Department of Administration

Health Care Authority (HCA) Feasibility Study

Presented by

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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

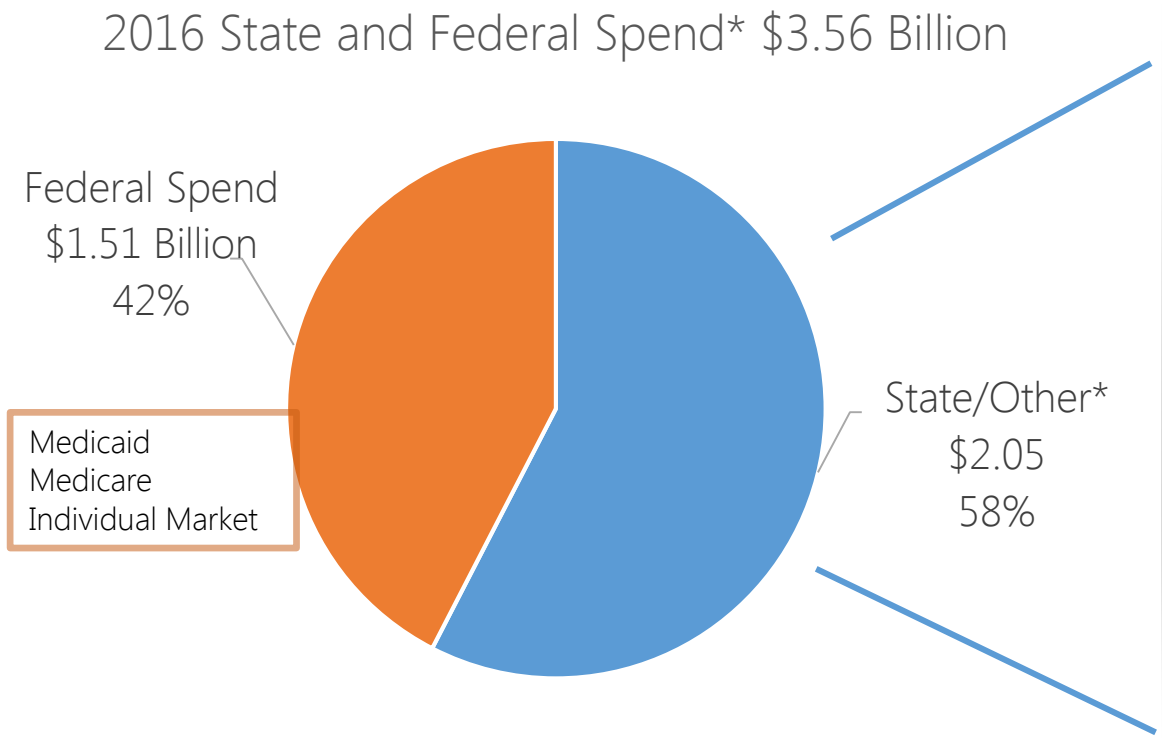
  Extended to November 13, 2017
- December 4, 2017 — Report addendum released

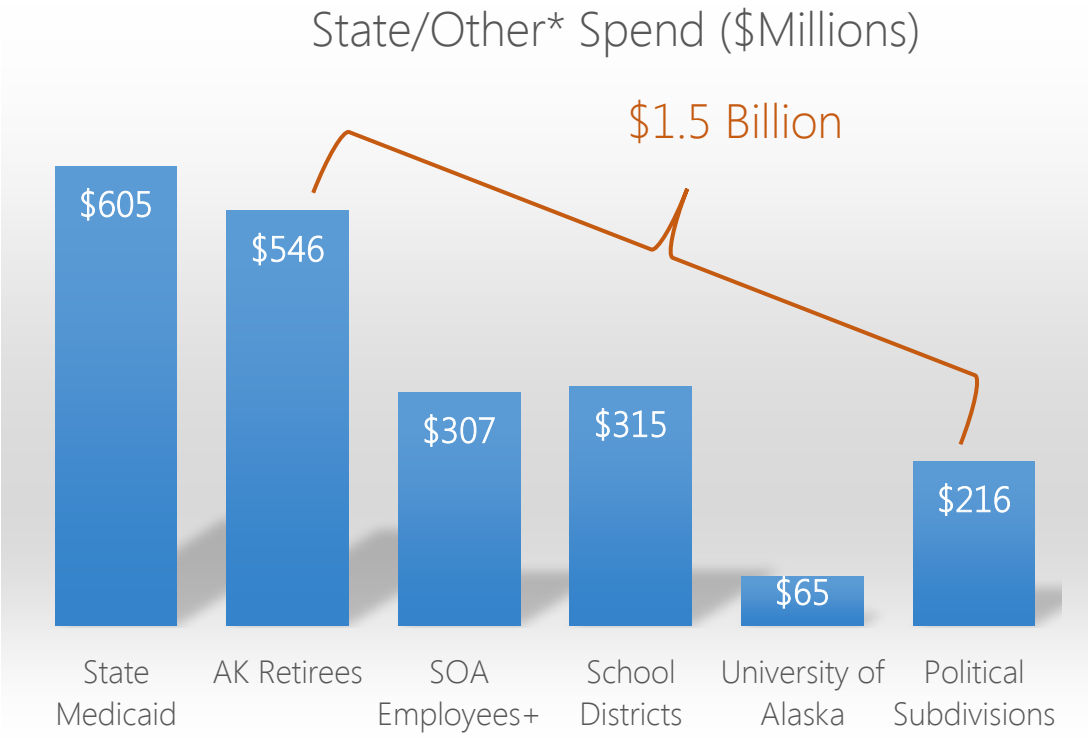
  Extended in conjunction with the public comment extension to December 22, 2017

Big Picture Takeaways

2016 Expenditures & Covered Lives

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





*Local contributions may be mixed into the funding stream for these benefits.
* This does include out of pocket costs by employees.
^This number includes duplicate lives & some retiree who live outside of Alaska.

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.

Current Actions

- Implement Employee Group Waiver Plan (EGWP)
  - Increases federal subsidies for pharmacy benefits in the AlaskaCare retiree health plans through a Medicare Part D EGWP
  - Estimated savings in GF range from $40 to $60 million/year
  - Target implementation date is January 1, 2019
- Pharmacy Benefit Management (PBM) Carve Out
  - The Division of Retirement and Benefits (the Division) issued an Request for Proposal In January for PBM services
  - Target implementation date is January 1, 2019
- Travel Coordination Plan
  - The Division issued a request for proposals for travel coordination and assistance
  - Goal is to assist members seeking care outside their community through high-value, cost effective service
  - Target implementation date is July 1, 2018 for employee plan, January 1, 2019 for retirees plan

Next Steps

- The fiscal year 2019 budget includes funding to evaluate and implement strategies to reduce the growth of state health care spending including:
  - Implementation of contractor recommendations- e.g. coordinated/integrated services, data analytics, clinical guidelines;
  - Voluntary participation of pooled purchasing of services (e.g. TPA); and
  - Developing recommended options on the governance structure of a health care authority that includes representation for employees and other stakeholders.

Next Steps

- Future Exploration
  - Analyze the ability for an established HCA to scale up and offer services to other groups including: individual market, private business, non-profits and the Medicaid expansion group on a cost neutral basis.

PRM Reports I & II

prm CONSULTING GROUP

Health Care Authority Feasibility Study

Senate Finance Committee
February 8, 2018

Purpose of the study

- To determine the feasibility of creating a Health Care Authority (HCA) to **coordinate health care plans** and **consolidate purchasing effectiveness** of health benefits funded directly or indirectly by the state including employees of the State of Alaska (all bargaining groups), school districts, University of Alaska, state corporations, political subdivisions, retirees and other groups that would benefit from participation.

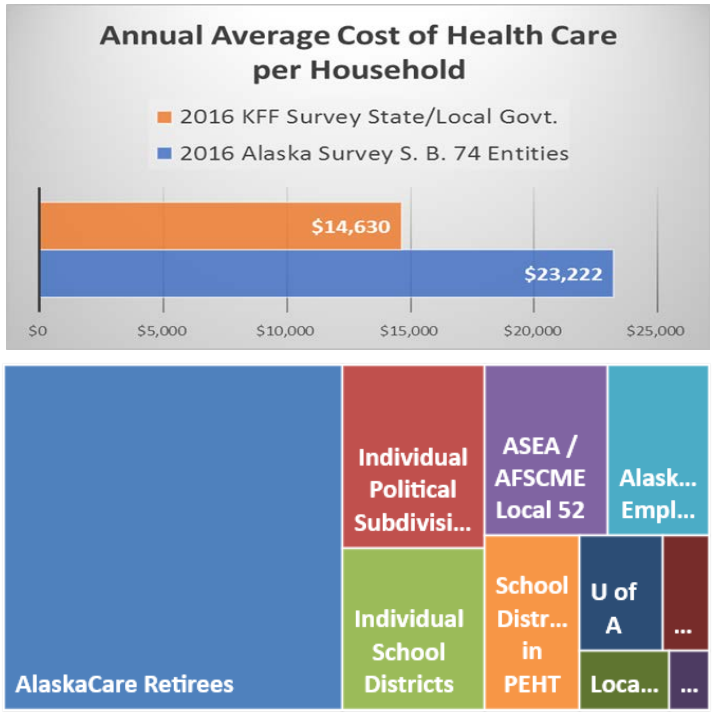
Phase I report focused on consolidated purchasing strategies

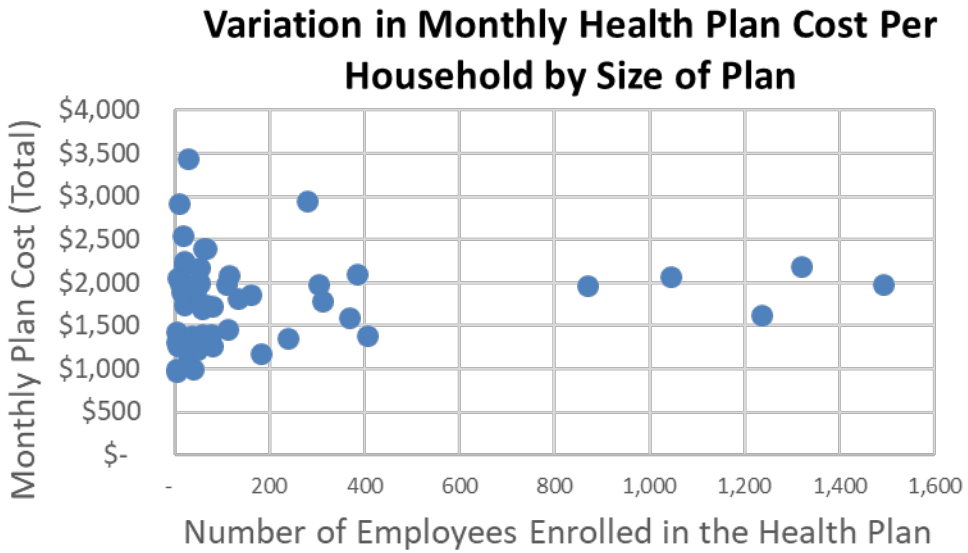
Phase II report focused on coordinated health plan administration

- includes several governance models
- includes template for providing flexibility in plan design to meet local needs
- includes 5-year savings estimates

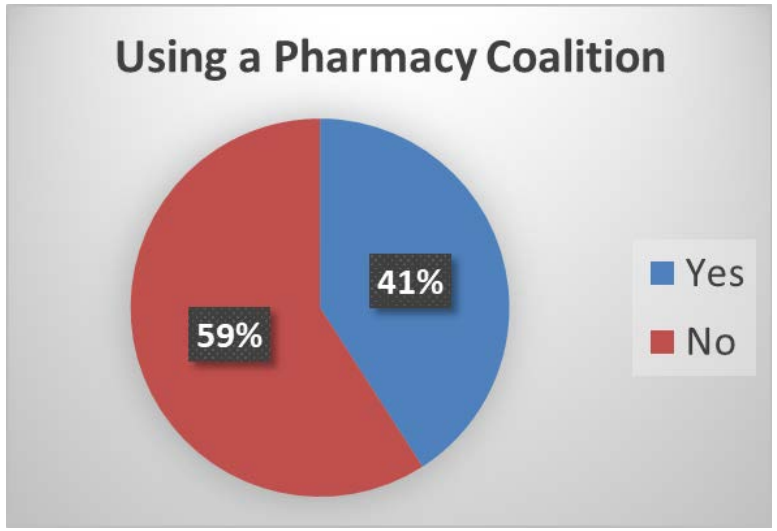
Phase I Report
Consolidated Purchasing Strategies

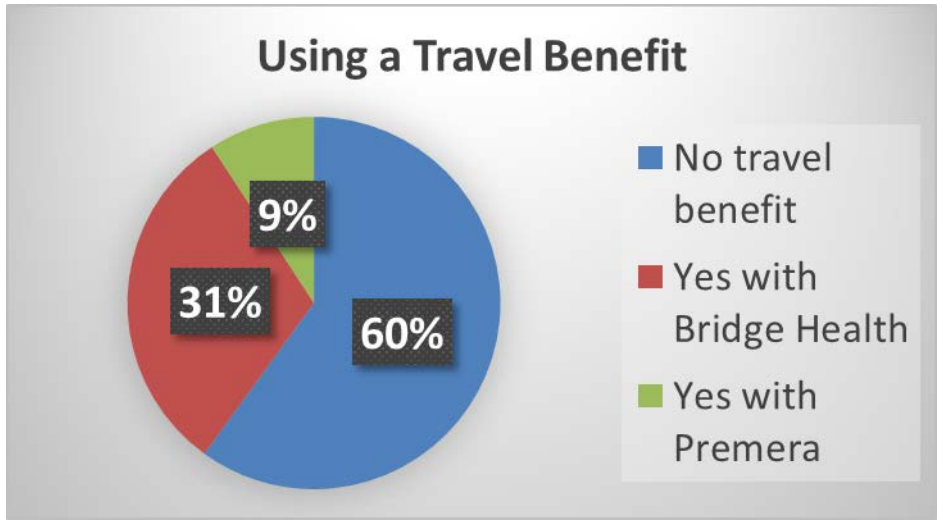
- Collected and analyzed data from participating employers
- Interviewed wide range of interested parties
- Analyzed the coverage, costs, funding, financing, and administration for the primary health plan
- Key observations – high costs, existing consolidation, wide variation in costs





Phase I Report
Opportunities for consolidated purchasing efficiencies





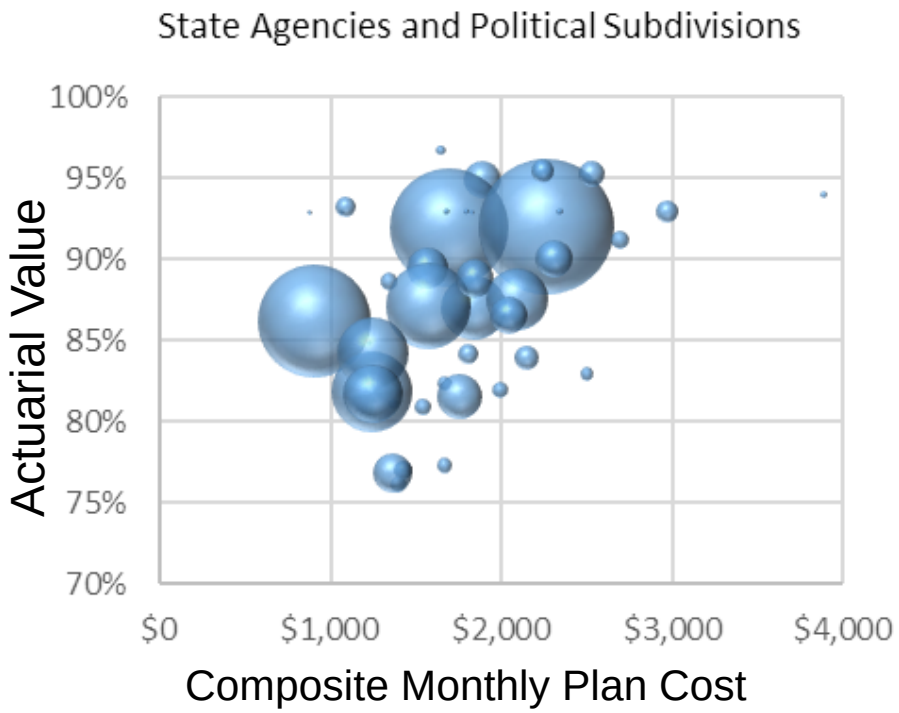
Opportunity	First Year Estimated Savings ($Million)
Pharmacy Benefit Carve-out	Range from $3.5 to $8.0
Centers of Excellence / Travel Benefit	Range from $2.9 to $3.5
Change to Employer Group Waiver Plan (EGWP) in AlaskaCare Retiree Plan for Medicare part D	$61.6

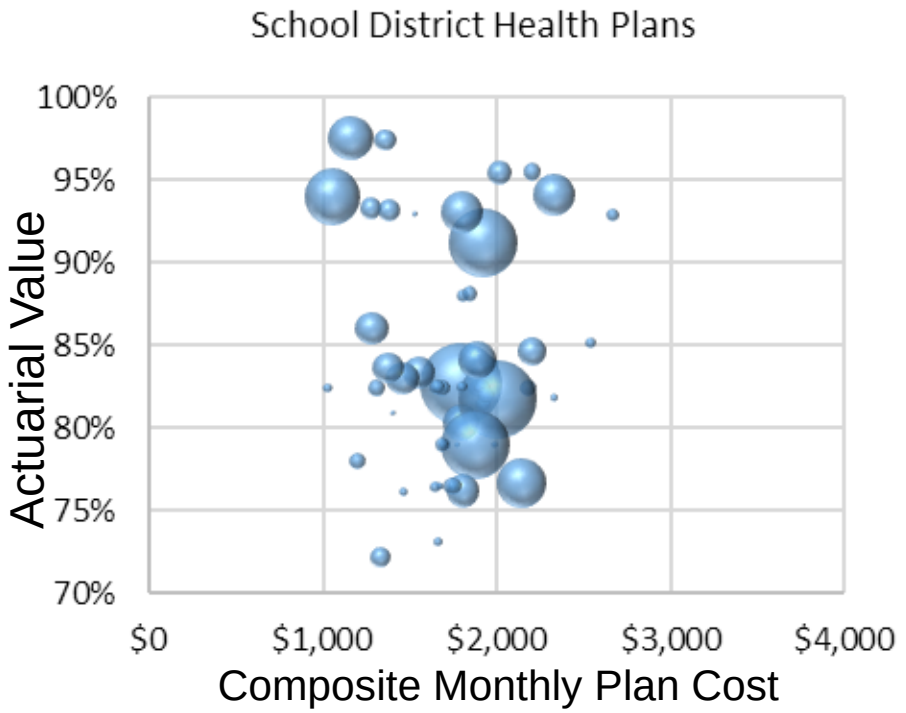
Phase II Report
Consolidated Health Plan Administration

- Evaluated experience of other states
- Collected and analyzed data from participating employers
- Interviewed wide range of interested parties
- Made observations on plan designs, costs, employee premium rates
- Evaluated five models, projected costs & savings over next five years:
- Recommendations

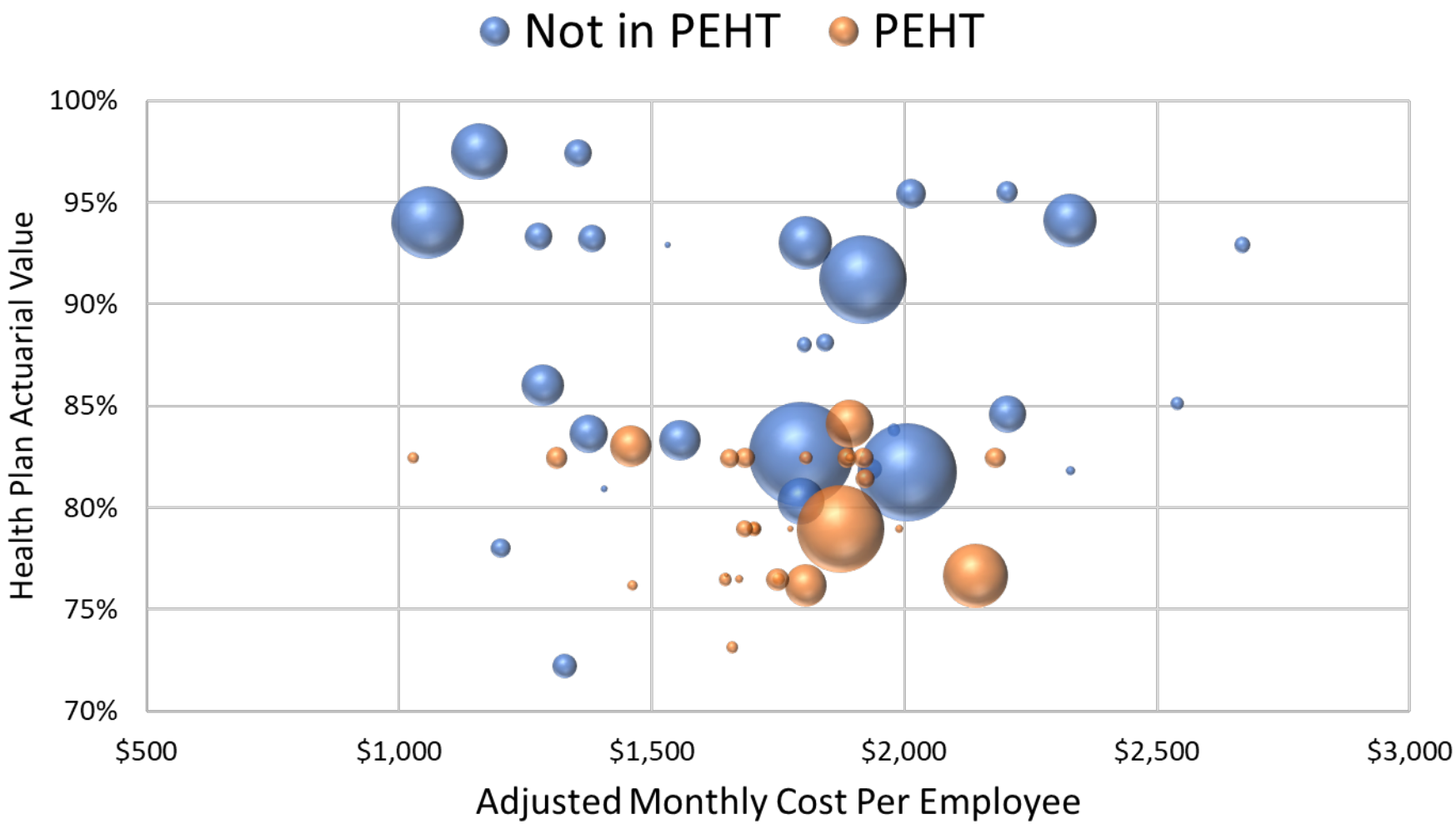
Phase II Report Observations
Wide range of health plan actuarial values

Actuarial value is a measure of the generosity of plan coverage. Bubble size represents the number of covered employees. Composite monthly cost or premium rate is per employee.

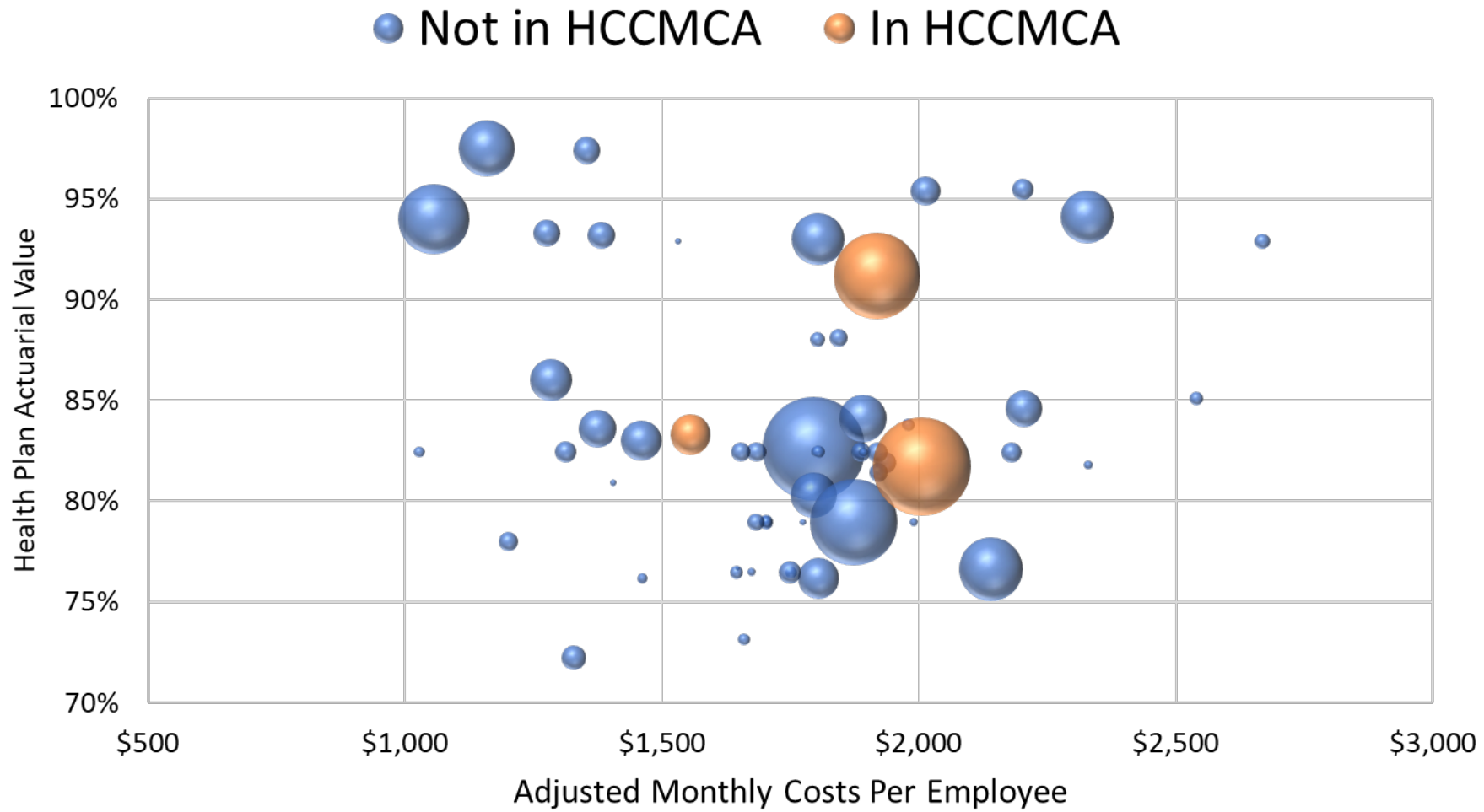




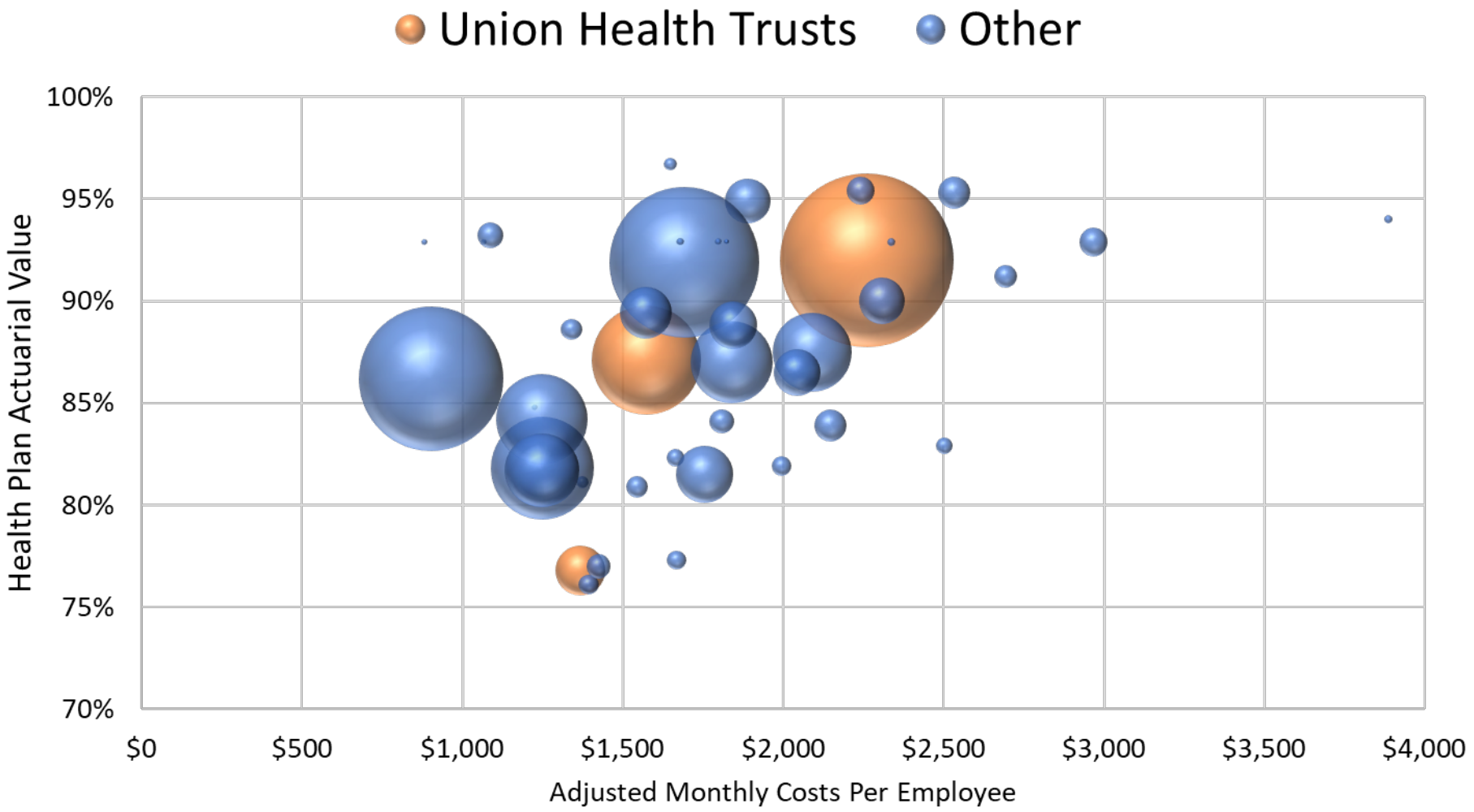
School Districts
Comparison of Plans in Public Education Health Trust (PEHT) to those not in PEHT



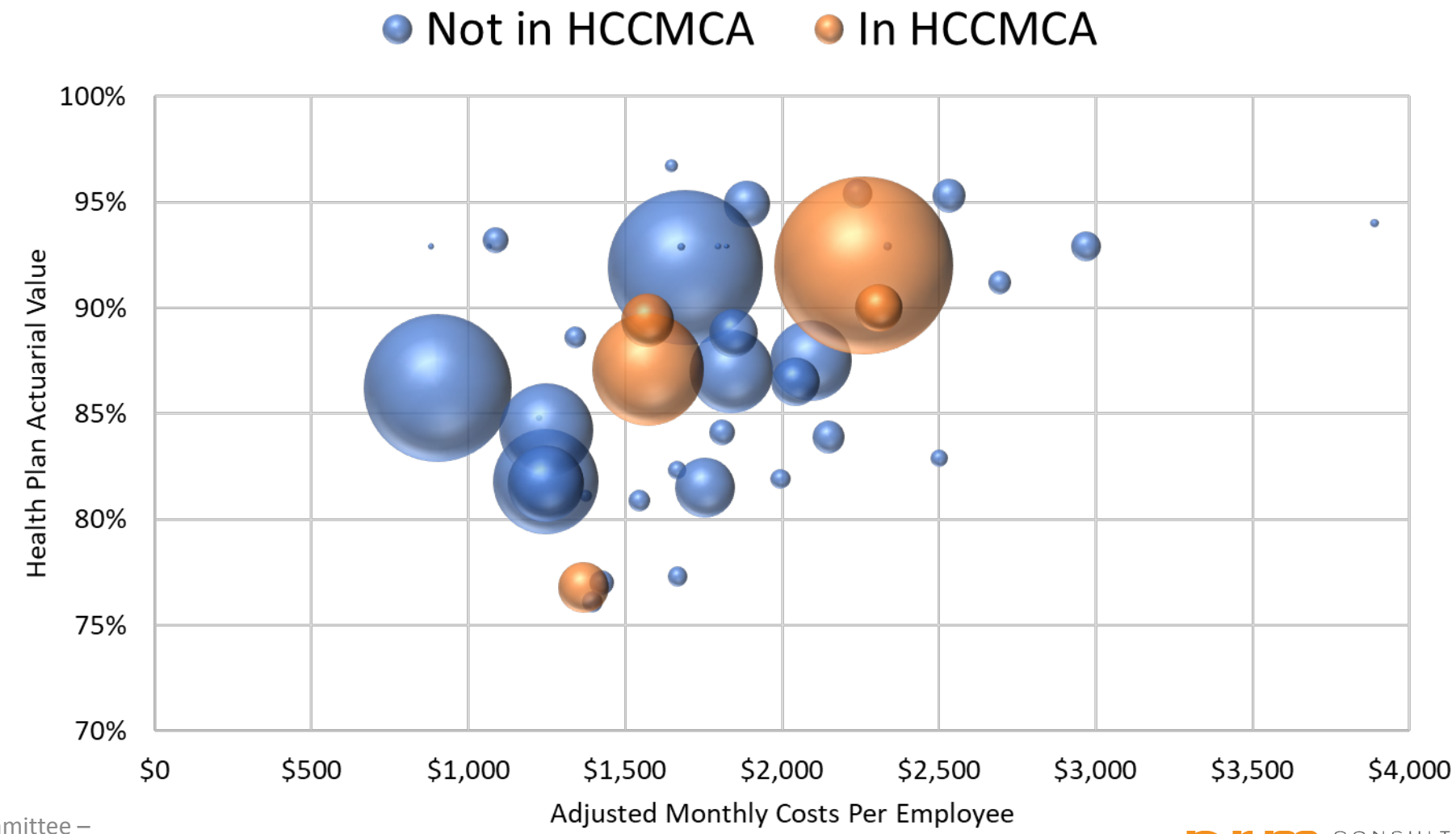
School Districts
Comparison of Plans in Health Care Cost Management Corporation of Alaska (HCCMCA) vs not in HCCMCA



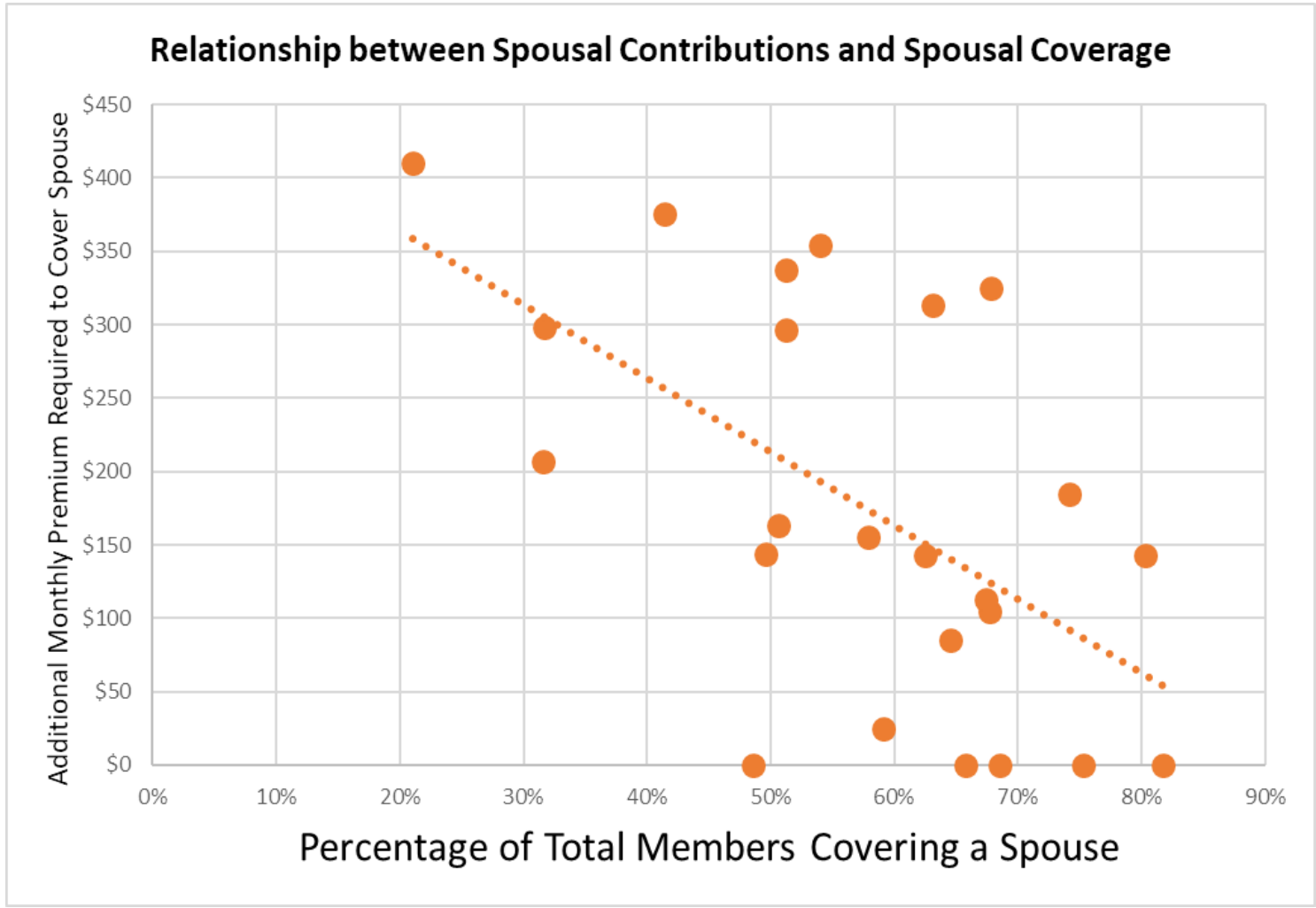
State Agencies and Political Subdivisions
Comparison to those in Union Trusts



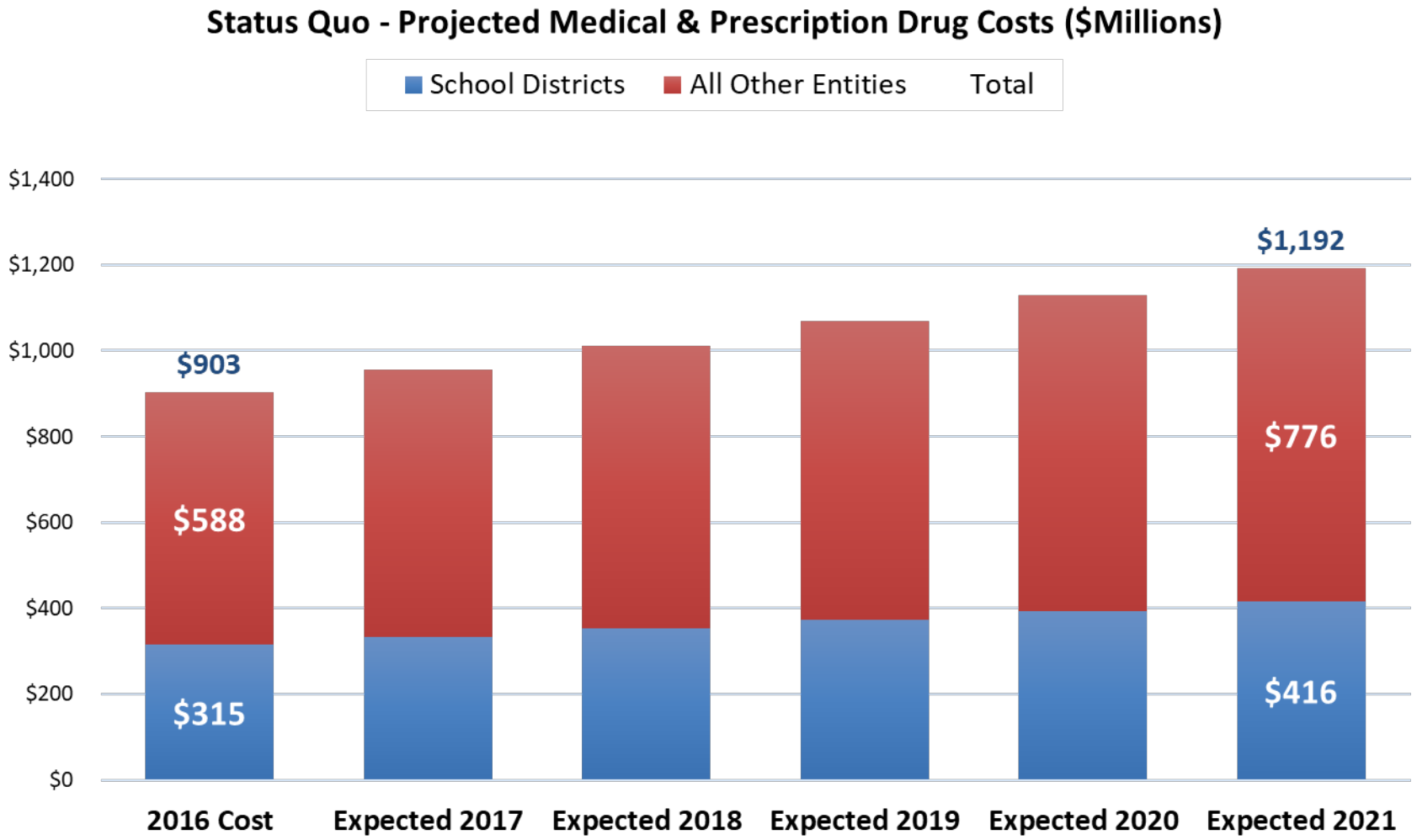
State Agencies and Political Subdivisions
Comparison to those in HCCMCA



Observation: Spousal premium requirements impact enrollment, which impacts total employer cost



Phase II Report
Status Quo: Expected Cost in 2021 is $1.19 billion



Coordinated Health Plan Administration
Projected savings over the next five years by model

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**	Deferred to 2022		
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)**

Does not reflect funds from 1332 Waiver

Summary Recommendations for Coordinated Health Plan Administration

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

MAFA Report

Overview

- 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:

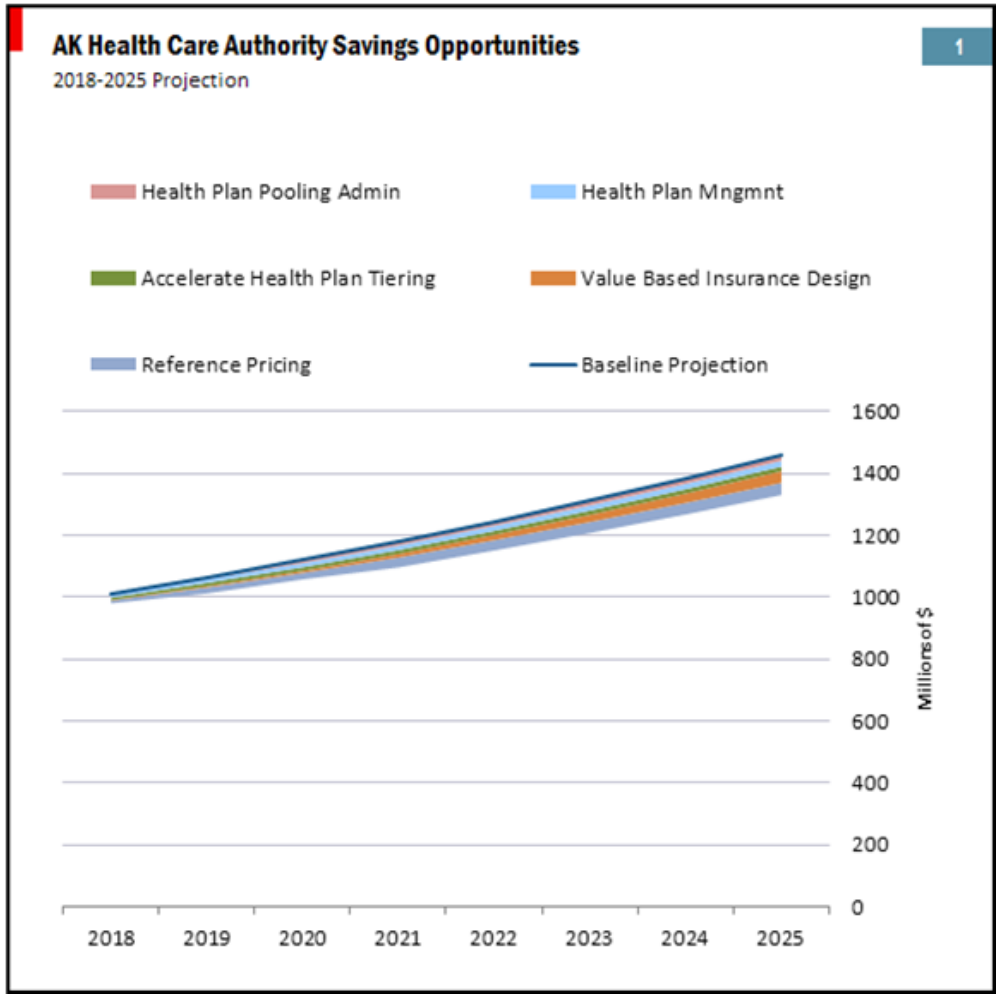
  "In aggregate, Alaska employees have foregone an estimated $2.74 billion in wage increases that have been crowded out by excessive health plan/medical service costs over the past decade."

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%	
4	PRM		Health Plan Pooled Purchasing	pct		0.1%	0.4%	0.9%	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%	
6	MAFA		Accelerate health plan tiering	pct		0.2%	0.5%	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%	
8			Savings v Baseline	pct		2.3%	4.3%	5.6%	7.1%	7.5%	7.9%	8.3%	8.7%	
9			Savings v Baseline	millions $		23.1	45.7	62.8	84.0	93.5	103.8	115.0	127.0	**$655.0**
10			Scenario 1 Projection	millions $		985.0	1,016.9	1,057.2	1,096.4	1,150.6	1,207.5	1,267.2	1,329.8	
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%	
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%	
15	MAFA		+ Benchmark **price trend** reduction	pct					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%	

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

Pacific Health Policy Group
Health Care Authority Feasibility Study – Medicaid Technical Assistance

Overview

- Areas of focus:
  - The Pacific Health Policy Group (PHPG) was retained by the Department of Administration to provide input regarding Medicaid-specific considerations for the development of a Health Care Authority (Authority)

- 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

HCAs 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 (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:

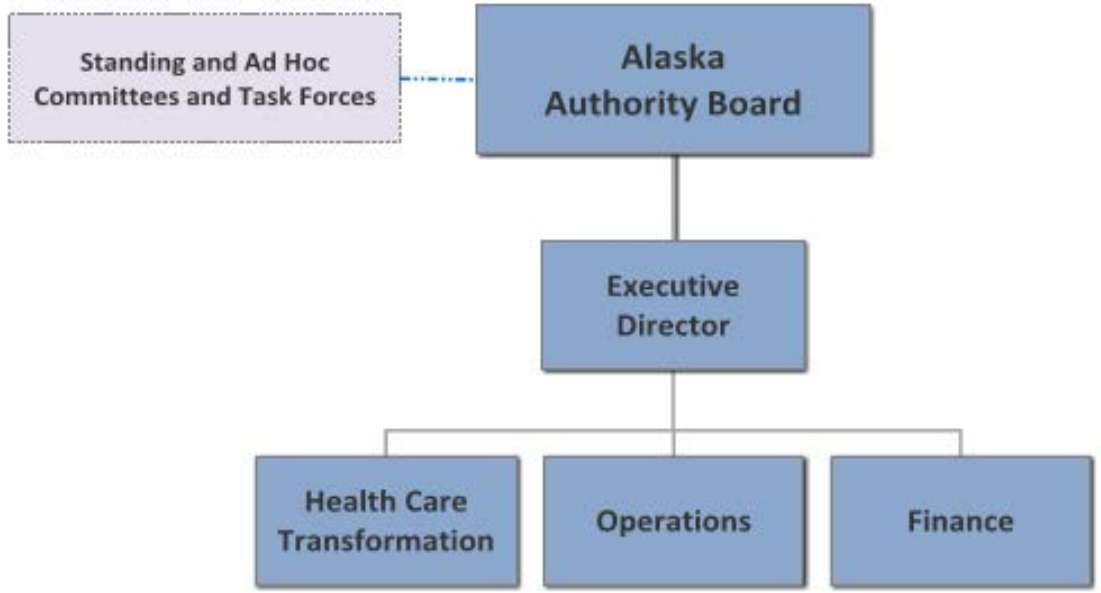
- Role of HCA
  - Public employees only v. all state-funded health plans
  - Administration (if Authority is an "umbrella" agency)
  - Coordination/support (board with agency representation)
  - Oversight (regulatory role)
  - Development of multi-payer initiatives (commercial payer representation)
  - Advance health reform
- Autonomy v. accountability
  - Benefits/risks of independence
  - Legislative control/appropriations process

Health Care Authority Design Elements

- An Authority would have the following responsibilities
  - Strong analytic capacity to support objective analysis and capability to access health care data
  - Fiscal management and administration of health benefits for publicly-funded health programs
  - Integration and coordination of certain administrative functions
  - Development of approaches that ensure access to care
  - Monitoring and enhancement of the Alaska health care delivery system
- An Authority's responsibilities, including its role as it relates to Medicaid, requires additional evaluation
- Existing examples include: Permanent Fund, Mental Health Authority, Alaska Housing and Finance Corporation, etc.

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



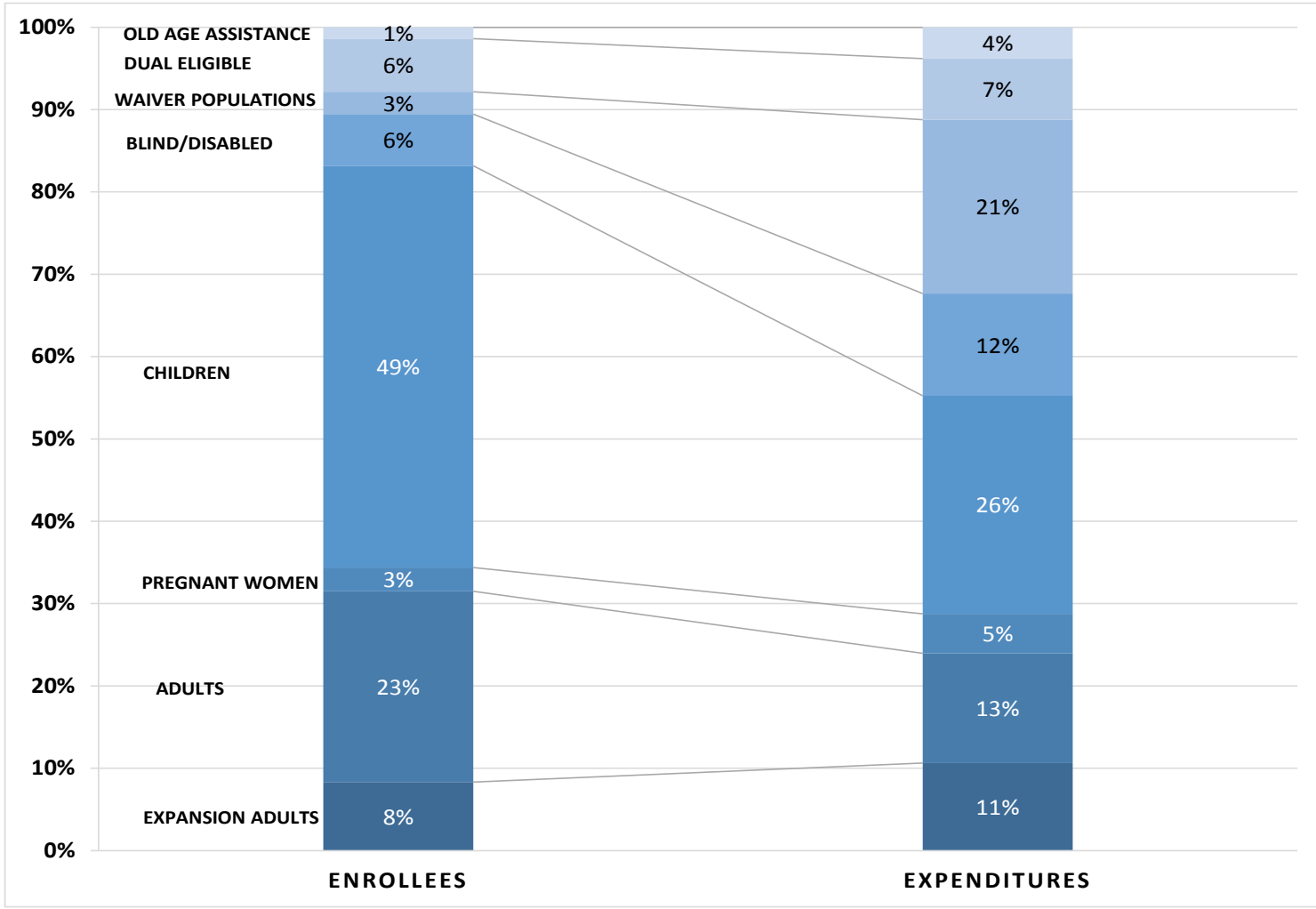
- Standing & ad-hoc committees:
  - Member advisory group
  - Provider council
  - Health information technology group
  - Quality & health transformation committee

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

2016 Alaska Medicaid Enrollment and Expenditures^

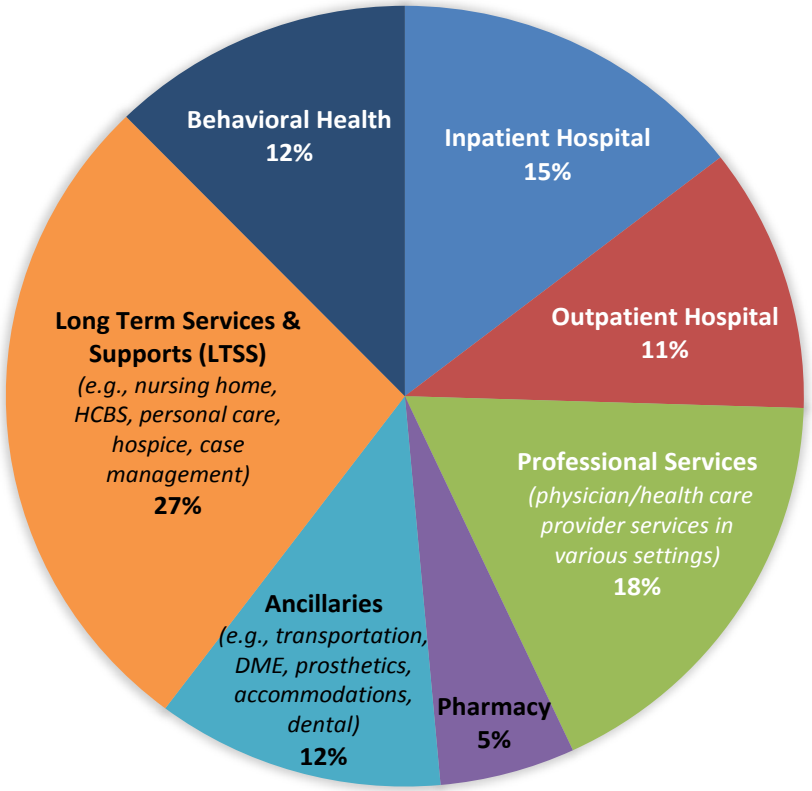
- 16% of enrollees (Old Age Assistance, Dual Eligible, Waiver Populations and Blind/Disabled categories) accounted 44 % of total expenditures.



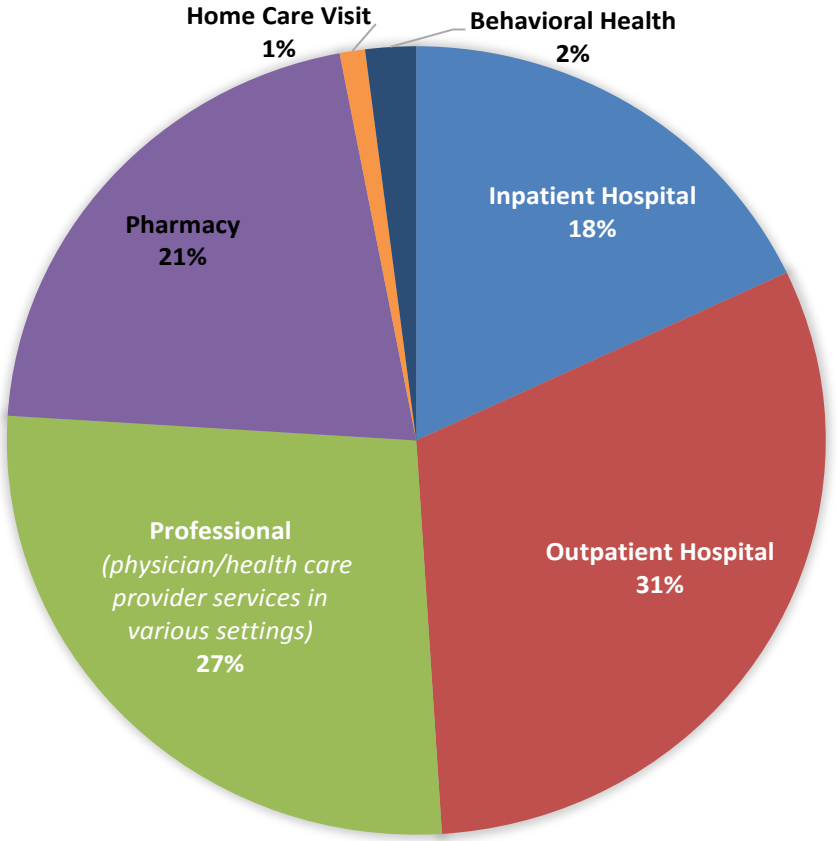
^Source: Milliman Alaska Medicaid Data Book

2016 Expenditures by Service Category

Alaska Medicaid^



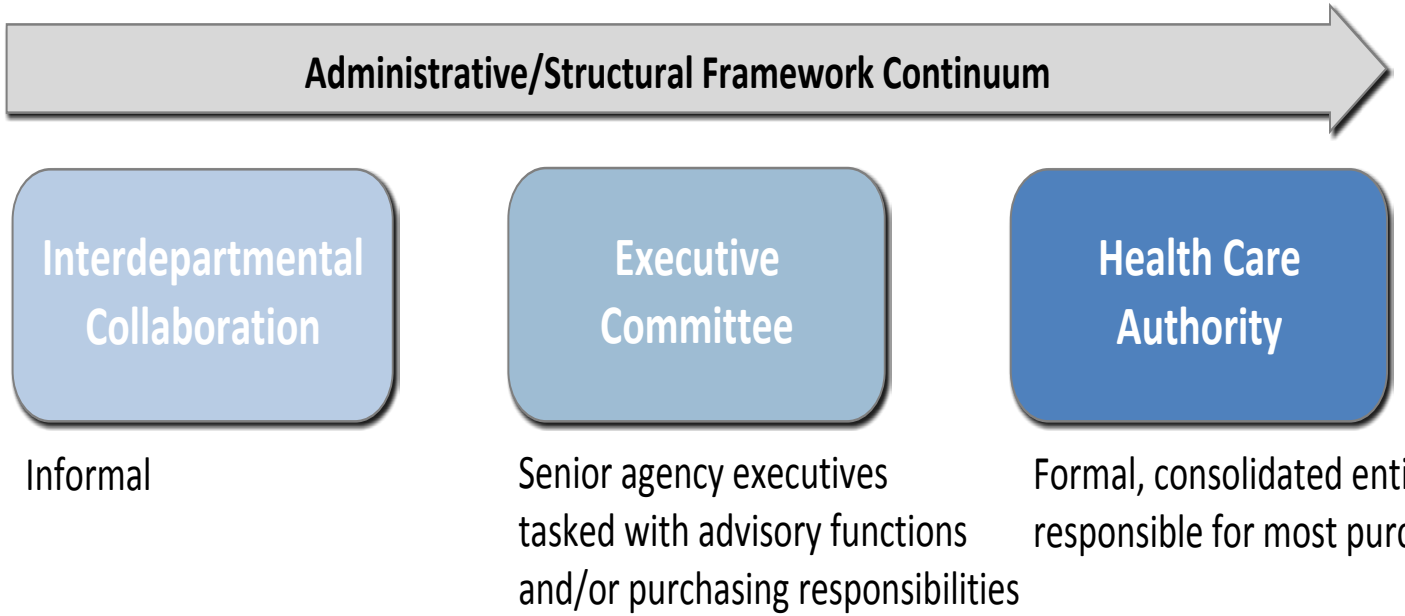
AlaskaCare Active Employees



^Source: Milliman Alaska Medicaid Data Book

Integration with Health Care Authorities

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



Approaches for Integration/Coordination

1) Coordinate and/or integrate purchasing efforts with Medicaid
2) Develop a common benefit design across public payer programs and Medicaid
3) Fully integrate Medicaid as part of an Authority

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

Medicaid Considerations

- Summary of key factors for consideration include:
  - Medicaid operates under a complex regulatory framework
  - DHSS is organized to address health and social needs
  - Impact on current operations

- Additional analyses to evaluate the feasibility of the three approaches are organized within the following objectives:
  - Impact on administrative costs
  - Impact on health care expenditures and growth
  - Impact on quality of care and access to care

Coordinated/Integrated Purchasing

- Types of Coordinated Purchasing
  - Examples include:
    - Coordinated care and payment reform (e.g., Maryland, Vermont)
    - Common provider management requirements such as network adequacy and program integrity for managed care (e.g., New York)
    - Designated directors or chief medical officers across agencies to facilitate coordination of quality initiatives (e.g., Oregon, Washington)
    - Consolidated or coordinated provider contracts and related activities (e.g., Georgia)
- Successful coordination is dependent on:
  - Structural framework
  - Sufficient resources
  - Sustained leadership/direction
  - Shared vision and values

Common Benefit

- Design Elements
  - Envisions centralized administration of a basic benefit package made available to all individuals receiving state-funded health care (but potentially includes only a subset of the Medicaid population)
  - Authority could be responsible for establishing and administering common benefit package
  - Pooling covered lives and coordinated purchasing could enable Alaska to leverage its purchasing power to increase competition and secure/negotiate more favorable rates among providers
  - Potential for creating single funding stream/appropriation
  - Options for inclusion of Medicaid should be explored

Learn More

Reports, presentations and webinars can be found at: Alaska.gov/HCA.html

Resources include:

- Senate Bill 74
- HCA Feasibility Study RFP
- Three reports (PRM, MAFA, PHPG)
- Three webinars (PRM, MAFA, PHPG)
- Public comment summary report

Thank you.

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