Department of Administration

Commissioner Sheldon Fisher

ASHNHA Conference

What is AlaskaCare?

- AlaskaCare is a term used to describe the State of Alaska self-insured health plans managed by the Division of Retirement & Benefits.
  - AlaskaCare Retiree Plans including:
    - Defined Benefit Medical Plan
    - Defined Contribution Retiree Medical Plan
    - Dental, Vision, and Audio Plan
    - Long Term Care Plan (not referred to as AlaskaCare)
  - AlaskaCare Employee Plans
    - Medical Plan
    - Dental Plan
    - Vision Plan

AlaskaCare Retiree Plan Overview

AlaskaCare Retiree Plans

- AlaskaCare Retiree Health Plans
  - DB Plan
    - 70,000+ members
      - 41,000 retirees
      - 29,000 dependents
  - Dental, Vision & Audio Plan
    - 53,000 members
  - Long Term Care Plan
    - 21,000 members
  - DCR Plan – Created July, 2016
    - 9 members

- $600 million annual spend in FY 16:*
  - $545 million Health plan
  - $40 million Dental, Vision & Audio plan
  - $15 million Long-Term Care plan

*Source: 2016 Audited Financial Statements

DB Retiree Plan Design

Defined Benefit Plan	Medical
Deductible	$150 individual / $450 family
Coinsurance	80%
Annual Out-of-Pocket Maximum	$800 individual
Preventive Care	Limited: mammogram, PSA, pap smear
Dependents	Covered up to age 19, 23 if full-time student
Lifetime Maximum	$2,000,000

	Pharmacy
Generic	$4 copay retail / $0 copay mail order Up to 90 day supply
Preferred Brand Name	$8 copay retail / $0 copay mail order Up to 90 day supply
Non-preferred Brand Name	$8 copay retail / $0 copay mail order Up to 90 day supply

Retiree Plan: Challenges & Solutions

Challenges

- Older plan design
  - No preventive coverage
  - Dependents only until age 23 if in school
  - Lifetime maximum of $2 million
- Changes subject to stringent legal evaluation:
  - Benefits protected by constitutional diminishment clause
  - Changes must be evaluated within that context
- Lack of meaningful cost saving measures
- Difficulty communicating with membership

Solutions

- Establish Retiree Health Plan Advisory Board
  - Provide a meaningful way for the Department to evaluate and discuss possible benefit changes to modernize the plan.
- Evaluate coverage changes including:
  - Preventive care
- Leverage Additional Federal Subsidies
  - Implement Employer Group Waiver Program
    (No change to benefits member receives)

The State of Alaska provides health care to its employees through a state health plan and union health trusts.

AlaskaCare Health Plan	Union Health Trusts
Employees: 6,350	**Employees: 10,500**
• AVTEC	• General Government (GGU/ASEA)
• Confidential Employees	• Labor, Trades and Crafts
• Correctional Officers	• Public Safety Employees Association
• Marine Engineers	• Masters, Mates & Pilots
• Mt. Edgecumbe Teachers	
• Supervisory	
• Inland Boatmen's Union	
• Exempt/Partially Exempt Employees -Includes Court System & Legislature	

Employer Spend on Health Care

- As an employer, the state pays an amount to AlaskaCare and the union health trusts on a Per Employee Per Month (PEPM) basis.
- In FY16, the total employer & employee contributions were $296.1 million+
- Employer contributions: $265.1 million
  - $107.2 million for AlaskaCare
  - $157.9 million to union health trusts
- Employee contributions: $31.0 million
  - $13.7 million by AlaskaCare members
  - $17.3 million by union health trust members

+Source: Based on payroll data with the additional $7.5M lump sum payment received in FY16 for AlaskaCare.

AlaskaCare Employee Plan Basics

AlaskaCare Employee Plan

- Self-insured plan
  - Aetna is the medical Third-Party Administrator (TPA)
  - Moda is the dental TPA
- 16,350 total covered lives (active employees & dependents)
  - 6,350 employees
  - 9,800 dependents
- Approx. $137 million annual spend
  - $130.7 million medical & pharmacy*
  - $6.2 million dental
- Plan pays around 82% of medical & pharmacy claims
- Members pay around 11% of medical & pharmacy claims+

* Source: 2015 Aetna Annual Report

+The remainder 7% is paid by secondary insurance which could include an AlaskaCare plan.

Employee Plan Design

Active Plan	Economy	Standard
Deductible	$600 individual $1,200 family	$400 individual $800 family
Coinsurance	70%	80%
Annual Out-of-Pocket Maximum	$2,850 individual $5,700 family Separate pharmacy OOP Max of $1,000 individual / $2,000 family	$1,850 individual $3,700 family Separate pharmacy OOP Max of $1,000 individual / $2,000 family
Preventive Care	Covered at 100% with no deductible in-network	
Dependents	Covered up to age 26	
	Pharmacy	
Generic	80% retail 30 day in network: $10 minimum/$50 maximum $20 copay for up to 90 days at mail order	
Preferred Brand Name	75% retail 30 day in network: $25 minimum/$75 maximum $50 copay for up to 90 days at mail order	
Non-preferred Brand Name	65% retail 30 day in network: $80 minimum/$150 maximum $100 copay for up to 90 days at mail order	

Employee Plan: Challenges & Solutions

Fiscal Challenges

- Employee plan costs are exceeding revenues
- This is due to a combination of factors:
  - A spike in utilization following layoff notices
  - Reduction of employees, reducing employer contributions
  - Emergence of double-digit pharmacy growth
  - Health care cost growing faster than anticipated
- Using reserves to cover the difference is not sustainable
- Health care cost increases are pressuring plans across the state and nation
- DOA is addressing these challenges through significant plan changes to AlaskaCare in 2017

Addressing Fiscal Challenges

Four tools available:

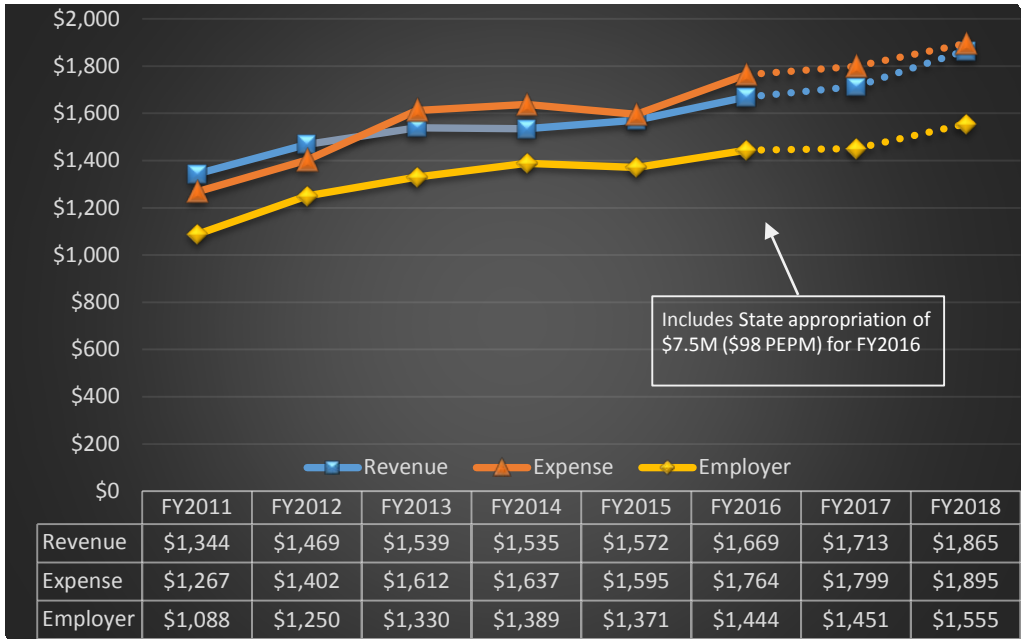
1. Increase employee contributions
   - Increased deductible & coinsurance
   - Increased employee share of premiums in 2018
2. Implement plan design changes
   - Three-tier pharmacy benefits
   - Facility steerage in Anchorage & outside of Alaska
   - Allow employees to opt-out of coverage
   - Eliminate Premium plan
3. Reduce cost of service
   - Renegotiate pharmacy contracts
   - Improve facility discounts
4. Increase employer contributions
   - Employer contribution rate increased to $1,555

2017 Initiatives to Address Challenges

Initiative	FY2017 Impact	FY2018 Impact	Comments
Anchorage Hospital Steerage	-$1.25M	-$2.5M	Annual savings when mature estimated to be $3.0M
Three-Tier Rx Cost Structure	-$900K	-$1.8M	Improves generic dispensing rate, preferred brand utilization and rebates
Dependent Eligibility Verification Audit	-$750K	-$800K	Almost 500 dependents disenrolled to date, with the expectation that some will verify eligibility and subsequently (re)enroll. Those remaining disenrolled are assumed to have below average per capita costs
Eliminate Premium Plan	-$300K	-$600K	Redistributes risk from highest cost plan
Pharmacy Contract Renegotiation	-$500K	-$1.6M	Improved discounts and rebates; rebate lag results in longer time to maturity
Surrender Grandfathered Status	$800K	$1.6M	Cost to implement addition coverage required by the ACA (preventive, etc)
Deductible and Out-Of-Pocket-Max	-$600K	-$1.2M	Increase deductible by $100/$200 and out-of-pocket-maximum by $250/$500 in both plans.
Opt-Out Provision	-$50K	-$125K	Allow employees to opt-out of AlaskaCare and/or not cover eligible dependents. Assumes the Employer contribution (pepm) is unaffected for EEs that opt-out. Otherwise there is a net loss.
Total Net Impact	**-$3.55M**	**-$7.03M**	

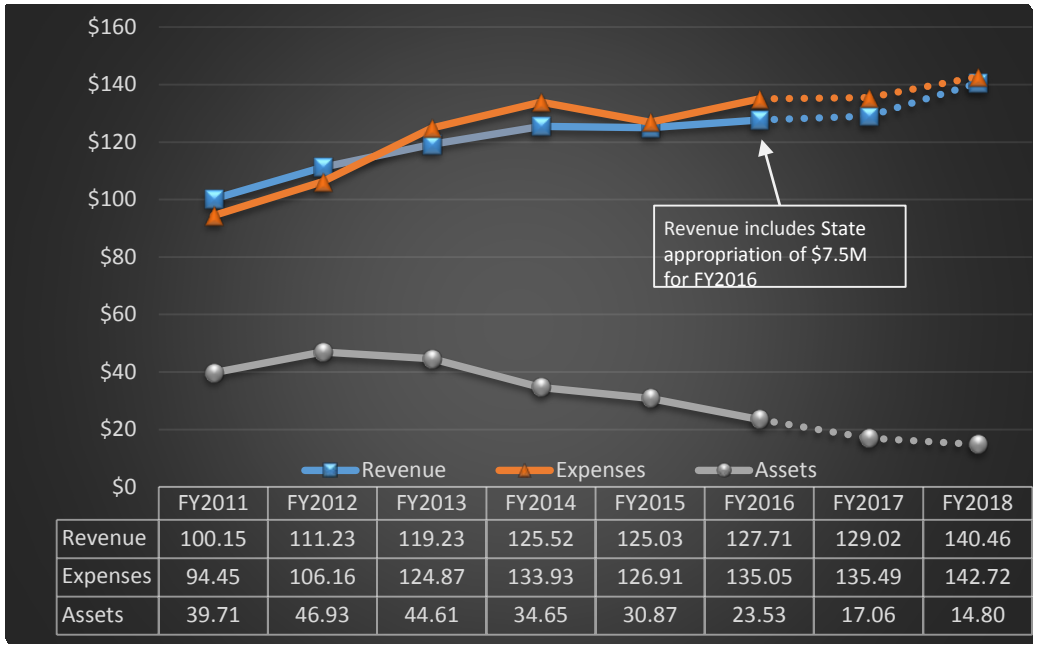
Active Historical/Projected Revenues, Expenses, Assets
State Monthly Funding Rate Increased to $1,555 on January 1, 2017

Revenue vs Expense PEPM



	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018
Revenue	$1,344	$1,469	$1,539	$1,535	$1,572	$1,669	$1,713	$1,865
Expense	$1,267	$1,402	$1,612	$1,637	$1,595	$1,764	$1,799	$1,895
Employer	$1,088	$1,250	$1,330	$1,389	$1,371	$1,444	$1,451	$1,555

Revenues, Expenses, Assets (millions)



	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018
Revenue	100.15	111.23	119.23	125.52	125.03	127.71	129.02	140.46
Expenses	94.45	106.16	124.87	133.93	126.91	135.05	135.49	142.72
Assets	39.71	46.93	44.61	34.65	30.87	23.53	17.06	14.80

- This includes an increase in the employer contribution to $1,555 beginning 1/1/17 and continuing through FY 18. (Submitted $6.2 million supplemental to cover FY 17 increase)
- Without additional changes, assets decline to $14.8M and funds 80%.
- Increased employee premium share and other initiatives are estimated to achieve 98% of IBNR level in FY 18.
- Management goal is 150% of IBNR.

Looking Ahead

Additional Initiatives Under Consideration

- Increase employee contribution
- Continue to increase cost share levels
- High Deductible Health Plan option
- Enhanced travel benefits
- Employee clinics
- Move to % of Medicare fee schedule for out of network services
- Telemedicine
- Enhanced Hi Tech Imaging review
- Incorporate value-based plan provisions

Health Care Authority Study

- Last session's SB 74 Medicare Reform directed DOA to conduct a study evaluating the feasibility of a Health Care Authority due by June, 2017.
- SB 74 requires the study to:
  - Identify cost-saving strategies that a health care authority could implement;
  - Analyze local government participation in the authority;
  - Analyze a phased approach to adding groups to the health care plans coordinated by the health care authority;
  - Consider previous studies procured by the Department of Administration and the legislature;
  - Assess the use of community-related health insurance risk pools and the use of the private marketplace;
  - Identify organizational models for a health care authority, including private for-profit, private nonprofit, government, and state corporations; and
  - Include a public review and comment opportunity for employers, employees, medical assistance recipients, retirees, and health care providers.

Study Outline

- Study looks at public employees in all bargaining groups, school districts, political subdivisions, the University, and other public entities providing health care benefits.
- Goal is to see if there are opportunities to create savings through greater efficiencies.
- Study will be completed in phases:
  - Phase 1: evaluates opportunities for savings through consolidated purchasing strategies.
  - Phase 2: evaluates opportunities for savings through coordinated plan administration.
- Data collection process complete, surveys sent to all entities, in analysis phase.
- More information available at https://alaskahcastudy.com/

Phase 1

- Evaluates opportunities for savings through consolidated purchasing strategies.
  - Partner Engagement
  - Data Collection
    - What are the health care plan designs?
    - What arrangements are in place for funding the health care plans (e.g. fully insured, self-insured with stop-loss, self-insured without stop-loss)?
    - Which health insurance companies and third-party administrators are used to administer the plans?
    - How is the cost of the coverage shared between the employer and the employee/member?
  - Actuarial Analysis
  - Develop Initial Findings

Survey Participation

The survey captured an estimated 84% of benefit eligible employees.

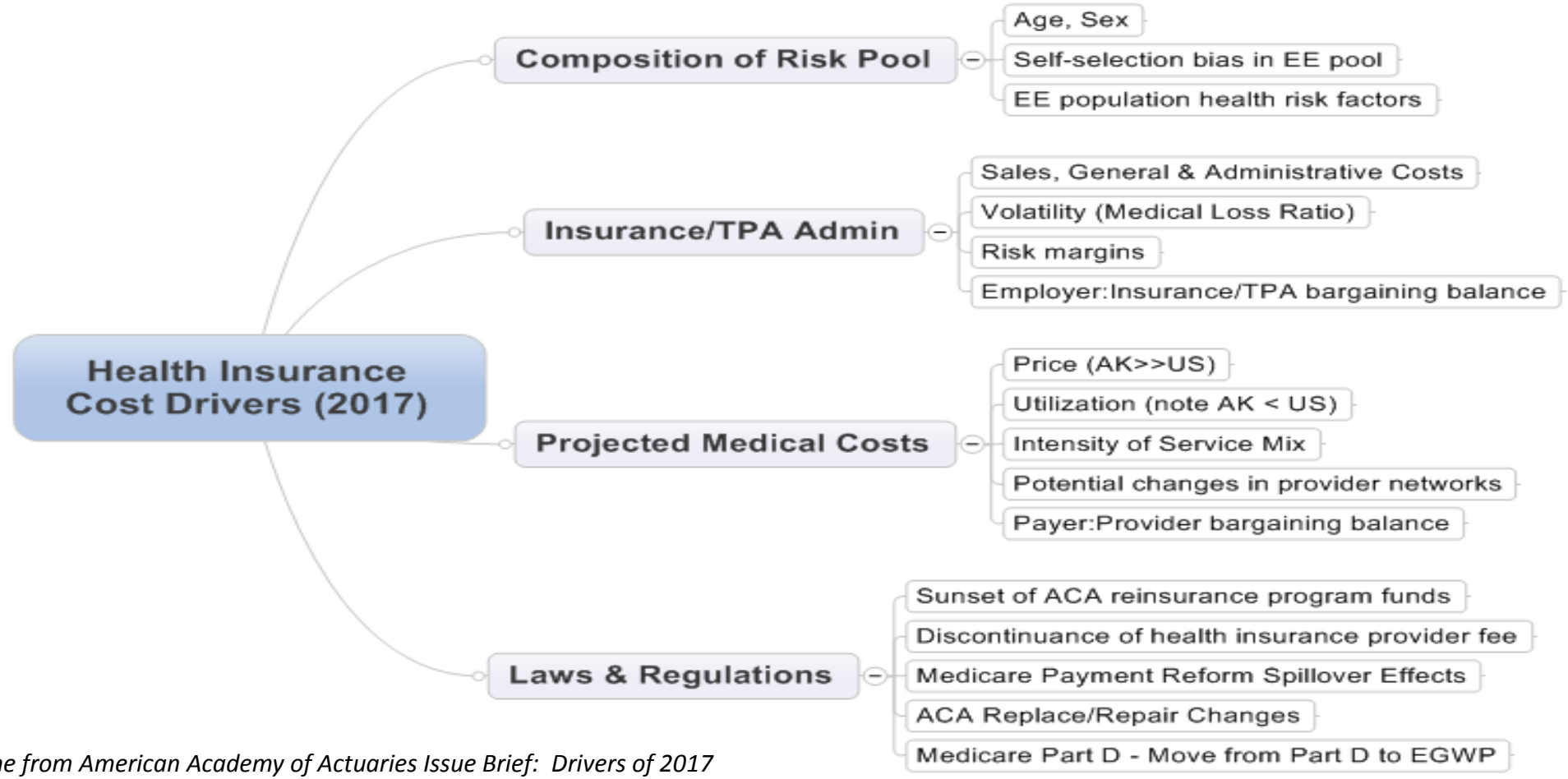
Table 4
Survey Responses by Type of Employer

Summary	Surveyed Entities	Completed	Not Complete	Percent Completed
State Employees & Retirees	6	5	1	83%
University of Alaska	1	1	0	100%
State Corporations	2	2	0	100%
School Districts	54	48	6	89%
Political Subdivisions	164	68	96	41%
Grand Total	227	124	103	55%

Table 5
Survey Responses by Region

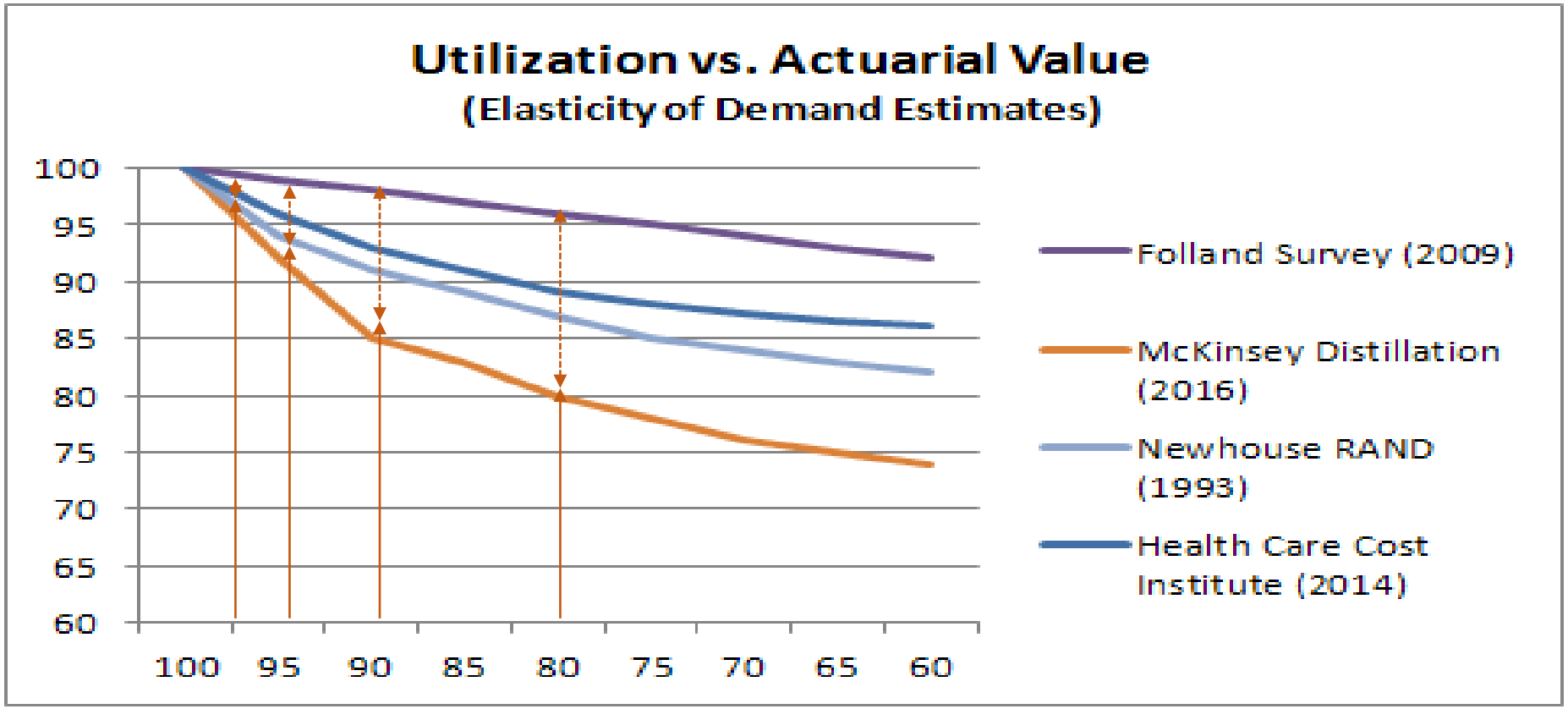
Regions	Surveyed Entities	Complete	Not Complete	Percent Completed	Civilian Labor Force	
Anchorage	2	2	0	100%	155,765	43%
Gulf Coast Region	23	14	9	61%	38,973	11%
Interior Region	34	18	16	53%	53,174	15%
Mat-Su	5	5	0	100%	43,893	12%
Northern Region	39	12	27	31%	10,421	3%
Southeast Region	44	33	11	75%	38,384	11%
Southwest Region	71	32	39	45%	19,858	6%
Statewide	9	8	1	89%		
Grand Total	227	124	103	55%	360,488	100%

Health Insurance Cost Drivers



Elements of outline from American Academy of Actuaries Issue Brief: Drivers of 2017 Health Insurance Premium Changes

Plan Value & Utilization



Actuarial Value 97, EE cost sharing 3; utilization <-1% to -5%
Actuarial Value 95, EE cost sharing 5; utilization -1% to -8%; HCCI ~-4%

Actuarial Value 90, EE cost sharing 10; utilization -2% to -15%; HCCI ~ -7%
Actuarial Value 80, EE cost sharing 20; utilization -4% to -20%; HCCI ~ -11%

Source: MAFA

Phase 2

- Evaluates opportunities for savings through coordinated plan administration
  - Researching other state HCA models
    - What could a HCA look like?
    - How are HCAs structured in other states?
    - Which structures seem to be most successful in managing health care costs and achieving system improvements?
  - Finalize recommendations based on Phase 1 findings and Phase 2 research
  - Identify opportunities and challenges, provide analysis on those
  - Review and incorporate public feedback
- Final report due by June 30, 2017

Questions?