prm CONSULTING GROUP

Health Care Authority Feasibility Study

Phase II – Analysis of Coordinated Health Plan Administration

PREPARED FOR: STATE OF ALASKA DEPARTMENT OF ADMINISTRATION

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PRM CONSULTING GROUP • 3206 TOWER OAKS BLVD • ROCKVILLE MD 20852

PHONE: 301.951.5104 • FAX: 301.951.5108 • PRMCONSULTING.COM

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INTRODUCTION

This document provides the Department of Administration (DOA) with the results of our analysis and evaluation of the feasibility of establishing a Health Care Authority (HCA) to coordinate health plan administration among the entities included in S.B. 74 and additional users of health care that DOA required to be studied.

PRM Consulting Group (PRM) was selected to conduct the analysis by the DOA following a request for proposal.

Data on health care benefits provided to employees of the entities included in S.B. 74 was obtained through a variety of channels, including an on-line survey sent to all entities for whom a valid email address was provided. The Phase I report documents our summary of the data gathered through the on-line survey as well as data obtained directly from many of the entities.

PRM identified three states that have established a Health Care Authority to coordinate health plan administration for the state's Medicaid population and other groups whose health care benefits are funded primarily with state funds. These states are Washington, Oregon, and Oklahoma. The experience of these states, and other states that have coordinated health plan arrangements for state employees, political subdivisions, and/or school districts is described in the section entitled "Experience of Other States."

Immediately following this introduction are PRM's observations and recommendations on the feasibility of establishing a HCA to coordinate health plan administration among the entities included in S.B. 74.

PRM wishes to thank the individuals who participated in the study, including the staff at the state entities, school districts, and political subdivisions who provided data and shared their experience on the unique characteristics of health care in Alaska. PRM also wishes to thank the organizations that provided valuable insights on health care delivery in Alaska and their views on how a Health Care Authority could support the goals of cost-effective and efficient health care benefit management. A complete list of entities that participated through the surveys or through interviews is included in Appendix D.

OBSERVATIONS AND RECOMMENDATIONS

OBSERVATIONS

Alaska's geography and relatively low population density create challenges for the delivery of professional services – and unique challenges for health care services. As noted in the Phase I report, in the absence of significant competition among health care providers, the state can expect to achieve only modest savings through pooled purchasing alone. This document examines opportunities for additional savings if the state coordinated plan management activities in the delivery of health care benefits for the various entities identified in S.B. 74 (i.e. School Districts, Political Subdivisions, University of Alaska, and the health plans funded directly by the State of Alaska). We examined a range of different approaches (models) for coordinating health plan management, including models similar to those that have been implemented in other states. For each of the models, we quantified the expected savings relative to the status quo, with a focus on the long-term savings when all entities would be able to participate (i.e. after the expiration of existing collective bargaining agreements (CBAs)).

RECOMMENDATIONS

1. We recommend that the State of Alaska establish a Health Care Authority 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. We recommend that all entities be required to participate in the HCA when first feasible and no later than upon the expiration of the current CBA.

3. We recommend that 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. Tables 18 and 19 describe illustrations of plan options that could be offered for medical and prescription drug coverage and Tables 23 and 24 provide illustrations of dental and vision plans.

4. We recommend 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. Rates for individual employers should be determined initially taking into account the current premium rates, size of the employer, and the standard premium rates.

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

6. We recommend a Health Care Committee or Board be established to provide insight and oversight to the HCA.

RATIONALE FOR RECOMMENDATIONS

This analysis documents the pooled purchasing savings and coordinated plan administration savings that can be achieved through the establishment of a Health Care Authority. The rationale for establishing an HCA is that it will 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, including employees where the employee contributions are stated as fixed percentage cost-share of the plan cost rate. A single HCA will be able to implement programs and adopt best practices in a uniform manner that benefits all public employees equally.

Utilizing two pools (one for school employees and one for all other employees) mirrors the approach the state has taken with respect to other programs, such as the state retirement programs which use separate retirement systems for public employees and teachers and pooled plan administration across the systems for investment, actuarial, and other professional services. The demographic composition of the employees in school district plans is sufficiently different from the demographic composition of the other groups that the two pools are expected to have different costs. Utilizing two pools therefore will better align the costs of the health benefit programs to their covered groups. The experience of other states that operate two pools supports this recommendation rather than using a single pool.

Unless all entities are required to participate in the HCA upon the expiration of the current collective bargaining agreement, the likelihood of success in achieving the goals of improved cost-effectiveness is minimal.

Rates for individual employers should be determined initially taking into account the current premium rates and size of the employer so that each entity will benefit from the pooled purchasing and coordinated plan administration savings. Rates for entities that decide to participate will be lower than they would be on their own, as the HCA will obtain the most favorable costs (e.g. through the use of a state-wide pharmacy purchasing contract).

The use of tiered premium rates across all entities facilitates the most efficient structure for establishing employee premium rates to incent households where both adults have access to employer provided health care to choose the most cost-efficient option for their health care coverage. In the absence of this differentiation in premium rates, dependents will always be covered under the state funded plans, thus subsidizing the costs of providing health care to the benefit of other employers.

A review of the various health care governance arrangements – both within the state of Alaska and for health care administration arrangements in other states – clearly showed that the more effective health plans used committees or boards that met frequently to review the health plan experience and explore and evaluate options for improving plan performance. To be effective, the board or committee should meet at least as frequently as quarterly. We found that the more efficiently administered health plans had governance boards or committees that met as often as monthly.

EXPERIENCE OF OTHER STATES

STATES THAT ESTABLISHED A HEALTH CARE AUTHORITY

PRM identified three states that established a Health Care Authority to administer the state's Medicaid program plus one or more other health programs covering state employees or other health plan participants. These states are Washington, Oregon, and Oklahoma. Oklahoma's Health Care Authority runs SoonerCare (Oklahoma's Medicaid program) as well as Insure Oklahoma, a program designed to make health care coverage more affordable for specific groups of low-income, uninsured adults. The Oklahoma Health Care Authority does not manage the health care benefits of state employees, which are managed through the Office of Management and Enterprise Services Employees Group Insurance Division. The Washington Health Care Authority and the Oregon Health Authority cover state employees and retirees as well as some school employees and employees of subordinate jurisdictions within the state. The experience of Washington and Oregon is therefore directly relevant to the feasibility study and we have included below details of their experience.

THE WASHINGTON STATE HEALTH CARE AUTHORITY EXPERIENCE

The Washington state legislature created the Washington State Health Care Authority in 1988 as an independent state agency responsible for developing and administering health care and other insurance benefit programs for eligible state employees, retirees, and their dependents. Those programs are operated through the Public Employee Benefits Board (PEBB). Responsibility for the state's Medicaid program – Apple Health – was transferred by the Legislature to the Health Care Authority much more recently, in 2011. Through these two programs, the HCA provides health care coverage for over 2.2 million Washington residents (approximately 1 of every 3 Washingtonians) and works with numerous partners with the goal of insuring access to better health care at a lower cost.

The goal of the HCA is to use innovative health policies and purchasing strategies to provide high quality health care and thereby create a healthier state population. The key principles of the HCA are to operate within a managed care environment and to transition, wherever feasible, from a fee-for-service health care delivery system to one that is value-based (i.e., reimbursing providers based on the quality of care delivered rather than on the volume of patients serviced). The HCA views managed care and the value-based approach as models that more effectively achieve better care coordination, disease management, and cost control while emphasizing quality of and access to care. The longer-term vision for this transition is set forth in "A Journey Toward Alignment" published by the Authority in September, 2015. We have included a copy of this document in Appendix F.

A particularly important initiative just getting under way is collaborating on possible purchasing opportunities such as "bundling" of payments for health care events (e.g. total joint replacement) across the health care programs for which the Authority is responsible. The Authority's longer-term vision is set forth in the HCA's "Value Based Purchasing Road Map" and we have included a copy of that document in Appendix E.

In addition, the Washington HCA has also embarked on major initiatives designed to address cost and efficiency issues in the purchasing of prescription drugs across both the Apple Health and PEBB programs. Ten years ago, the Washington HCA joined with the Oregon Health Authority to form the Northwest Prescription Drug Consortium.

Through the consortium, they have negotiated prescription drug purchasing arrangements across state payers, including the Washington PEBB program, the Department of Corrections, the state's Workers' Compensation program, and state hospitals (but not the Apple Health program). In addition, the state's PEBB program and the Apple Health fee-for-service programs are coordinating drug purchasing across a common formulary for preferred drugs.

More comprehensive information about the prescription drug initiatives can be accessed at the following link: https://www.hca.wa.gov/about-hca/prescription-drug-program

Overall HCA Structure

The HCA is staffed with approximately 1,100 employees and is principally financed through a combination of state and federal funding. The overall budgeted expenditure for the programs operating under the Health Care Authority is approximately $10.6 billion. The Apple Health program represents $8.2 billion. The PEBB program accounts for an additional $2.1 billion. Administrative expenses are 3% of total expenditures, or $317 million based on 2017 budgeted expenditures.

All of the HCA's areas of operations fall under the responsibility of the Health Care Authority Director. A description of the organization structure of the HCA and identification of the areas of operations and the leadership teams can be accessed at the following link: https://www.hca.wa.gov/assets/program/hca-org-chart.pdf

While the PEBB and Apple Health programs are operated largely independently under the HCA umbrella, they collaborate and share resources in a number of areas. In terms of business operations, they share resources across such areas as information technology, legal, finance, and human resources functions. Other areas of shared services include contracting and appeals functions within legal services, and legislative affairs coordination.

The programs also operate under a single Medical Director for the HCA, and there is coordination across a number of clinical initiatives. To date, examples of those initiatives include:

- Development of treatment protocols for Hepatitis C
- Reducing the inducing of delivery in childbirth where that will result in better health outcomes
- Treatment of opioid abuse
- Transgender care policy
- Applied Behavioral Analysis therapy for autism

The programs supported through the HCA are outlined below.

The PEBB Program

The PEBB program contracts with a number of health plans and delivery systems including Kaiser Permanente, Group Health Cooperative (acquired by Kaiser Permanente in early 2017), Regence (as the Third-Party Administrator of the state's self-insured medical plan), Premera (as a Third-Party Administrator for bundled episodes of care), Delta Dental

(as the Third-Party Administrator of the state's self-insured dental plan and for a fully-insured dental plan), and Williamette Dental. The links below include:

A summary of the medical plans can be accessed at the following link: https://www.hca.wa.gov/public-employee-benefits/employees/medical-plans-and-benefits

A summary of the dental plans can be accessed at the following link: https://www.hca.wa.gov/public-employee-benefits/employees/dental-plans-and-benefits

A summary of the other benefits can be accessed at the following link: https://www.hca.wa.gov/public-employee-benefits/employees/additional-benefits

The PEBB program provides the following benefits and services to active employees, Medicare and Non-Medicare retirees, and their dependents:

- Offers multiple medical plan options including (1) self-insured and fully-insured plans, (2) preferred provider organizations and managed care plans, (3) high deductible health plan options, and (4) a supplemental F Medicare plan.
- Offers multiple dental plan options including (1) self-insured and fully-insured plans and (2) preferred provider organizations and managed care plans.
- Offers a prescription drug benefit (embedded in the self-insured medical plan only) with an independent pharmacy and therapeutics committee which evaluates the effectiveness of the drugs that are prescribed.
- Offers a wellness program aimed at reducing health risk and improving the health of members enrolled in a PEBB medical plan.
- Offers life insurance, accidental death and dismemberment insurance, long-term disability insurance (employees only), and auto/home insurance.
- For employees only, manages the State's IRS Section 125 plan (Cafeteria Plan) allowing for pre-tax payroll deductions for medical plan premium payments, medical flexible spending accounts (FSA), dependent care assistance program (DCAP) benefits, and Health Savings Account (HSA) contributions.
- Administers legislatively required premium surcharges (related to enrollee tobacco use and if an enrolled spouse/state-registered domestic partner waived comparable medical benefits from his/her employer)
- Provides full account administration and customer service for retiree, COBRA, and self-pay members only
- Onboards local/subordinate governmental entities to PEBB program benefits (more detail below)
- Performs 1094/1095 Affordable Care Act reporting on behalf of state agencies and higher education institutions

All Washington State employees, retirees, and their dependents are eligible for the PEBB programs offered through the HCA. In contrast to the operational rules for school districts within the Oregon Health Authority programs, where

participation is generally mandated, the school districts as well as subordinate jurisdictions eligible to participate can join the Washington State PEBB program at any time, and can leave at any time.

The entities that are permitted by statute to join the plan include the following:

- Counties
- Municipalities
- Political subdivisions
- Tribal governments
- Employee organizations representing state civil service employees
- School districts and Educational Service Districts

Participation among school districts in particular is minimal. Within the state, there are 296 school districts and 9 Educational Service Districts (ESDs). Overall, these districts employ approximately 122,000 employees who would be participants if all districts participated in the PEBB program.

As of early 2017, 71 school districts/ESDs had elected to join the PEBB program for at least some of their employees. While that number represents some 25% of the total number of school districts/ESDs, the participation in terms of the percentage of employees represented is much smaller. The total enrollment in terms of covered employees is just 3,443 based on the latest data available—so less than 3% of the 122,000 total employees of the combined school districts/ESDs eligible to join the program.

Participation by other local government jurisdictions eligible to join is somewhat better, though still modest compared with the population eligible to be covered. An HCA study of participation as part of a legislative analysis in 2016 based on Washington Department of Retirement Systems data estimated that there were about 75,000 additional employees who would be included in the PEBB programs if all entities other than school districts/ESDs joined the program. At present, only about 14,600 employees are covered through the local jurisdictions who have joined the program, or about one-sixth of those who would be covered if participation were mandatory.

Where local jurisdictions voluntarily join the PEBB program, there is a modest surcharge in the rates they pay reflecting the claims experience of that portion of the overall non-Medicare risk pool.

Apple Health (Medicaid Program)

The five managed care organizations listed below are contracted to deliver care to Apple Health enrollees and 85 percent of enrollees receive care from among this group of MCOs:

- Amerigroup Washington
- Community Health Plan of Washington

- Coordinated Care Washington
- Molina Healthcare of Washington
- United Healthcare Community Plan

Apple Health provides services to low income residents. Some of the services provided are outlined below:

- Autism and Applied Behavioral Analysis Therapy aimed at improving behavior and skills related to the core impairments associated with autism and other developmental disabilities.
- Behavioral Health Services through the funding, support, and treatment of youth and adults with addiction and mental health conditions.
- Breast, Cervical and Colon Health Program which provides free cancer screenings.
- Dental Services which includes basic and restorative dental services (i.e., routine exams, cleanings, x-rays, fillings, fluoride applications, etc.) for eligible children up to age 20.
- Health Home Program which consists of a set of free services (e.g. individual and family support, transition planning, referral to community, and social support services) for individuals with serious chronic conditions and more than one medical or social service need.
- Immunizations which include hepatitis B, diphtheria, tetanus, pertussis, haemophilus influenzae type B, etc.
- Transportation Services which include non-emergency medical transportation for individuals who have no other means to access medical care

Other programs and initiatives

Additional programs include:

- The Program Integrity Initiative which ensures that state and federal tax dollars are spent appropriately by identifying improper payments and potential fraud, waste, and abuse. In fiscal year 2015, this program cost taxpayers $6.3 million to administer and recovered $39.3 million. In the past 6 years, approximately $150 million was saved or recovered.
- Making Informed Health Care Decisions Campaign which empowers individuals and family to become better informed shoppers and understand how to obtain high quality care and a good patient experience at an affordable cost.
- Tribal Affairs which provides health care support and communication for American Indian and Alaska Natives.
- The Bree Collaborative which consists of a group of public and private health care purchasers, health plans, physicians and other health care providers, hospitals, and quality improvement organizations who work together to evaluate health practice patterns that generate high cost and identify and recommend evidence-based strategies to improve the quality, outcomes, and affordability of health care.

- A health technology assessment program which includes a committee to evaluate scientific evidence to determine the necessity, safety, and effectiveness of medical treatments.

WASHINGTON HCA REVIEW OF OTHER STATES MEDICAID PROGRAMS

In conjunction with the Authority's Realignment Project, the Washington HCA authorized a survey of the Medicaid programs maintained by a number of other states. Complete responses to the survey were submitted by six states, including Washington, as follows:

- Arizona
- California
- Florida
- Michigan
- Oregon
- Washington

The most important observations to make about the contrast between the experience of those states compared with the situation in Alaska are the degree to which they follow the national pattern in relying on managed care programs in delivering Medicaid benefits to their eligible populations, and how much more scale they have in fashioning their Medicaid programs to the needs of those populations, including the development of managed care programs. We should also note that the data in the survey report on the populations covered by Managed Care programs is somewhat dated (2011 data) and of course does not reflect the effect of Medicaid expansion on the scale represented by the covered populations. It is worth noting that in each of these states, the Medicaid population who are receiving health care through managed care programs would exceed in every instance the entire population of Alaska, based on more current and post expansion data.

We have included a copy of the survey report (Washington State Health Care Authority Realignment Project—Task 1: State Medicaid Program Survey) as Appendix G.

THE OREGON HEALTH AUTHORITY EXPERIENCE

The Oregon Department of Human Services (DHS) has a history of almost 20 years, having been initiated under Governor John Kitzhaber in 1998. Many of the programs now housed within the Oregon Health Authority (OHA) were part of DHS until the OHA was established by passage of legislation in 2009. OHA now operates as a separate Authority within the state's overall governance structure.

There are three principal programs operated under the aegis of the Authority:

- Oregon Health Plan (OHP), which is the state's Medicaid Program. This program currently covers about 1 in 4 Oregonians, or more than one million participants. Participation increased by 71% (436,000 new participants) with the expansion provided for under the Affordable Care Act.
- Employee benefit plans provided through the Oregon Educators Benefits Board (OEBB). OEBB covers most of Oregon's K-12 school districts, education service districts and community colleges, as well as a number of charter schools and local governments. OEBB provides an array of benefits to about 150,000 active and retired employees and their families.
- Employee benefits provided through the Public Employees' Benefits Board (PEBB). PEBB similarly provides an array of benefits to about 140,000 active and retired employees, and their dependents from state agencies, universities, the Oregon Lottery, semi-independent agencies and local governments.

The goals of each program are encapsulated in their respective vision and mission statements, and invoke three principal objectives: better health, better care, and lower costs for participants and taxpayers.

While the programs operate somewhat independently of each other, they benefit from sharing resources across a variety of functions such as finance, information technology, continuous process improvement, quality management, and business support.

An organization chart illustrating the functional areas of operations and identifying the leadership team for each major area can be accessed at the following link:

http://www.oregon.gov/oha/Documents/OHA%20Organizational%20Chart.pdf

It's important to note that while the objectives are the same for each major area of operations (Medicaid, OEBB, and PEBB), each is organized somewhat differently.

Overall responsibility for policy-making and oversight for all operations of the Authority is in the hands of the nine member Oregon Health Policy Board (OHPB). The OHPB was established by legislation in 2009. Board members are appointed by the Governor and subject to confirmation by the State Senate.

PEBB's Board is made up of eight voting members, four of whom represent labor and four management. There are also ex officio management members and two non-voting members of the state legislature. OEBB's Board is made up of 12 members, including representatives of management, labor, and local governments, as well as citizen members of the board.

The array of plans provided under the PEBB program include:

- Core benefits of medical, dental, vision, and life insurance plans
- Optional benefits such as life, long term care, and short and long term disability insurance
- Flexible spending accounts (FSA) and a commuter assistance benefit

- An employee assistance program (EAP)

Under the OEBB program the following benefits are offered to participating employers:

- Core benefits of medical, dental, and vision plans
- Optional benefits including life, short and long term disability, and long term care insurance
- Health Savings Accounts (HSA), FSA, and commuter assistance benefits
- An employee assistance program (EAP)

In both the PEBB and OEBB programs, the Boards contract with multiple carriers. In an effort to offer members across the state choice, both programs contract with one statewide carrier and at least one regional carrier. Not all plans are available in all areas of the state.

All three OHA programs including Oregon Health Plan rely heavily on a Coordinated Care Model (CCM). All three have contracted with multiple partners in the formation and execution of this model of providing, monitoring and paying for care.

A key metric in terms of the objective of lowering costs is embedded in the Authority's demonstration waiver arrangements with CMS for the Oregon Health Plan. The waiver stipulates growth in per capita health care costs not to exceed 3.4% per year. It is important, however, that this objective is coupled with intensive monitoring of quality metrics tied to revenue sharing with providers in their coordinated care organizations. That same per capita cost growth metric also applies to the PEBB and OEBB health care programs.

In the most recent full year report issued by the Oregon Health Authority [Oregon's Health System Transformation: CCO Metrics 2015 Final Report (June, 2016)] the following OHP-specific data were reported:

> "The coordinated care model shows improvements in the following areas:
>
> - **Hospital readmissions have decreased**: The percent of adults who had a hospital stay and were readmitted for any reason within 30 days has improved by 33 percent since 2011. Fifteen of 16 CCOs have met or exceeded the benchmark.
> - **Increased access to primary care for children and adolescents**: The percent of children and adolescents who had a visit with their primary care provider in the past year has increased from 2014. Adolescent well-care visits have also increased 38 percent since 2011.
> - **Increased use of effective contraceptives**: The percent of women ages 15-50 who are using an effective contraceptive increased almost 9 percent since 2014, even with the addition of thousands of new OHP members in 2014.

- **Patient-centered primary care home enrollment continues to increase**: Coordinated care organizations continue to increase the proportion of members enrolled in patient-centered primary care homes. PCPCH enrollment has increased 69% since 2012."

The report also noted that "measures in this report that highlight room for improvement include continued engagement in treatment for alcohol or drug dependence, and tobacco users receiving advice and supports to quit from their doctor."

Finally, in an overview of Oregon's 1115 Medicaid 2012-2017 Demonstration, the Oregon Health plan reported the following:

> "In 2012, the Centers for Medicare and Medicaid Services (CMS) approved a renewal of Oregon's Section 1115 Demonstration, the Oregon Health Plan (OHP), initiating Oregon's groundbreaking health system transformation using the coordinated care model.
>
> During the 2012-2017 period, Oregon made significant progress toward the triple aim of better health, better care, and lower cost:
>
> - Providing care at the right time and place. Avoidable emergency department use decreased by nearly 50 percent over five years.
> - Better outcomes and care. Hospital readmissions were cut by a third. Substance misuse assessments, developmental screening and timely prenatal care all increased.
> - Lower costs. The Oregon Health Plan has saved the Federal and State governments $1.4 billion in Medicaid costs, just during the 2012 – 2017 waiver period, and has been responsible for the avoidance of billions more in costs since the OHP's inception more than two decades ago. Oregon's health reforms are projected to save a total of $10.5 billion between 2012 and 2022 by continuing to hold down OHP health care cost growth to no more than 3.4 percent per member per year."

The Medicaid demonstration project is supported by a $1.9 billion grant from the federal government, and is conditioned on not exceeding the 3.4% limitation on growth in costs, as well as monitoring and achieving agreed upon goals with respect to the Medicaid quality metrics.

The OEBB program was established and joined PEBB in the Department of Administrative Services (DAS) under legislation passed in March, 2007. Both programs were folded into the Oregon Health Authority in 2011.

Prior to the creation of OEBB, Oregon had consolidated many school district programs under a single umbrella, the OEA Trust. Now, under OEBB school districts are permitted to opt out, but they can only do so if they are self-insured or can show that they can secure comparable benefits at a lower cost. Very few school districts have chosen to opt out of the program.

It has only been within the last few years that local jurisdictions have been permitted to join PEBB and OEBB. Recognizing the benefit of bringing more people into the stable insurance pools, Oregon opened up the programs to local governments and special districts with legislation passed in 2013. Local government participation is optional. However, in order to avoid groups moving in and out of the risk pools, Oregon Administrative Rules state that once they've joined, they are obligated to stay with a very limited exception. Local governments can only terminate their PEBB or OEBB coverage to obtain insurance through Oregon's Insurance Marketplace (ACA – Health Insurance Exchange) on a one time only basis.

At present, about 85 percent of the care under OHP is provided through the Authority's sixteen coordinated care organizations, with the principal exception being the programs maintained for those participants covered through the state's tribal health programs. The tribal health programs continue to operate in a fee-for-service environment.

While PEBB and OEBB members are not enrolled in CCOs, both programs support the coordinated care model (CCM) by seeking optimal health for members through an organized system of care that is patient-centered, focused on wellness, coordinated and efficient, accessible, and affordable. The CCM system emphasizes the relationship between patients, providers, and their community; is focused on primary care; and takes an integrated approach to health by treating the whole person. Health plans offered through OEBB are insured. PEBB offers both insured and self-insured options.

Details of the benefit plans can be accessed in the following link:

https://www.oregon.gov/oha/pebb/Benefits/2017%20Plan%20Year%20New%20Hire%20Guide.pdf

Details of the dental benefits can be accessed at the following link: http://www.oregon.gov/oha/pebb/Benefits/Dental.pdf

Details of the vision benefits can be accessed at the following link: http://www.oregon.gov/oha/pebb/Benefits/Vision.pdf

OTHER STATES

While we found no other state with a Health Care Authority assuming responsibility for both the state's Medicaid program and the health benefits program available to employees and retirees of both the state and the state's subordinate jurisdictions, we have included in this report a brief description of some approaches that selected additional states have undertaken that may be of relevance to the considerations that will face the Alaska legislature and the Department of Administration as it makes decisions that will be necessary to attain the objectives set forth by the legislature in S.B. 74.

THE GEORGIA STATE HEALTH BENEFIT PLAN

The Georgia Department of Community Health provides a comprehensive set of health benefit plans for all state and school system employees and retirees throughout the state's governmental structure. The governmental groups covered include:

- State employees
- Teachers
- Non-faculty school system employees
- Retired employees who elect to continue coverage in retirement

The coverage is provided through three separate sets of plans, as follows:

- The State Employees Plan
- The Teachers Plan
- The Public School Employees Plan

Through the inclusion of all school system employees and employees of the state and all state agencies, Georgia has created significant scale and purchasing power in the development and maintenance of the plans. At present, the plans cover some 640,000 employees, retirees, and dependents.

It is notable that all plans include a comprehensive wellness program as part of the plans' offerings. In addition, the state has maintained a tobacco surcharge program for more than a decade. Under the surcharge program,[1] participants must pay an $80 per month surcharge over and above their regular contributions for the plan option they have selected if either the participant or a covered dependent is a smoker. The surcharge program is coupled with an intensive smoking cessation program including counseling services, and in the first six years of the program the number of plan participants paying the surcharge declined by 44%, to just 25,850.

The following link below takes you to the 2017 Enrollment Guide for participants in the Georgia State Health Benefit Plan (SHBP). Information about all the plans provided under SHBP can be accessed at the following link: https://dch.georgia.gov/sites/dch.georgia.gov/files/42578_Active-2016-9.21.16.pdf

PENNSYLVANIA

The Commonwealth of Pennsylvania has a centralized organization (the Pennsylvania Employees Benefit Trust Fund or PEBTF) that administers health benefits for active and retired Commonwealth employees. Health benefits for school employees and employees of the counties and cities are not the responsibility of the PEBTF.

PEBTF was established in 1988 and is charged with the following administrative functions:

- Enrolling and maintaining enrollment information on the following classes of participants:
  - Active employees
  - Non-Medicare eligible retirees
  - Medicare eligible retirees

[1] http://www.georgiahealthnews.com/2013/04/smokers-surcharge-effect/

- Administering Get Healthy, the Commonwealth's program to provide wellness screening for employees and covered spouses /domestic partners
- Providing through MyActiveHealth support information to encourage wellness through
  - FAQ's
  - A Webinar program
  - Registration information
  - Information on syncing a mobile device or application
- Through Quit for Life, encouraging members to quit smoking
- Providing extensive communications to members through such sources as:
  - Publications
  - News Bulletins
  - FAQ's
  - Various other programs to encourage a healthier and better informed member population
- Through the Trust managing the collection of participant and employer contributions, including the investment of trust fund reserves and distributing required premiums to participating vendors.

Employee Contributions

Commonwealth employees pay 5 percent of base pay for coverage. Coverage can be employee only or employee and dependents including a spouse so long as the spouse's employer does not offer health insurance coverage.2 The contribution of 5 percent of base pay is the same whether the employee enrolls in employee only or employee and dependent coverage. Employees who participate in the PEBTF "Get Healthy" program are eligible for a reduced contribution rate of 2 percent of base pay. If a Commonwealth employee's spouse is also covered by PEBTF, then both the spouse and the employee must participate in the Get Healthy program to be eligible for the lower contribution rate. About three quarters of employees are eligible for the reduced rate of 2 percent. The employee contributions cover all covered benefits under the program (medical, prescription drug, dental, and vision).

School Districts Health Benefits

Over 85 percent of Pennsylvania school districts obtain health care coverage for their employees from one of 37 health trusts or consortia. These consortia are generally local or regional in nature covering school districts in one or more adjacent counties. The consortia range in size from 4 to 48 school districts covering from between 1,450 lives to over 48,000 lives. The largest consortium, Allegheny County Schools Health Insurance Consortium (ACSHIC), includes 52 entities in total. This consortium alone covers over 48,000 lives, about one-quarter the size of the active employee membership in Pennsylvania Employee Benefit Trust Fund.

[2] https://www.wcupa.edu/hr/benefits/documents/PEBTFSpouseDomesticPartnerEligibility.pdf

VERMONT

The Department of Administration identified Vermont as a possible model for the State of Alaska, as Vermont was one of eight states that were selected for the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration Project, sponsored by the Centers for Medicare & Medicaid Services (CMS). The Multi-Payer Advanced Primary Care Practice was envisioned to join state-sponsored initiatives to promote the principles characterizing patient-centered medical home (PCMH) practices.

The Multi-Payer Advanced Primary Care Practice demonstration required each participating state's Patient-centered Medical Home initiative to be implemented by a state agency as part of a state-sponsored reform initiative. Medicare joined state reform initiatives already in progress.

Participation by commercial and public payers in the Vermont program was comprehensive, including Medicaid, the state employee's health insurance plan, Catamount Health (the state-subsidized insurance plan for the uninsured), and all major commercial health insurers (BCBS of Vermont, CIGNA, and Mohawk Valley Plan) who were required to participate. Participation by self-insured employers was voluntary.

The "Multi-Payers" in the MAPCP demonstration project were therefore:

- CMS as the payer for the Medicare population,
- Vermont and the federal government as the payers for the Medicaid population, and
- Vermont for funding state employee's health benefits.

The goal of the MAPCP is to promote transformation of practices to PCMHs and the establishment of Community Health Teams (CHTs). The Vermont Blueprint employs strategies to:

- improve access to and coordination of care through the use of CHTs;
- increase quality of care and patient safety by establishing self-management goals and tracking progress; and
- improve experience with care by enhancing beneficiaries' knowledge of their health conditions through self-management education and communication with their care providers and by increasing engagement in decision making about their care.

Successful interventions have the goal of more efficient utilization patterns, including increased use of primary care services and reductions in emergency room visits, avoidable inpatient admissions, and readmissions.

BASELINE OF CURRENT HEALTH BENEFITS

PRM collected health benefit information for Alaska's public employers using an on-line survey tool. Each of the entities was given the opportunity to submit details of the health plan (or multiple plans) that they provide or offer to employees. Key health plan data elements collected included:

- The health plan financing arrangement (i.e. whether the plan was fully-insured or self-insured, with or without stop-loss insurance)
- Details of the health plan design, including deductibles, copays, coinsurance levels, and out-of-pocket limits for in-network (preferred providers) and out-of-network (non-participating or non-preferred providers)
- Enrollment information; and
- Total annual plan cost (either a composite rate, or separate rates for each tier of coverage) and employee contribution rates.

HEALTH PLAN FINANCING ARRANGEMENTS

Table 1 below shows that most of the employees in the public employer plans today are covered through self-insured arrangements. Entities that contract with an insurance company for fully-insured coverage have limited their upside costs. These fully-insured arrangements allow for greater predictability in budgeting by the entity and are most often used by smaller political subdivisions. When setting the premium amount for fully-insured coverage the insurance carrier includes a loading for large or catastrophic claims, as well as a risk-premium to cover the cost of capital.

Most of the self-insured plans purchased stop-loss insurance. The stop-loss premiums protect the entity from very large or catastrophic claims incurred by individual plan participants (individual stop-loss) and/or from above normal levels of aggregate claims (e.g. over 125% of expected costs – aggregate stop-loss) which may happen if there is a higher than expected number of large claims or much greater utilization in general (e.g. due to an unusually virulent influenza strain) and above normal number of plan participants incur claims.

Table 1: Health Plan Financing Arrangements
(This data represents entities who provided complete information on their plans' funding arrangement)

	Employees	Aggregate Annual Premium / Claims	Prevalence Within Category	Prevalence % of Total
Self-insured				
Schools	10,280	$216,976,956	34%	33%
Non-School Entities	19,854	$401,505,487	66%	63%
Fully-insured				
Schools	427	$7,512,207	42%	1%
Non-School Entities	578	$12,000,056	58%	2%
Minimum Premium				
Schools	0	$0	0%	0%
Non-School Entities	240	$4,942,111	100%	1%
Total	**31,379**	**$642,936,817**		**100%**

Table 1 contains the aggregate data only for entities that provided complete information on their health plan financing arrangements. Entities that did not provide either the aggregate premium/claims information or whether the plan was self-insured, fully-insured or used the minimum premium financing method could not be included in the tabulation. Accordingly, the count of the number of employees in Table 1 is a subset of the count of the total number of employees for entities that submitted some data that was summarized in the Phase I report.

Table 2 below shows a list of the entities and their plans, along with the total monthly cost, which includes both employee and employer costs. It also shows the tier structure of the plans (i.e. whether the entity uses a composite rate or tiered rates that vary by household size and composition).

Table 2: Monthly Medical and Prescription Drug Plan Cost by Plan

Entity	Total Monthly Cost	Composite or Tiered
Alaska Gasline Development Corporation	$37,000	Tiered
Alaska Gateway Schools	$100,450	Composite
Alaska Housing & Finance Corp	$605,529	Tiered
AlaskaCare		
AlaskaCare Economy Plan	$3,120,561	Tiered
AlaskaCare Standard Plan	$6,585,071	Tiered
AlaskaCare Premium Plan	$483,935	Tiered
Aleutian Region Schools	$8,753	Composite
Aleutians East Borough Schools	$54,234	Tiered
Anchorage Schools		
Anchorage Schools CDHP	$568,142	Composite
Anchorage Schools PPO	$2,949,967	Composite
AEA Plan 1	$5,087,289	Composite
ASEA/AFSCME Local 52		
ASEA/AFSCME Local 52 Plan A	$10,441,581	Tiered
ASEA/AFSCME Local 52 Plan B	$2,490,306	Tiered
ASEA/AFSCME Local 52 Plan C	$274,696	Tiered
ASEA/AFSCME Local 52 Plan D	$8,360	Tiered
Bering Strait Schools	$447,542	Composite
Bristol Bay Borough	$85,109	Tiered
Bristol Bay Borough Schools	$21,747	Composite
Chugach Schools	$36,756	Tiered
City and Borough of Juneau	$1,365,134	Tiered
City and Borough of Sitka	$242,081	Tiered
City and Borough of Wrangell	$76,516	Composite
City of Chignik	$5,051	Composite
City of Delta Junction	$20,080	Composite

Table 2: Monthly Medical and Prescription Drug Plan Cost by Plan		
Entity	**Total Monthly Cost**	**Composite or Tiered**
City of Dillingham	$57,304	Tiered
City of Egegik	$6,735	Composite
City of Homer	$108,161	Tiered
City of Kodiak	$262,295	Composite
City of Nenana	$8,440	Composite
City of Palmer	$160,815	Tiered
City of Saint Mary's	$3,368	Composite
City of Saint Paul**	$22,344	Tiered
City of Saxman	$6,109	Composite
City of Seldovia	$11,787	Composite
City of Soldotna	$83,978	Tiered
City of Unalaska	$331,632	Composite
City of Valdez	$213,338	Composite
City of Wasilla		
City of Wasilla Plan 502	$94,547	Composite
City of Wasilla Plan A	$81,302	Composite
City of Wasilla Teamster-Employer Welfare Trust	$5,100	Composite
Copper River Schools	$106,106	Composite
Cordova City Schools	$90,000	Composite
Craig City Schools	$91,264	Composite
Delta/Greely Schools		
Delta/Greely Schools HDHP	$18,980	Composite
Delta/Greely Schools Plan BB	$87,860	Composite
Delta/Greely Schools Plan EB	$33,117	Composite
Denali Borough	$33,460	Tiered
Denali Borough Schools	$115,593	Composite
Dillingham City Schools	$97,079	Tiered
Fairbanks North Star Borough	$618,762	Tiered
Fairbanks North Star Borough Schools		
Fairbanks NSB Schools Plan A	$2,893,292	Tiered
Fairbanks NSB Schools Plan B	$379,940	Tiered
Galena City Schools	$425,351	Tiered
Haines Borough	$61,270	Composite
Haines Borough Schools		
Haines Borough Schools Plan 1	$49,296	Composite
Haines Borough Schools Plan 2	$36,024	Composite
Hoonah City Schools	$51,389	Tiered
Hydaburg City Schools	$15,416	Composite
Juneau Borough Schools		

Table 2: Monthly Medical and Prescription Drug Plan Cost by Plan		
Entity	**Total Monthly Cost**	**Composite or Tiered**
Juneau Borough Schools JEA Plan	$603,136	Composite
Juneau Borough Schools JESS Plan	$353,025	Composite
Juneau Borough Schools JESS Plan Waived	$16,841	Composite
Juneau Borough Schools Plan CA	$9,359	Composite
Juneau Borough Schools Plan EA	$36,710	Composite
Juneau Borough Schools Plan Exempt EA	$14,200	Composite
Juneau Borough Schools Plan FB	$3,500	Composite
Kake City Schools	$33,344	Composite
Kenai Peninsula Borough	$657,817	Composite
Kenai Peninsula Borough Schools	$2,163,474	Composite
Ketchikan Gateway Borough	$104,084	Tiered
Ketchikan Gateway Borough Schools	$323,961	Tiered
Klawock City Schools	$46,237	Tiered
Kodiak Island Borough	$80,410	Composite
Kuspuk Schools	$115,184	Tiered
Lake and Peninsula Borough Schools	$131,318	Tiered
Local 71		
Local 71 Blue Plan	$2,874,889	Tiered
Local 71 Yellow Plan	$505,814	Tiered
Lower Kuskokwim Schools	$781,470	Composite
Lower Yukon Schools	$698,322	Composite
Matanuska-Susitna Borough*	$555,291	Composite
Mat-Su Borough Schools		
Mat-Su Borough Schools AB Plan	$75,062	Composite
Mat-Su Borough Schools CB Plan	$1,883,363	Composite
Mat-Su Borough Schools FB Plan	$1,139,846	Composite
Mat-Su Borough Schools HDHP	$403,476	Composite
Municipality of Anchorage		
Municipality of Anchorage $500 Deductible Plan	$1,706,011	Composite
Municipality of Anchorage Copay 1000 Plan	$577,095	Composite
Municipality of Anchorage HDHP	$765,767	Composite
Nenana City Schools	$120,597	Composite
Nome Public Schools	$84,106	Composite
Northwest Arctic Borough Schools	$804,683	Composite
Petersburg Borough	$141,553	Tiered
Petersburg Borough Schools	$113,750	Composite
Pribilof Schools	$17,100	Composite
Sitka Borough Schools	$272,660	Tiered
Southeast Island Schools	$42,874	Composite

Table 2: Monthly Medical and Prescription Drug Plan Cost by Plan		
Entity	**Total Monthly Cost**	**Composite or Tiered**
Southwest Region Schools	$99,668	Tiered
Tanana Schools (was suppressed)	$7,151	Tiered
Unalaska City Schools	$143,834	Composite
University of Alaska		
University of Alaska 750 plan	$1,675,626	Tiered
University of Alaska CDHP	$1,104,061	Tiered
University of Alaska HDHP	$2,144,454	Tiered
Valdez City Schools	$240,120	Composite
Wrangell City Schools	$58,552	Composite
Yakutat City Schools	$25,000	Composite
Yukon-Koyukuk Schools	$132,035	Composite
*Excludes dental and vision costs **Excludes dental costs		

HEALTH PLAN ACTUARIAL VALUES

Appendix B lists the health plan actuarial values for those entities that provided sufficient health plan information for the plan to be evaluated. Some entities offer multiple plans. For each entity, PRM developed the actuarial value of each plan. A detailed description of the methodology used for determining the health plan actuarial values is included in appendix B. In brief, the actuarial value is a measure of the relative generosity of coverage. The larger the actuarial value, the greater the proportion of covered charges that will be paid by the plan, and consequently, the smaller the portion of covered charges that are the responsibility of the plan participant. If there are no deductibles, copays, or other types of participant cost-sharing, then the actuarial value would be 100%. The minimum actuarial value permitted as primary employer-provided coverage that is compliant with the Affordable Care Act is 60%.

Table 3 below shows the distribution of plans by actuarial value. By way of reference, the highest value (most generous) plan that can be purchased on the ACA "metal tier" exchanges is the Platinum plan. In 2016 platinum plans have a maximum actuarial value of 92%. The targeted actuarial value for platinum plans is expressed in the ACA as 90%, with a permissible variation of minus 2% to plus 2%, or 88% to 92%. Some 30 plans that submitted data in the survey covering just over a quarter of the covered population had actuarial values of 92% and above. Table 3 also shows that there were a few plans with actuarial values below 76%, although these plans had a relatively small number of enrollees covering only one percent of the total population of covered lives.

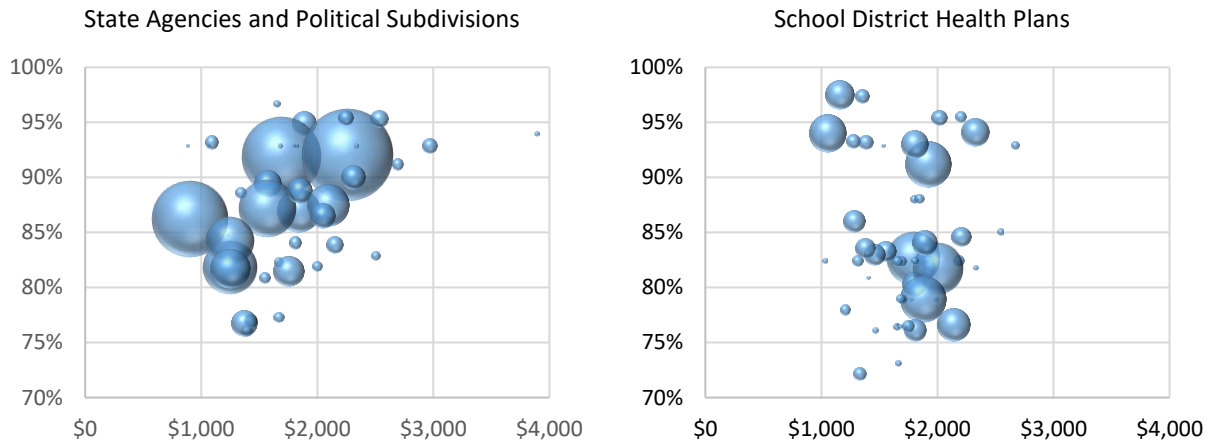
Table 3: Distribution of Plans by Actuarial Value			
Actuarial Value Range	**Number of Plans**	**Number of Employees**	**Percentage of Total Covered Population**
>96%	3	614	2%
92%-96%	27	8,254	26%
88%-92%	9	5,462	17%
84%-88%	12	8,665	27%
80%-84%	29	6,036	19%
76%-80%	20	2,613	8%
72%-76%	3	165	1%

Given the wide variation in health plans currently in use by the various employers, a consolidated health plan administration will require a menu of several plan options to meet the needs of the different employers.

Bubble Charts

The following "bubble charts" show the health plan actuarial value as well as the composite monthly cost or premium rate for each of the entities that provided complete information. The monthly "composite rate" cost is shown on the X-axis of the chart and the actuarial value is shown on the Y-axis. The size of the "bubble" represents the number of covered employees in each entity – with the large "bubbles" representing existing pooling. The chart on the left shows the actuarial values, cost, and enrollment for the state entities and political subdivisions. The chart on the right shows the actuarial values, cost, and enrollment for employees in the school district health plans. The same scale was used for both charts. The charts illustrate graphically that the majority of school districts are providing health plans with actuarial values below 85 percent, whereas the majority of state entities and political subdivisions are providing health plans with actuarial values above 85 percent.

Figure 1 – Bubble Charts of Health Plan Actuarial Values, Composite Rates, and Number of Covered Employees



The actuarial value of a health plan does not necessarily measure the employer provided value. The employer provided value includes the portion of the plan cost that is paid by the employer. For example, if an employer pays 80 percent of the premium for a plan with an actuarial value of 90 percent, the employer provided value is 72 percent. This is less than the employer provided value for an employer that pays the full cost of a plan that has an actuarial value of 80 percent.

HEALTH PLAN YEARS

There is wide use of both fiscal year and calendar year health plans but the HCA will need to consolidate to a single plan year structure across all entities.

Table 4: Number of Entities and Covered Employees by Health Plan Year

Plan year	Type of Entity	Number of Entities	Employees
Calendar Year			
	Schools	5	3,440
	Other	8	8,303
Fiscal Year			
	Schools	30	6,256
	Other	22	12,148

Employers whose plan years are different from the HCA's chosen plan year structure can administer a short plan year to align with the HCA. An example of plan year alignment is illustrated below.

Table 5: Sample of Plan Year Alignment

HCA Plan Year	Employer Plan Year	Short Plan Year Needed	Date Aligned with HCA
Calendar Year (January - December 2019)	Calendar Year (January - December 2019)	No	January 2019
Calendar Year (January - December 2019)	Fiscal Year (July 2017 - June 2018)	Yes (July - December 2018)	January 2019
Fiscal Year (July 2019 - June 2020)	Calendar Year (January - December 2018)	Yes (January - June 2019)	July 2019
Fiscal Year (July 2019 - June 2020)	Fiscal Year (July 2019 - June 2020)	No	July 2019

ADMINISTRATION FEES

Table 6 illustrates the range of fees that self-insured employers pay to insurance vendors to administer their health plans. The table below includes entities for whom the data was available.

Table 6: Range of Health Plan Administrative Fees

	Fees Per Employee Per Month
Minimum	$14
Maximum	$68
Overall Average	$36

Most employers (71 percent) have monthly administrative fees that are less than $40 per employee. Of the 29 percent of employers who have administrative fees above $40, 8 percent of them pay more than $60 per employee per month.

Table 7: Distribution of Health Plan Administrative Fees by Entity	
Under $20	17%
$20 - $29	33%
$30 - $39	21%
$40 - $49	13%
$50 - $59	8%
$60 - $69	8%
$70 and above	0%

COLLECTIVE BARGAINING AGREEMENTS

Table 8 provides a summary of the years when collective bargaining agreements end. Some entities have multiple bargaining groups and for these entities the table includes an indication for years where the CBAs expiration years are in different calendar years. At the time the information was collected in the fall of 2016, there were no CBAs that ended in 2020 or later years. Of the CBAs submitted as part of the data collection process, 40 percent end in 2017.

Table 8: CBA Contract by Entity and Expiration Year					
Entities	**2016**	**2017**	**2018**	**2019**	**2020 or later**
Total	**6**	**22**	**10**	**17**	**0**

PRESCRIPTION DRUG ARRANGEMENTS

The table below provides a summary of how the plans are managing their prescription drug benefits. The table shows that the pharmacy benefit is combined with medical for the majority of employers. However, the majority of covered lives are already in prescription drug arrangements that are managed separately from the medical plan. Only entities that provided complete information with respect to whether the prescription drug coverage was combined with the medical plan or provided separately from the medical plan were tabulated in this summary.

Table 9: Plans by Prescription Drug Arrangement Primary Plan Only for Entities with Multiple Plans (This data represents entities who provided complete information on their plans' prescription drug arrangement)		
Pharmacy Benefit	**Entities**	**Employees**
Combined with Medical	47	11,083
Separate from Medical	33	20,704
Total	**80**	**31,787**
Entities That Participate in Rx Coalitions		
Participate in HCCMCA Purchasing Coalition	7	9,860
Participate in Other Rx Coalition	18	3,139

HEALTH CARE COST TREND RATES

The baseline costs from 2016 are projected to increase over the next five years with an assumed set of health care cost trend rates. The selection of the assumed cost trend rates took into account health care cost trend rates in Alaska as well as the forces that continue to affect the growth in health care costs that have resulted in health care cost trend

rates that are larger than inflation, wage growth, and the annual growth in per capita GDP. To gauge the long-term difference in health care cost trend rates in Alaska from the rest of the US, data from the Centers for Medicare and Medicaid Services (CMS) covering state-wide health care costs from 1980 to 2009 was examined. The annual compound growth rate in per capita health care costs in the US was found to be 7.0% over the 29-year period, and 7.2% in Alaska. Recent trend rates for the larger self-funded Alaska entities included in the analysis ranged from a decrease of 3.5 percent to an increase of 9 percent. In the short-term, pharmacy claims are projected to increase at higher rates than medical claims, driven by the introduction of high-cost specialty drugs. Data from several entities showed that pharmacy costs are currently a smaller share of total costs in Alaska than in the US as a whole. While the absolute level of health care costs in Alaska are found to be higher than the average for all states, the forces that affect health care cost growth (wages of health care providers, rents, impact of new technology, changes in utilization patterns, etc.) are expected to impact Alaska at broadly the same rate of change as for other states. The lower weight for prescription drugs results in the medium-term projection that health care cost increases in Alaska will increase at a slightly slower pace than in the rest of the US.

The Society of Actuaries' Pension Section and Health Section Research teams commissioned Professor Thomas E. Getzen of Temple University to construct a resource model for the projection of long term health care cost trends. Baseline values and ranges for each variable in the Long Run Medical Cost Trends Model were developed by Professor Getzen and reviewed by a group of experienced health actuaries in August 2016. Annual rates of increase in medical costs were taken from the CMS Office of the Actuary National Health Expenditure estimates. Historical values of inflation and income were taken from the Bureau of Economic Analysis Current-Dollar and Real GDP series, with projections for 2016 to 2026 from the Congressional Budget Office Long Term Economic Outlook. Population data and projections were taken from the U.S. Census Bureau Resident Population series.

The baseline assumed short-term health care cost trend rates used in the current SOA-Getzen model are 5.9% in 2017, 5.8% in 2018, declining gradually to 5.5% in 2021. Taking into account the slightly higher (0.2%) long-term health care cost trend rate in Alaska, compared to the whole of the US, and the slightly lower (0.14%) short-term health care cost trend rate attributable to the lower share of claims costs from prescription drugs, the baseline SOA-Getzen rates have been used in the projection.

If there are no changes in benefits, and no changes in the relative share of total plan costs that are paid by employees through participant contributions, then the expected aggregate cost for all entities in 2017 is expected to be $957 million, reflecting an expected health care cost increase rate of 5.9% between 2016 and 2017. Table 10 shows the assumed health care cost trend rates for each of the next five years.

Table 10: Health Care Cost Trend Rates[3]

	2017 / 2016	2018 / 2017	2019/ 2018	2020 / 2019	2021 / 2020
Assumed health care cost trend rate	5.90%	5.80%	5.70%	5.60%	5.50%

[3] Source: Society of Actuaries -Getzen model; short-term health care cost trend rates. https://www.soa.org/research-reports/2016/research-hlthcare-trends/.

The projection anticipates that the composition of the population (i.e. average age) would not change materially over the next five years as retiring employees will be replaced with younger new hires, resulting in a stable average age. Individual entities with a small number of covered lives may experience some ageing – for example if the same employees are covered in each of the next three years, then the average age of the covered group will age three years. However, when one of the older participants retires then that entity would experience a drop in average age if the retiree is replaced by a younger new hire.

Table 11: Projected Medical and Prescription Drug Costs - Status Quo
In $Millions

	2016 Cost	Expected 2017	Expected 2018	Expected 2019	Expected 2020	Expected 2021
Based on survey data	$643	$681	$720	$761	$804	$848
Extrapolated costs for 44,000 employees with benefits	$903	$957	$1,012	$1,070	$1,130	$1,192
School Districts	$315.2	$333.8	$353.1	$373.3	$394.2	$415.9
All other entities	$588.0	$622.7	$658.9	$696.4	$735.4	$775.8

EMPLOYEE CONTRIBUTION RATES

COVERAGE TIERS AND EMPLOYEE CONTRIBUTION RATES

It is instructive to compare the participant contribution structures adopted by governments in managing their employee health care programs. As shown in Table 12 the large majority of states offer three-tier or four-tier systems for allocating the costs of dependent coverage, with four tiers being most common. The use of the single tier (also referred to as composite rate) is common among public employee health plans in Alaska. The use of a composite rate can lead to unintended consequences in terms of adverse selection by households where both adults have employment-based health care benefits made available to them.

Table 12: Coverage Tiers in State Employee Health Plans

Coverage Tier	State
Two tiers: Employee only; employee plus family	AL, FL, IA, IN, MA, MN, ND, NY, OH, PA, RI, WI
Three tiers: Employee only; employee plus one dependent; employee plus two or more dependents	CA, CT, HI, IL, NH, UT, VA, VT, WV
Four tiers: Employee only; employee plus spouse; employee plus child(ren); employee plus family	AR, AZ, CO, DE, GA, KS, KY, LA, MD, ME, MI, MT, NC, NE, NJ, NM, NV, OR, SC, TN, TX, WA, WY
Five tiers: Employee only; employee plus spouse; employee plus one child; employee plus two children; employee plus family	MS
Six tiers: Employee only; employee plus spouse; employee plus one child; employee plus two or more children; employee plus spouse and one child; employee plus spouse and two or more children	ID, MO, OK, SD

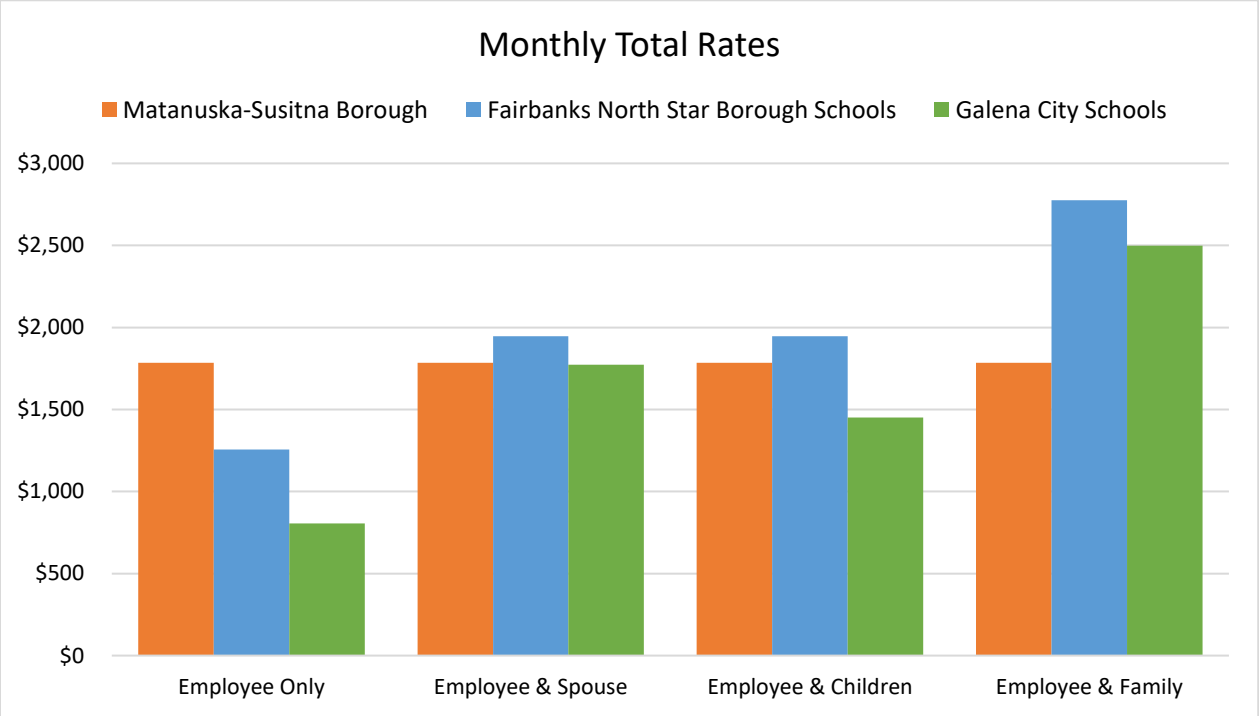
Source: 2013 publicly available information from the Pew-MacArthur Study, used with permission from The Pew Charitable Trusts.

We have illustrated the impact that the use of composite rates as well as employee contribution policies can have on net employer sponsored health care costs by reference to three employers who provided data for the study. The table below shows the total 2016 monthly health care rates (i.e. the total paid by the employee plus the employer) for the plan with the largest enrollment if the employer offered two or more plan options. The table shows that the "rate" for Matanuska-Susitna Borough is the same for all four tiers. This is referred to as a single tier or composite rate. Fairbanks North Star Borough Schools uses three tiers: the lowest rate is for employee only coverage, a middle rate is used for both the employee and spouse and the employee and children coverage tiers, and the highest rate is for employee and family coverage. Galena City Schools uses four tiers: the lowest rate is for employee only coverage, the next lowest rate is for employee and children coverage, a higher rate applies to a couple (employee and spouse), and the highest rate applied to employee and family coverage.

Table 13: 2016 Total Monthly Health Care Rates				
	Employee Only	Employee & Spouse	Employee & Children	Employee & Family
Matanuska-Susitna Borough	$1,786	$1,786	$1,786	$1,786
Fairbanks North Star Borough Schools	$1,256	$1,947	$1,947	$2,776
Galena City Schools	$806	$1,772	$1,450	$2,497

The following chart illustrates these rates graphically.

Figure 2 - Total Monthly Health Care Rates



EMPLOYEE CONTRIBUTION RATES

The following table shows the 2016 monthly employee contribution rates. Matanuska-Susitna Borough uses a single coverage tier and therefore charges the same employee contribution amount for employee only coverage as it does for employee and family coverage. Employees of Fairbanks North Star Borough Schools pay $169 per month for employee only coverage (coincidentally almost identical to the Matanuska-Susitna Borough required contribution level), but pay higher amounts for covering more family members in the health plan. Galena City Schools contribution policy has no contribution for employee only coverage; $205 per month for employee and spouse (or employee and children) coverage – about the same amount as required by Matanuska-Susitna Borough and Fairbanks North Star Borough Schools – and double that amount for employee and family coverage.

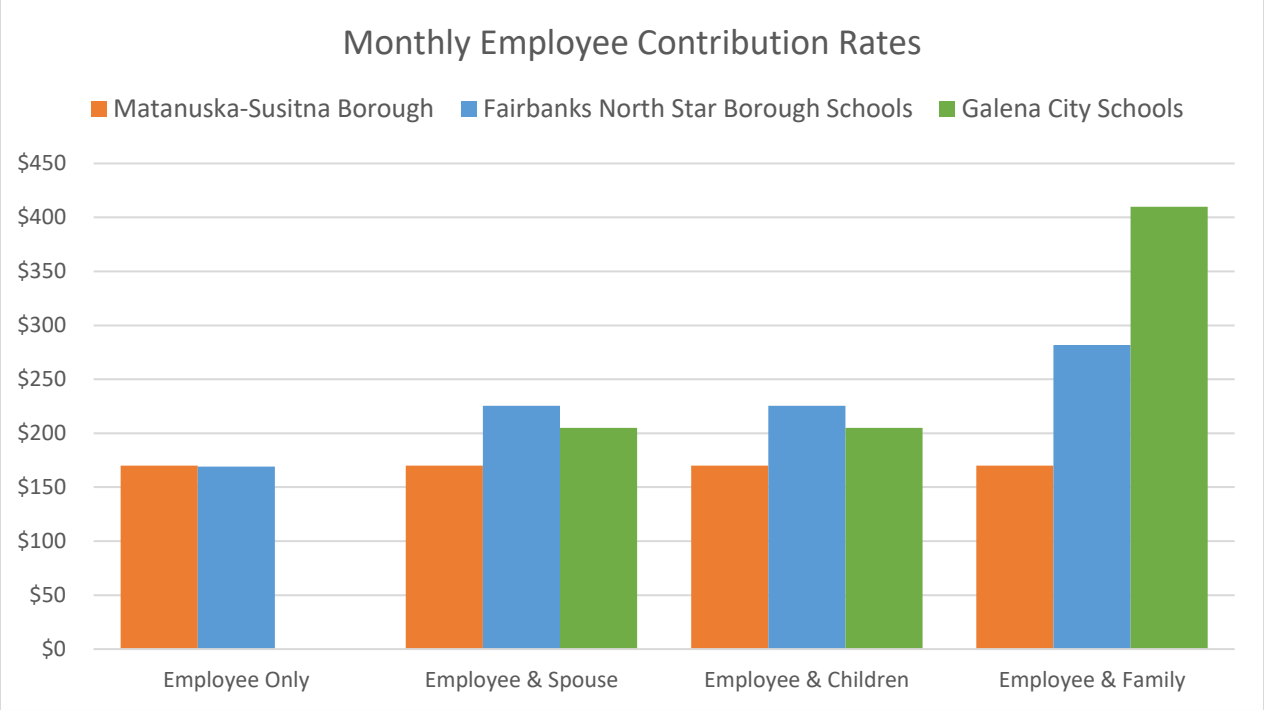
Another way of interpreting the employee contribution rate is to look at the additional cost for covering a spouse. At Matanuska-Susitna Borough, there is no additional cost for covering a spouse. At Fairbanks North Star Borough Schools, the additional cost is about $56 per month (the difference between $225 and $169, or the difference between $282 and $225). At Galena City Schools, the cost of covering a spouse is $205 per month.

Table 14: 2016 Monthly Employee Contribution Rates

	Employee Only	Employee & Spouse	Employee & Children	Employee & Family
Matanuska-Susitna Borough	$170	$170	$170	$170
Fairbanks North Star Borough Schools	$169	$225	$225	$282
Galena City Schools	$0	$205	$205	$410

The employee contribution rates are illustrated in the chart below the table.

Figure 3 - Monthly Employee Contribution Rates

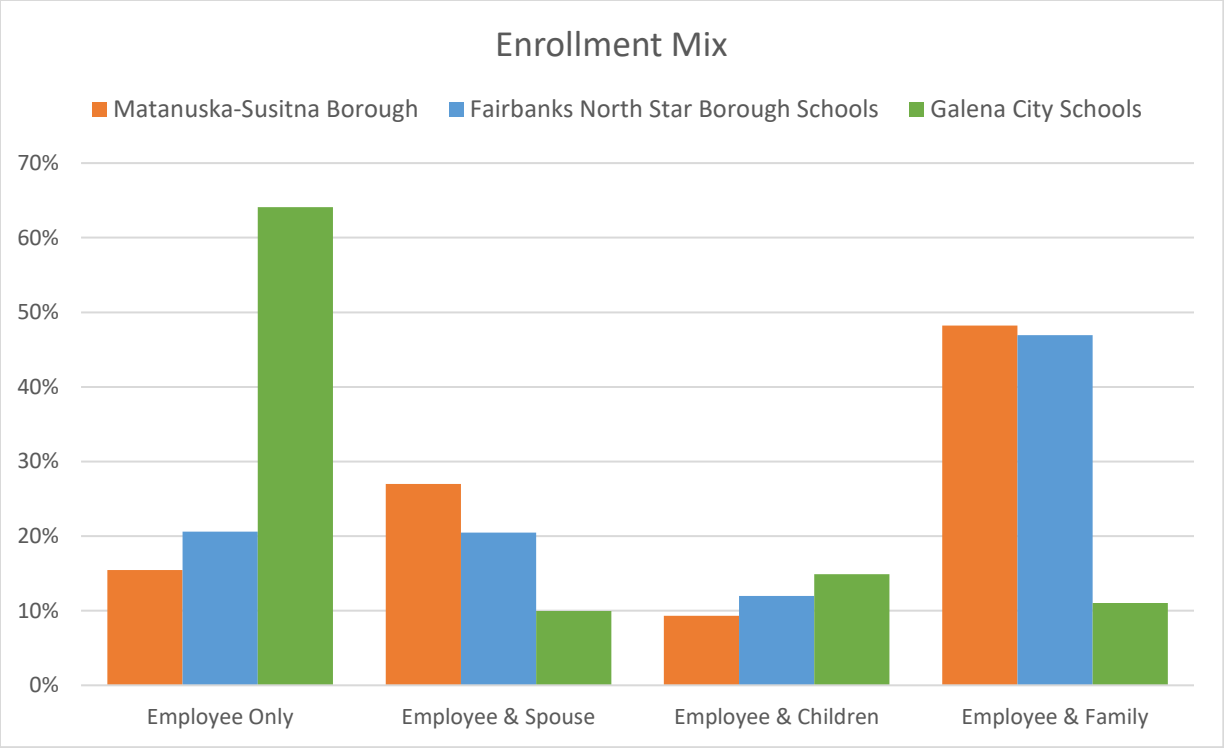


The following table shows the enrollment mix for 2016. Matanuska-Susitna Borough is covering the spouses for 75% of their employees, Fairbanks North Star Borough Schools are covering the spouses for 67% of their employees, while Galena City Schools are only covering 21% of the spouses of their employees. The larger percentage of spouses covered by the Matanuska-Susitna Borough and Fairbanks North Star Borough Schools plans is in part attributable to the low employee contribution requirement (or in Matanuska-Susitna Borough's case zero cost) incurred by the employee for covering their spouse.

The enrollment data is also shown graphically.

Table 15: 2016 Enrollment	Employee Only	Employee & Spouse	Employee & Children	Employee & Family
Matanuska-Susitna Borough	15%	27%	9%	48%
Fairbanks North Star Borough Schools	21%	20%	12%	47%
Galena City Schools	64%	10%	15%	11%

Figure 4 - 2016 Enrollment Mix



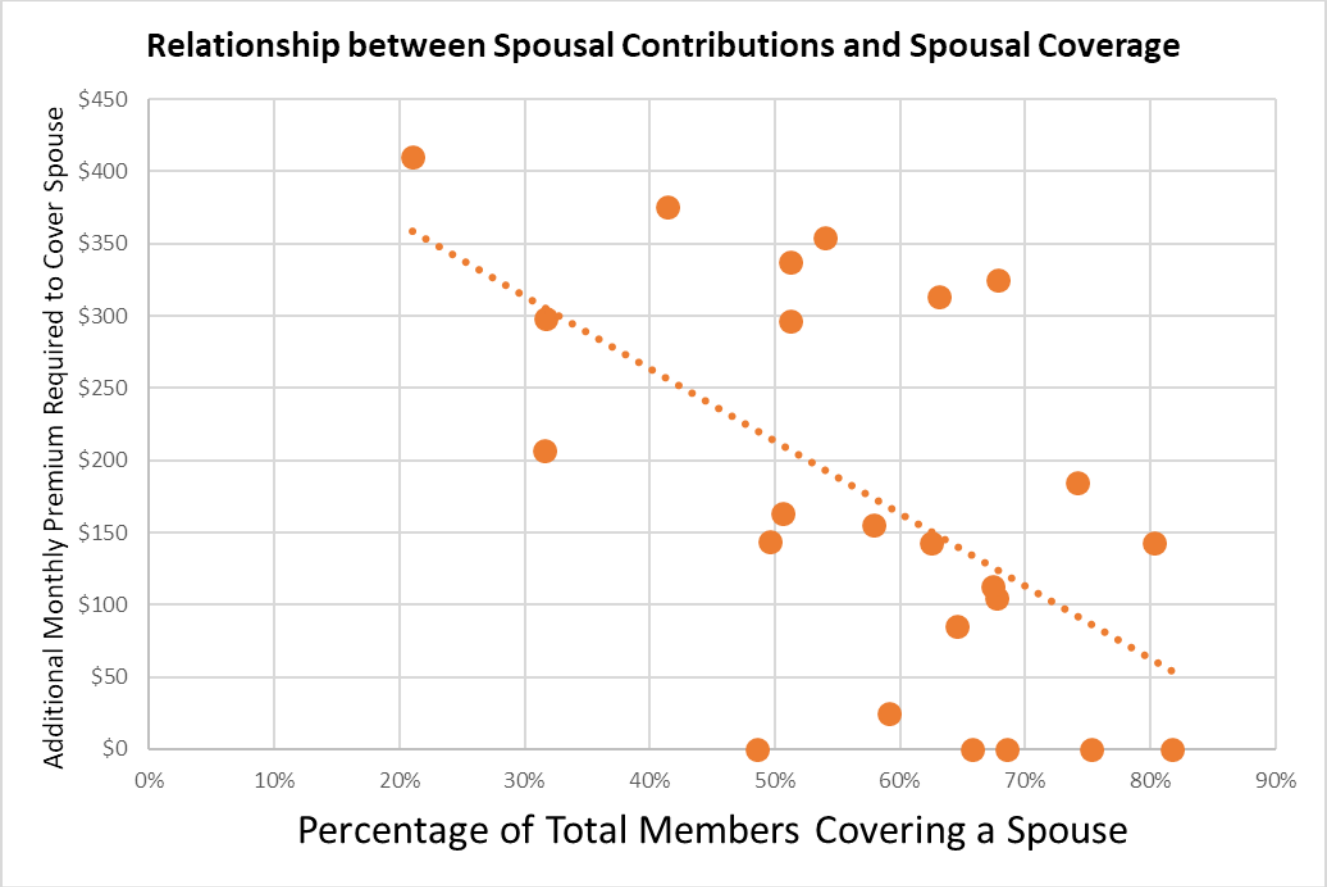
The impact on enrollment mix, and therefore employer costs, from changes in employee contribution rates can be significant. For example, if the contribution policy were adjusted and just 25% of the spouses currently enrolled in the plan enrolled in a different plan, Mat-Su Borough's costs would decline by over 10 percent.

These three employers and the different approaches that have adopted for contribution policies illustrate the impact that contribution rates can have on plan participation – and therefore costs.

The following chart shows the relationship between spousal contributions and spousal coverage for a broader set of entities. Only entities that require a contribution for employee and family coverage (even if that is the same contribution required for employee only coverage) are included and the data was also restricted to those entities with a minimum of

55 members. Five entities do not require an additional contribution for spousal coverage. These five employers are shown on the X (horizontal) axis as having spousal participation rates ranging from 49% to 82%. Eight employers require an additional contribution of at least $250 per month to cover the spouse. The effect of charging an additional higher contribution is clearly seen in the chart, with the percentage of total members covering a spouse declining to a range of 21% to 68%. Figure 5 includes a "best fit" line which shows the implied relationship between the amount of the spousal contribution and the percentage of members that cover a spouse.

Figure 5 - Spousal Contribution and Coverage Relationship



Effectively employers who require no or limited additional employee contributions for spouses and other dependents subsidize the costs of other employers by essentially always being the plan of choice where both spouses work and both working spouses have access to employer sponsored health care benefits. The following table illustrates the leveraged financial impact that relatively small changes in employee premium rates can have on an employer's net cost. Table 16 shows the total monthly cost and employee monthly premiums and enrollment for an entity and the modeled change in enrollment from setting the spousal premium equal to the premium required for employee only coverage. Based on the increase in the spousal premium from $56 (which is less than the premium required for employee only coverage) to $169, the same as the amount required for employee only coverage, the enrollment is

expected to change with a 25% reduction in the numbers electing Employee and Spouse and Employee and Family coverage (i.e. Employee and Spouse enrollment declines from 20% to 15%).

Table 16: Modeled Impact on Enrollment from Changes in Spousal Contribution Rates				
	Employee Only	**Employee & Spouse**	**Employee & Children**	**Employee & Family**
Total Monthly Cost	$1,256	$1,947	$1,947	$2,776
Employee Monthly Premiums	$169	$225	$225	$282
Current Enrollment mix	21%	20%	12%	47%
If Contributions adjusted for Spouses to	$169	$338	$225	$395
Expected enrollment mix	38%	15%	12%	35%

The weighted average cost per employee is currently $2,194 per month (i.e. 21% x $1,256 + 20% x $1,947 + 12% x $1,947 + 47% x $2,776). The weighted average employee premiums are $240 for a net cost of $1,953. After the employee premium change for spousal coverage, the modeled weighted average cost per employee declines by $221 to $1,973, and the weighted average modeled employee premium increases by $40 to $280. Therefore, the net cost to the employer declines by over 13% from $1,953 to $1,693. Some 85 percent of the savings are attributable to the reduction in the number of spouses covered under this employer's plan.

Table 17: Modeled Savings from Adjusting the Spousal Contribution	
1. Current Average Gross Cost per Employee	$2,194
2. Current Average Employee Contributions per Employee	$240
3. Current Net Cost per Employee	$1,953
4. Modeled Average Gross Cost per Employee	$1,973
5. Modeled Average Employee Contributions per Employee	$280
6. Modeled Net Cost per Employee	$1,693
7. Savings (3. Minus 6.)	$260
8. Savings as a % of Current Net Cost (7. / 3.)	13.3%

Please See Appendix I (page 178) for a more extended discussion of the issues involving in setting rates for employee and dependent contributions and the steps employers are taking to reduce costs by incenting participants in households where other employer coverage is available to elect other employers' health care plans.

PROPOSED BENEFITS FOR COORDINATED PLAN ADMINISTRATION

MEDICAL PLANS

Coordinated health plan administration utilizing a menu of health plan options would facilitate three key objectives:

- Employers could select a health plan with a very similar set of benefits and comparable actuarial value by choosing one (or more than one where multiple plans are now in place) of the HCA health plan designs. There would little if any change in costs moving from the former health plan to one of the new health plan options.
- The reduced set of benefit plan options would still provide the flexibility for each employer to tailor their benefit choices to fit their budget.
- A limited number of health plans will materially reduce the amount of time devoted to communicating and managing multiple health plan design and cost information.

After reviewing the range of health plan designs and considering the number of employees enrolled in each plan, PRM found that a set of four different health plans would be sufficient to provide choice, while facilitating mapping from the current plan to the plan with the closest actuarial value. While the plan designs below illustrate the concept and provide mapping to the range of values desired, we should note that other plan designs could also be used to achieve the same or similar results.

Table 18: Illustration of Medical Plan Options

Health Plan Options Medical Plan Type Prescription Drug Plan	Option 1 Qualified HDHP Drug: Plan A	Option 2 PPO 2 Drug: Plan B	Option 3 PPO 3 Drug: Plan C	Option 4 PPO 4 Drug: Plan C
Actuarial Value	76%	82%	89%	94%
In-Network Annual Plan Deductible (Individual / Family)	$1,500 $3,000	$1,000 $2,000	$350 $700	$150 $300
In-Network Coinsurance	30%	20%	20%	10%
Maximum Out-of-Pocket including deductible for in-network coverage (Individual / Family)	$6,500 $13,000	$4,000 $8,000	$1,850 $3,700	$650 $1,300
Out-of-Network Annual Plan Deductible (Individual / Family)	$3,000 $6,000	$2,000 $4,000	$700 $1,400	$300 $600
Out-of-Network Coinsurance	50%	40%	40%	30%
Out-of-Network OOP Maximum excluding deductible (Individual / Family)	No limit	No limit	No limit	$4,000 $8,000
Primary Care Office Visit	Coinsurance and deductible			
Specialist Office Visit	Coinsurance and deductible			
Emergency Room	Coinsurance and deductible			
Inpatient Hospitalization	Coinsurance and deductible			
Outpatient Hospitalization	Coinsurance and deductible			

Table 19: Illustration of Prescription Drug Plan Options			
Prescription Drug Plan Options	**Drug Plan A**	**Drug Plan B**	**Drug C**
Retail Generic	Subject to the combined medical and prescription drug $1,500 individual deductible ($3,000 family), 30% coinsurance, and $6,500 individual out-of-pocket limit ($13,000 family).	$10	$5
Retail Formulary Brand		20% (max $200)	$20
Retail Non-Formulary Brand		20% (max $200)	$40
Mail Order Generic		$20	$10
Mail Order Formulary Brand		20% (max $400)	$40
Mail Order Non-Formulary Brand		20% (max $400)	$80
Specialty		20% (max $400)	20% (max $400)

Using the above set of health plans, PRM mapped the existing health plans into one of the four options. The objective was to ensure the change in value (higher or lower) would be small and in all cases for the change to fall within the de minimis range of 4%.

- Plans with an actuarial value below 78% were mapped to Option 1. This mapping results in enrollment of 2,194 employees in Option 1, about 7% of the total. The largest change in actuarial value for any plan mapped to Option 1 is 1.8%, well below the 4% threshold.
- Plans with an actuarial value below 85.1% and above 78.9% were mapped to Option 2. This mapping results in enrollment of 8,913 employees in Option 2, about 28% of the total. The largest change in actuarial value for any plan mapped to Option 2 is 3%, below the 4% threshold.
- Plans with an actuarial value below 92.1% and above 86.0% were mapped to Option 3. This mapping results in enrollment of 13,059 employees in Option 3, about 41% of the total. The largest change in actuarial value for any plan mapped to Option 3 is 2.6%, below the 4% threshold.
- Plans with an actuarial value above 92.9% were mapped to Option 4. This mapping results in enrollment of 7,643 employees in Option 4, about 24% of the total. The largest change in actuarial value for any plan mapped to Option 4 is 2.7%, below the 4% threshold.

The table below summarizes the information on how plans were initially "mapped" to one of the four standard options.

Table 20: Mapping of Current Plans to Four Optional Plan Designs					
Plan Option	Actuarial Value	Current Plans Mapped to this Option if AV is		Enrollment	Percent of Total Enrollment
		Above	And Below		
Option 1	76%	72.0%	78.0%	2,194	7%
Option 2	82%	78.9%	85.1%	8,913	28%
Option 3	89%	86.0%	92.1%	13,059	41%
Option 4	94%	92.9%	97.5%	7,643	24%

DENTAL AND VISION PLANS

Approximately 74 percent of employers surveyed indicated that they offer dental and vision benefits to employees and in most instances these benefits are offered in conjunction with medical and prescription drug plans. This means that if an employee elects medical coverage, dental and/or vision is automatically included.

The table below shows the total aggregated costs (i.e., both employer and employee contributions) for 2016 and is based on enrollment and cost information from the entities that participated in the survey. We have estimated the total number of employees eligible for dental and vision benefits to be consistent with the medical plans (i.e., 44,000 lives) and the total expenditure was estimated to be $62 million in 2016. The projected cost through 2021 is also illustrated in the table below.

Table 21: Projected Total Costs - Status Quo In $Millions						
Extrapolated costs for 44,000 employees with benefits	2016 Cost	Expected 2017	Expected 2018	Expected 2019	Expected 2020	Expected 2021
Dental	$62.3	$65.4	$68.7	$72.2	$75.4	$78.8
Vision	$14.1	$14.5	$15.0	$15.4	$15.9	$16.4
Total for Dental & Vision	$76.4	$79.9	$83.7	$87.6	$91.3	$95.2

The estimated trend used to develop the projected cost are illustrated below and assumes no changes in benefits, contribution cost shares, or material change in the population.

Table 22: Dental and Vision Cost Trend Rates					
Assumed dental and vision cost trend	2017 / 2016	2018 / 2017	2019/ 2018	2020 / 2019	2021 / 2020
Dental[4]	5.0%	5.0%	5.0%	4.5%	4.5%
Vision[5]	3.0%	3.0%	3.0%	3.0%	3.0%

[4] Source: Metropolitan Life Insurance Company
[5] Source: National Vision Administrators

PRM modeled the dental and vision plan designs shown in the tables below to illustrate examples of plan options that could be offered to employees. The models are based on the range of plan designs that are currently offered to employees. Other design models could be used to achieve similar results.

Table 23: Illustration of Dental Plan Design Options

Dental Plan Features	Option 1	Option 2	Option 3
In-Network & Out-of-Network Services			
Annual Plan Deductible (per person)	$150	$100	$50
Annual Benefit Maximum (per person)	$2,500	$1,500	$1,000
Diagnostic and Preventive Services	100%	100%	100%
Basic Services	80%	80%	90%
Restorative Services	50%	50%	60%
Orthodontia (employers can choose whether to include ortho)	50%	50%	50%

Table 24: Illustration of Vision Plan Design Options

Vision Plan Features	Option 1	Option 2
Frequency (eye exam, frames & lenses)	12 / 24 / 24	12 / 12 / 12
In-Network Services		
Exams	$50 copay	$25 copay for eyes $60 copay for contacts
Standard Lenses	Plan pays up to $100	$25 copay
Bifocal Lenses	Plan pays up to $150	$30 copay
Trifocal Lenses	Plan pays up to $150	$30 copay
Frames	Plan pays up to $150	Plan pays up to $195
Medically Necessary Contacts	Plan pays up to $150	$30 copay
Elective Contacts	Plan pays up to $100	Plan pays up to $130
Out-of-Network Services		
Eye Exam	Plan pays up to $50	Plan pays up to $100
Standard Lenses	Plan pays up to $50	Plan pays up to $100
Bifocal Lenses	Plan pays up to $75	Plan pays up to $100
Trifocal Lenses	Plan pays up to $100	Plan pays up to $100
Frames	Plan pays up to $125	Plan pays up to $150
Medically Necessary Contacts	Plan pays up to $210	Plan pays up to $210
Elective Contacts	Plan pays up to $105	Plan pays up to $105

As seen with the medical health plans, coordinating plan administration of the dental and vision benefits are expected to generate additional savings. The expected savings for the next five years are illustrated in the table below.

Table 25: Projected Total Costs Under Coordinated Plan Management
In $Millions

	Expected 2017	Expected 2018	Expected 2019	Expected 2020	Expected 2021
1. Dental	$65.4	$68.7	$72.2	$75.4	$78.8
2. Vision	$14.5	$15.0	$15.4	$15.9	$16.4
Savings (%)					
1. Dental	0.2%	0.8%	2.8%	4.7%	4.7%
2. Vision	0.05%	0.24%	1.12%	2.0%	2.0%
Savings (Amounts in Millions)					
1. Dental	$.13	$.55	$2.0	$3.6	$3.7
2. Vision	$.01	$.04	$.17	$.32	$.33
3. Total for Dental and Vision	$0.14	$0.59	$2.17	$3.92	$4.03

IMPACT ON BASELINE OF COORDINATED PLAN ADMINISTRATION

Coordinated plan administration facilitates the optimal level of savings from both improved plan administration and cost-effective purchasing.

Establishing a Health Care Authority to administer health plans for the Political Subdivisions, School Districts, State employee health plans and other entities listed in S.B. 74 is expected to achieve savings in the following areas:

COORDINATED PLAN ADMINISTRATION

- The cost for fully-insured plans includes risk premiums (i.e. claims fluctuation margins) and profit as well as the administration charges and incurred claims costs. Moving from fully-insured to self-insured will reduce the cost by removing the risk premium and profit and reduced administration costs on a per person basis. Savings would also accrue from pooled purchasing. There would also be savings from no longer paying premium taxes, however these taxes are currently part of State receipts so from an aggregate state budget perspective, these will not result in net savings to the State.
- A large plan covering over 40,000 employees can achieve risk premium savings as it would not need to purchase stop-loss insurance. While some of the entities (e.g. the AlaskaCare plans) do not purchase stop-loss insurance, many of the self-insured plans do. The stop-loss insurance provides important protections for the trusts and other entities that have a one-year budgeting cycle and do not have the financial resources to weather a spike in claims due to cyclical effects (e.g. an unusually virulent influenza strain that results in a material increase in office visits and hospitalizations), or rare, but expensive treatments for a few individuals. For entities that provided details of the stop-loss premiums and recoveries, the savings can be estimated by comparing the cost of the premiums and subtracting the amount of recoveries. For entities that only provided stop-loss premium information, the savings were estimated at 40 percent of the stop-loss premiums. This estimate was developed from an analysis of stop-loss premiums and recoveries from other studies conducted by PRM.
- A third area of savings will accrue to the Health Care Authority, and therefore to the participating employers, by negotiating administrative fees. In prior procurements PRM has secured reduced administrative fee levels based on the size of the covered group, with lower per employee fees for larger group sizes.
- A fourth area of savings can be achieved through coordinated plan administration that reduces the complexity of the annual administration tasks, such as rate development, plan communications, and eliminating redundancies and inconsistencies in areas such as periodic bidding and procurement.

POOLED PURCHASING

- Pooled purchasing savings are expected to be achieved by carving out the prescription drug benefit and competitively bidding the coverage under a single policy. The exact amount of savings will only be known after the competitive bidding has been completed. For entities that already participate in a pharmacy purchasing coalition, the level of savings will be the marginal improvement from the current arrangement to the pooled PBM

contract. For those entities that have not carved out their prescription drug coverage and do not currently participate in a pharmacy coalition, PRM estimates that the amount of savings will be approximately 10 percent of the current pharmacy expenditures. For entities that provided a combined health plan cost and did not separately identify what portion was attributable to prescription drugs, PRM estimates that 15 percent of the cost is attributable to prescription drugs.

- Pooled purchasing savings are also expected to be achieved by competitively bidding a Travel Benefit / Centers of Excellence contract. Some entities already have a travel benefit contract. For these entities, PRM expects there will be some additional savings, primarily associated with savings in the administrative fees, which are expected to be lower under a single large contract.

The table below shows the projected baseline costs (status quo) in row 1 without pooled purchasing or coordinated plan management. Row 2 shows the expected costs with coordinated plan management and row 3 with pooled purchasing. Row 4 shows the expected costs under combined plan management and pooled purchasing. Row 5 shows the expected annual savings from coordinated plan management. Row 6 shows the expected annual savings with pooled purchasing. The savings are based on each entity participating in the HCA upon the expiration of the current CBA. For example, if a CBA expires in 2018, the savings under coordinated plan management will first accrue in 2019.[6]

Table 26: Projected Medical and Prescription Drug Costs Under Pooled Purchasing and Coordinated Plan Management
In $Millions

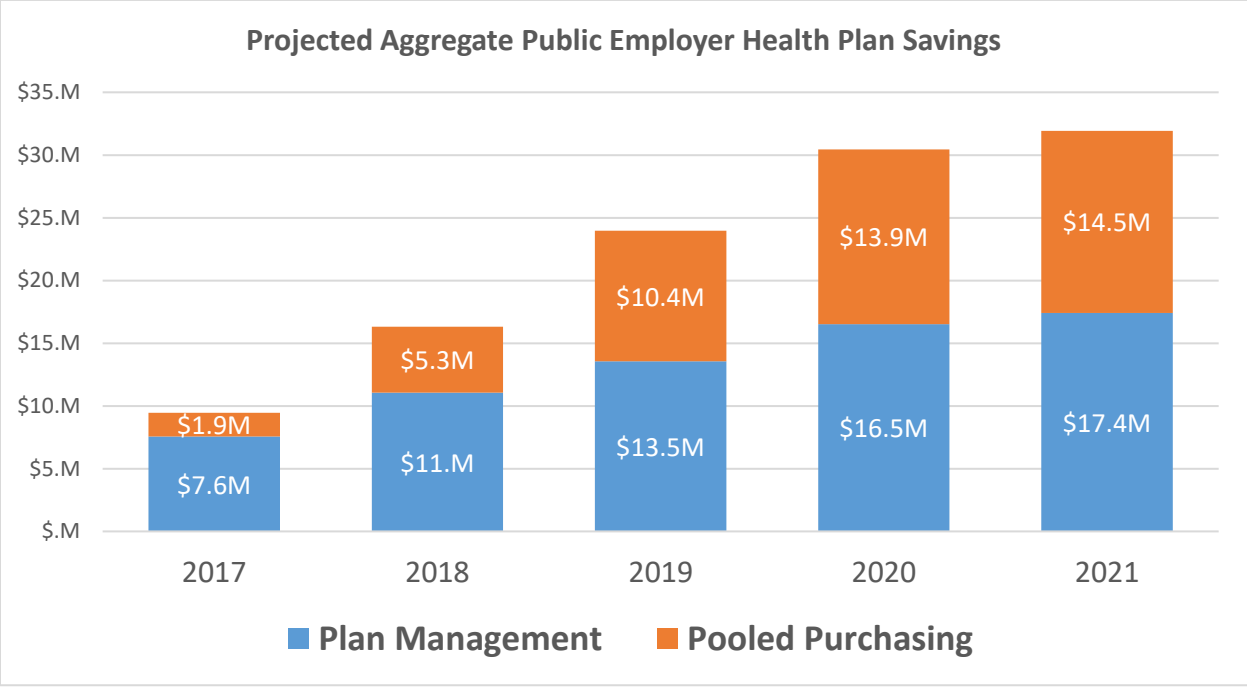
	Expected 2017	Expected 2018	Expected 2019	Expected 2020	Expected 2021	5-Year Savings
1. Status Quo	$956.5	$1,012.0	$1,069.7	$1,129.6	$1,191.7	
2. Coordinated Plan Management	$948.9	$1,000.9	$1,056.1	$1,113.0	$1,174.3	
3. Pooled Purchasing	$954.6	$1,006.7	$1,059.2	$1,115.6	$1,177.2	
4. Plan Management and Pooled Purchasing	$947.0	$995.7	$1,045.7	$1,099.1	$1,159.8	
Savings $Millions						
5. Coordinated Plan Management (2. – 1.)	$7.6	$11.0	$13.5	$16.5	$17.4	$66.1
6. Pooled Purchasing (3. – 1.)	$1.9	$5.3	$10.4	$13.9	$14.5	$46.0
7. Plan Management and Pooled Purchasing (4. – 1.)	$9.5	$16.3	$23.9	$30.4	$31.9	$112.1
Savings Percent						
8. Coordinated Plan Management (5. /1.)	0.8%	1.1%	1.3%	1.5%	1.5%	
9. Pooled Purchasing (6. /1.)	0.2%	0.5%	1.0%	1.2%	1.2%	
10. Plan Management and Pooled Purchasing (7. /1.)	1.0%	1.6%	2.3%	2.7%	2.7%	

[6] To assure that the most current data available from survey respondents was used we requested participation and premium rate data as of September 30, 2016. While the majority of survey respondents reported using a fiscal year basis for the operation of their plans, a substantial minority use a calendar year basis. The annual savings depicted in Table 26 for future years meld the savings estimates based on the data provided for fiscal year plans with plan years ending June 30, 2017 and calendar year plans ending December 31, 2016.

Table 26 shows that coordinated plan management savings increase over time to 1.5% of the cost and pooled purchasing savings rise to 1.2% by year 4. Combined, the plan management and pooled purchasing savings are expected to yield 2.7% annual savings.

The following chart shows the expected growth in savings as additional entities begin to participate in the HCA upon the expiration of the current CBAs.

Figure 6 – Projected Health Plan Savings



EVALUATION OF ORGANIZATION MODELS

PRM has evaluated several organizational approaches (models) for the coordinated plan administration of the various public employer health benefit plans.

We have described below the status quo in terms of the different groups of employees and / or retirees, and how their health care benefits are currently administered.

STATUS QUO

Group A	State retirees' health care benefits are administered in a separate pool. Two cohorts of retirees (legacy retirees in the defined benefit plans and the new cohort of retirees in the defined contribution plans) have access to specific health plans.
Group B	State employees participate in health plans established through their agency or union. The separate health plans includes: • AlaskaCare • Local 71 • ASEA / AFSCME Local 52 • PSEA • Masters Mates and Pilots • Health plan for University of Alaska employees • Alaska Gasline Development Corporation • Alaska Housing Finance Corporation
Group C	Employees working for school districts participate in health plans established by their employer.
Group D	Employees working for political subdivisions participate in health plans established by their employer.
Group E	Individual Alaskans not covered for health insurance by their employer. These individuals can purchase subsidy-eligible coverage through the ACA exchange (Premera only in 2017), or non-subsidy eligible coverage from one of several authorized insurance companies.

The following organizational models were evaluated. For each model, we provide a brief description with respect to which groups can participate, and whether the participation is optional or mandatory.

Model 1 (Similar to the Washington State PEBB Model)

- Single risk pool for non-retired state funded or supported public employees (Groups B, C, and D). Retirees are assumed to remain in a separate pool.

- Multiple benefit plan choices (e.g. the four medical plan options described in this report, plus three dental and two vision options)
- Mandatory participation for state employees (Group B), optional for school districts (Group C) and political subdivisions (Group D)
- No access to the pool from individual Alaskans (Group E)

Model 2 (Similar to the Oregon State PEBB and OEBB Model)

- Two risk pools for non-retired state funded or supported public employees
  - One pool for education employees (Group C)
  - Separate pool for other public employees (Groups B and D)
  - Retired employees (Group A) are assumed to remain in a separate pool.
- Multiple benefit plan choices (e.g. the four medical plan options described in this report, plus three dental and two vision options)
- Mandatory participation for state employees, school districts and political subdivisions
- No access to the pool from individual Alaskans (Group E)

Model 3 (State Administered Captive)

- 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. (Groups B, C, and D)
- Each entity can continue to select and administer its own health care benefits
- No access from individual Alaskans (Group E)

Model 4 (Multiemployer Plans – Designed to Minimize the PPACA High Cost Tax)

- Potential for multiple pools
- Initial pool of multiple employers opting to join for all or some of their employees. (Includes Groups B, C, and D)
- No access for individual Alaskans (Group E)

Model 5 (Public / Private Exchange Model)

- Single pool (Groups B, C, D, and E), maintain separate pool for retired employees (Group A)
- Multiple benefit plan choices (e.g. the four medical plan options described in this report, plus three dental and two vision options)
- Voluntary participation

SUMMARY OF EVALUATION OF MODELS

The following table summarizes the projected savings (or costs) under each of the models. Immediately following this summary table are detailed descriptions of each model and the assumptions utilized in projecting the savings.

Table 27: Projected Savings or (Costs)
In $Millions

	Expected 2017	Expected 2018	Expected 2019	Expected 2020	Expected 2021	5-Year savings (Costs)
Status Quo	$956.5	$1,012.0	$1,069.7	$1,129.6	$1,191.7	
Model 1 – Single Risk Pool. All state entities plus school districts and political subdivisions that opt to participate.	$5.9	$12.1	$18.6	$24.2	$25.4	$86.2
Model 2 – Two Risk Pools. All school districts in one pool. All Political Subdivisions and State employees in the second pool.	$9.4	$16.1	$22.5	$28.1	$29.4	$105.5
Model 3 – State Administered Captive	$1.0	$1.0	$1.1	$1.1	$1.2	$5.4
Model 4 – Multi-employer Plans	$0.0	$0.0	$0.0	$29.4	$31.2	$60.6
Model 5 – Public / Private Exchange. Single pool, state employees plus optional participation from school districts and political subdivisions and individuals.	($22.7)	($18.1)	($13.3)	($9.5)	($10.2)	($73.8)

MODEL 1 (SIMILAR TO THE WASHINGTON STATE PEBB MODEL)

This model utilizes a single risk pool for non-retired state funded or supported public employees (Groups B, C, and D). Employers would choose from multiple benefit plan choices (e.g. the four medical plan options described in this report, plus three dental and two vision options). Participation would be mandatory for state employees (Group B), and optional for school districts (Group C) and political subdivisions (Group D). There would be no access to the pool from individual Alaskans (Group E).

For Model 1 we quantified the financial savings compared to the status quo based on the following assumptions:

- Maximum pooled purchasing savings as a percentage of current costs can be achieved as the single pool will contain a sufficiently large number of plan participants to optimize the purchasing savings.
- Maximum pooled plan administration savings as there will only be one pool and the pool will contain a sufficiently large number of plan participants to achieve the lowest possible plan administration fees.
- Assume that only those school districts and political subdivisions whose costs are currently above the projected pooled plan cost will participate.

We mapped current health plans to one of four standard designs, targeting the health plan closest to the current plan's actuarial value. For a few employers with large enrollment whose plans value were between two of the four standard plans we mapped a portion of the enrollment to each of the two closest standard plans. Figures 7-10 show the entities whose plans were mapped into health plan options 1, 2, 3 and 4.

Table 28: Projected Costs and Savings under Model 1 In $Millions						
Based on 44,000 benefit eligible employees	**2017**	**2018**	**2019**	**2020**	**2021**	**5-Year savings**
1. Status Quo Costs	$956.5	$1,012.0	$1,069.7	$1,129.6	$1,191.7	
2. Plan Management	$951.8	$1,004.2	$1,059.2	$1,116.6	$1,178.0	
3. Pooled Purchasing	$955.3	$1,007.6	$1,061.6	$1,118.4	$1,180.0	
4. Plan Management and Pooled Purchasing	$950.6	$999.9	$1,051.1	$1,105.4	$1,166.3	
5. Number of Employees Assumed Joining	6,284	11,173	18,509	0	0	
6. Savings as a Percent of Status Quo	0.6%	1.2%	1.7%	2.1%	2.1%	
Savings $Millions						
7. Plan Management	$4.7	$7.7	$10.5	$13.0	$13.7	$49.6
8. Pooled Purchasing	$1.2	$4.4	$8.1	$11.2	$11.7	$36.6
9. Plan Management and Pooled Purchasing	$5.9	$12.1	$18.6	$24.2	$25.4	$86.2

Figure 7 shows the current health plans with actuarial values above 92 percent. Each circle (or bubble) on the chart represents three dimensions of the health plan. The plans are shown by (a) composite monthly cost (i.e. the total cost before employee premiums), (b) actuarial value (i.e. the relative generosity of the coverage), and (c) size of the plan in terms of covered employees. The "bubble" size represents the relative size of the covered population.

Figure 7 – Bubble Chart of 27 Plans Mapped to Option 4 Health Plan

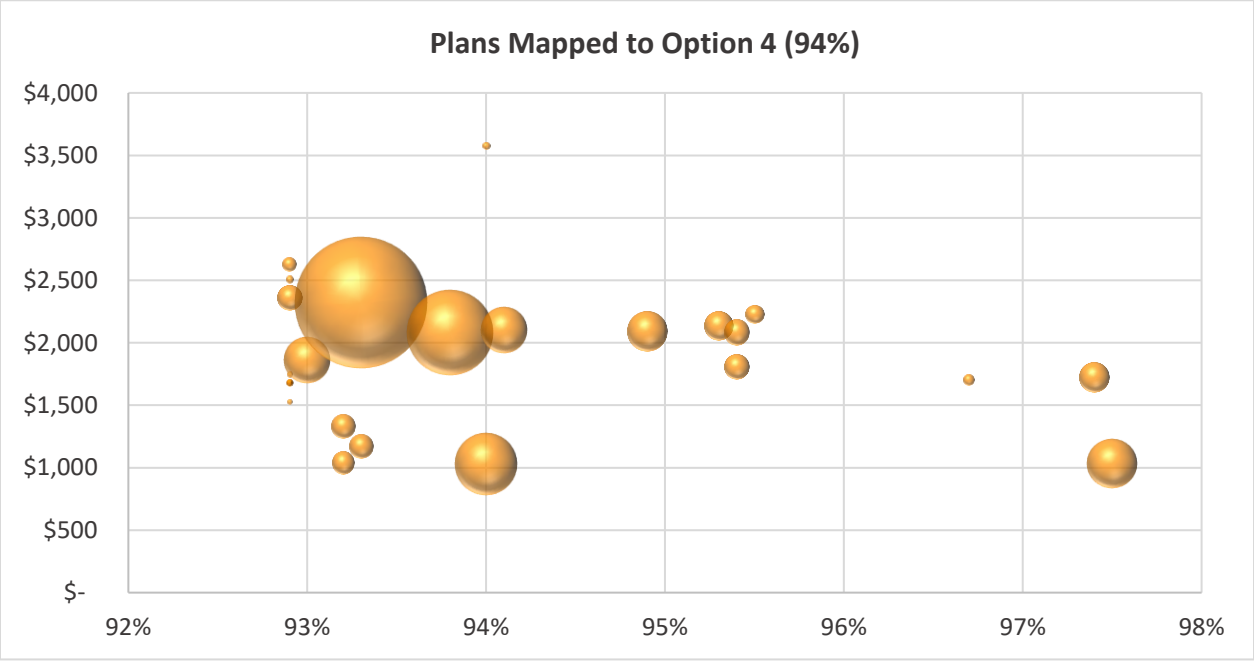


Figure 8 shows the current health plans with actuarial values above 86 percent and below 92 percent. Each circle (or bubble) on the chart represents three dimensions of the health plan. The plans are shown by (a) composite monthly cost (i.e. the total cost before employee premiums), (b) actuarial value (i.e. the relative generosity of the coverage), and (c) size of the plan in terms of covered employees. The "bubble" size represents the relative size of the covered population. For entities whose plans have an actuarial value below 89 percent, the expected cost reflects the increase from covering a slightly larger percent of covered charges. Similarly, for the six entities with plans whose actuarial values are above 89 percent, mapping to the Option 3 plan design is expected to result in a slightly lower cost as the plan will be covering a slightly smaller portion of the covered charges.

Figure 8 – Bubble Chart of 16 Plans Mapped to Option 3 Health Plan

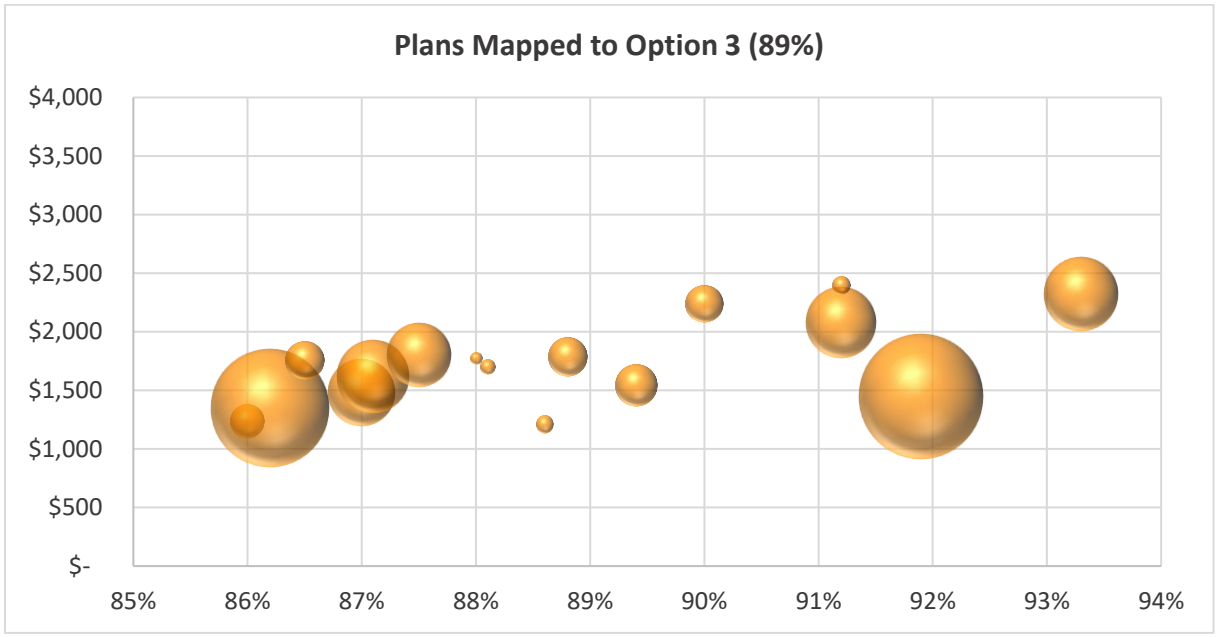


Figure 9 shows the current health plans with actuarial values above 78 percent and below 88 percent. Each circle (or bubble) on the chart represents three dimensions of the health plan. The plans are shown by (a) composite monthly cost (i.e. the total cost before employee premiums), (b) actuarial value (i.e. the relative generosity of the coverage), and (c) size of the plan in terms of covered employees. The "bubble" size represents the relative size of the covered population. For entities whose plans have an actuarial value below 82 percent, the expected cost reflects the increase from covering a slightly larger percent of covered charges. Similarly, for the six entities with plans whose actuarial values are above 82 percent, mapping to the Option 2 plan design is expected to result in a slightly lower cost as the plan will be covering a slightly smaller portion of the covered charges.

Figure 9 – Bubble Chart of 41 Plans Mapped to Option 2 Health Plan

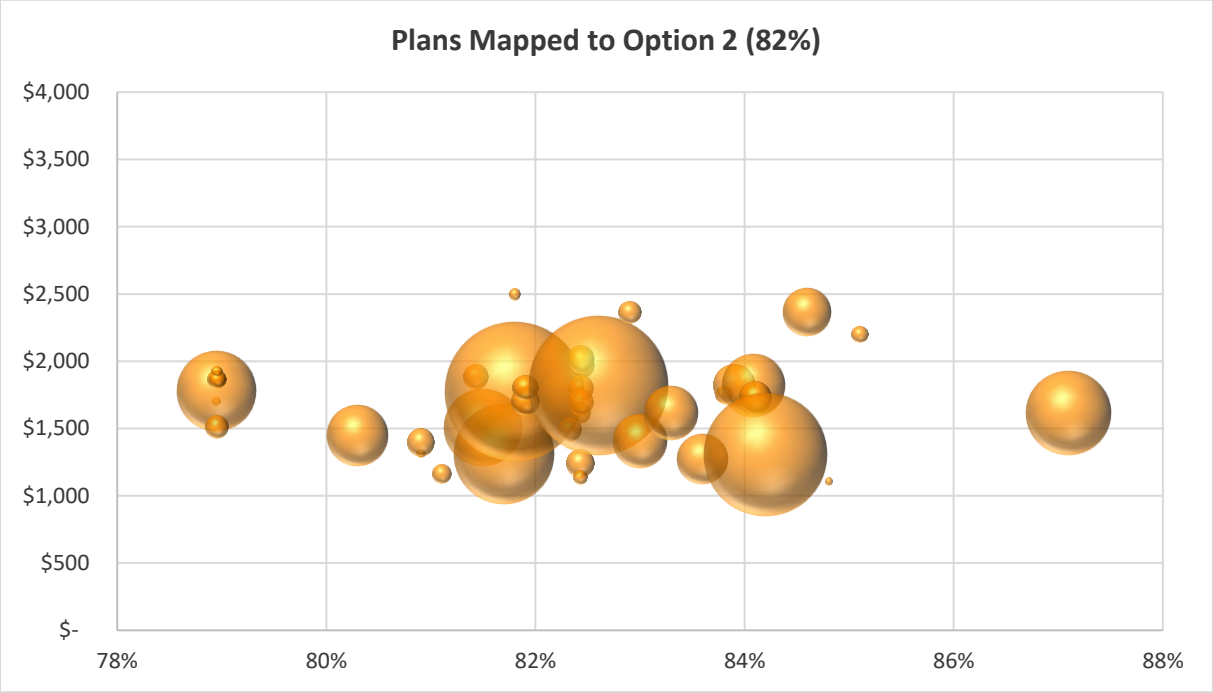
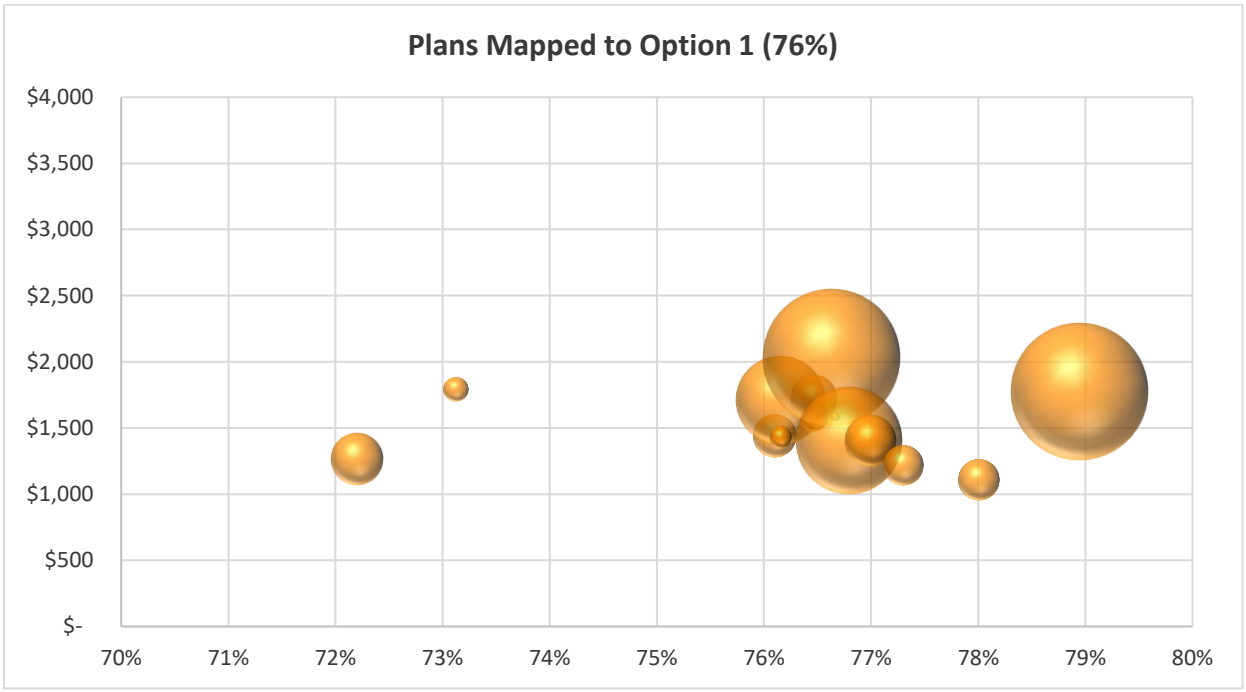


Figure 10 shows the current health plans with actuarial values below 79 percent. Each circle (or bubble) on the chart represents three dimensions of the health plan. The plans are shown by (a) composite monthly cost (i.e. the total cost before employee premiums), (b) actuarial value (i.e. the relative generosity of the coverage), and (c) size of the plan in terms of covered employees. The "bubble" size represents the relative size of the covered population. For entities whose plans have an actuarial value below 76 percent, the expected cost reflects the increase from covering a slightly larger percent of covered charges. Similarly, for the six entities with plans whose actuarial values are above 76 percent, mapping to the Option 1 plan design is expected to result in a slightly lower cost as the plan will be covering a slightly smaller portion of the covered charges.

Figure 10 – Bubble Chart of 16 Plans Mapped to Option 1 Health Plan



Model 1 will include all state entities (Group B). Participation by school districts and political subdivisions is voluntary, and therefore we assume that only those school districts and political subdivisions whose costs are currently above the projected pooled plan cost will participate, as they will recognize savings immediately. Employers are assumed to select health plan options that most closely match the current benefit plan choices and to maintain the employee contribution rates.

Pros/Cons for Model 1

Model 1 is expected to yield savings of just over 2% of the current cost. Employers would have the flexibility of selecting a plan or plans that meet their recruitment and retention needs with the knowledge that costs would be substantially more stable in future years and more predictable than under the status quo. As entities other than state agencies have the option whether to participate or not, this model would not capture the maximum amount of coordinated plan

administration savings, as some entities whose costs today are materially lower than the projected pooled plan costs may choose to remain outside the HCA.

In addition, based on the experience of Washington State where participation in the state's HCA programs is voluntary, the assumption in this model that jurisdictions and school districts with higher than average costs would participate may be too optimistic. That assumption implies that roughly half of all employers would participate—a much higher participation rate than the Washington HCA has been able to achieve over many years of operations. Lower participation would result in lower savings than this model predicts.

In addition, the state and its contractors would incur higher expenses in communicating and marketing the new programs, and would face competitive pressure from existing vendors who will have an economic stake in maintaining the status quo.

MODEL 2 (SIMILAR TO THE OREGON STATE PEBB AND OEBB MODEL)

This model utilizes two risk pools for state funded or supported public employees (Groups B, C, and D). Employers would choose from multiple benefit plan choices (e.g. the same four medical plan options described in this report, plus three dental and two vision options). Participation would be mandatory for state employees (Group B), school districts (Group C) and political subdivisions (Group D). There would be no access to the pool from individual Alaskans (Group E).

For Model 2 we quantified the financial savings compared to the status quo based on the following assumptions:

- Maximum pooled purchasing savings as a percentage of current costs as the single pool will contain all plan participants and achieve the optimal pooled purchasing savings.
- Substantial pooled plan administration savings, however as there will be two pools the administration fees will be somewhat larger than under a single pool (as claims and enrollment will need to be tracked separately for each pool), and therefore the savings from coordinated plan administration are reduced slightly.
- Entities in Groups B, C, and D will all participate upon the expiration of the current collective bargaining agreement.

First, we projected the costs under the status quo – and aggregated the extrapolated costs for all school districts, all other entities, and the total for all groups. The following table shows the projected costs by year and group.

Table 29: Status Quo Cost Projection for Schools Separately from all other entities Amounts in $Millions						
Based on 44,000 Benefit Eligible Employees	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**
Status Quo Costs						
Schools	$315.2	$333.8	$353.1	$373.3	$394.2	$415.9
Non-School Entities	$588.0	$622.7	$658.9	$696.4	$735.4	$775.8
State Entities	$328.5	$347.9	$368.1	$389.1	$410.9	$433.5
Political Subdivisions	$259.5	$274.8	$290.8	$307.3	$324.5	$342.3
Total	$903.2	$956.5	$1,012.	$1,069.7	$1,129.6	$1,191.7

Next, we projected the savings applying the plan management and pooled purchasing savings assumptions outlined above. In aggregate, we project that Model 2 would produce about $29.4 million in savings in 2021.

Table 30: Projected Savings ($) under Model 2 Amounts in $Millions						
	2017	**2018**	**2019**	**2020**	**2021**	**5-Year Savings**
Plan Management						
a. Schools	$4.0	$5.8	$7.3	$8.5	$9.0	$34.6
b. Non-School Entities	$4.3	$6.1	$5.9	$6.7	$7.1	$30.2
c. Total	$8.3	$12.0	$13.2	$15.2	$16.1	$64.8
Pooled Purchasing						
a. Schools	$0.9	$1.4	$2.4	$2.8	$2.9	$10.4
b. Non-School Entities	$0.2	$2.7	$6.9	$10.0	$10.4	$30.3
c. Total	$1.1	$4.1	$9.3	$12.8	$13.3	$40.7
Plan Management and Pooled Purchasing						
a. Schools	$4.9	$7.2	$9.7	$11.3	$11.9	$45.0
b. Non-School Entities	$4.6	$8.9	$12.8	$16.8	$17.5	$60.6
c. Total	$9.4	$16.1	$22.5	$28.1	$29.4	$105.5
Number of Employees Assumed Joining						
a. Schools	8,692	2,768	3,491	0	0	
b. Non-School Entities	1,213	8,921	18,916	0	0	
c. Total	9,904	11,689	22,407	0	0	

Table 31: Projected Savings (%) under Model 2					
	2017	2018	2019	2020	2021
Plan Management					
a. Schools	0.4%	0.6%	0.7%	0.8%	0.7%
b. Non-School Entities	0.5%	0.6%	0.5%	0.7%	0.6%
c. Total	0.9%	1.2%	1.2%	1.3%	1.3%
Pooled Purchasing					
a. Schools	0.1%	0.1%	0.2%	0.2%	0.2%
b. Non-School Entities	0.0%	0.3%	0.7%	0.9%	0.9%
c. Total	0.1%	0.4%	0.9%	1.1%	1.1%
Plan Management and Pooled Purchasing					
a. Schools	0.5%	0.7%	0.9%	1.0%	1.0%
b. Non-School Entities	0.5%	0.9%	1.2%	1.5%	1.5%
c. Total	1.0%	1.6%	2.1%	2.5%	2.5%

Pros/Cons for Model 2

Model 2 is expected to yield savings of just over 3% of the current cost for school districts and about 2% for all other entities. Employers would have the flexibility of selecting a plan or plans that meet their recruitment and retention needs with the knowledge that costs would be substantially more stable in future years and more predictable than under the status quo. As all entities would be required to participate, this model would capture close to the maximum amount of coordinated plan administration savings, as well as the maximum amount of pooled purchasing savings.

The principal disadvantage compared with Model 1 is some loss of control at the individual employer level. However, this can be substantially offset by careful design of the various plan choices that can be mapped to existing arrangements and the additional savings that this model creates for employers, participants and taxpayers.

MODEL 3 (STATE ADMINISTERED CAPTIVE)

This model evaluates the strategy of making available to all entities a state administered captive to provide stop-loss insurance. The model anticipates that the captive will set premium rates to cover the expected cost of individual and aggregate stop-loss coverage with allowance for administration of the captive, but no allowance for profit or risk charges. The availability of the captive will be limited to Groups B, C, and D, but individuals and would not be allowed to purchase coverage. Each entity can continue to select and administer its own health care benefits. For Model 3 we quantified the financial savings compared to the status quo based on the following assumptions:

- Entities that currently administer their self-insured plans without stop-loss will continue to do so.
- Entities that currently purchase fully-insured coverage will continue to do so.
- Entities that purchase stop-loss insurance will switch to the State administered captive.

- Savings, net of administration costs for the State administered captive are assumed to be 0.20% of claims costs.

It is our understanding that the Department of Administration, in its administration of the AlaskaCare Plans for active state employees and dependents and retired employees of all state funded employers and their dependents, has recently examined the issue of purchasing stop-loss coverage for the AlaskaCare plan and concluded that such a purchase was unnecessary and uneconomic. That decision is consistent with our experience with other employers whose health care plans cover as many participants or more than the plans aggregated under the AlaskaCare umbrella.

For this analysis, the AlaskaCare Plan covers 6,176 active participants and dependents, and 70,300 retired participants and dependents. For a plan of that size, in our experience stop-loss coverage would rarely if ever be purchased.

While stop-loss coverage can make sense—and indeed may be prudent and necessary for smaller employers who elect to self-insure their health care benefit program, especially given the removal of annual and lifetime limits required under the provisions of the Affordable Care Act—for large employers it is generally an uneconomic decision to purchase stop-loss insurance.

That reflects two related considerations:

- First, the larger the covered population, the smaller the fluctuations will be year to year from expected future claims experience, and the smaller the impact even a very large claim will have on the overall cost of the plan. The 2004 Society of Actuaries Large Claims Study reported that claims in excess of $500,000 represented between 0.26% and 0.43% of total claims costs in the three years of data studied.[7]
- Second, the carriers who offer stop-loss coverage are dealing with a different predictability issue. They must deal with the very large swings in expected experience when you accept liability only for the much smaller number of expected claimants who will exceed a given threshold (especially at higher specific stop-loss limits). They will necessarily structure their pricing to cover the increased risk of claims fluctuations above those limits, and generally target loss ratios not to exceed some 60% to at most 70% of earned premium. That substantial spread between premiums and expected claims reflects a number of expense items typically included in setting stop-loss premium rates, including:[8]
  - Sales expenses, both those directly incurred by the insurer and paid in the form of commissions to brokers and/or fees to third party administrators, which ordinarily are in the 10% to 15% range;
  - Underwriting and overhead expenses
  - Claims adjudication costs

[7] https://www.soa.org/experience-studies/2000-2004/research-medical-large-claims-experience-study/

Year	Claimants	Claims	Claims > $500,000	Percent of Total Cost
1997	1,241,438	$2,003,162,218	$5,128,533	0.26%
1998	1,460,854	$2,466,093,741	$5,275,949	0.21%
1999	1,591,738	$2,599,356,658	$11,178,358	0.43%

[8] http://www.ascende.com/Insight-Knowledge/Advisories-Publications/Using-a-Captive-to-Insure-Stop-Loss-Coverage-for-a-Medical-Benefit-Plan/

- Claims fluctuation margins
- Profit margin other than underwriting profits
- Contributions to surplus
- State premium taxes

Elimination of the necessity for purchasing stop-loss coverage is a not insubstantial factor in the development of potential savings for those smaller to medium-sized employers who might be aggregated under a coordinated approach to plan administration which covered all or a substantial portion of those state funded employers who now provide health benefits independently.

The potential additional scale associated with such an approach to plan administration is addressed elsewhere in this study. But the important—and we believe dispositive—point is that we concur that the DOA's analysis that resulted in the decision not to purchase stop-loss coverage for the AlaskaCare plan was a correct decision, and the analysis is only fortified by the potential expansion of covered participants under an approach which aggregates the purchasing power of all employers whose health care benefits are funded directly or indirectly by the State of Alaska.

Limited Savings from Establishing A Captive

We have quantified the potential savings that might be achieved by establishing a state-run captive, compared with the status quo. We assumed that those employers that currently self-insure without stop-loss coverage would continue to do so. Furthermore, we assumed that those entities that currently purchase fully-insured coverage would continue to do so. For all others, we assumed that the level of stop-loss coverage in place currently would not be changed, and that the State would establish premium rates for the state's captive to cover all operating costs, but with no profit or contribution to surplus. Across all public employer entities the expected savings moving from insurance company purchased stop-loss to the state's captive are estimated to be $1.0 million in 2017 and would increase to only $1.2 million in 2021.

Table 32: Projected Savings From Establishing a State Administered Captive
Amounts in $Millions

Based on 44,000 Benefit Eligible Employees	2016	2017	2018	2019	2020	2021
State sponsored captive		$1.0	$1.0	$1.1	$1.1	$1.2

Pros/Cons for Model 3

Model 3 is expected to yield savings of just over $1 million, or less than 0.1% of the current cost for all entities, compared with the status quo. This model would provide no economic benefit for those employers that are self-insured and do not use stop-loss, and only limited benefit to the entities who currently use stop-loss and purchase coverage from insurers. This model would not capture any economic savings from pooled purchasing nor from coordinated plan administration other than from the costs of stop-loss coverage. Given the level of effort needed to establish and manage a captive and the limited savings achievable, we do not recommend this model.

The model also implies that existing plan arrangements would remain in place, and thus the much greater savings projected from other models would be foregone. Particularly for Model 2, which assumes maximum participation and therefore savings, the necessity for purchasing stop-loss disappears altogether since the cost of large claims can be readily absorbed by the much larger pool of participants, just as they are absorbed now by the AlaskaCare plan.

MODEL 4 (MULTIEMPLOYER PLANS – DESIGNED TO MINIMIZE THE PPACA EXCISE TAX)

Model 4 would establish a multiemployer plan (or plans) with the initial pool of employers opting to join for all or some of their employees, and would be available to all entities including the state employees in Group B, School Districts and Political Subdivisions.

Under the Affordable Care Act, high cost plans would incur a tax of 40 percent of the excess of the cost of the health plan above the High Cost Tax threshold. As final regulations have not been issued, the estimates were based on good faith compliance with the law.

For Model 4 we quantified the expected PPACA excise taxes compared to the status quo based on the following assumption:

- Entities whose costs are projected to exceed the ACA High Cost tax threshold in 2020 are assumed to participate in a multiemployer plan. No other changes to the benefits are assumed (i.e. each employer will maintain their current health plan arrangements and employer/employee cost sharing).

The Potential Multiemployer Plan Opportunity for Alaska's Public Employer Health Plans in a Consolidated Administration Context

The Affordable Care Act (ACA) has already resulted in additional costs for all employer sponsored health benefit plans through the requirements for paying per person fees, including the Transitional Reinsurance Fee (which has now expired), and a fee for the Patient Centered Outcomes Research Institute (PCORI). These fees are now part of the base cost for health care, as is the cost associated with the requirements that preventive services must now be covered at 100 percent and that dependent children remain eligible for a parent's health care plan until age 26. Taken together, these fees and required plan changes generally amount to additive costs of about 1.5 to 2.5 percent of premiums.

A more pressing future concern is the fact that at present the impending imposition of the Excise Tax on so-called "Cadillac Plans" remains in the law. And as House Speaker Paul Ryan has stated following the decision to pull the American Health Plan Act before bringing that Act before the House of Representatives for a vote, given the political uncertainties which remain in play it is possible that the ACA will remain in effect "for the foreseeable future."[9]

The excise tax under the ACA was originally scheduled to take effect in 2018, but was delayed until 2020 by the passage in December, 2015 of the Consolidated Appropriations Act of 2016. Given the uncertain prospects of future

[9] http://www.cbsnews.com/news/no-health-care-bill-vote-ryan-obamacare-stay-foreseeable-future/

legislation that might further defer or repeal the tax, it is prudent especially for Alaska's public employers that we discuss the potential implications for sponsors of high cost health plans and set forth why we believe that if the excise tax remains in place it will be a major catalyst for the State of Alaska's public employers to consider combining plan administration in a multiemployer plan as a way of mitigating the costs that may lie ahead.

The original threshold for imposition of the tax in 2018 was $10,200 for self only coverage, and $27,500 for other than self only coverage. These tax threshold amounts are scheduled to be indexed by consumer price inflation (CPI-U) plus an additional 1 percent (i.e. CPI-U +1%) for 2018 & 2019 then CPI-U thereafter. While the changes in the thresholds can't be known now, it is reasonable to assume in estimating the future thresholds the same increases in CPI-U that were assumed in the Congressional Budget Office scoring of the ACA, which was an increase in CPI-U of 2% each year. Under that assumption, the thresholds would be projected to increase to $10,821 in 2020 for self only coverage, and $29,175 for other than self only coverage.

The determination of the tax will depend in part on the regulations to be issued by Treasury and the IRS. The IRS Notices issued to date call for adjustments to the actual costs to reflect differences in the age and gender profile of the health plan participants compared to the working population. Furthermore, the regulations include upward adjustments for non-Medicare participants between age 55 and 64. These age and gender adjustments are likely to push the thresholds up for many employers, increasing the thresholds by some 5 to 10 percent. We should note that Flexible Spending Account amounts will be added directly to the nominal cost of health care plans, as will amounts contributed toward HSAs and HRAs, which will make maintenance of these plans more problematic.

Of greatest importance in the context of this study of the potential benefits of a coordinated approach to health care plan purchasing and administration for Alaska public employer plans supported by state expenditures, there is in effect an exception to the normal thresholds that will apply to health care plans for levying the tax when such plans are provided as part of a multiemployer plan. 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. That 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.

The Potential Effect of the Excise Tax on Alaska Public Employers Who Maintain High Cost Health Plans

It is important to note first that given the high per capita health care costs of Alaska's population compared with the remaining states of the union, the excise tax will be expected to affect a much higher proportion of employer health care plans initially than will be the case in other states, and the effect will be more severe.

First, the national picture. In August 2015 the Kaiser Family Foundation published an Issue Brief on the impending effect of the tax, based on an analysis of the data from their 2015 Kaiser/HRET Survey of Employer Health Benefits. Based on the status quo (i.e., no reduction in current benefit levels) with respect to current and projected health benefit costs among their survey respondents, their data analysis projected that 16 percent of employers who sponsored health benefit plans would exceed the thresholds that trigger the tax in 2018 for at least one plan they offer, increasing to 36

percent by 2028. When the prevalence of Flexible Spending Account plans was taken into account, the percentage of employers with plans which will trigger the tax increased to 26 percent in 2018, and to 42 percent in 2028.

These data are shown in the Table from the Kaiser Issue Brief immediately below:

Table 33: High Cost Plan Tax (HCPT) Percent of Employers Offering Health Benefits with Plans that would exceed HCPT Threshold with 5% Annual Premium Growth			
Year	**Self-Only Threshold**	**Health Plan Premium, Employer Contributions to HSA, HRA**	**Health Plan Premium, Employer Contributions to HSA, HRA & FSA**
2018	$10,200	16%	26%
2023	$11,800	22%	30%
2028	$13,500	36%	42%
Source: Kaiser Family Foundation analysis			

The data we have developed in the survey of Alaska's public-sector employers that we conducted in the course of this study presents a more alarming picture. Based on the reported premiums, we show in the table below the estimated percentage of survey respondents for whom at least one of their plans would exceed the thresholds in 2020, and in 2025 and 2030. (For the purpose of the projections of the proportion of these plans exceeding the projected thresholds we have used the same factors as CBO used in scoring the Act—future increases in health care costs of 5.6% per year, and in CPI-U of 2% per year.)

Table 34: Projected Employers Exceeding Tax Threshold			
Year	**2020**	**2025**	**2030**
Percent	69%	84%	96%

Multiemployer vs. Single Employer Plans

In the context of this report, there is a particularly important distinction under PPACA between plans organized as multiemployer plans versus plans that are single employer plans or so-called multiple employer plans, for the purpose of imposing the excise tax for high cost plans.

The definition of multiemployer plans is provided in IRC § 414(f) as follows:

(1) Definition

For purposes of this part, the term "multiemployer plan" means a plan

(A) to which more than one employer is required to contribute,

(B) which is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer, and

(C) which satisfies such other requirements as the Secretary of Labor may prescribe by regulation.

Some but not all multiemployer plans are Taft-Hartley plans. In a Taft-Hartley setting the plan is governed by a board of trustees with equal numbers of representatives of management and labor.

In plans other than multiemployer plans, the cost thresholds above which the tax is assessed are separate for self only and family participants. For multiemployer plans, however, the cost threshold is set by IRC § 4980I(b)(3)(B)(ii), at the family cost level regardless of the mix of self only participants and those who cover dependents.

This multiemployer plan exception represents a major future opportunity for the State of Alaska plans which will exceed the taxing threshold in 2020 and in the future, if the plans are organized so that they meet the statutory definition of a multiemployer plan and qualify for this more favorable treatment.

The magnitude of this opportunity is illustrated in the examples on the following two pages. Example 1 shows the cost over ten years for a hypothetical single employer plan covering 1,000 total participants, the cost of which in 2020 is 1 percent over the projected thresholds for both self only ($10,821) and family ($29,175) coverage.

In Example 2, we show the same cost for a multiemployer plan assuming the same 1,000 total participants. Both examples assume that 30 percent of the participants cover self only, and 70 percent cover dependents. That would be approximately the ratio of self only to family participants we would expect in a typical plan which expressed costs on a per capita basis and did not differentiate in rates for self only versus family coverage.

Ignoring taxes, over the ten-year period 2020 – 2029 the total cost of both health care plans excluding the additional taxes would be $309.23 million, or $30,923 per participant per year.

Figure 11 - Ten-Year Projection of Single Employer Excise Tax

Alaska Study under S.B. 74
Example 1--Excise Taxes Over 10 Years if Plan Is a Single Employer Plan

		2018 CPI +1	3.0%
		2019 CPI +1	3.0%
		Indexing of Threshold	
Assumed Trend for Medical:	5.6%	2018 & 2019	CPI-U + 1%
Assumed CPI:	2.0%	Thereafter	CPI-U

	Example 1--Single Employer Plan Subject to Self Only and Family Thresholds									
Year	Self Only Cadillac Tax Threshold	Employer Plan Self Only Cost	Excess Subject to Excise Tax	Amount of Tax	Tax as % of Premiums	Family Cadillac Tax Threshold	Employer Plan Family Cost	Excess Subject to Excise Tax	Amount of Tax	Tax as % of Premiums
2020	$10,821	$10,929	$108	$43	0.4%	$29,175	$29,466	$292	$117	0.4%
2021	$11,038	$11,541	$504	$202	1.7%	$29,758	$31,117	$1,358	$543	1.7%
2022	$11,258	$12,188	$929	$372	3.1%	$30,353	$32,859	$2,506	$1,002	3.1%
2023	$11,484	$12,870	$1,387	$555	4.3%	$30,960	$34,699	$3,739	$1,496	4.3%
2024	$11,713	$13,591	$1,878	$751	5.5%	$31,580	$36,642	$5,063	$2,025	5.5%
2025	$11,947	$14,352	$2,405	$962	6.7%	$32,211	$38,694	$6,483	$2,593	6.7%
2026	$12,186	$15,156	$2,969	$1,188	7.8%	$32,856	$40,861	$8,006	$3,202	7.8%
2027	$12,430	$16,005	$3,574	$1,430	8.9%	$33,513	$43,150	$9,637	$3,855	8.9%
2028	$12,679	$16,901	$4,222	$1,689	10.0%	$34,183	$45,566	$11,383	$4,553	10.0%
2029	$12,932	$17,847	$4,915	$1,966	11.0%	$34,867	$48,118	$13,251	$5,300	11.0%
	Total Excise Taxes, 2020 - 2029		Self Only	$9,157				Family	$24,687	
	Compound Annual Increase in Taxes, 2020 - 2029			52.8%		Compound Annual Increase in Taxes, 2020 - 2029			52.8%	
	Total Assumed Participants			300		Total Assumed Participants			700	Grand Total
	Total Taxes, 2020 - 2029			$2,746,979		Total Taxes, 2020 - 2029			$17,280,833	$20,027,812
	Total Premiums, 2020 - 2029			$42,414,118		Total Premiums, 2020 - 2029			$266,820,843	$309,234,961
						Excise Taxes as % of Premiums, 2020 - 2029				6.48%

Figure 12 - Ten-Year Projection of Multiemployer Excise Tax

Alaska Study under S.B. 74
Example 2--Excise Taxes Over 10 Years if Same Plan Is Organized as Part of a Multiemployer Plan

		2018 CPI +1	3.0%
		2019 CPI +1	3.0%
		Indexing of Threshold	
Assumed Trend for Medical:	5.6%	2018 & 2019	CPI-U + 1%
Assumed CPI:	2.0%	Thereafter	CPI-U

	Example 2--Multiemployer Plan Subject Only to Family Threshold--Assumes 70% of Participants Have Dependents Coverage								
Year	Self Only Cadillac Tax Threshold	Employer Plan Self Only Cost	Excess Subject to Excise Tax	Family Cadillac Tax Threshold	Employer Plan, Family Cost	Blended Cost, 30% Self Only, 70% Family	Excess Subject to Excise Tax	Amount of Tax	Tax as % of Premiums
2020	N/A	$10,929	N/A	$29,175	$29,466	$23,905	$0	$0	0.0%
2021	N/A	$11,541	N/A	$29,758	$31,117	$25,244	$0	$0	0.0%
2022	N/A	$12,188	N/A	$30,353	$32,859	$26,658	$0	$0	0.0%
2023	N/A	$12,870	N/A	$30,960	$34,699	$28,151	$0	$0	0.0%
2024	N/A	$13,591	N/A	$31,580	$36,642	$29,727	$0	$0	0.0%
2025	N/A	$14,352	N/A	$32,211	$38,694	$31,392	$0	$0	0.0%
2026	N/A	$15,156	N/A	$32,856	$40,861	$33,150	$294	$118	0.4%
2027	N/A	$16,005	N/A	$33,513	$43,150	$35,006	$1,493	$597	1.7%
2028	N/A	$16,901	N/A	$34,183	$45,566	$36,966	$2,783	$1,113	3.0%
2029	N/A	$17,847	N/A	$34,867	$48,118	$39,036	$4,170	$1,668	4.3%
						$309,235		$3,496	

Total Assumed Participants	1,000	Grand Total
Total Taxes, 2020 - 2029	$3,496,399	$3,496,399
Total Premiums, 2020 - 2029	$309,234,961	$309,234,961
Excise Taxes as % of Premiums, 2020 - 2029		1.13%

As the examples show, there is a significant advantage under PPACA for multiemployer plans, both in deferring the date at which the tax will be imposed and substantially mitigating the effect of the tax indefinitely over time.

For the hypothetical single employer plan in Example 1, the tax is levied immediately for the 2020 plan year, since the example assumes that the plan is 1 percent above the cost threshold for both self only and family coverage as of that year. The tax in the first year for each self only participant is $43; by year ten (2029) the tax has increased to $1,966. Expressed as a percentage of premium, the tax grows from 0.4 percent of premiums in 2020 to 11.0 percent of premiums in 2029.

The same growth and order of magnitude for the tax increment applies for family coverage. The tax in 2020 is $117, or the same 0.4 percent of family premiums; by 2029 the tax has increased to $5,300 per family participant, or the same 11.0 percent of family premiums that applies to the self only premiums.

Over the entirety of the ten-year period illustrated in Example 1, the total taxes add just over $20 million to this hypothetical employer's health care expense, against a total cost excluding the tax of $309.23 million. The taxes thus represent an additional 6.5 percent burden over and above this employer's total health care cost, or just over $2,000 per year per participant.

In projecting future costs in both examples, we have used the same assumptions used by the Congressional Budget Office in preparing revenue and cost estimates for PPACA, namely that health care costs would increase over the period at a rate of 5.6 percent annually, and CPI would increase over the period at 2.0 percent annually.

Example 2 shows the much lesser tax burden created when this same calculation is done assuming the same 1,000 participants, with 700 participants covering dependents and 300 covering self only in a multiemployer plan setting. The blending of the self only and family costs produces a per capita cost in the first year of $23,905 per participant, well below the projected family threshold under the statute of $29,175 for 2020. Using the CBO assumptions, the multiemployer plan with the same underlying health care costs and distribution of self only and family participants will not incur additional tax cost until 2026, seven years into the period. And the total tax burden over the last four years of the ten-year period will be $3.5 million, versus the $20 million in tax cost incurred by a single employer plan with the same health care costs and mix of self only and family participants.

And as we pointed out earlier, a very large difference in tax liability will pertain indefinitely over time. In addition, since the tax can be avoided only by reducing benefit levels, it is obvious that this lesser tax burden for multiemployer plans compared with single employer plans will require less dramatic reductions in benefits to further delay the onset of the tax, and reduce the amount of the tax liability, than would be required if the plan were a single employer plan.

While it is beyond the scope of this report to examine in depth the legal requirements and other considerations that will be involved in determining whether to organize Alaska's public employer plans along those lines that would capture this benefit of multiemployer plan status, it is obvious that this particular approach to restructuring health care benefits for those employers is among those steps that could yield substantial savings to the State and to participants and taxpayers over time, assuming that the current statutory requirements imposing this tax remain in place.

Table 35 shows the estimated Excise Taxes payable under both the single-employer plan thresholds and the multiemployer plan thresholds. Use of the multiemployer thresholds significantly reduces the taxes.

Table 35: Estimated Excise Tax			
Estimated Excise Tax Threshold Under Single Employer Plan and Multi-Employer Plan Status			
Year	**2020**	**2025**	**2030**
Estimated Single-Employer Tax	$44.2	$101.0	$197.4
Estimated Multiemployer Employer Tax	$14.8	$50.2	$101.0
Estimated Savings	$29.4	$50.8	$96.4

Summary

The expected taxes payable in 2020 with single-employer thresholds is $44.2 million, and with multiemployer thresholds it would be $14.8 million. Therefore, using a multiemployer plan is projected to save $29.4 million in 2020. Table 35 shows the projected savings for 2020 and 2021.

Table 36: Projected Savings From Establishing Multiemployer Plans						
In $Millions						
Based on 44,000 Benefit Eligible Employees	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**
Estimated PPACA Excise Tax savings		N/A	N/A	N/A	$29.4	$31.2

Pros/Cons for Model 4

Assuming no changes in current law, Model 4 will reduce the growth in costs due to payment of excise taxes by over $29 million in 2020, the first year the tax is applicable. This model could be adopted in conjunction with either Models 1 or 2, and applied to each of the health plans administered by the HCA. Participants in the HCA would therefore benefit from both the coordinated plan administration & pooled plan purchasing savings associated with being a participant in a larger group health plan as well as minimize the amount of excise taxes payable.

To avoid equity issues among participating employers would require adopting the multiemployer plan model at the outset only for those employers who were above or very close to the thresholds for imposing the tax, and accepting new entrants as additional participating employers approached those thresholds.

Finally, the uncertain future of the efforts currently under way in the Congress to pass new health care legislation, including in the American Health Care Act of 2017 (H.R. 1628) a further delay in the effective date for this tax to 2025, makes a wait and see posture appropriate at this time.

MODEL 5 (PUBLIC / PRIVATE EXCHANGE MODEL)

This model would establish a single risk pool open to all groups, including plans covering state employees, school districts, political subdivisions and individual Alaska residents who want to purchase individual health insurance coverage. The risk pool would include the same multiple benefit plan choices (e.g. the four medical plan options

described in this report, plus three dental and two vision options), and participation would include all state employees with other groups that opt to participate.

For Model 5 we quantified the financial savings/ (costs) compared to the status quo based on the following assumptions:

- Maximum pooled purchasing savings as a percentage of current costs as the single pool will contain a sufficiently large number of plan participants to optimize the purchasing savings.
- Maximum pooled plan administration savings as the single pool will contain a sufficiently large number of plan participants to achieve the lowest possible plan administration fees.
- Assume that all state employees will participate in the public/private exchange pool (Group B)
- Assume that only those school districts (subset of Group C) and political subdivisions (subset of Group D) whose costs are currently above the projected pooled plan cost will participate.
- Assume that individual Alaskans will participate if the premium rate is lower than the rate quoted in the individual insurance marketplace for a plan of equivalent value.

The four health care plans are projected to have the following composite rates, ranging from $1,507 for the lowest value plan to $1,842 per employee per month for the highest value plan. The Single Premium rate was estimated to be 60 percent of the composite rate.

Table 37: Rates by Plan Option

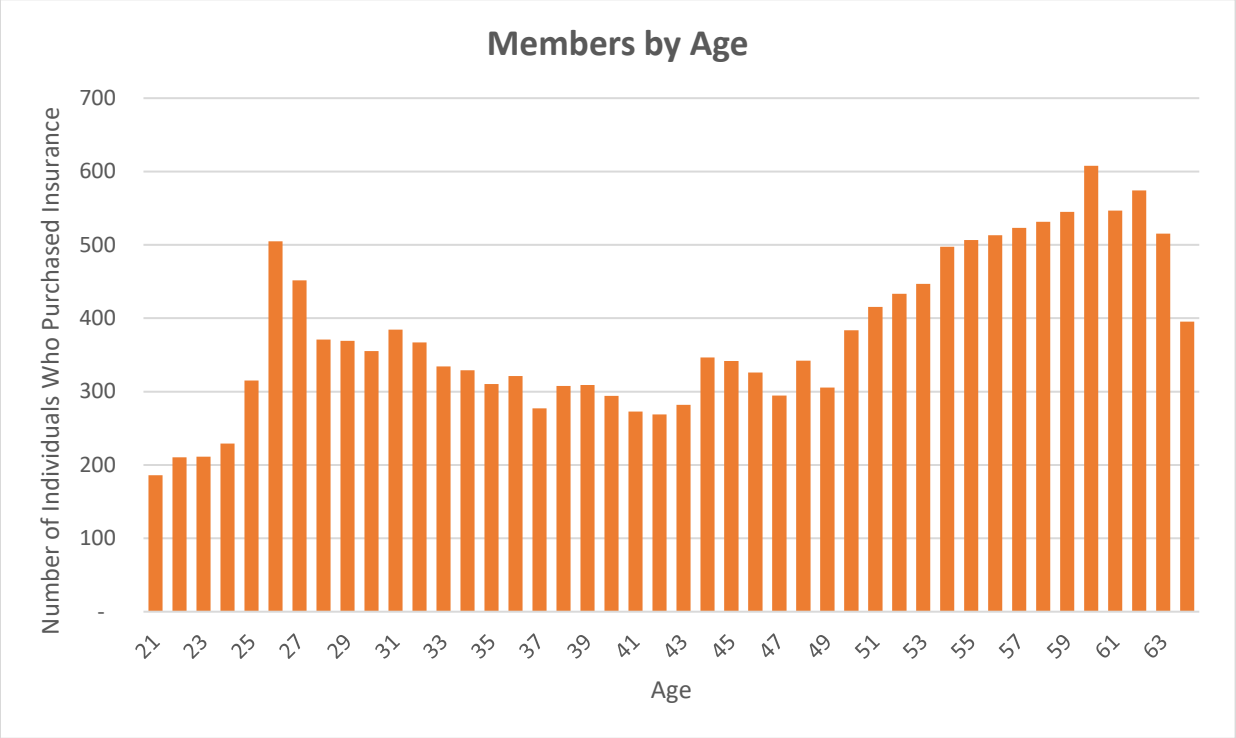
	Composite Rate	Actuarial Value	Single Premium Rate
Option 1	$1,507	76%	$904
Option 2	$1,633	82%	$980
Option 3	$1,759	89%	$1,056
Option 4	$1,842	94%	$1,105

Based on marketplace individual insurance premium rates[10], individuals not eligible for a PPACA subsidy whose premium rate is above the HCA plan rates are assumed to purchase individual coverage in the HCA. The pooled premium rate of $980 per month for Option 2 plan is expected to fully cover the cost for an individual age 39. For individuals under age 39, the HCA will receive more in premiums than is expected to be needed to cover the claims. For individuals over age 39, the cost of the claims is expected to exceed the premium received.

The distribution of the number of individuals by age was taken from the actual 2015 enrollment, as shown in the following chart.

[10] Source: https://www.healthsherpa.com/

Figure 13 - Members by Age



***Source**: Alaska Division of Insurance*

Table 38 illustrates the projected costs or savings vary based on how many individuals choose to obtain coverage in the HCA. The column labeled "100%" assumes that all individuals whose marketplace age-based insurance premium is higher than the pooled HCA rate would choose to purchase coverage under this model. The 100% assumption translates into just over 10,000 individuals. As the age-based claims cost for these individuals is projected in aggregate to exceed the pooled premium rate, expanding the pool to cover individuals would increase the cost to the HCA by $57.1 million. In aggregate, we project that the pooled purchasing and plan management savings accruing to the entities would be $5.9 million in 2017, increasing to $25.4 million in 2021.

Table 38: Projected Savings (Cost) Under Public Private Exchange in 2017 **In $Millions**				
Percentage of Individuals Currently Buying Individual Insurance Who Are Assumed to Purchase Coverage in the HCA When Doing So Results In a Lower Cost to the Individual				
Percentage Assumed to Purchase Coverage in the HCA	100%	75%	50%	25%
Enrollment[11]	10,819	8,114	5,410	2,705
Cost to HCA ($M)	$57.1	$42.8	$28.6	$14.3
Pooled Savings (Table 28, Item 9)	($5.9)	($5.9)	($5.9)	($5.9)
Net Financial Cost (Savings) ($M)	$51.2	$36.9	$22.7	$8.4

[11] Based on the 2015 individual insurance enrollment data, there were 10,819 individuals age 39 or older. Assuming 25% enrollment in the HCA, there would be 2,705 individuals obtaining coverage.

Table 39: Projected Savings (Cost) Under Public / Private Exchange Model In $Millions Assuming 50% of Individuals Currently Buying Individual Insurance Purchase Coverage in the HCA When Doing So Results In a Lower Cost to the Individual					
	2017	**2018**	**2019**	**2020**	**2021**
Net Financial Cost (Savings) ($M)	$22.7	$18.1	$13.3	$9.5	$10.2

Pros/Cons for Model 5

A fundamental problem with the public/private exchange model is that individual purchase of coverage on a participant pay all basis cannot overcome the adverse selection issue. Regardless of where rates and plan provisions are set the nominal rates will be insufficient to cover the emerging claims costs. The pooled claims rates for public employees are expected to be more favorable than the general population for a number of reasons, including the fact that employment is a selective criterion: only those individuals fit for work will be hired, whereas non-working individuals will be able to purchase coverage on the public/private exchange.

Given the size of the individual health insurance enrollment in Alaska, even if only a portion of those eligible purchase individual coverage through the HCA, the costs incurred by the HCA from covering these individuals (i.e. claims less premiums collected) would likely be large enough to increase the average cost of the HCA program and more than offset pooled savings. Increases to the cost of the HCA program would reduce the likelihood of voluntary participation which would therefore limit the ability of the HCA to achieve the full benefits of pooled purchasing. The costs incurred by covering these individuals (i.e. claims less premiums collected) would increase the average cost of the HCA coverage, reducing the likelihood that the participation would be large enough to achieve the full benefits of pooled purchasing.

A public/private exchange model could create a backstop or safety net for individuals if there is no availability of coverage through the ACA marketplace. However, a particularly important point is that the individual marketplace offering would have to comply under current law with all requirements for an exchange program under the provisions of the Affordable Care Act in order to maintain eligibility for Alaskans for the federal subsidies provided by the Act for low income participants. Without those subsidies costs to individual participants would increase markedly for those individuals currently purchasing health care coverage under the state's existing exchange program.

PROPOSED BENEFIT RULES FOR THE ALASKA HCA

The following proposed benefit rules are designed to promote certain policy goals for the HCA, including premium rate stability, flexibility for employers in meeting their recruitment and retention needs, and optimizing the cost for health care delivery by the HCA.

1. Employers that participate in the Alaska HCA can choose to provide medical and prescription drug coverage, dental coverage, vision coverage, or a combination of the three. For each line of coverage chosen, one plan design can be offered to employees, or two or more plan choices may be offered.
2. The benefits available through the HCA will only be available to employees who work an average of 30 hours per week, consistent with the guidance offered employers under the Patient Protection and Affordable Care Act..
3. Dependent spouses who are eligible for medical or supplemental benefit coverage through his or her own employer must take his or her employer's coverage as his or her primary coverage regardless of any employee contribution the spouse must pay and regardless of whether the spouse had been offered an incentive to decline such coverage
4. Participating employers may not offer benefit programs that compete with the benefits offered through the HCA.
5. The rates set by the Alaska HCA will be designed to cover the long-term cost (i.e. claims plus all administration fees and cost to administer the HCA) of the health plan options, taking into consideration the demographic and health status characteristics of the enrollees in each plan.
6. The rates set by the Alaska HCA will include the benefit options chosen (i.e., medical, dental, and/or vision, etc.).
7. The HCA will pay claims and administrative fees directly to the carriers and employers will pay monthly rates to the HCA.
8. Employee contribution rates, which are collected via payroll contributions, will remain the decision of the employer, subject to any collective bargaining agreements. However, employee contributions must vary by tier (i.e., individual, family, etc.).
9. Rules 9 and 10 will apply only if Model 1 were adopted—participation by an employer is voluntary. If an employer elects to participate in the HCA, they must continue to participate for the entire 12 months of the plan year in which they enroll.
10. Employers will be allowed to leave the HCA at the end of a plan year but a 60-day written notice will be required and all accumulated reserves will be forfeited. If an employer decides to leave the HCA, they will not be able to participate again for five years. Rates applied to employers re-joining will include a 10 percent surcharge in the first year.
11. Alternatively if participation by employers is mandatory, they must join the HCA plans at the earliest date possible, immediately for non-bargaining employees and at the expiration of the current bargaining agreement for bargaining employees.

ACTUARIAL CERTIFICATION

The Department of Administration retained PRM Consulting Group to conduct this feasibility study. The study includes determinations of health plan actuarial values as well as estimates of expected savings and costs under a range of projected pooled plan administration arrangements. The study has been conducted in accordance with generally accepted actuarial principles and practice. The actuarial assumptions and methods employed in the study have been selected by PRM.

The work has been performed in accordance with Actuarial Standards of Practice (ASOP), including ASOP 23 – Data Quality. The study is based on information gathered from survey participants who voluntarily submitted health plan details, including claims and administrative expenses or premium cost, enrollment information, and health plan design information. The data was scrutinized for consistency and reasonableness and adjusted where information submitted appeared unreasonable or inconsistent with plan documents or other supporting information. For example, survey participants were asked to describe what percent of covered hospital charges their plan paid. A response of 20% was examined and found to be inconsistent with the plan document, which described the member coinsurance as 20%. The survey data was reviewed for these types of inconsistencies and corrected. A large volume of data was collected for the study from all types of employers including small fully-insured to large self-funded health care plans in all regions of Alaska. PRM also undertook a data validation process. During this process, a summary of key information for each entity was prepared and was sent back to those entities. This gave each participating entity an opportunity to correct any data. We then used the updated data in the analysis. The data validation process documented that the original data was very accurate. In aggregate the validated data total claims costs was adjusted by 0.2%. While the data was not perfect, there was sufficient quality data to support the analysis and conclusions in this report.

The results shown in this report are reasonable actuarial results. However, a different set of results could also be considered reasonable actuarial results. The reason for this is that the selection of the assumptions used requires professional judgment from the actuary. Thus, reasonable results differing from those presented in this report could have been developed by another actuary.

The actuary certifying to the study findings and conclusions of the actuarial analysis is a member of the Society of Actuaries and other professional actuarial organizations, and meets the General Qualification Standards of the American Academy of Actuaries for purposes of issuing Statements of Actuarial Opinion.

Adam J. Reese

Adam J. Reese, FSA, FCA, MAAA, EA
August 2017

NECESSARY STEPS FOR IMPLEMENTATION

Outlined below are the key steps for implementing a Health Care Authority that would provide health care coverage to employees of state agencies, School Districts, and political subdivisions.

IMPLEMENTATION

1. Develop legislation establishing a Health Care Authority
   a. Should establish the administrative structure needed to implement the core functions
   b. Should contain authority needed for both short-term implementation as well as scope for longer-term capabilities

2. If participation is mandatory, include conditions under which each entity would be required to join the HCA (e.g. upon expiration of CBA for bargaining employees)

3. Vest authority on specific details of plan design with the HCA
   a. Include provisions for choice
   b. Allow for future changes in health insurance delivery systems

4. HCA tasked with preparing a timetable for implementation, conforming to the enabling legislation.

5. HCA develop range of health care plan options

6. HCA negotiate health coverage with health care providers and insurers throughout the state

7. HCA establish the organizational framework needed to administer the programs:
   a. Director's office
   b. Enrollment verification and processing
   c. Claims administration section
   d. Section to monitor and audit health care providers and health insurance contracts
   e. Call center

STAKEHOLDER FEEDBACK

The completion of this study was made possible by the numerous stakeholders who took the time to discuss their concerns and ideas, share their knowledge, and respond to survey questions. The comments made by the stakeholders were generally consistent and are outlined below.

COST OF HEALTH CARE

The stakeholders indicated that the cost of health care in Alaska is unaffordable and is increasing to unsustainable levels. They view doing nothing and maintaining the status quo as not acceptable. Health care costs are increasing at a faster pace than the income of Alaskans. Some stakeholders believe that contributing factors to the high cost of health care are (a) lack of competition, (b) specialists are not ready to move away from fee-for-service, and in some cases, are unwilling to contract with claims payers on any basis, (c) doctors moved to Alaska to "avoid" managed care, and (d) that doctors work for themselves rather than the hospitals or the insurance companies, and therefore have greater control over the price that is charged for the services they provide.

Ideas and suggestions offered to reduce the cost of health care include: creating a managed care structure with a value-based provider reimbursement strategy, and introducing proactive case management services where members would be contacted before rather than after a major medical event occurred.

MEDICARE REFERENCE PRICING AND BALANCE BILLING

Several stakeholders commented on the level of fees relative to Medicare rates (e.g. cardiologist rates above 500% of Medicare, neurologists above 450% of Medicare and orthopedic surgeons' fees above 300% of Medicare rates). While the use of reference pricing based on Medicare at lower levels (e.g. 125% to 200%) may help manage costs, stakeholders commented that balance billing placed a high financial burden on plan members. One stakeholder proposed that balance billing be restricted legislatively.

TRAVEL BENEFIT

The general provider networks are considered to be small and access to specialists is limited compared to the continental United States. In response, some individuals have chosen to seek care out of the area or out of state. Although a travel benefit program may be seen as competing with hospitals and providers, stakeholders using a travel benefit have experienced significant savings from these programs and recommend incenting members to utilize them and seek care where cost is lower and the perception is that quality is equal or better. In order to increase utilization, any travel benefit program that is implemented should pay first dollar rather than requiring members to pay out-of-pocket first and be reimbursed. Stakeholders mentioned that follow-up care is sometimes not readily available for procedures performed out of the area or out of state but did not have recommendations on how to solve this issue.

PRESCRIPTION DRUG COALITION

Several stakeholders mentioned that they already participate in a prescription drug purchasing coalition and that it had reduced the cost of their pharmacy program.

WELLNESS

Numerous comments were made on the advantages of a fully funded wellness program. Some saw their wellness programs as having a dual benefit – providing additional services (e.g. free flu shots) and helping to keep cost increases to a minimum. Stakeholders mentioned several approaches for wellness including: incentivizing healthy behavior, monthly newsletters, paid wellness coordinator, weight watchers-type programs and smoking cessation programs.

RECRUITMENT AND RETENTION

Several school districts mentioned the use of "better" health care plans as an incentive to attract teachers. Others mentioned that it would be preferable for benefits not to be included in bargaining. Several stakeholders mentioned the desire for flexibility in health benefits.

HEALTH BENEFITS COMMITTEE

Some of the stakeholders that have implemented benefits committees commented that they were working well and introducing new ideas to address emerging costs. Some committees meet as frequently as quarterly and are seen as an effective way to manage the plan.

EVOLVING HEALTH CARE COVERAGE

Several entities commented that the information provided (i.e. 2016 plan designs and 2016 costs) will not be representative of their costs in 2017 as they have undertaken major reforms and changes to the level of benefits and/or premium cost-sharing.

ACHIA

The operations of the Alaska Comprehensive Health Insurance Association were examined as part of the study to assess the feasibility of using the existing ACHIA organizational structure as a platform for a future Health Care Authority. ACHIA currently administers under 150 participants and serves the goal of providing coverage to individuals who would not otherwise be able to obtain health insurance. While its operation could increase in scale to accommodate a larger number of covered lives (as it covered over 500 participants just a few years ago), it is not well suited to expand over 100-fold to cover the multiple entities and tens of thousands of covered lives that would likely participate in a Health Care Authority.

HEALTH CARE AUTHORITY

In regard to the creation and administration of an HCA, stakeholders suggested the following:

- The HCA should include at least one representative from each set of entities (i.e., schools, state, political subdivisions, hospitals, etc.).
- The staff should consist of claims payers, plan administrators and individuals to answer members' questions.
- The HCA should be insulated from politics and be administered with sufficient autonomy.
- Health care best practices and current trends should be considered when implementing benefit programs.
- A prescription drug coalition should be created.

APPENDICES

APPENDIX A

List of organizations interviewed

Health Care Authorities

Oregon Health Care Authority
Washington Health Care Authority

Departments

Dept. Health & Social Services
Division. of Insurance
Division. of Risk Management
Dept. of Education and Early Development
Dept. of Administration

Health Insurance Companies & Brokers

Aetna
Bridge Health
Moda
Northrim Benefits Group
Premera
Wilson Agency

Other Interviewees

AeHN
Alaska Association of Health Underwriters
Alaska Association of School Boards
Alaska Association of School Business Officials
Alaska Behavioral Health Association
Alaska Comprehensive Health Insurance Association
Alaska Council of School Administrators
Alaska Dental Society
Alaska e Health Network
Alaska Hospitalist Group
Alaska Medical Group Management Association
Alaska Mental Health Board/ABADA/Suicide Prev. Council.
Alaska Mental Health Trust Authority
Alaska Municipal League
Alaska Native Tribal Health Consortium
Alaska Nurse Practitioners Association
Alaska Primary Care Association
Alaska Radiology Associates
Alaska State Hospital & Nursing Home Assn.
Alaska State Legislative Finance
American College of Emergency Physicians - AK Chapter
Anchorage Economic Development Corporation
Anchorage Neighborhood Health Center
Anchorage School District
ASEA/AFSCME Local 52
Central Peninsula Hospital
City and Borough of Juneau
Department of Health and Social Services-State Health Information Technology Office
Effective Health Design
Fairbanks North Star Borough
Fairbanks North Star Borough Schools
Geneva Woods Pharmacy
Green Mountain Care Board
Health Care Cost Management Coalition
Juneau School District
Kenai Peninsula Borough
Ketchikan Gateway Borough
Ketchikan Gateway Borough Schools
Lower Kuskokwim School District
Matanuska-Susitna Borough
Mat-Su Health Foundation
Mat-Su School District
Municipality of Anchorage
National Education Association- AK
Public Safety Employees Association
University of Alaska

APPENDIX B

The table below lists the actuarial values for entities that provided sufficient health plan information for the plan to be evaluated. Some entities offer multiple plans. For each entity, PRM developed the "actuarial value" of each plan. The actuarial value is a measure of the relative generosity of coverage. The larger the actuarial value, the greater the proportion of covered charges that will be paid by the plan, and consequently, the smaller the portion of covered charges that are the responsibility of the plan participant.

The actuarial value is the ratio of the portion of the covered charges that are paid by a health plan to the total covered charges for a given set of claims and given population. Therefore, if a plan paid 100% of all covered charges it would have an actuarial value of 100%. If a plan had no deductible, paid 90% of all covered charges (both in-network and out-of-network) and had no limit to the annual out-of-pocket that a participant could pay, the actuarial value would be 90%. The actuarial values shown in the table below were developed using a health actuarial software tool developed by Windsor Strategies.

A consistent set of assumptions were used in valuing all plans.

Table 40: Actuarial Values by Plan

Entity	Actuarial Value
Alaska Gas Line Development Corporation	96.7%
Alaska Gateway Schools	82.4%
Alaska Housing & Finance Corp	94.9%
AlaskaCare	
Economy	86.2%
Standard	91.9%
Aleutian Region Schools	92.9%
Aleutians East Borough Schools	78.0%
Anchorage Schools	
PPO	82.6%
CDHP	80.3%
AEA	79.0%
ASEA/AFSCME Local 52	
Plan A	93.3%
Plan B	93.3%
Plan C	Up to 20%[12]
Plan D	72.0%
Bering Strait Schools	97.5%
Bristol Bay Borough	82.9%
Bristol Bay Borough Schools	82.4%

[12] Plan C is only available to individuals who also have coverage under another plan. Spouses of ASEA /AFSCME Local 52 employees will receive coverage on a primary basis from the other plan, and this plan will cover the spouse's deductibles and coinsurance payments up to a maximum of 20%. If, for example, the spouse's plan has an actuarial value of 90%, the value from this plan can be no more than 10%.

Table 40: Actuarial Values by Plan	
Entity	**Actuarial Value**
Chatham Schools	79.0%
Chugach Schools	83.8%
City and Borough of Juneau	87.0%
City and Borough of Sitka	83.9%
City and Borough of Wrangell	76.1%
City of Bethel	92.1%
City of Chignik	92.9%
City of Delta Junction	92.9%
City of Dillingham	77.3%
City of Egegik	92.9%
City of Homer	77.0%
City of Kaktovik	92.9%
City of Kodiak	92.9%
City of Nenana	92.9%
City of Palmer	91.2%
City of Saint Mary's	92.9%
City of Saint Paul	81.1%
City of Saxman	92.9%
City of Seldovia	92.9%
City of Soldotna	80.9%
City of Tanana	92.9%
City of Unalaska	95.3%
City of Valdez	95.4%
City of Wasilla	
Plan A	88.6%
Plan 502	81.9%
Teamster-Employer Welfare Trust	84.8%
Copper River Schools	82.4%
Cordova City Schools	82.4%
Craig City Schools	82.4%
Delta/Greely Schools	
Plan BB	81.4%
HDHP	76.2%
Plan EB	76.5%
Denali Borough	94.0%
Denali Borough Schools	82.4%
Dillingham City Schools	81.9%
Fairbanks North Star Borough	89.4%
Fairbanks North Star Borough Schools	
Plan A	93.8%

Table 40: Actuarial Values by Plan	
Entity	**Actuarial Value**
Plan B	83.3%
Galena City Schools	84.6%
Haines Borough	
Yellow Plan	76.8%
Blue Plan	87.1%
Haines Borough Schools	79.0%
Hoonah City Schools	88.0%
Hydaburg City Schools	79.0%
Juneau Borough Schools	
JEA Plan	84.1%
Plan CA	79.0%
Plan EA	76.5%
Plan FB	76.6%
JESS Plan	83.0%
Kake City Schools	73.1%
Kenai Peninsula Borough	90.0%
Kenai Peninsula Borough Schools	91.2%
Ketchikan Gateway Borough	93.2%
Ketchikan Gateway Borough Schools	86.0%
Klawock City Schools	85.1%
Kodiak Island Borough	88.1%
Kuspuk Schools	93.3%
Lake and Peninsula Borough Schools	97.4%
Local 71	
Yellow Plan	76.8%
Blue Plan	87.1%
Lower Kuskokwim Schools	94.0%
Lower Yukon Schools	93.0%
Matanuska-Susitna Borough	88.8%
Mat-Su Borough Schools	
Plan CB	79.0%
Plan FB	76.6%
Plan AB	82.4%
HDHP	76.2%
Municipality of Anchorage	
$500 Deductible Plan	87.5%
Co-Pay 1000 Plan	86.5%
HDHP	81.5%
Nenana City Schools	82.4%
Nome Public Schools	92.9%

Table 40: Actuarial Values by Plan	
Entity	**Actuarial Value**
Northwest Arctic Borough Schools	94.1%
Petersburg Borough	84.1%
Petersburg Borough Schools	76.5%
Pribilof Schools	82.4%
Sitka Borough Schools	83.6%
Southeast Island Schools	82.4%
Southwest Region Schools	72.2%
Tanana Schools	80.9%
Unalaska City Schools	95.5%
University of Alaska	
HDHP	81.8%
750 Plan	84.2%
CDHP	81.7%
Valdez City Schools	95.4%
Wrangell City Schools	79.0%
Yakutat City Schools	81.8%
Yukon-Koyukuk Schools	93.2%

A description of the methodology and assumptions is included below.

ACTUARIAL METHODS AND ASSUMPTIONS USED FOR MEASURING THE HEALTH PLAN ACTUARIAL VALUES.

The actuarial value of a health plan is a measure of the relative breadth of coverage (generosity) in terms of the share of the cost of covered services that are paid by the plan. For purposes of this analysis, the following assumptions and approaches were used consistently in determining the actuarial value of each of the health plans. Actuarial values were determined using the Windsor Strategies actuarial software. The underlying claims costs in the Windsor Strategies actuarial software dataset were projected to 2018 using health care cost trend rates. The underlying claims costs were adjusted to reflect regional costs and industry utilization. The geographic factors used to reflect regional costs were determined using a parameter based on 3-digit Alaska zip code (995). The industry classification factor used to reflect utilization was based on the classification of "General Government, Not Elsewhere Classified". A standard demographic population was used to ensure consistency, based on an average age of 40 and 55 percent of the covered lives assumed to be male. These calibrations resulted in a lower proportion of pharmacy claims as a percent of the total than was observed in the claims data provided by some of the Alaska entities, therefore a utilization adjustment was applied to the prescription drugs to increase the weight of prescription drug costs to align more closely with the observed percentage of total claims attributable to prescription drugs.

Network Utilization

As noted in the Phase I Report, over 90 percent of the primary (most prevalent) health plans offered are either PPO plans or POS plans. Some seven percent of employers offer a High Deductible Health Plan as their primary plan and about one percent of health plans valued were fee-for-service (traditional indemnity) plans.

The key features of a health plan that impact the actuarial value are the size of the plan's out-of-pocket limit, the coinsurance percentage paid by the plan, and the size of an annual deductible, or per admission copay if required. When comparing a PPO plan to a fee-for-service plan, the actuarial value can consider differences in the plan features where services are obtained from both network providers and non-network or non-preferred providers. A network utilization assumption is therefore needed to assess these differences and is also needed to compare two PPO plans where both have the same level of in-network cost-sharing but have differences in the out-of-network or non-preferred provider cost-sharing.

A common set of assumptions was used to determine the actuarial values for all plans, including an assumption that 95 percent of services would be adjudicated as in-network claims. As noted in the Phase I report, some plans experienced a higher out-of-network utilization rate than 5 percent as some specialists have not contracted with any insurance carriers. Given the higher observed out-of-network usage, PRM examined the impact on actuarial values using alternative network usage assumptions. PRM examined several of the plan designs that cover large numbers of employees and found that changing the network usage assumption had a negligible impact on the actuarial value. Even for a plan with a high out-of-network out-of-pocket maximum (e.g. over $7,000 individual / $14,000 family), the change in actuarial value from using a 95% in-network assumption to a 70% in-network assumption was less than 1%. To illustrate the impact that alternative network usage assumptions have on the plan's actuarial value, we have prepared the following table with details for two types of services.

Figure 14 – Alternative Network Usage Assumptions

In-Network Usage		**95%**	**70%**	**Difference**	**% diff**
Inpatient Med/Surg					
	Average Cost per Service	$7,658	$9,148	$1,490	19%
	Expected Cost PMPM	$132.92	$160.21	$27	21%
	Expected Plan Payment PMPM	$117.15	$145.14	$28	24%
	Percent paid by the plan	88.1%	90.6%	2.5%	3%
Outpatient Other					
	Average Cost per Service	$1,061	$1,261	$200	19%
	Expected Cost PMPM	$98.65	$116.51	$18	18%
	Expected Plan Payment PMPM	$98.65	$116.51	$18	18%
	Percent paid by the plan	100.0%	100.0%	0.0%	0%
Total Health Plan Coverages					
	Expected Cost PMPM	$535.16	$612.15	$77	14%
	Expected Plan Payment PMPM	$492.24	$563.63	$71	15%
	Actuarial Value	92.0%	92.1%	0.1%	0%

For inpatient med/surg claims, the average cost per service is 19% higher when using the 70/30 network mix compared to the 95/5 network mix as the cost for out-of-network services is generally higher. The expected cost for the inpatient med/surg claims is $27 PMPM higher (21%) using the 70/30 network mix compared to the 95/5 network mix whereas the expected plan payment is $28 PMPM higher (an increase of 24%) using the 70/30 network mix. The illustration used a plan with a $1,500 in-network maximum out-of-pocket and a $2,700 out-of-network maximum out-of-pocket. The detail illustrates that for some health care services, including high cost surgeries, greater usage of the out-of-network providers can result in a *larger* share of total costs being paid by the plan (i.e. a higher actuarial value). After a member reaches the maximum out-of-pocket amount all further charges for the year are paid at 100%. The higher out-of-network usage assumption combined with the larger costs for out-of-network services can therefore result in slightly higher actuarial values.

Also, when certain services are paid at 100% (e.g. outpatient other services), a 70/30 network mix results in a larger dollar amount for this category. The actuarial value is determined by comparing the ratio of aggregate plan paid claims to aggregate covered charges, so a higher usage of non-network providers can result in a larger weighting to the services covered at 100%, which will also lead to a higher actuarial value for the 70/30 network mix.

The total across all services shows that the expected cost increases from $535.16 PMPM using the 95/5 mix to $612.15 PMPM using the 70/30 mix. This is an increase of $77 PMPM. However, the expected plan payment increases by $71.39. The increase in plan paid ($71.39) is 92.7% of the increase in the plan expected cost ($76.99). This share of the additional costs paid by the plan using the 70/30 mix (92.7%) is higher than the 95/5 plan actuarial value (92.0%), resulting in a slightly higher actuarial value assuming the 70/30 mix.

In practice, when a plan has a substantially lower level of benefits payable when services are provided by for non-network providers, the financial incentives impact plan participant behavior and network utilization. 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.

Taking the above factors into account, the 95/5 network mix was selected as the standard assumption in measuring the actuarial value across all plans.

APPENDIX C

Table 41: CBA Contract by Entity and Expiration Year

Entities	2014	2015	2016	2017	2018	2019	2020 or later
Alaska Gateway Schools					X		
Alaska Housing & Finance Corp					X		
AlaskaCare Standard Plan	X		X	X	X	X	
Anchorage Schools				X	X		
ASEA/AFSCME Local 52						X	
Bristol Bay Borough Schools				X			
Chatham Schools					X		
Chugach Schools						X	
City and Borough of Juneau						X	
City and Borough of Sitka						X	
City of Dillingham						X	
City of Soldotna						X	
City of Unalaska						X	
City of Wasilla				X			
Copper River Schools				X			
Cordova City Schools						X	
Delta/Greely Schools					X		
Denali Borough Schools			X				
Dillingham City Schools			X				
Fairbanks North Star Borough					X		
Fairbanks NSB Schools Plan A						X	
Galena City Schools						X	
Haines Borough						X	
Haines Borough Schools				X			
Hoonah City Schools						X	
Juneau Borough Schools						X	
Kake City Schools				X			
Kenai Peninsula Borough						X	
Kenai Peninsula Borough Schools		X					
Ketchikan Gateway Borough				X			
Klawock City Schools						X	
Kodiak Island Borough			X				
Kuspuk Schools				X			
Lake and Peninsula Borough Schools				X			
Local 71					X		
Lower Kuskokwim Schools				X			

Table 41: CBA Contract by Entity and Expiration Year							
Entities	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020 or later**
Matanuska-Susitna Borough				X			
Mat-Su Borough Schools				X			
Municipality of Anchorage					X		
Nenana City Schools				X			
Nome Public Schools				X			
Petersburg Borough				X			
Petersburg Borough Schools					X		
Pribilof Schools				X			
Southeast Island Schools			X				
Southwest Region Schools						X	
Tanana Schools				X			
Unalaska City Schools				X			
University of Alaska		X	X	X			
Valdez City Schools				X			
Yakutat City Schools				X			
Grand Total	**1**	**2**	**6**	**22**	**10**	**17**	**0**

APPENDIX D

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

School Districts that provided data

Alaska Gateway Schools
Aleutian Region Schools
Aleutians East Borough Schools
Anchorage Schools
Annette Island Schools
Bering Strait Schools
Bristol Bay Borough Schools
Chatham Schools
Chugach Schools
Copper River Schools
Cordova City Schools
Craig City Schools
Delta/Greely Schools
Denali Borough Schools
Dillingham City Schools
Fairbanks North Star Borough Schools
Galena City Schools
Haines Borough Schools
Hoonah City Schools
Hydaburg City Schools
Iditarod Area Schools
Juneau Borough Schools
Kake City Schools
Kenai Peninsula Borough Schools
Ketchikan Gateway Borough Schools
Klawock City Schools
Kuspuk Schools
Lake and Peninsula Borough Schools
Lower Kuskokwim Schools
Lower Yukon Schools
Mat-Su Borough Schools
Mount Edgecumbe
Nenana City Schools
Nome Public Schools
Northwest Arctic Borough Schools
Pelican City Schools
Petersburg Borough Schools
Pribilof Schools
Sitka Borough Schools
Skagway Schools
Southeast Island Schools
Southwest Region Schools
Tanana Schools
Unalaska City Schools
Valdez City Schools
Wrangell City Schools
Yakutat City Schools
Yukon-Koyukuk Schools

Political Subdivisions that provided data

Bristol Bay Borough
City and Borough of Juneau
City and Borough Sitka
City and Borough Wrangell
City and Borough Yakutat
City of Adak
City of Aleknagik
City of Anaktuvuk Pass
City of Anderson
City of Atka
City of Atqasuk
City of Bethel
City of Chignik
City of Chuathbaluk
City of Clark's Point
City of Craig
City of Delta Junction
City of Dillingham
City of Edna Bay
City of Egegik
City of Ekwok
City of False Pass
City of Holy Cross
City of Homer
City of Houston
City of Huslia
City of Kaktovik
City of Kasaan
City of Kodiak
City of Kotzebue
City of Kupreanof

City of Larsen Bay
City of Lower Kalskag
City of McGrath
City of Nenana
City of Nome
City of Palmer
City of Pelican
City of Pilot Point
City of Platinum
City of Port Alexander
City of Port Lions
City of Russian Mission
City of Saint Mary's
City of Saint Paul
City of Saxman
City of Seldovia
City of Shaktoolik
City of Soldotna
City of Tanana
City of Tenakee Springs
City of Unalakleet
City of Unalaska
City of Upper Kalskag
City of Valdez
City of Wainwright
City of Wasilla
City of White Mountain

Denali Borough
Eastern Aleutians Tribes
Fairbanks North Star Borough
Haines Borough
Kenai Peninsula Borough
Ketchikan Gateway Borough
Kodiak Island Borough
Matanuska-Susitna Borough
Municipality of Anchorage
Petersburg Borough

State Corporations that provided data
Alaska Gasline Development Corporation
Alaska Housing Finance Corporation
Anchorage Economic Development Corporation

Health Trusts that provided data
ASEA/AFSCME Local 52
National Education Association
Public Employee Local 71

Other Entities that provided data
Department of Administration
Department of Health and Social Services
Division of Insurance
Division of Risk Management
University of Alaska

APPENDIX E—WASHINGTON STATE HEALTH CARE AUTHORITY VALUE BASED ROAD MAP: 2017 – 2021

Washington State Health Care Authority

HCA Value-based Road Map, 2017-2021

Introduction

There is a national imperative led by Medicare, the biggest payer in the U.S., to move away from traditional volume-based health care payments to payments based on value. Over the past year this movement has gained significant traction since Medicare declared its own commitment to value and quality, announced its own purchasing goals (similar to HCA), and made substantial progress in meeting its goals. At the same time, federal legislation—the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, supports Medicare's acceleration of value-based purchasing by rewarding providers through higher Medicare reimbursement rates for participation in advanced value-based payments (VBPs) or Alternative Payment Models (APMs) starting in 2019.

Like Medicare, the Washington State Health Care Authority (HCA) is transforming the way it purchases health care. As directed by the Legislature in statute, and as a key strategy under Healthier Washington, HCA has pledged that 80 percent of HCA provider payments under State-financed health care programs—Apple Health (Medicaid) and the Public Employees Benefits Board (PEBB) program—will be linked to quality and value by 2019. HCA's ultimate goal is that, by 2019, Washington's annual health care cost growth will be 2 percent less than the national health expenditure trend.

To further align with the Centers for Medicare and Medicaid Services (CMS) payment reform efforts and accelerate the transition to value-based payment, HCA is currently in negotiations with CMS for an 1115 Medicaid transformation waiver. If approved, the waiver presents a unique opportunity to accelerate payment and delivery service reforms and reward regionally-based care redesign approaches that promote clinical and community linkages through State-purchased programs. Moreover, if the waiver is approved, HCA commits that 90 percent of its provider payments under state-financed health care will be linked to quality and value by 2021.

Washington State Health Care Authority

HCA Value-based Road Map, 2017-2021

Purpose and Goals

The HCA Value-based Road Map lays out how HCA will fundamentally change how health care is provided by implementing new models of care that drive toward population-based care. This HCA VBP Road Map braids together major components of Healthier Washington (Payment Redesign Model Tests, Statewide Common Measure Set and Accountable Communities of Health (ACHs), for example), the Medicaid transformation waiver, and the Bree Collaborative care tranformation recommendations and bundled payment models. The Road Map is built on the following principles:

- Reward the delivery of patient-centered, high value care and increased quality improvement;
- Reward performance of HCA's Medicaid and PEBB Program health plans and their contracted health systems;
- Align payment and delivery reform approaches with CMS for greatest impact and to simplify implementation for providers;
- Improve outcomes for patients and populations;
- Drive standardization based on evidence;
- Increase long-term financial sustainability of state health programs; and
- Continually strive for the Triple Aim of better care, smarter spending and healthier people.

HCA's Framework and Purchasing Goals

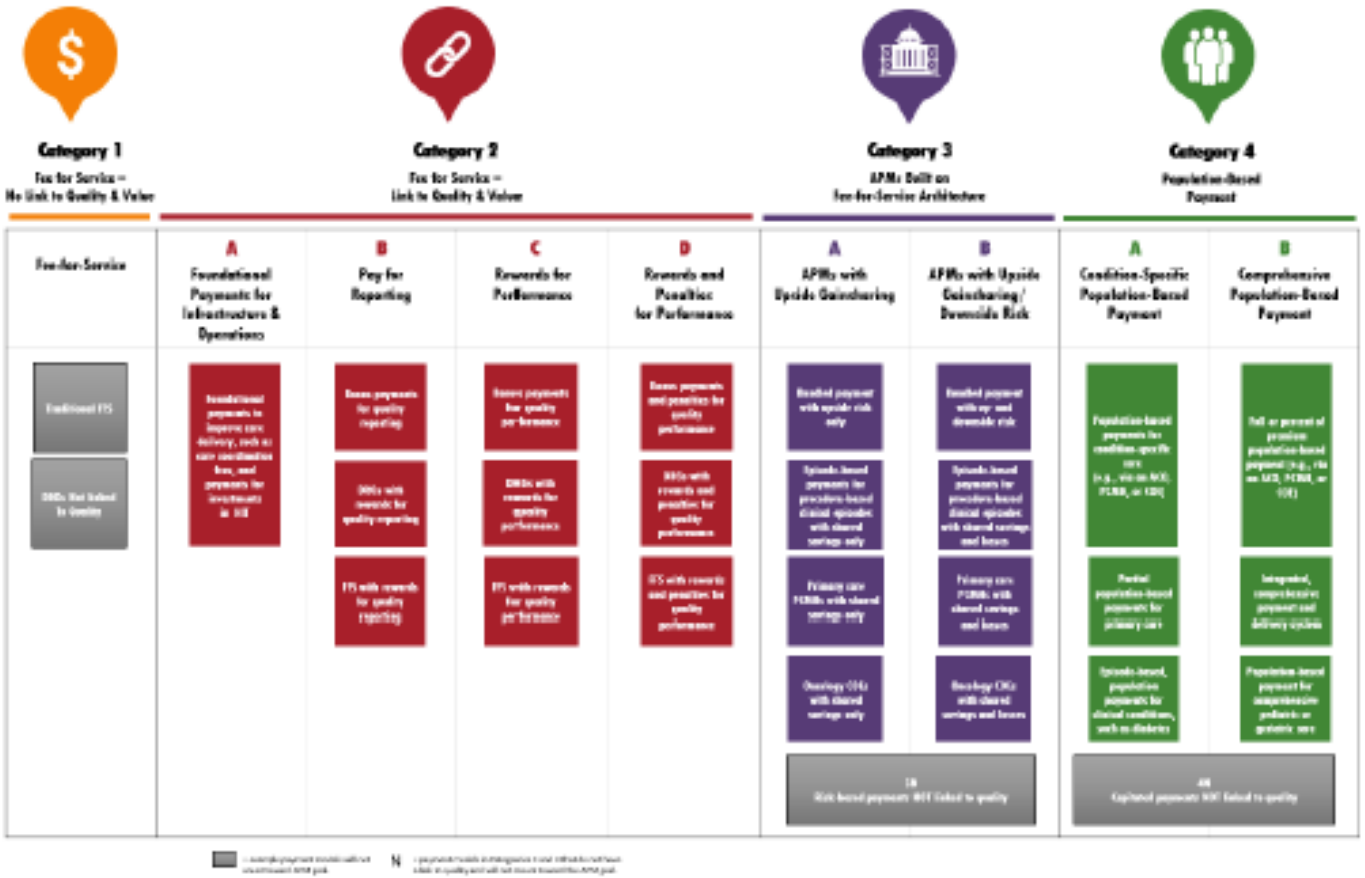
As the largest purchaser in Washington State, HCA purchases care for over 2.2 million Washingtonians through Apple Health and PEBB. Annually, HCA spends 10 billion dollars between the two programs. As a purchaser and state agency, HCA has market power to drive transformation using different levers and relationships.

As stated in the HCA Paying for Value survey released in March 2016, HCA has adopted the framework created by CMS to define VBPs, or APMs (see Chart 1, next page).

Washington State Health Care Authority

HCA Value-based Road Map, 2017-2021

Chart 1: CMS Framework for Value-based Payments or Alternative Payment Models

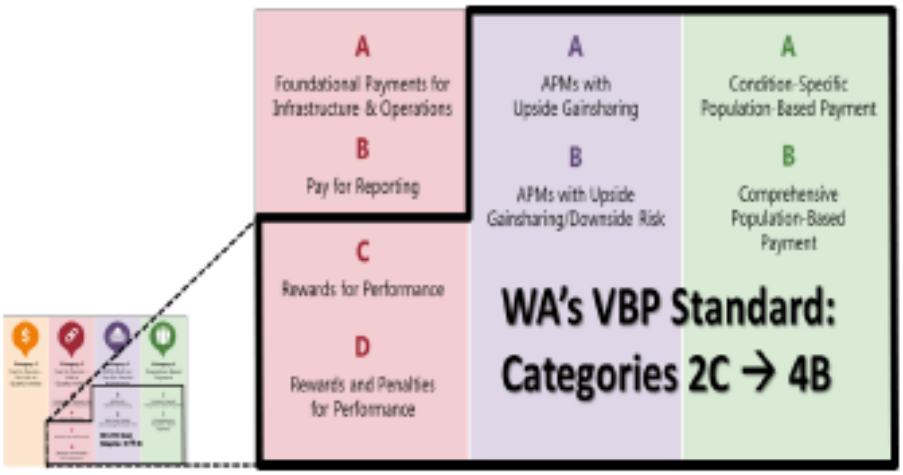


Washington State Health Care Authority

HCA Value-based Road Map, 2017-2021

HCA's implementation of the CMS framework is shown below in Chart 2.

Chart 2: Washington State's Value-based Payment Framework



To reach its purchasing goal, HCA expects 90 percent of state-financed health care payments to providers will be in CMS' categories 2c-4b by 2021. HCA's ultimate vision for 2021 is:

- HCA programs implement VBPs according to an aligned purchasing philosophy.
- Nearly 100% of HCA's purchasing business is entrusted to accountable delivery system networks and plan partners.
- HCA exercises significant oversight and quality assurance over its contracting partners and implements corrective action as necessary.

HCA's interim purchasing goals and key VBP milestones along the path to 90 percent in 2021 are shown below.

- 2016: 20% in VBP
- 2017: 30%
- 2018: 50%
- 2019: 80%
- 2020: 85%
- 2021: 90%

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Washington State Health Care Authority

HCA Value-based Road Map, 2017-2021

APPENDIX
CHANGES TO APPLE HEALTH CONTRACTS STARTING IN 2017

This document reflects specific, imminent changes pertaining to the Apple Health program, in alignment with HCA's VBP Roadmap. This document is not all-inclusive of expected long-term changes to the Apple Health program.

Consistent with HCA's VBP targets, there will be significant changes to Apple Health contracts starting in January 2017. MCO contracts will require that a growing portion of premiums be used to fund direct provider incentives tied to attainment of quality. To ensure quality and performance thresholds are being met, HCA will withhold an increasing percentage of plan premiums, to be returned based on achieving a core subset of metrics from the statewide common measure set. HCA will use the same measures in all provider VBP arrangements.

In addition, through use of time-limited funding under the Medicaid transformation waiver, MCOs will be able to earn financial incentives for achieving annual VBP targets (described further in the visual below). In 2018 and each year thereafter, the MCOs' accountability for each of these new contract components will grow progressively.

Finally, the Apple Health program changes include the creation of a "challenge pool" to reward exceptional managed care performance and a "reinvestment pool" to provide similar regional incentives for exceptional performance attributable to the broader participants in an ACH[1].

A description of the approaches as well as the parties to each approach is described in further detail below. A visual summary of funds flow and a table that provides additional detail on how the new incentive structures would work are included at the end of this document.

APPROACHES

TIME-LIMITED INCENTIVES FOR MCOS AND ACHS

HCA-MCO AND HCA-ACH

VBP INCENTIVES

MCOs will earn incentives funded through Initiative 1 of the Medicaid transformation waiver for exceeding VBP target thresholds, starting with 30 percent in 2017. These incentives will be in place for the five years of the waiver, but will not extend beyond the waiver period. Performance will be measured consistent with the approach taken in HCA's Paying for Value RFI, by looking at the

[1] This document refers to the ACH role broadly, recognizing ACH participants include MCOs and providers, for which specific roles are also highlighted.

proportion of payments tied to value-based arrangements (as defined in the HCP-LAN framework). Through the waiver, ACHs will also be able to structure incentive programs regionally to reward providers who are undertaking new VBP arrangements, these will be tied to the same VBP targets.

PROVIDER INCENTIVES UNDER MANAGED CARE

MCO-PROVIDER

MANAGED CARE ORGANIZATION (MCO) INCENTIVES

Value-based payment strategies require risk sharing and other financial arrangements between providers and plans that reward value outside of a fee-for-service model. To ensure that providers are being adequately incentivized in these arrangements, HCA will establish a percentage of premium threshold that each MCO must meet as part of its contractual obligations. Beginning in 2017, MCOs must ensure that at least 0.75 percent of their premium is going to providers in the form of incentives that help ensure that value-based arrangements are adequately rewarding and incentivizing providers to achieve quality and improved patient experience.

QUALITY WITHHOLD

HCA-MCO

MANAGED CARE ORGANIZATION (MCO) INCENTIVES

HCA will withhold a progressively increasing percentage of premiums paid to MCOs on the basis of quality improvement and patient experience measures. MCOs will need to demonstrate quality improvement against a standard set of metrics to earn back the withheld premium amount. Today, HCA utilizes a 1 percent withhold related to the quality of data submissions from MCOs to HCA. This approach broadens the quality standards being measured and increases the percentage of withhold gradually each year, until it reaches 3 percent in 2021.

COMMON MEASURES

HCA-MCO-ACH-PROVIDERS

HCA has committed to using standard measures of performance across its purchasing activity, consistent with the statewide common measure set. In addition, these measures will drive the evaluation and incentive payments under the Medicaid transformation waiver. Specifically, HCA anticipates a core subset of common measures to be used in its contracts with MCOs around the quality withhold and also expects to see this same core set of measures used in VBP arrangements between plans and providers. A good example of how the common measure set is already being used in HCA purchasing efforts can be found here.

Washington State Health Care Authority

HCA Value-based Road Map, 2017-2021

CHALLENGE POOL

HCA-MCO

CHALLENGE POOL

Washington State has embraced the value of a competitive managed care model for delivering Medicaid services. HCA's approach to VBP seeks to reward exceptional performance of MCOs through use of a "challenge pool." Unearned VBP incentives from the waiver and uncollected withhold payments from managed care premiums will be made available in a challenge pool that rewards plans that meet an exceptional standard of quality and patient experience, based on a core subset of measures.

REINVESTMENT POOL

HCA-MCO-ACH-PROVIDERS

REINVESTMENT POOL

The value-based payment structure for Medicaid also provides a reinvestment pool, funded similarly to the "challenge pool," which would use unearned ACH VBP incentives and a share of unearned MCO incentives to provide meaningful reinvestment in regional health transformation activities, based on performance against a core subset of measures. This provides a continuing incentive for multi-sector contributions to health transformation and rewards the delivery system and supporting organizations for achieving quality and improved patient experience.

VALIDATING VBP ATTAINMENT IN MANAGED CARE PROVIDER CONTRACTING

To adequately measure the status of payer-provider arrangements under Medicaid that are proprietary in nature, HCA will use a third-party assessment organization to review and validate detailed plan submissions. A similar model is used today through the federally required External Quality Review Organization that provides annual reports on the performance of each MCO.

SUMMARY

Taken together, these components reflect a phased incentive approach that emphasizes more equal weight being placed on ACHs and statewide managed care organizations (payer and provider networks) in achieving the state's roadmap to value-based payment over the next five years. They also show how contractual and financial levers are used to sustain community reinvestment and sustainable incentive structures that can last well beyond the waiver. This approach ensures mutual accountability for the performance of the health system in service of whole-person health outcomes and quality improvement.

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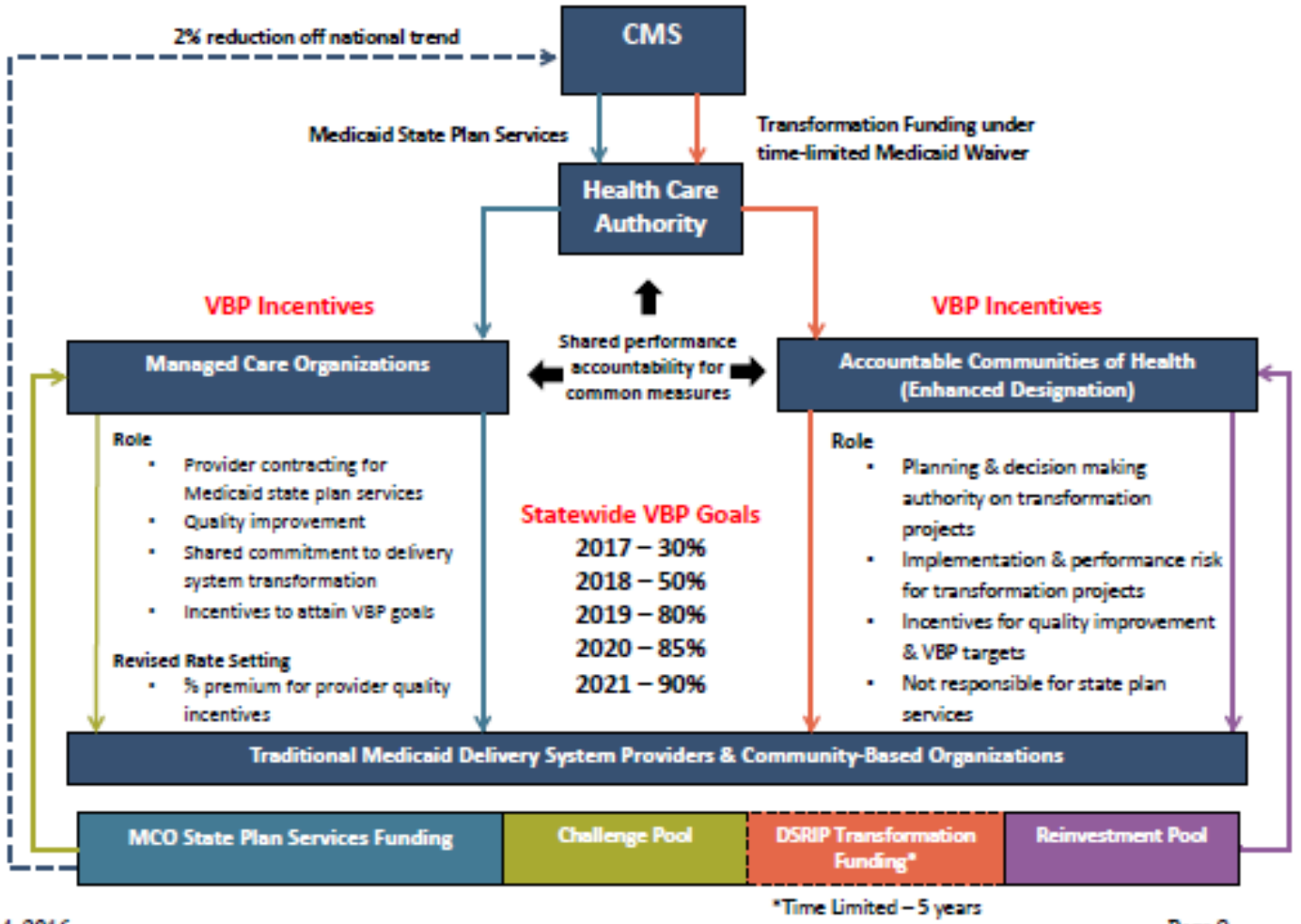
Washington State Health Care Authority

HCA Value-based Road Map, 2017-2021

Washington State Value-Based Purchasing Framework: Apple Health Program Changes



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Apple Health Value Based Payment - Overview and Sample Scenario

CALENDAR YEAR	VBP INCENTIVES			MANAGED CARE ORGANIZATION (MCO) INCENTIVES		CHALLENGE POOL	REINVESTMENT POOL
	Managed Care Organization (MCO specific) VBP Target Incentive[1] % of each incremental % point of premium over/under VBP target[2]	Accountable Communities of Health (ACH Specific) Region Specific VBP Target Incentive[1] $ tied to each 1% over State VBP Target[3]	STATE VBP Target	Managed Care Organization (MCO specific) Provider Incentives % premium for provider quality incentives	Managed Care Organization (MCO specific) Quality Withhold % premium at Risk for performance[4]	Managed Care Organization (MCO specific) Unearned VBP Incentives[5,6] % of unearned MCO Incentives and withhold	Accountable Communities of Health (ACH Specific) Unearned ACH VBP Incentives[5,6] % of unearned ACH VBP and a share of unearned MCO incentives
Pre	-	-	20%	-	-	-	-
2017	(+/-) 2%	$200k for each 1%	30%	0.75%	1.0%	(up to) 1%	
2018	(+/-) 1.5%	$300k for each 1%	50%	1.0%	1.5%	(up to) 1%	
2019	(+/-) 1%	$666k for each 1%	75%	1.5%	2.0%	(up to) 1%	
2020	(+/-) 0.75%	$1m for each 1%	85%	2.0%	2.5%	(up to) 1%	

2021	(+/-) 0.5%	$1.2m for each 1%	90%	2.5%	3.0%	(up to) 1%	
Post	Not extended beyond the five year waiver period		90%+	3.0%	2.5%	0.25% + 25% of remaining withhold[2]	0.25% + 75% of remaining withhold[2]

SAMPLE SCENARIO							
2017	MCO "A" with $1B of premiums exceeds VBP target statewide by 20% in year 1 and earns $4M. MCO "B" with $1B of premiums is short in meeting the VBP targets statewide by 10% in year 1 and pays $2M out of its premium withhold.	ACH "A" exceeds VBP regional target by 10% in year 1 and earns $2M of DSRIP incentive. ACH "B" is short in meeting the VBP regional target by 10% in year 1 and does not earn a DSRIP incentive.	30%	MCO "A" is contractually obligated to allocate at least 0.75% of its premium to providers in the form of incentives that help ensure value-based arrangements are adequately rewarding and incentivizing providers to achieve quality and improved patient experience.	MCO "A" demonstrates quality improvement against common measures and earns back 1% withheld premium amount. To earn back the 1% premium withhold, MCO "A" must also achieve the state VBP target and pass at least the required % premium for provider quality incentives.	MCO "A" exceeds quality improvement target by 5 basis points—earns back complete premium withhold and is eligible for challenge pool, not to exceed 1% of premium.	ACH "A" meets quality improvement target and is now eligible for its share of the reinvestment pool.

[1] Challenge and reinvestment pools funded by unearned MCO VBP incentives and ACH VBP incentives (under DSRIP) as well as any unpaid premium withhold for quality

[2] Not to exceed 1% of managed care organization's total premium payment, with a $20m annual aggregate maximum across all MCO VBP incentives

[3] Not to exceed $7.5M for any region in any year, with a $20M annual aggregate maximum across all ACH VBP incentives

[4] Or 75% of year to year trend increase (averaged across eligibility groups), whichever is lower, but not below 1%

[5] Dollars accrued for reinvestment and challenge pools are split equally between MCO and ACHs.

[6] Total combined value of challenge and reinvestment pools will not exceed $25M on an annualized basis.
[7] Post waiver period, challenge pool is composed of 0.25% of all MCO premiums and 25% of any unearned withhold - the reinvestment pool is funded similarly with 75% of remaining withhold.

Example for MCO "A" 2017

Experience	Calculation	Result
Total premium		1,000,000,000
Quality improvement withhold	1% of premium	(10,000,000)
Achieves 50% VBP vs. 30% target	2% incentive x 20% excess x $1B premium	4,000,000
Amount for provider incentives	0.75% of premium	(7,500,000)
Demonstrates quality improvement	1% of premium	10,000,000
Meets exceptional performance standard	Up to 1% of premium, depending on amount in pool	5,000,000
Total premium plus incentives		1,001,500,000

APPENDIX F—WASHINGTON STATE HEALTH CARE AUTHORITY: A JOURNEY TOWARD ALIGNMENT

Washington State Health Care Authority

A Journey Toward Alignment

Ensuring HCA's people, infrastructure, and data are set up to support value-based purchasing

September 2015

2

Washington State Health Care Authority

Director's Note

We at the Health Care Authority (HCA) cover 1 in 3 non-Medicare Washington residents with health care services through Apple Health (Medicaid) and the Public Employees Benefits Board (PEBB) Program. It is a tremendous responsibility, and one in which we all take great pride.

As Washington and the nation continue to shift to value-based purchasing, we must ensure our agency is structured to fulfill that vision. We have committed to moving away from a fee-for-service model of purchasing, in which we pay per service provided, to a system in which we pay based on health outcomes, cost, and customer experience. This means making some fundamental changes to the way we purchase care and monitor quality on behalf of Washington residents.

Although Realignment first became a familiar word at HCA last fall, the fact is that we began this journey many years ago. Emerging research into the "Triple Aim" of better health, better care, and lower costs has led many states and our federal partners to the realization that paying for volume is not the way to get the best health outcomes. Federal and state policies have provided a path to value-based purchasing, and we are moving our PEBB and Apple Health programs down that path. Through Realignment, we are taking a close look to ensure HCA's people, infrastructure, and data are set up to support value-based purchasing.

Alignment of agency resources to a managed care delivery structure is more than adjusting the organization chart or changing employee duties; the agency's culture, infrastructure and operating processes must be realigned to fully embrace and support a new way of operating.

I know many here at HCA have been through tough reorganizations and large-scale mergers before in your careers, and I do not take that lightly. Realignment brings with it some challenges. Some HCA functions will change. Some will go away to avoid duplication of work with the managed care plans with which we contract. I commit to supporting impacted employees by offering resources to help you with your next career step, whether in HCA or not. With the skills and talents each of you bring to our agency, I am confident we will succeed and emerge a more nimble, responsive place to work.

A core focus of Realignment has been sharing information as it is available, and asking for input along the way. This initiative is stronger because of the many employees who participated by joining Realignment subgroups, sharing feedback via email or their managers, and attending the many "Q & A forums."

HCA is a dynamic organization, and we are always looking at our work and how to do things better. That is part of what makes us strong. As we move through Realignment, I hope you will continue to ask questions, share ideas, and support one another through change. You are our agency's best resource, and in the end, this is about making sure we harness our collective talents to be One HCA.

Dorothy Frost Teeter, Director

Washington State Health Care Authority

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Executive Summary

We are realigning to ensure HCA's people, infrastructure, and resources support our managed care business model and the path to value-based purchasing. The policy goal is to shift from volume-based payment (fee-for- service) to payments that are more closely related to achieving cost, quality, and health outcomes; our agency must be set up to ensure we achieve that goal.

Realignment decisions are based on a careful and thorough year-long process that included extensive research into our own work and the structures of other states' health agencies. The Executive Leadership Team built a Realignment structure that included a core Realignment Design Team and sub-groups charged with examining various components of our fee-for-service and managed care work. Subject matter experts from our management staff served on the sub-groups.

The sub-groups met over the summer, and delivered a description of the current work, ideas, and risks and issues associated with improving the way we approach the work. ELT discussed and analyzed the subgroup work, and made decisions that include policy and organizational changes:

Policy changes

(Will take place over the next several months)

- Eliminate submission of paper claims; allow for exceptions in extreme cases. Direct clients to the online Medicaid application rather than providing a paper application with Medicaid booklets; we will give them a phone number to get a paper application if needed.
- Reduce claims processing resulting from suspension of claims and manual examination and approval as much as possible.
- Cap enrollment in the Employer-Sponsored Insurance (ESI) program; plan for a program phase-out supporting existing clients in moving to other insurance options.
- Reduce prior authorization of claims except in high-risk cases (safety, cost, quality); focus on examining data and reviewing claims for compliance with rules and requirements.
- Transition Medicaid enrollees with third party liability (TPL) to managed care.

Organizational changes

(New reporting relationships begin Oct. 16; Work will continue to be performed as it is today. Policy, process and staffing will be adjusted over time)

Clinical policy and operations—both Medicaid and PEBB—are centralized under the Chief Medical Officer (CMO).

- The section handling utilization management Healthcare Benefits and Utilization Management (HBUM) moves from Health Care Services (HCS) to the CMO.
- Authorization Services moves from Eligibility Policy and Service Delivery (EPSD) to the CMO.
- The Prescription Drug Program (PDP) moves from Policy, Planning and Performance (PPP) to the CMO.
- The Health Technology Assessment (HTA) program moves from PPP to the CMO.

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Program integrity for Medicaid and monitoring (both fee-for-service and managed care) will be moved to the Medicaid Program Division (currently HCS).

- Office of Program Integrity (OPI) moves from Program and Payment Integrity (PPI) to the Medicaid Program Division.
- Fraud and abuse investigation moves from PPI to the Internal Auditor.
- Claims Processing moves from EPSD to the Medicaid Program Division.

There will be three functions within the new Medicaid Program division:

- *Program Development* will develop and implement new Medicaid managed care programs and demonstrations, in conjunction with Policy, Planning and Performance, Financial Services, and the Chief Medical Division.
- *Program Operations* will oversee and manage established Medicaid programs and contracts.
- *Program Integrity and Monitoring* will include managed care plan monitoring, fee for service monitoring, and program integrity activities.

A new function called decision support will be located in Enterprise Technology Services, with analysts staffing each program across the agency. The goal of decision support is to ensure our programs have high-quality, standardized data and reports, and use them consistently in our work. The organizational location of decision support may be adjusted as the function is developed. Analysts currently located in divisions remain the divisions.

Functions supporting ProviderOne will move from PPI to the Central Services Administration.

- Over the next year work will be performed to determine how Provider One operations fit into the Decision Support function and information technology.
- Coordination of Benefits will continue to report to the ProviderOne Division as this population is moved to managed care.
- Medicare Buy-In will continue to report to the ProviderOne Division.

Document Control (DCC) will be moved from EPSD to the Employee Resources Division to support centralizing agency mail, imaging, and processing functions.

Others areas that will get new resources are financial and program decision support, actuarial work, contracts management, project management, and internal audit.

The Path to Realignment: What Got Us Here?

What is Realignment?

Realignment is an initiative to **ensure HCA's people, infrastructure, and data are set up to support value-based purchasing**. Value-based purchasing is a broad class of strategies used by purchasers, payers, and providers to promote quality and value of health care services. The goal is to shift from pure volume-based payment (fee for service) to payments that are more closely related to health outcomes. In fact, our agency mission reflects this direction of innovation and value: *Provide high-quality health care through innovative health policies and purchasing strategies.*

Contracting with managed care organizations—and holding them accountable for quality and cost containment—is fundamental to ensuring that those we serve get the highest quality, most affordable health care possible. With the national shift away from fee-for-service to value-based purchasing, the time is right for HCA to examine our structure and make sure we are realigning our resources and talent to support this strategic shift in our health care purchasing approach.

Catalysts for Realignment

The move to managed care is the first step in shifting our focus to value-based purchasing. Washington currently contracts with six managed care organizations to deliver Apple Health around the state. About 85 percent of Apple Health clients are enrolled with managed care plans. Our PEBB program also contracts with health plans and delivery systems to deliver care (Kaiser, Group Health, and Regence).

Washington began moving toward managed care in the late 1980s, when it was recognized that a fee-for-service model does not easily lend itself to care coordination and disease management, and that managed care can control costs while ensuring quality of care and access to care. More populations have moved to managed care over time, with the last large shift occurring in 2012 when the Medicaid blind and disabled population moved to managed care. Washington State continues to move Medicaid enrollees to managed care, including foster children, the homeless and newly enrolled clients.

Legislative mandate. In the 2013-15 state operating budget, the Legislature directed HCA to "...conduct a review of its management and staffing structure to identify efficiencies and opportunities to reduce full time equivalent employees and other administrative costs." The Legislature mandated the review to determine if HCA's administrative costs could be reduced since fewer clients required the support provided by state employees under the fee-for-service infrastructure.

HCA delivered the review and recommendations in a report submitted to the Legislature in February 2014.

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In the report, HCA disagreed with the assumption that administrative costs in Medicaid would be reduced as clients moved from fee for service to managed care. The work necessary to manage the Medicaid program does change, but the level of support needed is similar whether the program structure is managed care or fee-for-service.

The report articulated new kinds of work that must be performed , including:

- Developing clear, effective contracts to hold managed care plans accountable for providing health care to Medicaid clients.
- Using data and analytics to analyze how effective plans are at achieving expectations and outcomes as required in the contracts.
- Monitoring managed care activities through effective use of decision support tools and structures.
- Setting and communicating clear, consistent clinical requirements of managed care plans.

These activities replace the transaction-based review, payment and audit that occur in a fee-for-service environment.

HCA sent the report to the Legislature, and had several discussions with stakeholders, including the Governor's Office, legislative staff, and the Office of Financial Management. These discussions confirmed that HCA must realign its resources to support value-based purchasing in general, and in Medicaid a managed care purchasing structure specifically.

The State Health Care Innovation Plan. The state was awarded $1 million from the Center for Medicare & Medicaid Innovation (CMMI—established with the Affordable Care Act) to develop our State Health Care Innovation Plan, which is our roadmap to build a Healthier Washington. A key strategy in the plan is to encourage value-based purchasing, beginning with state-purchased health care.

We applied for the innovation funding to help us build a delivery system that is responsive to the needs of the populations we serve, focusing on value-based purchasing.

House Bill 2572, passed in 2014, supported the plan and specifically requires HCA to *"increase the use of value-based contracting, alternative quality contracting, and other payment incentives that promote quality, efficiency, cost savings, and health improvement for Medicaid and public employee purchasing."*

This continues to move Washington further along the journey toward value-based purchasing of health care.

Early Work: Research and Discussion

Researching other states

At the outset of Realignment, HCA reached out to other states' Medicaid and public employee benefits programs to collect information about their size, structure, and other program details.

We heard back from Medicaid programs in five states—Arizona, California, Florida, Michigan and Oregon. All five had at least 74 percent of their Medicaid population enrolled in managed care. Arizona was the highest at 88 percent. All also had some portion of their business as fee-for-service.

In general, the other states had evolved their Medicaid role from overseeing claims payment providing prior authorization to monitoring the managed care plans, improving plan accountability, and increasing focus on value-based outcomes. The states advised Washington to ensure we had adequate in-house actuarial capacity and data analytics support to ensure financial and quality oversight for the managed care plans.

We heard back from six public employee benefits programs—Arizona, Florida, Michigan, New York, Oregon, and Washington. We learned that most public employee benefits programs contract for health services, whether fee-for-service or managed care, so they are not faced with the same transition from fee-for-service that many Medicaid programs are facing.

The important lessons learned from research on other states included:

- The need to develop effective decision support structures (including actuarial resources)
- Understanding and developing processes to effectively manage the complex managed care contract.
- Shifting from the role of a direct payer of health care services to an outcome- and expectation-driven monitor of managed care plan work.

Because each state is different, we did not find a state that could be used completely as a model for Washington's Realignment.

Examination of HCA data resources, reporting, and decision support

As part of this review, we asked a consultant to look at HCA's data resources, including cataloguing reports produced on fee for service business. The work was intended to identify management reports available to inform drivers in HCA's fee for service operations.

While identifying reports proved useful, the work also indicated that while HCA has many data sources available, the agency lacks a decision support structure to enable consistent use of data in making decisions (see a description of **decision support** in the section titled "Foundational Principles: What are they and how do they fit with HCA's mission and vision?"). The review of HCA's data confirmed information received from other states: Washington needs a more robust decision support infrastructure.

October 2014 Employee Forums

After the research and review of data, HCA held a series of employee forums to share the results, to inform and educate employees on the meaning of "value-based purchasing," and to seek input and feedback from staff. Nearly 800 agency employees attended the forums, which included 20 informational sessions held over two days.

Feedback on the content and presentation was positive, with employees saying they appreciated the presentation on value-based purchasing the most, gaining knowledge of what it means to purchase for value. While employees were interested in the results of the research and data review conducted, they expressed concern about the ultimate outcome of Realignment.

Over the next six months, executive leaders continued discussing Realignment, including results of the research and data review and possible next steps in the process. The scope of the Realignment effort became clearer as discussions progressed. The scope—coupled with a lengthy legislative session and securing the federal State Innovation Model grant to support Healthier Washington—delayed the Realignment project by about four months. The delay was clearly difficult for staff, as it became the most common negative comment in focus groups held as part of HCA's Employer of Choice work.

Later Work: Development of Realignment Strategic Direction

Setting up a Realignment project structure

Continuation of Realignment work began in July 2015 with a Realignment design team identified and a change management consultant procured (Mass Ingenuity). Design team members are listed on page 12. The design team has managed and directed the Realignment work since that time, with ELT's input and direction.

ELT decided that additional work was needed to better understand the work performed in sections that support fee-for-service Medicaid enrollees, sections managing clinical policy and operations, and sections involved in monitoring Medicaid contractors and providers. Subgroups were formed to complete this work, with the following mandates:

- List the tasks performed by the sections included in the subgroup.
- Identify risks and issues that may arise when work performed in the section is changed so that agency resources can better support managed care operations.
- Brainstorm and list ideas on how HCA can manage its work and resources under a managed care structure.

Each subgroup had a charter, all of which are posted on the Realignment page. The workgroup participants were selected by ELT based on EMT and ELT members who understand and who have managed the work under review by the subgroup. Each group was asked to meet twice for two hours, completing the work within that time.

ELT discussed and analyzed the subgroup work to make decisions on the next steps in Realignment.

Project purpose statement and charter

Ensure HCA's people, infrastructure, and data are set up to support value-based purchasing.

The Executive Leadership Team is responsible for Realignment decisions and implementation.

The Realignment Design Team reviewed data gathered throughout the process, including from the subgroups, and made recommendations to agency leadership. The team hosted monthly Realignment "Q & A forums" for employees and met with individuals and work units upon request. The team met at least weekly from April through September.

The Realignment Design Team includes:

- Susan Lucas, Chief Operations Officer
- Preston Cody, Director of Health Care Services Division
- Kari Karch, Deputy Director for Policy, Planning and Performance
- Jody Costello, Director of Employee Resources Division
- Amy Blondin, Chief Communications Officer
- Brian Coolidge, Project Management Office Manager

Design team guiding principles

The Realignment Design Team agreed to a set of guiding principles, approved by the Executive Leadership Team, and often referred to them when reviewing information and making recommendations.

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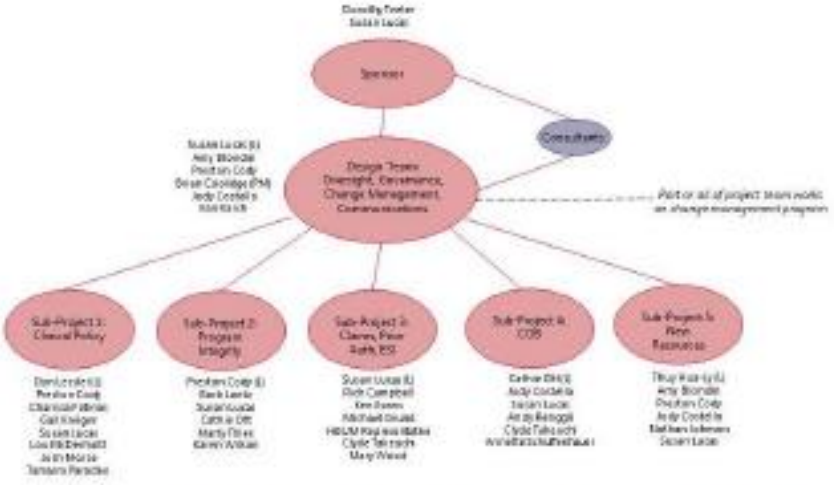
Sub-group work: Purpose and structure

In addition to project sponsors and the Realignment Design Team, sub-groups met. The sub-group participants were selected as subject matter experts. They were charged with documenting current work, issues and risks, and ideas related to their subject area.

The first three sub-groups completed their work in August. The Coordination of Benefits (COB) sub-group completed its work in September. The COB documents will be shared on Inside HCA, likely by the end of September.

A "New Resources" sub-group that had originally been planned to discuss what gaps in agency capacity needed to be resourced did not meet, as that assessment was able to occur without it.



Key themes that emerged from the sub-groups

- We are currently structured to essentially three different purchasing structures within one organization (Apple Health fee-for-service, Apple Health managed care, and the PEBB Program). Each has its own policies, procedures, and culture.
- We need to use data to assess whether we have achieved the outcomes we set for ourselves.
- We administer our Medicaid business differently depending on whether the client is managed care or fee-for-service.
- We need to identify one agency policy for monitoring Apple Health, both fee-for-service and managed care.
- Our frontline employees getting calls from clients have to deal with managed care and fee-for-service differently.
- We need to take action to move toward a more efficient operation.

Realignment communication and outreach

It has been important throughout Realignment to share information with employees and key stakeholders, and provide venues for questions and ideas.

Key Realignment communications activities include:

- A Realignment page on the intranet. This is where documents and key dates are posted, including:
  - A Realignment questions and answers document.
  - Realignment subgroup documents, posted for employee input.
  - Videos and documents from the fall 2014 Realignment Communications Forum.
- Monthly Realignment "Q & A forums." These informal meetings are held over the lunch hour and open to all employees. Realignment Design Team members answer questions and hear concerns and ideas.
- Design Team members attended work unit or division meetings upon request, talking with nine teams at their invitation.
- A realignment@hca.wa.gov email inbox. Employees can send their questions, concerns, and ideas to be answered by a member of the Realignment Design Team.
- A Realignment Resources Team page on the intranet. This is where information relating to transition services such as training and coaching are posted, in keeping with our guiding principle of retaining and retraining impacted employees.
- Realignment updates at the June Currents and at an Extended Management Team meeting.

In addition to these internal communication efforts, HCA has worked to keep external partners and stakeholders updated, including the Title XIX Advisory Committee, the Washington Federation of State Employees, the contracted managed care plans, and the Governor's Office of Financial Management.

Five Foundational Principles: What Are They and How Do They Fit with HCA's mission and Vision?

Over the past several years, the Apple Health (Medicaid) program has transitioned its clients from fee-for-service health care delivery to a managed care structure. The goal of moving Apple Health clients to managed care as mandated by the Legislature and the Governor has been largely accomplished; almost 85 percent of all Apple Health clients are now enrolled in managed care plans. At the same time, the Public Employees Benefits Board (PEBB) Program has consistently moved forward to adopt value-based purchasing for its clients.

We have contracted with innovative managed care programs, we have successfully increased expectations and outcomes of the Uniform Medical Program, and new innovative health care options will soon become available for PEBB enrollees through Healthier Washington. Over this same time period, however, operational resources have not kept pace with these changes. Some resources have been moved from supporting fee-for-service operations, but many have not been aligned to support a managed care structure.

Foundational principles will be adopted and used to guide HCA toward a successful realignment of operations. **A foundational principle describes the basis for design, strategy and operation of HCA's business.** Principles are developed from the agency's vision of a Healthier Washington and our agency mission to provide high-quality health care through innovative health policies and purchasing strategies.

HCA will be better positioned to accomplish our mission if we set foundational principles that ensure our processes, structure, and operations align in support of our mission and vision. By setting foundational principles, our managers and staff will have guideposts to refer to as we continue on the journey toward value-based purchasing.

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Principle #1: HCA must develop and work within a decision support structure

Our research of other states' transition to a managed care structure and our examination of how HCA uses data to analyze and support decisions indicated a need to improve the decision support function throughout the agency. A centralized decision support function must be created. This function will not replace analysts already located throughout the agency; instead this group will support, govern and guide analysts to use data consistently and in a standard format.

The decision support section will be housed within ETS to start. As the function is developed and implemented, we will determine the long-term structure and organizational location of decision support.

The decision support section will guide and support analysts in each program. Part of this responsibility is to provide information, services and technical support to ensure analysts are able to provide the data services their programs require. The decision support group will create and support an agency dashboard for use by ELT and other managers to communicate information about how well HCA is achieving its goals and outcomes and where risks and issues are arising that must be resolved.

Another vital role of the decision support section is to clearly articulate the expectations and qualifications for analysts. Analysts are not always information technology staff: Analysts must know the program, be able to communicate with division managers and staff, and develop reporting mechanisms that support achievement of program goals.

Divisions without sufficient decision support resources may be able to increase their capacity.

Principle #2: HCA will operate all its businesses in a consistent structure

The HCA has a long history of purchasing health care services through various delivery methods, including managed care organizations (MCO), fee-for-service, primary care case management, and self-insured models.

HCA must align our internal purchasing strategies into two general areas: The Public Employees Benefits Board (PEBB) Program and Apple Health (Medicaid). HCA will continue to operate a fee-for-service program for those populations that cannot be enrolled in a MCO, which represent approximately 10 to15 percent of the overall Apple Health program. It's critical the fee-for-service program operates in concert and under one overall Medicaid structure consistent with management and oversight of the Medicaid program in its entirety.

Principle #3: HCA will develop and support risk-based work processes and use data to support decisions

As HCA realigns, resources to support the basic operating structure and business processes for managed care must be adjusted. HCA must adjust work away from a transaction based examination of each claim, payment and transaction toward a structure that analyzes, monitors and holds accountable those organizations charged with providing appropriate health care to our clients.

In the managed care structure, HCA has transferred risk to the managed care plans; our role is to set expectations and mandate outcomes clearly in the contract with plans. HCA no longer has the role of performing work or determining details of how work will be performed – we are moving from "doing the work" to "monitoring the work."

This change requires the knowledge and abilities many of our staff possess – the difference is how the work is performed to ensure our clients receive appropriate quality care at the lowest cost possible. While the kind of work required differs, employees who have worked in Medicaid for many years have the knowledge necessary to ensure the work is performed by the plan.

While fee-for-service work does not include a transfer of insurance risk to a contractor, HCA must set requirements, expectations, and desired outcomes in the fee-for-service portion of our delivery system as well. Monitoring the effectiveness of the delivery system must incorporate data analysis from a risk based structure, examining areas where safety, quality and cost are endangered in a significant fashion.

Principle #4: HCA will support the development of a value-based health care delivery system while ensuring program integrity

Part of this transition is moving away from a structure where the fee-for-service requirements govern how managed care plans are to carry out their work. Instead, HCA must identify expectations, outcomes, goals and requirements in the contract so that plans can be held responsible for providing access, quality care and cost effective care in a manner acceptable to HCA but determined by the plans. HCA must align oversight and monitoring of managed care plans while maintaining a strong program integrity operation.

We must ensure close coordination and collaboration of program integrity and other state and federally mandated activities performed by HCA. The best way to ensure this occurs is by merging the work of two separate units into one division. Additionally, HCA recognizes the need to have an independent internal auditor for those cases when fraud or abuse is suspected. The internal audit activities must work closely with the Medicaid Fraud Control Unit at the Attorney General's Office.

Principle #5: HCA will administer the delivery system through our plans and delivery system partners using value-based purchasing strategies	The HCA is committed to purchasing health care services through partners who are willing and able to enter into value-based purchasing agreements which focus on outcomes rather than volume of services provided. These agreements will be with managed care organizations (MCO) and other partners who take on responsibility (financial risk) for their performance while serving our clients and members. As HCA realigns, resources to support managed care the basic operating structure and process must be adjusted. HCA must adjust work away from a transaction based examination of each claim, payment and transaction toward a structure that analyzes, monitors and holds accountable those organizations charged with providing appropriate health care to our clients. Part of this transition is moving away from a structure where the fee-for-service requirements govern how managed care plans are to carry out their work. Instead, HCA must identify expectations, outcomes, goals and requirements in the contract so that plans can be held responsible for providing access, quality care, and cost effective care in a manner acceptable to HCA but determined by the plans.

Aligned Organization Structure
(functions, not titles)

*Matrixed reporting with COO and Director
**Matrixed reporting with COO and Medicaid Director

Horizontal connections across HCA: Authority and collaboration

Under the newly aligned organizational structure, HCA will ensure there are systems and structures in place for communications and decision making across the agency.

With the new structure, HCA will establish cross-divisional teams so there are appropriate horizontal and vertical methods to communicate within HCA. The overall goal is to operate as one HCA for consistent messaging, reporting, decision-making, and, ultimately, effective implementation of our value-based purchasing initiatives.

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Decision support: A federated strategy

As noted in Foundational Principle #1, decision support will be developed as a central function in Enterprise Technology Services. It will act as information architects, ensuring systems data and reports are available and used in a consistent, standard fashion to accomplish the goals, requirements, and expectations of each division.

Each program will continue to employ business analysts, who will identify the reporting and data requirements necessary to ensure strong decision-making processes. These analysts are responsible for translating the needs of program managers and staff into technical requirements and for working with the decision support staff to ensure data is reported in a consistent, accurate and usable fashion. The decision support group will create agency data dashboards, portfolios, and regular management reports, so that HCA has a single, consistent decision support function across all sources of data.

The staff supporting ProviderOne will remain in the current structure, with additional work needed over the next year to determine how ProviderOne resources fit into the agency's IT and decision support organizational structure. At that time, HCA will determine how ProviderOne and the central decision support function will be organized.

Clinical policy and operations

HCA is consolidating functions related to clinical policy and operations into one division. This includes: designing and implementing clinical policy; operating clinical oversight and monitoring of all programs; communicating with stakeholders, providers, plans, and delivery system partners on clinical activities and issues; and operating clinical processes. Clinical policy and operations include all PEBB and Medicaid work.

Current prior authorization activities are within the clinical division; over the next six months, clinical managers will design and implement a transition from transaction-based prior approval to primarily risk-based data analysis and review. Clinical operations will set expectations of plans and providers, review and monitor compliance, require corrective action or penalties if compliance is not maintained, and limit prior authorization to extreme risk of client safety or system cost.

Medicaid development and operations

Over the past three years, HCA has more than doubled the number of Apple Health clients who get services through managed care plans (currently, more than 1.4 million clients are enrolled in managed care). At the same time, HCA has not increased the number of FTEs to meet this demand. HCA will redeploy resources to augment the current managed care development and oversight staff, and make needed adjustments to programs and systems to improve overall monitoring of managed care plans.

There will be three functions within the new division: *Program Development* will develop and implement new Medicaid managed care programs and demonstrations. *Program Operations* will oversee and manage established Medicaid programs and contracts. *Program Monitoring and Integrity* will take on managed care plan monitoring, contract compliance, and program integrity activities. This will support overall management of our Medicaid programs.

Healthier Washington staffing

In December 2014, HCA was awarded a nearly $65 million grant to bolster health system transformation in Washington from the Center for Medicare and Medicaid Innovation (CMMI). While the Healthier Washington testing grant award is for four years, the funding is approved each year by CMMI.

Of the total grant budget, approximately 20 percent of the grant is allocated for personnel and benefits, which is distributed between HCA, DOH, DSHS and OFM. As the lead agency, HCA's portion of the personnel and benefits budget is higher, funding at 28 positions, due to managing grant operations, in addition to the policy and content development outlined in the grant application.

The funding for these positions decreases each year, with many of the positions being phased out in years two and three as processes and systems are operationalized. HCA leadership will be reviewing how the work is transitioned into agency operations and identifying the necessary resources to sustain the work in future years. While we anticipate a need for carrying some of these positions forward, we do not have the positions accounted for in the HCA budget at this time.

Agency functions

Several agency functions will receive additional resources through Realignment.

Resources supporting HCA's actuarial capacity, fraud/abuse and internal audit capacity, project management and contracts administration are required to ensure appropriate monitoring and oversight of agency programs.

To support Realignment, HCA plans to increase staff resources in the following areas:

Division	Function
Enterprise Technology Services	Decision Support
Financial Services	Financial Monitoring and Analytics
Financial Services	Actuary
Policy, Planning, and Performance (PPP)	Decision Support
PPP	Planning/Policy
Division of Legal Services	Contracts/Risk
Health Care Services	Program Operation
Project Management Office	Project Manager
Internal Audit	Auditor

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Transition from current structure to new structure: Where does my section fit?

The following table illustrates which functions and sections are moving or changing as part of Realignment. If a function or section is not listed, there are no changes in organization.

Current section name	Where this section is now	Where this section will be starting on Oct. 16	New section working title (may change)
Healthcare Benefits and Utilization Management	Health Care Services	Chief Medical Officer	Clinical Policy Implementation; Pharmacy Policy Implementation
Prior Authorization	Eligibility Policy and Service Delivery (EPSD)	Chief Medical Officer	Clinical Operations
Claims Processing	EPSD	Medicaid Program	Operations
Document Control Center/Imaging	EPSD	Employee Resources	Mail Operations
Office of Program Integrity	Program and Payment Integrity (PPI)	Medicaid Program (3 FTEs will move to fraud/abuse within Internal Audit)	Monitoring/Program Integrity
Office of Medicaid Systems and Data	PPI	Operations/ProviderOne	Office of Medicaid Systems and Data
Coordination of Benefits	PPI	Operations/ProviderOne *	Coordination of Benefits
Provider Enrollment	PPI	Operations/ProviderOne	Provider Enrollment
Medicare Buy-in	PPI	Operations/ProviderOne	Medicare Buy-In
Health Technology Assessment	Policy, Planning, and Performance (PPP)	Chief Medical Officer	Clinical Policy
Prescription Drug Program	PPP	Chief Medical Officer	Pharmacy Policy Implementation
Employer-Sponsored Insurance	Financial Services	Remains in Financial Services—Program will be capped and phased out	Employer-Sponsored Insurance

* *Will transition to Medicaid Program/Operations after policy change occurs moving Third Party Liability to managed care*

Timeline for organizational changes

Date	Action
Sept. 24, 2015	• Organizational changes announced • Organizational chart with ELT members assigned published • All-employee Q&A
Oct. 15, 2015	Org chart with all staff assigned published
Oct. 16, 2015	Reporting relationships change; functions don't change yet
Oct. 19, 21, and 23, 2015	All-employee forums
Oct. 22, 2015	All-employee Q&A

Still to be determined: Timing of physical moves of employees (likely not before March 2016)

Medicaid Policy Changes

Changes in agency policy and process are integral to aligning agency resources. The sub-groups identified changes that will allow HCA to redirect resources to ensure the effectiveness and efficiency of our operations. This will only be possible if the five policy changes explained below are successful.

Each policy change must take place over a several month period. Staffing changes, system adjustments, work process changes and stakeholder work are all part of the implementation of each change. It is important to note that while organizational changes will be made as of Oct. 16, 2015 the time period for policy, process, and staffing adjustments is much longer, requiring in-depth project work to implement.

Policy change #1: Eliminate submission of paper claims and paper applications; allow for exceptions in extreme cases

Which units perform this work and how will they change?	Document Control Center and Imaging units perform this work. A reduction in the FTEs in these units of about 30 to 35 FTEs is expected.
What policy changes will we make?	HCA will change its policy on accepting paper claims to be consistent with Provider One/Phase 2, so that no paper claims will be accepted. All claims must be submitted electronically. In the event of an extreme case an exception process may be implemented. HCA will no longer send paper Medicaid applications in the Medicaid booklet sent to prospective clients or community agents. The booklet will direct prospective clients to the online application process. A phone number will be included in case a prospective client wishes to request a paper application.
What are some steps we will take to change this work?	1. Validate WAC, provider billing instructions and agency policies. 2. Develop the exception process for paper claim submission and to allow prospective clients to request an application form. 3. Update the provider billing instructions and guides. 4. Develop communication plan to help community agencies and clients understand how to submit an application using the electronic process. 5. Notify providers and other stakeholders. 6. Accept feedback; provide responses. 7. Prepare and train staff on the change. 8. Offer training and assistance to providers. 9. Manage the project overall.

Washington State Health Care Authority

When do we expect changes to be complete?	April 2016

Policy change #2: Eliminate claims processing resulting from suspension of claims and manual examination and approval

Which units perform this work and how will they change?	Claims Processing unit performs this work. A reduction in the FTEs in this unit of about 25 to 30 FTEs is expected.
What policy changes will we make?	HCA will stop suspension of claims in Provider One in most cases. Review of claims data will be enhanced to examine patterns of inappropriate payment; recoupment actions will be taken where necessary.
What are some steps we will take to change this work?	1. Investigate why suspension of claims is performed in more detail to understand where this function must continue. 2. Identify and review all the edits that suspend claims. 3. Develop agency criteria and a process to determine when claims should be suspended. 4. Develop recommendations for changing from a policy of suspension to either pay or deny with analysis of impacts. 5. Adjust the system to implement changes in claims suspension. 6. Develop a review process on claims payments, including patterns of inappropriate payments and evidence of payment risks; include recoupment of payments where necessary. 7. Communications plan for providers and staff.
When do we expect changes to be complete?	April 2016

Policy change #3: Cap enrollment in the Employer-Sponsored Insurance (ESI) program; plan for a program phase-out that supports existing enrolled clients

Which units perform this work and how will they change?	The ESI unit in Finance performs this work. This unit would be phased out as the program is ended.
What policy changes will we make?	Enrollment in ESI will be stopped when appropriate. Each enrollee in the program will be contacted and insurance options offered to replace ESI coverage. This change is possible as a result of ACA implementation.
What are some steps we will take to change this work?	1. Examine the legal authorization and requirements for the ESI program. 2. Review the return on investment for ESI clients; examine the possibility for loss of funding if ESI is phased out. 3. Develop a communication plan explaining why we are eliminating this program and how enrollees will be supported when making a change. 4. Communicate with stakeholders in the Legislature, Governor's Office and directly with ESI enrollees. 5. Work with enrollees to transition them to new health care options.
When do we expect changes to be complete?	Updated Oct. 20, 2015: Cap the program after open enrollment is completed in 2015. Work with each client to transition them to the best insurance option available. Phase out the program by Dec. 31, 2016.

Policy change #4: Reduce prior authorization activity except in high-risk cases (safety, cost, quality)

Which units perform this work and how will they change?	Clinical oversight and decisions occur in the HBUM unit. EPSD's Authorization Services Office (ASO) performs the work to approve or deny routine prior authorizations as well as interacting with providers on questions and issues. For both units, the work will change but resource levels are not expected to be reduced. Staff classifications could be adjusted as the policy change work moves forward.
What policy changes will we make?	Prior authorization policies will be changed from transaction by transaction prior authorization to examination, monitoring and analysis of claims activity and managed care plan monitoring to ensure appropriate clinical actions. Recoupment actions may be initiated in cases of inappropriate claim activity. For areas where high risk is identified on the cost, quality or safety of clinical actions prior authorization on a transaction by transaction basis may continue.
What are some steps we will take to change this work?	1. Research and validate the mandate for this work. 2. Review current practice for prior authorization today. 3. Develop a new clinical review and monitoring program to cover both fee for service and managed care Medicaid work; develop new policies, criteria and processes for cases that require transaction level prior authorization. 4. Document procedures and processes; educate and train staff. 5. Develop a communication plan for providers and stakeholders on the new program structure.
When do we expect changes to be complete?	July 2016

Policy change #5: Transition Medicaid enrollees with third party liability (TPL) to managed care

Which units perform this work and how will they change?	The Coordination of Benefits Unit manages TPL. A reduction in the FTEs in this unit of about 25 to 30 FTEs is expected.
What policy changes will we make?	Clients with TPL will be assigned to managed care plans. Plans will be expected to collect and avoid TPL payments at the same or higher level as HCA.
What are some steps we will take to change this work?	1. Validate how TPL can be outsourced to the plans in compliance with federal mandates. 2. Define and document the different tasks, functions and issues related to TPL identification and data matching. 3. Create new processes to ensure TPL issues and activities are appropriately addressed, including monitoring of plan activity on TPL. 4. Determine how managed care rates must be determined when TPL is included. 5. Develop language for MCO contract updates, including expectations and measurements for TPL activity. 6. Develop a communication plan for stakeholders, plans and clients.
When do we expect changes to be complete?	July 2016

Employee Resources

Hiring plan: Internal candidate preference

As HCA works toward implementation of realignment activities, the Washington Federation of State Employees (WFSE) and HCA have agreed the following hiring process will take effect September 24, 2015, and continue until further notice:

- For work units and/or job classifications that will be reduced as a result of the shift from fee-for-service to managed care, HCA will make internal non-permanent appointments to temporarily address workload concerns. Employees moving from a permanent to a non-perm will have return rights as outlined in Article 4.5.A.2. If no internal candidates are appointed, on a case-by-case basis, HCA may hire external non-permanent appointments to address workload. External non-permanent appointments must be coordinated and approved through the HR Director as an exception.

- For work units and/or job classifications that will be increased, HCA will make internal permanent appointments. Internal recruitments will be posted for at least seven (7) days. If no internal candidates are appointed, HCA may hire external non-permanent appointments.

- For positions requiring an advanced degree or licensures and specialized skills (i.e., physicians, nurses, IT), the hiring authority may seek an exception to this process through the HR Director.

The non-permanent appointments in this agreement are being made in accordance with Article 4.5 A.1. of the WFSE Collective Bargaining Agreement.

Definition Note:
Internal – A permanent HCA employee
External – Any person that is not a permanent HCA employee

Employee support during downsizing: Retrain and retain

The Realignment Resources Team's focus is to ensure HCA successfully retrains and retains staff. Details of the services the team is offering are included on the Realignment Resources Team page.

We encourage employees who believe they may be affected by Realignment to take advantage of these services. If you would like to sign up for services or would like to talk with one of our representatives, we are here to help you. Email RealignmentHRTeam@hca.wa.gov if you have any questions.

Washington State Health Care Authority

Employee Assistance Program

The Employee Assistance Program (EAP) helps employees and their family members resolve personal or work-related problems. EAP is free, and can offer information and resources to help you process the changes you may be facing as a result of Realignment. Go to www.hr.wa.gov, and look for the Employee Assistance (EAP) tab at the top right of the screen.

Washington Federation of State Employees

The Washington Federation of State Employees (WFSE) is available to assist represented employees as a result of HCA's realignment activities. You can contact the Olympia Field Office at (360) 786-1303 or at www.wfse.org.

How change affects each of us

"The only thing that is constant is change" – Heraclitus

Today, we experience changes in nearly every aspect of our lives, almost continually. As so simply stated in the quote above, change is the constant. We receive new laws, fancy social apps to keep up on family and even new ways to track our exercise and health. Even though we all might experience changes differently, what can we learn from each other? How can we draw upon our collective experiences to thrive during organizational change?

Research in neuroscience tells us that our brains are governed by the principle of maximizing reward and minimizing threat. That means that we are constantly assessing whether something is going to be helpful for us, or potentially hurtful. When we think it will be hurtful, we often shut down or shut out the new information and are less able to engage positively.

A comprehensive study identified actions each of us can take during the change that typically have a positive outcome. These actions can help us help our brains to process change in a positive, productive way:

1. Ask questions about the future.
2. Ask how the change will impact day-to-day operations.
3. Provide input to the solution.
4. Find out what new skills and abilities you will need to perform effectively after the change is in place.
5. Assess your own strengths and weaknesses.
6. Seek training that will be available to fill skill gaps.
7. Take advantage of the change to develop new skills and grow professionally.

Change involves personal decisions and the actions you take will have a direct impact on the outcome you experience.

Source: Employee's Survival Guide to Change: Jeffrey M. Hiatt. © 2013 by Prosci, Inc.; "SCARF" by David Rock, NeuroLeadership Journal.

Washington State Health Care Authority

Conclusion: The Journey Toward a Healthier Washington is Ongoing

The decisions and plans for implementation laid out in this document are not the end of change at HCA. As Realignment implementation plans are completed, there will be additional projects undertaken to improve processes, increase operational efficiency, and continue the adoption of value-based purchasing strategies.

As we continue on the journey toward value-based purchasing and alignment of our resources, we encourage all employees to:

- Engage in discussions on principles listed above.
- Use a mindset of "How can we be successful in the new world?" instead of "This is the way we've always done it."
- Provide constructive feedback.
- Take advantage of opportunities offered to expand your skills, to retrain and to move into new job duties.
- Seek to understand and accept the new path HCA is on, even if it means large changes in our work.
- Learn about how to manage the effect of change in yourself and with co-workers.
- Submit your ideas and feedback; advocate for your ideas in a respectful and professional manner.
- Perform your job to the best of your ability.

The agency is committed to a continuous improvement culture. We will continue to use the latest research and best practices to better serve the more than 2 million Washington residents for whom we purchase health care.

APPENDIX G—WASHINGTON STATE HEALTH CARE AUTHORITY REALIGNMENT PROJECT: TASK 1—STATE MEDICAID PROGRAM SURVEY

Washington State Health Care Authority

Washington State Health Care Authority Realignment Project
Task 1: State Medicaid Program Survey

Survey Results

August 29, 2014

MassIngenuity SEE. BELIEVE. ACHIEVE.

TREINEN

Contents

Project Purpose

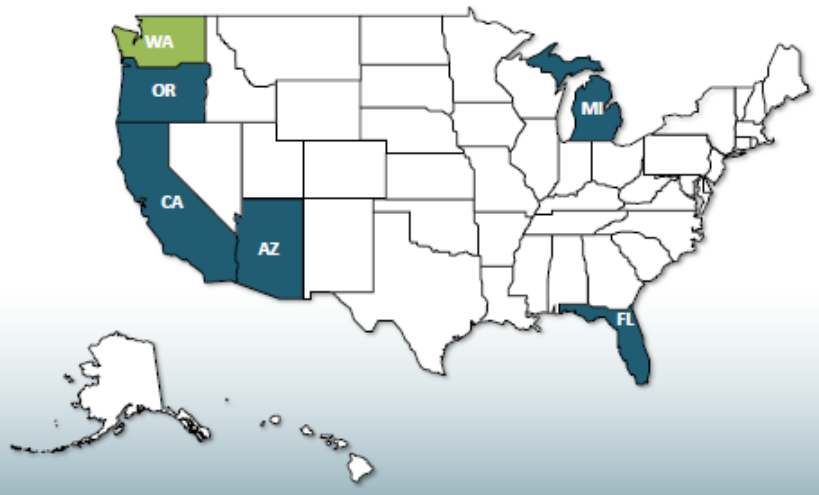
The **Realignment Research Project** includes the following activities:

- Survey other Medicaid programs to collect information on their size, structure and other program details as specified by the HCA and document the survey results.
- Conduct a review of the existing data inventory to: identify gaps in data/reports that would inform analysis of work processes and functions; and identify trends, anomalies and issues. Document a list of current and potential new data sources for informing the agency's work.
- Facilitate meetings with each selected ELT member and their management teams to discuss the potential impacts of a managed care organizational structure
- Document results of the facilitated sessions

Purpose of Task 1

Survey other Medicaid programs to collect information on their size, structure and other program details as specified by the HCA; document survey results.

States Selected to Survey



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States Selected to Survey

State Selection Criteria	AZ	CA	FL	MI	OR	WA
ACA Medicaid Expansion	✓	✓	✓	✓	✓	✓
CMS Innovation Models	✓	✓	✓	✓	✓	✓
Managed Care (MC) as a % of Enrollment (*Kaiser Foundation data*)	89%	60%	64%	88%	98%	88%
Number of MC Enrollees (*2011 data*)	1.2 M	4.5 M	1.9 M	1.6 M	640 K	1 M
Fee-for-Service (FFS) Reimbursement	✓	✓	✓	✓	✓	✓
>50% Share: Public Sector Unions	–	✓	–	✓	✓	✓
Operates under a Health Care Authority Approach	–	–	✓	–	✓	✓
State Responded to the Survey	✓	✓	✓	✓	✓	✓

*NY is leaning toward Medicaid expansion

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Survey Method

- HCA compiled a list of 10 survey questions
- Email request from HCA to State Medicaid Directors
- States could respond via email or phone interview – or both
- Organization charts and staffing data were requested
- Survey responses were 'streamed' to the project team for review as they were collected
- Even with multiple follow-ups, not all states responded to all survey questions, or responded in the same way – so there is some unavoidable inconsistency in some areas

Executive Summary

1. Five Medicaid Programs (AZ, CA, FL, MI, OR) responded to the survey.
2. All have high managed care (MC) enrollment – between 74% (MI) to 88% (AZ).
3. All have some degree of fee-for-service reimbursement.
4. All are part of larger state organizations.
5. Each program's organizational structure is unique. Models range from an integrated organization that includes MC and FFS to separate divisions for MC and FFS.

Continued

Executive Summary

6. Transition stage/approach differs among states – some programs devote a small percentage of resources specifically to MC (MI – 6%), while others devote a much larger percentage (92% - FL).
7. In general, as an organization transforms from mostly FFS to mostly MC, roles change from claims payment oversight (PA and UM) to monitoring plan capabilities, improving plan accountability and increased attention to value-based outcomes.
8. Standard operational metrics were provided by only two of the states; others said they were in development or could not be provided.
9. Lessons shared include the value of having in-house actuaries (AZ); expecting transition to take time (FL); and striving for patient-centered care delivered through local managed care organizations (OR).

Contents

Medicaid State Plan Administration

State	Medicaid is a 'stand-alone' agency	Medicaid is part of a broader umbrella agency	All Medicaid services are part of the umbrella agency
AZ	No	Yes	No
CA	No	Yes	Yes
FL	No	Yes	No
MI	No	Yes	No
OR	No	Yes	No
WA	No	Yes	No

Contents

Service Administration

State Selection Criteria	AZ	CA	FL	MI	OR	WA
Services administered by the single state agency	Acute physical care and Long-Term Care (LTC) for the elderly and physically disabled	All services except those noted on Slide 14	All services except those noted on Slide 14	All services except those noted on Slide 14	Medical, dental, mental health, CD/A&D, case management, NEMT, behavioral rehabilitation for youth	All services except those noted on Slide 14

Service Administration

State Selection Criteria	AZ	CA	FL	MI	OR	WA
Services administered by other agencies	Services for DD and individuals with serious mental illness; Foster Care medical and dental services	DD services; In-Home Supportive Services; Multi-Purpose Senior Services Program; Health Care Program for Children in Foster Care	Eligibility determin-ation; waivers for HCBS, ID/DD and TBI	Eligibility determin-ation (performed by Department of Human Services)	Social Support Services Home & Community Based Services	LTC; Behavioral Health; DD services

Service Administration

State Selection Criteria	AZ	CA	FL	MI	OR	WA
Types of agreements with other agencies	MCO Contract Agreements	Interagency Agreements	Memoranda of Understanding (MOU's) Inter-Government Agreements (IGA's)	Date Use Agreements Interagency Agreements	IGA's Joint Steering & Management Committees	MOU's Service Level Agreements

Contents

Medicaid Expansion Status

State Expansion Under the Affordable Care Act (ACA)	AZ	CA	FL	MI	OR	WA
Participates in ACA Medicaid Program Expansion	Yes	Yes	No	Yes	Yes	Yes
Program Expansion Begin Date	1/1/14	1/1/14	N/A	4/1/14	1/1/14	1/1/14
Number of Medicaid Enrollees Post-ACA Implementation	1.6M	~11M	N/A	1.5M	1.1M	1.6M

Contents

Managed Care vs. FFS Enrollment

Enrollment Comparison	AZ	CA	FL	MI	OR	WA *
Managed Care	88%	78%	85%	74%	85%	80%
Fee-for-Service (FFS)	12%	22%	15%	26%	15%	20%

* Based on enrollees with full Medicaid benefits

Contents

Managed Care vs. FFS Costs *

Cost Comparison	AZ	CA	FL	MI	OR	WA
Monthly or Annual Capitated Cost of Care per Enrollee (PMPM) for Managed Care	$446 PMPM **	$399 PMPM	**	$355 PMPM	$450 PMPM	No response
Total PMPM or Annual Cost including any FFS Carve-Outs	No response	$435 PMPM	No response	$415 PMPM	$460 PMPM	$291 PMPM ***
Monthly or Annual Cost for FFS Care	$729 PMPM	$443 PMPM	No response	$965 PMPM	$90M/ month	$344 PMPM

* Note that state MC rates may differ due to differences in covered services
** FL provided detailed age-banded, geographic rate tables, but not an aggregate PMPM rate
*** Projected for FY14

Program Resources

Resource Comparison	AZ	CA	FL	MI	OR	WA
Number of Medicaid Program Staff	950*	3,403*	650	482	440	1,140*
Employees are Represented by Union	Yes**	Yes	Yes*	Yes	Yes	Yes
Percentage of Union-Represented Employees	N/A	80%	5%	30%	9.8%	50%

AZ: * Includes 400 eligibility staff for long-term care
** AZ does not negotiate with unions for wages or other benefits
CA: * Includes 55 part-time positions
FL: * Collective bargaining with nurses only
WA: * Excluding PEB staff

Contents

AZ Managed Care Services

- Behavioral Health
- Dental Screening/Treatment
  - Under the Age of 21
- Dialysis
- Office Visits
- Emergency Care
- Family Planning
- Hearing Exams/Aids
  - Under the Age of 21
- Hospital Services
- Immunizations
- Lab and X-rays
- Physical Exams
- Pregnancy Care
- Prescriptions
  - Not Covered for Dual Eligibles
- Specialist Care
- Surgery Services
- Non-Emergency Medical Transportation (NEMT)
- Vision Exams/Glasses
  - For Children Under the Age of 21
- Well Child (EPSDT)
  - Medicaid Eligible Under the Age of 21

CA Managed Care Services

- Mental Health (low to moderate levels of functional impairment):
  - Individual and Group Therapy
  - Psychological Testing when Clinically Indicated to Evaluate a Condition
  - Outpatient Monitoring of Drug Therapy
  - Psychiatric Consultation
- Pharmacy
  - Certain Specialty Drugs Not Covered
- Physical Health

CA Managed Care/FFS 'Split' Services

- Dental Services
  - Are generally provided FFS with the exception of the availability of Dental Managed Care in two Counties
- Long Term Care
  - Carved-in in some Counties, but most are carved-out
- Personal Care Services (IHSS)
  - Began a Pilot in eight Counties for LTSS Services:
    - Long Term Nursing Facility
    - In-home Support Services
    - Adult Day Healthcare Center Services
    - 1915 c waiver Multi-purpose Senior Services
- Substance Use Disorder (SUD)
  - Carved-in in some Counties, but most are carved-out

CA Services Not Covered Under Managed Care

- Mental Health (serious mental illness or serious emotional disturbances):
  - Adult Crisis/Residential Services
  - Crisis Stabilization and Crisis Intervention
  - Day Treatment/Rehabilitation
  - Medication Support
  - Psychiatric Health Facility Services
  - Psychiatric Hospital Inpatient Services
  - Targeted Case Management
  - Therapeutic Behavioral Services
  - Therapy
- Specialized Services for Children with Specified Illnesses
- Transplant Services

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FL Managed Care Services

- Ambulance
- Ambulatory Surgery
- Chemotherapy Services
- Chiropractor
- Clinic (FQHC, RHC)
- Dental
- Dialysis
- Durable Medical Equipment
- Emergency Room
- Hearing
- Home Health
- Hospital Inpatient
- Hospital Outpatient Surgery
- Lab and X-rays
- Maternity/Family Planning
- Mental Health
- Outpatient Hospital Services
  - Non-emergency
- Outpatient Therapy
  - Physical/Respiratory
- Pharmacy
- Podiatrist
- Primary Care Physician/ARNP/PA
- Specialty Physician
- Transplant Services
- Transportation (NEMT)
- Vision Services

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FL Services Not Covered Under Managed Care

- Eligibility Groups Under the SSA are excluded
  - Breast Cancer and Cervical Cancer
- Some are excluded or are voluntary (not mandated)
  - ID, DD, Pediatric Extended (Medical) Daycare, Juvenile Justice Residential Treatment Population (excluded populations are very small)

MI Managed Care Services

- Ambulance
- Certified Nurse/Midwife
- Certified Pediatric & Family NP
- Chiropractor
- Diagnostic lab, x-ray, imaging
- Durable Medical Equipment
- Emergency Services
- End Stage Renal Disease Services
- Family Planning
- Health Education
- Hearing and Speech
- Hearing Aids
  - Under the Age of 21
- Home Health
- Hospice
- Immunizations
- Inpatient and Outpatient Hospital Services
- Intermittent or Short-term Services in a Nursing Facility
  - Up to 45 Days
- Mental Health Care
- Out-of-state Services
  - Authorized by a Contractor

MI Managed Care Services, continued

- Outreach Services for Pregnancy-related and Well Child Care
- Parenting and Birthing Classes
- Pharmacy
- Podiatrist
- Practitioners
- Prosthetics and Orthotics
- Restorative/Rehab Services (not in a Nursing Facility)
- Tobacco Cessation Treatment
- Therapy*
  - Speech
- Therapy - Continued*
  - Language
  - Physical
  - Occupational
- Transplant
- Transportation (NEMT)
- STD Treatment
- Vision
- Weight Reduction
  - Medically Necessary
- Well Child (EPSDT)
  - Under the Age of 21

* Excluding services provided to people with development disabilities, which are billed through Community Mental Health Services Program providers or Intermediate School Districts.

OR Managed Care Services

Nearly all services in the state plan are in global budget capitation to CCOs, including:

- Dental
- Mental Health
- Physical Health
  - These are integrated into one CCO contractor who manages and integrates these benefits for the population.

Services being integrated now, that were carved out of managed care in the past, include:

- Residential Mental Health
- Substance Use Disorder (SUD) Treatment
- Transportation (NEMT)
- Leveraged Case Management for targeted populations and some smaller programs that wrap social supports around certain high needs individuals.

All eligibility categories are covered through managed care except the populations mentioned above who have exemptions (Tribes, CAWEM, TPL, Medicare) but they can enroll in a CCO by choice if they want.

WA Managed Care Services

- Physical Health
- Pharmacy
- Durable Medical Equipment
- Imaging/X-rays
- Physical Therapy

All States Managed Care Services

Types of Services	AZ	CA	FL	MI	OR	WA
Abortion						N
Ambulance			Y	Y		
Behavioral Health	Y					N
Certified Nurse/Midwife/NP				Y		
Chemical Dependency				Y		N
Chemotherapy			Y			
Chiropractor			Y	Y	Y	
Dental/Orthodontia	Y	Some	Y		Y	N
Developmental Disabilities						N
Dialysis	Y		Y			
Durable Medical Equipment			Y	Y		Y
Emergency Care	Y		Y	Y		
Family Planning	Y		Y	Y		N
Hearing Services and Aids	Y		Y	Y		

All States Managed Care Services

Types of Services	AZ	CA	FL	MI	OR	WA
Home Health Services			Y	Y		
Hospice				Y		
Hospital Services	Y		Y	Y		
Imaging (Lab and X-rays)	Y		Y	Y		Y
Immunization	Y			Y		
Interpreters						N
Long Term Care		Some				N
Maternity Support	Y		Y	Y		N
Mental Health		Some	Y	Y	Y	
Neurodevelopmental Care						N
Office Visits	Y		Y	Y	Y	
Outpatient Hospital Surgery, Services and Therapy			Y	Y		
Out-of-state Services (Authorized)				Y		

All States Managed Care Services

Types of Services	AZ	CA	FL	MI	NY	OR	WA
Personal Care		Some		Y			
Pharmacy	Y	Y	Y	Y			Y
Physical Health	Y	Y	Y			Y	Y
Physical Therapy			Y	Y		Y	Y
Podiatry			Y	Y			
Prenatal Genetic Counseling							N
Prosthetics and Orthotics				Y			
Restorative/Rehab, Intermittent or Short-term in Nursing Facility				Y			
Restorative/Rehab (not in nursing facility)				Y			
School-based Medical Services		N					N
Specialist Care	Y		Y				
STD Treatment				Y		Y	

All States Managed Care Services

Types of Services	AZ	CA	FL	MI	OR	WA
Sterilizations Under Age 21						N
Substance Use Disorder		Some				
Surgery Services	Y		Y	Y		
Therapy (Speech, Language, Physical and Occupational)				Y		
STD Treatment				Y		
Tobacco Cessation Treatment				Y		
Transplant		N	Y	Y		
Transportation (NEMT)	Y		Y	Y	Y	N
Vision Exams/Glasses	Y		Y	Y		
Weight Reduction (medically necessary)				Y		
Well Child (EPSDT) Under 21	Y			Y		
WIC Program						N

Managed Care by Enrollees/Eligibility Groups

State	Managed Care Program covers the same set of services for all of the enrollees/eligibility groups included in managed care?
AZ	No
CA	Generally Yes
FL	Yes with one exception – Expanded State Plan benefits
MI	No
OR	Yes
WA	Yes

Managed Care Differences by Enrollees/Eligibility Groups

State	Differences in Covered Managed Care Services by Eligibility Group
AZ	AZ has a ALTCS (Arizona Long Term Care System) program, which includes a separate group of contractors providing services to enrollees who are at risk for institutionalization.
CA	N/A
FL	N/A
MI	The Healthy Michigan Plan covers adult oral health, vision services, & habilitative services that are not covered for Medicaid enrollees
OR	N/A
WA	N/A

FFS by Enrollees/Eligibility Groups

State	Types of Services	Enrollees/Eligibility Groups
AZ	Acute Care & Long Term Care	100K American Indians + 82K Federal Emergency Services Members
CA	Dental & some specialty drugs	Pregnancy only, ER only, Medicaid eligible children & youth with special health care needs
FL	Medically Needy (SOC), ID/DD	"Churn" recipients not yet enrolled in managed care
MI	Home and Community Based Waiver (not enrolled in managed care), Healthy Kids Expansion, Emergency Services only, Hospice & Intermediate Care Facility	Individuals with Intellectual Disabilities, and beneficiaries enrolled in Medicaid prior to health plan enrollment.

FFS by Enrollees/Eligibility Groups

State	Types of Services	Enrollees/Eligibility Groups
OR	All state plan services are available in both FFS & Managed Care, except certain case management services	Behavioral Rehab for youth, Supported Employment & Housing, Mental Health (7-11) drugs, CAWEM, CAWEM Prenatal & QMB populations
WA		AI/AN Enrollees w/3rd party coverage, Enrollees in the 1st several weeks of eligibility, dual eligibles, & other various exemptions (smaller groups)

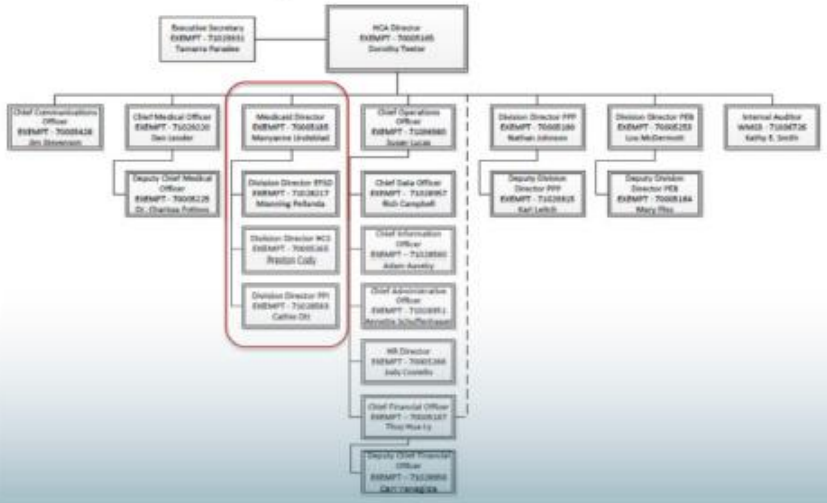
Contents

Washington State

Washington State Current Structure

- The Washington State Health Care Authority serves 1.6M Medicaid enrollees.
- 80% of the Medicaid clients are enrolled in managed care.
- HCA has ~ 1140 positions (excluding PEB staff).
- Approximately 50% of the employees are union members.

WA HCA Organization Chart



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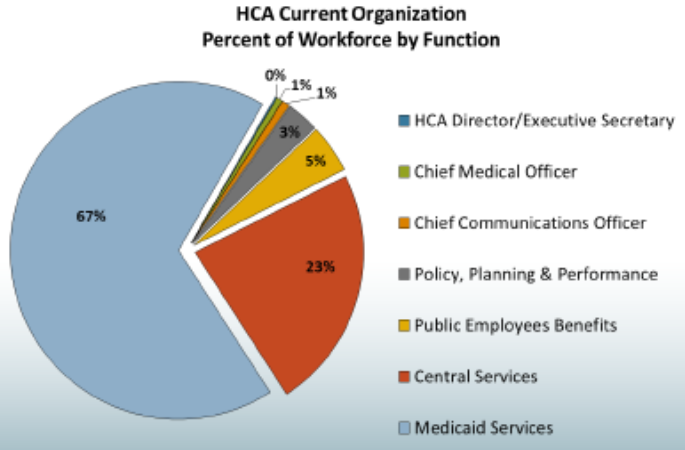
Washington State Current Structure

Medicaid and Central Services are the largest divisions



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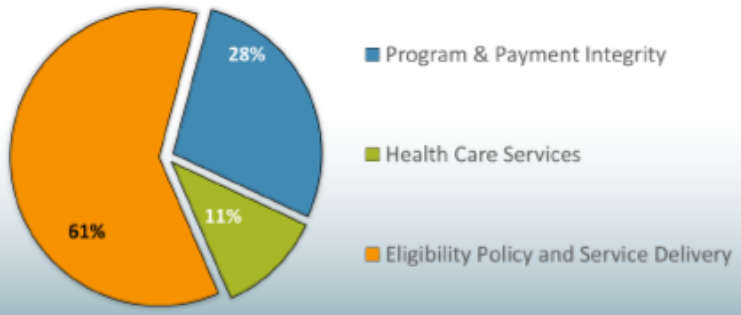
Washington State Current Structure

Medicaid Services is comprised of three divisions:
Eligibility is the largest, followed by Program & Payment Integrity

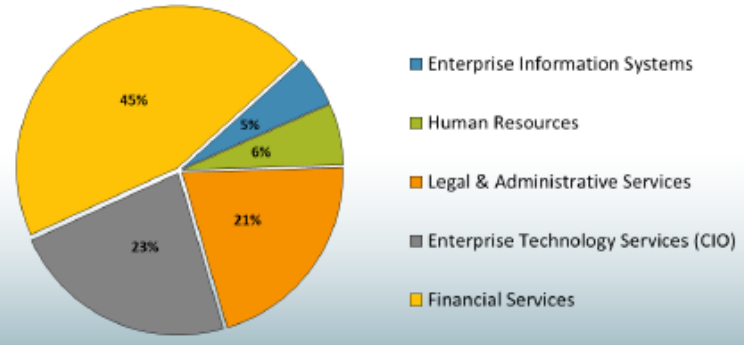
HCA CURRENT Medicaid Services Division
Percent of Workforce by Function



Washington State Current Structure

Central Services encompasses five functions,
the largest of which are financial and enterprise technology services.

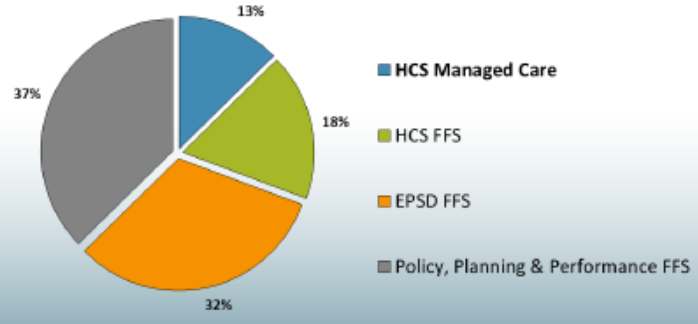
HCA Current Central Services Division
Percent of Workforce by Function



Washington State Current Structure

- 300 positions specifically support either managed care or the FFS business.
- Only 13% of these positions are devoted to the managed care business, although approximately 80% of the enrollment is in managed care.

Percent of Staff Support for Managed Care vs. FFS



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Arizona Health Care Cost Containment System (AHCCCS)

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Washington State Health Care Authority

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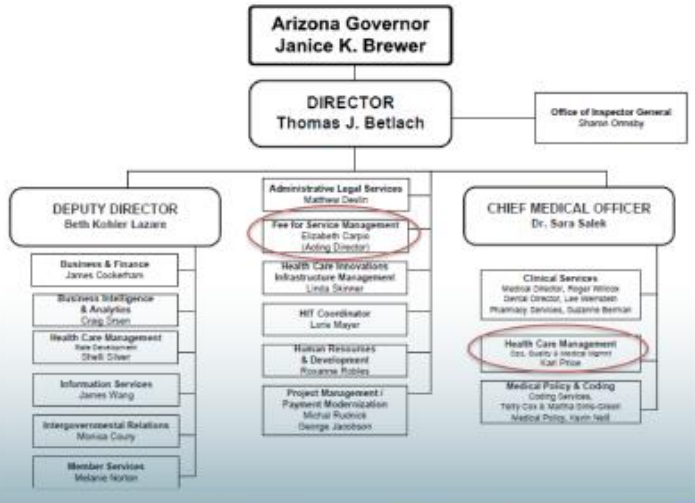
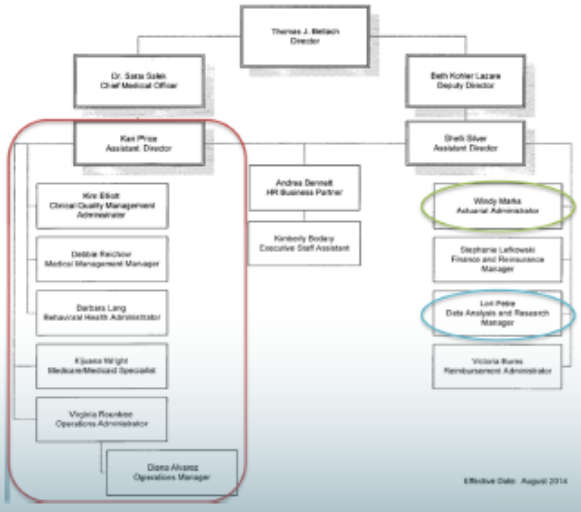
AHCCCS

- AHCCCS serves 1.6 M Medicaid enrollees; growth rate is 40K/month.
- 88% of the Medicaid clients are enrolled in managed care.
- Acute care and LTC services are delivered through managed care.
- Approximately 950 staff, including ~ 400 eligibility staff for LTC.
- Does not negotiate with unions for wages or other benefits.
- Separate divisions for managed care and FFS.

AHCCCS Organization Chart



AHCCCS Division of Health Management



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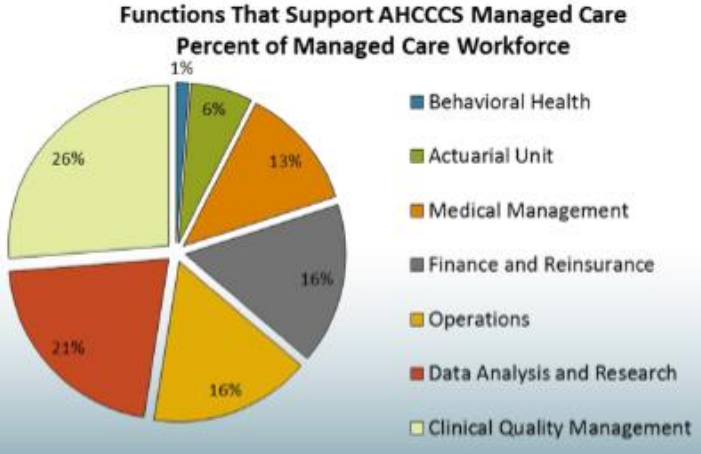
AHCCCS

Within the Division of Health Care Management, 80 staff support MC.



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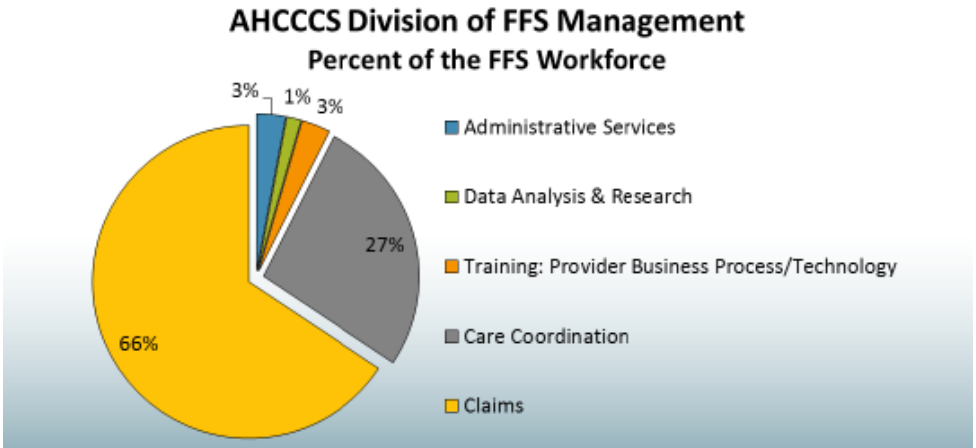
AHCCCS

- **Behavioral Health** performs oversight on a sister agency that provides BH services
- **Actuarial** calculates capitation rates for contractors and performs trending and utilization analysis
- **Clinical Quality Management** performs quality management and oversight functions for all populations
- **Data Analysis & Research** assists contractors with encounter submission, validates encounter data, designs and performs statistical analysis of performance improvement projects, audits and performance measures
- **Finance & Reinsurance** oversees financial condition of all contractors via quarterly and annual reviews
- **Medical Management** oversees contractors' medical management functions such as prior authorization, utilization review, disease management; audits appeals adverse decisions; coordinates and case manages transplants; monitors specialty contracts and reinsurance
- **Operations** oversees the operations of 12 acute care carve-out contractors and 9 LTC contractors

In addition to the 80 staff noted above, DHCM includes the Director, Chief Medical Officer, Deputy Director, HR Business Partner, and Executive Assistant.

AHCCCS

Within the Division of Fee for Service Management, 67 staff support FFS:



AHCCCS

- **FFS Claims** makes up the bulk of the workforce and includes administration, receipt and imaging, testing, customer service, adjudication and research, policy, auditing, grievances, and claims medical review.
- **FFS Care Coordination** includes utilization management, prior authorization, utilization review, care management and transportation.
- In addition to the 67 staff noted above, the DFSM includes an Administrator and a Medical Director.

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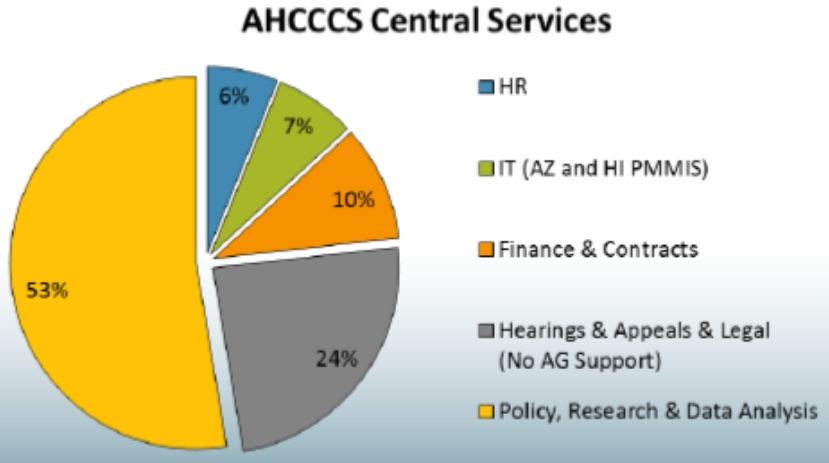
AHCCCS

Like the HCA, approximately 24% of the staff is devoted to Central Services.



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California
Department of Health Care Services

California Department of Health Care Services

- California DHCS serves almost 11 M Medicaid enrollees.
- 78% of Medicaid clients are enrolled in managed care.
- DHCS has 30+ divisions; did not provide total staff count for the Department.
- Approximately 80% of Department employees are union members.
- 180 staff support the Medicaid Managed Care Division.
- See DHCS organization chart on the following slide.

California Department of Health Care Services

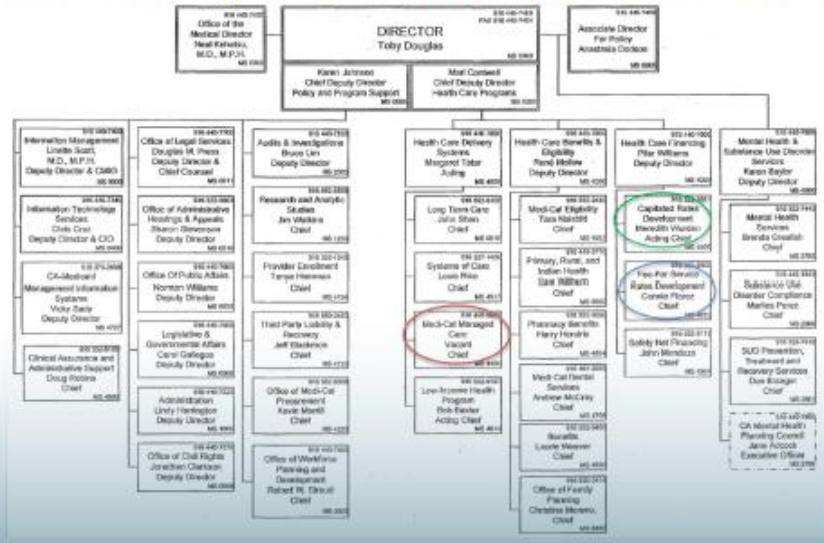
The **Medicaid Managed Care Division** contracts with managed care organizations. The Division is comprised of three branches: Plan Monitoring/Program Integrity; Policy and Financial Management; and Plan Management.

Several other divisions support activities and policy in both FFS and managed care. Of interest:

- The **Capitation Rates Development Division** includes several units:
  - *Actuarial* calculates capitation rates;
  - *Financial Management* calculates FFS rates;
  - *Financial Analysis* assures correct application of rates with regard to contract agreements and policy and acts as a liaison between DHCS' Fiscal Forecasting Branch and CMS;
  - *Financial Review* ensures timely reporting of financial and accounting data by managed care organizations.
- **FFS Rate Development** develops rates for non-institutional and LTC services, performs analysis for cost savings/avoidance, and serves as a point of contact in negotiations with providers, patient advocates, other state agencies, etc.

More detailed information on divisional responsibilities is available in documents provided by DHCS.

California Department of Health Care Services



Florida
Agency for Health Care Administration (AHCA)

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Washington State Health Care Authority

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Florida AHCA

- Florida Medicaid serves approximately 3 M Medicaid enrollees.
- Florida did not participate in the ACA Medicaid expansion.
- 85% of clients are enrolled in managed care.
- FFS clients are generally beneficiaries with partial Medicaid benefits (e.g., dual eligibles, medically needy clients who have a share of cost, etc.).
- Medicaid has 650 staff, plus additional Program Integrity staff located in the Office of the Inspector General.
- **Medicaid just transitioned 3 M enrollees to statewide acute managed care.** Reorganization is in process; they did not provide exact staffing figures post-reorganization.
- **Florida said their reorganization will closely follow consultant recommendations made in a study from May 2013. The transition to the target functional model will be implemented in phases.**

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Washington State Health Care Authority

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Florida's Target Functional Model

- **Strategic Governance:** Strategic Planning, Alignment and Leadership; Project Portfolio Management
- **Plan Management:** Plan Oversight; Plan Relations; Contract Management; Plan Performance Management; Plan Risk Management; Customer Satisfaction
- **Provider/Recipient Services**
- **Policy/Program Management**
- **Performance & Quality Management:** Plan Quality Oversight; Medical Quality Oversight (Medical Management); Clinical Quality Oversight
- **Analytics:** Actuarial Analytics; Budgeting and Reporting; Performance Analytics
- **System Support:** IT Initiatives; MMIS; Architecture Services; Infrastructure Services; Security Services

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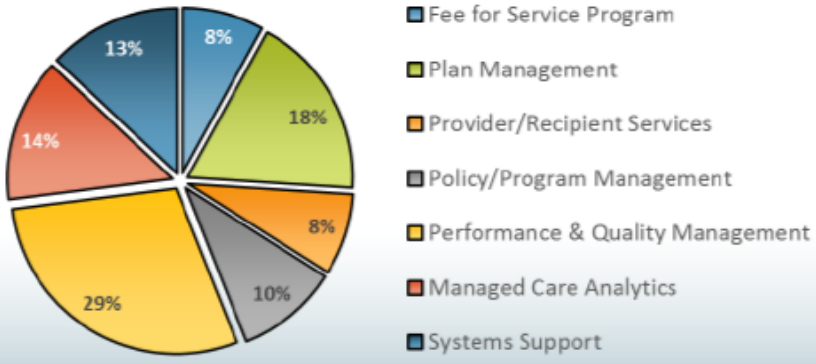
Florida's Target Workforce Allocation



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Florida's Transition Phases

Phase 1

Consolidate and centralize specialized managed care functions and workforce competencies

- Minimize bureaucracy
- Standardize operating processes
- Establish a clear span of control for each functional area

Phase 2

Process improvements and workforce transition to new organization

- Workforce demand study to identify number and type of positions needed
- Map positions to the approved model
- Create a capacity plan for staffing going forward

Phase 3

Transition to a shared services organization (years 3-5) to integrate application of health care information and quality assurance outcomes

Michigan Department of Community Health

Michigan State Current Structure

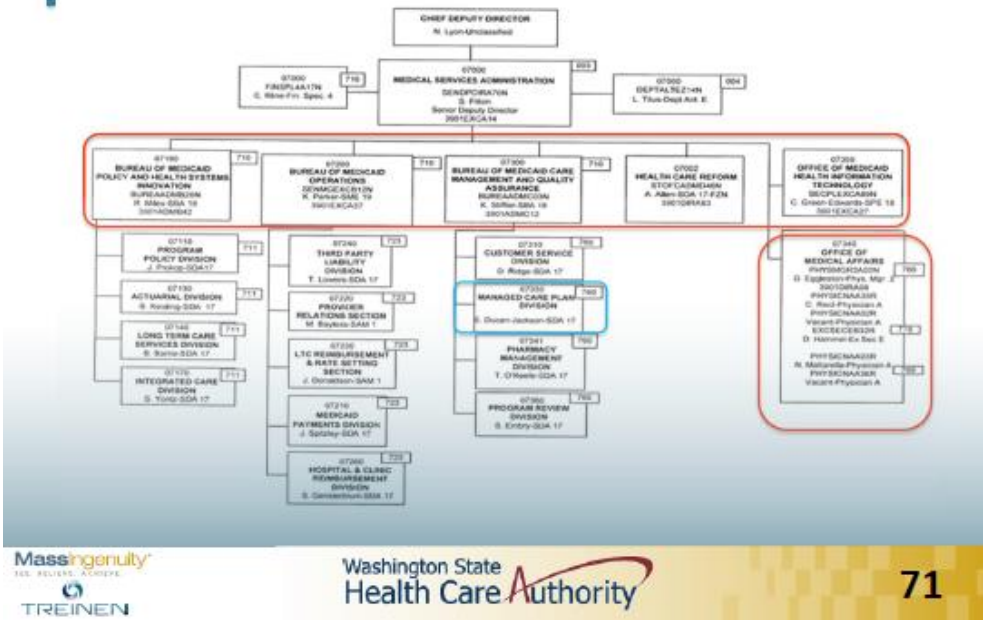
- Medicaid is part of the Michigan Department of Community Health.
- The Medicaid program serves 1.5 M enrollees.
- 74% are enrolled in managed care.
- Medical Services Administration has 482 staff.
- Approximately 30% of the employees belong to a union.

Michigan State Current Structure

Medicaid is comprised of the following six functional units:

- Bureau of Medicaid Health Policy & Health Systems Innovation
  - Program Policy, Actuarial, LTC, Integrated Care
- Bureau of Medicaid Operations
  - TPL, Provider Relations, LTC Reimbursement/Rates, Medicaid Payments, Hospital & Clinic Reimbursement
- Bureau of Medicaid Care Management and Quality Assurance
  - Customer Service, **Managed Care Plan**, Pharmacy Management, Program Review
- Office of Health Care Reform
- Office of Medicaid Health Information Technology
- Office of Medical Affairs

Michigan Department of Community Health



Washington State Health Care Authority

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Michigan State Current Structure

- Of 482 Medical Services Administration staff, 94% support Administration, Central Support, FFS and other functions not specifically dedicated to managed care.
- 29 positions (6%) in the Managed Care Unit (under the Bureau of Medicaid Care Management and Quality Assurance) are responsible for health plan contract management, systems support and quality improvement/ program development.

Washington State Health Care Authority

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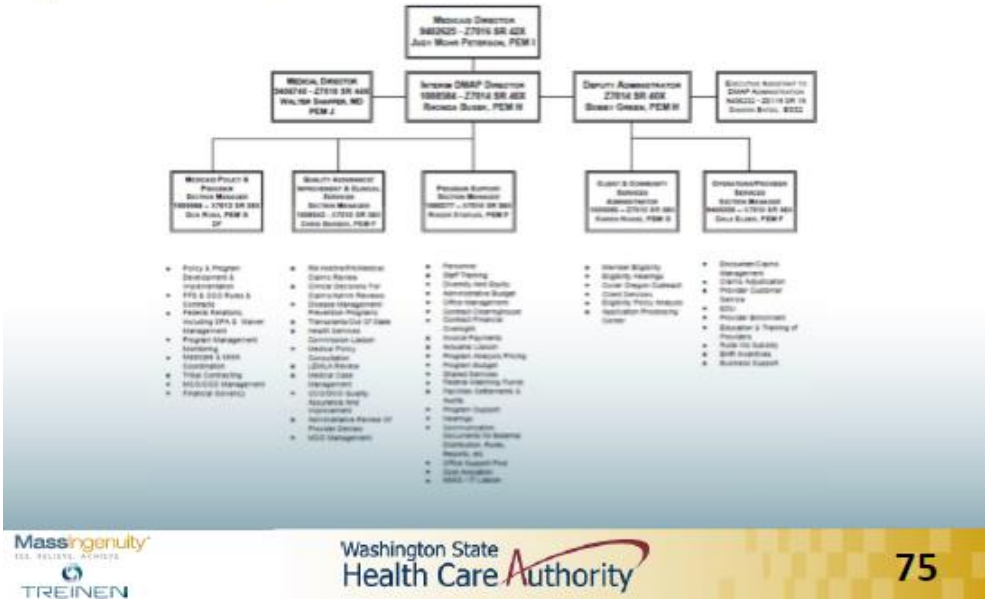
Oregon Health Authority (OHA)

OHA Current Structure

- The Medical Assistance Program (MAP) within the Oregon Health Authority (OHA) serves 1M Medicaid enrollees.
- 85% are enrolled in managed care.
- MAP is comprised of 440 staff.
- Approximately 9.8% of the employees are union members.

OHA Organization Chart



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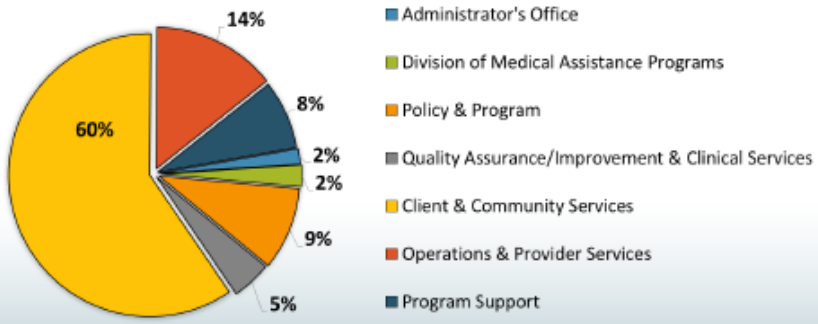
Oregon MAP Current Structure

Oregon Health Authority
Medical Assistance Programs
Percent of Workforce by Function



MAP includes five functional sections, plus administration:
Client & Community Services is the largest section

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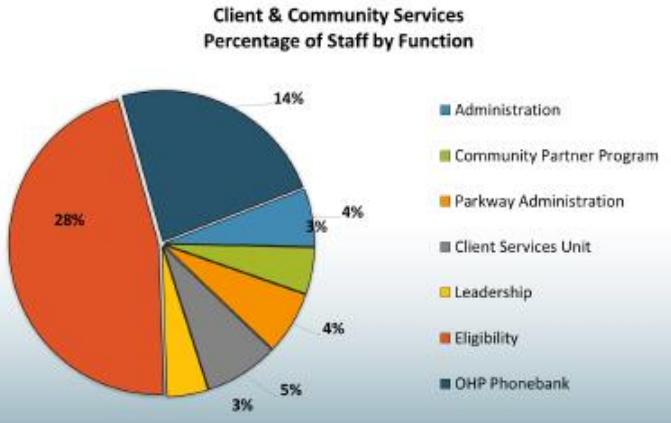
Oregon MAP Current Structure

Client & Community Services is the largest section of MAP; eligibility staff comprise 28% of the 340 staff in this section.



Oregon MAP Current Structure

- All MAP sections support both managed care and FFS.
- Central Services supports two agencies – Oregon Health Authority (OHA) and Department of Human Services (DHS), which administers some Medicaid-funded services.
  - There are IGAs in place with DHS documenting authority of the single state Medicaid agency to perform oversight of programs and expenditures.
  - There is also a joint operational and management oversight steering committee of DHS and OHA leaders who meet regularly on these issues.
- Some functions, such as IT, Research, and Forecasting are shared services for both OHA and DHS.

Contents

Operational Metrics

- AHCCCS shared operational dashboards for MCOs:
  - Membership
  - HCBS Enrollment by County/Enrollment Target
  - Membership Placement by Care Setting (Acute, HCBS, NF, None)
  - Claims Dashboard
  - Financial Viability Standards
  - Encounter Processing
  - Hearing Requests
  - Grievances
- Oregon's MCO metrics are in development. FFS metrics include processing rule amendments, provider enrollment, and call center productivity
- CA, FL and MI had nothing to share at this time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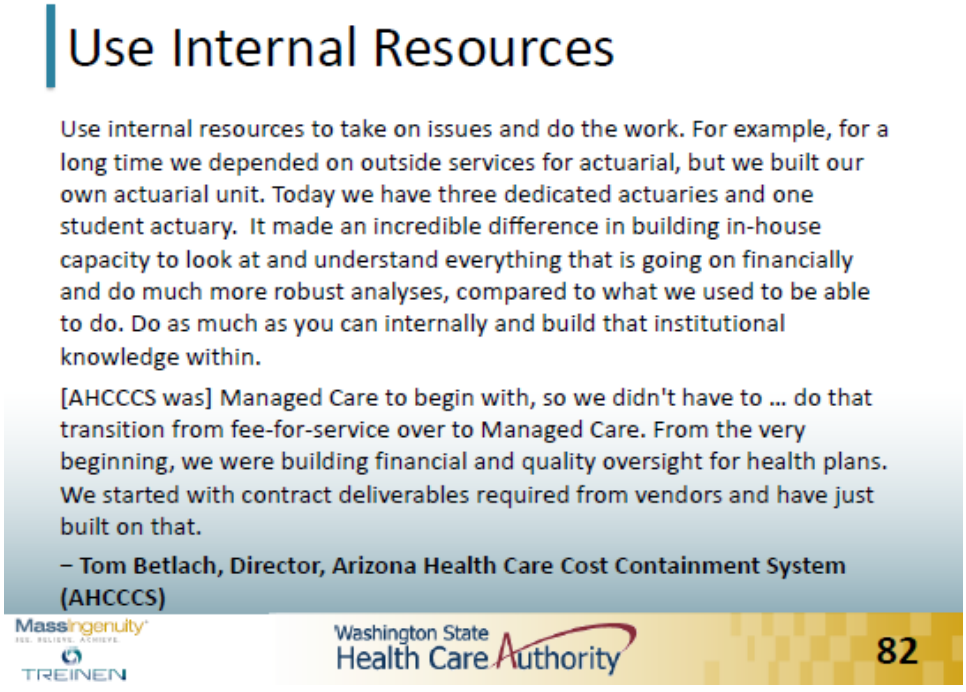
Use Internal Resources
Use internal resources to take on issues and do the work. For example, for a long time we depended on outside services for actuarial, but we built our own actuarial unit. Today we have three dedicated actuaries and one student actuary. It made an incredible difference in building in-house capacity to look at and understand everything that is going on financially and do much more robust analyses, compared to what we used to be able to do. Do as much as you can internally and build that institutional knowledge within.
[AHCCCS was] Managed Care to begin with, so we didn't have to … do that transition from fee-for-service over to Managed Care. From the very beginning, we were building financial and quality oversight for health plans. We started with contract deliverables required from vendors and have just built on that.
– Tom Betlach, Director, Arizona Health Care Cost Containment System (AHCCCS)
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Managed Care Principles

Develop a Global Strategy

- Promote competition and choice in the marketplace
- Establish the proper infrastructure for oversight
  - Sufficient staff to oversee plans
  - Complete, accurate and timely encounter data for rate setting and quality measures
- Demand improved member outcomes and plan performance
  - Track quality measures – impose sanctions for poor results
- Establish broad networks that ensure member access
  - Perform regular monitoring
- Be a competitive payer that attracts providers
  - Professional/OP rates typically at Medicare levels

– Arizona Managed Care Principles, Managed Care Workshop, NAMD January 2013

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Transition Takes Time

Our staff levels are still a moving target – we have a disproportionate number [of staff] in customer services [and] we are moving staff from FFS to managed care functions. We are decreasing provider relations staff and increasing staff in analysis and financial oversight. To some degree, we can transition existing staff, but we are still early in the transition.

The communication effort needs to be really well thought-out. Three years from the time the legislation passes is about right for the timeframe for the transition.

– David Rogers, Deputy Assistant Director, Florida Agency for Health Care Administration

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Strive for Patient-Centered Care

Place administration of Medicaid and CHIP benefits in the hands of local managed care to better meet community needs. Make sure the local connections and control are in place to ensure that Medicaid and CHIP work the way they need to in each community.

We repeatedly saw evidence that having different benefits funded by separate funding streams was not successful. For example, physical health plans know that persistent mental illness, homelessness, and lack of social supports are drivers of costs they experience, but they don't manage or pay for those services and struggle to get those things addressed. Likewise, every medical visit was a missed opportunity for oral health screenings, and referrals to mental health, substance use disorder treatment, and dental care.

For those reasons, our current system capitates Coordinated Care Organizations (CCOs) for managing the benefit, service delivery, and costs for physical health, dental, mental health, A&D/Chemical Dependency care, and many other services.

Strive for Patient-Centered Care

We are nearing the end of the integration as we add transportation, case management, and residential mental health to CCO budgets. After initial assessment of needs, a patient-centered plan can be developed for each individual, and one payer is responsible for arranging, paying for, measuring and reporting outcomes for all the individual's needs.

Efficiencies can be achieved in many ways but the most obvious is that certain points of service can be used to deliver all these things.

We are beginning to see improved outcomes and cost containment … to make Medicaid and CHIP sustainable programs that contribute to the stability and strength of the state as a whole.

– Don Ross, Manager, Policy & Planning, & CCO Contract Administration, Division of Medical Assistance Programs, Oregon Health Authority


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The Washington State HCA acknowledges the generous participation by:

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Rhonda Busek, Interim Director and Don Ross, Manager, Policy & Planning, & CCO Contract Administration, Division of Medical Assistance Programs, Oregon Health Authority

Susan Lucas, Chief Operations Officer, Washington State Health Care Authority

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APPENDIX H—HEALTHCARE PROVIDERS IN ALASKA – THE COMPETITIVE LANDSACPE

We observed briefly in both the Phase I report and this Phase II Analysis that we have concluded that there are only limited possibilities for additional savings from consolidated purchasing alone, given the lack of competition in the health care marketplace in Alaska.

That judgment reflects the following:

- Certain features of the health care marketplace that are essentially unique to Alaska;
- Our discussions in the stakeholder interview process with the major insurers, brokers and consultants in the Alaska marketplace, and
- The fact that there is already meaningful scale in the major health care programs—AlaskaCare for active state employees and their dependents, and all retirees from public employers in Alaska and their dependents—to support negotiations with providers, either directly or through AlaskaCare's business partners (i.e. Aetna and Health Care Cost Management Corporation of Alaska). The additional scale through further consolidation alone is not sufficient, in our judgment, to alter significantly the outcome through classical negotiation approaches. Further, even if more favorable outcomes can be achieved, it is not possible to quantify the level of savings that might be achieved with any degree of certainty.

What Makes Alaska Different

No state shares with Alaska all the features that, taken together, help drive the cost of health care in Alaska and limit the effectiveness of health care payers in negotiating more favorable contracting arrangements. Those important features include:

- The state's relatively small population.
- The dispersion of that population over a vast land mass.
- The higher cost of living associated with the need to import products, and to some degree services, produced outside the state.
- The small number of population centers, and principally Anchorage, which have the scale to support multiple providers of health care, including hospitals, urgent care centers, physician practices, diagnostic facilities, etc.
- The fact that in Anchorage, providers, particularly physicians in certain specialty practice areas (e.g. orthopedics, cardiology) have coalesced into a single large practice, essentially giving those practices greater leverage in negotiating with health care payers, or choosing not to contract with such payers.

That combination of factors produces an imbalance in the negotiating framework that characterizes the health care marketplace compared with other states, and has resulted in key differences in Alaska compared with other states. Examples of those differences include:

- There are no Health Maintenance Organizations operating in Alaska. Alaska is alone among other states in its exclusive reliance on fee-for-services reimbursement arrangements to providers. In contrast, the Kaiser Family Foundation and Health Research and Educational Trust reported in their 2016 survey that among the 1933 public and private employers they surveyed, 15% of their health care plan participants were enrolled in HMO plans.
- There are no Medicare Advantage (MA) programs available to Alaskans. Under MA programs, a qualified vendor negotiates contractual arrangements with the Centers for Medicare and Medicaid Services to provide all services needed for the health care of participants, including the care that would normally be paid for under Medicare Parts A and B, and the supplemental care that may be offered through the particular MA program. At present, more than thirty per cent of Medicare beneficiaries are enrolled in MA programs, administered by major vendors including Kaiser Permanente, Humana, UnitedHealthcare and others.
- In the State's Medicaid program, reimbursement to health care providers remains on a fee-for-services basis. This is in contrast to almost all other states. In the table below, we show the percentage of Medicaid care that is provided in selected states through some form of managed care arrangement, rather than through fee-for-services reimbursement to providers:[13]

Percent of Medicaid Population enrolled in Managed Care	
North Dakota	58%
Alaska	0%
Montana	69%
Delaware	86%
Wyoming	0.1%
Florida	76%
Michigan	98%
California	68%
New Jersey	92%
Rhode Island	85%
Washington	100%
Oregon	92%
United States	77%

Only Connecticut (0.0% and Wyoming (0.1%) remain along with Alaska in reporting effectively no enrollment in managed care programs for the Medicaid population they serve.

- Other than in Anchorage and Fairbanks and perhaps a handful of other population centers, there is either no or very limited competition among health care providers. Indeed, in certain locations, the principal problem in obtaining needed care is arranging transportation to that source of care. And in Anchorage and perhaps other

[1]http://www.kff.org/medicaid/state-indicator/total-medicaid-mc-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

population centers, as we observed above, the coalescing of providers, particularly specialty practices, into large physician groups has further limited competition.

How Much Additional Scale Will the Establishment of a Health Care Authority Create?

In certain respects, there is already meaningful scale in the programs managed now for Alaska's state employees and all public sector retirees, and their families, although the state may not be leveraging that scale. At present, the total population represented by these entities is as follows:

	Subscribers	Total Participants including Families
AlaskaCare Employees	6,245	16,259
AlaskaCare Retirees	41,628	68,268
Totals	47,873	84,527

The State of Alaska has successfully leveraged this entire population in negotiating administrative fees. We note, however, that the State of Alaska represents that due to anti-diminishment restrictions found in the Alaska Constitution, it has been reluctant to leverage the retiree population in negotiation with providers. As a result, there is limited steerage such that there no differential in benefit coverage for in network and out of network, and there is no differential in reimbursement rate for in network and out of network. In other words, the state has offered no incentive to providers to negotiate with the state with respect to AlaskaCare retirees.

The additional scale associated with mandatory inclusion of all eligible entities is estimated to be as follows:

	Subscribers	Total Participants including Families
All Eligible Entities	85,628	178,268

Thus, 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 arrangements. Further, since there are now just two dominant health care payers in the public employer marketplace (Aetna and Premera) who already serve as aggregators representing the interests of the public employers they serve, 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. In our judgment, for the State of Alaska to achieve additional savings, it would need to develop new and creative responses to the lack of competition. By definition, given the lack of experience with such strategies, we are unable to quantify the level of savings that might be achieved with any degree of certainty.

Observations of Health Care Payers and Other Marketplace Participants in the Stakeholder Interview Process

In the course of this work authorized under S.B. 74 we met with numerous stakeholders including those insurers/health care payers active in Alaska (Aetna, Premera and MODA Health) and with brokers, consultants and administrators active in the employer plan marketplace.

We should make the point that in the current health care environment, Aetna, Premera and MODA Health have interests that are largely if not entirely congruent with those of the employers they serve, in negotiating the most favorable contracting and reimbursement terms with providers. To the extent that they are successful in negotiating more favorable terms, that has a direct effect on their ability to gain market share, and to minimize churn in their business, both key factors in success and ultimately profitability.

They consistently expressed frustration with the difficulties presented in Alaska in those contract negotiations with providers, and their inability to reach their targeted business goals to continue to move toward reimbursement and contracting arrangements that have proven effective in other states and localities in improving both financial outcomes and quality of care provided to the populations they serve.

Given the dominance of just two vendors in the public employer health care market in Alaska (Aetna and Premera) and the other factors discussed above leads us to the conclusion that material changes in progress toward more efficacious financial and care arrangements will require both time and resources, and makes predicting additional savings speculative.

APPENDIX I – EFFECT OF PROVIDING HIGHER CONTRIBUTIONS FOR FAMILY/SPOUSAL COVERAGE

We describe in the body of this analysis the prevalence of so-called "composite" rates for coverage under Alaska's public employer health plans, versus the more common practice (including among state and local government plans) of providing health plan coverage where premium rates (and participant contributions) are differentiated for self only coverage compared with the rates and contributions required of employees who elect to cover their dependents.

We describe in this appendix in more detail the potential effect on costs of requiring or incenting employees electing family coverage now to forego covering dependents where other coverage is available, generally through a spouse's employer's plan.

Under a composite rate structure, the plan sponsor states rates (or in self-insured plans, what are called "rate equivalents") on the same basis regardless of whether an employee electing to participate in the plan is a single individual or has one or more individuals in the household qualifying under the terms of the plan as eligible dependents. Under a composite rate structure, an individual electing to participate in the plan will always cover all household members eligible for the plan, since there is no additional cost for doing so. Among the respondents to the survey conducted in compiling the Phase I report and the Phase II analysis, sixty percent of the employers employing thirty-seven percent of total participants reported that they continue to use a composite rate structure.

Where this is coupled with relatively generous plan provisions (indicated by a plan's actuarial value) and relatively low participant contributions compared with other employers' plans, a couple in households where both spouses or eligible adult members of the household are employed and eligible for health benefits at their respective employer's plan will as a matter of course elect the plan providing more generous and less costly benefits.

Employers in structuring their rating and contribution arrangements have recognized this effect, and have taken steps to take advantage of it to lower the aggregate funding costs of their plan. Stated simply, those steps have the effect of shifting claims costs that would otherwise be borne by the employer's plan to the plans of other employers, by encouraging or requiring dependents of employees to enroll in other employer's plans where health care coverage is available.

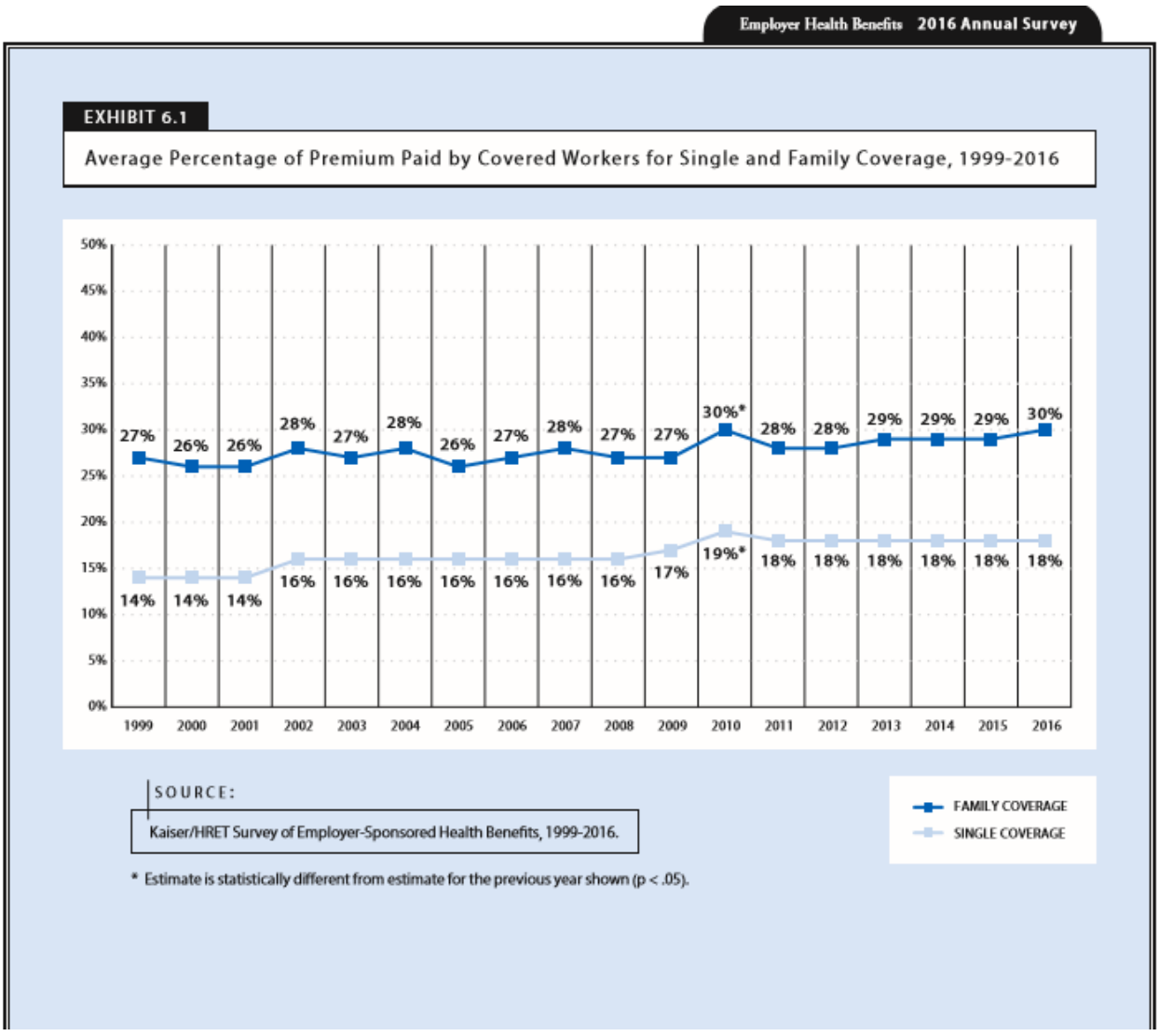
Some of these steps are described in the most recent (2016) Kaiser Family Foundation and Health Research & Educational Trust (KFF-HRET) Survey of Employer Health Benefits. In the narrative under Section 2, Health Benefit Offer Rates, the survey reported the following:

> "Virtually all firms offering family coverage offer coverage to spouses. Among firms offering health benefits to spouses, 13% do not allow an employee's spouse to enroll in the firm's plan if that spouse is offered coverage from another source, and an additional 5% allow the spouse to enroll subject to conditions. Among firms offering health benefits to spouses, 12% require an employee's spouse to contribute more to the coverage if that spouse is offered coverage from another source. Very large

firms (5,000 or more workers) are more likely than smaller firms to require higher spousal contributions when the spouse is offered coverage elsewhere (26% vs. 12%)."

Even where these more direct approaches to shifting costs to other employers' plans are not utilized, there is an observable effect in terms of employers using higher contributions for dependents coverage to incent employees to look to other employers for coverage where health benefits are made available to another member of the household.

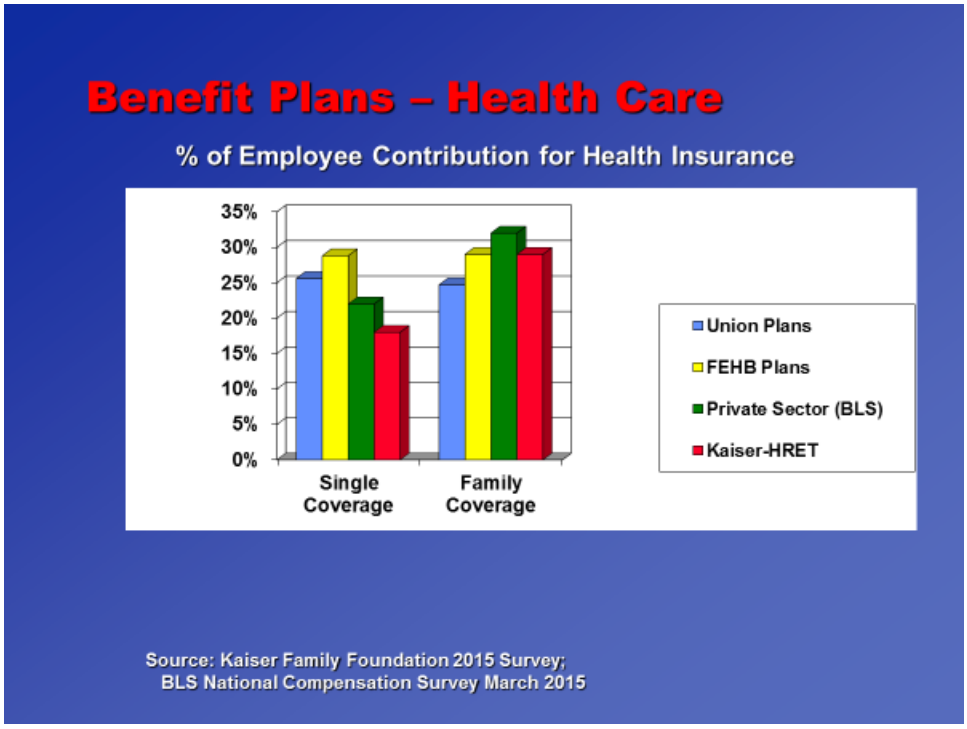
We show below from the same KFF-HRET survey the most recent data reporting the difference in the required contributions among survey respondents for single and family coverage.



As can be observed from Exhibit 6.1 from the survey, among the KFF-HRET respondents there has been a consistent gap over an extended period of time in the percentage of premiums workers who elect family coverage are required to pay, compared with the percentage of premiums required of participants who elect self only coverage. Note that the higher percentage is applied to the larger family premium rate. Based on the KFF-HRET average Single coverage and Family coverage premiums, the spread between the single coverage employee premium rate and the family coverage employee premium rate results in an even larger "spousal" of "dependent" percent of premium (36.6% in this example).

	Annual Premium (2016 KFF-HRET Survey)	Percent Paid by Worker	Annual Amount Paid by Worker
Single	**$6,435**	18.0%	$1,158.30
Family	**$18,142**	30.0%	$5,442.60
Additional cost for Family coverage (i.e. Family less Single)	**$11,707**	36.6%	$4,284.30

For households where both spouses have access to employer sponsored health benefits this gap reflects plan sponsors' decisions to influence the choice that their employees will make, in determining which employer's plan to elect. Where one employer maintains plans of equal or greater value, and requires participants to pay less for electing those plans than is required by other employers, the percentage of employees covering families will increase. To illustrate this effect, we show below data from a recent interest arbitration presentation involving a governmental bargaining unit that has access to the plans provided through the Federal Employees Health Benefits Program (FEHBP), and whose members pay a lower percentage of the premiums than required of other federal employees, and a much lower percentage of premiums compared with the percentages reported in various surveys for family coverage.



As this first graph shows, the union plans in this example require on average contributions of 25.6% of premiums for single coverage, and 24.7% of premiums for family coverage (the difference is attributable to a different mix of plans selected by self only and family participants, from among the array of plans available through FEHBP).

The corresponding percentage of premiums paid by other FEHBP participants is higher, at 28.8% of premiums and 29.0% of premiums for single and family coverage respectively.

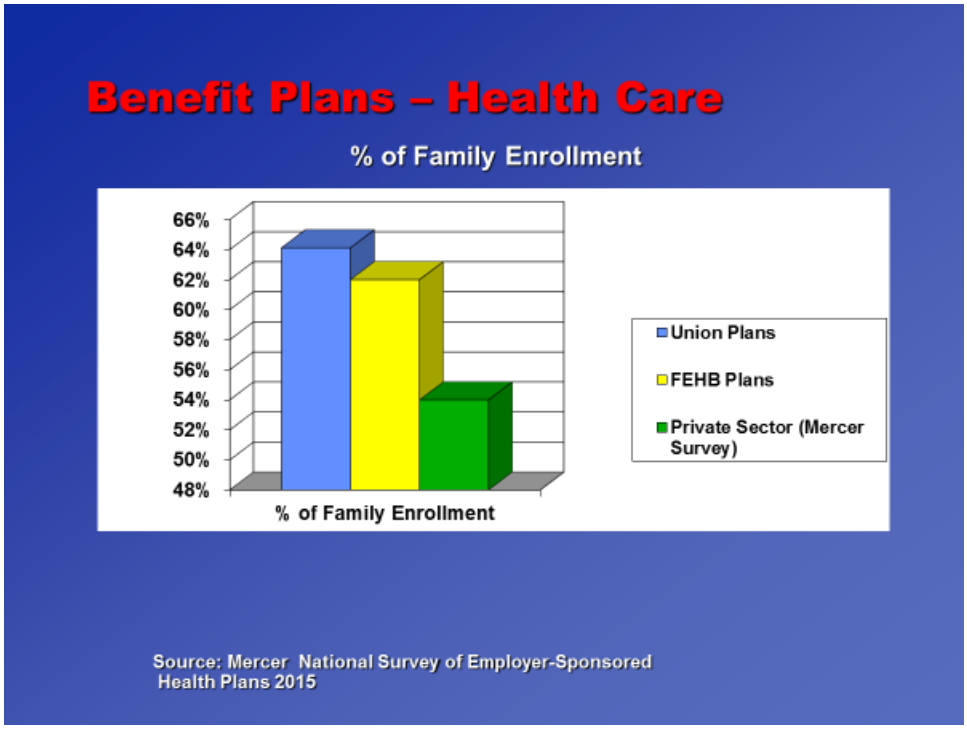
For single coverage, based on both Bureau of Labor Statistics data and data from the 2015 KFF-HRET survey reflecting private sector practice, the contributions required for single coverage in the private sector are lower than those required of either the union plans or the plans available to other FEHBP participants. But there is a marked difference when it comes to contribution percentages required of those electing family coverage.

For family coverage, the percentages of premium contributions required on average are shown in the following table:

Percentage of Premiums Required for Family Coverage

Plans	% of Premiums
Union Plans	24.7%
FEHBP Non-Union	29.0%
Private Sector (BLS)	32.0%
KFF-HRET	29.0%

These higher contribution requirements have the expected effect, with the union plans requiring the lower contribution percentages having higher percentages of members electing family coverage, compared with both FEHBP participants generally, who have access to precisely the same plans but must pay a higher percentage of the premiums; and with the private sector data reflected in the Mercer 2015 survey of employer sponsored health plans. (We should note that the KFF-HRET survey no longer reports the percentage of plan participants electing family coverage, nor is that data reported by the Bureau of Labor Statistics. The percentage of those electing family coverage shown in the Mercer survey is consistent, however, with data reported in earlier versions of the KFF-HRET survey).



As the graph shows, there is a significant decrement in the percentage of participants electing family enrollment as contribution percentages increase. For the union plans, the percentage of participants electing family coverage is 64.1%. We should note that this percentage has declined over time as arbitration awards and concessions in labor negotiations have steadily narrowed the gap between employee contributions required of these union participants compared with other federal employees participating in FEHBP.

The corresponding percentage of family enrollment for the FEHBP plans generally is 62.0%; and the percentage reported in the Mercer survey reflecting private sector results is much lower, at 54.0%.

The cost advantage created by lower family participation flows from the high percentage of working Americans in married couple households who are in households where both spouses work. The Bureau of Labor Statistics reported

in its News Release of April 2017 on the Employment Characteristics of Families Summary that in 2016, "Among married-couple families, both the husband and wife were employed in 48.0% of families."[14]

Let's examine now the effect on plan costs that flows from taking steps that will over time drive down the percentage of an employer's participants who elect family coverage. The table below illustrates the powerful effect this can have on plan costs, as an employer takes steps to reverse or mitigate the cost shifting taking place when other employers' plans provide less generous and/or more costly health benefits, or take more direct steps to require employees with coverage available through a spouse's plan to elect that coverage.

To illustrate the effect, we have used in the table below the same data in Figure 10 of this Phase II Analysis, where we used a hypothetical employer with 1,000 participants to illustrate the favorable effect on excise taxes under a multiemployer plan model for delivering benefits.

In our experience, family participation in health plans generally tops out at some 70% to 75% of total participants, reflecting the fact that some irreducible number of participants are single or live in a household with no eligible dependents as defined by the terms of the employer's health plan. In this example below, we show the results of each percentage decrement in family coverage percentage from 70% through 60% for this employer, using for simplicity's sake the single and family premiums represented by the single and family thresholds for the excise tax projected to the tax effective date under current law (2020). We should make the point that the premiums used for the illustration do not matter, since the percentage decrements will be the same for lower or higher premiums.

Employer Sponsored Health Plans
Illustration of the Effect of a Declining Percentage of Participants Electing Family Coverage

Summary of Assumptions:	Hypothetical employer with 1,000 participants in the employer's health plan						
	Assumption of participant elections currently:			Self Only	Family	Total	
				300	700	1000	
	Annual premiums per capita (projected to 2020)			$10,929	$29,466	N/A	
	Total premiums			$3,278,818	$20,626,548	$23,905,366	
	Savings for each 1% decrement in family participation percentage, from current 70% family participation						
	Self Only	Family	Total	Self Only Premiums	Family Premiums	Total Premiums	Percentage Savings
	310	690	1000	$ 3,388,111	$ 20,331,883	$ 23,719,995	0.78%
	320	680	1000	$ 3,497,405	$ 20,037,218	$ 23,534,624	1.55%
	330	670	1000	$ 3,606,699	$ 19,742,553	$ 23,349,253	2.33%
	340	660	1000	$ 3,715,993	$ 19,447,888	$ 23,163,882	3.10%
	350	650	1000	$ 3,825,287	$ 19,153,223	$ 22,978,511	3.88%
	360	640	1000	$ 3,934,581	$ 18,858,558	$ 22,793,139	4.65%
	370	630	1000	$ 4,043,875	$ 18,563,893	$ 22,607,768	5.43%
	380	620	1000	$ 4,153,169	$ 18,269,228	$ 22,422,397	6.20%
	390	610	1000	$ 4,262,463	$ 17,974,563	$ 22,237,026	6.98%
	400	600	1000	$ 4,371,757	$ 17,679,899	$ 22,051,655	7.75%

[14] https://www.bls.gov/news.release/famee.nr0.htm

As the table illustrates, each 1% decrement in the percentage of employee's electing family coverage produces savings of just under 0.8%, assuming that the total number of employee participants remains the same at 1,000 participants. That assumption is somewhat conservative, in that the greater contributions required for family coverage or other incentives to choose the spouse's employers plan will also result in some employees now choosing family coverage to forego coverage altogether. As a rough rule of thumb, each 1% decline in family percentage participation coupled with current family participants exiting the employer's plan altogether will generally produce a savings of about 1% of total premiums for each 1% decrement in family participation at the starting participation level in this example.

Moving away from the composite rate structure and further incenting or requiring participants to elect coverage available from another employer could have a powerful effect on reducing the costs associated with Alaska's public employer health care plans. In addition, the negative effect on participants could be mitigated by increasing compensation to offset the additional participant contributions required. The cost of those compensation increases would be far less than the savings that would be achieved by reversing the cost shifting now in place, in which Alaska's public employer plans will typically be the plan of choice for participants whose spouse has access to coverage through another employer.

FEHB Data on Alaska Enrollment

Comparing 2012 FEHB enrollment data for federal employees in Alaska to the total number of federal employees in Alaska, we observe that only 71% of federal employees are enrolled in FEHB plans. Throughout FEHB, the average rate of non-participation is about 10%. This additional data point illustrates the leverage that contribution policy can have on which employer plan is selected by a family where both workers have access to an employer sponsored healthcare plan.

The Potential Effect on Plan Costs Among Alaska's Public Employers in Changing the Pattern of Dependent Participation

We describe above and in the body of this Phase II analysis the various ways employers are taking steps to reduce or remove the incentive to enroll in their plan where a family member is eligible for coverage through another employer. Reversing the cost shifting in place now, where both FEHBP and typical private sector plans provide greater incentive for households to almost always choose Alaska's public employer plans where a choice is available would have a powerful effect in reducing the expenditure for health care coverage for Alaska's public employers.

For example—if Alaska's public sector employers moved over time to align the required contributions for dependents coverage with contribution requirements on average for the FEHBP plans and private sector plans as reported in the KFF-HRET survey, we would estimate that for the great majority of those employers family participation would decline to levels more consistent with those observed in the FEHBP plans and in the private sector, or by approximately one-seventh (from an estimated seventy percent to no more than sixty percent). That would produce a reduction in family participation that could reasonably be expected to reduce costs by at least some eight percent to ten percent of total plan costs, compared with the status quo.

APPENDIX J – ADDITIONAL SAVINGS OPPORTUNITIES

While we have identified through the course of Phases I and II of this study various savings opportunities that might be implemented at the outset and over time, and with some modifications based on factors that will require further analysis, we should make the central point that under the aegis of a health care authority properly structured and with appropriate authority and governance procedures, it will be possible to manage toward any particular budget and fiscal requirements, coupled with appropriate quality measurements.

Such management is in place now under the Oregon Health Authority including their demonstration waiver arrangements in the state's Medicaid program, where they have successfully managed to a per capita growth rate of 3.4% per year over the period the waiver arrangements have been in place, coupled with compliance with sixteen quality of care measurements subject to annual review.

For example, the Authority could limit the maximum actuarial value of the plans available, as a tool to reduce costs. Using the data in Table 3, page 21, depicting the distribution of actuarial values among survey respondents, if the plans with actuarial values above 87% were reduced to 87%, and the employee contribution cost-sharing in place currently was maintained as a percentage of cost, then the aggregate reduction in cost would be about 2.75 percent. The details of the calculation are shown in the following table.

Plans with a value between 92% and 96% (average 94%) would see a 7/94 reduction in cost. Enrollment in these plans represents 25.9% of all lives, so the savings from these plans is 1.93% (25.9% times 7.4%).

Actuarial Value	Percent of Population	Cost Reduction	Percent of Band	Aggregate Reduction
Above 96%	1.90%	10.3%	100%	0.20%
92%-96%	25.90%	7.4%	100%	1.93%
88%-92%	17.20%	3.3%	100%	0.57%
84%-88%	27.20%	1.1%	20%	0.06%
Total				**2.76%**

Alternatively or in addition, participant contribution arrangements could be structured over time to capture necessary savings to achieve fiscal requirements as necessary. As discussed in the previous appendix addressing cost shifting among employers through incenting those in dual income households to select other employers' plans, reversing the cost shifting now in place that benefits other employers in Alaska at the expense of Alaska's public sector employers could produce substantial savings compared with the status quo.

GLOSSARY

Actuarial Value
The proportion of covered charges that are expected to be paid by the plan for the covered population.

ACHIA
The Alaska Comprehensive Health Insurance Association (ACHIA) is a nonprofit incorporated legal entity established under the provisions of Alaska Statute Title 21, Chapter 55, and is exempt from the payment of fees and taxes levied by the state or any of its political subdivisions except taxes levied on real or personal property. The Plan is governed by a Board of Directors composed of seven individuals. Five board members represent participating member health insurance companies of the association approved by the Director of the Division of Insurance and two are consumers selected by the Director of the Division of Insurance. The Director or the Director's designee serves as a nonvoting ex-officio member of the Board.

AEA
Anchorage Education Association

AFSCME
American Federation of State, County & Municipal Employees

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

BCBS
Blue Cross Blue Shield

Captive
A form of self-insurance in which the insurer is owned by the insured.

CCO
A Coordinated Care Organization.

CDHP
A consumer directed health plan.

Coinsurance
The percentage of cost, for covered health care services, members must pay after the deductible is met. May also be expressed as the percentage of cost that the plan pays.

Composite Rate
A uniform rate for all members of the group regardless of their status as self only or self plus family members.

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

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

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

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

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

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

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

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

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

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

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

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

MCO
A Managed Care Organization

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

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

Minimum Premium Plan
An employer sponsored health plan which strikes a balance between fully-insured and self-insured plans, in that the protection of the insurance plan is maintained while allowing for the cash flow advantages of self-insured plans.

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

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

Out-of-Pocket Maximum
The most a member would pay for health care service in a year. It typically includes deductibles, copays and coinsurance. Depending on the plan provisions certain charges may not be subject to the limit (e.g. charges for treatment that is determined not to be medically necessary, or that exceeds the allowable limits in a plan).

PCMH
Patient Centered Medical Home

Pharmacy Benefit Manager (PBM)
Third party administrator of prescription drug programs.

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

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

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

Premium
The amount employers pay for health insurance every month.

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

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

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

Stop-Loss
Insurance purchased by a self-insured employer or group to reduce risk and protect against excessive or large claims. Stop-Loss insurance can protect against large claims incurred by one individual and it can provide a cap on the dollar amount an employer would pay the insurance company during the contract year.