Health Care Authority Feasibility Study

Prepared for State of Alaska Department of Administration
September 2017
Purpose of the study

To determine the feasibility of creating a Health Care Authority (HCA) to coordinate health care plans and consolidate purchasing effectiveness for all state employees, retired state employees, retired teachers, medical assistance recipients, University of Alaska employees, employees of state corporations, political subdivisions, school district employees, and other entities.

Phase I report focused on consolidated purchasing strategies

Phase II report focused on coordinated health plan administration
  • includes several governance models
  • includes template for providing flexibility in plan design to meet local needs
  • includes 5-year savings estimates
Phase I Report

Consolidated Purchasing Strategies

- Collected and analyzed data from participating employers
- Interviewed wide range of interested parties
- Analyzed the coverage, costs, funding, financing, and administration for the primary health plan
- Observations
  - High costs relative to US average
  - Existing structure already has significant consolidation
  - Wide variation in health plan cost per employee
  - Opportunities for consolidated purchasing savings
Findings
Alaska costs are materially higher than US average
Findings
Existing structure already has significant consolidation

AlaskaCare Retirees

Individual Political Subdivisions

Individual School Districts

ASEA / AFSCME Local 52

AlaskaCare Employees

School Districts in PEHT

U of A

Fairbanks

Local 71

Other
Findings
Wide variation in health plan cost per employee
Opportunities for consolidated purchasing savings
Larger savings from Medicare Part D

Medicare Part D Employer Enrollment (Millions of Retirees)

RDS  EGWP

2006  1.4  7.2
2007  1.8  7.1
2008  2.1  6.8
2009  2.3  6.7
2010  2.4  6.8
2011  2.8  6.2
2012  3.6  5.6
2013  5.9  3.3
2014  6.5  2.7
2015  6.5  2.2
2016E  6.5  1.9
2017E  6.8  1.6
2018E  7.1  1.3
Opportunities for consolidated purchasing efficiencies

**Using a Travel Benefit**
- No travel benefit: 9%
- Yes with Bridge Health: 60%
- Yes with Premera: 31%

**Using a Pharmacy Coalition**
- Yes: 59%
- No: 41%

**Scatter Plot**
- High Cost, Low Quality
- Low Cost, High Quality

Quality Measure (100 = Best)
## Phase I Report Findings
Opportunities for consolidated purchasing efficiencies

<table>
<thead>
<tr>
<th>Opportunity</th>
<th>First Year Estimated Savings ($Million)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change Medicare Part D coordination method from Retiree Drug Subsidy (RDS) to Employer Group Waiver Plan (EGWP) in AlaskaCare Retiree Plan</td>
<td>$61.6</td>
</tr>
<tr>
<td>Pharmacy Benefit Carve-out</td>
<td>Range from $3.5 to $8.0</td>
</tr>
<tr>
<td>Centers of Excellence / Travel Benefit</td>
<td>Range from $2.9 to $3.5</td>
</tr>
</tbody>
</table>
Coordinated Health Plan Administration

- Evaluated experience of other states
- Collected and analyzed data from participating employers
- Interviewed wide range of interested parties
- Made observations on plan designs, costs, employee premium rates
- Evaluated five models, projected costs & savings over next five years:
  1. Single risk pool for employees – voluntary participation
  2. Two risk pools for employees – all school districts in one pool, all others in second
  3. State administered captive
  4. Multiemployer plans
  5. Public / Private exchange – single pool, voluntary for school districts and political subdivisions, access for Alaska individual residents
- Recommendations
Observations
Wide range of health plan actuarial values

Actuarial value is a measure of the generosity of plan coverage. A plan with a 90% actuarial value will cover, on average for a group, 90% of covered charges.
Observation
Spousal premium requirements impact enrollment

**Relationship between Spousal Contributions and Spousal Coverage**

- **Y-axis:** Additional Monthly Premium Required to Cover Spouse
- **X-axis:** Percentage of Total Members Covering a Spouse

The graph shows a downward trend, indicating that as the percentage of total members covering a spouse increases, the additional monthly premium required decreases.
Phase II Report

Status Quo - Projected Medical & Prescription Drug Costs ($Millions)

<table>
<thead>
<tr>
<th>Year</th>
<th>School Districts</th>
<th>All Other Entities</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016 Cost</td>
<td>$315</td>
<td></td>
<td>$903</td>
</tr>
<tr>
<td>Expected 2017</td>
<td>$588</td>
<td></td>
<td>$776</td>
</tr>
<tr>
<td>Expected 2018</td>
<td>$416</td>
<td></td>
<td>$1,192</td>
</tr>
<tr>
<td>Expected 2019</td>
<td>$776</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expected 2020</td>
<td>$1,192</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expected 2021</td>
<td>$1,192</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Coordinated Health Plan Administration

Models that were examined and evaluated

<table>
<thead>
<tr>
<th>Model</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – Single Risk Pool for Employees</td>
<td>Multiple benefit plan choices (e.g. the four medical plan options, plus three dental and two vision options). Mandatory participation for state employees, optional for school districts and political subdivisions. Separate risk pool for retirees.</td>
</tr>
<tr>
<td>2 – Two Risk Pools for Employees</td>
<td>All school districts in one pool. All Political Subdivisions and State employees in the second pool. Mandatory participation for state employees, school districts and political subdivisions. Multiple benefit plan choices. Separate risk pool for retirees.</td>
</tr>
<tr>
<td>3 – State Administered Captive</td>
<td>Status quo for all entities, with the availability of purchasing stop-loss insurance from a state administered captive. Captive sets rates to cover the cost of individual and aggregate stop-loss coverage with allowance for administration of the captive, but no allowance for profit or risk charges.</td>
</tr>
<tr>
<td>4 – Multiemployer Plans</td>
<td>Designed to minimize the impact of PPACA’s High Cost Tax. Potential for multiple pools Initial pool of multiple employers opting to join for all or some of their employees</td>
</tr>
<tr>
<td>5 – Public / Private Exchange</td>
<td>Single pool, state employees plus optional participation from school districts, political subdivisions, and individuals.</td>
</tr>
</tbody>
</table>
## Projected Savings or (Costs) in $Millions

<table>
<thead>
<tr>
<th>Model Description</th>
<th>Expected 2017</th>
<th>Expected 2018</th>
<th>Expected 2019</th>
<th>Expected 2020</th>
<th>Expected 2021</th>
<th>5-Year Savings (Costs)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Model 1 – Single Risk Pool. All state entities plus school districts and political subdivisions that opt to participate.</strong></td>
<td>$5.9</td>
<td>$12.1</td>
<td>$18.6</td>
<td>$24.2</td>
<td>$25.4</td>
<td>$86.2</td>
</tr>
<tr>
<td><strong>Model 2 – Two Risk Pools. All school districts in one pool. All Political Subdivisions and State employees in the second pool.</strong></td>
<td>$9.4</td>
<td>$16.1</td>
<td>$22.5</td>
<td>$28.1</td>
<td>$29.4</td>
<td>$105.5</td>
</tr>
<tr>
<td><strong>Model 3 – State Administered Captive.</strong></td>
<td>$1.0</td>
<td>$1.0</td>
<td>$1.1</td>
<td>$1.1</td>
<td>$1.2</td>
<td>$5.4</td>
</tr>
<tr>
<td><strong>Model 4 – Multiemployer Plans.</strong></td>
<td>$0.0</td>
<td>$0.0</td>
<td>$0.0</td>
<td>$29.4</td>
<td>$31.2</td>
<td>$60.6</td>
</tr>
<tr>
<td><strong>Model 5 – Public / Private Exchange. Single pool, state employees plus optional participation from school districts and political subdivisions and individuals.</strong></td>
<td>($22.7)</td>
<td>($18.1)</td>
<td>($13.3)</td>
<td>($9.5)</td>
<td>($10.2)</td>
<td>($73.8)</td>
</tr>
</tbody>
</table>

**Coordinated Health Plan Administration**

Projected savings over the next five years by model.
Summary Recommendations for Coordinated Health Plan Administration

1. State of Alaska establish a Health Care Authority (HCA) with three separate pools: one pool for retirees and two pools for employees, with separate pools for school district employees and all other governmental employees.

2. All entities be required to participate in the HCA when first feasible and no later than upon the expiration of the current collective bargaining agreement.

3. The HCA develop multiple plan options for medical, prescription drugs, dental, and vision benefits to provide a wide range in health plan choices to meet the recruitment and retention needs of the various employers and the health plan needs of their employees.

4. The HCA establish standard premium rates for the plans that reflect the expected costs of each plan option taking into account the covered population and expected health care utilization.

5. The HCA establish a tiered premium rate structure, with separate rates that vary with the size and composition of the household.

6. A Health Care Committee or Board be established to provide insight and oversight to the HCA.
Questions and Comments

Webinar 2: Pacific Health Policy Group (PHPG) Report
Monday, September 11, 2017 | 2:00 – 3:00 p.m.

Webinar 3: Mark A. Foster & Associates (MAFA) Report
Wednesday, September 13, 2017 | 2:30 – 3:30 p.m.

Submit Public Comments by October 30, 2017!
The public review and comment period began Friday, September 1, 2017 and ends Monday, October 30, 2017. Public comments can be submitted in writing to AlaskaHCA@alaska.gov or by mail to:
Department of Administration, Office of the Commissioner
Attention: Health Care Authority Feasibility Study
550 W 7th Avenue, Suite 1970
Anchorage, Alaska 99501
Please contact AlaskaHCA@alaska.gov with questions about this project or comments on the study reports.