



Alaska Health Care Authority Feasibility Studies

Summary of Public Comments Received
December 2017

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1. Introduction + Project Overview

Health Care Authority (HCA) Feasibility Study

The Alaska Legislature passed Senate Bill 74 in April 2016 (SB74), which established a series of provisions intended to fundamentally redesign Alaska's Medicaid program to increase its quality and cost effectiveness. Included in SB74, Section 57(b) is a provision that required the Department of Administration (the Department), in collaboration with the House and Senate Finance Committees, 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 a number of different entities including all state employees, retired state employees, retired teachers, medical assistance recipients, University of Alaska employees, employees of state corporations, and school district employees. The study required the contractor to develop appropriate benefit sets, rules, cost-sharing, and payment structures for all employees and individuals whose health care benefits are funded directly or indirectly by the state, with the goal of achieving the greatest possible savings to the state through a coordinated approach administered by a single entity.

This language further directed the Department to seek input from the Department of Health and Social Services, administrators familiar with managing government employee health plans, and human resource professionals familiar with self-insured health care plans. SB 74 specifically directed the study to evaluate the following:

- Identify cost-saving strategies that an HCA could implement;
- Analyze local government participation in the authority;
- Analyze a phased approach to adding groups to health care plans coordinated by the HCA;
- Consider previous studies procured by the Department of Administration and the legislature;
- Assess the use of community-related health insurance risk pools and the use of the private insurance marketplace;
- Identify organizational models for an HCA, including private for-profit, private nonprofit, government, and state corporations; and
- Include a public review and comment opportunity for employers, employees, medical assistance recipients, retirees, and health care providers.

The Department engaged several contractors in this effort:

- **PRM Consulting Group (PRM)**
Scope: public employee and retiree health plans. The firm was tasked with survey development, data collection, identification of potential consolidated purchasing opportunities and coordinated pooling analysis.
- **Pacific Health Policy Group (PHPG)**
Scope: identify opportunities to align or integrate the Medicaid program. The firm provided Medicaid technical assistance and analysis on opportunities and consideration for incorporating Medicaid into an HCA as well as an overview of HCA and HCA-like structures in other states.

- **Mark A. Foster & Associates (MAFA)**

Scope: Alaska health care market analysis, peer review of PRM's findings and identification of additional opportunities for Alaska-specific purchasing strategies.

The consultants conducted research and analysis within their respective scopes of work, resulting in four reports that each explore different issues regarding the feasibility of establishing an HCA. The reports address the statutory requirements outlined in SB 74. Extensive public discourse, stakeholder engagement, and consensus among leadership will be required for the state to move forward with the recommendations contained in the reports. The public comment and outreach process that accompanied release of the reports was intended to share the general concept and accompanying analysis with interested stakeholders.

Reports' Findings + Recommendations

PRM Consulting Group: Phase I

PRM's analysis spans two reports. The first focused on understanding and analyzing the current landscape of publicly funded health care plans, and identifying areas for potential cost savings.

The report is available online at: <http://doa.alaska.gov/pdfs/Phase1Report.pdf>.

PRM Consulting Group: Phase II

The second PRM report considered how an HCA could be structured to maximize cost savings and achieve efficiency in scale and operations.

The report is available online at: <http://doa.alaska.gov/pdfs/Phase2Report.pdf>.

Pacific Health Policy Group (PHPG)

PHPG provided technical assistance and analysis for Alaska's Medicaid program, identifying the advantages, disadvantages, and regulatory or policy challenges to including Medicaid in an HCA as well as possible governance models for an HCA based on other states experience and a review of other Alaska organizations.

The report is available online at: <http://doa.alaska.gov/pdfs/PHPGReport.pdf>.

Mark A. Foster & Associates (MAFA)

In addition to providing peer review of the other consultants' work, MAFA was asked to assess the current landscape of health care costs, and potential savings from the consolidation of Alaska public employer health plan administration and procurement.

The report is available online at: <http://doa.alaska.gov/pdfs/MAFAResults.pdf>.

2. Public Comment Process

The Department engaged Agnew::Beck Consulting to assist staff in the public comment process, including organizing and hosting informational webinars, collecting and organizing public comments received by the Department, and preparing a summary report.

Written Comments

The Department released the consultants' four studies on August 30, 2017, and announced a 60-day public comment period on the reports from September 1 through October 30, 2017. The Department extended the comment period an additional two weeks, through November 13, 2017, and continued to informally accept comments after the official comment period had closed. A total of 28 public comments were received.

Project Website

To publish the consultant team's reports, the Department created a project web page describing the purpose of the feasibility study and the four reports produced by the contractor team, and providing links to the reports and other items of interest about the study. The website is available at Alaska.gov/HCA. Information about the webinar series was published on the page, and following the webinars links to the recordings were posted as well.



Screen shot of HCA Feasibility Study website, Alaska.gov/HCA. Retrieved December 1, 2017.

Webinar Series

Recognizing that the subject matter and contents of the studies are technical and complex, the Department hosted a series of three webinars summarizing the consultants' findings in September 2017. Webinars included opening remarks and a brief introduction to the project by Department staff, a summary presentation by each consultant, and a question and answer period moderated by Department staff. Agnew::Beck provided hosting and logistical support for the webinars, as well as assisting the Department in compiling questions and comments from participants. Webinars were recorded and published on the Department website following the series. Questions and answers for each webinar are provided in Appendix A, and additional responses from PRM Consulting are available in Appendix B.

Webinar 1: PRM Phase I + II Reports

- Thursday, September 7, 2017 | 12:30 – 1:30 p.m.
- PRM Presenters: Adam Reese, Thomas Rand
- 86 attendees
- Recording link: <http://agnewbeck.adobeconnect.com/p21bfki1kc9i/>

Webinar 2: PHPG Report

- Monday, September 11, 2017 | 2:00 – 3:00 p.m.
- PHPG Presenter: Scott Wittman
- 81 attendees
- Recording link: <http://agnewbeck.adobeconnect.com/pb9869g777rx/>

Webinar 3: MAFA Report

- Wednesday, September 13, 2017 | 2:30 – 3:30 p.m.
- MAFA Presenter: Mark Foster
- 80 attendees
- Recording link: <http://agnewbeck.adobeconnect.com/psnm3dju1eta/>

Other Public Outreach

In addition to soliciting public comments and hosting informational webinars, Department staff and consultant Mark Foster have made several community and stakeholder presentations about the Health Care Authority Feasibility Study and related findings throughout fall 2017. The presentations were similar to the information provided in the webinar series, including an overview of consultants' findings and some of the significant policy considerations that have been identified during the research process, and which should be the subject of continuing public dialogue in the future. These include: where and how the State could achieve significant savings; concerns expressed by benefit managers, providers and others about how an HCA would impact the current health care system in Alaska; and questions regarding the design and implementation of such a system in the future.

3. Summary of Public Comments

Collection of Comments

Method

In all presentations, published notices and project website postings, the Department directed comments to be submitted in writing via e-mail, fax or in hardcopy to Department staff. Each comment was forwarded to Agnew::Beck, the firm contracted to review and summarize all comments received, and compiled into an electronic packet (Appendix E). Agnew::Beck reviewed the comments and drafted a brief summary that formed the basis of this report.

Who Submitted Comments?

The Department received 28 comments, primarily from organizations already involved in Alaska's health care or public employee benefit systems who could be directly impacted by the creation of an HCA. While all members of the public were invited to submit comments, the technical and exploratory nature of the four reports, which analyzed the state's options and made recommendations on behalf of the consultant team, but did not propose a specific path forward, likely contributed to the relatively small number of comments submitted.

Most comments were from individuals, organizations or local governments in Alaska, including some associations or companies with a statewide presence. Additional comments were received from organizations not based in Alaska, but who conduct business in the state, such as insurance providers. Additionally, three individuals who did not identify as being affiliated with an organization submitted comments: a health care provider, a current State of Alaska employee and a retired public employee. Organizations that submitted comments are listed below.

Local Governments and Political Subdivisions

- City and Borough of Sitka
- City of Homer
- Fairbanks North Star Borough

Other State Boards, Commissions and Agencies

- Alaska Commission on Aging
- Alaska Mental Health Trust Authority
- University of Alaska

Private Organizations and Associations

- Alaska Association of Health Underwriters
- Alaska Municipal League
- Alaska Laborers District Council
- Alaska Pharmacists Association

- Alaska State Hospital and Nursing Home Association (ASHNHA)
- Alaskans for Sustainable Health Care Costs
- ASEA/AFSCME Local 52 Health Benefits Trust
- Bartlett Regional Hospital
- Healthcare Cost Management Corporation of Alaska (HCCMCA)
- IBEW Local 1547
- Imaging Associates + Alaska Radiology Associates
- MSI Communications
- NEA-Alaska
- Northland Audiology
- Northwest Auto Parts
- Premera Blue Cross Shield of Alaska
- United HealthCare Group + Optum
- Wilson Agency

Comment Themes

As noted above, the four reports comprising the study provided analysis of the state’s current landscape of public employee health care plans, analyzed the potential impacts and cost savings of different models to implement some form of consolidated purchasing and/or administration of health care benefits through an HCA, and made some recommendations on behalf of each consultant based on their analysis. The reports provided a great deal of information and concepts, but did not advance a specific proposal and did not make any representations on behalf of the Department about a future policy direction.

General Consensus: Alaska’s Current Health Care System Is Costly

Many comments began in general agreement: the current health care system and associated costs borne by organizations and their employees, including state and local governments, cannot continue without expecting increasingly negative impacts on Alaska’s state spending, workforce and the overall economy. Public and private sector employers alike expressed their understanding of this problem, and appreciation for the Legislature and the Department for seeking solutions. While the comments did not indicate unified support for a specific concept and raised many concerns about how an HCA might affect them or their stakeholders, the shared acknowledgment that some form of change is needed provides a foundation for further public dialogue about how to address this serious and complex issue.

Common Topics

Commenters expressed diverse views about the concept of an HCA and how successfully it might be implemented, but there are some common themes that emerged, generally reflecting the concerns and questions of those who would be directly impacted by changes to the current system. These perspectives are summarized below.

Mandatory participation in a shared plan. Commenters representing individual local governments and the Alaska Municipal League (AML) generally did not favor the idea of mandatory participation in an

HCA, replacing the current level of autonomy and choice in the market that they have now. While AML's comments, as stated upfront, did not necessarily reflect the views of all member governments on the details of the proposal, local governments consistently support retaining their position of self-determination and being able to design plans that are fiscally sustainable and help them attract and retain qualified employees. Commenters were not necessarily opposed to the HCA concept, but urged the state to consider voluntary participation instead, at least during the early years of the HCA, to minimize disruption of other government entities' plans, and to better demonstrate the benefits of participation with actual performance data. Additionally, commenters representing local governments and employee unions pointed out that as benefits are negotiated through collective bargaining agreements, mandating participation of other entities may be complicated.

Potential loss of current level of benefits. As noted above, commenters expressed consensus about the need for addressing Alaska's high health care costs and developing a more sustainable trajectory for health care spending in the public sector. Employers and employees who are currently covered by existing plans expressed concern about what would happen to their current plan(s) and whether either party (the employer offering the plan, or the individual employees on the plan) would be losing their current benefits or be required to pay significantly more for health insurance. Similar concerns were expressed about spouse and family coverage, particularly those who have been identified as eligible for other employer coverage but are eligible for and enrolled in a State of Alaska plan via another member of the household. Commenters expressed concern that changing benefit levels and/or coverage policies for families of employees could place additional burden on these households.

Degree to which health care costs would be significantly reduced by implementing an HCA. The consultants' reports offer a range of estimated cost savings based on multiple models of an HCA, with assumptions such as mandatory or voluntary participation, number of plan tiers offered, and other variables. Additionally, the MAFA report explored other cost drivers in Alaska's health care system, particularly the price and rate of price increase for in-state care. Several commenters expressed uncertainty or skepticism about projected cost savings, particularly in regard to reducing administrative costs and whether individual political subdivisions would see savings compared to the costs of their current plans. Some also had technical questions regarding the methodology, assumptions or probability of achieving the projected savings.

Multiple commenters focused on whether the creation of an HCA, pooling a larger group of people together who are currently served by separate plans, would have sufficient impact on the market to require health care providers to negotiate prices lower than current levels. Regarding providers' current prices, commenters noted that not all types of medical providers, or medical services provided, are high priced compared to other markets. Others stated that Alaska's sparse, rural geography will continue to be a challenge for achieving lower prices. However, several commenters pointed out that the issue of controlling health care costs will require other actions, beyond pooling covered lives under an HCA:

- Some commenters supported repealing the 80th percentile rule, a state regulation designed to protect consumers by creating a minimum reimbursement level for insurers to pay providers who are not in their networks. This regulation applies to fully insured plans, however, and commenters did not articulate how this would impact the largely self-insured plans included in the studies. A self-insured plan subject to the Employee Retirement Income Security Act of 1974

(ERISA) is excluded from state regulation, but state and local government sponsored self-insured plans are not subject to ERISA.

- Some commenters suggested that reimbursements to providers should be negotiated at a percentage of the Medicare reimbursement rate (e.g. 125 percent of Medicare) with a balance billing limit to protect consumers from large, unexpected medical bills that arise when the billed charges are higher than the charges covered by the plan. If the 80th percentile rule was repealed, a reimbursement/coverage floor for health care insurance and limitations on balance billing by out-of-network health care providers could become more critical for consumer protection.
- Some expressed support for better price transparency from health care providers to consumers prior to agreeing to receive a service or pursue a specific plan for treatment.
- Commenters who self-identified as being affiliated with the Alaskans for Sustainable Healthcare Costs Coalition noted that management of health care costs must include a long-term strategy to avoid future inflation that replicates current problems in subsequent years.

One provider shared optimism about health care reform as a means of streamlining administrative burden on physicians, and expressed interest in making this a priority so that providers can focus more on health care delivery and less on paperwork. The studies did not undertake a detailed analysis of how much a consolidated set of plans would save in administrative costs, but it was noted as a potential opportunity to manage costs and increase provider satisfaction. Plan consolidation could create opportunities to reduce administrative costs and paperwork burdens through negotiated alternative billing structures based on outcomes rather than complex fee for service models.

Phased or multi-part implementation, beginning with Alaska state employees. As described above, other political subdivisions are concerned about whether and how implementation of an HCA would impact them and their employees, including whether their participation would result in cost savings and/or higher value care. A few commented that, assuming an HCA is likely to generate significant benefits to the state and can be effectively managed to sustain these benefits, a phased approach would allow the concept to be tested and administrative structures developed and refined before more groups join an HCA. Others questioned the potential magnitude of startup costs, including funding, staff resources, training, and outreach to affected employees if they are included in an HCA-managed plan. These commenters requested more detailed information about estimated costs to better characterize the potential net savings.

Travel benefits and incentivizing out-of-state care. Some plans currently reimburse for out of state care, particularly for procedures that are not available in Alaska or are sufficiently less costly to receive in another state (including travel and lodging for the Alaska patient).

Alaska health care providers who commented on this study did not favor prioritizing out-of-state care as a solution for controlling costs, citing the current choice and quality Alaskans have with local providers; the practicality of long-distance travel for routine or non-emergency care; the need to recognize that higher costs are inherent to Alaska's system; and unintended economic consequences of steering business away from local providers (see the following category for more on the latter). One provider also noted that traveling for a procedure may also make follow-up care more difficult, requiring additional travel and/or coordination between providers in different states to ensure the patient is being adequately monitored.

Another member of the public also expressed skepticism about promoting out of state care as an affordable alternative, as it would make accessing health care less convenient and ultimately more costly for employees and families, and make the state a less attractive place to work.

Impacts on the supply of health care (providers and services offered) in Alaska’s market, particularly in smaller communities. As noted in the comments regarding out of state travel, many providers were concerned about the impacts of a consolidated purchasing entity on the financial feasibility of local health care practices. These concerns were amplified for smaller communities who serve smaller local populations and may have higher prices or more limited services. Regarding hospitals in these communities, the Alaska State Hospital and Nursing Home Association (ASHNHA) suggested that while rural hospitals and other providers may have higher costs, they serve the community’s health needs in a limited market and should therefore be valued not only on cost but on availability and proximity of necessary health services. Other providers made similar comments regarding the value of having local providers to meet local needs.

Several other commenters expressed support for value-based care models, creating incentives based on population health and patient outcomes rather than solely on services provided. Providers who shared comments acknowledged the positive potential of value-based care, but cited the existing challenges of providing quality care in Alaska and questioned how specifically “value” would be measured as it relates to their performance or the health of their patients.

Concerns about the financial feasibility of reducing health care prices, and unintended consequences for other insurance plans and payers. Commenters expressed concern that an unintended consequence of an HCA negotiating lower prices could be cost shifting to the private sector resulting in higher prices for those not participating in an HCA. Some commenters pointed out that changes such as shifting reimbursement rates to some form of Medicare benchmark may reduce prices, but potentially at the expense of providers’ ability to cover overhead costs, continue to see other patients, and keep fees reasonable for other patients to make up the difference between different reimbursement rates.

The Alaska Commission on Aging summarized their stakeholders’ comments, not specifically about an HCA but about the many health care related challenges faced by Alaska’s fast-growing senior population. Among the top concerns is the ability to find primary care providers who accept Medicare patients, especially in smaller communities but also in larger communities like Anchorage; and the ability to find quality, affordable in-home and community-based services to support aging in place. The Commission supported consideration of an HCA to help address these systemic issues and help more retirees access care, including expanding access to providers who accept Medicare patients, offering plans with services such as dental, vision and hearing services not covered by Medicare, and offering other options such as more comprehensive long-term care insurance.

Skepticism about the ability to achieve further cost savings, in light of specific plans’ current structure and performance. Comments on this topic generally focused on the current function of health plan management entities like the Health Care Cost Management Corporation of Alaska (HCCMCA), a regional organization providing access to coordinated purchasing agreements for participating employers, including many large public employers. Commenters representing HCCMCA, one of its member plans, or otherwise familiar with the services offered through this model pointed out that the organization already provides consolidated purchasing and other cost-management mechanisms to its

members, including travel and pharmacy benefit management. Other representatives of health care trusts and the University of Alaska shared similar belief that they are already effectively managing costs for members, with low overhead costs, and achieving some of the savings associated with negotiating for a larger pool of individuals.

Concerns about Pharmacy Benefit Managers (PBMs). Some commenters expressed particular concern about a proposal to carve out pharmacy services and use a PBM to manage these services for the State. The Alaska Pharmacists Association also questioned what impacts the use of a PBM would have on the ability of small, independent pharmacists in Alaska to fairly compete against large networks or mail-order pharmacy services and recent negative reporting on practices of PBMs in other parts of the country. They suggested the state consider the acting as its own PBM. A few commenters expressed support for the PRM recommendation to shift current state retirees' Medicare Part D program from a Retiree Drug Subsidy to an Medicare Part D Employer Group Waiver Plan, independent of any future decisions or action to create an HCA.

Inclusion of the Medicaid program, and/or improved access to behavioral health services, in an HCA. Most of the comments focused on impacts to commercial insurance for public sector employees, but the study also identified issues that would need to be addressed in an analysis of whether to include Medicaid in an HCA, similar to the structure of two other states' HCAs. The Alaska Mental Health Trust Authority noted that high health care costs impact Trust beneficiaries across the state, including those who receive needed services through Medicaid, and that more analysis would need to be undertaken in partnership with the Department of Health & Social Services to assess the opportunities and impacts of moving Medicaid into an HCA. Multiple commenters also acknowledged the need for additional analysis before a decision could be made to include Medicaid in a potential future HCA. Other commenters urged continued work on Medicaid reform.

Comments About Methodology and Analysis in Consultants' Reports

Some comments included questions or concerns specifically about the methodology, assumptions, and conclusions drawn by the consultant team as a result of their analysis. Comments of this nature about a specific report were provided to the appropriate consultant for consideration, and in some cases consultants prepared a response explaining, supplementing or correcting the relevant information related to the comment. PRM Consulting's responses to specific questions or concerns are included in Appendix C this report, and additional information about PRM's analysis of administrative costs and data validation are included in Appendix D.

Questions Posed in Comments

Many comments included one or more questions, ranging from technical questions for the authors to broad questions about the design and implementation of an HCA. Many in the latter category cannot be adequately addressed through the public comment process, as these questions identify many of the fundamental policy decisions that need to be informed by further dialogue, analysis and investigation of what, if any, HCA structure would be beneficial for Alaska. The questions posed in the comments are presented below, grouped by general topic, but most must be answered in a venue other than this report. Where feasible, comments are presented as written (direct quotes), and contextual information has been added where necessary within brackets or following the direct quote.

Magnitude and Character of Savings from a Health Care Authority

- Is the creation of an HCA a necessary step in controlling Alaska's health care costs?
- "Most likely, the savings will probably be seen by larger entities [political subdivisions participating in HCA plans], but what will this do to the smaller ones?"
Will local governments of all sizes achieve significant cost savings?
- "Integrating Medicaid has a potential for reduced federal payments. Has this been factored in?"
- "Is there any definitive proof that insurance pooling will force medical providers to lower their prices in negotiations? In a September webinar, representatives of PRM Consulting stated that there was no evidence that insurance pooling would result in lower health care prices."

Plan Design and Participation

- What pool size or number of covered lives is required to achieve a sufficient threshold of savings, particularly if participation is voluntary for organizations who cover populations other than State of Alaska employees and/or retirees?
- "What is the rationale for recommending three insurance pools and four health plan options?"
- "Where are the specific areas of opportunity and what are the projected gains and risks? How would moving the Medicaid program under an HCA impact beneficiaries? How would such a move contribute to or detract from current reform efforts?"
- "Would the cost of the insurance be tiered, and would there be a family plan option?"

Impacts on Current Employers, Employees and Families

- "What would the cost be to our members? Would the cost of health care go up or down?"
- "The reports appear to present cost savings that are actually cost-shifting of dependent and spousal coverage from the State of Alaska directly onto employees and to other employers. What estimated new costs would be borne by public employees, their families, and private employers due to these proposed changes to dependent coverage?"
- "Two of the recommendations for cost savings [utilizing Centers of Excellence and travel benefits] are available in many plans today, so how is this additional savings going to be generated, or more important, what plan design strategies would need to be employed in order to create the right level of motivation for the State to realize this savings?"
- "[Public sector organizations'] healthcare agreements are negotiated through collective bargaining and carry the force of law. Who would bear the financial burden should members sue for breach of contract?"

Impacts on Providers and Supply of Health Care Services

- The reports recommend pursuing higher-value care, and designing a system that rewards positive health outcomes. How will these outcomes be measured, and what criteria would providers be measured against?
- "What is meant by a 'Center of Excellence?'" How is this designation defined, what criteria would be required to meet this definition, and who would determine whether criteria are met?
- "If the health care authority is successful at negotiating large discounts for its plans, will the medical community compensate by increasing their charges to non-health care authority plans in order to make up their margin?"
- "What is expected to happen to private employer and individual rates if the public plans move to an HCA, would the delivery system reduce overall costs or shift costs to private employers?"

- “If an HCA was to consolidate 200,000 lives with one insurer, this could drive others out of the market and centralize all the insurance offering in Alaska with one carrier. How would creating an insurance monopoly in Alaska control costs and benefit of employers and employees?”

Governance, Structure and Oversight

- “How would the health care authority be structured?”
- “What are the estimated costs to the state of creating, staffing, and operating a new health care authority? How many new positions will be created to run an authority?”
- “What is the additional cost of building and running the HCA? Additional governmental salaries, benefits, retiree benefits, for example. How many employees are estimated to be needed for call centers, monitoring, auditing, and negotiating with provider?”

Implementation Process

- “What is the timeline for implementation to create a statewide health care authority?”
- “What actions does the administration plan to take right away, and what steps will require regulatory and statutory changes?”
- “How long might the legislative process to create an authority take, and how does this impact estimated cost savings in future years?”

4. Appendices

Appendix A. Responses to Questions Received During the September 2017 HCA Study Webinar Series

1. PRM Consulting Reports, September 7, 2017
2. PHPG Report, September 11, 2017
3. MAFA Report, September 13, 2017

Appendix B. Additional Responses from PRM Consulting to Questions Received During Webinar Series

Appendix C. Additional Responses from PRM Consulting to Selected Questions in Public Comments

Appendix D. Memos from PRM Consulting Regarding Study Methodology and Assumptions

1. PRM Memo Addressing Administrative Costs
2. PRM Memo Addressing Data Validation

Appendix E. Compiled Public Comments, Received September 5 through November 15, 2017

Questions and Answers

HCA Feasibility Study Webinar, PRM September 7, 2017

1. *Will the presentation slides be posted on the website?*

Response: Yes, please visit Alaska.gov/HCA.

2. *Can people see this webinar online later?*

Response: Yes, please visit Alaska.gov/HCA.

3. *Do you know what proportion of AlaskaCare Retirees live in Alaska?*

Response: Answered in the webinar, please see recording.

4. *How would you address flagrant conflicts of interest with PBMs such as this recent example?
<http://www.businessinsider.com/cvs-lawsuit-claims-collusion-with-pharmacy-benefit-managers-to-raise-prices-2017-8>*

Response: Answered in the webinar, please see recording.

5. *On Slide 12 - What are the 5 entities that don't have to pay additional costs for coverage of the spouse?*

Response: Answered in the webinar, please see recording.

6. *Would non-profits be allowed to participate in these programs if they are affiliated with the State?*

Response: Answered in the webinar, please see recording.

7. *How did you determine trend?*

Response: Answered in the webinar, please see recording.

8. *How will the proposed plans control health care prices?*

Response: Answered in the webinar, please see recording.

9. *How many plans would be offered in the HCA as well as the integration of FSA, HSAs or HRA?*

Response: Answered in the webinar, please see recording.

10. *Do we account for duplicate insurance coverage, i.e., one spouse works for a school district and the other works for the state or a muni? isn't this essentially duplicating some costs?*

Response: Answered in the webinar, please see recording.

11. *How would a Health Care Authority improve quality of care and maintain benefits and access?*

Response: Answered in the webinar, please see recording.

12. *Re: Slide 4: comparing health care costs data.cms.gov has data sets which is pulled directly from hospitals. A hospital to hospital and state to state comparison for each service is provided.*

Response: This is considered a comment, thank you for providing this comment.

Questions and Answers

HCA Feasibility Study Webinar, PRM September 7, 2017

13. *Re Slide 8: Travel benefits, this effort on a statewide basis needs to bring local hospitals into the discussion because while we want to lower healthcare costs, we do not want to cripple local hospitals by taking away "customers" there must be a balance so Alaska can keep its hospitals open.*

Response: This is considered a comment, thank you for providing this comment.

14. *The state of Washington HCA mandates 100% transparency from their PBMs to eliminate the PBMs ability to pocket "the spread," something the PBMs have come under scrutiny for recently. It would be important to incorporate this oversight into our HCA if adopted.*

Response: This is considered a comment, thank you for providing this comment.

Questions and Answers

HCA Feasibility Study Webinar, PHPG September 11, 2017

1. *Will the presentation be made available? When the recordings be posted? Thank you.*

Response: Yes, please visit Alaska.gov/HCA.

2. *Can we get a copy of the presentation slides in addition to the webinar recording?*

Response: Yes, please visit Alaska.gov/HCA.

3. *How long will it be before the slides and recordings will be available?*

Response: They are currently available, please visit Alaska.gov/HCA.

4. *19 states haven't expanded Medicaid to able-bodied, childless, working-age adults up to 138% of the federal poverty guidelines. Isn't it true that the Medicaid expansion population is an optional population that isn't required to be covered by the State of Alaska?*

Response: Answered in the webinar, please see recording.

5. *What are waiver populations?*

Response: Answered in the webinar, please see recording.

6. *According to KFF [Kaiser Family Foundation], elderly and disabled Alaskans on Medicaid are much more expensive (on a dollar basis) than the national average as compared to the dollar differential between Alaska and the national average for child and adult Medicaid participants; for the elderly, this seems to correspond to the generally higher cost of long term care in Alaska compared to other states. Is there any indication a change in purchasing structure could substantially change those long term care costs without significantly cutting benefits?*

Response: Answered in the webinar, please see recording.

7. *What is the rationale for having members of the Health Care Authority board appointed by legislative leaders, versus having all members appointed by the governor and confirmed by the legislature?*

Response: Answered in the webinar, please see recording.

8. *So, based on slide 33 first statement, this report does NOT evaluate whether creation of an HCA including Medicaid is in the best interest of the state, correct?*

Response: Answered in the webinar, please see recording.

9. *It's said that the expansion population saves money but your chart shows the 5% population is responsible for 11% of Medicaid costs. Would elimination of the expansion population result in an 11% reduction in Medicaid costs?*

Response: This question is not within the scope of this study.

10. *Tribal entities have a degree of sovereign immunity. What happens when there's a disagreement about money management? Is that a cause for concern? How would that work?*

Questions and Answers

HCA Feasibility Study Webinar, PHPG September 11, 2017

Response: This question is not within the scope of this study.

11. *Re: slide 22 – sending Alaskans out of state hurts local hospitals. This Alaska Healthcare Authority needs to incorporate Alaska's hospitals vs. alienating them.*

Response: This is considered a comment, thank you for providing this comment.

12. *Among the Medicaid adult population, Oregon and Washington have Medicaid costs that are substantially higher than the national average per participant, despite having much more competition among health care providers.*

Response: This is considered a comment, thank you for providing this comment.

13. *Are there opportunities to coordinate Alaska's Medicaid program (as an HCA) with Alaska's long term care insurance for services?*

Response: The Medicaid program would always be separate from the long-term care insurance available to State of Alaska Retirees. To learn more about Long Term Care which is available to those who qualify, <http://doa.alaska.gov/drb/alaskaCare/retiree/plans/ltc/options.html>. For more information about services available to Seniors and those with Disabilities please visit, <http://dhss.alaska.gov/dsds/Pages/default.aspx>.

14. *Would the HCA programs be self-funded by participants through PPOs or full medical coverage by one provider through a competitive process?*

Response: See memos prepared by PRM Consulting for more information (Appendices B, C and D).

15. *Is there a way for DHSS to prioritize "optional services"?*

Response: This question is not within the scope of this study.

Questions and Answers

HCA Feasibility Study Webinar, MAFA September 13, 2017

1. *When will the webinar recording be available, slide deck available?*

Response: They are currently available, please visit Alaska.gov/HCA.

2. *When you talk about "tiers" what would that look like? Would it be like PERS/TRS which is dependent on hire date?*

Response: Answered during the webinar, please see recording.

3. *Helpful to get examples of high value versus lower value care.*

Response: Answered during the webinar, please see recording.

4. *How does Value Based Insurance work effectively for employers in remote locations where primary care providers are not readily available? Will the plan accommodate individuals to fly to a metropolitan location to receive such care?*

Response: Answered during the webinar, please see recording.

5. *Am I correct to understand that your calculations do not include the incorporation of any of your recommendations for Alaska's 185,000 Medicaid population?*

Response: Answered during the webinar, please see recording.

6. *Am I correct to understand that you have incorporated stronger clinical evidence based savings potential for benefit design and chronic disease management but do not calculate potential savings from stronger evidence based acute care medical management (e.g., prior authorization process, complex case management, concurrent review, etc.)?*

Response: Answered during the webinar, please see recording.

7. *When you consider provider supply did you take into account that Alaska has the highest growing elderly population in the nation? With an aging population, you see greater demand on the supply.*

Response: Answered during the webinar, please see recording.

8. *How does reference based pricing work in a limited supply market for services that are too inexpensive to justify travel?*

Response: Answered during the webinar, please see recording.

9. *As consultants, we have determined in many cases where moving plans to tiering from composite pricing was actually more expensive. If the employer is paying 100% of the premium which some public entities practice, then tiering may or may not save money.*

Response: This could occur in the situation the questioner describes, but only in a small insured plan in which the insurer's rate factors do not accurately reflect the fact that the insurer's risk does not change regardless of whether the rating structure is based on a composite rate, self and family rates, or self and multiple tiers for dependent coverage.

Questions and Answers

HCA Feasibility Study Webinar, MAFA September 13, 2017

In an employer sponsored health plan in which the employer pays the full cost of coverage, it is logical to assume that every participant—employee, spouse and dependents—eligible for the benefit will elect to be covered under the plan regardless of the rating structure. Thus, the population covered will be the same. The same participants will become ill or injured and incur covered medical expenses in any given time period, and the insurer's claims costs will be exactly the same under any rating structure used.

It is axiomatic that the insurer's costs cannot increase in this situation because of a change in rating structure. However, as the report points out, if employers take the steps through the combination of a tiered rating structure for dependents coverage and increasing participant's contributions for dependents, that will incent participants' use of other employer's plans for coverage for employees and/or dependents. Claims costs will therefore be less, as other employers' plans absorb some of the claims liability previously absorbed by the employer sponsored plan.

10. Please explain how this is not going to reduce benefits and increase employee costs.

Response: The HCA is expected to be explicitly designed to avoid indiscriminate benefit reductions and cost sharing and to ensure that the benefits of consolidating procurement and administration at a larger scale are shared with employees and their families throughout the state.

For example, enabling legislation for a health care authority can directly address the concern that the Authority will indiscriminately cut costs by reducing benefits and shifting costs to employees by developing a findings section that includes these considerations. For example:

Purpose & Intent

- Modern, affordable, efficient health care service is essential to the people of Alaska.
- Reduced costs, high quality, and increased consumer choices resulting from the increased buying power of an Alaska Health Care Authority will improve the value of health care throughout the state and enhance the State's economic development.
- Benefits of the Alaska Health Care Authority should be shared throughout the state.
- The board of the Alaska Health Care Authority should ensure that health benefit plans are focused on high value services and avoid excessive coverage of low value services.

In addition, it may be helpful to note that empirical evidence in Alaska suggests that medical provider price reductions can be negotiated without reducing benefits and shifting costs to health plan participants. For example, Medical specialty groups which have reduced prices and joined network, e.g., OPA press announcements regarding joining Primera, Cigna and AETNA networks, do not appear to have reduced high value benefits or shifted costs to beneficiaries.

11. RE: page 10, was Alaska the smallest number of employees also and thus highest costs?

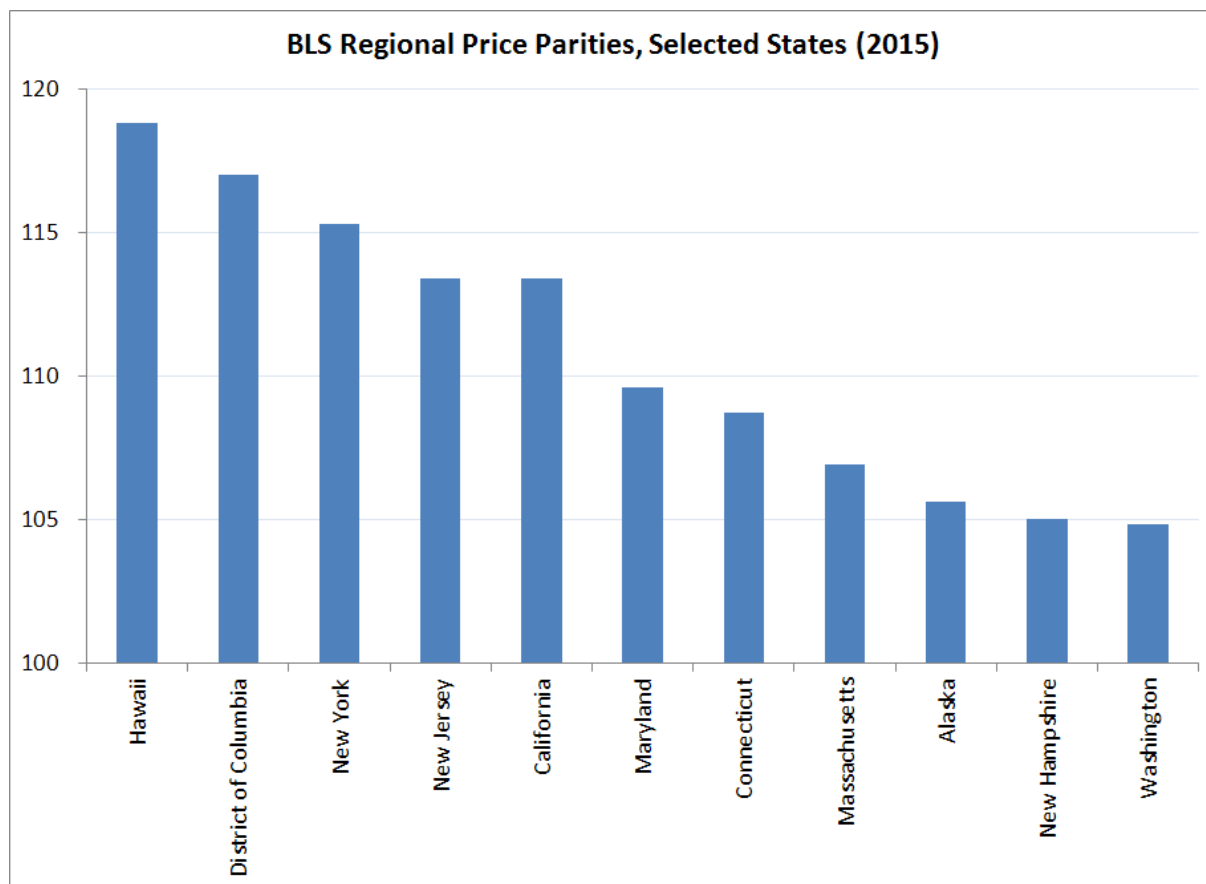
Response: No, Alaska continues to have more employees than Wyoming or Vermont. Source: Bureau of Labor Statistics (BLS) State and Metro Area Employment data, 2017.

Questions and Answers

HCA Feasibility Study Webinar, MAFA September 13, 2017

Alaska has higher medical service costs, lower utilization of medical services and much higher medical prices than other states, including smaller population states that have markedly smaller commercial centers. Anchorage (population ~290,000) is considerably larger than the largest city in Wyoming (Cheyenne, population ~59,000) or Vermont (Burlington, population ~40,000).

Please note that BLS regional price parity research (2015) indicates that the aggregate cost of living in Alaska was less than several states, and was within 1% of Washington State (see graph below).¹

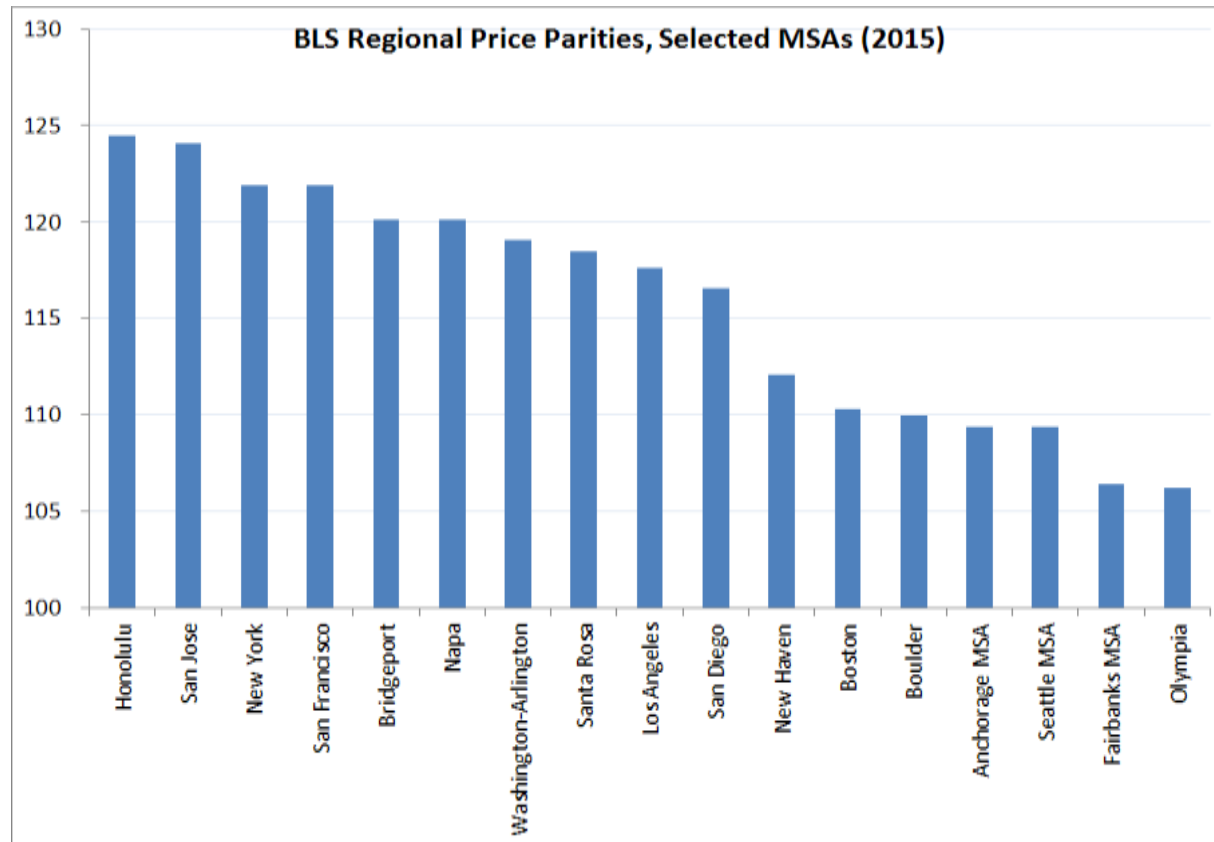


Please also note that BLS regional price parity research indicates that the aggregate cost of living in Anchorage was comparable or lower than many metropolitan areas in the U.S. (see graph on the following page).

¹ Given relative flat real estate markets in Alaska and continued escalation in real estate markets in Washington, especially the Seattle metropolitan area, it is likely that Alaska's regional price parity in 2017 is on track to be below Washington. It also appears likely that Anchorage's regional price parity will continue to slide below Seattle and many other notable metropolitan areas going forward into 2018.

Questions and Answers

HCA Feasibility Study Webinar, MAFA September 13, 2017



12. *Explain assumptions about benefit levels. There are considerable differences between different populations included in the universe of covered lives.*

Response: The estimated savings associated with consolidating procurement and moving toward value based insurance design assumes that:

- 1) extremely high profits and associated prices will be moderated; and
- 2) benefit levels will improve for high health benefit care and that health plans will encourage plan participants to consider how much they are willing to pay for low health benefit care.

The HCA estimated savings also assumes that the shift to value-based insurance design will use a collaborative process with a fair and balanced mix of participants in the advisory group to avoid excessive hoarding of low value benefits at the expense of enabling better coverage for higher value benefits that can be broadly shared among plan beneficiaries.

13. *Would this buying power use exclusive providers? If so, with such a large population, do you jeopardize the non-participating providers payer mix by increasing Medicaid and Medicare populations for non-members?*

Response: Given the extraordinarily high prices that remain in the Alaska and especially within Anchorage's medical service provider markets, the empirical supply and demand evidence suggests that modest price reductions among high margin customers appear more likely to reduce excessive

Questions and Answers

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profits than to reduce provider supply (the number of medical personnel and their aggregate capacity to provide service to Alaskans) below reasonable levels.

14. *Can you explain what a center of excellence is and how you see them in the context of lowering provider reimbursement through leveraged purchasing?*

Response: See “Centers-of-excellence contracting” in Payers Test Reference Pricing and Centers of Excellence to Steer Patients to Low-Price and High-Quality Providers, Robinson and MacPherson, Health Affairs, September 2012, available at:

<http://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2011.1313>.

Private employers in Alaska, such as GCI, have been successful in their use of high quality competitive priced provider networks. See for example:

- BridgeHealth: High Quality / Competitively Priced Provider Network
- CareChex: Quality Rating System

15. *Did you consider extra costs from confusion in transition to the Health Care Authority and then inherent inefficiencies/frustration for members to deal with a provider with a huge increase in membership.*

Response: We recognize that it can be frustrating for plan members at times dealing with changes in healthcare arrangements.

The Health Care Authority is anticipated to select a health insurance company and/or a pharmacy benefit manager through a competitive procurement process. Each of the major health insurance companies and PBMs that are likely to bid on this coverage (Aetna, Premiera, UnitedHealth Care, Express Scripts, Optum, CVS Caremark) have tens of millions of customers, and therefore the addition of 40,000 to 50,000 new members would be a very small increase that they each would easily be able to handle.

We did not quantify the indirect savings at each entity from reduced paperwork and simplified administrative processes using a single Health Care Authority and a common set of health plans instead of the multiple structure, policies, and plans in place currently. These savings would be annual and ongoing, whereas the change to a Health Care Authority would incur only one-time transitional costs.

16. *Can you explain how you see the logistics behind leveraging the buying power? Right now, don't we just use a TPA network?*

Response: In and of itself, periodic bidding among insurers or TPA networks in Alaska has rarely resulted in price reductions. A more nuanced procurement process is required to encourage insurers and TPAs to move beyond the historic détente and toward more aggressive negotiations for discounts. For example, at least one moderately sized group plan has “rented” a TPA network and has successfully negotiated additional discounts directly with medical providers. By increasing the

Questions and Answers

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book of business on the order of 10 to 100 times under the HCA compared to the current buy side fragmentation, the HCA should be able to leverage savings on the order of 5 to 15%, without unduly impacting the supply of local services.

17. Did you exclude out of state claims, meaning claims for services provided outside of Alaska?

Response: The analysis focused on finding opportunities to reduce prices and improve quality. Claims data illuminated that in-state providers tended to cluster around very high prices and variable quality compared to out-of-state providers, who tended to cluster around lower prices and high quality.

The opportunity to improve quality and lower prices appears likely to remain focused on high priced and variable quality that is associated with in-state provider claims.

Memorandum

To: Natasha Pineda
From: Adam Reese
Re: Alaska Health Care Authority Feasibility Study – Webinar Questions and Answers
Date: December 14, 2017

This memorandum outlines the questions posed during the Health Care Authority (HCA) Feasibility Webinar that took place on September 7, 2017, and PRM's responses to those questions.

Question 1 – Reserve Levels

If the state moves forward with option 2; what are the anticipated reserve levels each pool would need and what is the strategy for developing that?

Answer 1.

We would envision something similar to the management of the Federal Employees Health Benefit (FEHB) program could be adopted in the management of an HCA. First, multiple carriers could be selected to offer coverage through the HCA so in addition to the four plan design options, employers could choose from approved health insurers (e.g. Premiera plan 1, Aetna plan 1, Cigna plan 1). FEHB uses a target reserve¹ of 3 months. We would recommend a somewhat smaller target reserve than 3 months claims (e.g. 1.5 to 2 months claims). This level of reserve could be built up in 2-4 years. If the HCA held the reserve for claims incurred but not yet reported or paid – the IBNR reserve (which, for a state-based arrangement PRM believes is preferable to the approach used by the FEHB where the reserves for claims incurred but not yet paid is held by the plan) then given the lag between incurral of claims and payment, the HCA would most likely achieve a reserve of between 1.3 and 1.8 months claims at the end of the first year if claims experience was in line with expectation, of which 1 to 1.5 months claims would be needed for the IBNR reserve. The reserve would be credited with pharmacy rebates and subrogation payments.

Under Option 2, separate claims pools would be established for the separate pools of covered lives, and the above approach could be utilized for each pool. Only one reserve would be needed for each pool, and for year-end accounting purposes only one IBNR reserve would need to be developed and accounted for by the HCA.

¹ The target reserve is a pool of assets available to the health plan. The target reserve can include the IBNR reserve for claims incurred but not yet paid (i.e. claims runoff), as well as a contingency reserve to fund short-term fluctuations in claims (e.g. unusually high volume of claims in a high severity 'flu season). If the actual reserves are above the target reserves, the excess can be used to reduce or moderate premium rate increases in subsequent years.

Question 2 - ERISA

Are there any ERISA issues from your perspective with mandating employees currently covered under union health trusts to participate in a state pool?

Answer 2.

In general, ERISA does not cover group health plans established or maintained by governmental entities (see <https://www.dol.gov/general/topic/health-plans/erisa>), therefore there should not be any ERISA issues, however PRM cannot provide a definitive answer as we are not attorneys.

Question 3 – Travel Benefit Savings

What are the estimated savings by entity for implementing Travel Benefits?

Answer 3.

The estimated savings at the entity level upon implementing the Centers of Excellence Travel Benefit depend primarily on the type of program currently in place at each entity.

Our analysis of those employers that were already using a travel benefit showed different savings levels by type of program. Those employers that had a “member pays first and is reimbursed after travel” approach saved less on average than those that used the BridgeHealth program where all travel arrangements were made for the member, the facility costs were bundled case rates and therefore the member had none or much reduced out of pocket medical costs. The BridgeHealth program has two types of fees. One part is incurred when a member uses the service and the fee includes:

- a) Bundled case rate (i.e. discounted facility contract rate covering all services)
- b) Member travel expenses
- c) Administrative fee

The second type of fee is a per employee per month access fee that also covers second opinion surgical review. PRM projected the Health Care Authority using consolidated group purchasing would achieve a \$1 PEPM lower monthly administration fee than the current contracts.

The methodology used for quantifying the travel benefit savings were therefore based on the type of program in place currently, as illustrated in the chart below.

Type of Program Currently in Place	Savings Included in Model (per employee per year)
No travel program	\$97
Members pay first and are reimbursed after travel	\$50
Existing BridgeHealth contract	\$12

The aggregate savings from those entities that provided details of their travel programs were then extrapolated to the total for all employers in the study based on the estimated number of employees. Additional information was obtained directly from Bridge Health on their Alaska clients to validate the aggregate number of employees with this type of program in place currently.

Question 4 – Calendar Year vs Plan Year.

In Table 29 (Phase II Report) are the costs in the table fiscal year or calendar year? Or is it both?

Answer 4.

The base period for the calculation is the data developed in the survey, which asked that current cost data be reported as of September 2016. That struck us all as a good date, since it had the effect of getting very current data given the timing of sending the survey out and the requested response date and it had a further advantage of capturing the most recent data. Many school districts use a fiscal year of July 1 to June 30 for their plan years. And other entities use calendar year for their plan years. As the reports indicate, more entities responding to the survey identified that their plan years are fiscal years, but a significant minority indicated calendar years. The data collection date of September straddles both, in that it will fall within the fiscal year beginning July 1, 2016 and ending June 30, 2017 for fiscal year plans, thus capturing the most current data; and will capture current data as well for calendar year plans, for the year beginning January 1, 2016 and ending December 31, 2016.

So, the savings projected for each year 2017 – 2021 is the sum of:

1. The savings for each entity for the five years subsequent to the fiscal year 2016/2017 in which the September 2016 data was reported; and
2. The savings for each entity for the five years subsequent to the calendar year 2016 in which the September 2016 data was reported.

So, as the questioner supposed, the correct answer is that it is both.

Memorandum

To: Emily Ricci
Copy: Natasha Pineda
From: Adam Reese & Tom Rand
Re: Alaska Health Care Authority Feasibility Study – Response to Public Comments
Date: December 15, 2017

This memorandum provides PRM's responses to certain comments submitted during the public comment period.

Comment 1: Which Entities Will See Savings?

More favorable savings for entities who participate in the Health Care Authority (HCA) rather than remaining on their own.

Response 1:

The expected savings will be greater if all entities participate in the HCA rather than remaining on their own because the larger scale of members will allow the HCA to achieve lower administrative fees, and lower cost through the BridgeHealth program and a pharmacy coalition. Scale plays a large factor in negotiating with vendors and in maximizing operational efficiency in employer sponsored health care programs.

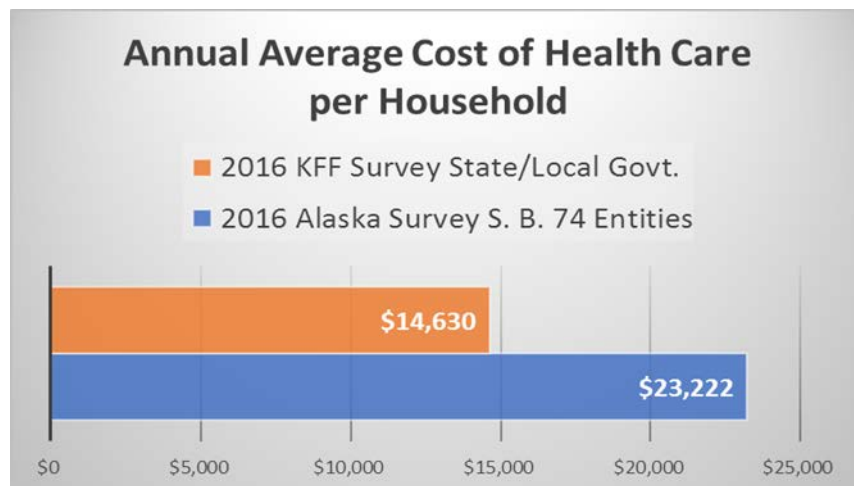
Although some employer groups are currently experiencing savings by utilizing a subset of the recommended cost saving measures (e.g., participating in the BridgeHealth program or a pharmacy coalition, etc.) the HCA as a single entity utilizing all of these measures will be able to generate more favorable rates for employer groups.

Comment 2: Administrative Fees

A comment was made regarding Washington State Health Care Authority's reported administration fees of 3% of claims costs and a belief that the administrative costs would be larger than 3% in Alaska.

Response 2:

As shown in Figure 1 in the Phase I Report, health care costs per household in Alaska are 50 percent higher than the average State and Local Government health care. Therefore, an administrative fee of 3% of health care expenditure in Alaska will result in a much larger dollar amount per covered member than in Washington State.



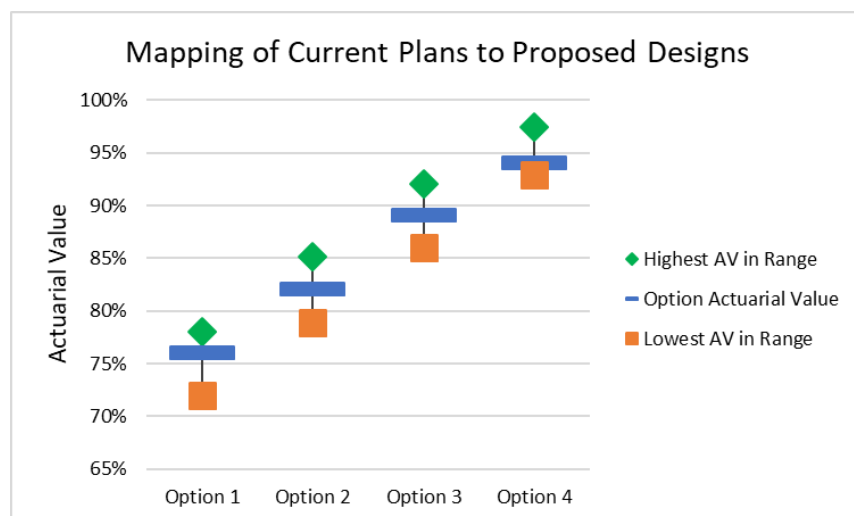
We prepared a separate memorandum focused on administrative fees that contains additional details.

Comment 3: Recommended Insurance Pools and Health Plan Options.

Comment made regarding the recommended three insurance pools with only four health plan options and a concern that this approach will leave little room for flexibility at the local level, particularly for rural communities.

Response 3:

One of the HCA models recommended three insurance pools for three different pools of covered lives; a retiree pool and two pools for employees allowing for separate pools for school district employees and all other groups. The four health plan designs were selected to provide flexibility at the local level – matching the observed range of health plan generosity as shown in Table 18 (Phase II) and illustrated graphically below.



"

Depending on the model that is selected for the HCA, employers will have the flexibility to participate or not and regardless of the model chosen, employers will retain the flexibility to determine the health plan coverage richness (i.e. actuarial value) as well as the level of employee and employer premium sharing.

The four health plan designs were created after reviewing the range of health plans that are currently offered by employer groups and determining the number of employees enrolled in each plan. The proposed four plan designs provide employers with the flexibility to choose the option or options that best suit their recruitment and retention needs. Option 4 has the highest actuarial value at 94%. A few employers had slightly richer plans including one with an actuarial value of 97.5%. That employer could choose Option 4 and fund an HRA to cover a portion of the member's out-of-pocket costs – essentially matching the actuarial value of 97.5%.

It is important to note that the health plan options demonstrate a concept and the HCA can use other plan designs to achieve the same or similar results.

Comment 4: Methodology for Determining the Savings

Several comments were made regarding the savings methodology.

Response 4:

The HCA is expected to generate savings through coordinated plan administration and pooled purchasing.

For fully insured plans with fewer than 50 lives, the net savings were assumed to be 20% of the current fully insured premium rate. For fully insured plans with 50 or more employees, net savings were assumed to be 15% of the current fully insured premium rate.

The savings for carving out and competitively bidding the prescription drug benefits were estimated using up to 10% savings depending on the current arrangements. Where pharmacy benefits were already carved out a smaller level of savings was used and for entities utilizing HCCMCA's pharmacy coalition a small incremental level of savings was applied. For entities that provided separate pharmacy costs these savings levels were applied directly to the actual pharmacy expenses. For entities that did not provide separate pharmacy costs they were assumed to be 15% of the total for medical and pharmacy.

The methodology used for quantifying the travel benefit savings was based on the type of program in place currently, as illustrated in the chart below.

Type of Program Currently in Place	Savings Included in Model (per employee per year)
No travel program	\$97
Members pay first and are reimbursed after travel	\$50
Existing BridgeHealth contract	\$12

For plans that reported administration costs, savings amounts were determined assuming an HCA would be able to negotiate an administration fee of \$18 per employee per month. For plans that did not report the current administration costs savings were assumed to be 1% of the total monthly rate.

Comment 5: The pharmacy carve-out model.

A comment was made about the pricing model the carve-out pharmacy plan would utilize.

Response 5:

The HCA is expected to generate savings by carving out the pharmacy benefits and competitively bidding it under a single policy. Pharmacy benefit managers typically offer a few pricing models (e.g., traditional, transparent, etc.). These pricing models vary by administrative fees, rebates, discounts, etc. During the competitive bid, the HCA is expected to evaluate each pricing model and choose the one that is most cost effective.

Comment 6: Reduced benefits for public employees and oversight of pharmacy benefit managers (PBMs)

A comment was made that PRM recommended reducing benefits for public employees and there was a query about who will oversee the selected PBM.

Response 6:

Neither the Phase I nor the Phase II report advocates reducing benefits of public employees or any other entity. Rather, PRM's recommendations propose to provide more favorable costs for employer groups which are expected to be passed on to employees.

If the HCA decides to coordinate a pharmacy benefit carve-out, oversight of the PBM is expected to be accomplished through the contracts and policies.

Comment 7: Tiered Premium Rates

Several comments were submitted with respect to PRM's recommendation that the HCA should use tiered premium rates. Will the HCA mandate use of tiered premium rates? What will the impact of tiered premium rates be on private employers? Much of the savings commented in the

reports is around tiering. If the push to tiering is approved, then it is even more likely that the family tier will exceed the Cadillac tax as opposed to the composite rate.

Response 7:

PRM recommended that the HCA use tiered premium rates – with differential total premium rates for households of different sizes (e.g. single household, employee and child, employee and family).

PRM’s reports did not recommend whether employees should or should not be required to pay employee contributions, nor the amount of any employee contributions. These decisions should remain with employers at the local entity level. The report pointed out that current contribution policies are resulting in cost-shifting from the private sector to governmental employers. The use of tiered premium rates rather than composite rates will have no impact on private employers unless there are changes in the contribution policies of the governmental employers that incentivize working spouses of governmental employees to obtain healthcare coverage under their own employer plan.

None of the savings estimated in the PRM reports are associated with the use of tiered premium rates.

The use of tiered premium rates has no impact on the calculation of the high-cost excise tax (“Cadillac Tax”).

Comment 8: Travel Benefit Savings

A comment was submitted that the estimated savings of \$85 per employee per year seemed very high “given that there is no change to employee benefits for those who travel and many members experience the same out-of-pocket expenses whether or not they travel”

Response 8:

PRM found that some employer health plans included Travel Benefits where the member was not responsible for certain copays or coinsurance payments if they utilized this service - therefore there could be a change in benefits. For employers that utilized BridgeHealth, the savings were shared and employees experienced lower out-of-pocket costs and no up-front costs for travel. A detailed description of the estimated claims savings amount of \$85 per employee per year is included in PRM’s memorandum answering questions in response to the webinar.

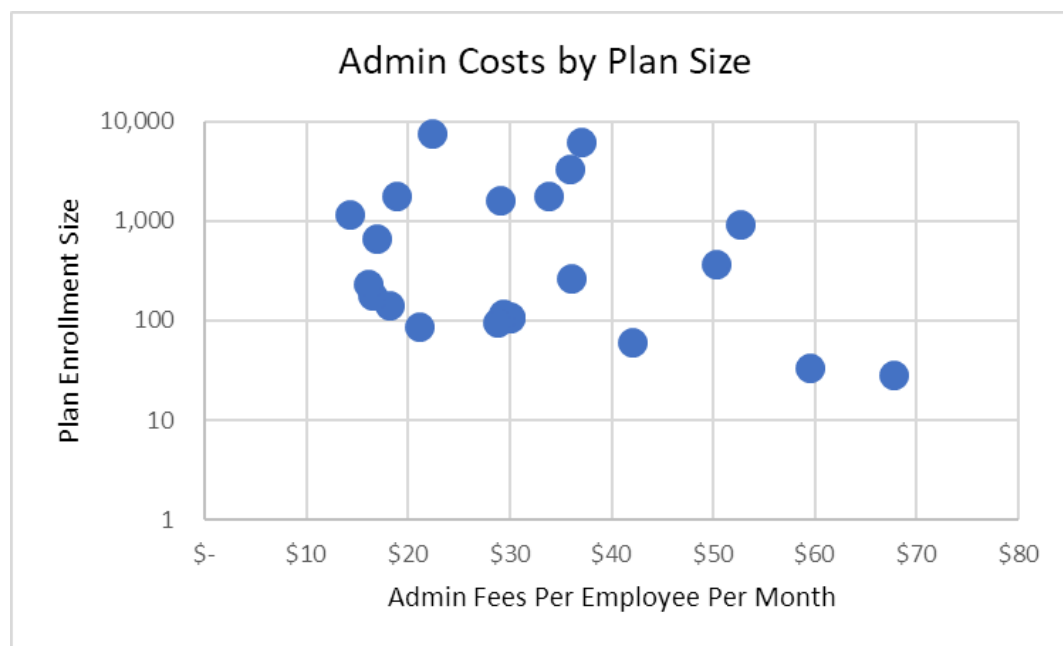
Comment 9: Scale

A comment was submitted that alluded to an inconsistency in PRM’s report with respect to how additional scale impacted administrative fees. The comment focused on statements made on pages 38 and 173 of the Phase II report.

Response 9:

The comment on page 173 took stock of the current scale in place for the AlaskaCare plans covering 47,800 subscribers (84,500 members) and noted that in PRM’s judgment the addition of another 90,000 members to a group of this size would not materially change the negotiating dynamics.

The comment on page 38 described the savings that would accrue to the Health Care Authority, and therefore to the participating employers, through coordinated plan administration where based on the size of the covered group, lower administrative fees can be negotiated for larger group sizes. This comment correctly addressed the observed importance of scale in determining the range of the administration fees. As observed in the data gathered for the survey and shown in the following chart, the highest administrative fees are associated with the plans with the smallest enrollment. Pooling many or all of the small plans into one group, the negotiated admin fees would be at the lowest rate (under \$20 per employee per month from the chart below) and therefore there would be savings of up to \$50 per employee per month depending on the size of the current admin costs.



The chart shows that even for larger groups with over 1,000 members there is considerable variation in the size of the administration costs.

Memorandum

To: Emily Ricci
Copy: Natasha Pineda
From: Adam Reese & Tom Rand
Re: Health Care Authority – Administration Fees
Date: December 14, 2017

This memorandum provides our responses to the questions regarding administrative assumptions.

Question 1: What assumptions did you use in calculating the administrative savings for the models in phase II? Was there a percentage basis you used, and if so what was that?

Scale is a factor in negotiating administrative fees from vendors and in maximizing operational efficiency (and therefore lowering administrative costs as a percentage of total costs) in employer sponsored health care programs. This observation is reinforced when one compares the administrative costs incurred currently by the multiple entities with the administrative fees reported by the Office of Personnel Management (OPM) for the administration of the Federal Employees Health Benefits Program (FEHBP).

By law, OPM is not permitted to spend more than 1% of premium for administration of the FEHBP plans. And for 2014, for example, OPM reported expenditures of \$47 million, or just 1/10th of one percent (0.1%) of premiums. The balance by which the 1% legislative requirement exceeds actual operating expenses each year is retained in contingency reserves, which support the financial stability of the insurers who participate and are utilized periodically to moderate rate changes.

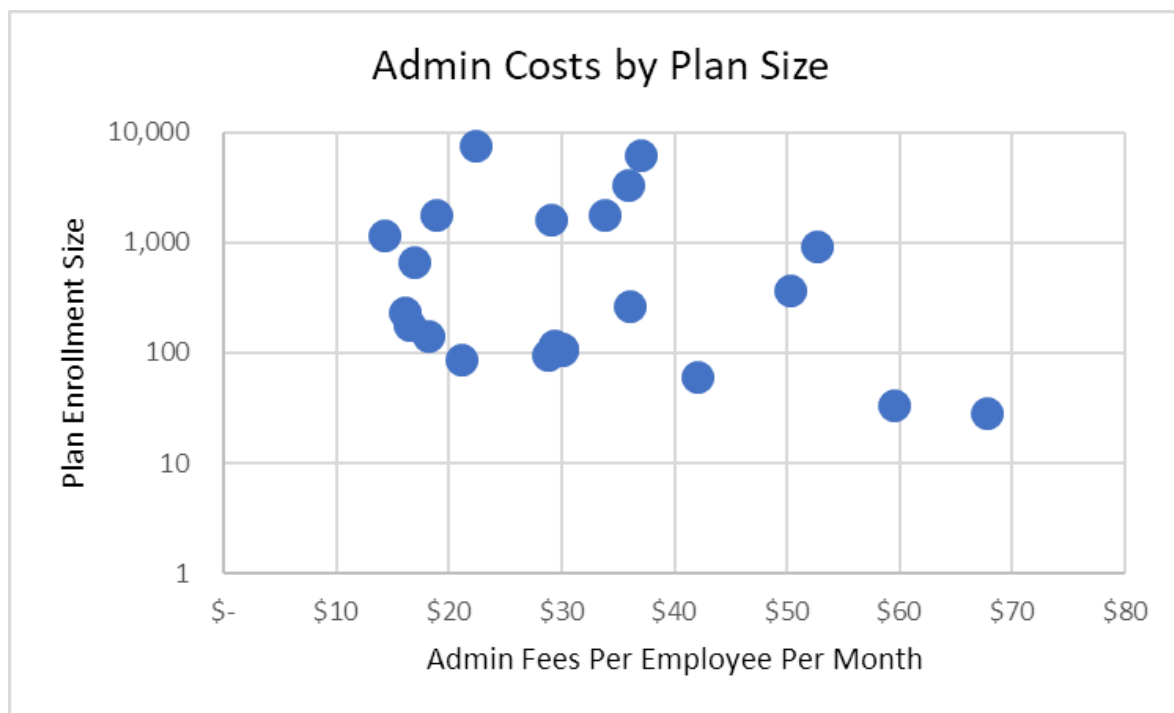
To examine the entire picture as to administrative costs would involve (as is also the case with the FEHBP plans) also examining the costs associated with other vendors involved in the programs, including insurers, health care companies with whom the Health Care Authority would contract and other vendors (e.g. contractors providing health care management services, wellness services, etc.).

In our estimates of potential administrative savings in an HCA consolidating plans for all Alaska public employers, we followed a conservative approach in that we did not assume any direct savings at the participating public employer level, through such factors as simplifying plan offerings, managing a more streamlined communications process and other operational efficiencies that can flow from a more structured and centrally managed program.

More specifically, the assumptions that underlie our estimates of potential administrative saving were based on the survey data and our professional judgment from recent experience with health plan procurements:

- Survey data collected on administration fees (covering over 25,000 employees) ranged from just over \$14 PEPM to more than \$65 PEPM.

- As expected, smaller plans had higher administration costs than larger plans (see chart)
- The largest plans did not have the lowest administration costs
 - The administration fee structures used by carriers differ, so some could include other fees (e.g. disease management fees).
- An expected cost of \$18 PEPM was used for the HCA.



The economies of scale that flow from an aggregation of employer programs such as those programs already in place for PEHT and other coalitions of employers (e.g. those managed by the Health Care Management Corporation of Alaska) should only increase, as the scale produced by the further aggregation of public employer plans in Alaska increases through the implementation of a larger coalition managed by an Alaska Health Care Authority.

Question 2: What is a reasonable or typical % for administrative costs in your experience?

Administrative fees always should be measured against the depth and quality of the services that are being provided. For large plans, we would expect typically to see fees in the range of 3% to 8%. However, fees can vary around those “typical” ranges. As noted in Report I, the per capita costs in Alaska are substantially higher than in the rest of the US, and as most of the administrative tasks are independent of the claims level per claim, plans in Alaska should expect to have lower administrative costs as a percentage of the claims costs. It is also exceedingly important that the selected vendors for a program have a demonstrable and well documented ability to effectively manage claims costs—which is where the bulk of an employer-sponsored health program’s costs reside. Thus, seeking the lowest possible administrative costs should not be the sole goal of assuring effective management of a health care program. Rather that goal should be built around the dual objectives of obtaining the best value measured both by the administrative costs negotiated and an evaluation of the vendor’s ability to manage claims costs without eroding the quality of health care outcomes.

Memorandum

To: Natasha Pineda
From: Adam Reese
Re: Alaska Health Care Authority Feasibility Study - Data Validation Process
Date: December 14, 2017

This memorandum describes the data validation process and summarizes the impact that the revised data had on the existing survey data and analysis.

Background

The primary data gathering tool for individual entities was an on-line survey. The survey was administered in October and November 2016 with an “as of” date of September 2016 for most data elements. Responses from the questions in the survey were consolidated into a file, which contained a unique identifier for each entity. Study participants also had the opportunity to upload supporting files, including Summary Plan Descriptions, Collective Bargaining Agreements, and health insurance rate sheets.

PRM recorded a webinar describing the survey tool and how to complete the survey. The recording was posted and made available to survey participants. In addition, entities were informed that they could call or email PRM staff if they had questions. PRM staff then contacted the respondent and assisted with data entry as well as receiving SPDs CBA, rate sheets, etc.

Aggregate population data was collected from a number of sources, with the primary data source being the number of employees who were eligible for and participating in one of the public retirement and retiree healthcare systems.

Information from the survey data was then extrapolated to estimate the aggregate health plan cost for all public employees who could potentially participate in an Alaska Health Care Authority.

No extrapolation was needed for the published data on retirees as the retiree files contained 100% of the eligible retirees.

Data Validation

In May 2017, study participants were given the opportunity to review and change or update a subset of the original information that they had submitted. The data summary sent to survey participants included:

- Plan names for up to seven plans per entity
- Number of employees enrolled in each of the plans
- Total monthly cost for September 2016 for each of the plans
- Employee monthly premium for September 2016
- Employer monthly premium for September 2016

- Indication of what coverages are included in the premium or cost information (e.g. medical & prescription benefits, dental, vision)
- Administration fees
- Name of travel benefit administrator, if any, and
- Funding arrangements and details on stop-loss insurance, if used

A sample of the data validation table is shown below.

Health Care Authority Feasibility Study (S.B. 74) Data Validation

Entity Name:	
Entity Contact Name:	
Entity Contact Email:	
Instructions:	<p>Please take this opportunity to review and update the data shaded in yellow and, if possible, provide the missing data identified with red question marks.</p> <p>All data elements represent September 2016 with the exception of the actuarial values which represent 2018.</p>

	Plan Numbers	Plan Name	Number of Employees	Total Monthly Cost for September 2016	Employee Monthly Premium for September 2016	Employer Monthly Premium for September 2016	Monthly Cost Per Employee Per Month	Estimated Actuarial Value as of 1/1/2018	Estimated # of Total Covered Lives
1.	Plan 1								
2.	Plan 2								
3.	Plan 3								
4.	Plan 4								
5.	Plan 5								
6.	Plan 6								
7.	Plan 7								
8.a.	What benefits are included in the above costs?								
8.b.	Medical and prescription drugs								
8.c.	Dental								
8.d.	Vision								
9.a.	September 2016 administrative fees per employee per month								
9.b.	Confirm that the administrative fees, in item 9a above, represent only the fees paid to the insurance vendor and do not include other in-house fixed costs.								
10.	Name of travel benefit administrator, if any								
11.	Funding arrangement								
12.	Name of vendor to whom prescription drug claims are submitted								
13.	Name of the prescription drug coalition, if participating in one								
14.a.	Is stop loss coverage purchased? If yes, enter the information requested below for September 2016								
14.b.	Specific premium (per employee per month)								
14.c.	Specific deductible								
14.d.	Aggregate premium (per employee per month)								
14.e.	Aggregate corridor (i.e., 115%, 125%, etc.)								
14.f.	Name of the stop loss vendor								

Results of Data Validation Process

With respect to the number of employees, no changes were made for plans representing 70% of the total employees. Some 5% of the plans reported higher counts for employees and 9% reported lower counts, with an aggregate reduction of 131 employees, which represents less than 0.5% of the total employee count. One entity added new plan information for a plan that was not included in the original data submission. The covered group in this plan was part of Public Education Health Trust (PHET), therefore the aggregate total of covered lives did not change as this group had been accounted for in the extrapolation from survey data to aggregate data.

With respect to the total monthly cost, only 13% of the plans representing 11% of the aggregate September 2016 monthly cost provided updated cost information. Some 7% of the plans were updated with higher costs and 6% were updated with lower amounts. The aggregate cost data after data validation resulted in the aggregate monthly costs decreasing by less than 0.2%. In addition, two entities reported costs in the data validation whereas no costs were submitted as part of the original data collection process. Both entities were schools participating in PEHT, therefore their costs had already been included through the extrapolation process.

Updated information from the administration fees, funding arrangement, and stop-loss data was reviewed for consistency and the original survey data was updated where appropriate¹ to reflect information received through the data validation process.

¹ For example, no changes were made for one entity that changed their response to question 11 to “fully insured” as the entity was part of PEHT which is a self-insured trust.

NOTE: Contact information for individuals who did not self-identify as part of a business or other organization has been removed to protect privacy. Comments are otherwise presented in their original form, in the order received by the Department.

From: HCAStudy, Alaska (DOA sponsored) <AlaskaHCA@alaska.gov>
Sent: Tuesday, September 05, 2017 10:23 AM
To: Anna Brawley
Subject: FW: submission of public comment for SB 74

Here is the first public comment we have received in our alaskaHCA@alaska.gov mailbox.

Thank you,
Natasha Pineda

From: Emily Kane [REDACTED]
Sent: Saturday, September 02, 2017 5:47 PM
To: HCAStudy, Alaska (DOA sponsored) <AlaskaHCA@alaska.gov>
Subject: submission of public comment for SB 74

Dear Policy Leaders

SB 74 contains concrete ideas for starting to solve the relative low value per dollar spent in the health care delivery arena for Alaskans. Alaska unfortunately, despite a quite good Native American health consortium, falls behind other states (and abysmally behind other developed nations) in access to care, life expectancy, suicide rates, maternal and infant mortality, and lethal addiction disorders.

The problem is, it is very expensive to deliver healthcare, much less high quality healthcare, in Alaska. This problem is compounded by several unnecessary costs which do not add to health care value. Specifically, we lack political ability to negotiate exorbitant drug pricing, we are burdened by the high cost of specialty physicians especially orthopedists, radiologists and anesthesiologists, and most importantly, we pay top dollar for the highly complex morass of health care insurers.

The health care insurance industry at this moment seems necessary in order to spread the risk. However, streamlining the administrative aspects of health care finances, which is the main objective of SB 74, with a more centralized health authority, is projected to save millions of dollars short term, and billions by 2025. Multiple independent consultants, who were hired per mandates within Medicaid expansion subsidies, came to similar conclusions about cost savings. SB 74 represents potential for cost savings without diminishing quality of care. In fact, quality of care might well go up.

As a primary care physician, insurance paperwork is absolutely the least favorite part of my job to supervise. I prefer to spend my time in the office giving excellent patient care. It is discouraging to tack on hours of paper-pushing at the end of my day. If the re-imbursement component of healthcare delivery were streamlined, all personnel actually delivering care would have more time to do what they were trained to do.

There may be some reasonable concern about the employees in the healthcare insurance industry. I don't believe SB 74 addresses this problem directly, but a single-payer proposal at the federal level (HR 676, with 220 co-sponsors) allocates funds to provide vocational training for insurance workers, and extends unemployment benefits for up to 12 months. Further, most insurance companies have multiple products. They won't fall apart because healthcare becomes a social priority, as opposed to a commodity.

I am very much in support of SB 74 as a necessary partial solution to the high cost, and inequitable delivery, of health care in Alaska.

Sincerely
Dr Emily A Kane
Juneau AK

[REDACTED]
[REDACTED]
[REDACTED]

From: HCAStudy, Alaska (DOA sponsored) <AlaskaHCA@alaska.gov>
Sent: Wednesday, September 06, 2017 1:52 PM
To: Anna Brawley
Subject: FW: Comment Response to: Study says creating Alaska health care authority could save hundreds of millions of dollars

From: Katie Peck [REDACTED]
Sent: Tuesday, September 05, 2017 2:39 PM
To: HCAStudy, Alaska (DOA sponsored) <AlaskaHCA@alaska.gov>
Subject: Comment Response to: Study says creating Alaska health care authority could save hundreds of millions of dollars

Hello,

I recently read the article in the subject line by Alaska Public Media and followed the link to leave a response.

I was born and raised in Alaska and currently work for the State of Alaska at the Department of Transportation and Public Facilities.

I have a comment regarding this quote from the article: "Allowing people to go outside to get their care, could improve savings both for those who go outside, but also it's a mechanism to bring additional competition to Alaska," Fisher said. "So it might even improve some of the delivery of care inside Alaska."

I can totally understand how this would save the State of Alaska money. They wouldn't be required to provide any health care. The other states would pay to keep the infrastructure and health providing systems running. The State of Alaska would just offer options in other states, passing the cost to the employee who has to pay to leave the state to even get to the health care. The cost of leaving Alaska is high. Making Alaskans go out of state to get health care is not cost effective for Alaskans. By removing health care from Alaska is essentially saying that people shouldn't live here. A State that doesn't take care of its people is not a good State to invest in.

Thank you for considering my comments.

--
Katie



September 30, 2017

Comments on "Alaska Health Care Authority Feasibility Study"

Alaska Municipal League

Thank you for the opportunity to comment on the Alaska Health Care Authority Feasibility Study. This is perhaps one of the biggest issues within the State of Alaska and I congratulate the Legislature for addressing these needs.

While municipalities throughout the State have varying ideas on how health care and insurance should be provided, I will attempt to keep my comments to those items that will affect all municipalities and need to be further addressed before the Alaska Municipal League and its member municipalities could decide on whether to support a Health Care Authority. I believe that it might have been more cost-effective for the Legislature to seek out comments from those entities that are potentially included in this proposal, before money was spent on a study.

1. Municipalities are very hesitant to ever get behind any State-wide program that is "mandatory." Self-governance is an important aspect in local government within the State of Alaska. Municipalities are adamant about continuing to have choices based upon their population, culture, location, economy, etc. If this plan goes forward, we would very much be opposed to any program that is "mandatory."
2. While most Alaskans agree that something must be done, a plan which attempts to include all municipalities, despite their differences (as listed above) will have a much different effect on each municipality. What may work for one, could devastate another. Municipalities should be able to evaluate the costs and benefits on their specific municipality before taking a strong stand as to whether to support or not support.
3. Mentioned in the study is that the Washington HCA is staffed with 1,100 employees and administrative costs are 3% of total expenditures (Phase II, page 5). I am convinced that Alaska's administrative costs would be higher. I believe this begins to put more affordable costs at great risk.
4. Also mentioned is that an HCA would be able to "provide health care coverage that is comparable to the plans in place currently at a lower cost to the entities that fund the coverage (Phase II, page 3)." That seems to be a very general, blanket statement with no data behind it. Hardly a statement on which to base a well-thought out comment.
5. The statement that this approach mirrors the approach the state has taken with respect to other programs such as the state retirement program..... (Phase II, page 3)," gives us added concerns. Under the current deficit facing the state,

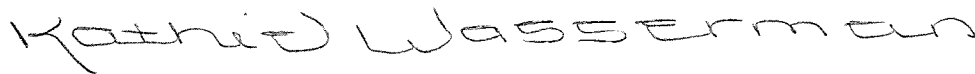
Member of the National League of Cities and the National Association of Counties

one of the programs that has put us in this financial position is the poorly administered retirement system. It would take some heavy convincing to show municipalities that the history of the PERS/TRS retirement system would not be repeated with a Health Care Authority.

6. Throughout the documents, I noticed no mention of any negatives in moving towards a state-wide Health Care Authority. That does not seem possible. There must be some drawbacks. It tends to make me question the results.
7. Small items which are mentioned will severely impact the cost of an HCA to municipalities, such as a simple mention that the most “efficiently administered health plans had governance boards or committees that met as often as monthly (Phase II, page 3).” The consulting group seems a bit out-of-touch to cost drivers in this state.
8. There is a blanket statement that “Rates for entities that decide to participate will be lower than they would be on their own..... (Phase II, page 3).” When this idea was presented as a Legislative bill (SB 90), it was never shown that was the case and I don’t believe it has been shown in this document. Many municipalities feel they have a plan they are very happy with and are opposed to ditching it for a plan that has more “equality,” and yet, might cost more after factoring in administrative fees.
9. Other plans shown in this study share administrative resources, which are listed to include “legislative affairs coordination.” I do NOT believe this is a service that municipalities want to add to their health care costs.
10. Throughout the study, there are many charts showing “savings.” But that is difficult to translate into “who” saves, and to what degree. Most likely, the savings will probably be seen by larger entities, but what will this do to the smaller ones? There are actually no cost estimates which we could use to make knowledgeable decisions. Short cost estimates, municipalities will be adamantly against a proposal without seeing the cost “up-front.” Also, the Legislature’s habit of taking on the cost of plans only to see them then pass those expenses on to municipalities when money is short, lends to our hesitancy to support.

Again, we thank you for the opportunity to comment. This document can serve, regardless of the results of this particular study, to begin an in-depth conversation that needs to take place.

Sincerely,

A handwritten signature in black ink that reads "Kathie Wasserman". The signature is written in a cursive, flowing style.

Kathie Wasserman
Executive Director

Anna Brawley

From: HCAStudy, Alaska (DOA sponsored) <AlaskaHCA@alaska.gov>
Sent: Thursday, September 21, 2017 9:12 AM
To: Anna Brawley
Subject: FW: Insurance

Public Comment Recieved

-----Original Message-----

From: Rhonda Atkins [REDACTED]
Sent: Wednesday, September 20, 2017 6:04 PM
To: HCAStudy, Alaska (DOA sponsored) <AlaskaHCA@alaska.gov>
Subject: Insurance

This is in response to your studies, trying to mingle our health benefits with Medicaid.
It sounds rather like socialized medicine to me, and couldn't be a good thing for the retirees.
Please do not take away the insurance we have worked for and earned just when we need it the most.
It is a travesty to all of us that have been loyal, good hard working people, and do not deserve to be thrown under the bus at this point in our lives.

Regards,
Rhonda Atkins
[REDACTED]

Sent from my iPhone

.



City of Homer

www.cityofhomer-ak.gov

Office of the City Manager

491 East Pioneer Avenue

Homer, Alaska 99603

citymanager@cityofhomer-ak.gov

(p) 907-235-8121 x2222

(f) 907-235-3148

October 9, 2017

Attention: Department of Administration, Commissioners Office
550 W. 7th Avenue
Suite 1970
Anchorage, Alaska 99501

Re: SB 74

To Whom It May Concern,

The City of Homer appreciates the State's willingness to tackle the ever rising cost of healthcare. The recommendation that the State establish a Health Care Authority with three separate pools: one for retirees, one for school district employees, and one for governmental employees may very well be a step in the right direction. The City of Homer supports the open dialogue and the State's vision, but has specific concerns regarding the possibility of mandatory participation.

The implementation of an HCA could help the State, and individual municipalities such as Homer save money on health care costs. This is an exciting opportunity and we are thankful that the State is looking for solutions. However at this point, there are simply too many unknowns to require mandatory participation. There is another scenario addressed in which the State develops legislation establishing an HCA but does not require mandatory participation. This would be preferred.

The City of Homer remains optimistic regarding the possibility of an alternative to rising health care costs - but we urge the State to allow us the choice to participate, rather than making participation mandatory through legislation.

Respectfully,

Katie Koester

City Manager, City of Homer

From: Pineda, Natasha M (DOA) <natasha.pineda@alaska.gov>
Sent: Tuesday, October 24, 2017 3:10 PM
To: Anna Brawley; Thea Agnew Bemben
Subject: Fw: AK Health Care Authority Public Comment

Juneau, AK 99811

RE: Public Comment on proposed Alaska Health Care Authority

Dear Commissioner Ridle:

Thank you for issuing a draft version of the Department of Administration's study on the creation of an Alaska Health Care Authority, and for beginning a discussion about how to best address the high cost of health care in Alaska. As an organization representing 13,000 active and retired teachers and education support professionals, NEA-Alaska stands ready to be a part of this conversation, and to offer our expertise with school district health insurance coverage and plans across Alaska. Like many other stakeholders in Alaska, we are very concerned about the rising cost of health care for Alaska's families.

That being said, after reviewing the information assembled by the Department of Administration's consultants, we remain skeptical that a statewide health care authority is an approach that will lower the cost of health care in a state like ours, with the unique geographic challenges we face. In particular, we disagree with one assumption that lies at the heart of these reports: that insurance pooling lowers the cost of health care. The number of employees in an insurance pool is only half of the picture when it comes to negotiating the price of health care in Alaska. On the other side of the table is a small number of medical providers in any given specialty in communities across Alaska, large and small. No matter how large a pool of employees is involved, it will not change the fact that medical providers can largely set the price they choose.

After we have had a chance to review the public data underlying this study, we hope to give you specific examples of why we disagree with the study's conclusions about cost savings. In particular, we would like to better understand how PRM Consultants arrived at an initial calculation of \$112 million in savings over five years, and how Mark Foster and Associates then used those numbers to project \$655 million over seven years. In the meantime, we have a number of comments about the study in its current form.

Understanding that this is a draft study, we would like to register a number of questions and concerns with the Department, with the hope that this dialogue will lead to a larger discussion of how we can address the issues that are at the root of Alaska's high health care costs.

1. Can the Department's consultants point to any definitive proof that insurance pooling will force medical providers to lower their prices in negotiations? In a September webinar, representatives of PRM Consulting stated that there was no evidence that insurance pooling would result in lower health care prices.
2. Can the Department's consultants estimate the costs to the state of creating, staffing, and operating a new health care authority? How many new positions will be created to run an authority? Many school districts and municipalities already have lower overall administrative costs than a state-run authority could achieve.
3. What the Department's consultants present in one part of these reports as cost savings is actually cost-shifting of dependent and spousal coverage from the State of Alaska directly onto employees and to other employers. Can the Department's consultants estimate the new costs that would be borne by public employees, their families, and private employers due to these proposed changes to dependent coverage?
4. What is the timeline for implementation to create a statewide health care authority? What actions does the administration plan to take right away, and what steps will require regulatory and statutory changes? Do the projections made by the Department's consultants in these reports account for the time it will take for the administration and the Legislature to create a statewide health care authority?

5. Why did the Department's consultants decide to recommend three insurance pools with only four health plan options? We are concerned that this approach will leave little room for flexibility at the local level, particularly for rural communities.

Thank you for taking the time to hear our concerns. We welcome any feedback you might have for us, and are available to meet with you and your staff to discuss these issues in more detail. We recognize that health care is a complex issue, to say the least, and I look forward to delving deeper into this discussion with you. With any luck, we will be able to work together to find a path forward that will be beneficial to the State of Alaska and all of Alaska's working families.

Sincerely,



Tim Parker

President, NEA-Alaska

CC Governor Bill Walker
Commissioner Valerie Davidson, DHSS
Scott Kendall, Office of the Governor
Emily Ricci, Department of Administration
Natasha Pineda, Department of Administration



Tim Parker

President

NEA-Alaska

907-274-0536 or 1-800-996-3225

NEA-Alaska exists to be an advocate for an excellent public education for each child in Alaska and to advance the interests of public school employees.



City and Borough of Sitka

100 Lincoln Street • Sitka, Alaska 99835

Coast Guard City, USA

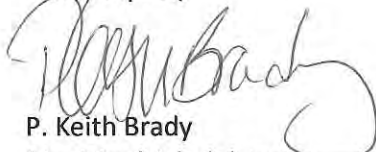
Department of Administration
Commissioners Office
550 W. 7th Avenue, Suite 1970
Anchorage, AK 99501

Dear Commissioner Ridle,

The City and Borough of Sitka respectfully makes comment on SB 74, directing the State of Alaska to study whether a state Health Care Authority is feasible and/or cost effective. After reviewing the Health Care Authority Feasibility Study, it is the City and Borough of Sitka's recommendation that this plan be optional for municipal governments to join.

As local governments continue to feel constrained by annual healthcare increases and struggle with the balance of personnel costs versus services, we appreciate the State of Alaska looking to reduce the hardship on local municipalities. However, it is essential that any Health Care Authority should be an optional program and not mandated.

With respect,


P. Keith Brady
Municipal Administrator

Providing for today...preparing for tomorrow

Bartlett Regional Hospital

3260 Hospital Drive, Juneau, Alaska 99801 907.796.8900 www.bartletthospital.org

October 26, 2017

Dear Commissioner Fisher,

As CEO of Bartlett Regional Hospital in Juneau, Alaska, I would like to comment on the Alaska Healthcare Authority Feasibility Study.

First, I want to applaud the state for taking this measured approach to identify the feasibility of different options to reduce healthcare costs in Alaska. We all know that, with the state's economy what it is, we need to be prudent with these expenditures. I do have a couple of significant concerns with the study and what I heard on the webinars.

1. I believe that the savings projected for the program are very inflated, reflecting best-case scenario, not reality. I would suggest that an independent auditor verify these numbers.
2. I am appalled that beneficiaries would be encouraged or required to leave the State of Alaska to get care at so-called "Centers of Excellence". The quality of care in Alaska is quite high, often exceeding that provided in the lower 48. The inconvenience and added cost to the patient and family for preliminary assessment, procedure, and follow up often requiring multiple trips out of state must be factored into the equation. Additionally, this is the absolute wrong time to talk about taking revenue out of the state.
3. I am seriously concerned about the disruption/elimination of care alternatives for rural Alaskans. The quota system identified by Mr. Foster could easily have this impact and when he was asked about that, he responded that he really had not considered that at all.

In summary, I do believe there could be significant savings to the State of Alaska through a Healthcare Authority. By far, the greatest opportunity for savings is in the Anchorage area. It is imperative that the rural communities be protected from losing their healthcare in this process.

Thank you for your consideration.


Chuck Bill, C.E.O.
Bartlett Regional Hospital



Alaska Pharmacists Association

Board of Directors

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Kathryn Sawyer
Nome

Ashley Schaber
Anchorage

Sara Supe
Anchorage

October 25, 2017

Department of Administration
Commissioner's Office
550 W. 7th Avenue, Suite 1970
Anchorage, AK 99501

To Whom It May Concern:

The Alaska Pharmacists Association (AKPhA) represents over 250 pharmacists, pharmacy technicians, and pharmacies in the State of Alaska. Please accept our comments regarding pharmacy services as addressed in the HCA feasibility study reports. We are concerned with how carving out pharmacy services and awarding a bid to one single pharmacy benefit manager (PBM) could affect pharmacies and their patients.

While PBMs provide a valuable role in drafting medication menus and processing prescription claims, they have also become a major middleman in the pharmacy world. Page 33 of the Phase 1 HCA study report indicates that a PBM can achieve as much as 5% savings in prescription drug costs. However, as reported in a March 3, 2017 Bloomberg news article, PBMs “keep about 10 percent of the rebates from manufacturers vying to get their medicines covered; they sometimes charge health plan clients more for generics than they reimburse the pharmacies dispensing them; and they channel clients to their own specialty pharmacies.” Without a truly transparent PBM model, we question whether the State would really ever quantify the savings potential.

We are also concerned that a single PBM controlling such a large percentage of pharmacy business in Alaska could ultimately threaten the viability of smaller Alaskan pharmacies. PBMs often present “take-it-or-leave-it” contracts offering no allowance for the higher cost of doing business in Alaska. Given the large percentage of business involved, if Alaskan pharmacies are unable to obtain an equitable contract they may be forced out of business. Additionally, heavily promoted or mandatory use of the PBM owned mail order pharmacy pose a threat to Alaskan pharmacies. This could especially affect rural areas and pharmacies serving specific populations (e.g. nursing homes and assisted living facilities).

E-mail: akphrmcy@alaska.net

203 W. 15th Ave., Suite 100 • Anchorage, Alaska 99501 • (907) 563-8880 • (907) 563-7880

We found no mention in the HCA reports of the possibility of the State acting as their own PBM. Large corporations, such as Caterpillar Inc, have seen large savings by cutting out the PBM middleman. Additionally, in a September 2017 policy report by the National Academy for State Health Policy, it was suggested that States becoming their own Pharmacy Benefit Manager would allow for a “long-range view of spending and recalculate how they view the long-term value of pharmaceuticals to society.”

The AKPhA leadership and membership is ready and willing to offer its assistance to the State of Alaska regarding any questions about pharmacy services in Alaska. Thank you for the opportunity to comment on this important matter.

Sincerely,

Della Cutchins, PharmD
President, Alaska Pharmacists Association
dccutchins@anthc.org

Ward Hinger
CEO Imaging Associates
CAO AK Radiology Associates
3650 Piper St Suite A
Anchorage AK 99508

The Honorable Leslie Ridle, Commissioner
Department of Administration
550 W. 7th Ave, Suite 1970
Anchorage, AK 99501

Commissioner Ridle,

I serve as Chief Executive Officer for Imaging Associates and Chief Administrative Officer for Alaska Radiology Associates. I thank you for giving me the opportunity to officially comment on the Health Care Authority Feasibility Study.

Imaging Associates (IA) proudly offers high quality patient-centric diagnostic imaging in Anchorage and Mat-Su Valley. IA is managed by the largest radiology group in the State – Alaska Radiology Associates (ARA). Over the years we have pioneered dozens of innovative services in AK, many of which continue to be offered only by us. Offerings such as:

- ✓ The only subspecialized radiology practice in the state – so neuro exams are read by fellowship trained neuroradiologists, bone/joint exams by musculoskeletal radiologists, mammograms by breast radiologists, etc. Our physicians have trained at the top radiology residency and fellowship programs in the country, including Stanford, Duke, UAB, Harvard, UVA, Michigan, University of Washington, Penn State, Dartmouth and Mallinckrodt.
- ✓ The only Breast Center of Excellence in the Mat-Su Valley, a critical designation by the American College of Radiology when it comes to early detection and treatment of breast cancer.
- ✓ The first - and still only - High Field Open MRI which means the patients are not enclosed, an important consideration in treating some patients including veterans with post-traumatic stress disorder.
- ✓ The first and only radiology group in AK that provides 24/7 access to a local radiologist with similar teleradiology support.
- ✓ Fast turnaround times for finalized reports which will flow back directly into physicians electronic medical records via a bi directional HL7 interface. Our reports are routinely finalized/signed under two hours of study completion (averaging less than 30 minutes for emergent studies).
- ✓ The most accomplished vascular intervention practice in the state, with three interventional radiologists, two vascular surgeons, and multiple midlevels for support. Our non-vascular interventional practice is unparalleled in Alaska.

I encourage you to take a few moments to review our many innovative achievements at <https://www.alaskarad.com/our-diagnostic-achievements/>.

As a healthcare administrator with over 20 years of experience both in and outside of AK, I recognize that overall medical costs in AK are higher than other States and as a concerned state resident, I also applaud efforts to utilize health care dollars wisely and efficiently. Nevertheless, as we all understand, AK is unique in its geographical size, small population, and has many challenges of meeting the health care needs of Alaskans and quite frankly the desires of Alaskans in how and where they want to receive that care. Our main concerns with the study, or frankly any health care policy, is preserving competition and ensuring patient access to quality care is not diminished or sacrificed for budget cost savings. Thus with regard to Health Care Authority Feasibility Study, please accept my comments as follows:

1. Phase I

- a. We are concerned over potential consequences of the expansion of travel benefits.
 - i. AK currently enjoys the highest level of access to quality health care in the history of our young state. In many cases the development of local access to care involves taking risk, working through years of less than capacity patient usage and accepting payor mixes with high percentages of low reimbursing government healthcare programs. While increasing travel benefits for such a large pool of insured may initially save money for the covered individuals it will result in more expensive local services for persons out of the State managed pool including Medicaid, Medicare, and Workers' Comp recipients. This will also potentially drive some local providers out of the market thus diminishing competition and further reducing access while increasing costs.
 - ii. Concerns over travel benefits aren't just AK versus lower 48. Encouraging travel from smaller communities to larger ones, whether it be Fairbanks and Kenai to Anchorage or Sitka to Juneau, increases the likelihood that smaller communities will lose local access and quality healthcare will be concentrated in larger communities. The loss of local services would be a major step backwards for our State and impact health care needs that are not conducive to travel such as emergent care or care for persons who need to continue working or care for others.
 - iii. Travel benefits also require travel for follow-up care. A very important element of successful results in health care is access to follow-up care. Having to travel for such care removes patients from family, from jobs, and increases the likelihood that patients will forego follow-up care impacting quality and possibly removing access to care for persons who for whatever reason can't travel.
- b. I also do not understand what is meant in the study by the term "center of excellence" to qualify for travel benefits.
 - i. While we support efforts to raise the quality of care the report does not have adequate specificity to understand how the term "center of excellence" will be defined or implemented. Who will certify? What will be the criteria?
 - ii. The Phase 1 report on page six references quality of care based on proven outcomes. How will this be scored? With such a large pool of insured providers, in order to stay in business, will have to compete for access to State managed insured. Outcomes can be skewed by payor mix. It is a reality that Medicaid recipients generally have more complex issues than private insured. Any attempt to measure proven outcomes should be careful to ensure that providers don't refuse care to patients with complex issues or a history of not following provider advice in order to boost "proven outcomes" to meet a government test.

- iii. Please provide greater detail for “centers of excellence” so that providers can provide more substantive comments. Again, we have general concerns over the lack of details.

2. Phase II

- a. Phase II of the report analyzes the advantages, challenges, and feasibility of establishing a state HCA to coordinate and administer common plan designs across a large pool of public employees and other political subdivisions of the state and makes recommendations as to the structure of the HCA.
- b. We have concerns about the potential consequences to both competition and access in AK if an entity were able to negotiate exclusive contracts for lower prices and steer such a significant number of insured to a select and limited number of providers. Those select providers receiving state HCA-covered patients would have a large enough pool to allow them to no longer treat lower government-reimbursed patients such as Medicaid, Medicare, charity, and others. Essentially, those providers would be able to provide health care services only to Alaskans with the richest benefits in the state. While the payor mix of the non-preferred providers would be disproportionately tilted to treating patients reimbursed at a much lesser amount. This would likely drive those providers out of business with the loss of ability to cost shift across a more balanced payor mix; the likely result being less competition and reduced health care access for other Alaskans.
- c. The report lacked analysis on the potential consequences of affecting competition by allowing such a large pool to negotiate contracts for lower prices with certain providers who would then no longer have to accept lower reimbursed patients. As the report states, lack of competition is a factor for costs in Alaska. Adopting a policy that results in less competition only exacerbates the problem. Less competition not only drives costs up, it creates a larger problem of access to healthcare for others. One way to prevent that is to ensure any negotiated rates be made available to any provider choosing to participate. This allows providers to maintain a balanced payor mix, continue providing access to those non-HCA covered patients, and preserve competition in AK not limit it. We believe this should be a requirement in any plan developed for an HCA model.

In summary, while the State of AK focuses on controlling its health care costs it also has a responsibility to consider the affects and consequences of the decisions it makes to providers who’ve made significant investment to provide quality care locally as well as Alaskans who will not be covered under its plan. Thorough analysis should be given to determining how access to health care will be affected for all Alaskans under such a plan but especially those non-state and non-public employees, Medicaid, and Medicare beneficiaries prior to any new policy or program is adopted.

Again, I thank you for the opportunity to submit my comments. I am look forward to hearing from your staff on how I and other healthcare leaders can help in driving clarity to my aforementioned concerns. I can be reached at (907) 562-1282 or via email – ward.hinger@imagingak.com.

Sincerely,



Ward Hinger

CC: Dr. Chris Reed – Medical Director for IA and Dr Jonathan Coyle President of ARA

Alaska Radiology Associates Shareholders

- Dr. Coyle
- Dr. Inampudi
- Dr. Kottra
- Dr. Maurer
- Dr. Moeller
- Dr. Reed
- Dr. Tauschek
- Dr. Winn
- Dr. York



A collection of handwritten signatures in blue ink, each corresponding to a shareholder listed on the left. The signatures are written over horizontal lines. The first signature is a large, dense scribble. The second is a stylized 'I'. The third is a cursive 'K'. The fourth is a cursive 'M'. The fifth is a cursive 'D'. The sixth is a cursive 'R'. The seventh is a cursive 'T'. The eighth is a cursive 'W'. The ninth is a cursive 'Y'.



THE STATE
of ALASKA
GOVERNOR BILL WALKER

Department of
Health and Social Services

ALASKA COMMISSION ON AGING

P.O. Box 110693
Juneau, Alaska 99811-0693
Main: 907.465.3250
Fax: 907.465.1398

October 27, 2017

Commissioner Leslie Ridle
Alaska Department of Administration
550 West 7th Ave., Suite 1970
Anchorage, AK 99501

Regarding: Public Comment on the Proposed Health Care Authority

Dear Commissioner Ridle:

The Alaska Commission on Aging ("ACoA and "the Commission") is pleased to provide public comment concerning the findings from the contractor studies that examined the feasibility of creating a Health Care Authority (HCA) in Alaska. Alaska is the state with the highest costs of health care insurance and medical care in the nation due to our low population density, high transportation costs, and complicated health care delivery system. The aging of Alaska's population also presents unique challenges to our state's health care system as seniors, more than any other age category, are consumers of health care and their numbers are rising as well.

The ACoA is a Governor-appointed commission within the Department of Health and Social Services that is responsible for planning services for seniors, educating Alaskans about matters related to aging, and making recommendations directly to policymakers and other officials concerning policy and budget items that affect Alaska's growing senior population. Given this role, we write to express our comments with a particular focus on State of Alaska retirees.

Alaska is the state with the fastest growing senior population of persons age 65 and older. In 2016, Alaska's population of people age 60 and older numbered 125,886 representing 17% of our State's population, of which 78,980 are persons age 65 years and older. In FY2016, there were an estimated total of 22,033 Alaskan public service retirees representing PERS (16,318) and TRS (5,715) beneficiaries.

We would like to take this opportunity to share with you stakeholder input that we have received in order to provide context for our comments regarding the proposed Health Care Authority as described below. The Commission regularly requests and receives feedback from seniors during public comment periods scheduled at each of its quarterly meetings; conducts senior and provider surveys as part of needs assessment activities for the Alaska State Plan for Senior Services and other planning projects; and hosts Elder-Senior Listening Sessions/community forums for older adults, family caregivers, senior service providers, and other public members to provide opportunities for stakeholders to offer input on topics related to aging.

Access to primary health care and long-term supports are particularly critical for those who may experience, or are at risk for developing chronic health conditions, physical disabilities, and cognitive impairments such as Alzheimer's disease and related dementias. Based on senior survey findings that were reported in the current Alaska State Plan for Senior Services, *access to health care* was identified as the most pressing concern for Alaska seniors according to 48% of the 2,280 survey respondents age 55 years and older. Over the years,

seniors insured by Medicare, particularly those living in the Railbelt, have informed the Commission about their challenges in finding primary care providers who offer medical and behavioral health care services for Medicare patients in their communities. The Commission has heard about this issue repeatedly through public comment and senior survey responses in addition to similar concerns expressed by the Alaska State Medical Association and the Alaska State Hospital and Nursing Home Association concerning Medicare administration requirements and low reimbursement rates as barriers to the provision of care.

Moreover, the availability of in-home services is also “very important” for seniors. Sixty-five percent of seniors responding to the last senior survey identified the need for community-based long-term supports. These lower cost, effective services support senior health and well-being by providing in-home supports to older adults who require assistance with activities of daily living so that they may live safely and comfortably at home and in the community. Alaska’s annual cost of nursing home is significant. The Genworth Cost of Care Survey 2017 reports the state annual median cost at \$292,000 for nursing home care. For a Medicaid patient, the annual cost per resident is \$153,009 (Division of Senior and Disabilities Services 2017). Community-based services are considerably less costly, provide caregiver support, and serve seniors at home.

The Commission recognizes the gravity of the State’s fiscal situation, the increasing costs of health care, and appreciates the Division’s efforts to engage stakeholders and encourage public discourse concerning the future for publicly funded health care in Alaska. The ACoA offers the following comments for consideration based on the information reviewed:

- Adopt PRM Consulting Group’s consolidated purchase recommendations for the Employer Group Waiver Plan (EGWP) in the AlaskaCare Retiree Plan in order to maximize cash savings for the retiree health care trust, achieve a reduction in the actuarial liability, and lower the requirements for funding the benefits by reducing the “normal cost” for these benefits. Based on our understanding, the proposed consolidated purchasing strategies would result in no change to pooling beneficiaries except for the purchase of prescription drugs and providing travel benefits for health care services when appropriate so that beneficiaries are in a better position to recover travel expenses paid out of pocket.
- Move forward with adopting “model 2” as proposed by PRM Consulting Group to coordinate plan administration and increase purchasing power in order to maximize savings over time for three separate pools: Retirees, school district employees, and all other government employees.
- Adopt “value-based insurance design” and “reference based pricing,” as recommended in the MAFA report, by providing incentive payment for primary care utilization as well as safe and efficacious treatment plans to reduce fragmentation, enhance patient health and wellness, replace fee for service models, and maximize savings to the state and individuals. Based on our understanding, many seniors use specialty care providers for the treatment of their chronic conditions as well as for primary care as specialty care providers receive a higher Medicare reimbursement and thus are more likely to accept Medicare patients. There could be some cost savings if patients needing primary care used primary care providers instead of specialists for their primary care needs, however, that may require incentives such as easier reimbursement for health care professionals (such as primary care doctors, nurse practitioners, and physician assistants) as well as behavioral health care professionals (psychologists and clinical MSWs). The Commission also recommends the inclusion of “geriatric health care” as an added specialty care for value-based insurance under the retiree plan premised on the increasing numbers of public service retirees.
- Implement a comprehensive health and wellness program as part of the proposed Health Care Authority (HCA) to lower costs and insure better health outcomes. This approach, used successfully in the City and Borough of Juneau for the last twenty years, has worked to keep premium costs and

health care expenses low and is a model worth considering for the state. Further, a comprehensive wellness program could be used to buy down premiums. ACoA also recommends that the HCA develop multiple plan options for dental, vision, prescription drugs, behavioral health, and other health care services to provide consumer options for whole person, integrated health care. Routine dental, vision, and hearing services are not covered by Medicare.

- Incorporate a phase-in approach of the proposed HCA, pending its approval, with an emphasis on limiting disruption to patients and providers. This “go-slow” approach should include education/training for providers and public members regarding the new health care delivery system and allow time for providers to adapt to a new delivery system while continuing to provide quality services during a potentially disruptive transition.
- Explore options not addressed in the HCA report findings to include an affordable, sustainable, and modernized long-term care insurance plan for public employees. This option, structured as a public-private partnership, could potentially save the state and individuals significant funds in long-term care costs. Currently, Alaska offers long-term, care insurance to public employees only on their last day of employment prior to retirement. The plan is expensive and provides limited coverage for community-based long-term supports, especially in-home care and adult day services. In comparison to assisted living and nursing home care, community-based services are significantly less expensive and serve seniors at home, where most prefer to be. Many soon-to-be retired employees may opt to purchase a long-term care insurance plan if it is affordable, provides coverage for services across the continuum of care, and is offered earlier in their employment which would fortify the plan’s resource base. By increasing the number of Alaskans using long-term care insurance, the financial burden on Medicaid services could also be reduced.

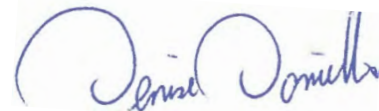
In closing, we would also like to recognize and personally thank Emily Ricci, Chief Health Policy Administrator, Division of Retirements and Benefits for her proficient review of the studies’ findings with ACoA members and providing follow-up to questions. We greatly appreciate the time she took to personally explain this complex subject matter with us. Thank you for this opportunity to provide comment.

Sincerely,



David Blacketer
Chair, Alaska Commission on Aging

Sincerely,



Denise Daniello
ACoA Executive Director

Alaska Department of Administration
Health Care Authority Feasibility Study Public Comment
alaskahca@alaska.gov

October 30, 2017

To Whom It May Concern:

The Alaska Mental Health Trust Authority (Trust) is writing to thank the Alaska Department of Administration and its contractors for their work investigating the feasibility of creating a Health Care Authority (HCA) and to offer public comment on the potential impact to beneficiaries. The Trust serves as a catalyst for change and improvement in the systems that serve Trust beneficiaries, who include people with mental illness, chronic alcoholism and addictions, developmental disabilities, Alzheimer's disease and other dementias, traumatic brain injury and other brain-based disorders.

This study documents current health plan structure among the public employers targeted for possible participation in the HCA and highlights the high cost of health care among both public and private employers in Alaska, estimating Alaskan health care costs are more than 50 percent higher than the national average. These reports also put into stark relief the significant strain that high health care costs place on State and employer budgets, employee wages, and the affordability of health care among individuals and families.

Impact of high health care costs on Trust beneficiaries

1. In an environment of declining State financial resources, high health care costs threaten the sustainability of Medicaid and essential services that many Trust beneficiaries rely on for their health, safety, and wellbeing. This pressure is particularly concerning given the growth in Alaska's aging population and the economic uncertainty facing families today. Reducing State health care costs will produce needed cost savings. Trust beneficiaries are also employees of the public organizations recommended for inclusion and should benefit directly from reduced health care costs to these employers.
2. Beneficiaries may be of retirement age or experience barriers to and/or interruptions in employment that disparately impact their ability to afford health care. High health care costs place burden on businesses and households, especially individuals and families struggling to pay for basic needs.
3. Nonprofit organizations serving beneficiaries grapple with the same financial burden as the public employers included within the scope of this study. Exorbitant health care costs can make it difficult to hire sufficient personnel, offer competitive wages, and recruit from a national talent pool all of which can influence the volume and quality of services available for beneficiaries.

Recommendation to establish a Health Care Authority

The analyses and recommendations presented in these three reports appear to make a strong case for establishing a HCA to consolidate purchasing strategies and coordinated health plan administration and achieve cost savings for the State of Alaska and participating employers while maintaining plan flexibility and value. A smarter, less fragmented approach to health care purchasing and administration may prove an essential ingredient to health care reform efforts in Alaska. The Trust would also welcome the opportunity to engage in dialogue about how the creation of a HCA can serve as a catalyst for enhancing access to early assessment and intervention services, home- and community-based services, and mental health and substance use disorder services.

The question of whether or not to include the Medicaid population in the HCA is of particular interest to the Trust because of the Medicaid program's critical role in providing health care coverage to Trust beneficiaries. These reports do not recommend moving the Medicaid program under the entity initially. The experiences of Washington and Oregon suggest that there may be value in incorporating aspects of administration or other facets of the Medicaid program into the HCA at a later date. However, more analysis needs to be undertaken in partnership with the Department of Health and Social Services to assess the opportunities and impacts as well as timing of such a move. For example: Where are the specific areas of opportunity and what are the projected gains and risks? How would moving the Medicaid program under a HCA impact beneficiaries? How would such a move contribute to or detract from current reform efforts? For now, a phased approach to implementation of an HCA seems prudent and we are hopeful that such an entity could help bend the cost curve on health care in Alaska to benefit all Alaskans.

Sincerely,

A handwritten signature in dark ink, appearing to read 'Steve Williams', with a long horizontal flourish extending to the right.

Steve Williams
Chief Executive Officer (Acting)
Alaska Mental Health Trust Authority

From: HCAStudy, Alaska (DOA sponsored) <AlaskaHCA@alaska.gov>
Sent: Wednesday, November 01, 2017 3:58 PM
To: Anna Brawley; Thea Agnew Bemben
Cc: Ricci, Emily K (DOA)
Subject: FW: Public comment regarding the MAFA report conclusions for cost savings through an Alaska Healthcare Authority

Public comment received for your review.

From: Nancy Shima [REDACTED]
Sent: Tuesday, October 31, 2017 4:31 PM
To: HCAStudy, Alaska (DOA sponsored) <AlaskaHCA@alaska.gov>
Subject: Public comment regarding the MAFA report conclusions for cost savings through an Alaska Healthcare Authority

The MAFA presentation for AK Healthcare Authority cost savings opportunities suggests enacting a reimbursement rate “reset” starting closer (ex 1.5-3x) to Medicare reimbursement rates, which are referenced as a benchmark scale. (While it is a fallacy to think that Medicare rates actually reflect reasonable costs to provide a service, there are set standard formulas/ratios/methodologies used to determine maximum amounts Medicare pays. And, Medicare rates are not only not adjusted for inflation, but in fact, reimbursement rates for many services continue to decline—payment for services even 10 years ago was often higher than today.) MAFA’s suggested drastic insurance reimbursement rate reset is an unrealistic and undesirable first step if we wish to sustain adequate access to healthcare services in Alaska.

Healthcare services will always cost more in Alaska. It is well accepted that Alaska has a high cost of living, and that the state’s vast size coupled with low population densities reduces the likelihood that many Alaska healthcare provider practices are afforded sufficient economy of scale needed to best optimize practice cost efficiencies. As a means to support available practice capacity and healthcare access, especially in sparse population regions, Alaskan specialty providers may adopt creative practice models such as providing periodic remote/satellite clinics in order to see patients throughout the region. Any business model is viable only if overall practice income is sufficient to cover overhead expenses. Understandably, the mentioned model will never be the most “efficient” revenue model (expense and time lost to travel, additional costs for duplicate equipment/staff/office rent etc etc.) and it requires that normal provider fees charged for services must be set higher than MAFA benchmark considerations. Fees charged must be increased even more when providers accept Medicare/Medicaid patients, since their associated “allowed” reimbursement rates are far inadequate to meet overhead costs, even in the ‘best’ of conditions. (Consider as evidence, the “failed” experimental Medicare Clinic models tried in Anchorage. Despite best efforts, they were just not financially feasible. Benchmark Medicare reimbursement rates alone do not pay the bills.) The primary means Alaskan providers use to overcome reimbursement shortfalls is to set their service fees (normally paid by private sector patients including those covered by AK state employee plans) to the rates needed to subsidize Medicare/Medicaid underpayment rates. Or an alternate option is to not see Medicaid/Medicare patients at all, however that is problematic for the overarching issue of HB 79, Medicaid Reform, which is the basis by which the legislature requests MAFA and other contracted Alaska Healthcare Authority feasibility studies.

From a simplistic view, an analyst could conclude that Alaskan providers charge far too much for healthcare services, especially when compared to fees charged in other states. In fact, it could seem that some specialty providers monopolize the market and feel free to charge as much as the market will bear. However, as the only specialty provider in the area, it is also highly likely the provider cares for the region’s entire load of Medicaid/Medicare patients who need

their service. So while MAFA's concept of achieving great savings from a state Healthcare Authority that 'squeezes' plan reimbursement rates to near Medicare benchmark rates, would appear at first blush to be a 'good idea,' it must be kept in mind that if these Authority-assisted reimbursement rates would be far too low to adequately subsidize the other "insufficient" (ex Medicare/Medicaid) reimbursement rates. It would tend to force providers to cease seeing state Medicaid/Medicare beneficiaries. The beneficiaries would need to be sent to any remaining Medicaid providers in other regions of the state, where they are likely to overload those practices to the point that would be unsustainable. Such resulting reduced healthcare access, increased expenditures tied to travel costs, and a higher financial risk piled on any remaining Medicaid providers will not yield a healthy, sustainable Alaska healthcare delivery model.

The state of Alaska could assist with Medicaid Reform issues in another way—that helps reduce costs to providers (therefore helping providers to charge less) by addressing the large inefficiencies heaped on Medicaid providers just in order to get paid. When Medicaid was looking for ways to reduce costs, they contracted with an administrator who understood that providers would be unlikely to see Medicaid patients if reimbursement rates were further reduced. So instead, the selected contractor promised the state savings through requiring the provider do twice as much work for the reimbursement. In essence, the Medicaid plan transferred many of the state's administrative tasks to the provider. For many practices, this, more than most any other requirement for doing business with the state, assures that such provider practices will never meet the MAFA suggested ideal for high efficiency, and it is likely a large contributor for the high provider/admin staff ratio MAFA concludes plague many Alaska healthcare practices. It is my hope that an Alaskan Healthcare Authority would not consider Alaska Medicaid's "do twice as much work for payment" model as another payment alternative. Many Alaskan healthcare providers are approaching retirement age and pushing them "over the edge" in an effort to get the "most value" in healthcare services would be likely to exacerbate the Alaska provider shortage that now exists. Healthcare reimbursement is a whack-a-mole proposition, and the first kneejerk response to lowering the reimbursement growth rates should not be the MAFA-suggested "reset" based on Medicare rates.



November 6, 2017

The Honorable Leslie Ridle, Commissioner
State of Alaska, Department of Administration
PO Box 110200
Juneau, AK 99811

Re: Comments on Health Care Authority Feasibility Study

Dear Commissioner Ridle,

Thank you for the opportunity to comment on the Department of Administration's health care authority feasibility study. Following please find general feedback and specific comments related to the various reports.

General Comments

ASHNHA applauds the state for seeking to better manage health care costs. Many of our members are also large employers and face the same challenge of providing high value health care benefits to their employees. ASHNHA has in the past noted that the state and other large public payers have not adopted many of the strategies used by large self-funded employers to manage health care cost escalation, including adopting tiered benefit structures and high-deductible plans with employer-sponsored Health Savings Accounts. We are encouraged that this report addresses some of these strategies, which represent prudent ways to manage cost. In addition, a basic principle of insurance is the spreading of risk. In general, the larger the risk pool the more stable premiums will be. Thus, the state's current practice of fragmenting its employee population into multiple risk pools makes little sense from an actuarial standpoint.

The health care authority structure itself is simply a tool that the state could use to manage its health care spending. The report shows limited savings from simply implementing the tool – the savings come from management strategies. We are agnostic as to the implementation of this tool, but have comments and suggestions on various proposals for managing the state's health care spend within the authority structure, and for how Medicaid would interface with a health care authority. Following are comments specific to each of the four reports within the overall study.

Phase I

The Phase I study addresses pooled purchasing without consolidation of covered lives into a single plan. The savings for this option are minimal. The single largest opportunity identified, the Employee Group Waiver Plan, is an option that can be implemented for the retiree population absent an authority structure. Savings from this option should not be attributed to an authority.

We are concerned about the Centers of Excellence/Travel Benefit proposal, which shows minimal savings. While sending employees out of state for certain procedures may save money in the short term, it has the potential for eroding the health care infrastructure and services available to Alaskans in the long term. Many of our small and mid-size hospitals can be compared to public utilities. They serve a community purpose and their cost structure is born by the community they serve. Services like a 24-hour emergency room with its associated diagnostic equipment and staffing are costly, but critical to the safety and well-being of the community. Significant outmigration of services in those communities does not change the underlying cost structure of the services, but it erodes the community's ability to pay for them.

Overall, the savings in the Phase I model are not sufficient to justify pursuing a health care authority.

Phase II

Phase II recommends the creation of a health care authority with three separate pools, one for retirees, one teachers and one for other state and municipal employees. Participation would be mandatory.

Given that the state is not even currently managing its own employees in one pool, we believe it is premature for the state to consider mandatory participation by school district and municipal employees. ***If the state elects to establish a health care authority, it should first aggregate its own population and demonstrate success in managing this expanded group.*** The process of negotiating with public employee unions to return those employees to the AlaskaCare plan will be difficult and controversial. Only after the state has demonstrated the will to take this step and then the ability to successfully manage the larger population should there be consideration of including municipalities or the school districts within the authority. If and when the plan is open to other employers, election into the plan should be voluntary, not

mandatory.

Finally, while the report recommends a governance structure or board for the authority, it does not go into any detail about that structure. Before taking a position on an authority, ASHNHA members would need a better understanding of the governance structure. A proposed governance model is outlined in the Medicaid technical assistance report, but it is not clear if the state has a preferred model at this point in time.

Mark A. Foster and Associates (MAFA) Report

The MAFA report provides an interesting economic analysis of the current health care market and recommendations on purchasing strategies for an authority. While these strategies provide the most opportunity for savings, it is important to note that they are not exclusive to an authority structure, but could be pursued at any time by any self-insured employer. Mr. Foster's assumption is that the more aggressive strategies would require the volume provided by mandating municipality and school district participation in the pool. However, some of the strategies noted, such as value-based plan design and health plan tiering are not dependent on aggregating volume. Mr. Foster's recognition of the role of plan design in incentivizing the right kind of care is an important contribution to the report.

The savings associated with reference pricing and health plan pooling would likely be dependent on aggregating volume. The potential implications of reference pricing, in particular, should be considered carefully. In his analysis, Mr. Foster describes the market power held by some providers, specifically specialist providers. In some cases, this market power is a result of the small number of specialists required to serve the state. Aggressive reference pricing could result in the loss of the services those specialists provide. This option should not be considered without analysis of how the purchasing power structure of such a large commercial structure could impact competition and the availability of certain specialty services in the state.

Medicaid technical assistance report

The Medicaid technical assistance report provided a good outline of the existing Medicaid program and a description of some of the issues that would need to be addressed before Medicaid could be considered in an authority structure. While the report provided a nice compilation of information, there was little data or analysis to

inform decision-making. Absent more analysis, it is impossible to conclude whether the state could benefit from including Medicaid in an authority structure, which seems to be fundamental to the question of whether the state should pursue establishment of an authority. We were surprised that the study did not result in a recommendation or conclusion, given the significance of Medicaid as a state health care obligation. Given that both the Department of Administration and Department of Health & Social Services are tasked with managing health care, it appears that at the very least there would be opportunities for leveraging and sharing resources, whether within an authority structure or outside of one.

Thank you for the opportunity to comment.

Sincerely,

A handwritten signature in black ink that reads "Becky Hultberg". The signature is fluid and cursive, with the first name "Becky" and last name "Hultberg" clearly distinguishable.

Becky Hultberg
President/CEO



ALASKA DISTRICT COUNCIL OF LABORERS

Laborer's International Union of North America

2501 Commercial Drive • Suite 140 • Anchorage, Alaska 99501

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Dennis Moen

Business Manager
Secretary-Treasurer
District Council

Business Manager
Public Employees Local 71

Joey Merrick

President
District Council

Business Manager
Laborers Local 341

Scott Eickholt

Vice President
District Council

Business Manager
Laborers Local 942

November 9, 2017

Department of Administration, Office of the Commissioner
Attention: Health Care Authority Feasibility Study
550 W. 7th Avenue, Suite 1970
Anchorage, AK 99501

Submitted via email: AlaskaHCA@alaska.gov; leslie.ridle@alaska.gov

Subject: Health Care Authority Feasibility Study

Dear Commissioner Ridle:

Based on the State of Alaska's Health Care Authority Feasibility Study, the Alaska District Council of Laborers opposes the creation of a health care authority. The Alaska Laborers urges the Department of Administration and the Legislature to exercise caution in considering the recommendations offered in the feasibility study. Not only do the three consultants' studies requested by the Department of Administration exhibit analytical flaws, they fail to offer a convincing reason that a health care authority would result in cost savings without significantly reducing the quality of health care for public employees.

The District Council opposes the creation of a health care authority for five key reasons:

- (1) The creation of a health care authority would duplicate existing efforts such as the Health Care Cost Management Corporation of Alaska, Inc. (HCCMCA), which has been accomplishing the primary recommendation—consolidation to enhance leverage in price negotiations—since 1994;
- (2) PRM Consulting's recommendations appear to favor reducing benefits for public employees and fail to address the need for oversight of pharmacy benefit managers, which have been subject to congressional investigations and allegations of actually increasing the price of prescription drugs for consumers;

- (3) The recommendations failed to address the underlying issue of high health care costs in Alaska and do not show that the management of public employee plans is responsible for the costs of public employee health plans;
- (4) The three reports fail to provide any evidence why the State of Alaska is better prepared to represent the interests of participants than an organization like the HCCMCA that already implemented innovations and represents the best interests of participants.
- (5) By removing large numbers of plan participants from other health plans, establishing an HCA pursuant to the recommendations could destabilize those plans, sending ripple effects through the private sector in Alaska and private sector employees' access to health care.

First, the Health Care Cost Management Corporation of Alaska, Inc. is a member-driven organization that helps member health plans manage health care costs by negotiating better pricing on services. The Health Care Cost Management Corporation of Alaska already has member plans with around 100,000 covered lives in the Pacific Northwest, with 75,000 of those lives in Alaska. The Coalition includes a range of plan types, including government health plans, public sector health trusts, single employer plans, and Taft-Hartley trusts. The HCCMCA negotiates service contracts for its member health plans and has successfully reduced annual health care costs for members by over \$1,200 per employee. Given the large number of covered lives, the HCCMCA is able to negotiate better pricing. In addition, the HCCMCA Board of Directors, made up of two representatives from each member health plan, ensures that the organization is following best practices and serving the best interests of the member plans and participants. The recommendation that an HCA would increase negotiating leverage would therefore replicate an existing strategy. Similarly, PRM Consulting proposed directing travel to centers of excellence for patients to have medical procedures. Again, this is a duplicative recommendation because several public employee health plans not managed by the State already use a service provided by Bridge Health to allow travel for procedures when cost effective.

Second, PRM Consulting's recommendations could result in reduced benefits for public employees and ignore the risks associated with pharmacy benefit managers. PRM Consulting suggested lowering costs by making it more expensive to enroll spouses or family members in employee health plans. While such a change could reduce costs to the State, it merely shifts costs to public employees, which, along with other trends in public employee wages and benefits, could reduce state employee tenure and encourage experienced employees to look for more lucrative employment elsewhere.

PRM Consulting made it clear that its strategy was to take the range of current plans' actuarial values—meaning the “measure of the relative generosity of coverage”—and bring those values to somewhere in the middle of the current range. Rather than increasing efficiency, therefore, a major component of their recommendations is to lower the relative generosity of coverage. Public employee benefits are one incentive for employee retention, and the District Council objects to developing a cost-savings strategy grounded in minimizing coverage options for public employees. Not surprisingly, PRM Consulting's reliance on the Oregon and

Washington HCA examples fails to take into full consideration how the HCAs affected quality of care and benefits in those states.

PRM Consulting proposes using pharmacy benefits managers (PBMs) to achieve a savings of \$3.5 to 8 million annually. But because allegations that PBMs have increased the costs of prescription drugs for consumers with health insurance have been the source of congressional hearings and lawsuits, experience from the lower 48 demonstrates that using PBMs requires thorough oversight. The HCCMCA, for example, is already well-positioned to maintain such oversight given that it is managed by member plans, and the consultants fail to explain how an HCA would do better.

Third, Alaska has some of the highest health care costs in the United States. According to Mark A. Foster and Associates, a “key driver” in differences in health plan prices across the U.S. is “the relative level of competition within each region.”¹ Given that there is already an economy of scale through the HCCMCA, the consultants fail to explain how an HCA would address the key driver of high health care costs in Alaska—the monopolies and tight oligopolies among medical providers.

Mark A. Foster and Associates also asserts that its recommendations will result in lowered administrative costs without explaining which inefficiencies would be eliminated. Rather, the consultant implicitly assumes that current management of plans should change even though, at the same time, it acknowledges that lack of competition among medical providers is the key driver of health costs in Alaska. The report further offers the general suggestion of adopting best practices without giving examples of which best practices are not adopted by public employee plans in Alaska.

Fourth, not only do the three consultant reports fail to show how an HCA would seriously mitigate the lack of competition in the health care sector in Alaska—the reports do not address a fundamental issue: Which organization is most prepared to represent participants’ best interests—an HCA through the State of Alaska or an organization such as the HCCMCA that has decades of experience and has already taken steps to improve quality of benefits and achieve cost savings? Although the consultants intend an HCA to be independent of political pressure, negotiations through an HCA would be subject to greater risk of political intervention by providers when providers are dissatisfied. By contrast, the HCCMCA is independent of political pressure and is directly accountable to member plans. The HCCMCA is therefore more likely to serve the best interests of participants effectively. Comparing the budget and benefits-management track records of the State with the HCCMCA—it’s clear that the HCCMCA is more prepared to innovate and represent the best interests of participants.

Fifth, by removing large numbers of members from existing health plans, many of which have participants from both the private and public sector, the HCA recommendations could destabilize other health plans in Alaska. As a result, the HCA would be cost-shifting onto those

¹ MARK A. FOSTER & ASSOCIATES, ESTIMATE OF THE POTENTIAL VALUE OF CONSOLIDATING ALASKA STATE, LOCAL AND SCHOOL DISTRICT PUBLIC EMPLOYEE HEALTH PLANS 5 (Aug. 24, 2017).

other plans as opposed to reducing overall health care costs. The reports fail to offer an analysis of the potential risks of destabilization of such other health plans or the resulting impacts on remaining participants' access to health care and the cost of their health care.

Finally, not only are there significant unknowns involving potential plan destabilization—the recommendations fail to provide data concerning the administrative, transition, and implementation costs or the legal risks of initiating an HCA pursuant to the reports. For example, the reports do not address the fact that benefits constitute a mandatory subject of bargaining or that an HCA would result in significant start-up costs such as establishing reserves.

In sum, the three consultants' reports primarily rely on their theory that further consolidation of plans will lead to greater price-negotiating leverage, which, in turn, will lead to lower health care prices. The consultants also assume that such consolidation would only reduce inefficiencies. At the same time, the consultants fail to compare the costs and benefits of an HCA with the existing HCCMCA system, which already represents 100,000 covered lives and negotiates lower prices for member health plans. Finally, another underlying assumption in the studies appears to be that the generosity or value of coverage should be reduced for certain public employee plans, and that would be detrimental to the State of Alaska. Thank you for your consideration.

Best,



Dennis Moen



A.J. "Joey" Merrick II



Scott Eickholt

CC: Governor Bill Walker
Senator Lyman Hoffman, Co-Chair, Senate Finance Committee
Senator Anna MacKinnon, Co-Chair, Senate Finance Committee
Representative Neal Foster, Co-Chair, House Finance Committee
Representative Paul Seaton, Co-Chair, House Finance Committee
Senator David Wilson, Chair, Senate Health & Social Services Committee
Representative Ivy Spohnholz, Chair, House Health & Social Services Committee

From: HCAStudy, Alaska (DOA sponsored) <AlaskaHCA@alaska.gov>
Sent: Monday, November 13, 2017 10:54 AM
To: Thea Agnew Bemben; Anna Brawley
Cc: Ricci, Emily K (DOA)
Subject: FW: SB 74 and HCA Feasibility Studies
Attachments: SB74 Public Comment-ASHC.docx

Public comment for your review.

From: Ellen Izer [REDACTED]
Sent: Monday, November 13, 2017 10:42 AM
To: HCAStudy, Alaska (DOA sponsored) <AlaskaHCA@alaska.gov>
Cc: [REDACTED]
Subject: SB 74 and HCA Feasibility Studies

I would like to add my personal support of the Alaskan's for Sustainable Healthcare Cost Coalition comments.

Regards,
Ellen Izer
[REDACTED]

This email and any attachments are intended solely for the individual or entity to whom they are addressed. If you have received this message in error, please notify us by sending a reply email to the sender and delete this message and any attachments. Unauthorized use of the information in this email may be a violation of the law.

Email your comments to: AlaskaHCA@alaska.gov

Or mail to address below by November 13, 2017

State of Alaska
Department of Administration, Commissioner's Office
550 W 7th Avenue, Suite 1970
Anchorage, AK 99501

RE: Health Care Authority Feasibility Study

On behalf of the Alaskans for Sustainable Healthcare Costs Coalition (the Coalition), we would like to share our own observations and concerns with 4 studies that were produced as a result of SB74. It is fully understood that the cost of healthcare in Alaska is the highest in the nation and measures must be taken to bring these costs under control. As our name implies we are looking for sustainable solutions that address the broad concern of costs.

We have read the reports and from many different perspectives as we are a group of concerned employers representing employees from across the state in every industry including public sector employees. As much as we understand that something must be done, there are a number of concerns we have with the conclusions and the data within the 4 reports from the feasibility study.

The Feasibility Studies Data

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19. More private employers may have no choice but to drop coverage if costs continue to rise without controls in place.

In order to achieve long term changes in the cost of health care in Alaska, we need a long term vision and a stable group of people leading that vision. The Health Care Authority will be comprised of a group of political appointees who will change as the philosophy of the governor's office changes, resulting in vastly different visions for change and long-term sustainable improvement.

The State is already acting as their own Stop Loss carrier, adding these additional lives is ill-advised in the face of what the Affordable Care Act has done by eliminating lifetime maximums. For 2016, the highest claimant nationwide has reached \$36 million in expenses or the Iowan teenage hemophiliac that has expenses that are \$1 million a month. An ongoing expense with the potential to continue for years. A similar situation could impact the state. In Iowa there were 3 primary insurers not unlike our 2 carriers. At least one carrier has announced they will not continue to offer insurance exchange plans in Iowa and the other 2 are considering pulling out.

Alaska needs our carriers. They have negotiated vast networks that we didn't have 20 years ago. Continuing to create the legislative atmosphere that brings all parties to the table for reasonable and sustainable solutions is in the best interest of the entire state including public and private employers alike. We need our providers just as much and need to work together for the right balance.

Aetna and Premiera currently hold the majority of health plans at about 90% of the claims processed and have the most contracts with the medical community. Premiera already has more Alaskan lives in their pool than the State would have in The Health Care Authority. How would a smaller pool (HCA) negotiate better savings than a larger pool? If HCA was to consolidate 200,000 lives with one insurer, this could drive the others out of the market and thus centralize all the insurance offering in Alaska with one carrier. How would creating an insurance monopoly in Alaska control costs and work to the benefit of employers and employees?

In conclusion, the Coalition believes the studies need to be looked at more closely for the concerns and comments outlined above. We also feel that the legislature is in the best position to solve the looming health care crisis not by creating a large health care bureaucracy but by leaning into 3 major issues that have the potential for real cost control, which are:

1. Eliminating the 80th Percentile rule and developing a more controllable reimbursement limit such as 125% of Medicare with a balance billing limit to protect consumers.
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3. Addressing Medevac costs by closing the loophole in how they are governed within Alaska.

We all feel the pressure of out of control medical expenses personally and socially. We can work together to develop solutions that can be sustained.

Regards,

<Insert Signature>

ASEA/AFSCME Local 52 Health Benefits Trust

111 West Cataldo Avenue, Suite #220
Spokane, WA 99201
(509) 328-0300 (866) 553-8206

11 November 2017

Public Comment

RE: Health Care Authority

SB 74 study

Dear Commissioner:

As Chair of the ASEA/AFSCME Local 52 Health Benefits Trust, I am writing to express my concerns about the proposed Health Care Authority recommendations.

The ASEA Trust was created in November 2000 to provide benefits to the employees of the State of Alaska General Government Unit and their families. Since that time, the Trust has been able to provide better benefits at a lower cost than the State has provided to employees covered by the Alaska Care plan. Outreach from an Alaska-based firm shows that more than 90% of plan participants surveyed report being satisfied with the services they receive from the Trust.

The PRM Group study recommended formation of a Health Care Authority to provide benefits to our members, as well as the employees of municipalities, boroughs and school districts. This recommendation was based on cost savings in 3 areas:

1. Implementing travel benefits and carving out prescription drugs. The ASEA Trust already uses the Bridge Health travel program. We have carved out prescription benefits for more than a decade. In order to obtain the best pricing and contract terms, we are members of National CooperativeRx, a non-profit cooperative with approximately 300,000 covered lives. Neither of these recommendations will yield additional savings for our members.
2. Consolidated administration. The Trust's administrative costs are low as a percentage of overall plan costs. We anticipate little or no savings for our population resulting from consolidation. Instead, we are concerned that administrative costs would increase as a result of staffing the HCA.
3. Tiered premium rate structure with no coverage for part-time employees and restrictions on dependent participation if dependents have access to other coverage. It is logical that employers can save money by reducing the number of people covered under the plan. However, access to coverage for part-time employees is subject to collective bargaining. We also question the ability of the HCA to require dependents

to enroll in other coverage regardless of cost, particularly in light of the state regulation requiring coverage for dependents of state employees.

The MAFA study took the HCA concept further, suggesting the HCA would be able to contract with providers, and implement strategies such as referenced based pricing and value based design. One of the reasons our Trust has been able to provide better benefits than the State's Alaska Care plan, at a lower cost, is that the Trust has pursued aggressive cost containment strategies for many years. The Trust is a member of the Health Care Cost Management Corporation of Alaska, a non-profit purchasing coalition. Through the HCCMCA, we have taken advantages of direct provider contracts with local providers, implemented strong steerage provisions, and undertaken initiatives such as chronic kidney disease management or near site clinics. In my experience, the State has been a poor purchaser of health care, and is slow to adopt cost containment initiatives. We believe that consolidation under a State-run Health Care Authority would be a step backwards.

We appreciate the legislature's interest in controlling health care costs. We share that interest. We do not believe a Health Care Authority is the right answer.

Thank you for the opportunity to participate in the study and to provide comments.

Sincerely,



Michael Williams
Chairman, Board of Trustees



Fairbanks North Star Borough

Human Resources

907 Terminal Street P.O. Box 71267 Fairbanks, Alaska 99707-1267 (907) 459-1202 FAX (907) 290-2443

November 13, 2017

State of Alaska – Department of Administration
550 W 7th Avenue, Suite 1970
Anchorage, AK 99705

Sent via email: AlaskaHCA@alaska.gov

RE: Comments on Proposed Health Care Authority

The Fairbanks North Star Borough (FNSB) provides benefits to approximately 370 employees and their families. We operate a self-funded health plan and have been able to provide an excellent plan of benefits to our employees at a reasonable cost. Although we've experienced year-to-year fluctuations in costs, our health plan expenditure has been stable over time. On a per employee per month basis, our FY17 costs are only 9% greater than our cost in FY12. Our FY17 costs are less than those of the Alaska Care plan's cost for FY16 (the latest year the data is publicly available.)

We have aggressively managed our health plan by:

- Joint purchasing select services. We obtain economies of scale by purchasing some services in conjunction with the Fairbanks North Star Borough School District. We are also members of the Health Care Cost Management Corporation of Alaska and National Cooperative Rx, in order to take advantage of group contracting for PPO contracts, near site clinics, travel benefits, prescription drug management, and other services.
- Working with our Labor Management Committee on Employee Benefits to make plan changes which will contain costs and encourage appropriate health care utilization.

We are concerned that a Health Care Authority would result in higher health plan costs and less flexibility in crafting a benefit plan to attract and retain employees.

The PRM Phase I study identified two cost savings opportunities, neither of which would provide any additional savings to the FNSB:

1. Center of Excellence / Travel Benefit. The Borough already participates in the program operated by Bridge Health.

2. Pharmacy Benefit Carve-Out. The Borough already carves out prescription drug benefits and contracts with Caremark through the National CooperativeRx non-profit purchasing cooperative.


The PRM Phase II study recommended that public entities be **required** to participate in the HCA. The plan options we could offer our employees would be limited and the rate structure would be set by the HCA. We have several concerns with this approach:

- Health benefits are the subject of collective bargaining.
- We will lose the ability to customize our benefit plan to our employee population or to address challenges or opportunities with local providers. Local control is critical.
- We doubt the HCA will achieve significant administrative savings for the FNSB. We already take advantage of joint purchasing to keep our administrative costs low. If modeled after the Washington HCA with 1,100 employees, the Alaska HCA staffing costs would increase the administrative burden.

The MAFA study focused on potential savings opportunities by using the collective market power of a larger pool to reduce provider payment, such as through referenced based pricing or value based plans. While we believe these programs may have merit, it is not necessary to create a Health Care Authority to explore these options.

In summary, we have serious concerns as to whether a State-sponsored Health Care Authority would be able to successfully contain health care costs and meet our local needs.

Sincerely,
FAIRBANKS NORTH STAR BOROUGH



Sallie M. Stuvek, SHPR, SHRM-SCP
Human Resources Director

cc: Karl Kassel, FNSB Borough Mayor
Jim Williams, FNSB Chief of Staff
Read File



Department of Administration, Commissioner's Office
State of Alaska
550 W 7th Avenue
Suite 1970
Anchorage, AK 99501

Re: Public Comment on Health Care Authority Feasibility Study Phase I & II

Commissioner:

The Wilson Agency is an Alaskan firm that provides employers with consulting services related to traditional employee benefit programs, retirement plans and human resource strategies. We appreciate this opportunity to comment on the Health Care Authority Feasibility Study Phase I and II produced by PRM Consulting Group. Our staff have reviewed the reports and offer the following comments.

First item we see is that the studies don't address long-term health care inflation for Alaskans. There may be a short-term positive correction, but long-term growth of costs is not addressed. While changes of this magnitude could create immediate savings, this serves as a "reset" of a cost base from which health care cost trend will continue to increase health care cost.

In Phase I PRM lists under Key Findings that "Health Care Costs in Alaska Are Substantially Higher Than In Other States And The High Costs Are A Major Concern For Employers." We agree with this statement, however it would have been helpful if PRM had listed major cost drivers contributing to the "substantially" higher medical costs. Does PRM see that the drivers of cost could be directly impacted by proposed changes listed in their study? The study seems to focus more on insurance mechanisms that would curb premiums for one group of people as opposed to providing solutions for cost reduction to the whole system.

Of specific concern is the fact that there is no reference to how the rest of the market in Alaska will be impacted if the State goes through with either the recommendations made in PRM 1 or PRM 2. Possible negative impacts we see could include providers raising the cost of services to offset the discounts the State will/may achieve through its additional ability to negotiate. We see a high potential for cost shifting to the private sector, similar to the current

November 13, 2017

30% cost shift due to Medicare and Medicaid. If this happens then we will continue to have "high costs" perhaps even higher for some segments.

PRM 1 and 2 suggest that the State would have a stronger purchasing situation yet no one has quantified specifically what the right number is to have in the purchasing pool that will garner the discounts referenced in the reports. What if the population isn't enough to generate these savings that are suggested?

We believe a more complete analysis would recognize and quantify the unintended consequences of mandating that school districts and political subdivisions, who are currently participants in other pooling arrangements, join the new state-sponsored pool.

Along this line of analysis we feel there should be a comparison of Per Employee Per Year costs (PEPY) broken out by actual claims and administrative costs. The reports provide a lot of claims information but few meaningful numbers. For example, in the PRM Phase I study, on page 9, table 1 lists employers with enrollment and "medical expenditures" but it's not clear what's included in medical expenditures for every response. Some include wellness program costs, etc., but it's not clear if that's the case for all employers listed.

Another question we would like to raise from your report is about pharmacy for retirees. The largest single (one time) savings cited in the report is from transforming coordination of the Medicare Part D program from a Retiree Drug Subsidy (RDS) to Employer Group Waiver Plan (EGWP). It seems to us that the State could do this now since all the retirees are already in a State-sponsored plan. Why wait until the time when or if an HCA is established? Furthermore, if there is opposition among the beneficiaries of the retiree program today (preventing the State from making this change) what does implementation of the HCA do to change this situation?

Along this same line PRM 1 suggests that additional savings of about 3M per year could be realized by utilizing Centers of Excellence and Travel benefits. These two items are available today so how is this additional savings going to be generated, or more important, what plan design strategies would need to be employed in order to create the right level of motivation for the State to realize this savings?

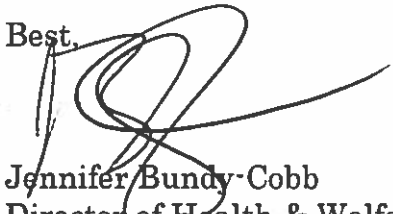
November 13, 2017

The last point we would like to make is that much of the savings commented on in these reports is around tiering. With the mandate of tiering benefits in the government plans we would expect a higher number of dependents seeking coverage from their own respective employer. This will likely put more cost on the private sector. This could also lead to a higher number of people being uninsured if the dependents don't have an affordable alternative.

And on this point of tiering, PRM 2 suggests that the Cadillac Tax can be avoided because Multiemployer plans will be taxed only if they exceed the family threshold cost, regardless of the mix of self only and self plus dependents participation. The report goes on to say that this "could represent a major savings opportunity for Alaska's public employers with high cost health plans who organize the purchase and administration of their plan under the IRC provisions which govern multiemployer plans." However, if the push to tiering is approved (as outlined in PRM 1) then it is even more likely that the family tier will exceed the Cadillac tax (as opposed to when it was a composite rate); ergo, wouldn't the risk of getting charged the Cadillac tax be higher? And if so, wouldn't this counter any savings achieved through the tiering process?

In closing, we recognize that the State needs to reduce expenses. We just ask that the State examine the unintended consequences of this action particularly toward the people in Alaska who are left paying insurance premiums through individual or private coverage. These people may not be employees of the State but they are citizens living in Alaska who deserve our consideration.

Best,



Jennifer Bundy-Cobb
Director of Health & Welfare
The Wilson Agency, LLC a division of Wilson Albers & Company



SustainableHealthcareForAlaska.com
SustainableHealthcareAK@gmail.com

State of Alaska
Department of Administration, Commissioner's Office
550 W 7th Avenue, Suite 1970
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Regards,

Alaskans for Sustainable Healthcare Costs

SustainableHealthcareForAlaska.com

SustainableHealthcareAK@gmail.com





UNIVERSITY
of ALASKA
Many Traditions One Alaska

November 13, 2017

State of Alaska
Department of Administration
Attn: Commissioner's Office
550 W 7th Avenue, Ste 1970
Anchorage, AK 99501

Via E-Mail to AlaskaHCA@alaska.gov

Re: SB74 Health Care Authority Feasibility Study

Dear Commissioner Ridle,

Thank you for the opportunity to comment on the SB74 Health Care Authority Feasibility Study ("the Study").

The reports issued from the Study cover a lot of ground, and do a good job of listing possible actions that could be taken, and the impacts, pros and cons of each. The University of Alaska (UA) is included in the Study, and I'd like to submit comment on behalf of the university and its health plan.

My first concern is that the Study includes the University of Alaska with the State of Alaska plans and employees. We are not state employees though, and being a constitutionally separate entity means we should be included as a political subdivision of the state. This also means the percent of state plans covered by Aetna and Premera is inaccurate.

Pharmacy benefits that are included in the health plan can have significant discounts and cost management features. The report indicates that a coalition is the best way to manage pharmacy costs, and while that may be true I don't think there was an exhaustive look at the discounts currently negotiated in the plans. For example, the university's plan, administered by Premera Blue Cross, uses Express Scripts for the pharmacy benefit. We "carved out" our pharmacy plan several years ago, but incorporated it into our latest contract with Premera to realize administrative savings and operational efficiencies with our consumer-directed health plan and health savings account (HSA).

The Phase I report looks at savings possible from consolidated purchasing by combining plans into one very large pool. The conclusion that savings from this approach would be limited is not surprising. Alaska's health care market of providers and insurers just isn't conducive to significant savings from increased competition. The report does recommend three options to consider:

- Changing the AlaskaCare retiree plan's Medicare Part D Drug Subsidy program to an Employer Group Waiver Plan (EGWP). The potential savings from this change, not only from the current year cash savings but from the reduced actuarial liability and normal

cost of the programs into the future, represent sustainable savings to the state and all participating PERS and TRS employers. *This option should be pursued as soon as administratively feasible.*

- Provide a Centers of Excellence / Travel Benefit on either a voluntary or mandatory basis. The travel benefit option is something the university is already doing, which is why the report shows us having minimal additional savings if implemented. *However, if this concept is expanded and standardized statewide, UA would probably see increased utilization which would increase our savings.* Having a statewide program could be beneficial in improving the process and authorization requirements, which are currently being cited by UA members as reasons they don't utilize our program.
- Pharmacy Benefit Carve-Out/Coalition to pool all plans to leverage negotiation advantage for deeper discounts on pharmaceuticals. The savings expected could be between 5-10% in aggregate, with individual plans having greater or lesser savings based on their current contract arrangements. This could increase savings to the university, but it would be at the expense of our current plan design with the Consumer-Directed Health Plan (CDHP) and the Health Savings Account (HSA). This plan requires close coordination between the health plan and the Pharmacy Benefit Manager (PBM), which we have with our current arrangement with Premera and Express Scripts. The University is currently trying to increase participation in the CDHP/HSA because of the lower cost plan design (to both the University and the employee) and the long-term savings opportunities of the HSA. Also, our plan currently has active management of the pharmacy benefit through the Premera contract with Express Scripts. *Any development of this concept should be thoroughly examined to make sure the discounts are sufficient to offset plan disruption.*

The Phase II report looks at various options for coordinated health plan administration across the state, with various models and assumptions to predict potential savings. PRM does preface their recommendations with the observation that Alaska's characteristics of few providers in much of the state, and limited competition among specialists even in the population centers, limits the ability to leverage much savings from negotiating with providers or payers. Smaller employers, especially in rural areas, would benefit from a larger pooling of members more than the larger employers (including the University of Alaska) that already have more covered lives and administrative efficiencies.

It's important to note that there were several cost savings approaches to plan management that were discussed and recommended, and the university is already doing several of them, including:

- Tiered pricing vs composite pricing, where the cost to the employee varies depending on enrolled family size and composition
- Committee governance where a committee of management and employees meets regularly to monitor plan performance and recommend plan design changes
- Charging more for spousal coverage than for employee coverage
- Travel benefits for high cost procedures

- Value-based care, such as the university's plan providing generic maintenance drugs at no cost to the employee to encourage treatment for chronic conditions

The state's biggest opportunity for cost savings would be to develop a coordinated care model for its Medicaid population, much like the Southcentral Foundation has developed for their members to care for and treat the individual in a more holistic manner. The Oregon Health Authority (OHA) relies heavily on this model of care for all its programs.

The models described in the Phase II report include two variations of a health care authority comparable to Washington State and Oregon with the primary differences being the voluntary nature of participation. Here, the university being included with the state of Alaska employees is problematic. Since UA is already actively managing its plan and has successfully managed cost trend in recent years, UA savings with either model would be on the lower end of the estimates. The smaller plans such as many school districts and smaller municipalities would realize the most savings, and they should be the focus of these models.

The designation of multi-employer plan status should be pursued as a means to limit the impacts of the Affordable Care Act's (ACA) excise tax on high cost plans. This model could be used with either of the first two models and should be implemented if the state proceeds with the HCA concept.

The models for a state captive for stop loss insurance and the public/private exchange should not be considered. The captive wouldn't yield sufficient savings and the exchange would be subject to adverse selection to the point of increasing costs for the state plans.

Proposed Rules for the Alaska HCA

The report lists several proposed rules for management of the HCA, including eligibility, enrollment and rate setting standards. The only concern with these proposed rules is the requirement of full time status to be eligible for coverage, using the ACA's definition of full-time as 30 hours per week. Most employers in the state offer coverage to part-time employees, including the University with a 20 hours per week threshold, and the state of Alaska with 15 hours per week.

Summary:

The creation of a health care authority in the State of Alaska holds some promise for controlling the cost of providing health care to public employees. The feasibility study presents several good points that should be pursued for future consideration. There are, however, several flaws in the analysis and assumptions, such as that the University of Alaska employees are state employees and that pharmacy benefits provided through the medical plan don't have negotiated discounts.

The University of Alaska has already incorporated many of the recommended practices in managing its plan, including a tiered rate structure, negotiated administrative rates, sustainable cost sharing provisions with employees, travel benefits, an integrated wellness program and a health benefits committee with representatives from all covered employee groups.

The state would save the most in the long term from adopting the recommendations for the retiree health plan's Medicare Part D Employer Group Waiver Program (EGWP), and

developing a coordinated care program for Medicaid participants. A standardized travel benefit administered centrally for all plans would also be very beneficial.

From an employer health plan perspective, the greatest savings could be seen from combining smaller, less efficient and fully insured plans into a larger pool to maximize their purchasing power and administrative economies of scale. The larger plans in the state are already realizing those savings, and would not benefit from a HCA model sufficiently to justify the disruption to plans and members.

Thank you for the opportunity to submit comments on the Study, and I'd be happy to answer any questions or provide clarification if necessary.

Sincerely,



Erika Van Flein, Director of Benefits
University of Alaska
ervanflein@alaska.edu

From: HCAStudy, Alaska (DOA sponsored) <AlaskaHCA@alaska.gov>
Sent: Monday, November 13, 2017 3:56 PM
To: Thea Agnew Bemben; Anna Brawley
Cc: Ricci, Emily K (DOA)
Subject: FW: Comments Regarding: Health Care Authority Feasibility Study
Attachments: SB 74 Comments of HCA Feasibility Study - Premera (2).doc

Public comment for your review.

From: Lynn Rust Henderson [mailto:Lynn.Henderson@PREMERA.com]
Sent: Monday, November 13, 2017 3:48 PM
To: HCAStudy, Alaska (DOA sponsored) <AlaskaHCA@alaska.gov>
Subject: FW: Comments Regarding: Health Care Authority Feasibility Study

Thank you for the opportunity to comment on the Health Care Authority Feasibility Study. Comments from Premera Blue Cross Shield of Alaska are attached in this email.

For any follow up questions, please contact: **Sheela Tallman |Senior Manager, Legislative Policy |Premera Blue Cross| p: 425.918.6013 f: 425.918.5635 sheela.tallman@premera.com**

Premiera Blue Cross Blue Shield of Alaska Comments of Alaska Health Care Authority Analyses

PRM Phase 1

1. In Table 27 there are employer groups that already have Rx carve out and correctly show no savings for implementing this program. However, in Table 28, these same employer groups now show a savings for Rx Carve Out. There is no justification for the additional savings shown in Table 28 for groups that already have Rx Carve Out.
2. There is a published study involving 1.8 million members nationally that shows Rx carve in members were found to have a statistically significant 11% ($p < 0.0001$) lower medical costs than Rx carve out members after adjusting for baseline population differences and severity of illness. How are the carve-out savings justified in the studies?
3. The Travel Benefit Savings in Table 27 is \$0 for employer groups that already have a travel benefit, but then in Table 28, savings for this program appear without justification.
4. The savings for the Travel Benefit is determined to be \$85 Per Employee Per Year (PEPY), but this assumes that the Health Care Authority (HCA) would be able to negotiate reimbursement rates with providers in the lower 48 states to achieve the savings. There is discussion of utilizing a vendor for this service, but no analysis of the cost of the vendor.
5. Alaska has a requirement, unique only to Alaska in the US, to reimburse the 80th percentile of billed charges to providers who are not contracted which establishes a beginning point for discussions with providers. These reports do not seem to consider the impact of this regulation on high costs or affordability of premiums, and do not attempt to explain how costs would be impacted if this regulation was eliminated/modified, nor evaluate impacts on provider-insurer negotiations. Neither does the report consider that with this regulation in place negotiating lower costs with providers becomes problematic. In addition to the 80th percentile regulation, it is thought that AlaskaCare reimburses non-contracted providers at billed charges or the 90th percentile of UCR. Page 38 References the constitutional limitations on diminishment of retiree benefits. If this is in place how are costs lowered given reimbursement for AlaskaCare at the 90th percentile?
6. Page 29 states that AlaskaCare will have greater scale so will have greater leverage in negotiations with providers. With the added requirement of reimbursing at the 90th percentile this limits negotiation power significantly.

7. EGWP (pages 5,38,39,56,57) – This program may lower costs for Alaska, but does not lower overall health care costs for retirees, rather it just shifts costs to taxpayers through the federal government.
8. Travel savings estimates of \$85 PEPY seem to be very high given that there is no change to employee benefits who travel and many of these members experience the same out of pocket expenses whether they or not they travel.
9. What is expected to happen to private employer and individual rates if the public plans move to an HCA, are you expecting the delivery system to reduce costs or shift costs to private employers?

PRM Phase 2

1. The trends used for Health Care cost for the years 2017 through 2021 range from 5.5% to 5.9% annually. It is noted as an assumption that the average age of the pool will not change over the 5-year period based on this: “retiring employees will be replaced with younger new hires.” However, since this analysis is to potentially include the Alaska state retirees, this assumption is not valid. The trend should be increased for aging of the population. Additionally, there was no consideration given to deductible leveraging in the trends used.
2. Savings from Coordinated Plan Administration consist of moving fully insured groups to self-funding, removing the purchase of stop-loss, negotiating administrative fees, and coordinated plan administration. Although the reduction in state revenues due to less premium tax is mentioned, it is not clear that the savings shown are net of this impact. It is also not clear if the impact of the previously pooled large claims covered by the stop-loss policies is added back to the claims once stop-loss protection is removed. Since excess claims increase at rates higher than the average medical trend, it does not appear that the savings anticipate this additional cost. It is also not clear how the savings for these items increase as a percentage over the five years. Since several of these items grow at a trend less than medical claims trends – the percentage impact over the years should decrease not increase.
3. Savings from Pooled Purchasing consist of carving out the pharmacy benefit and utilizing Travel Benefit/Centers of Excellence. The impact for these items increases over the years as a percentage total, although it is not clear what’s driving that.
4. Model 1 (Similar to the Washington State PEBB Model) assumes that only those school districts and political subdivisions whose costs are currently above the projected pooled plan cost will participate. However, the author acknowledges that this assumption is much higher participation rate than the Washington HCA has been able to achieve over

many years of operations. Therefore, this assumption is not reasonable and the expected savings are overstated. The lower participation would reduce the savings due to Coordinated Plan Administration and from Pooled Purchasing for the remaining groups.

5. Model 3 – (State Administrative Captive) uses a study from 2000-2004 to estimate the percent of total cost for large claims. This experience is significantly outdated and not adjusted for the higher cost of care in Alaska. Therefore, the impact of large claims without the presence of stop-loss is significantly understated and the associated savings are commensurately overstated.
6. Model 4 – Multi-employer plans shows savings from the impact of the Cadillac Tax due to the advantage of a Multi-employer plan. Since some of the entities already purchase plans through what appear to be Multi-employer plans, the savings from this model are overstated.
7. Model 5 – Public/Private Exchange assumes 25% of the Individual population would obtain coverage through the state. This is based on the assumption that is the population not eligible for Advanced Premium Tax Credit (APTC) subsidies in the individual market. In reality the number of non-subsidy Individuals is a much lower percentage of the Individual market. Additionally, this model does not take into consideration the impact on the Federal 1332 Waiver that the state has received for the Affordable Care Act (ACA) Individual plans.
8. In the Network Utilization Section of the Appendix, “Some plans in Alaska include a provision that use of a non-network provider is adjudicated using the in-network cost sharing if there are no network providers in the specialty category within a specified number of miles.” Since this is required by the state of Alaska, the implication is that the author ignored this requirement when establishing savings for common benefits across employer groups and the state’s ability to negotiate more favorable reimbursement levels from providers.
9. Throughout the Phase 1 and Phase 2 analyses, no thought or consideration appear to have been made as to the impact to the rest of the commercial insurance market that creation of a consolidated HCA will have on employer groups currently purchasing coverage in the commercial market. If the HCA were able to negotiate reduced provider reimbursements, providers will very likely shift that cost to the remaining commercial market participants.
10. Where is the additional cost of building and running the HCA included in the report? Additional governmental salaries, benefits, retiree benefits, for example. How many employees are estimated to be needed for call centers, monitoring, auditing, and negotiating with provider? It does not appear that these additional costs were considered.

11. Page 173 – Comment states that additional covered lives will not materially change the negotiating dynamics with respect to administrative fees, yet, page 38 indicates administrative fees are an area of savings. Please explain this.

MAFA

10. The savings figure of 9% from the baseline projection by 2025 which is equivalent to \$655 million across the period 2018-2025 is based on 1) the state resetting benchmark prices on the order of 1.5-3.0 x Medicare and 2) lowering the 5.4% trend utilized in the PRM study by 1% per year. This ignores the requirement that AlaskaCare is thought to reimburse non-contracted providers at billed charges or the 90th percentile of UCR, and the impact this has on provider reimbursement rates. If this is in place how are costs lowered given reimbursement for AlaskaCare at the 90th percentile? Additionally the study does not justify or explain how consolidation is going to lower the trend below 5.4%. The study suggests also that this is a conservative estimate with a 50% probability of being achieved.
1. On page 2 of the report it is stated that administrative savings of 2.4% will be achieved. However, in the PRM Phase 2 analysis, it is stated “the population now served by the AlaskaCare plans is already a very large group and capable of securing very favorable administrative fee arrangements. In our judgment the addition of another 50,000 to 90,000 covered lives will not materially change the negotiating dynamics now in place with respect to negotiating administrative fee arrangement. ...there is a question regarding the degree to which the State of Alaska can achieve further savings in negotiating with providers, at least to the extent that it utilizes classical negotiations techniques.” (page 173)

UNITEDHEALTH GROUP®

November 13, 2017

Department of Administration, Commissioner's Office
550 W 7th Avenue
Suite 1970
Anchorage, AK 99501

Re: Health Care Authority Feasibility Study

To Whom It May Concern:

UnitedHealth Group (collectively on behalf of UnitedHealthcare Community & State and Optum) is pleased to respond to Alaska's request for comments regarding the health care authority feasibility study.

Please find enclosed our response to the Department of Administration's request for comments. Should you have any questions or seek further information, please do not hesitate to contact us.

Sincerely,

A handwritten signature in blue ink, appearing to read "Catherine L. Anderson".

SVP, Policy & Strategy
UnitedHealthcare Community & State

UnitedHealth Group appreciates the opportunity to respond to the Alaska Department of Administration's (Department) solicitation of comments related to the health care authority feasibility study. We applaud the State's efforts to seek data and comments to inform the creation of a Health Care Authority (HCA) to coordinate plan administration and consolidate purchasing effectiveness for state funded health benefits to support the unique characteristics of Alaska. We have broad experience in administering plans for publicly funded health programs such as Medicare Advantage, Medicaid managed care and Medicaid Fee-For-Service, county and state-funded behavioral health programs, and Dual-Eligible Special Needs Plans (DSNPs). Through our business relationships in Alaska, we are keenly aware of the health care challenges facing the State and its citizens.

The feasibility studies presented the Department with a number of options to consider for structuring an Alaska HCA and some activities the HCA might conduct, as well as what the State might expect to achieve through HCA. We believe the studies supplied reliable analysis and insights for the Department's consideration. Among other things, the studies described what an HCA might be able to accomplish for the State and its citizens in terms of efficiencies, cost-savings and improved health outcomes. These are, of course, key elements in transforming a state's health system to be more effective and sustainable. The studies, however, did not address the topic of health insurance coverage in general, nor the role an HCA could play in improving health coverage in Alaska. UnitedHealth Group believes that increasing access to affordable health coverage is a key element in transforming the health system. We suggest that the State consider adding the goal of increasing health coverage for Alaskans as it contemplates the purpose and feasibility of an HCA in Alaska.

A Continuum of Coverage

It is difficult to improve overall health, achieve savings and slow the growth of costs in the health care system when a significant portion of individuals remain uninsured and lack regular access to primary care services to prevent illness and manage chronic health conditions. The lack of health care coverage drives inappropriate utilization of the health care system that increases costs and prevents individuals from achieving their best possible health. Access to health insurance coverage creates regular and reliable access to high value health care and is an important aspect of a sustainable health care system.

In 2016, 14% of the Alaska's population, or just under 104,000 individuals were uninsured even with Medicaid expansion beginning in September 2015. Nationally, the Congressional Budget Office (CBO) estimated that 40% of the 28 million uninsured individuals in the United States chose not to purchase health insurance from their employers, the exchanges or an insurer.¹ While there are several factors at play for those who did not sign up for coverage, affordability is likely the most influential factor in the decision to opt-out of purchasing health insurance. Exchange plans may not be affordable, even with subsidies. Limited competition and regulatory barriers combined with uncertainty regarding the federal cost share reduction payments mean further exacerbated coverage affordability and, in-turn, increased cost pressures felt by individuals purchasing on the exchange. Even though Alaska's exchange premiums will be lower in 2018 thanks to its Section 1332 waiver, it is likely many Alaskans will still find purchasing coverage from the exchange to be unaffordable.

¹ Congress of the United States Congressional Budget Office. Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2017-2027. September 2017.

UnitedHealth Group suggests that the State consider using an HCA to create access to affordable coverage for all of its citizens by building on the foundation of the Medicaid program, with the HCA acting as the organizing entity as well as administering some of the eligibility tiers. By combining resources from Medicaid and the federal funding currently directed to subsidize exchange coverage, the State could use its HCA to reform its publicly subsidized health care system and offer a continuum of coverage through a single platform for individuals whose income ranges from 0 to 400% of the Federal poverty level (FPL). This approach would simplify system administration, more effectively leverage the State's purchasing power to drive system change, and smooth eligibility and affordability "cliffs" for individuals as they experience changes in income or health status. This approach would also allow the State to design a program that would progressively support a shift toward commercial insurance models for its low-income citizens.

Why Leverage Medicaid?

Medicaid is a stable, tested, and economical foundation to build on. It serves individuals with the most complex needs, but has learned to do so with limited resources. Its benefit package is comprehensive and is easily modified and tiered to address the needs of different populations. Leaders in Medicaid have developed a keen awareness and attention to program sustainability and efficiency that is necessary when serving a significant portion of the population. This awareness is reflected in the design of Medicaid programs and benefits across the country. This experience can be leveraged when looking to make health coverage more affordable overall.

In addition, the current Federal administration has signaled a willingness to grant states enhanced flexibility to test new concepts within Medicaid and the Affordable Care Act (ACA) marketplaces. The foundation on which to establish a continuum of coverage exists in Section 1332 (ACA) and Section 1115 (Social Security Act) waiver authorities that, taken together with Federal approval, will allow the necessary modifications to both the Medicaid program and the ACA requirements. Funding for such a program would be achieved by blending various state and federal dollars currently supporting these populations. The continuum of coverage would look like this:

- For those from 0-100% FPL, the program focuses on providing benefits that align with the individual based on a clinical and socioeconomic profile of need and is funded through state and federal Medicaid dollars.
- For the population from 100-138% FPL, consumer engagement and financial literacy tools are introduced and funding continues through state and federal Medicaid dollars.
- For those who are 138-200% FPL, benefits and premium responsibilities would mirror the Basic Health Program approach (Section 1331 of the ACA) and funding would be a blend of individual responsibility and federal funding.
- From 200% - 400% FPL, the reinsurance pool could be paired with program design that includes passive enrollment and is built on the foundational structure from Medicaid (e.g. pricing, high risk health insurance program with experience managing individuals with

clinical, behavioral and socioeconomic barriers) but is funded through commercial-like tactics such as individual contributions and repurposed federal funding subsidies.

Insurers would be required to offer coverage across all four income categories therefor spreading insurance risk across the continuum. In addition to making participation more attractive to insurers, individuals will benefit from continuity of care as they move along the income continuum. While funding source, cost sharing and incentive design features will change as beneficiaries' circumstances change, the insurers, the providers and the tools and communication channels beneficiaries have become accustomed to will remain consistent.

Summary

An HCA is an excellent vehicle for designing, implementing and managing a continuum of publicly funded coverage with the Medicaid program as its foundation in addition to consolidating the State's purchasing effectiveness. For the aforementioned reasons we would recommend the State continue to explore the option of moving the administration of Medicaid and other state and federally subsidized health benefits programs to the HCA. It can also be an effective instrument in the transformation of Alaska's health system into a modern and sustainable system that addresses Alaska's unique challenges. UnitedHealth Group is committed to supporting the State in this effort. We will bring our expertise, broad experience and national thought leadership to the Department to support the development and operation of a robust HCA that achieves the State's goals. We would welcome the opportunity to meet with the Department on this topic.



Alaska Chapter Mission Statement

AAHU is a state chapter of the National Association of Health Underwriters. We provide professional development, promote high ethical standards of our members, advocate responsible legislation and proactively educate Alaskans on health and financial security needs.

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Kate Gootee

November 13, 2017
Leslie Ridle, Commissioner
Department of Administration
PO Box 110200
Juneau, Alaska 99811-0200

Re: Public Comment on Health Care Authority Feasibility Study Phase I & II

Commissioner Ridle,

The Alaska Association of Health Underwriters (AAHU) appreciates this opportunity to comment on the Health Care Authority Feasibility Study Phase I and II – produced by PRM Consulting Group. AAHU is an association of health insurance agents, brokers, consultants, and advisors who work with public and private employers, as well as individuals, to design employee benefits programs, including health care management. Our members and board of directors have reviewed the report and offer the following comments:

In Phase I PRM lists under Key Findings that “Health Care Costs in Alaska Are Substantially Higher Than In Other States And The High Costs Are A Major Concern For Employers.” We agree, and hope this is something you will take very seriously. For years, AAHU and our clients – public and private employers in Alaska – have been telling policymakers that current costs, and the trend of increases in costs, are unsustainable. In the intervening time health insurance carriers have exited the private market in Alaska and employers have been forced to reduce health care benefits.

It would have been helpful if PRM had listed major cost drivers contributing to the “substantially” higher medical costs. One driver many people have identified is the so-called “80th Percentile Rule” codified as 3 AAC 26.110. This particular cost driver is notable because, as a government regulation, the administration could easily repeal it. While in one sense it may be helpful for an Outside consultant to repeat what Alaskans have been saying for years about medical costs, unless the administration takes some action to provide relief the value will be lost.

A significant amount of care in Alaska is delivered by out-of-network providers who are unwilling to contract with insurance carriers. This is not surprising considering the lack of incentive to contract. The 80th percentile rule allows providers to be reimbursed at the 80th percentile, and they don’t have to agree to forgo balance billing. Replacing the 80th percentile rule with a reimbursement based on a multiple of Medicare reimbursement would help control costs and ensure that providers are paid a fair fee. This in addition to balance billing legislation would protect the consumers.

We consider this finding of “substantially” higher costs as the prime component of PRM’s work in that virtually everything else they produced revolves around it, or is dependent upon it. Were it not for the unsustainable costs of providing health care we doubt the legislature would have directed the department to study strategies to reduce



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the costs to pay for it. Unfortunately, this approach simply focuses on how to afford the insurance coverage for the service, not how to lower the intrinsic cost of the service itself.

In Phase II, at page 41, PRM considers 5 organizational models for coordinated health care plan administration, summarized in Table 27 at page 43. AAHU cautions that the potential savings represented as accruing to Model 2 are illusory and incomplete. Mandatory participation, as envisioned under Model 2, would cause unacceptable economic disruptions the authors either ignore or fail to mention.

A more complete analysis would recognize and quantify the unintended consequences of mandating that school districts and political subdivisions, who are currently participants in other pooling arrangements, join the new state-sponsored pool. The most easily identifiable consequence of Model 2 would be the contraction of the existing pools and the resulting cost increases to the remaining Alaskan members. These consequences would come largely at the expense of the private sector, both to the companies that work with the public entities as well as to those who participate in the pools.

Model 2 also contains an inherent conflict. By dividing the pool in two, economies are certainly lost. The reason given for this is to be able to offer a wider variety of plans, which on its face may be laudable, but the variation and diversity of organizations covered will likely render menu plan options unsuitable.

Again, we appreciate the opportunity to review and comment on these documents.

Thank you,

Tiffany Stock
AAHU President



November 13, 2017

Department of Administration, Commissioners Office
550 W 7th Avenue, Suite 1970
Anchorage, AK 99501
Via email: AlaskaHCA@alaska.gov

Public Comment: re Proposed Creation of an Alaska Health Care Authority

In my capacity as Executive Director of Healthcare Cost Management Corporation of Alaska (HCCMCA), I am writing to express our concerns as to the results of the Alaska Health Care Authority (HCA) feasibility study, procured by the Alaska Medicaid Redesign Bill, SB 74, released on August 30, 2017.

HCCMCA is comprised of over 45 member health benefit plans in Alaska and the Pacific Northwest. These include employer-sponsored health benefit plans, including Alaska State, Borough, Municipal and School District sponsored plans, as well as Alaska and Pacific Northwest private employer and health benefit trusts. Our member funds represent nearly 100,000 employees and, including their dependents and retirees, over 250,000 covered lives. In Alaska alone, this number is approximately 100,000 covered lives.

We applaud the State's recognition that steps need to be taken to control Alaska's underlying healthcare cost drivers, which are unsustainable. Unfortunately, as briefly summarized below, the recommendations to create a State-run HCA will not effectively address these costs, and the savings projected in the associated reports are illusory.

For example, the PRM Consulting Group identified three cost savings opportunities, without a full understanding of the associated context:

- ✓ Employer Group Waiver Plan – for the retiree plans. Nevertheless, this would have no impact on the active groups. The State could do this already, and there is no need for an HCA to accomplish this.
- ✓ Centers of Excellence / Travel Benefit. According to the study, 40% of the employers already offer this. HCCMCA offers this benefit option

through Bridge Health. PRM estimated \$839,000 in travel savings for Alaska State Employees Association (ASEA), Public Employees Local 71 (PE 71) and Fairbanks North Star Borough and School District (FNSB and FNSBSD), but this is false, as these entities already contract with Bridge Health.

✓ Pharmacy Benefit Carve-out.

- The study erroneously states that 90% of the employers have prescriptions administered within the medical plan. This is also false. Many HCCMCA groups, including most of our members covering public employees) contract with Caremark through National Cooperative Rx. PRM estimates \$238,000 in savings for pharmacy carve-out for PE 71, which is already a member of HCCMCA / National Cooperative Rx. The report is unclear as to whether it also estimates similar savings for other groups participating in the Coalition-affiliated contract.
- We agree that the carve-out may save money for groups currently purchasing drug coverage alone or through an insurer, but we do not agree the HCCMCA groups would achieve additional savings, because the National Cooperative Rx purchasing cooperative is a nationwide non-profit cooperative with approximately 300,000 covered lives – approximately 3 times larger than the proposed HCA-covered group.

Accordingly, of the \$6.4 million in estimated savings PRM identified, we can immediately reduce that figure by over \$1 million, because PRM either did not recognize the programs the groups participate in, or because the group has implemented a program such as Bridge Health, since the studies' original data gathering period concluded.

Additionally, the studies did not recognize the proposed Alaska HCA has the potential to increase the administrative cost burden for participating entities. The PRM study stated the Washington HCA is staffed with 1,100 employees, which suggests a similar program in Alaska would require the hiring of hundreds of additional state employees. Moreover, the studies are misplaced in suggesting the Oregon and Washington HCAs are models of performance.

While the PRM reports focused on administrative savings, the MAFA report concentrated on provider costs. According to the MAFA report, reference based pricing and value based insurance design are the two areas that will generate the most cumulative savings over time. Unfortunately, both of these strategies will

be unpopular with the provider community, which will lobby heavily against meaningful change in these areas. The State has shown no appetite to adopt these strategies in the past. They only recently began to implement PPO provisions with meaningful steerage, common in private sector health plans. It will be impossible to insulate the HCA from politics and therefore we question how the HCA will have the political fortitude to accomplish the goals identified in the MAFA report.

In summary, we do not believe the creation of an Alaska HCA will accomplish the desired objective of lowering overall healthcare costs. Nevertheless, we think the legislature can take other steps to facilitate meaningful medical cost savings. Two examples include:

- Pass legislation that makes it easier for health plans to deploy strategies, such as referenced based pricing, by limiting balance billing by non-contracted providers against participants who follow their plans' PPO steerage requirements.
- Encourage voluntary consolidated purchasing through existing private sector entities or association plans, which could facilitate expansion into providing insured benefits.

Thank you for your consideration. If I can answer any questions, please do not hesitate to contact me.

Sincerely,

Fred G. Brown

Fred G. Brown, Esq.

Executive Director

www.HCCMCA.org

(907) 474-4226

CC: Senator Kelly
Senator Micciche
Senator MacKinnon
Senator Hoffman
Senator Coghill
Senator Giessel
Senator Wilson
Senator Bishop

Senator Von Imhof
Senator Olson
Senator Stevens

Representative Edgmon
Representative LeDoux
Representative Foster
Representative Seaton
Representative Gara
Representative Grenn
Representative Guttenberg
Representative Kawasaki
Representative Ortiz
Representative Pruitt
Representative Thompson
Representative Wilson
Representative Tilton
Representative Neuman
Representative Stutes
Representative Spohnholz

State of Alaska
Department of Administration, Commissioner's Office
550 W 7th Avenue, Suite 1970
Anchorage, AK 99501

RE: Health Care Authority Feasibility Study

On behalf of the Alaskans for Sustainable Healthcare Costs Coalition (the Coalition), we would like to share our own observations and concerns with 4 studies that were produced as a result of SB74. It is fully understood that the cost of healthcare in Alaska is the highest in the nation and measures must be taken to bring these costs under control. As our name implies we are looking for sustainable solutions that address the broad concern of costs.

We have read the reports and from many different perspectives as we are a group of concerned employers representing employees from across the state in every industry including public sector employees. As much as we understand that something must be done, there are a number of concerns we have with the conclusions and the data within the 4 reports from the feasibility study.

The Feasibility Studies Data

1. There needs to be a comparison of Per Employee Per Year costs (PEPY) to make comparisons which should be broken out by actual claims and administrative costs. It seems there's a lot of claims but not much for actual numbers. For example, in the PRM Phase I report, on page 9, table 1 lists employers with enrollment and "medical expenditures" but it's not clear what's included in that for every response. Some include wellness program costs, etc., but it's not clear if that's the case for all employers listed.
2. Administrative savings suggested in the PRM-2 study are not realistic. With any large change there will be startup costs for the state and for all the subdivisions participating under the direction of the Health Care Authority. There needs to be further examination of the startup impacts.
3. PRM-2 suggests consolidation into 3 state run pools with mandatory participation. Union trusts, smaller municipalities and school districts must have the flexibility to design a plan that helps them attract and retain the talent they need to fill positions. The proposed Health Care Authority would eliminate choice and remove efficient free market decisions from operating.
4. Shifting from current premium models to forced tiered premiums is likely to shift costs to private employers. The larger groups will also be subsidizing smaller groups. Absorbing smaller plans with high costs may drive up costs for everyone.
5. The studies don't address long-term health care inflation. There may be a short-term positive correction, but long-term growth of costs is not addressed. While changes of this magnitude could create immediate savings, this serves as a "reset" of a cost base from which health care cost trend will continue an increase in costs.
6. The MAFA report does not have data supporting the projected savings. Simply statements.
7. MAFA estimates total savings of 8.8% but appears to be double counting the savings projected in PRM-1 and PRM-2.
8. Couldn't many of the savings referred to in the MAFA report be achieved without the creation of the HCA.

9. Consolidating 80 different plans is a huge upheaval for what appears to be an uncertain and *de minimus* cost savings.
10. Small groups may benefit from a large employer pool, however most have high deductible plans with up to a \$5000 deductible and a Health Reimbursement Account or Health Savings Account to help cover the deductible after they pay \$1500 out of pocket, this plan design may cost less than the \$1500 deductible with 80/20 coinsurance option.
11. Analyze the Oregon healthcare system to determine what works and what might not work in Alaska. Reforming how Alaska cares for Medicaid participants could yield the biggest return on investment. The Southcentral Foundation is already seeing positive results from their holistic approach to patient care. The challenges in Alaska are unique to Alaska from a market, regulatory, cultural and logistical standpoint and very different from Oregon.
12. PHPG Study integrating Medicaid strongly recommends launching HCA without Medicaid. We concur that this makes sense—different service mix and different consumer groups, plus complex government process to address. Application for a waiver must also be made to continue with this approach.
13. Integrating Medicaid has a potential for reduced federal payments. Has this been factored in?
14. Public Education Health Trust (PEHT), which covers 17,000 Alaska teachers and other school professionals, has only three employees. It contracts with a small company in Billings, Montana, to handle claims. The plan's total overhead is about 3 percent — 97 cents of every dollar go to care. I am sure the Health Care Authority would need a far larger number of employees. With a state budget where would this money come from.
15. The PEHT and several other self-insured entities have implemented a cost measure to allow claim reimbursement at 125% of Medicare for out-of-network providers. Other plans in the state currently use a percent of Medicare reimbursement for these providers. This approach is more in line with the Coalition belief in controlling costs long term. What still needs to be addressed is balance billing to members.
16. The state already has 17,000 employees and plenty of purchasing power in small Alaskan market—any increase in the group size not likely to have much impact. However, greater ability to negotiate directly with providers (Hospitals, Doctor Groups, Pharmacy...) for the lowest costs is a potential. It could create a buying consortium for all Alaska employers both private and public. The Coalition would like to see some success in negotiating savings without the HCA.
17. High potential for cost shifting to the private sector, similar to the current 30% cost shift due to Medicare and Medicaid. If government controlled healthcare were viable, we wouldn't hear of the Medicare/Medicaid and Veterans Administration difficulties. If the Health Care Authority is successful at negotiating large discounts for its plans, will the medical community compensate by increasing their charges to Non-Health Care Authority plans in order to make up their margin?
18. Under 1621(e) only Self-Funded Native Tribes and Corporations as well as Government Entities are exempt from the requirement to make third party payments to the Indian Health Service and Contract Providers. Funding from third party Insurance has provided a very large revenue stream of discretionary funds to the Indian Health Service Contract Providers. This has resulted in increased employment and community building projects that have improved healthcare services available in rural communities. If State School Districts and Government Entities who currently purchase fully insured products are rolled into the State of Alaska's Self-Funded plan this could affect the revenue stream to these Contract providers and the communities they serve.
19. More private employers may have no choice but to drop coverage if costs continue to rise without controls in place.

In order to achieve long term changes in the cost of health care in Alaska, we need a long term vision and a stable group of people leading that vision. The Health Care Authority will be comprised of a group of political appointees who will change as the philosophy of the governor's office changes, resulting in vastly different visions for change and long-term sustainable improvement.

The State is already acting as their own Stop Loss carrier, adding these additional lives is ill-advised in the face of what the Affordable Care Act has done by eliminating lifetime maximums. For 2016, the highest claimant nationwide has reached \$36 million in expenses or the Iowan teenage hemophiliac that has expenses that are \$1 million a month. An ongoing expense with the potential to continue for years. A similar situation could impact the state. In Iowa there were 3 primary insurers not unlike our 2 carriers. At least one carrier has announced they will not continue to offer insurance exchange plans in Iowa and the other 2 are considering pulling out.

Alaska needs our carriers. They have negotiated vast networks that we didn't have 20 years ago. Continuing to create the legislative atmosphere that brings all parties to the table for reasonable and sustainable solutions is in the best interest of the entire state including public and private employers alike. We need our providers just as much and need to work together for the right balance.

Aetna and Premiera currently hold the majority of health plans at about 90% of the claims processed and have the most contracts with the medical community. Premiera already has more Alaskan lives in their pool than the State would have in The Health Care Authority. How would a smaller pool (HCA) negotiate better savings than a larger pool? If HCA was to consolidate 200,000 lives with one insurer, this could drive the others out of the market and thus centralize all the insurance offering in Alaska with one carrier. How would creating an insurance monopoly in Alaska control costs and work to the benefit of employers and employees?

In conclusion, the Coalition believes the studies need to be looked at more closely for the concerns and comments outlined above. We also feel that the legislature is in the best position to solve the looming health care crisis not by creating a large health care bureaucracy but by leaning into 3 major issues that have the potential for real cost control, which are:

1. Eliminating the 80th Percentile rule and developing a more controllable reimbursement limit such as 125% of Medicare with a balance billing limit to protect consumers.
2. Require cost transparency by providers. Health care is the only industry where the cost is learned after the fact. No-one buys a car and waits to see what the loan payments are after they drive off of the lot. A reasonable solution such as publishing a master charge rate needs to occur.
3. Addressing Medevac costs by closing the loophole in how they are governed within Alaska.

We all feel the pressure of out of control medical expenses personally and socially. We can work together to develop solutions that can be sustained.

Regards,

Kris Ossenkop

***International Brotherhood Of Electrical
Workers
Local Union 1547***

**3333 Denali Street, Suite 200, Anchorage, Alaska 99503
Phone: 907-272-6571 FAX: 907-777-7255**

TO: Commissioner Leslie Ridle Department of Administrations	FAX: 907-465-2135
FROM: Dave Reaves, Business Manager IBEW Local 1547	RE: Public comment on proposed Alaska Health Care Authority
DATE: November 15, 2017	Pages: 2 with cover sheet

Hard Copy to follow Via: Regular Mail ☒ Certified Mail ☐ Hand Delivery ☐ None ☐

MESSAGE:

Letter sent Via Fax.

Thank you,

If you receive this FAX in error, have problems with the transmission,
please call 907-777-7234.

International Brotherhood of Electrical Workers

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DAVE REAVES
BUSINESS MANAGER • FINANCIAL SECRETARY

KNUTE ANDERSON
PRESIDENT



November 13, 2017

Commissioner Leslie Ridle
Department of Administration
P.O. Box 110200
Juneau, AK 99811

RE: Public Comment on proposed Alaska Health Care Authority

Dear Commissioner Ridle:

Thank you for the opportunity to submit comments regarding the Department of Administration's proposed Health Care Authority.

We appreciate the State's participation in this important conversation. The cost of health care continues to grow at a rapid pace such that businesses and organizations across Alaska are feeling the strain of this increased obligation. We believe that having a thorough and thoughtful discussion is to the benefit of all parties.

With that being said, we are interested in more detailed specifics. For instance, how would the Health Care Authority be structured? What would the cost be to our members? Would the cost of health care go up or down? Would the cost of the insurance be tiered, and would there be a family plan option? Our healthcare agreements are negotiated through collective bargaining and carry the force of law. Who would bear the financial burden should members sue for breach of contract? And finally, what would be the timeline for implementation of the statewide authority?

We believe the answers to these questions are an essential component of our dialog as we continue engaging in this important conversation.

Sincerely,

Dave Reaves
Business Manager
IBEW Local 1547

PROUDLY SERVING 586,000 SQUARE MILES ON TOP OF THE WORLD

From: HCAStudy, Alaska (DOA sponsored) <AlaskaHCA@alaska.gov>
Sent: Monday, November 20, 2017 11:10 AM
To: Thea Agnew Bemben; Anna Brawley
Cc: Ricci, Emily K (DOA)
Subject: FW: Public Comment

From: Amy Clifford [mailto:amy@msialaska.com]
Sent: Monday, November 20, 2017 10:34 AM
To: HCAStudy, Alaska (DOA sponsored) <AlaskaHCA@alaska.gov>
Cc: Laurie Fagnani <laurie@msialaska.com>; Keith Popely <keith@msialaska.com>
Subject: Public Comment

To Whom it May Concern:

I realize that I may have missed the public comment deadline, but thought I would still respond as this is an important topic for employers in Alaska.

We are a woman-owned company that has been in business in Anchorage for 22 years. Our health insurance costs have increased dramatically – up to 32% - and premiums are now one of our top three expenses. Yet only 64% of our employees participate in our healthcare plan. If we had full participation, it would be our #2 expense, following only salary costs. In order to keep premiums affordable for employees, it has been necessary to increase the employer paid portion of premiums as well as increase deductibles. It is simply unacceptable for me that one of our employees would be unable to take her child to the doctor because he/she cannot afford to pay the out of pocket costs until the high deductible is met. **I support requiring cost transparency in the health care field, eliminating the 80th Percentile Rule and developing more controllable reimbursement limits within contracts.** This healthcare debate is about economics, but more importantly, it is about human beings. Alaska's employers need to be able to provide affordable health insurance to our employees and our employees must be able to afford the health care services.

Sincerely,



Amy Clifford
Director of Finance
& Administration

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