

# Department of Administration

Health Care Authority Feasibility Study  
Alaska State Hospital and Nursing Home Association



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# Study Overview

- In 2016, SB 74 directed Department of Administration (DOA) to procure a study evaluating the feasibility of a Health Care Authority.
- 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 evaluates health benefits funded directly or indirectly by the state for the following groups:
  - Medicaid
  - State of Alaska retirees (PERS, JRS and TRS)
  - Employees in the following groups:
    - State of Alaska (all bargaining groups)
    - School districts
    - University of Alaska
    - State corporations
    - Political subdivisions
    - Other groups that would benefit from participation (e.g. individual market)
- Goal is to see if there are opportunities to create savings through greater efficiencies.
- Evaluate opportunities for consolidated purchasing strategies and coordinated plan administration.

# Study Contractors

## ➤ Contractors:

- PRM Consulting Group (PRM) - survey collection, data analysis, phase 1 & phase 2 findings focusing on public employee benefits
- Mark A. Foster Associates (MAFA) – peer-review, Alaska specific market analysis & opportunities
- Pacific Health Policy Group Consulting (PHPG) - Medicaid technical assistance and analysis
- Agnew::Beck – public comment and review process

# Important Dates

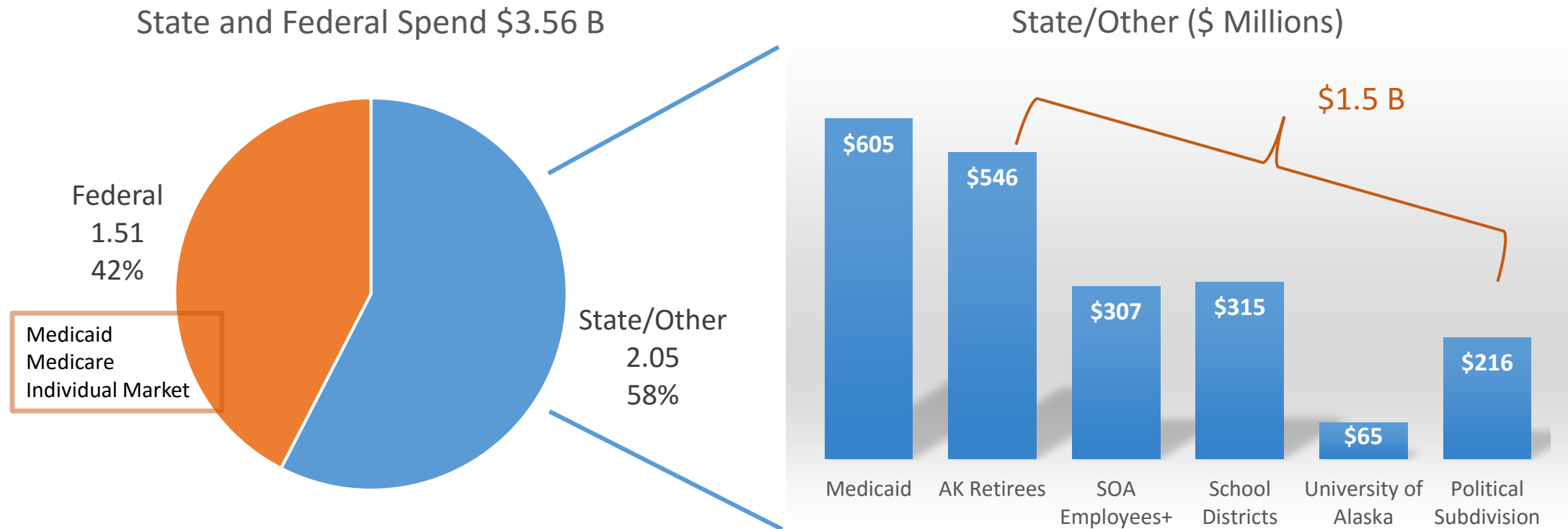
## Timeline:

- August 30, 2017 PRM, PHPG, MAFA reports released
- September 1, 2017 Public comment process opens
- September 7, 2017 PRM webinar (12:30pm – 1:30pm)
- September 11, 2017 PHPG webinar (2:00pm – 3:00pm)
- September 13, 2017 MAFA webinar (2:30pm – 3:30pm)
- October 30, 2017 Public comment process closes  
*\*\*Extended to November 30, 2017\*\**
- December 4, 2017 Report addendum released

# Big Picture Takeaways

# 2016 Expenditures & Covered Lives

The State of Alaska & other publicly funded health benefits covering over 340,000 lives.



# Health Plan Consolidation

- Health plan consolidation exists in the Medicaid and AlaskaCare retiree population with administrative entities covering a combined 233,000 covered lives.
- The State of Alaska, along with school districts and political subdivisions provide coverage to an estimated 44,000 benefit eligible employees through more than 100 different health insurance plans.
- This includes a mix of fully insured and self-insured plans as well as union health trusts.



# PRM Phase I & Phase II Reports

# Overview

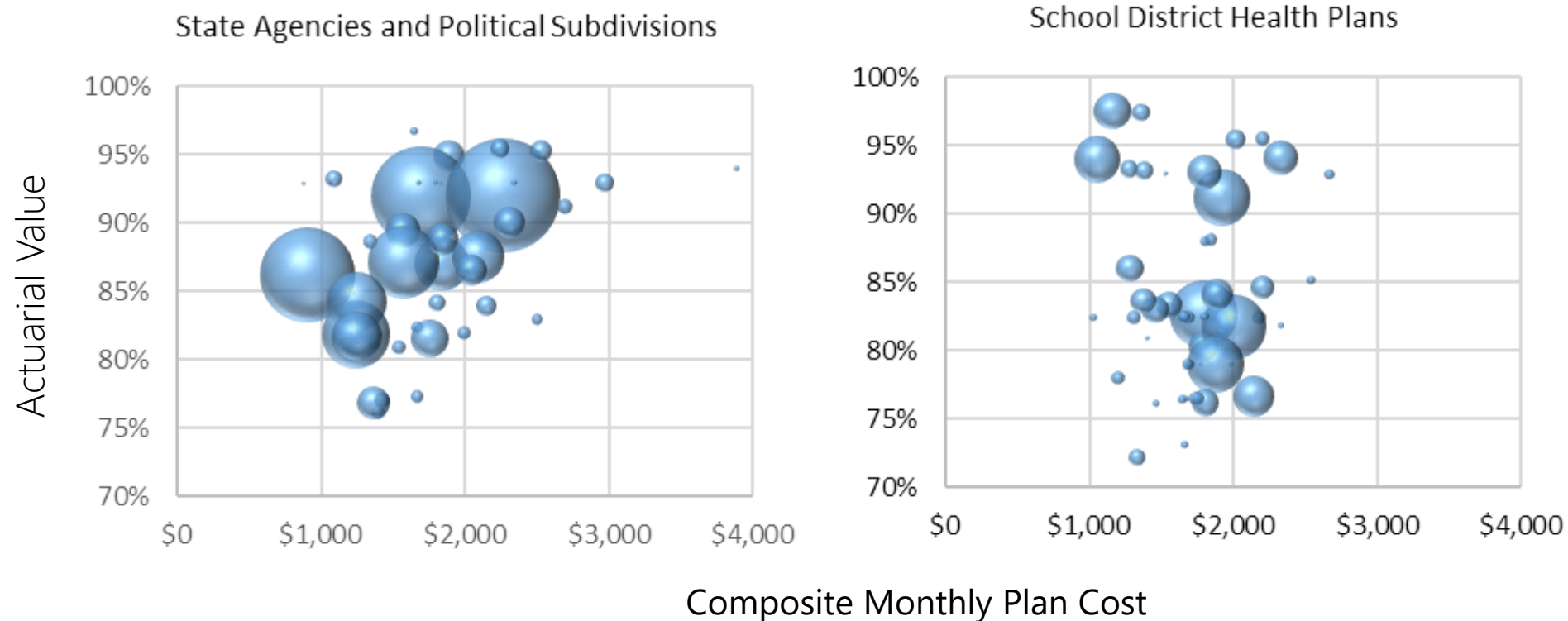
- Areas of focus: Public employee and retiree plans
- Activities:
  - Conducted survey of public employee plans
  - Identified potential purchasing opportunities
  - Conducted actuarial analysis for establishing different risk pools

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

| 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%               |

# Key Observations

- Average cost \$21,738/year almost 60% greater Kaiser Family Foundation state & local govt. average
- Purchasing consolidation already exists across different public employee health plans
- Higher use of composite rates rather than tiering rates across public employers
- Wide range of health plan actuarial values



# Consolidated Purchasing Savings

| Opportunity  | First Year Estimated Savings (\$Million) |
|--|--|
| Change Medicare Part D coordination method from Retiree Drug Subsidy (RDS) to Employer Group Waiver Plan (EGWP) in AlaskaCare Retiree Plan | \$61.6                                   |
| Pharmacy Benefit Carve-out   | Range from \$3.5 to \$8.0                |
| Centers of Excellence / Travel Benefit   | Range from \$2.9 to \$3.5                |

# Coordinated Plan Administration Savings

| Projected Savings or (Costs) in \$Millions  |               |               |               |               |               |                        |
|---|---------------|---------------|---------------|---------------|---------------|------------------------|
|   | Expected 2017 | Expected 2018 | Expected 2019 | Expected 2020 | Expected 2021 | 5-Year Savings (Costs) |
| 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 – Multiemployer 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)               |

# PRM Phase II Recommendations

1. State of Alaska establish a Health Care Authority (HCA) with three separate pools: one pool for retirees and two pools for employees, with separate pools for school district employees and all other governmental employees.
2. All entities be required to participate in the HCA when first feasible and no later than upon the expiration of the current collective bargaining agreement.
3. The HCA develop multiple plan options for medical, prescription drugs, dental, and vision benefits to provide a wide range in health plan choices to meet the recruitment and retention needs of the various employers and the health plan needs of their employees.
4. The HCA establish standard premium rates for the plans that reflect the expected costs of each plan option taking into account the covered population and expected health care utilization.
5. The HCA establish a tiered premium rate structure, with separate rates that vary with the size and composition of the household.
6. A Health Care Committee or Board be established to provide insight and oversight to the HCA.

# MAFA Report

# Overview

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- Areas of focus: Public employee plans
- Activities:
  - Peer review
  - Identify any additional Alaska-specific purchasing strategies



# Key Observations/Findings

- Aggregate cost of public employee plans in 2017 will be \$956.5 million (PRM findings)
- Annual inflation (8%-12%, 2014-2016) exceeds US growth rate (5%-6%, 2014-2016)
- Primary driver of higher prices in Alaska is highly concentrated medical services markets
- Public employer groups are highly fragmented (100 plans covering 44,000 employees)
- The largest group only 3.76% of the employer health insurance market
- Consolidation of public employees would expand scale to 114,000 covered lives and dramatically increase market share
- Health care growth is crowding out wage growth:

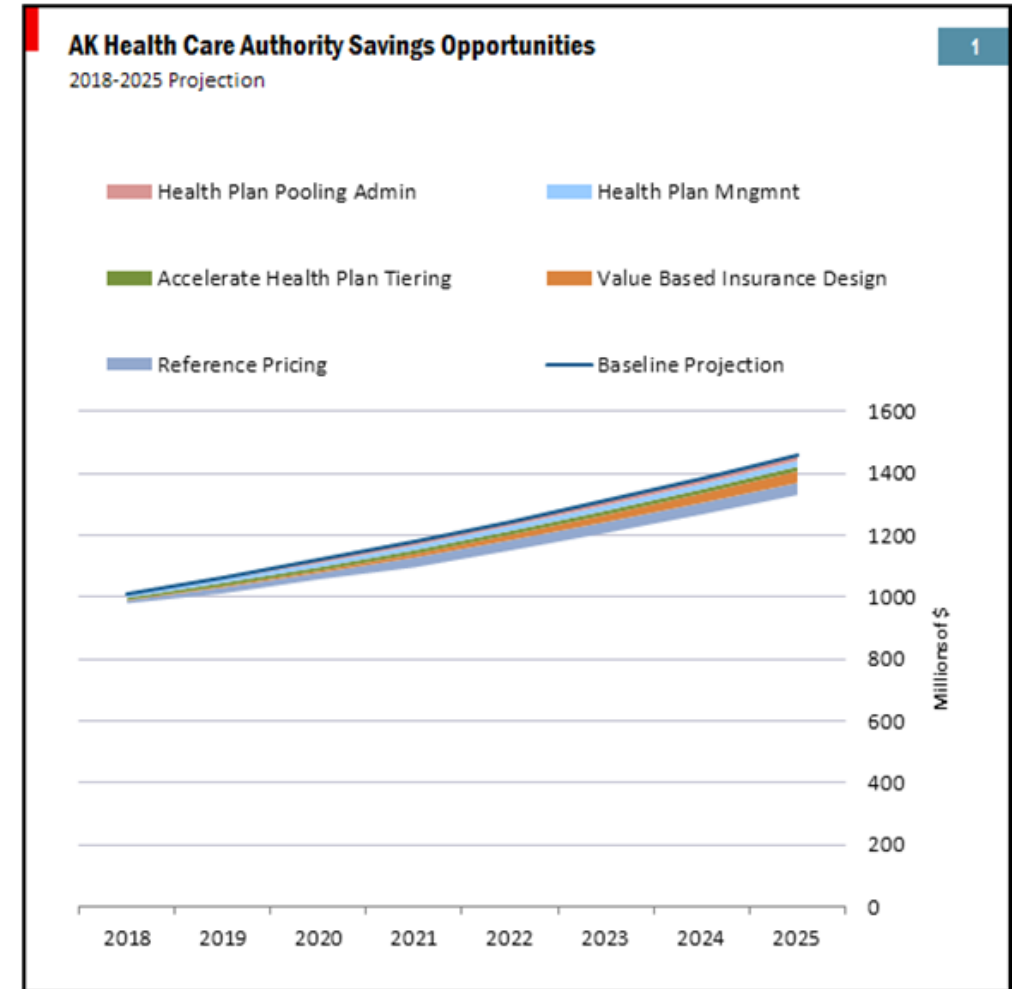
*"In aggregate, Alaska employees have foregone an estimated \$2.74 billion in wage increases that have been crowded out by excessive health plan/medical service costs over the past decade."*

# Potential Public Employee Savings Estimates

- \$655 million over 7 years
- 8.7% public employee spend
  - \$23 million/annually year one
  - \$127 million/annually when mature

Savings achieved through:

- 2.4% reduction (PRM estimate)
  - Health plan management and pooled purchasing
- 6.3% reduction
  - Increase collective employer purchasing power to improve health outcomes and reduce excessive costs growth



# Outline of Savings Estimates

| Line #                        | Alaska Health Care Authority - Summary of Potential Savings |  |             | 2017        | 2018         | 2019           | 2020           | 2021           | 2022           | 2023           | 2024           | 2025           | Cumulative Savings |
|-------------------------------|---|--|-------------|-------------|--------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|--------------------|
| 1                             | Baseline Projection   |  |             | millions \$ | 956.5        | 1,008.2        | 1,062.6        | 1,120.0        | 1,180.4        | 1,244.2        | 1,311.4        | 1,382.2        | 1,456.8            |
| 2                             | Baseline projection growth above 2017                       |  |             |             |              |                |                |                |                |                |                |                | 1.52               |
| Cumulative Savings v Baseline |   |  |             |             |              |                |                |                |                |                |                |                |                    |
| 3                             | PRM   | Health Plan Management                             | pct         |             | 0.9%         | 1.2%           | 1.2%           | 1.3%           | 1.3%           | 1.3%           | 1.3%           | 1.3%           | 1.3%               |
| 4                             | PRM   | Health Plan Pooled Purchasing                      | pct         |             | 0.1%         | 0.4%           | 0.9%           | 1.1%           | 1.1%           | 1.1%           | 1.1%           | 1.1%           | 1.1%               |
| 5                             | MAFA  | Reference Pricing                                  | pct         |             | 0.9%         | 1.8%           | 1.9%           | 2.7%           | 2.7%           | 2.7%           | 2.7%           | 2.7%           | 2.7%               |
| 6                             | MAFA  | Accelerate health plan tiering                     | pct         |             | 0.2%         | 0.5%           | 1.0%           | 1.0%           | 1.0%           | 1.0%           | 1.0%           | 1.0%           | 1.0%               |
| 7                             | MAFA  | Value based insurance design                       | pct         |             | 0.2%         | 0.4%           | 0.6%           | 1.0%           | 1.4%           | 1.8%           | 2.2%           | 2.6%           | 2.6%               |
| 8                             |   | Savings v Baseline                                 | pct         |             | <u>2.3%</u>  | <u>4.3%</u>    | <u>5.6%</u>    | <u>7.1%</u>    | <u>7.5%</u>    | <u>7.9%</u>    | <u>8.3%</u>    | <u>8.7%</u>    |                    |
| 9                             |   | Savings v Baseline                                 | millions \$ |             | <u>23.1</u>  | <u>45.7</u>    | <u>62.8</u>    | <u>84.0</u>    | <u>93.5</u>    | <u>103.8</u>   | <u>115.0</u>   | <u>127.0</u>   | \$655.0            |
| 10                            |   | Scenario 1 Projection                              | millions \$ |             | <u>985.0</u> | <u>1,016.9</u> | <u>1,057.2</u> | <u>1,096.4</u> | <u>1,150.6</u> | <u>1,207.5</u> | <u>1,267.2</u> | <u>1,329.8</u> |                    |
| 12                            |   | Scenario 1 growth above 2017                       |             |             |              |                |                |                |                |                |                |                | 1.39               |
| 13                            |   | Reference Pricing Savings Estimate                 | pct         |             | 0.9%         | 1.8%           | 1.9%           | 2.7%           | 2.7%           | 2.7%           | 2.7%           | 2.7%           | 2.7%               |
| 14                            | MAFA  | Price reset targeting reference pricing benchmarks | pct         |             | 1.1%         | 2.1%           | 2.5%           | 2.5%           | 2.5%           | 2.5%           | 2.5%           | 2.5%           | 2.5%               |
| 15                            | MAFA  | + Benchmark price trend reduction                  | pct         |             |              |                |                | 1.0%           | 1.0%           | 1.0%           | 1.0%           | 1.0%           | 1.0%               |
| 16                            | MAFA  | Offset by an increase in primary care utilization  | pct         |             | 0.2%         | 0.4%           | 0.6%           | 0.8%           | 0.8%           | 0.8%           | 0.8%           | 0.8%           | 0.8%               |

# MAFA Key Recommendations

1. Create a health care authority for public employees
2. Allow groups to opt-out only under specific circumstances
3. Build and sustain local expertise and professional staff to support the authority
4. Consolidate health plan data analytics and procurement under the authority
5. Benchmark reference pricing and performance
6. Increase the use and development of value-based plan design

# PHPG Report

# Overview

➤ Areas of focus:

- Provide technical expertise on incorporating Medicaid into an HCA
- Overview of HCAs and coordinated purchasing models in other states

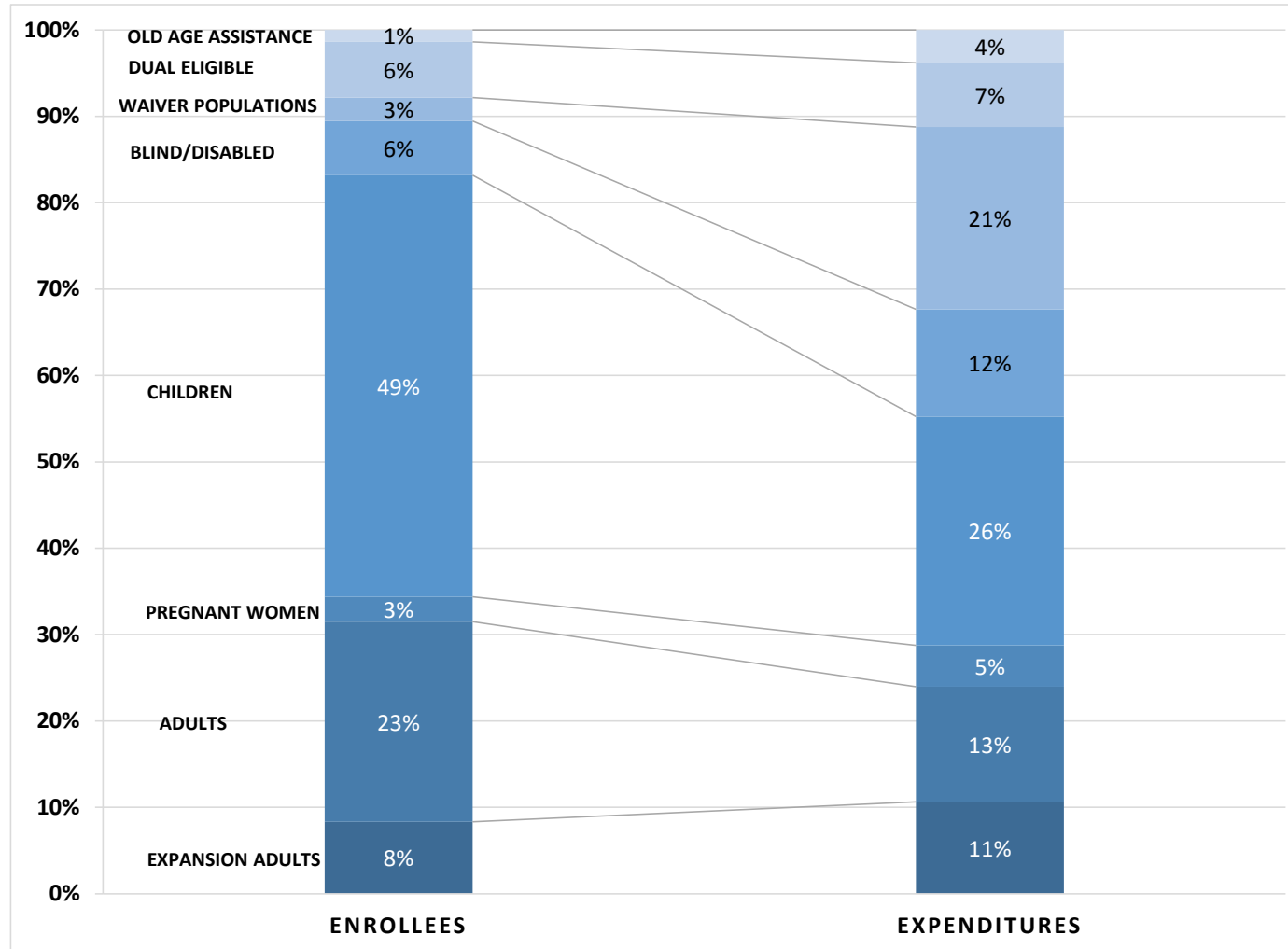
➤ Activities:

- Provide background on national and Alaska Medicaid programs
- Outline other states efforts to consolidate/coordinate public health plans & Medicaid
- Describe HCA or HCA-like structures
- Identify approaches that Alaska could consider
- Outline a provisional governance model

# Key Observations/Findings - Medicaid

- Alaska Medicaid background:
  - Alaska's Medicaid program covers more than 1 in 4 Alaskans
  - Over 185,000 Alaskans were enrolled in May of 2017
  - Enrollment grew by 23% from May 2016 to 2017
  - Nearly 40% of Alaska Medicaid clients are American Indian/Alaska Native (AI/AN)
  - Federal government funds approximately 65% of the program
  - Alaska's program expenditures the highest in the country per enrollee
  - 16% of enrollees old age assistance, dual eligible, waiver populations and blind/disabled categories accounted 44 % of total expenditures

# 2016 Alaska Medicaid Enrollment and Expenditures

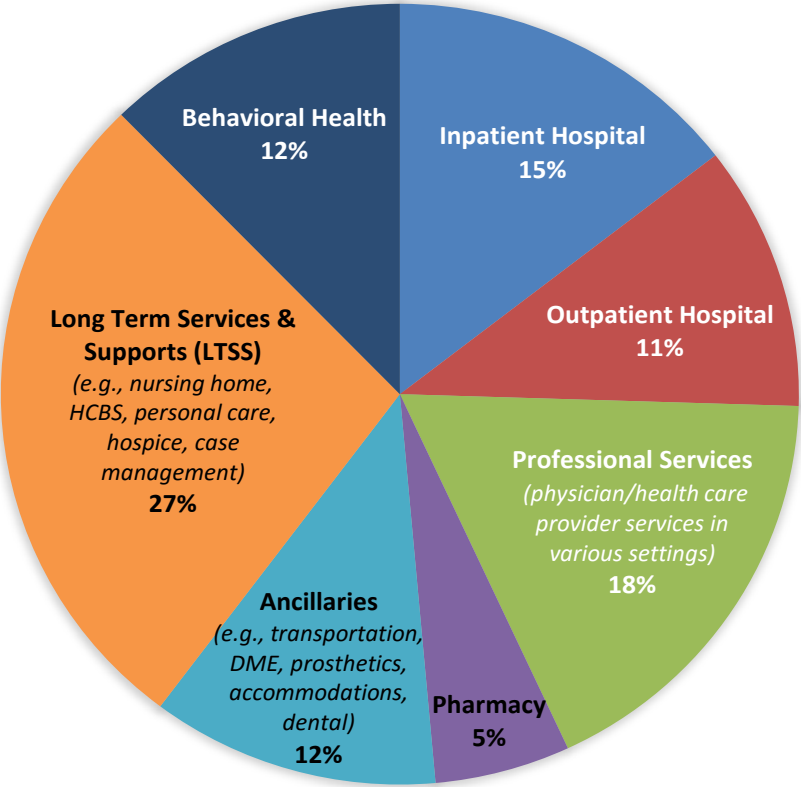


September 2017

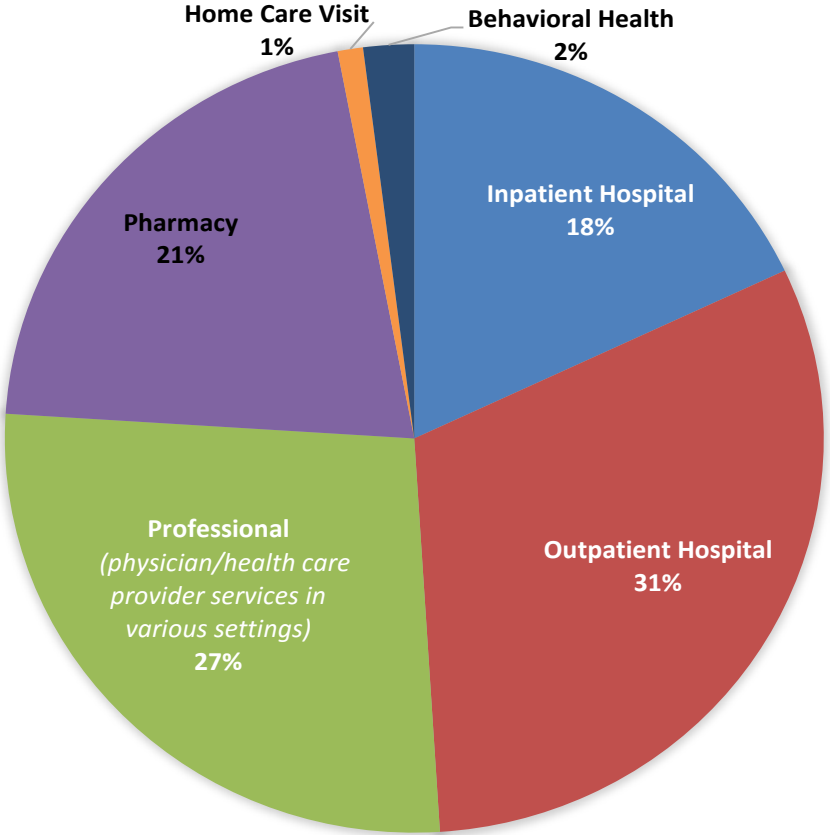


# Expenditures by Service Category

## Alaska Medicaid

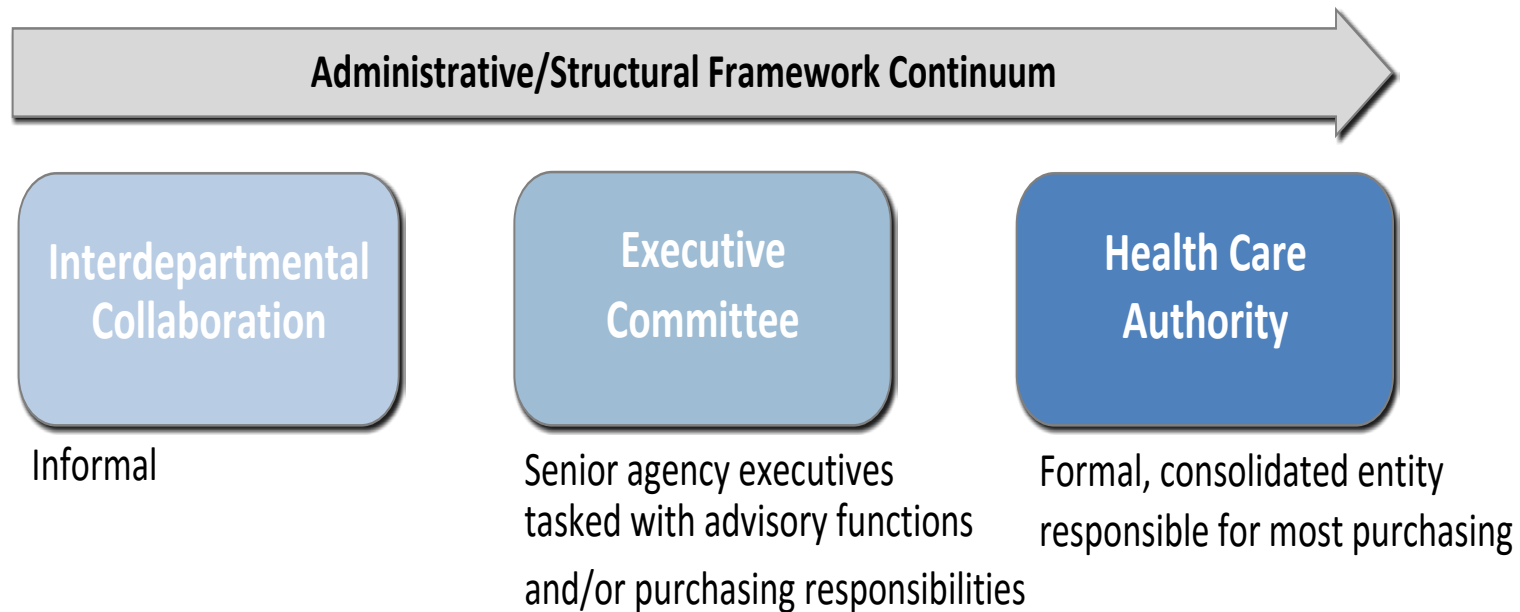


## State of Alaska Employees



# Integration with Health Care Authorities

- Examples exist but they are limited (Oregon & Washington)
  - Difference in program requirements create complexity and challenges to integration
  - Success dependent on administrative or structural framework to support coordination



# Approaches for Integration/Coordination

- Coordinate and/or integrate purchasing efforts with Medicaid
  - Example: data, utilization management, clinical policy bulletins, quality/provider oversight, wellness activities, contracting for specific services
- Develop a common benefit design across public payer programs and Medicaid
  - Example: commercial package developed and administered to certain Medicaid populations
- Fully integrate Medicaid as part of an Authority
  - Example: Washington's HCA

*These ideas require additional analysis before a decision is made; but they are a starting point for policy discussion and future analysis.*

# HCA's in Other States

## Overview of Health Care Authorities

| State Model   | Implemented              | Role  |
|---|--------------------------|---|
| Hawaii Health Authority (HHA)   | 2009                     | Health Planning   |
| Maryland All Payer Model - Health Services Cost Review Commission (HSCRC) | 1971                     | Hospital Rate Setting and Administration of All Payer Model             |
| Mississippi Health Care Finance Authority (HCFA)                          | 1994<br>(abolished 2017) | Health Planning and Purchasing  |
| New Mexico Retiree Health Care Authority (NMRHCA)                         | 1990                     | Retiree Benefits Administration   |
| Oklahoma Health Care Authority (OHCA)                                     | 1993                     | Medicaid Policy and Administration                                      |
| Oregon Health Authority (OHA)   | 2009                     | Public Employees, School Employees and Medicaid Policy Administration   |
| Vermont Green Mountain Care Board (GMCB)                                  | 2011                     | All Payer Model Oversight and Hospital Rate Setting                     |
| Washington State Health Care Authority (WHCA)                             | 1988                     | Public Employees and Medicaid Policy Administration                     |
| West Virginia Health Care Authority (WVHCA)                               | 1983                     | Hospital Rate Setting, Hospital Budget Approval and Certificate of Need |

## Features

HCA Structure/Governance Model is Dependent on:

### ➤ Role of HCA

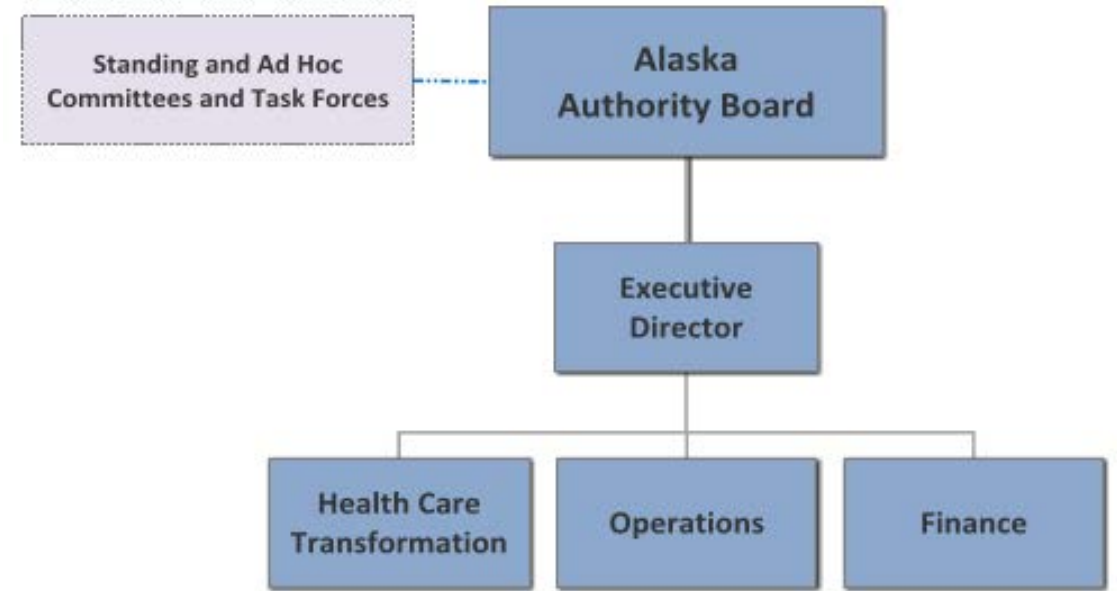
- Public employees only v. all state-funded health plans
- Administration (if Authority is an “umbrella” agency)
- Coordination/support (board with agency representation)
- Oversight (regulatory role)
- Development of multi-payer initiatives (commercial payer representation)
- Advance health reform

### ➤ Autonomy v. accountability

- Benefits/risks of independence
- Legislative control/appropriations process

# PHPG Provisional Model

- Authority would be overseen by a Board :
  - One Board Chair appointed by Governor
  - Two additional members appointed by Governor
  - One member appointed by Senate President
  - One member appointed by Speaker of House
  - Two non-voting members who are active heads of principal Alaska State government departments
- Executive Director head of Authority w/three divisions



- Standing & ad-hoc committees:
  - Member advisory group
  - Provider council
  - Health information technology group
  - Quality & health transformation committee

# Next Steps

# Learn More

- Reports, presentations and webinars can be found at <http://doa.Alaska.gov/HCA.html>
- This is the beginning of a larger discussion about what Alaskans see as the future for publicly funded health care.
- The opportunities and concepts outlined in these reports would require considerable change in the provision and financing of health benefits, but could also create significant value.
- Extensive public discourse, stakeholder engagement and full legislative buy-in will be required for the state to move forward with any of these recommendations.
- Encourage everyone to review the materials online, reach out with any questions.

# Public Comment

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Public comments can be submitted in writing via email or hard copy to:  
*Attention Department of Administration, Commissioners Office*

Email: AlaskaHCA@alaska.gov

Hard Copy: 550 W 7<sup>th</sup> Avenue, Suite 1970, Anchorage, AK 99501

More information available at: <http://doa.Alaska.gov/HCA.html>



Thank you