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March 28, 2013

The Honorable Fred Dyson, Chair
Senate State Affairs Standing Committee
Alaska State Capitol, Rm. 121
Juneau, AK 99801

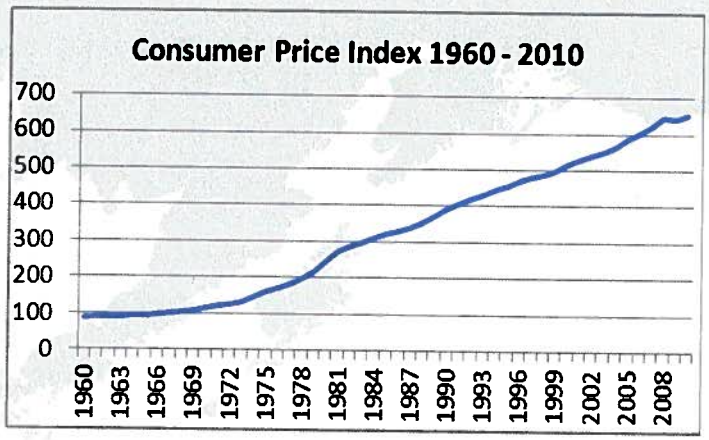
The Honorable Bob Lynn, Chair
House State Affairs Standing Committee
Alaska State Capitol, Rm. 108
Juneau, AK 99801

Dear Senator Dyson and Representative Lynn:

Thank you for the opportunity to meet with the Joint State Affairs Standing Committee on February 7 and 14 to present an overview of the AlaskaCare employee health plan. I apologize for the delay in responding. Responses to the committee members' questions took time to research and we wanted to provide thorough and thoughtful answers. Following are the questions raised during our meeting and the responses to those questions:

Q1: With regard to slide 2 on "Health Care Spending in the U.S.", what was the rate of inflation over the same time period from 1960 to 2010? (Sen. Dyson)

A1: The Consumer Price Index from 1960 to 2010 is illustrated in the chart below (Bureau of Labor Statistics, 2013). To provide additional perspectives on how inflation over the decades has affected medical cost growth and national health expenditures, we have included Figure 1 which depicts the national health expenditures as a share of Gross Domestic Product (GDP) during the same time period (Kaiser Family Foundation, 2012). Table 127 identifies inflation factors associated with the growth of personal health expenditures (National Center for Healthcare Statistics, 2011).



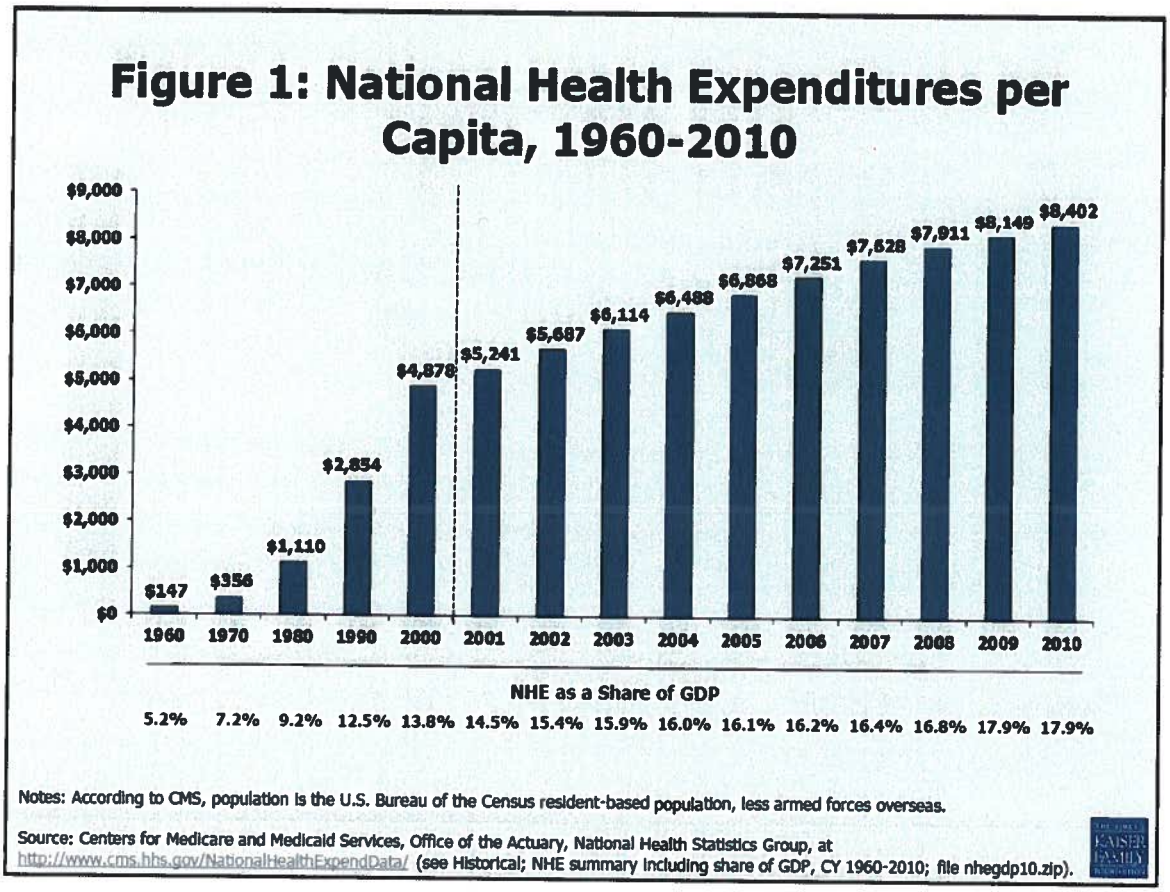


Figure 1: National Health Expenditures per Capita, 1960-2010
$9,000
$8,000
$7,000
$6,000
$5,000
$4,000
$3,000
$2,000
$1,000
$0
$147
$356
$1,110
$2,854
$4,878
$5,241
$5,687
$6,114
$6,488
$6,868
$7,251
$7,628
$7,911
$8,149
$8,402
1960 1970 1980 1990 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010
NHE as a Share of GDP
5.2% 7.2% 9.2% 12.5% 13.8% 14.5% 15.4% 15.9% 16.0% 16.1% 16.2% 16.4% 16.8% 17.9% 17.9%
Notes: According to CMS, population is the U.S. Bureau of the Census resident-based population, less armed forces overseas.
Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at http://www.cms.hhs.gov/NationalHealthExpendData/ (see Historical; NHE summary including share of GDP, CY 1960-2010; file nhegdp10.zip).

Table 127. Growth in personal health care expenditures and percent distribution of factors affecting growth: United States, 1960–2009

Excel and PDF: http://www.cdc.gov/nchs/hus/contents2011.htm#127.

[Data are compiled from various sources by the Centers for Medicare & Medicaid Services]

Period	Average annual percent increase	Factors affecting personal health care expenditure growth				
		All factors	Inflation[1]		Population growth	Intensity growth[4]
			Economy-wide inflation[2]	Excess medical price inflation[3]		
		Percent distribution of factors affecting growth[5]				
1960–2009	9.6	100	39	13	11	36
1960–1965	8.3	100	17	9	18	56
1965–1970	12.7	100	33	11	8	47
1970–1975	12.4	100	55	0	8	37
1975–1980	13.9	100	54	12	7	27
1980–1985	11.7	100	46	30	9	15
1985–1990	10.4	100	32	21	10	37
1990–1995	7.2	100	35	17	16	32
1995–2000	5.9	100	29	10	17	43
1995–1996	5.6	100	35	5	18	42
1996–1997	5.7	100	31	1	19	49
1997–1998	5.5	100	21	17	19	43
1998–1999	5.9	100	26	17	17	40
1999–2000	6.9	100	32	11	14	43
2000–2005	7.8	100	32	11	13	44
2000–2001	8.6	100	27	17	12	44
2001–2002	8.5	100	20	17	12	52
2002–2003	7.8	100	28	11	12	49
2003–2004	7.2	100	40	10	14	36
2004–2005	6.8	100	50	–4	14	40
2005–2006	6.3	100	53	–3	16	34
2006–2007	5.9	100	51	7	18	24
2007–2008	4.9	100	45	9	19	26
2008–2009	4.6	100	20	40	19	21

[1]Two measures of inflation are presented: economy-wide and excess medical inflation (changes in medical-specific prices in excess of those included in economy-wide inflation).
[2]Economy-wide inflation is calculated using the implicit price deflator (IDP) for gross domestic product (GDP). The IDP is a broad measure of the prices of the goods and services that the U.S. produces.
[3]Excess medical price inflation is the measured amount of medical price growth above general economy-wide price growth. This excess rate captures if medical prices have tended to rise more or less quickly than general economy-wide prices.
[4]Intensity is the residual percentage of growth that cannot be attributed to inflation or population growth. It includes changes in the use or kinds of services and supplies and captures any errors in measuring prices or total spending.
[5]Percents may not sum to 100 due to rounding.

NOTES: The inflation rates used to calculate the factors affecting growth have a base year of 2005. Starting with *Health, United States, 2010*, estimates are based on a revised methodology that incorporates available source data and methodological and definitional changes. These revisions are due to a comprehensive change in the classification structure of how estimates are defined and presented. For more information on the impact of these revisions, see: http://www.cms.gov/NationalHealthExpendData/downloads/benchmark2009.pdf. See Appendix I, National Health Expenditure Accounts (NHEA) and Appendix II, Health expenditures, national; Gross domestic product (GDP).These data include revisions in health expenditures for all years and population for 2000 and subsequent years. Data have been revised and differ from previous editions of *Health, United States*.

SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group, National Health Expenditure Accounts, National health expenditures and unpublished data. Available from: http://www.cms.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage/. See Appendix I, National Health Expenditure Accounts (NHEA).

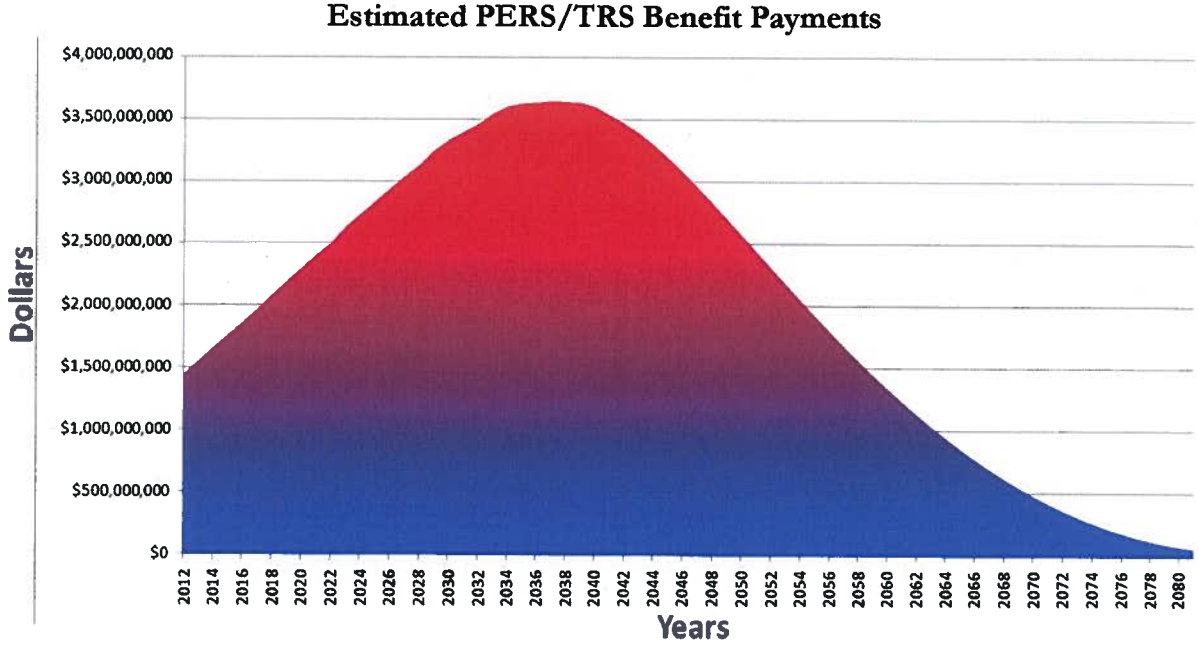
Sources:
National Center for Health Statistics. (2011). Health, United States, 2011: with special feature on socioeconomic status and health. Retrieved from: http://www.cdc.gov/nchs/data/hus/hus11.pdf

The Kaiser Family Foundation. (2012). Health Care Costs: A Primer. Retrieved from: http://www.kff.org/insurance/upload/7670-03.pdf

United States Department of Labor, Bureau of Labor Statistics. (2013). Databases, Tables & Calculators by Subject. Retrieved from: http://data.bls.gov/pdq/SurveyOutputServlet

Q2: Slide 2 – On the PERS cost, is that predominately tiers 1, 2 and 3 and do we expect that cost to drop? Can you provide a copy of the expected costs? (Sen. Wielechowski)

A2: The estimated PERS/TRS payments for tiers I, II, and III are depicted in the chart below. This chart was provided to the House Finance Subcommittee on February 7, 2013.



Q3: Do you have the number of participants and the cost per participant for each of the categories on slide 5 and the comparison between each category? (Rep. Hughes)

A3: In 2011, for each of the categories in the chart the estimated health care cost per year per participant were as follows:

- State of Alaska PERS: $10,935
- State of Alaska TRS: $9,386
- State of Alaska JRS: $7,153
- State of Alaska Employee: $15,960
- Medicaid: $10,116
- Corrections: $6,997
- Workers Compensation: $14,328
- Contribution to health trust: $15,960

Q4: Slide 6 – Please provide additional information on members of the LTC health trust and a list of LTC and Public Safety members in the plan? (Sen. Dyson)

A4: The Labor, Trades and Crafts (LTC) bargaining unit was established in 1974 and as of June 30, 2012 had a total of 1,808 positions. The LTC bargaining unit includes the job classifications below:

- Airport foremen
- Occupational safety and compliance officers
- Safety inspection and compliance inspectors (electrical, elevator, plumbing)
- Equipment operators
- Maintenance specialists
- Mechanics (general, automotive, aircraft)
- Drillers
- Engineering technicians
- Materials laboratory technicians
- Food service
- Surveyors
- Stock and parts services
- Environmental services

Sources:
Master Agreement between the State of Alaska and the Public Employees Local 71 representing the Labor, Trades, and Crafts Unit. Effective July 1, 2012 through June 30, 2015. Retrieved from: http://doa.alaska.gov/dop/fileadmin/LaborRelations/pdf/contracts/LTC2012-2015.pdf

The Public Safety Employee Association was established in 1978 and represents 487 members. Its members consist of the following:

- State troopers
- State fish and wildlife protection troopers
- Police and fire officers for the Anchorage and Fairbanks International Airports
- Court service officers
- Deputy fire marshals

Sources:
Public Safety Employees Association. Retrieved from:
http://www.psea.net/about-psea.html
Additional information for the bargaining unit is available at:
http://doa.alaska.gov/dop/fileadmin/LaborRelations/pdf/buprofiles/PSEA.pdf

Q5: Please provide additional details about the MM&P bargaining unit. (Sen. Dyson)

A5: The Masters, Mates and Pilots (MM&P) bargaining unit consists of a total of 98 positions. MM&P represents all deck officers described below:

- Regularly assigned deck officers
- Vacation relief deck officers
- Extra relief deck officers
- Masters
- Pilots
- Chief mates
- Second and third mates and third mate trainees

Sources:
Agreement between the State of Alaska Operating the Alaska Marine Highway System and the International Organization of Masters, Mates, and Pilots. July 1, 2008-June 30, 2011. Retrieved from:
http://doa.alaska.gov/dop/fileadmin/LaborRelations/pdf/contracts/MMP2008-2011.pdf

State of Alaska Workforce Profile Fiscal Year 2012. Retrieved from:
http://doa.alaska.gov/dop/fileadmin/DOP_Home/pdf/dopannualreport.pdf

Q6: Provide detail of what you call "the network", basically the provider discount? What discounts do we get from the different kind of providers in what the Department refers to as "a network"? (Rep. Lynn and Sen. Dyson)

A6: The term "network" in the health care industry refers to a group of providers that have negotiated discounted services with an organization and have agreed not to "balance bill" a

member, often in exchange or in expectation of, an increased volume of customers. The health plan encourages members to procure services from these providers in order to benefit from the financial discounts. The term "in-network provider" refers to those providers who have offered a discount and are considered network providers for an organization or health plan. The term "out-of-network provider" refers to providers who have not negotiated a discount for their services and are thus not part of the network.

Traditionally the "network" for AlaskaCare plans is established by the Third-Party Administrator (TPA) and is therefore subject to change when the TPA changes. Under the current TPA, HealthSmart, as of December 2012 at least 1,171 providers in Alaska were participating in the network. The discounts negotiated between the TPA and the individual providers are considered proprietary. However HealthSmart estimates that their network has achieved an overall savings of approximately 32% for the AlaskaCare Employee plan based on claims incurred over the past calendar year. During that same time period, 60% of services were incurred through in-network providers.

Source:
HealthSmart Second Quarter FY 2013 Performance Review Employee Plan.
July-September 2012.

Q7: Pharmacies are complaining about getting the short end of the stick because the State goes to outside providers? How much have you saved by going out-of-state? (Rep. Lynn and Sen. Dyson)

A7: AlaskaCare pharmacy claims and the provider network are managed by a Pharmacy Benefit Manager (PBM) which is currently administrated through the TPA. The current PBM is called Envision. Quarterly reports they provide indicate the volume of prescriptions filled by retail and mail order providers. Between July 1 and September 30, 2012, a total of 24,172 prescriptions were filled through retail providers and 2,699 prescriptions were filled through mail order providers. The average savings per prescription was $85 for prescriptions filled at retail providers and $163 for prescriptions filled through mail order providers.

Source:
HealthSmart First Quarter FY 2013 Performance Review Employee Plan.
July-September 2012.

Q8: I have heard about numbers over the years that show uninsured patient costs for Alaska are $100 million per year and that every employee picks up $2,000 of this payment. Is this because the State pays for those people who are uninsured? (Sen. Wielechowski)

A8: We are unable to find a specific reference to the $2,000 mentioned by Sen. Wielechowski. However the AlaskaCare Employee Plan premiums are based on the plan experience and are not directly related to any State costs associated with programs for uninsured individuals.

Q9: Slide 12 – Can you explain what the level of subsidization in dollars is between the plans? (Rep. Hughes)

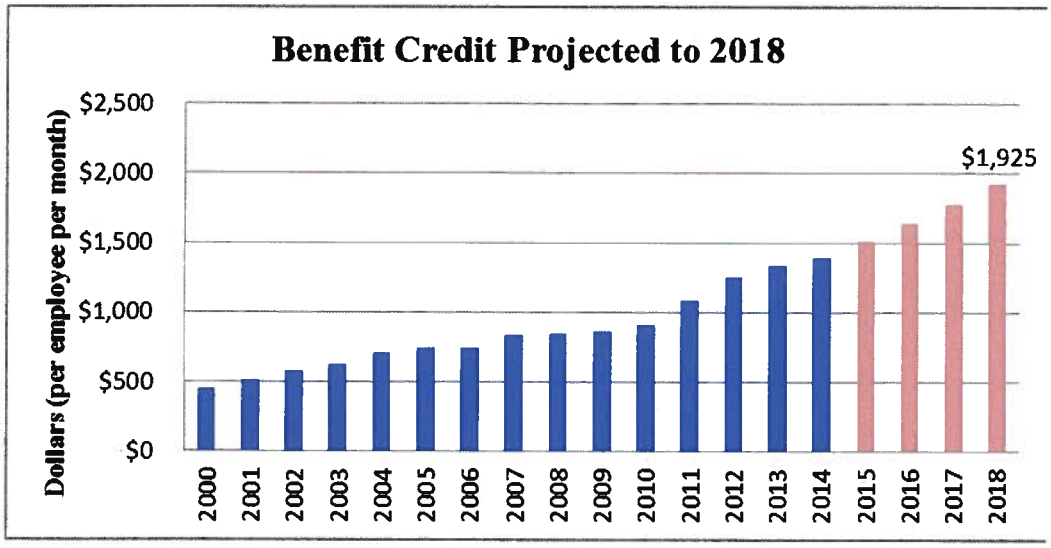
A9: The chart below provides the results of the most recent actuarial analysis of the cost Per Employee Per Month (PEPM) for each of the four plans currently offered in the AlaskaCare Employee plan during the benefit year. These are based on analysis of the FY 11 benefit year and were determined by Buck Consultants, the company providing benefits consulting and actuarial services to the Division of Retirement and Benefits.

Plan	Members	Premium	Average Cost (per member per month)	Difference (per member per month)
Premium family	1,651	$1,546	$2,081	+$535
Premium employee/ Standard family	15	$1,310	$1,401	+$91
Standard	8,117	$1,201	$1,280	+$79
Economy	5,969	$1,036	$668	-$368

Traditionally, the premiums in each plan have been increased by the same percentage rather than by plan experience further exacerbating the differences between costs incurred in each plan and their respective premium. Were the status quo to be applied in FY 2014, it would result in even greater disparities with premium plan members incurring an estimated $798 more than the associated premium while economy plan members would incur $469 less than their premium.

Q10: Pertaining to the point of sustainability, the IRS projected the cost per family for premiums will be around $20,000 by 2018. Can you project the State premium costs out to 2018 according to the past decade trend? (Rep. Keller)

A10: The trend over the past decade was an annual increase of 8.5%. This trend has been applied to the benefit credit (economy plan premium and preventive dental) projected out to 2018 in the table below.



Q11: Slide 15 – What is the per unit service cost comparison between an urban and a rural hospital? Has cost escalation been higher in areas with more than one provider? (Sen. Dyson)

A11: In calendar year 2012, the average paid per member per day for services among rural hospitals (Juneau, Fairbanks, and Ketchikan) in the plan's top facilities was $5,406. In urban hospitals, which for purposes of this response are hospitals in Anchorage and Matanuska-Susitna, the same cost averaged $8,275. It is important to take into consideration that this data has certain limitations. It does not account for severity or acuity of illness which could result in higher expenses and are more likely to be treated at an urban hospital. The average cost per day among all hospital facilities was $7,706 in calendar year 2012 representing a 21.6% increase from the previous year. Our current capacity to analyze the cost escalation among rural hospitals and urban hospitals is limited.

Q12: Slide 17 – Do we have proof that case management is working to drive costs down? What are the estimated savings for the program? (Rep. Hughes)

A12: The summary of case management activity for the past two quarters encompassing claims from July 1, 2013 through December 31, 2013 is listed below. Over 50% of individuals participating in the case management program were diagnosed with neoplasm (cancer), 19% with diseases of the circulatory system, 11% with diseases of the genitourinary system and 9% with diseases of the digestive system.

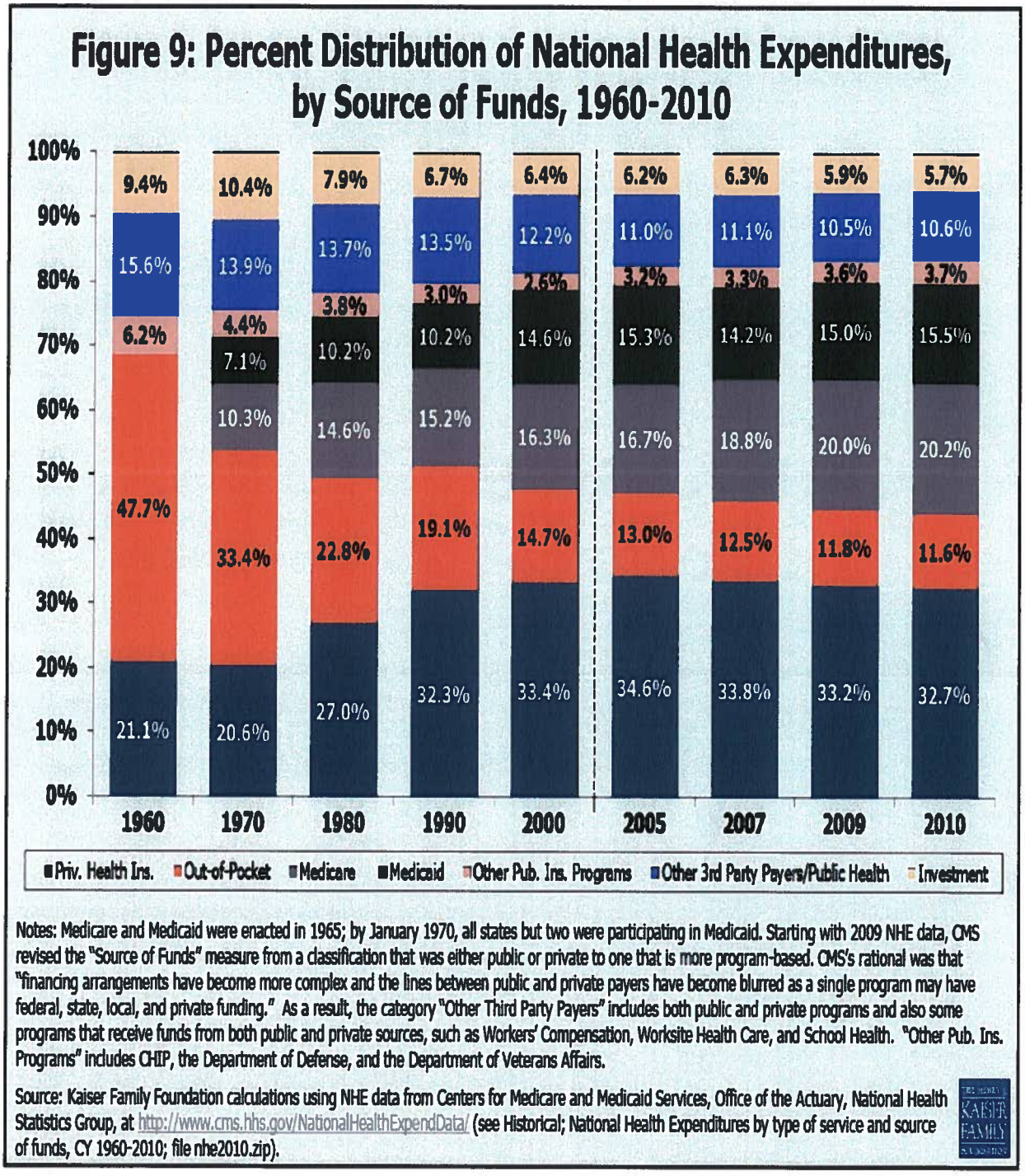
Case Management Activity	1st Quarter FY 13 (7/1 – 9/31)	2nd Quarter FY 13 (10/1 – 12/31)
Cases open at end of reporting period	39	47
Total case management savings due to case interventions	$225,348	$105,690
Savings per case management participant	$4,507	$1,428
Case management return on investment	$5.80	$2.90

Q13: Slide 19 – What are the percentages based on? (Sen. Dyson)

A13: The table depicts payment comparisons per state expressed in percentage terms. In this table, the average commercial mean across the five comparison states (excluding Alaska) for each payer category is equal to 100%. The percentages indicate the level of reimbursement above the average commercial mean.

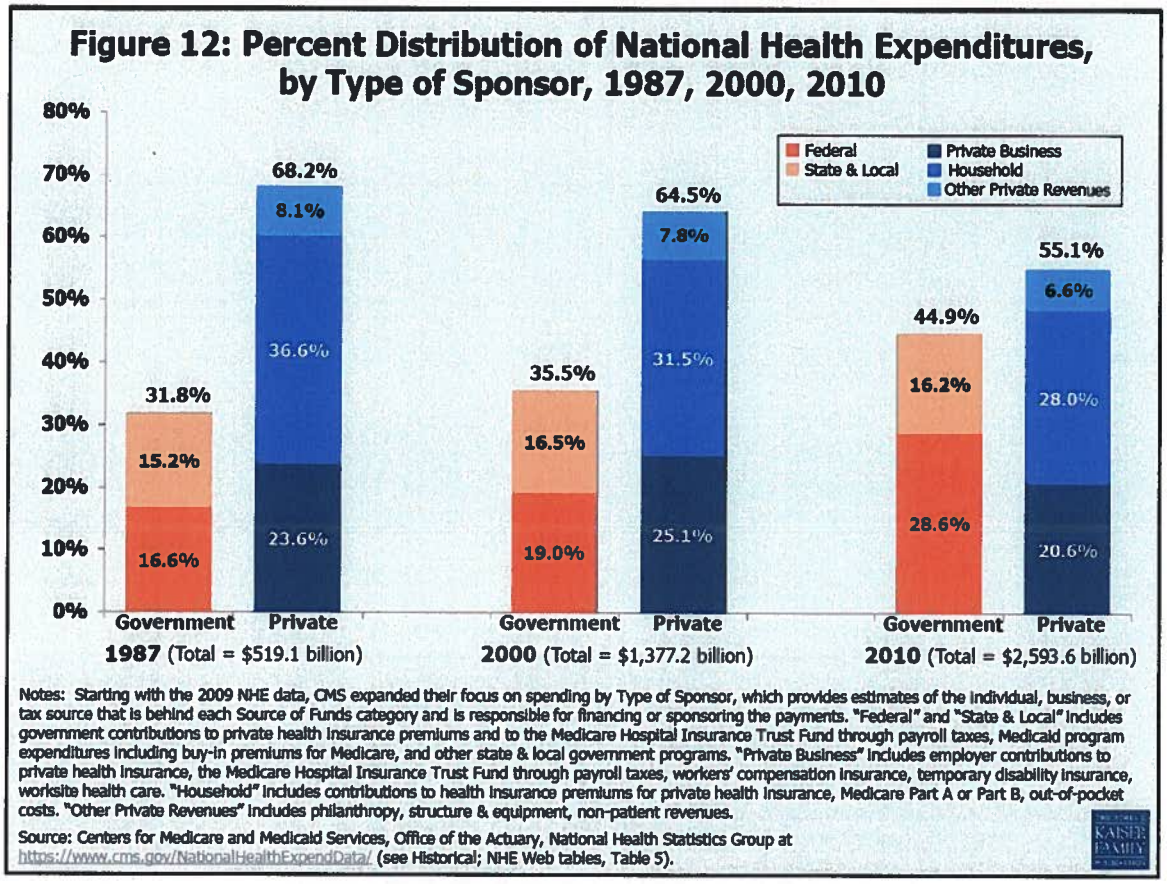
Q14: Slide 20, bullet 4 – How does our state compare to other states when it comes to paying for health care costs? (Rep. Keller)

A14: State, local and federal government spending made up approximately 60% of Alaska health care expenditures in 2011 (ISER, 2011). This is higher than the national trend of approximately 50% (Kaiser Family Foundation, 2011). According to the Kaiser Family Foundation, Medicare made up 20.2% of national health expenditures, Medicaid 15.5%, other public insurance programs 3.7% and other third party payers (public and private) 10.6% as shown in the following chart, Figure 9. Figure 12 provides additional background information, the distribution of government spending as a proportion of national health expenditures have grown over the past two decades.



Notes: Medicare and Medicaid were enacted in 1965; by January 1970, all states but two were participating in Medicaid. Starting with 2009 NHE data, CMS revised the "Source of Funds" measure from a classification that was either public or private to one that is more program-based. CMS's rational was that "financing arrangements have become more complex and the lines between public and private payers have become blurred as a single program may have federal, state, local, and private funding." As a result, the category "Other Third Party Payers" includes both public and private programs and also some programs that receive funds from both public and private sources, such as Workers' Compensation, Worksite Health Care, and School Health. "Other Pub. Ins. Programs" includes CHIP, the Department of Defense, and the Department of Veterans Affairs.

Source: Kaiser Family Foundation calculations using NHE data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at http://www.cms.hhs.gov/NationalHealthExpendData/ (see Historical; National Health Expenditures by type of service and source of funds, CY 1960-2010; file nhe2010.zip).



Sources:
The Kaiser Family Foundation. (2012). Health Care Costs: A Primer. Retrieved from: http://www.kff.org/insurance/upload/7670-03.pdf

Institute of Social and Economic Research. (2011). Alaska's $7.5 Billion Health Care Industry – What is the outlook? Where are the opportunities to improve value? Retrieved from: http://dhss.alaska.gov/ahcc/Documents/meetings/201106/201106-23akhealthcarecost_execsum.pdf

Q15: How does the State deal with the coordination of benefits when there is multiple coverage? How does coordination of benefits work with Indian Health Services? (Rep. Keller)

A15: Coordination of benefits under the AlaskaCare Employee Plan is described below in several different scenarios. Please note that these are for example purposes only and individuals with

case-specific questions are encouraged to contact the Third-Party Administrator, HealthSmart, directly.

Example 1 – Employee is covered by Medicare, AlaskaCare Retiree Plan, Tricare, and Indian Health Service (HIS):

1) AlaskaCare Employee Plan pays 70/80/90% depending on plan selected
2) Medicare
3) AlaskaCare Retiree
4) Tricare
5) IHS

Example 2 – Employee is covered by Medicare, TriCare and IHS:

1) AlaskaCare Employee Plan pays 70/80/90% depending on plan selected
2) Medicare
3) TriCare
4) IHS

Example 3 – Employee is covered by AlaskaCare Retiree, TriCare and IHS:

1) AlaskaCare Employee Plan pays 70/80/90% depending on plan selected
2) AlaskaCare Retiree Plan
3) TriCare
4) IHS

I hope all questions have been answered to your satisfaction. Please feel free to contact me if you need any additional information.

Sincerely,

Becky Hultberg
Commissioner

cc: Senate State Affairs Standing Committee members
House State Affairs Standing Committee members