therefore did not include the AlaskaCare retiree health care plan as all retirees are already administered in a consolidated plan.

and family") pay $167 per month, on average, in medical premium when enrolled in a composite plan and $265 per month when enrolled in a non-composite plan. According to data from KFF's 2016 Employer Health Benefits Survey, employees of other State/Local Governments pay on average $94 per month for "employee only" coverage and $440 per month for "other-than-self" coverage on average. The monthly employee contributions for "employee only" coverage in composite plans are similar to the national average. However, the employee contributions in non-composite premium plans for "employee only" coverage are higher than the national average and the employee contribution required for "other-than-self" coverage, for both composite and non-composite plans, are substantially smaller than the average across all other State/Local government employee health plans.

Table 13 shows the average enrollment and the range of employee contributions, as of September 2016, for medical coverage by coverage tier. The data in Table 13 is a subset of the survey data and only includes those employer plans that utilized separate coverage tier rates. The data shows that for these employers the average cost for employer only coverage was $1,138 per month and the average cost for employee and family was $2,277 per month.

Table 13
Average Health Plan Total Cost, Employer Cost and Employer Premium Rates for Plans with Tiered Rates Based on Prevalent Plan[14]

	Survey Total	Employee only	Employee + Spouse	Employee + Child	Employee + Children	Employee + Family
Enrollment	6,799	2,174	966	260	367	3,032
Total Plan Cost	$1,817	$1,138	$1,998	$1,522	$1,766	$2,277
Average employer contribution	$1,601	$1,026	$1,759	$1,331	$1,560	$1,991
Average employee contribution	$216	$112	$239	$191	$206	$286
Average employee contribution as a percent of cost	12%	10%	12%	13%	12%	13%

[14] For employers with two or more plans, this summary included the plan with the largest enrollment.

Table 14 shows the average health plan total cost, employer portion and employee premium just for those employers that utilized composite rates. The average total cost for these employers was slightly higher at $1,644 and the average premium paid by employees was lower at $140 per month or 9% of the plan cost.

Table 14 Average Health Plan Total Monthly Cost, Employer Cost and Employee Premium Rates for Plans with Composite Rates Based on Prevalent Plan	
	Survey Total
Enrollment	15,658
Total Plan Cost	$1,643
Average employer contribution	$1,503
Average employee contribution	$140
Average employee contribution as a percent of cost	9%

FINANCIAL INCENTIVES FOR WAIVING COVERAGE

Some survey participants indicated that financial incentives are provided to employees who elect to opt-out or waive medical coverage. The incentives range from $300 to $5,000 per year. The average financial incentives are illustrated in Table 15.

Table 15 Average Annual Opt-Out Financial Incentives	
	Medical
Single coverage	$1,370
Family coverage	$1,920

For employers that have the flexibility to offer opt-out credits, this can be a financial benefit to both employer and employee. For the employer that has fully-insured coverage, the opt-out credit is less than the annual premium. For the employee who waives coverage and enrolls in a spouse's plan, the opt-out credit can be used to pay the cost of the premiums charged by the spouse's employer. For households where both working adults have health insurance the use of opt-out credits can substantially reduce the employer's health care premium costs by incentivizing the employee (and his/her spouse) to enroll under the spouse's employer's health plan.

SUMMARY OF PLAN FEATURES

The range of health plan features offered by employers varies widely and the charts that follow illustrate the provisions in aggregate and by percentiles. The meaning of each percentile is also described below.

- 10th percentile means that 10 percent of survey responses were below the indicated amount and 90 percent are above the indicated amount.

- 25th percentile means that 25 percent of survey responses were below the indicated amount and 75 percent are above the indicated amount.
- 50th percentile means that 50 percent of survey responses were below the indicated amount and 50 percent of survey responses were above the indicated amount.
- 75th percentile means that 75 percent of survey responses are below the indicated amount and 25 percent are above.
- 90th percentile means that 90 percent of survey responses are above the indicated amount and 10 percent are below.

All survey participants indicated that their medical plans include an annual in-network deductible that ranges from $50 to $5,950. The average individual deductible from the 2016 Kaiser Family Foundation Survey was $1,478 which is larger than the 75th percentile from the Alaska survey participants. The average family deductible from the 2016 Kaiser Family Foundation Survey was $4,343, which is above the 90th percentile from the Alaska survey participants.

Table 16
Variation in Medical Plan Design and Comparison to KFF Survey

	10th percentile	25th percentile	Median	75th percentile	90th percentile
Deductible – In-Network					
Individual – Alaska Survey	$100	$100	$300	$1,000	$1,850
Individual - 2016 KFF Survey			*$1,478 (average)*		
Family – Alaska Survey	$300	$300	$750	$2,850	$4,000
Family – 2016 KFF Survey			*$4,343 (average)*		
Out-of-Pocket Maximum – In-Network					
Individual – Alaska Survey	$645	$1,455	$2,800	$5,988	$6,850
Family – Alaska Survey	$2,250	$3,250	$6,960	$12,850	$13,700

Almost all plans require copays for office visits and hospitalization services. As noted in the following table, there was little variation found in the size of the copay for an office visit (under 2-to-1 for the 90th percentile compared to the 10th percentile). In contrast, there was a much wider variation observed in the emergency room copay and hospital admission copay.

Table 17 Variation in Medical Plan Copays					
Medical Plan Features - Copays	**10th percentile**	**25th percentile**	**Median**	**75th percentile**	**90th percentile**
Office Visit	$25	$25	$28	$30	$33
Outpatient Hospital	$13	$18	$25	$28	$29
Emergency Room	$75	$100	$200	$500	$500
Inpatient Hospital per Admit	$75	$500	$500	$500	$500

Over 91 percent of employers have flat dollar copays for their prescription drug plan features and none have a separate deductible. Table 18 shows there is not a wide variation in pharmacy plan design, which may facilitate both usage of a PBM to manage the current array of benefit designs for the current employers and if a pooled arrangement were to be established improved plan administration across a smaller number of discrete plan designs that represent the range of low-medium-high copays found in the plans today.

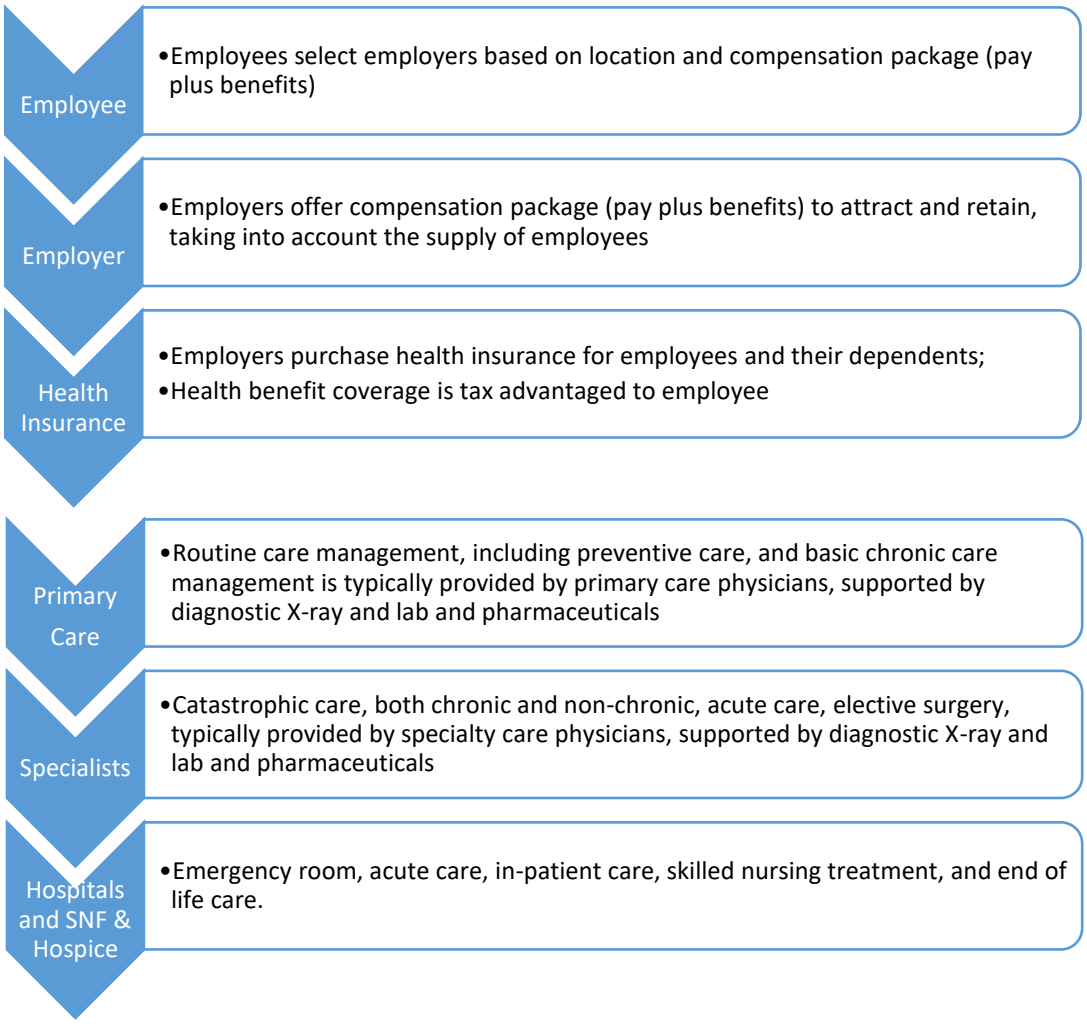
Table 18 Prescription Drug Plan Features					
Prescription Drug Plans With Copays	**10th percentile**	**25th percentile**	Median	**75th percentile**	**90th percentile**
Retail Generic Copay	$5	$10	$10	$14	$17
KFF Average Generic Copay[15]			*$11*		
Retail Formulary Brand Copay	$20	$25	$25	$30	$30
KFF Average Formulary Brand Copay			*$33*		
Retail Non-Formulary Brand Copay	$29	$40	$50	$50	$60
KFF Average Non-Formulary Brand Copay			*$57*		
Mail Order Generic Copay[16]	$5	$10	$24	$30	$34
Mail Order Formulary Brand Copay	$10	$30	$50	$60	$75
Mail Order Non-Formulary Brand Copay	$10	$34	$100	$120	$125

[15] http://kff.org/health-costs/report/2016-employer-health-benefits-survey/
[16] Mail Order 90-day copays are typically twice the copay for 30-day retail supply.

NETWORK ANALYSIS

The following health insurance and medical care value chain may be useful in understanding the implications of health insurance networks and the impact of pooled purchasing on cost effectiveness through network or carrier negotiations or consolidation.

Figure 4-Health Insurance & Medical Care Value Chain[17]



Networks are an important element in managing the cost of a health plan. As noted earlier, the Alaska public employer plans predominately use Preferred Provider Organizations (91%) – which create steerage to network providers. When employees use network providers they receive a higher level of plan payment than when members use non-preferred or non-network providers. Our experience with large employers including state health plans in the continental United States is that on average, about 90% to 95% of covered charges will be incurred with network providers and only a

[17] Mark A. Foster & Associates

small amount, typically less than 10% and often less than 5% is incurred with non-network providers. Based on an analysis of claims for the self-insured plans included in the study, the landscape in Alaska is materially different from the lower 48, with about 65% to 70% of covered charges incurred with network providers and therefore a much larger than usual amount of care is delivered by non-network providers. Providers who do not contract with carriers to be in-network providers can set the level of their fees and rates, rather than having to agree to maximum reimbursement rates. The relatively low percentage of claims that are paid in-network indicates that for a significant portion of covered services, plan participants are unable to find an in-network provider. The standard value chain, where larger numbers of enrollees in health insurance plans affords the insurers with greater leverage and stronger negotiating power with hospitals and providers breaks down in Alaska, due to the lack of competition among health care providers.

INSURANCE VENDORS

The table below summarizes the prevalence of insurance vendors and separates them by political subdivisions, school districts and state employers.

Table 19
Employer Coverage by Entity and Medical Vendor

Medical Insurance Vendors	Political Subdivision	School District	State	Total
Aetna	59%	70%	80%	65%
Cigna	2%	2%	0%	2%
First Choice Health	0%	4%	0%	2%
MultiPlan	5%	4%	0%	4%
Premera	34%	20%	20%	26%

An analysis of which insurance companies were most commonly used by the health plans shows that Aetna and Premera are used by over 90% of the employers. If there were three major insurance companies each with 25% or more of the employer plans as customers (or four insurers each with 20% or more), then that would indicate that there might be an opportunity for savings from consolidation of carriers and greater leverage from increased steerage to network providers. However, given the lack of robust networks (as indicated by the 30% to 35% of care that is currently being delivered outside of the existing networks) and the high concentration among the existing vendors (two carriers have 90% of the business) the health care landscape in Alaska does not appear to currently present any traditional network savings opportunities.

PURCHASING COALITIONS

Approximately 30 percent of employers indicated that they participate in a purchasing coalition, which refers to a collective of employers who use their combined size to leverage greater purchasing power to obtain the best benefits at the lowest prices. Of the employers who utilize a purchasing coalition, about 80 percent obtain medical benefits through a Health Trust and 20 percent have contracted with the Health Care Cost Management Corporation of Alaska (HCCMCA).

Table 20 below illustrates the coalition participation by employer subgroup.

Table 20
Participation in Health Trust or HCCMCA

	Political Subdivision	School District	State
HCCMCA	3	2	2
Health Trusts	4	18	2

Health Trusts reported by public employer plans included the Alaska Electrical Trust Fund, Alaska Public Entity Insurance group, ASEA/AFSCME L52, Public Education Health Trust (PEHT), and Public Employees Local 71.

MEDICARE REFERENCE PRICING

As noted earlier, a much larger than usual amount of care is being delivered through non-network or non-preferred providers. Some of these non-network providers (particularly in the specialty practices) have set their bill charge rates at or above 400% of Medicare rates[18]. In most instances, these providers receive 75 to 90 percent of their billed service charges paid by the plan, through a combination of the standard plan coinsurance and the application of the plan's out-of-pocket maximum for non-preferred providers. For example, if the plan coinsurance for non-participating providers is 70%, the plan will pay more than 70% if the participant reaches their out-of-pocket (OOP) maximum. For an $80,000 provider fee, the plan will initially pay 70% ($56,000) leaving $24,000 to be paid by the member. If the plan has a $15,000 out-of-pocket limit for non-participating provider charges, the plan will pay an additional $9,000 (capping the member's OOP costs at $15,000). The plan therefore pays 75% of the cost.

When an individual receives care from a non-network provider, the insurer does not have a contractual relationship with the provider and must determine independently how much to reimburse for a service. Some plans place a dollar limit to the allowed charges for non-preferred providers. Typically, the reimbursement level is based on a percentile of billed charges for that service within a geographic area and time frame. If billed charges for that service increase over time, the allowed amount for that service will also increase.

To manage these costs, several self-insured employers have changed their non-network (or non-preferred provider) benefit feature to a maximum of 125% of the Medicare fee schedule or to another percentage referenced to Medicare, such as 200%. This type of fee schedule is not influenced as easily by increases to the billed amount for a particular service.

[18] Insurance carrier.

Table 21 below is an example of the effects of such Medicare reference pricing on a hypothetical claim.

Table 21
Impact of Medicare Reference Pricing

	400% of Medicare Rates	200% of Medicare Rates	125% of Medicare Rates
Participating Provider Coinsurance Out-of-Pocket Maximum	80% $2,500	80% $2,500	80% $2,500
Non-Participating Provider Coinsurance Out-of-Pocket Maximum	70% $15,000	200% of Medicare Unlimited	125% of Medicare Unlimited
Provider Service Fee **Medicare Rate**	$40,000 Not utilized	$40,000 $10,000	$40,000 $10,000
For Non-Participating Services Plan Pays Member Pays	$28,000 $12,000	$20,000 Provider can balance bill to collect the remaining $20,000	$12,500 Provider can balance bill to collect the remaining $27,500

From a plan perspective, the introduction of the Medicare reference pricing has reduced the cost from (in this example) $28,000 to $20,000 (if the plan used 200% of Medicare) or $12,500 (if the plan used 125% of Medicare). From a plan participant's perspective, the member would have received invoices from the provider seeking payment of the 30% of their fee that was not paid by the plan ($12,000 in this example) and now will receive invoices from the provider seeking the balance of the bill, which is $20,000 under the 200% of Medicare rates and $27,500 under the 125% of Medicare rates. Faced with the possibility of large out-of-pocket costs, the plan design places an onus on the member to inquire about the cost of services and to "shop" for lower cost options. A possible impact from this plan change is that providers who are unable to collect all or most of these large balance bills may then have an incentive to contract with the insurer as a participating provider; however, it also potentially exposes the member to large out-of-pocket costs.

INCENTIVIZING PROVIDERS TO RELOCATE OR PRACTICE IN ALASKA

Increased competition should influence pricing, especially for specialist practices. A few providers have established practices in Alaska (both on a full-time and a part-time basis). For example, Virginia Mason Hospital and Medical Center of Seattle established a cardiology practice in Juneau and two orthopedists, from California, are providing services on the campus of the Alaska Regional Hospital (although they are not practicing through the hospital). In addition, some of Peace Health Medical Group's physicians provide services in Alaska on a periodic basis.[19]

Interviews with various provider groups identified a potential challenge or barrier to this strategy. Before a provider can practice in Alaska they need to complete an approval process, which could take up to one year.

[19] Source: Health insurance industry representative.

ESTABLISHING EMPLOYEE HEALTH CLINICS

Employee health clinics are a strategy used by self-insured employers to provide easy and cost effective access to basic primary care through clinics that are managed by the employer or health plans. In Alaska, The HCCMCA has established employee clinics in Anchorage and Fairbanks that members may elect to make available to their employees for a set price per visit. The Anchorage School District recently announced they will be opening their own employee clinic in 2018. Depending on the efficacy of these clinics, this may provide an additional strategy for cost savings while retaining access to care for other Alaskan employers.

By establishing on-site or local health care clinics, employers provide employees with convenient, accessible medical care, resulting in many benefits for both the employer and employee. A study by the Department of Health and Human Services[20] revealed that companies can cut health expenses, reduce short-term sick leave, and boost productivity with wellness programs and on-site (or near-site) clinics.

[20] Source: https://aspe.hhs.gov/pdf-report/report-congress-workplace-wellness

CONSOLIDATED PURCHASING STRATEGIES – ADMINISTRATION MODELS

ASSESSMENT OF CURRENT CONSOLIDATION EFFORTS

For the most part, each entity independently managed the procurement of health care benefits for its employees or covered individuals. Some pooling of resources does exist currently, including the following:

- Fairbanks North Star Borough manages the health care plan for both the Borough and school district
- Public Education Health Trust, covers over 5,000 employees from 18 school districts and 4 education associations.
- Health Care Cost Management Corporation of Alaska (HCCMCA) provides services to multiple political subdivisions and a few school districts, including access to negotiated hospital rates and a multi-state prescription drug purchasing pool.

It is important to note that due to collective bargaining agreements the aggregate employer purchasing power is often dissipated among multiple health care arrangements in place for employees of a single entity. This is the case currently for the State of Alaska, and for several school districts and municipalities.

The proper starting point for developing models for the administration of a consolidated purchasing strategy across the different entities identified in S.B. 74 is to first examine the efficacy of the models currently in place, including the administration of the AlaskaCare Employee Plan and AlaskaCare Retiree Plan from all public-sector employers within the state of Alaska.

Particularly the AlaskaCare Retiree plan, which provides consolidated health benefits and administration of those benefits across all Alaska public sector entities has obvious advantages both for participants and for the State of Alaska. Those benefits include:

- Uniformity of benefits available for all retirees and their families, regardless of where they were employed within the state's public sector entities (including service with multiple employers), for those who qualify for retiree health benefits.
- Uniformity of claims and administrative processes, including eligibility determination, which provides equitable treatment to participants across all the jurisdictions whose retirees participate.
- Greater scale which gives Alaska and its business partners in the administration of AlaskaCare more leverage in negotiations with providers – an essential element given the characteristics of the provision of health care services to Alaska's citizenry.
- The ability to coordinate activities across the entirety of the retiree population, including new initiatives entered into from time to time to improve care and help contain costs for state taxpayers and participants. Such initiatives have included:
  - Application for the Retiree Drug Subsidy under the Medicare Modernization Act of 2003.

- Emphasis on better discounts in the most recent competitive bidding for the plan, resulting in improved discounts for both active and retired participants and their families; and
- More recently successful negotiations to improve pricing terms including discounts for the prescription drug benefits provided participants under AlaskaCare.

Some of the initiatives that have been undertaken and are in the planning stages now, would be beyond the reach of smaller public employers within the state, or costlier than justified by the benefits that might be produced for a single employer acting alone.

HEALTH CARE AUTHORITY

For this Phase I report, the feasibility of establishing a Health Care Authority with the limited purpose of improving purchasing effectiveness through consolidated purchasing strategies has been examined. Under this Phase I analysis, each of the employers participating in the HCA would retain autonomy over their health care plan, both in terms of plan design features (such as the amount of the annual plan deductible, or required copayment for office visits or prescription drugs) and cost-sharing with employees (i.e. what percent of the overall plan cost would be paid by the employer and how much would be required to be paid by the employee). Additional analysis in Phase II will focus on opportunities to achieve additional savings through coordinated administration of health plans.

NETWORK DEVELOPMENT AND MANAGEMENT

There are two essential elements for developing and managing a network of providers that can yield economic benefits to plan sponsors and participants, without unduly compromising access to health care and the quality of care provided. Those elements are scale and competition.

Scale

In the current arrangements for many health care plans measures are already in place that recognize the importance of scale, as noted in the current relationships with the principal vendors servicing the plans:

- Aetna in combination with CVS for prescription drug benefits which serves the AlaskaCare plan and many other municipal employers;
- PEHT, which combines the pooled purchasing power of multiple school districts, and
- The Health Care Cost Management Corporation of Alaska (HCCMCA) which already includes as participating members:
  - AlaskaCare Employee Plan
  - ASEA/AFSCME Local 52
  - Fairbanks Northstar Borough and Schools
  - Kenai Peninsula Borough
  - Kenai Peninsula Borough Schools, and
  - Matanuska-Susitna Borough

HCCMCA Programs[21]

The negotiated discount programs developed by HCCMCA are available for self-insured plans only. These programs include:

- Preferred Provider Organization (PPO) agreements with – Alaska Regional Hospital in Anchorage, Mat-Su Regional Medical Center in Palmer, Chugach Physical Therapy, Alaska Hand Rehabilitation and Ascension Physical Therapy in Anchorage.
- Dialysis Cost Containment Program – addressing the plan and member costs for end-stage renal dialysis treatment during the time period when the employer plan is primary and Medicare is secondary.
- Coalition Health Centers – convenient centers that provide additional options for accessing urgent care, including access to EKG, labs, and a prescription dispensary.
- Geneva Woods Birth Center - outpatient services and outpatient delivery. This includes medically necessary medical and birth center services, supplies and accommodations for which an enrollee is eligible under the terms of the plan and that are customarily provided by Geneva Woods Birth Center.

From the information developed in our survey of school districts and other state funded and local government entities, Aetna was found to have the largest footprint in the governmental sector in Alaska now, driven in significant part by the fact that they are the vendor responsible for administering the AlaskaCare health plans. Additional scale is provided by the relatively new arrangements with HCCMCA, in that HCCMCA is in turn part of a prescription drug purchasing coalition which currently serves employers covering more than 250,000 participants in several states. Moreover, some elements of that current scale are additive in the sense that the principal vendors serving the HCCMCA employers are Aetna and their prescription drug partner, CVS. Premera was the only other insurance carrier to have a substantial number of school districts and political subdivisions in its network, and is the only remaining insurance company on the federal exchange for individual purchase of health insurance for 2017.

When each of the self-insured plans negotiates with the carriers independently, they will only be able to secure contract terms based on the expected size of the business they will bring to the carrier. By pooling all their business under a single negotiated contract, all the groups currently administered with a common carrier should be able to secure contract terms with respect to discounts and administration fees that are preferential, given the combined size and scale of the business.

[21] http://www.hccmca.org/

Competition

Competition presents a different set of issues, and any discussion of network development and management must start with the recognition that except for the few major population centers, there is little or no competition among health care providers in Alaska.

Given the general lack of competition, it is possible that only in Anchorage (where some competition does exist) does the landscape offer opportunities to use steerage of participants to providers and scale to negotiate favorable pricing arrangements among competing providers. And some of those arrangements are currently in place, in the network management initiatives through Aetna/CVS and HCCMCA (e.g. the Preferred Provider Organization agreements described above).

The simplest and most immediate initiatives that could result in an effective consolidated purchasing arrangement for offering health benefit services to a new coalition of purchasers managed by an HCA in Alaska in its formative stages would seem to be most logically structured around leveraging the arrangements currently in place with those providers serving the AlaskaCare Health Plans and the other large self-insured plans that currently use Aetna/CVS and HCCMCA. Such initiatives could offer services to school districts and other entities funded directly or indirectly by the state—consistent with the language in S.B. 74—either for the entirety of the entity's health care offerings, or for discrete programs which assist such employers in lowering their health care claims costs and ultimately the costs borne by the entity and its employees and families.

Some of the purchasing strategies that might be considered in addition to leveraging the relationships through the current vendors that serve the AlaskaCare health plans are described below.

PHARMACY BENEFIT CARVE-OUT

Currently over 90 percent of the employers responding to our survey have the prescription drug benefit administered within the medical plan. Another common approach is to "carve out" the prescription drug benefit program by contracting directly with one of the major Pharmacy Benefit Managers (PBMs). PBMs have taken advantage of scale in negotiating more favorable pricing for prescription drug purchases. They also participate in purchasing coalitions, and partner with major health care companies in providing the management of prescription drug purchasing. Collectively, U.S. PBMs provide prescription drug purchasing management services to some 266 million Americans, with the three largest companies providing those services to just under 80% of that marketplace. [22]

By carving out the prescription drug benefit and pooling the plans to bid for a single pharmacy benefit manager we estimate that the aggregate pharmacy costs can be reduced by between 5% and 10%.[23] Indeed, some of the employers surveyed and interviewed indicated that they already participate in a pharmacy purchasing coalition. For these employer groups, we would expect smaller level of savings to be achieved. For those employers, whose prescription

[22] Balto, David A. (November 17, 2015). "The State of Competition in the Pharmacy Benefits Manager and Pharmacy Marketplaces" (PDF). House Judiciary Subcommittee on Regulatory Reform, Commercial, and Antitrust Law. Retrieved 2016-03-29
[23] Based on results from recent pharmacy procurements. Aon Hewitt Pharmacy Coalition, 2015 results ranged from 4% to 20%, average of 11%. See: http://ars-us.aon.com/Global/National/National%20Brochures/PDFs/Rx%20Coalition%20Brochure.pdf

drug benefits are managed by their medical carrier, larger level of savings is expected.[24] The exact amount can only be determined through a competitive bidding process. However, based on our experience with recent pharmacy coverage procurements, employers collectively would be expected to be able to achieve savings of at least 5% of prescription drug costs.

CENTERS OF EXCELLENCE / TRAVEL BENEFIT

The survey data submitted indicates that 40 percent of employers currently offer a travel benefit to their employees. This travel benefit seeks to narrow the gap between cost and quality of care by steering members to the highest quality providers, both within and outside of Alaska, who have proven outcomes and predictable costs and savings.

The survey data showed that travel benefit designs and plan administration varied materially, including some plans that required plan participants to make their own arrangements to find alternative lower cost facilities and book and pay for their own travel and lodging in advance, and be reimbursed after the surgery/medical care. Other programs provided more of a concierge service with no requirement for up-front payment of travel costs. Of the employers who offer a travel benefit, 77 percent use BridgeHealth as their vendor (either directly or indirectly through Aetna) and 23 percent offer the travel benefit through Premera. The Centers of Excellence / Travel Benefit can be added to existing fully-insured or self-funded plan arrangements. The program is expected to save about $85 per employee per year on average by utilizing high quality low cost facilities for a range of needed and specified procedures.

Where there is no provider locally that can meet the needs of a member, travel will be required. Not all travel will be outside of Alaska, but when such travel is needed, the employees will need to address the matter of any follow up care, which may be arranged using a local primary care provider and telemedicine, or for more complicated cases follow up travel. Given the financial savings to both the member and the plan, travel to the lower 48 for specialized care is often the preferred option, and by including a Centers of Excellence / Travel Benefit program the costs and quality of health care can be optimized.

Table 22
Travel Benefit

	Participation Percent
Employees not offered a travel benefit services	60%
Employees offered travel benefit services	40%
BridgeHealth	77%
Premera	23%

Based on an analysis of the claims from the employers who used the travel benefit, it is estimated that employers saved between $4 and $9 per employee per month and incurred a fee that ranged between $1 and $2 per employee per

[24] For fully insured plans that participate in this purchasing strategy, carving out the prescription drug benefit would require a revised (reduced) premium rate to cover just the medical benefit. Based on experience in other states, insurers may be willing to offer a small reduction off the current premium if the employer keeps the pharmacy benefit with the insurer. The strategy may therefore yield savings without having to modify claims administration.

month. Table 23 below summarizes participation and the estimated cost and savings of the travel benefit programs currently in place among the employers responding to the survey.

Table 23
Travel Benefit Program Estimated Cost and Savings

	Per Employee Per Month
Program Savings	$4 - $9
Program Cost	$1 - $2
Net Savings	$3 - $7

For an employer who does not provide a travel benefit currently, estimated savings from adopting such a program would be just over $7 per employee per month, or $85 per year. This is the expected savings in the plan cost, however there are additional expected savings at the member level in terms of reduced out-of-pocket costs (see for example the member out-of-pocket costs illustrated in Table 21).

ADDITIONAL POTENTIAL CARVE OUT AND NETWORK DISCOUNTS

Durable Medical Equipment (DME) Benefit Carve-out

A Health Care Authority (or other pooled purchasing cooperative arrangement) could solicit competitive bids for a contract to provide DME for all the employers participating in the HCA. This equipment is usually supplied by the health plan, which may not have the lowest cost supplier in the state. Health plan members care more about the reliability and cost of their needed supplies and do not in most instances have a relationship with the DME supply companies, which makes this health benefit another candidate for a carve-out approach.

Preferred Diagnostic Radiology and Lab Network

A Health Care Authority would be positioned to negotiate discounted fee arrangements for certain services in locations where there are multiple service providers. These preferred service categories could include diagnostic radiology and laboratory services. While many regions in Alaska are served by a single hospital, even smaller cities may have multiple lab and radiology facilities, so a negotiated network arrangement could provide preferred pricing to most of the covered population.

HCA WITH CONSOLIDATED PURCHASING AND POOLED SAVINGS

If an HCA is established (and after it has at least one years' experience), it may be feasible for the HCA to offer a pooled rate for those employers that are currently fully-insured and are interested in moving to a self-insured basis.[25]

[25] PRM's study on health benefits for school employees in Pennsylvania identified several health care Consortia that had been formed to purchase health care for participating school districts. Each Consortium comprised groups of school districts (the smallest had 6, while the largest had 52) that pooled their employees to gain improved purchasing power. Some Consortia shared the savings by developing single health care pools, while others used a range of approaches to share the Consortium savings among the group participants. Most of the Consortia maintained autonomy for each school district with respect to health plan design and all maintained autonomy with respect to cost-sharing between employers participating in the Consortium and employees.

This subject will be addressed in more depth in Phase II of this project, in the examination of opportunities to coordinate more fully the purchasing of health care benefits among participating employers.

VOLUNTARY VS. MANDATORY PARTICIPATION IN CONSOLIDATED PURCHASING PROGRAMS

For the purposes of this Phase I report it is assumed that participation of other local government entities would be on a voluntary basis, following the models that are in place now for the Public Employees' Benefits Board (PEBB) programs in Washington and Oregon for the plans managed by their Health Care Authorities, and that also effectively mirror voluntary participation arrangements in other states now.

While the more extensive exploration of coordinated purchasing and management of HCA offerings suitable for Alaska will be undertaken in the Phase II report due later this year, it is nonetheless useful to observe now that voluntary participation of other governmental entities will likely limit the scope of what can be accomplished and makes that scope much more difficult to predict.

With voluntary participation, planning and negotiating covered population size-based discounts becomes difficult and it would be unlikely to achieve material additional savings above those already achieved under the status quo. Even if the HCA were to develop a shared risk pool, the size of the group on a voluntary basis and the potential for a larger number of higher cost plans choosing to join at the onset creates a risk that the savings from group purchasing are not sufficiently large to offset the higher cost of those groups.

Mandatory participation, which will be examined in more depth in Phase II, resolves those problems and confers additional advantages. It assures maximum scale, which will have a beneficial effect across a wide range of considerations.

These issues will be discussed in more detail in the Phase II report.

ORGANIZATIONAL STRUCTURE, STAFFING, AND GOVERNANCE

If a decision is made to create a Health Care Authority focusing on consolidating purchasing power, the organization will be responsible, albeit indirectly, for large amounts of State expenditures. Accordingly, PRM recommends that the HCA be established as an agency that can meet the needed operational excellence qualities of:

- Accountability
- Flexibility
- Transparency

Operational needs at the outset could be accomplished with a small administrative staff supported as needed with consultants and other experts. Initial staffing could be established with just an Executive Director and an administrative

assistant.26 Additional staff could then be added as actual enrollment on a voluntary basis is observed and as the emerging scale and administrative tasks dictate. Care should be taken in the selection of the Executive Director, to ensure the role is filled with a subject matter expert with knowledge of the local health care marketplace.

Based on our interviews and analysis of the existing self-insured health plans among the schools, municipalities, and other entities, PRM observed that the most cost efficient plans had committees that met several times per year to review the operations of the health plan and explored options and ideas for improving the management of the plan. It is therefore recommended that representatives from the various employers participating in the HCA have a seat at the table. Depending on the size of the number of employers participating in the HCA, governance rules may be required to limit the size of the HCA committee and to ensure appropriate representation from constituents (e.g. representation from bargaining groups and business managers at School Districts and Boroughs).

PROVIDER NETWORK MANAGEMENT AND CLAIMS ADMINISTRATION

In our view, provider network management and claims administration should be considered together. There are models in some health care programs where claims administration is to some degree separate from network management (e.g. certain of the plans sponsored by bargaining organizations that offer plans within the Federal Employees Health Benefits Program, Taft-Hartley plans administered by third party administrators including the ASEA health trust). However, even in those plans it is commonly the case the party responsible for claims adjudication and payment will partner with another vendor for network management. In these partnering arrangements, the claims payer is effectively renting those network management services from organizations investing the capital and resources required to perform all the functions associated with developing and managing quality and cost efficient networks.

The partnering is necessary since the claims payer must have the information and data in real time to determine:

- Whether the service is being rendered by an in-network or out-of-network provider;
- The precise contractual arrangements that govern the payment requirements to in-network providers;
- Whether turnover among network providers has changed the status of a particular provider for payment purposes.

Network development and management is critical to be cost competitive in offering these partnered services in competition with those organizations offering a more integrated model.

It is difficult to overstate the requirements, including managerial expertise, that are associated with developing and managing an integrated and effective claims administration and network development and management system, in an environment with the scale and complexity of the health care system in the United States. Perhaps the magnitude of the capital, resources and effort required to compete in this arena is best illustrated by the rapid and continuing consolidation among providers active in the employer-sponsored plan marketplace.

[26] Commonwealth of Pennsylvania's largest consortium, which covers 52 separate groups and including 49,000 covered lives has no full-time staff, instead relying on consultants/contractors, overseen by Trustees appointed by representatives from the consortium.

Thirty years ago, the health insurance marketplace included, in addition to the few remaining national players, many large, well-capitalized and well-managed companies providing services to employer sponsored health care plans. That array of providers included household names such as MetLife, Prudential, Lincoln National, John Hancock, Travelers and Principal Financial Group. Those and other similarly situated companies have exited the health care plan administration business in a steady stream over the last few decades, selling their health care operations to the companies better positioned and with sufficient scale to remain in this demanding business.[27]

In addition, consolidation continues apace among the nation's Blue Cross/Blue Shield plans, and in the ongoing consolidation of companies in the pharmacy benefit management space. Notable recent examples include OptumRx's acquisition of Catamaran and the partnering of CVS Pharmacy with OptumRx, to offer certain services through CVS' retail pharmacy chain, which had previously been offered exclusively to CVS Pharmacy employer-sponsored plan customers. That partnering arrangement was just announced on November 29, 2016.[28]

We also should point out that while decades ago some employers adjudicated and paid claims for their employees, including some very large employers (e.g. Marriott Corporation) those arrangements are essentially in the past. PRM knows of no U.S. employer, large or small, that continues to pay health care claims and to develop and manage its own network of health care providers.

The marketplace in the U.S. as it has developed over the recent past makes clear that the preferable business model for the management of employer-sponsored health plans includes strong network development and management and claims adjudication and payment functions in a fully integrated environment. The management of employer-sponsored health plans through strong partnering arrangements is especially important in terms of continuing to contract for services for the AlaskaCare plan, and we expect that those or similar partnering arrangements will continue to be the preferred model if the current programs and/or redesigned health care offerings are extended to a broader group of public sector employers in Alaska and even ultimately to the Medicaid program or certain aspects of that program.

PHARMACY PURCHASING AND MANAGEMENT

In effect, the State of Alaska already has experience with consolidation of pharmacy benefits through its management of the AlaskaCare employee plan and with the administration of the retiree plans which includes all retirees from public employer plans within the state. As noted, current experience has generally been favorable.

In the administration of pharmacy benefits, scale is the most significant factor in extracting the most favorable pricing terms from the major pharmacy benefit vendors and through those vendors from the pharmaceutical industry. The continuing consolidation of the pharmacy benefit management industry, and the formation of pharmacy benefit coalitions, has demonstrably generated better pricing terms, though concededly in an era marked by continuing escalation of drug prices relative to the other components of employer and participants' health care spend.

[27] Source: None of the insurers mentioned are currently listed with health insurance premium revenues in Alaska's Division. of Insurance latest report.
[28] http://www.businesswire.com/news/home/20161129005768/en/

Another significant factor apart from scale is the diligence that employers (and coalitions representing multiple employers) have shown in more frequent competitive bidding and/or pricing negotiations with current vendors in the pharmacy arrangements. In the largest and most efficient of those coalitions, annual pricing review and negotiations are the norm.

Should the State of Alaska decide to move forward with considering further consolidation of the current purchasing arrangements for health care benefits, whether the process contemplates extending AlaskaCare offerings or a revised set of health care offerings to additional state funded employers, rebidding and/or renegotiation of the current partnering arrangements with Aetna and Aetna's current prescription drug benefit partner, CVS Pharmacy, should be undertaken in accordance with the state's normal procurement procedures. The bid specifications should be organized to compare pricing based on the status quo with alternative pricing designed to measure the effect of greater scale through the inclusion of additional employers whose plans are supported by state funding.

Finally, bids should also be solicited from the major pharmacy purchasing coalitions. The three largest employee benefit consulting firms all manage such coalitions and each contract with the major pharmacy benefits management firms for employer plans involving billions of dollars of drug spend. In addition, the HCCMCA is part of a purchasing coalition that includes some 200,000 members participating in the prescription drug purchasing arrangements currently with CVS – another example of using scale and intensive management of pharmacy purchasing to improve terms relative to what individual employers or unions participating would be able to negotiate on their own.[29]

THE EMPLOYER GROUP WAIVER PLAN CONCEPT

One pooled purchasing approach that the State will be able to implement with shared benefits across many of the S.B. 74 entities is to change the method by which the AlaskaCare retiree plan coordinates with the Centers for Medicare and Medicaid Services with respect to prescription drug benefits under the Medicare Part D program. This is an example of how a purchasing strategy can be coordinated across many employers through the existing structure. Currently, the State of Alaska coordinates with CMS using the Retiree Drug Subsidy (RDS) program. Any changes to the administration of the retiree medical benefits program will need to consider the contractual and constitutional limitations on diminishment of benefits. There are distinct advantages and benefits to the State of Alaska changing from the RDS program to the use of an Employer Group Waiver Plan (EGWP). Benefits also accrue to the school districts and political subdivisions whose employees participate in the Teachers' Retirement System (TRS), Public Employees' Retirement System (PERS), or the Judicial Retirement System (JRS).

Retiree Drug Subsidy

The RDS program permits eligible plan sponsors to apply for payments for eligible prescription drug costs incurred by Medicare-eligible plan participants. For calendar year 2016, the amount of the payment from CMS is 28 percent of eligible prescription drug expenses in excess of a per person deductible of $360 up to a threshold maximum of $7,400. The expected future payments from CMS are considered in the funding valuations of TRS and PERS, resulting in a reduction in the Normal Cost for retiree health insurance benefits of about 5.5% ($5.4 million in aggregate for FY2016)

[29] Note that the 200,000 members includes lives in Alaska as well as other states.

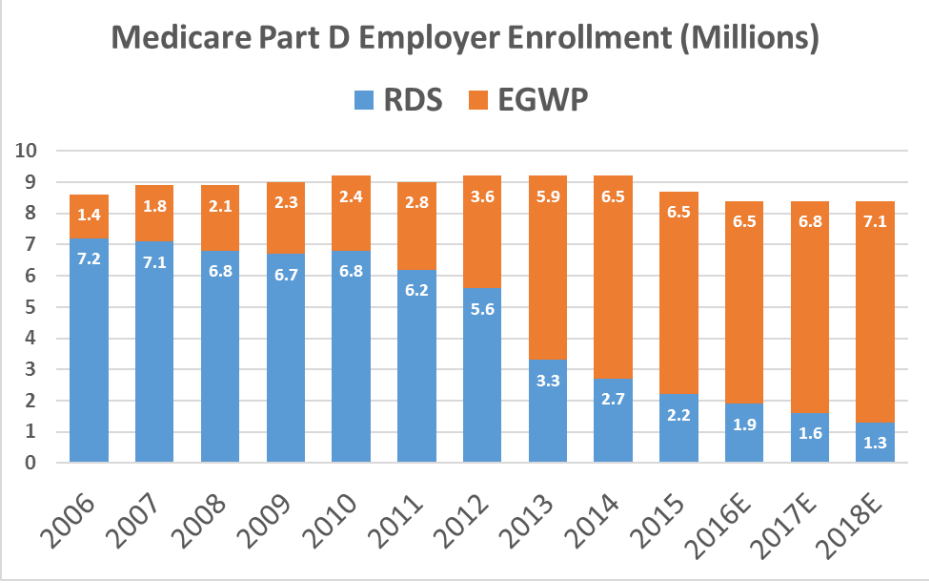
and a reduction in the Actuarial Accrued Liability for retiree health insurance of 6.2% ($666 million in aggregate for FY2016).

Employer Group Waiver Plan

An Employer Group Waiver Plan (EGWP) is an alternative way of using federal funding to reduce the cost of prescription drug benefits for employer sponsored retiree health care plans. Employers who contract directly with CMS or indirectly through a CMS approved insurance company for an EGWP plan benefit from three funding payment streams. First, a direct subsidy payment is made monthly for each eligible plan participant with the amount of the subsidy payment determined by CMS based on each individual's "risk score" which is determined based on a range of factors including the age, gender, and Medicare enrollment status of the individual as well as factors based on the individual's recent health care encounters. Second, a payment is made that offsets 80% of the incurred expenses above the catastrophic claim level as defined in the Medicare D program. The third funding payment stream is administered by CMS but comes from the pharmaceutical manufacturers who agreed to provide a 50% discount on applicable drug expenses above the initial coverage level ($3,310 in 2016) and up to the catastrophic claim level.

The chart below shows the count of the number of retirees from employer sponsored prescription drug plans with participation in Medicare Part D nationally under both the RDS and EGWP programs with CMS. As the chart shows, the increased savings associated with EGWP programs compared with the RDS subsidy has resulted in steady growth in EGWP plan participation and a corresponding decline in employers applying for the RDS subsidy. This rapid increase in EGWP enrollment coincided with the expansion of Medicare part D under the Affordable Care Act, which includes the additional Pharma payments that offset a portion of the cost of brand drug expenses.

Figure 5 - Medicare Part D Employer Enrollment



Source: 2016 Medicare Trustees Report, Table IV.B7.

In contrast to the accounting treatment for the RDS payments, the Governmental Accounting Standards Board permits recognition of EGWP payments as an offset to future retiree health care costs, thus reducing governmental employers' reported liabilities.

Based on insurance carrier range estimates for the three funding payment streams, it is estimated that implementing EGWP would increase the reduction in Normal Cost by a further $6.9 million for FY2016 (over and above the amount reflected through RDS) and reduce the Actuarial Accrued Liability for retiree health insurance by a further $847 million for FY2016. Details of these estimates are included in Appendix B.

Table 24
EGWP Savings Estimates
As of June 30, 2015

	Actuarial Liability[30]	Normal Cost[31]
	$Millions	$Millions
A. Gross Liability	$10,751.6	$99.2
B. Net of RDS	$10,083.8	$93.7
C. Savings due to RDS (A – B)	$667.9	$5.5
D. Net of EGWP	$9,236.7	$86.8
E. Additional savings due to EGWP (B – D)	$847.1	$6.9

As the participating employers of the active plan participants in PERS, JRS, and TRS (including the employees in the Defined Contribution Retirement Plans) are required to contribute towards the funding of the retiree health insurance coverage, adoption of the EGWP Medicare Part D integration approach will reduce each employer's required funding payments.

In addition to these plan sponsor benefits, adoption of an EGWP program would also provide possible additional benefits to certain low income AlaskaCare retirees. CMS would administer eligibility for these additional benefits which include monthly premium subsidies as well as plan design cost-sharing subsidies. To the extent that a premium subsidy is payable and the AlaskaCare retiree is not incurring monthly premium charges for coverage, the State would receive the premium subsidy amount. Similarly, to the extent that the plan design cost-sharing provisions do not result in any required reduction in copays or out-of-pocket costs for these low-income members, the CMS cost-sharing subsidy payments would further reduce the State's costs.

[30] Total accumulated cost of postemployment benefits arising from service in all prior years.
[31] That portion of the actuarial present value of benefits assigned to a particular year in respect to an individual participant or the plan as a whole.

MEDICAID

The foundation of the Medicaid program is a federal/state partnership in all 50 states. The programs are governed by statute and regulations at both the federal and state levels. In addition, the effectiveness of the program within any state is dependent on a successful working relationship between the authorities with responsibility for the program at the state level and those charged at the federal level with administration of the program, particularly through the oversight function of the Centers for Medicare and Medicaid Services (CMS).

Given the outcome of the November 8, 2016 elections and the pending appointments of new leadership at the cabinet level – the Secretary of the Department of Health and Human Services – and CMS as well as the various legislative efforts underway at the federal level, it is prudent to reserve to Phase II of this engagement the more extensive analysis of the possible roles and responsibilities for a new Health Care Authority with respect to Alaska's Medicaid program. The Phase II report will examine how responsibility for a broadened coalition of public-funded employer sponsored health care programs and Medicaid might be leveraged with the goal of both improving the economics of delivering needed care to Alaskans and improving access and health care outcomes for the state's population covered by these programs.

Nonetheless, it is useful to comment on the status of delivering services to the state's population covered by Medicaid, as a predicate for the more extensive analysis that will be undertaken in Phase II of this engagement.

BACKGROUND

The Medicaid program is an important part of the health care landscape for Alaskans. At present, the program covers over 20% of the state's population, and an essentially equal proportion of Alaskan's total spend for health care, or $1.7 billion in FY2016.

MEDICAID SERVICE CONTRACTORS

Currently, the Alaska Medicaid program contracts with organizations that provide certain health plan functions for state Medicaid programs. These organizations include:

- Qualis Health – Behavioral Health & Health Care Services:
  - Utilization management activities
    - Pre-admission review
    - Concurrent review
  - Retrospective review
  - Expedited and standard appeals
  - Case management
  - Special case review
  - Assessment (quality of care) review
  - Educational seminars on care management

- MedExpert – Care Coordination & Management
  - Care coordination for high utilizers
  - Primary care case management
- Magellan – prescription drug benefit manager
- Conduent State Healthcare LLC – Information technology and provider payment system architect (formerly Xerox State Healthcare, LLC)

Currently there is no overlap between these organizations and the carriers and third-party administrators that provide services to the school districts and political subdivisions for their health plan administration. Accordingly, PRM does not project any immediate cost savings from consolidated purchasing across Medicaid and the public employer health plans for these health care services.

MANAGED CARE AND MEDICAID

Another observation that should be noted, which distinguishes Alaska's Medicaid program from counterparts in almost all other states, is the current absence of managed care in the Medicaid program. We do not suggest that this is for lack of effort but rather from lack of opportunity, reflecting the reality that there is limited scale and little competition among health care providers in Alaska, and essentially none outside population centers, both of which are arguably prerequisites for developing robust managed care models.

Nonetheless the reported data is instructive. Shown below in Table 25 are the percentages of selected states' Medicaid population enrolled in managed care programs, also reported by the Kaiser Family Foundation:

Table 25
Percent of Medicaid Population enrolled in Managed Care

North Dakota	58%
Alaska	0%
Montana	69%
Delaware	86%
Wyoming	0.1%
Florida	76%
Michigan	98%
California	68%
New Jersey	92%
Rhode Island	85%
Washington	100%
Oregon	92%
United States	77%

http://kff.org/medicaid/state-indicator/total-medicaid-mc-enrollment/?

As the data in Table 25 indicates, Alaska (as of the 2014 data) had zero percent of its Medicaid population in managed care programs, so it continues to operate in a fee-for-service environment as other states continue to trend toward adoption of managed care initiatives. Nevertheless, it should be noted that the S.B. 74 Medicaid reforms described below may facilitate movement away from fee-for-service in Alaska's Medicaid program. At present, more than 50% of Medicaid beneficiaries receive most or all their care from risk-based managed care organizations. And more than 70% receive some portion of their care from managed care organizations or programs.[32]

The strong growth trend in these managed care initiatives in the Medicaid program has been documented in a report published by Medicaid.gov. The report shows that the national Medicaid managed care penetration rose steadily from 56% in 2000 to 74% in 2013.[33]

That trend is likely to accelerate in future years due to the continued growth in the population covered by Medicaid expansion under the Patient Protection and Affordable Care Act, and the continuing pressure that is likely at both the state and federal level to constrain the growth in the costs of the Medicaid program.

[32] http://kff.org/data-collection/medicaid-managed-care-market-tracker/
[33] https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/medicaid-managed-care/downloads/2013-medicaid-managed-care-trends-and-snapshots-2000-2013.pdf

S.B. 74 MEDICAID REFORMS

In addition to authorizing this study, Senate Bill 74 also set out several Medicaid reforms, summarized in the following table. These reforms were reviewed to identify if there is an opportunity for consolidated purchasing or procurement that could be established across Medicaid and the public employer health plans. These reforms will also be evaluated in the Phase II report which will explore opportunities for coordinated care or coordinated program management.

Table 26
S.B. 74 Medicaid Reforms

Delivery System Reforms	
1) **Primary Care Case Management & Health Homes**	• Expanding existing contract with MedExpert to expand case management services to all Medicaid recipients, except those who are Alaska Native/American Indian • Health Homes to be implemented July 1, 2018
2) **Behavioral Health System Reform**	• Partnering with the Alaska Mental Health Trust Authority to develop a comprehensive and integrated behavioral health program under a Section 1115 Waiver to provide flexibility in Medicaid coverage and payment policies. • 6 public-private teams working on designing different aspects of the reformed system: the Policy, Benefit Design, Quality, Cost, Data, and Writing Teams. • Timeline: Waiver Concept Paper submitted to CMS by the end of December; Waiver application submitted to CMS by July 1, 2017.
3) **Coordinated Care Demonstration Project**	• Mandated under S.B. 74 to test new delivery system and payment models, such as Accountable Care Organizations, and shared-savings/shared-risk reimbursement. • Issued a Request for Information to learn which organizations are interested and what they are considering. Received 12 responses, ranging from regional Accountable Care Organization (ACO)-type models, to limited case management services for Per Member Per Month plus Fee-for-service payment, to statewide full risk managed care. • Contracts in place with Pacific Health Policy Group for technical assistance, and with Milliman, Inc. for actuarial consulting and analysis. • RFP released on December 30, 2016. • Anticipate intensive and iterative proposal evaluation and negotiation process throughout CY 2017. Anticipate go-live for projects in CY 2018.
4) **1915(i) & 1915(k)**	• S.B. 74 authorizes implementation of these two federal authorities, which are optional Medicaid services that support recipients with long-term care needs to be served in their homes and communities. • Contract with an HMA (Health Management Administrator) to evaluate costs, potential savings, and options recently completed. • Department evaluating recommendations and developing an implementation plan.
5) **Criminal Justice Reform (SB 91) – Led by DOC**	• Working closely with Department of Corrections (DOC) on aspects of SB 91 that link to DHSS programs, such as support for prisoners reentering the community to access Medicaid and public assistance benefits if eligible, enhanced access to rehabilitation programs, and removal of the lifetime ban on food stamps for those with felony drug convictions.

Table 26 S.B. 74 Medicaid Reforms	
6) **Emergency Department (ED) Care Improvement – Led by ASHNHA**	• S.B. 74 requires the department to partner with the Alaska State Hospital & Nursing Home Association (ASHNHA) to establish this hospital-based project to reduce the use of emergency department services by Medicaid recipients. • ASHNHA is working with ACEP (American College of Emergency Physicians) to design and implement emergency department best-practices, including opioid prescription policies, real-time information exchange between emergency departments, and primary care referrals. • Includes shared-savings payment reform provision.
Delivery System Infrastructure	
7) **Telehealth and Quality & Cost-Effectiveness Targets Workgroups**	• Convened two stakeholder workgroups that are meeting throughout FY 2017 to identify and develop recommendations to address barriers to telehealth, and to set annual targets for Medicaid quality and cost-effectiveness.
8) **Health Information Infrastructure Plan**	• S.B. 74 requires the department to develop a plan to strengthen the health information infrastructure to support reform, including health data analytics. The department has contracted with HealthTech Solutions to conduct an infrastructure assessment, and the department will be convening a stakeholder workgroup to assist with development of the plan during CY 2017.
9) **Tribal Claiming Policy**	• Implementing new federal policy that reinterprets services "received through" an Indian Health Service/tribal facility, allowing state to claim 100% federal reimbursement for services provided to Alaska Natives and American Indians who are also Medicaid recipients in non-tribal facilities. • DHSS effort to collaborate with tribal and non-tribal health system partners on federal compliance requirements. • Improves access to care for Alaska Native and American Indian Medicaid recipients and improves coordination of care between tribal and non-tribal health systems.
10) **Medicaid Reform Program**	• Annual Report distributed to Legislators by November 15 of each year. First report distributed on November 15, 2016.
11) **Prescription Drug Monitoring Program (PDMP) – Led by DCCED**	• Registering with the database – Adds Dentists, Physicians, Advanced Nurse Practitioners, Optometrists, Pharmacists • Exemptions when prescribing or dispensing schedule II or III controlled substances – Submit data on at least a weekly basis; changed from monthly • Create guidelines for the prescription of Schedule II controlled substances.
Internal Systems Improvements	
12) **Regular Reporting to the Legislature and Stakeholders**	• Internal Departmental Workgroup to meet reporting requirements in S.B. 74.

Table 26 S.B. 74 Medicaid Reforms	
13) **Eligibility Verification System**	• System required by S.B. 74 to verify eligibility, eliminate duplication of public assistance payments, and deter waste and fraud in public assistance programs.
14) **Fraud & Abuse Prevention**	• S.B. 74 implements the Alaska Medicaid False Claim Act • Dept. of Law transmitted the Annual Fraud Report to the Legislature on Nov. 15, 2016
Exploring Options	
15) **Privatization Feasibility Studies**	• S.B. 74 mandates studies of the feasibility of privatization of select Juvenile Justice Facilities, Alaska Psychiatric Institute, and Pharmacy Services for the Pioneer Homes • Reports due to the Legislature within 10 days of start of session.

PROJECTION OF THE EXPECTED SAVINGS TO EACH PARTICIPATING ENTITY

As noted earlier, PRM identified three cost saving strategies that could be implemented for the current entities without having to immediately change or modify their plan design or premium sharing arrangements.

ESTIMATED SAVINGS BY EMPLOYER GROUP

Tables 27 and 28 show estimated annual savings if two of these strategies—a comprehensive travel benefit program and prescription drug carve out program--were to be implemented. For the travel benefit and pharmacy carve out, we have shown two sets of possible savings. Table 27 illustrates the expected savings with limited participation. In this estimate, only entities that would be expected to achieve a reduction in costs are assumed to participate. Table 28 shows the additional savings that accrue from larger scale when all groups are combined in a larger purchasing pool. In addition, we describe more fully the development of potential savings from moving to an EGWP program for pharmacy benefits for Medicare eligible retirees in Appendix B.

The estimated savings in Table 27 take into account the current structure and presence of travel benefit programs and existing pharmacy carve-outs and pharmacy purchasing coalitions. Thus, for example there are no savings shown in Table 27 under the travel benefit for the University of Alaska and the school districts in PEHT as they already have such a program. Similarly, there are no pharmacy carve-out savings attributed to ASEA/AFSCME Local 52, and Fairbanks North Star Borough and School District as they already participate in a pharmacy purchasing coalition.

Table 27
Estimated Savings by Employer Group - If Some Entities Participate

Employee Groups	Total Estimated Enrollment-Households	Travel Benefit Savings	Rx Carve Out Savings	Total Savings
State Employees				
ASEA/AFSCME Local 52	7,548	$644,000	$0	$644,000
Local 71	1,876	$160,000	$238,000	$398,000
AlaskaCare	6,176	$527,000	$0	$527,000
University of Alaska	3,403	$0	$431,000	$431,000
State Corporations	291	$25,000	$37,000	$62,000
PSEA	465	$40,000	$59,000	$99,000
MMP	90	$8,000	$11,000	$19,000
School Districts & Political Subdivisions				
Individual School Districts	8,124	$693,000	$879,000	$1,572,000
School Districts in PEHT	5,898	$0	$747,000	$747,000
Individual Political Subdivisions	9,209	$786,000	$1,090,000	$1,876,000
Fairbanks North Star Borough and School District	1,906	$35,000	$0	$35,000
Total Savings		**$2,918,000**	**$3,492,000**	**$6,410,000**

Table 28 shows the additional savings that accrue from larger scale when all groups are combined in a larger purchasing pool.

Table 28
Estimated Savings by Employer Group - If All Entities Participate

Employee Groups	Total Estimated Enrollment-Households	Travel Benefit Savings	Rx Carve Out Savings	Total Savings
State Employees				
ASEA/AFSCME Local 52	7,548	$735,000	$383,000	$1,118,000
Local 71	1,876	$183,000	$475,000	$658,000
Alaska Care	6,176	$601,000	$469,000	$1,070,000
University of Alaska	3,403	$41,000	$862,000	$903,000
State Corporations	291	$28,000	$74,000	$102,000
PSEA	465	$45,000	$118,000	$163,000
MMP	90	$9,000	$23,000	$32,000
School Districts & Political Subdivisions				
Individual School Districts	8,124	$790,000	$1,819,000	$2,609,000
School Districts in PEHT	5,898	$71,000	$1,495,000	$1,566,000
Individual Political Subdivisions	9,209	$896,000	$2,211,000	$3,107,000
Fairbanks North Star School District and Borough	1,906	$58,000	$97,000	$155,000
Total Savings		**$3,457,000**	**$8,026,000**	**$11,483,000**

IMPACT ON EXISTING VENDORS

For the Phase I report PRM identified three purchasing strategies that could be implemented without having to modify or change the existing health care plan designs and funding arrangements. These strategies would represent immediate savings opportunities that would have only a limited impact on the current vendors.

EMPLOYER GROUP WAIVER PLAN

Adopting an Employer Group Waiver Plan should have no impact on current vendors as the additional funds under EGWP come from CMS and the pharmaceutical manufacturers responsible for funding the coverage gap discount program. The carrier that is selected to administer the EGWP would have additional data management responsibilities which would be covered through fees negotiated through the procurement process.

CENTERS OF EXCELLENCE / TRAVEL BENEFIT

The Centers of Excellence / Travel Benefit is not expected to have a material impact on current insurance vendors. The State or a Health Care Authority is anticipated to secure the best arrangement for all entities through a competitive bidding process pooling the purchasing power of the over 100,000 covered lives under a single contract. Any existing travel benefit coverage from a non-winning vendor would either terminate or expire at the end of the existing contract, and therefore for those affected vendors, there would be a loss of renewal revenues.

If implemented across all, or almost all, public employer health plan entities included in S.B. 74, some higher-cost non-preferred providers may, over time, see a reduction in the number of patients seeking their services due to the availability of the Centers of Excellence / Travel Benefit. This may have an ancillary impact on hospital or ambulatory surgical center facility revenue and utilization rates. Some lower cost non-preferred providers located in Alaska may see an increase in the number of patients seeking their services given the availability of the travel benefit to identify and support travel to lower cost service providers.

PHARMACY BENEFIT CARVE-OUT

Moving the prescription drug coverage from current arrangements (i.e. coordinated with the medical coverage) to a separate pharmacy contract will have an impact on existing medical carriers. The impact would vary from carrier to carrier depending on whether the prescription drug benefits are administered in a traditional arrangement (i.e., some rebates are retained by the vendors and no administrative fee is charged) or in a transparent arrangement (where all rebates are passed on to the employers but administrative fees are charged).

NECESSARY STEPS FOR IMPLEMENTATION

We have set out below the implementation steps and timetables for the three cost saving strategies identified in this Phase I report that could be implemented without the individual employers having to revise or modify their existing health care plan designs or premium cost sharing arrangements with employees.

Administration and implementation of these strategies will require coordination and therefore a necessary first step would be to identify the agency that would provide the resources to coordinate, market, and implement the travel benefit and pharmacy carve out strategies. If a decision is made to establish a HCA to implement these strategies, the following steps would be needed:

- Administration develops budget for HCA, including fiscal impact and other supporting materials
- Discuss proposal with stakeholders and adjust as needed
- Enabling legislation introduced
- Enabling legislation enacted
- New agency established (or existing agency's role expanded), with appointment of Executive Director with the requisite subject matter expertise and knowledge of local health care issues. Administrative support for first year tasks.
- Timetables for travel benefit and pharmacy carve-out programs distributed to S.B. 74 entities and solicited to participate on a voluntary or mandatory basis.

EGWP – implementation date of January 1, 20XX+1 (e.g. 2018)

Table 29 - EGWP Timetable

April 20XX- - - - - - - - - - -	- - - - - - - - - - - - - - - -	- - - - January 20XX+1
Request for Proposal (RFP)	- Issue RFP	April – July 20XX
Planning	- Notify vendor of decision - Implementation kick-off - Finalize detailed implementation and milestone plans	August - October 20XX
Pre-enrollment	- Communication strategy discussion - Finalize key deliverables and timelines - Define eligibility rules, file requirements and subsidy strategy - Retiree education sessions - Discussion with call center advisor - Initiate communication mailing sequence - Open call center	October 20XX
Open Enrollment	- Enrollment processing and reporting - ID card and welcome kit mailing	November - December 20XX
Plan Effective	- Plan year begins	January 20XX+1
Post Implementation	- Post implementation review/ongoing administrative discussions	February 20XX+1

Pharmacy carve-out. Implementation either January 1, 2018 (many plans have a July 1 to June 30th plan year), or July 1, 2018.

Table 30 - Prescription Drug Timetable			
Timetable for implementation as of		January 1, 2018	January 1, 2019
Determine groups that would participate	- Communicate strategy and savings potential to all plans and solicit interest in pooled arrangement	March 2017	March 2018
Request for Proposal (RFP)	- Issue RFP	April – May 2017	April – May 2018
Planning	- Notify vendors of decision - Implementation kick-off - Finalize detailed implementation and milestone plans	September 2017	September 2018
Pre-enrollment / Implementation	- Communication strategy discussion - Finalize key deliverables and timelines - Entity education sessions	October 2017	October 2018
Plan Effective (CY)	- Plan year begins for calendar year plans	January 2018	January 2019
Plan Effective (Non-CY)	- Plan year begins for non-calendar year plans	Plan year commencing after January	

Centers of Excellence / Travel Benefit. Sample implementation timetable assuming effective date of January 1, 2019.

Table 31 - Centers of Excellence / Travel Benefit Timetable March 2017- September 2017		
Determine groups that would participate	- Communicate strategy and savings potential to all plans and solicit interest in pooled arrangement	March 2018
Request for Proposal (RFP)	- Issue RFP	May 2018
	- Due date for responses from vendors	July 1, 2018
Planning	- Notify vendors of decision - Implementation kick-off - Finalize detailed implementation and milestone plans	July 2018
Pre-enrollment / Implementation	- Communication strategy discussion - Finalize key deliverables and timelines - Entity education sessions	August 2018
Communication	- Summary plan documents amended to include descriptions of the benefit - Communication outreach to entities, video, FAQs and other elements of the strategy	September – December 2018
Plan Effective	- Program year begins for all plans	January 1, 2019

ACKNOWLEDGMENTS

The following stakeholders responded to the request for survey data and provided information that was included in the study. We wish to recognize and thank the many individuals who invested their time in providing the core data needed for the study.

School districts that provided data

Alaska Gateway Schools
Aleutian Region Schools
Aleutians East Borough Schools
Anchorage Schools
Annette Island Schools
Bering Strait Schools
Bristol Bay Borough Schools
Chatham Schools
Chugach Schools
Copper River Schools
Cordova City Schools
Craig City Schools
Delta/Greely Schools
Denali Borough Schools
Dillingham City Schools
Fairbanks North Star Borough Schools
Galena City Schools
Haines Borough Schools
Hoonah City Schools
Hydaburg City Schools
Iditarod Area Schools
Juneau Borough Schools
Kake City Schools
Kenai Peninsula Borough Schools

School districts that provided data

Ketchikan Gateway Borough Schools
Klawock City Schools
Kuspuk Schools
Lake and Peninsula Borough Schools
Lower Kuskokwim Schools
Lower Yukon Schools
Mat-Su Borough Schools
Mount Edgecumbe
Nenana City Schools
Nome Public Schools
Northwest Arctic Borough Schools
Pelican City Schools
Petersburg Borough Schools
Pribilof Schools
Sitka Borough Schools
Skagway Schools
Southeast Island Schools
Southwest Region Schools
Tanana Schools
Unalaska City Schools
Valdez City Schools
Wrangell City Schools
Yakutat City Schools
Yukon-Koyukuk Schools

Political subdivisions that provided data

Bristol Bay Borough
City and Borough of Juneau
City and Borough Sitka
City and Borough Wrangell
City and Borough Yakutat
City of Adak
City of Aleknagik

Political subdivisions that provided data

City of Anaktuvuk Pass
City of Anderson
City of Atka
City of Atqasuk
City of Bethel
City of Chignik
City of Chuathbaluk

Political subdivisions that provided data

City of Clark's Point
City of Craig
City of Delta Junction
City of Dillingham
City of Edna Bay
City of Egegik
City of Ekwok
City of False Pass
City of Holy Cross
City of Homer
City of Houston
City of Huslia
City of Kaktovik
City of Kasaan
City of Kodiak
City of Kotzebue
City of Kupreanof
City of Larsen Bay
City of Lower Kalskag
City of McGrath
City of Nenana
City of Nome
City of Palmer
City of Pelican
City of Pilot Point
City of Platinum
City of Port Alexander
City of Port Lions
City of Russian Mission
City of Saint Mary's
City of Saint Paul
City of Saxman
City of Seldovia
City of Shaktoolik
City of Soldotna
City of Tanana
City of Tenakee Springs
City of Unalakleet

Political subdivisions that provided data

City of Unalaska
City of Upper Kalskag
City of Valdez
City of Wainwright
City of Wasilla
City of White Mountain
Denali Borough
Eastern Aleutians Tribes
Fairbanks North Star Borough
Haines Borough
Kenai Peninsula Borough
Ketchikan Gateway Borough
Kodiak Island Borough
Matanuska-Susitna Borough
Municipality of Anchorage
Petersburg Borough

Corporations that provided data

Alaska Gasline Development Corporation
Alaska Housing Finance Corporation
Anchorage Economic Development Corporation

Health trusts that provided data

ASEA/AFSCME Local 52
National Education Association
Public Employees Local 71

Other entities that provided data

Department of Administration
Department of Health and Social Services
Division of Insurance
Division of Risk Management
University of Alaska

APPENDICES

APPENDIX A

List of organizations interviewed

Health Care Authorities

Oregon Health Care Authority

Washington Health Care Authority

Departments

Dept. Health & Social Services

Division. of Insurance

Division. of Risk Management

Dept. of Education and Early Development

Dept. of Administration

Health Insurance Companies & Brokers

Aetna

BridgeHealth

Moda

Premera

Wilson Agency

Other Interviewees

AeHN

Alaska Association of Health Underwriters

Alaska Association of School Boards

Alaska Association of School Business Officials

Alaska Behavioral Health Association

Alaska Council of School Administrators

Alaska Dental Society

Alaska Hospitalist Group

Alaska Medical Group Management Association

Alaska Mental Health Board/ABADA/Suicide Prev. Council.

Alaska Mental Health Trust Authority

Alaska Municipal League

Alaska Native Tribal Health Consortium

Alaska Primary Care Association

Alaska State Hospital & Nursing Home Assn.

American College of Emergency Physicians - AK Chapter

Other Interviewees

Alaska eHealth Network
Anchorage Economic Development Corporation
Municipality of Anchorage
Anchorage Neighborhood Health Center
Anchorage School District
ASEA/AFSCME Local 52
Central Peninsula Hospital
Effective Health Design
Fairbanks North Star Borough
Fairbanks North Star Borough School District
Geneva Woods Pharmacy
Health Care Cost Management Coalition
City and Borough of Juneau
Juneau School District
Kenai Peninsula Borough
Ketchikan Gateway Borough
Ketchikan Gateway Borough School District
Alaska State Legislative Finance
Lower Kuskokwim School District
Matanuska-Susitna Borough
Mat-Su Health Foundation
Mat-Su Borough School District
National Education Association - AK
Public Safety Employees Association
Department of Health and Social Services-State Health Information Technology Office
University of Alaska

APPENDIX B

Overview of the Prescription Drug Benefit under Medicare Part D

Beginning in 2006, Medicare beneficiaries had the option of obtaining prescription drug coverage through stand-alone private drug plans or through private preferred provider organizations or health maintenance organizations. Beneficiaries pay monthly premiums. Under the Standard Design, after an annual deductible, beneficiaries pay 25 percent of costs up to the Initial Coverage Level for all prescription drug costs, with Medicare paying 75 percent. Once annual drug costs reach the initial coverage level, beneficiaries were required to pay 100 percent of their drug costs until their out-of-pocket expenses reach a maximum out of pocket threshold. Above that level the catastrophic coverage feature of Medicare pays 95 percent of the drug costs with beneficiaries paying just 5 percent.

Table B-1
Medicare Part D Thresholds

	2013	2014	2015	2016	2017
1. Deductible	$325	$310	$320	$360	$400
2. Initial Coverage Limit	$2,970	$2,850	$2,960	$3,310	$3,700
3. Out of Pocket Threshold	$4,750	$4,550	$4,700	$4,850	$4,950
4. Catastrophic Coverage	$6,734	$6,455	$6,680	$7,063	$7,425
Copays above 4.					
a. Generic/Preferred Multi-source Drugs	$2.65	$2.55	$2.65	$2.95	$3.30
b. Other	$6.60	$6.35	$6.60	$7.40	$8.25
Plan Coinsurance between 2. And 4.					
5. Non-applicable drugs	21%	28%	35%	42%	49.0%
6. Applicable drugs	2.50%	2.50%	5%	5%	10.0%
Retiree Drug Subsidy Amounts					
7. Cost Threshold	$325	$310	$320	$360	$400
8. Cost Limit	$6,600	$6,350	$6,600	$7,400	$8,250
9. Estimated RDS Payment (from Trustees Report)	$541	$593	$625	$659	$693

Table B-2 shows the National Average Bid and National Average Premium amounts for 2016 and 2017. Together with the member's risk score (which varies by individual and is determined by CMS) these values are used to determine the direct subsidy payments, one of the funding sources for the EGWP plans. The amount of the direct subsidy is determined as the product of the individual member's risk score times the National Average Bid amount, from which the National Average premium is subtracted. Therefore, for an individual with a risk score of 0.9, the 2016 direct subsidy would be $27.63 per month. If there was no change in the risk score throughout the year the direct subsidy amount received would $331.56 for this retiree.

Table B-2 Medicare Part D National Average Bid and Premium Payments		
Calendar Year	**2016**	**2017**
National Average Bid	$64.66	$61.08
National Average Premium	$34.10	$35.63
Monthly Direct Subsidy (based on a risk score of 1.0)	$30.56	$25.45

Under an approved EGWP plan, the approved insurance carrier receives up to five payments from CMS which will offset the costs to the State. The CMS payments are:

1. **Direct Subsidy Amounts.** These are paid monthly. The direct subsidy amounts are determined based on each eligible plan member's "risk score." CMS determines the risk score using input factors to their model including age, gender, Medicare enrollment (aged, disabled), medical diagnoses (from Medicare claims history), and pharmacy usage.

2. **Low Income (LI) Premium Subsidies.** These are additional payments that are triggered by household income data. CMS makes these determinations.

3. **Low Income Cost Subsidies**. These are additional payments that are paid by CMS in support of lower copays by low income individuals. The EGWP administers the lower copays, and as this creates a higher cost to the plan, CMS payments make up for the difference. These subsidies can therefore be considered a benefit to members with no associated cost or savings to the plan.

4. **PHARMA Discount Payments.** Health care reform modified the structure of the Part D program. Thus, brand drug expenditures above $3,310 in 2016 are eligible for a 50 percent discount, funded by the pharmaceutical manufacturers. These "Pharma" payments will be paid to the EGWP carrier quarterly, with a lag after the end of the quarter for processing and CMS approval.

5. **Reinsurance Payments.** The Standard Part D Plan includes a federal reinsurance payment made to the carrier when an individual's out of pocket costs reach the OOP limit. These reinsurance payments can be quite large for the few individuals who have large pharmacy expenditures. The rules for counting the members' out-of-pocket costs have been clarified recently so that the 50 percent Pharma discount dollars also count. Accordingly, these reinsurance payments will be material and will help offset the health plan costs. The reinsurance payments are made retrospectively for 2016 but will be made prospectively starting in 2017.

Table B-3 shows the development of the estimated EGWP subsidy for FY2015, which aligns with the latest Alaska valuation reports available at the time this report was prepared. Table B-3 shows that the EGWP amount is expected to be just over twice the RDS amount, with the largest component attributable to the federal reinsurance payments. Plans, like the AlaskaCare Retiree plan have experienced steep increases in high cost prescription drugs. For a high

cost drug, such as Harvoni, a typical cost per retiree per year of $76,000 would result in the maximum payment of $7,040 under the RDS program (about 9% of the plan cost), compared to $55,000 under the Federal Reinsurance component of EGWP funding (about 72% of the plan cost).

Table B-3
Estimate of EGWP Subsidy Compared to RDS Subsidy

Source	Benchmark Data from Carrier Webinar	2015 Valuation Report (18% of Rx Claims Cost)
•Direct Subsidy	$24 - $33 per month	
•Pharma	$25 - $35 per month	
•Federal Reinsurance	$25 - $40 per month	
Total per month	$74- $108 per month	
Total per year	**$1,200**	**$529**

Estimate of Liability Reduction from EGWP

Table B-4 Estimate of Reduction in Liability					
Plan	Employees	Source	RDS	EGWP	Additional
	Payroll $M	Valuation	$529	$1,200	Savings
	Average pay	Reports			
PERS DC	17,098	Actuarial Accrued Liability (AAL) - Gross Liability	$66,473,000	$66,473,000	
PERS DC	$946	AAL - Net of Part D	$58,683,000	$48,802,000	
PERS DC	$55,299	Part D savings	$7,790,000	$17,671,000	$9,881,000
PERS	17,660	AAL - Gross Liability	$7,781,368,000	$7,781,368,000	
PERS	$1,294	AAL - Net of Part D	$7,310,734,000	$6,713,767,000	
PERS	$73,248	Part D savings	$470,634,000	$1,067,601,000	$596,967,000
TRS DC	4,095	AAL - Gross Liability	$22,251,000	$22,251,000	
TRS DC	$261	AAL - Net of Part D	$19,768,000	$16,618,000	
TRS DC	$63,635	Part D savings	$2,483,000	$5,633,000	$3,150,000
TRS	5,502	AAL - Gross Liability	$2,862,909,000	$2,862,909,000	
TRS	$748	AAL - Net of Part D	$2,677,393,000	$2,442,079,000	
TRS	$135,951	Part D savings	$185,516,000	$420,830,000	$235,314,000
JRS	76	AAL - Gross Liability	$18,641,877	$18,641,877	
JRS	$14	AAL - Net of Part D	$17,207,952	$15,388,877	
JRS	$177,723	Part D savings	$1,433,925	$3,253,000	$1,819,075
Total	44,431	AAL - Gross Liability	$10,751,642,877	$10,751,642,877	$0
Total	$3,261	AAL - Net of Part D	$10,083,785,952	$9,236,654,877	$0
Total	$73,398	Part D savings	$667,856,925	$1,514,988,000	$847,131,075
			Liability Savings	Liability Savings	Additional
			RDS	EGWP	Liability Savings
PERS DC		Part D savings	$7,790,000	$17,671,000	$9,881,000
PERS		Part D savings	$470,634,000	$1,067,601,000	$596,967,000
TRS DC		Part D savings	$2,483,000	$5,633,000	$3,150,000
TRS		Part D savings	$185,516,000	$420,830,000	$235,314,000
JRS		Part D savings	$1,433,925	$3,253,000	$1,819,075
Total		Part D savings	$667,856,925	$1,514,988,000	$847,131,075

Table B-5 Estimated Reduction in Normal Cost					
Plan	Employees	Source	RDS	EGWP	Additional
	Payroll $M	Valuation	$529	$1,200	Savings
	Average pay	Reports			
PERS DC	17,098	Normal Cost	$9,963,000	$0	$0
PERS DC	$946	NC- Net of Part D	$8,801,000	$0	$0
PERS DC	$55,299	Part D savings	$1,162,000	$2,636,000	$1,474,000
			$0	$0	$0
TRS DC	4,095	Normal Cost	$2,619,000	$0	$0
TRS DC	$261	NC- Net of Part D	$2,326,000	$0	
TRS DC	$63,635	Part D savings	$293,000	$665,000	$372,000
			$0	$0	$0
TRS	5,502	Normal Cost	$17,583,000	$0	$0
TRS	$748	NC- Net of Part D	$16,737,000	$0	
TRS	$135,951	Part D savings	$846,000	$1,919,000	$1,073,000
			$0	$0	$0
JRS	76	Normal Cost	$645,479	$0	$0
JRS	$14	NC- Net of Part D	$605,706	$0	
JRS	$177,723	Part D savings	$39,773	$90,000	$50,227
			$0	$0	$0
PERS	17,660	Normal Cost	$68,385,000	$0	$0
PERS	$1,294	NC- Net of Part D	$65,266,000	$0	
PERS	$73,248	Part D savings	$3,119,000	$7,075,000	$3,956,000
			$0	$0	$0
Total	44,431	Normal Cost	$99,195,479	$0	$0
Total	$3,261	NC- Net of Part D	$93,735,706	$0	$0
Total	$73,398	Part D savings	$5,459,773	$12,385,000	$6,925,227
					Normal Cost Savings
			RDS	EGWP	Additional
PERS DC		Part D savings	$1,162,000	$2,636,000	$1,474,000
TRS DC		Part D savings	$293,000	$665,000	$372,000
TRS		Part D savings	$846,000	$1,919,000	$1,073,000
JRS		Part D savings	$50,227	$39,773	$90,000
PERS		Part D savings	$3,119,000	$7,075,000	$3,956,000
Total		Part D savings	$5,459,773	$12,385,000	$6,925,227

Table B-6 shows how the reduction in actuarial accrued liability and Normal Cost translate into lower funding costs for the participating employers in the retirement systems.

Table B-6
Estimated Annual Savings from Implementing EGWP

	Liability Savings	Amortization Factor	First Year Amortization Savings	Normal Cost Savings	Total First Year Savings
PERS DC	$9,881,000	13.74	$719,000	$1,474,000	$2,193,000
TRS DC	$3,150,000	12.33	$255,000	$372,000	$627,000
TRS	$235,314,000	15.52	$15,159,000	$1,073,000	$16,232,000
JRS	$1,819,075	15.53	$117,000	$90,000	$207,000
PERS	$596,967,000	15.53	$38,443,000	$3,956,000	$42,399,000
Total	$847,131,075		$54,693,000	$6,965,000	$61,658,000

APPENDIX C

GLOSSARY

Balance Billing
This occurs when an out-of-network provider bills a member for the difference between the provider's charges and the amount allowed by the plan. For example, if the provider's charge is $1,000 and the plan allows $800, the provider may bill the member for the remaining $200. Preferred providers may not balance bill for covered services.

Coinsurance
The percentage of cost, for covered health care services, members must pay after the deductible is met; alternatively, sometimes expressed as the percentage of cost reimbursed by the plan after the deductible is met.

Composite Rate
A uniform rate for all members of the group regardless of their status as single or members of a family.

Copay
A fixed dollar amount that is paid when health care services are received. The amount varies depending on the type of service.

Coverage Tiers
One or more tiers used for health plan rating based on the size and composition of the household that is enrolled in or participating in the health care plan

DCCED
Alaska Department of Commerce, Community, and Economic Development

Deductible
The amount that must be paid for covered health care services before the insurance plan begins to pay.

DHSS
The Department of Health and Social Services

Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care provider for everyday or extended use. DME includes wheelchairs, hospital beds, crutches, oxygen equipment, blood testing strips for diabetics, etc.

Employer Group Waiver Plan (EGWP)
Employer Group Waiver Plans are offered by Medicare Part D approved providers to employer or union sponsored group members where the employer or union does not contract directly with the Centers for Medicare and Medicaid Services (CMS).

Fee-for-Service
A payment model by which doctors and health care providers are paid for each service they perform.

Fully-Insured Plan
An employer sponsored health plan in which the company pays a total fixed monthly premium to the insurance vendor.

Health Maintenance Organization (HMO)
A type of health insurance plan that limits coverage to care from designated health care providers and doctors who work for or contract with the HMO. Generally, care received from out-of-network doctors (except in an emergency) will not be covered.

Health Reimbursement Account (HRA)
An employer funded account in a health plan from which employees are reimbursed tax-free for qualified medical expenses. Reimbursements are capped to an annual fixed dollar amount and unused amounts can be rolled over to subsequent years.

High Deductible Health Plan (HDHP)
A plan that typically has a higher deductible and lower monthly premium than a traditional medical insurance plan. An HDHP can be combined with a health savings account or a health reimbursement account allowing the member to pay for certain expenses with untaxed dollars.

Health Savings Account (HSA)
An employee owned savings account that allows the member to set aside money, on a pre-tax basis, to pay for certain medical expenses. HSA funds roll over from year to year, stays with the employee if he/she changes jobs and earns interest.

Managed Care
A system of health care in which patients agree to visit only certain doctors and hospitals, and in which the cost of treatment is monitored.

Medicare Advantage Program
A type of Medicare health plan offered by a private company that contracts with Medicare to provide all Medicare Part A and Part B benefits in addition to any supplemental benefits that may be offered.

Member
Refers to employees and their dependents who participate in a health plan.

Network / Preferred Provider
A provider who contracts with the health insurance vendor at agreed upon rates. Members pay less when they receive care from these providers

Non-network / Non-preferred Provider
A provider who does not have a contract with the health insurance vendor. Members pay more when they receive care from these providers.

Out-of-Pocket Maximum
The most a member would pay for health care service in a year. It typically includes deductibles, copays and coinsurance.

Pharma
The Pharmaceutical and Research Manufacturers of America companies that agreed to participate in funding a portion of the prescription drug cost for Medicare Part D members' claims in the "donut hole".

Pharmacy Benefit Manager
Third party administrator of prescription drug programs.

Point of Service Plans (POS)
A type of health insurance plan which allows member a choice of paying lower cost if care is received from providers who contract with the plan's health insurance vendor. Referrals are sometimes needed to see a specialist.

Preferred Provider
A provider who has a contract with the health insurance vendor to provide services at a discount. The health plan may have participating providers who also contract with the health insurance vendor but the discounts may not be as great and members may have to pay more.

Preferred Provider Organization (PPO)
A type of health insurance plan which allows members a choice of paying lower cost if care is received from providers who contract with the plan's health insurance vendor. Referrals are not typically needed to see a specialist.

Premium
The amount employers pay for health insurance every month.

Referral
A written order from a primary care physician that allows members to see a specialist or obtain certain medical services.

Self-Insured Plan
An employer sponsored health plan, usually utilized by larger companies, where the employer collects premium from employees (via payroll deduction) and takes the responsibility of funding the claims incurred by members.

Specialist
A physician who focuses on a specific area of medicine.