

**ALASKA STATE LEGISLATURE
HOUSE LABOR AND COMMERCE STANDING COMMITTEE**

October 7, 2014

1:11 p.m.

MEMBERS PRESENT

Representative Kurt Olson, Chair
Representative Lora Reinbold, Vice Chair
Representative Mike Chenault
Representative Charisse Millett
Representative Dan Saddler
Representative Andy Josephson
Representative Craig Johnson

MEMBERS ABSENT

Representative Bob Herron

COMMITTEE CALENDAR

PRESENTATION: PATIENT PROTECTION AND AFFORDABLE CARE ACT

- HEARD

PREVIOUS COMMITTEE ACTION

No previous action to record

WITNESS REGISTER

LORI WING-HEIER, Director
Division of Insurance
Department of Commerce, Community, and Economic Development
Juneau, Alaska

POSITION STATEMENT: Testified on the Patient Protection and Affordable Care Act (ACA).

BECKY HULTBERG, President and CEO
Alaska State Hospital and Nursing Home Association (ASHNHA)
Juneau, Alaska

POSITION STATEMENT: Testified on the ACA.

SHEELA TALLMAN, Senior Manager, Legislative Policy
Premera Blue Cross
Seattle, Washington

POSITION STATEMENT: Testified on the ACA.

JASON GOOTEE, Regional Manager
Moda Health, Alaska
Palmer, Alaska

POSITION STATEMENT: Introduced his supervisor.

KRAIG ANDERSON, Senior Vice President and Chief Actuary
Moda Health
Portland, Oregon

POSITION STATEMENT: Testified on the ACA.

VINCE O'SHEA, Vice President
Pacific Seafood Processors Association (PSPA)
Juneau, Alaska

POSITION STATEMENT: Testified on the ACA.

BILL STREUR, Commissioner
Department of Health and Social Services (DHSS)
Juneau, Alaska

POSITION STATEMENT: Testified on the ACA.

ACTION NARRATIVE

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CHAIR KURT OLSON called the House Labor and Commerce Standing Committee meeting to order at 1:11 p.m. Representatives Reinbold, Josephson, Saddler, Johnson, and Olson were present at the call to order. Representative Sam Kito III was on line. Representatives Millett and Chenault arrived as the meeting was in progress.

PRESENTATION: Patient Protection and Affordable Care Act

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CHAIR OLSON announced that the only order of business would be a discussion related to the federal Patient Protection and Affordable Care Act (ACA) and the impact of rate increases. When the ACA was rolled out, he said, people were told that if they liked their doctors they could keep them and if people liked their health care plans, they could keep them. The ACA would also lower healthcare costs for families and for businesses, he stated. He said if he was still in the insurance business, "and I sold a product like that, I'd probably be in jail for any number of violations of the insurance statutes." He added that he is trying not to let his bias show.

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LORI WING-HEIER, Director, Division of Insurance (DOI), Department of Commerce, Community, and Economic Development (DCCED), said there have been many statements made about the DOI. Its mission is to regulate the insurance industry to protect Alaska consumers. She said that sometimes decisions need to be made and issues need to be resolved that result in "no clear winner" and that the division needs to make a decision after reviewing hundreds of pages of data and holding countless meetings to have a viable, financial, secure product for Alaska consumers that is available today and tomorrow. Interestingly, "sometimes our hands are tied [and] our creativity is stifled by a statute or regulation or court decision that dictates how we meet our mission." She noted that on March 23, 2010, President Obama signed a sweeping piece of legislation called the Patient Protection and Affordable Care Act (ACA) to provide affordable healthcare insurance to those who were uninsured and to expand certain benefits to those that were already insured.

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MS. WING-HEIER showed a timeline on slide 4 of her PowerPoint presentation. In the fall of 2013, the insurance industry canceled health insurance for five million Americans. She spoke of shock and dismay, and it was unsettling for stakeholders and for her division. Approximately 5,500 of the consumers were in Alaska, she explained. These consumers were to go from a noncompliant to a compliant plan, and people were shocked, she said. In October, open enrollment began and there were problems with the website, she reported, and repeated attempts to log in caused distress. In November, people were notified that they could keep their insurance for a year, through 2014, but that delayed the individual enrollment. The "SHOP option" was also delayed for one year [Small Business Health Options Program], she stated. So the question given to the state was: Would you allow your consumers to keep their current benefits for a year?

MS. WING-HEIER said that after some analysis, DOI issued Bulletin 1309, and "it did not, per se, allow the transition, but what it did allow was for the insurers to make a choice in their business decisions to cancel and rewrite the current insurance policies effective December 31 for a period of one year." She said if a policy was to expire in April, it would have been canceled on December 31, 2013, and would now expire December 31, 2014, and it would continue to be a non-grandfathered plan and out of the ACA. She said this was

distressing to consumers as they did not know if they were supposed to enroll or not, and it created anxiety for the insurers too as they had to adjust to the new plan. She said it was upsetting for many. The progress was halted for the time being, and the issues continued with the ACA website through the spring of 2014, she explained. In March, President Obama announced that those who like their insurance would be able to keep it, and current plans, at the direction of the state, could stay in place until October, 2016, she added. She noted that two insurers, Premera and Moda, kept their plans in place. She continued:

They were given notice, and, again, this is their decision, if they keep those plans. The Division of Insurance can only allow it; we cannot dictate it. It's their business decision. Under Bulletin 1403 they received a notice that they had to make a decision if they were going to continue the noncompliant plans. We felt it was important to do so because we realize the impact of the premiums in ACA compliant plans, and we hope to delay it as long we could for those that we could.

MS. WING-HEIER questioned if the division made the right decision, but she feels that it did because it gave about 5,000 Alaskans the choice to stay out of the ACA compliant plans unless they preferred them.

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MS. WING-HEIER noted that, in an attempt to keep costs to a minimum for consumers, on June 2, the division petitioned Health and Human Services to opt out of "SHOP" (for small business owners) for one year. The ACA, she believes, allows for the individual employee of small businesses to get a set amount of money to go into the marketplace to buy his or her own plan. She said she heard from several small business owners who did not like that concept because of their concern with the possibility of administering multiple plans in one small business. So, the division did the petition and was granted the authority to opt out of SHOP for one year.

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MS. WING-HEIER stated that people who had insurance on March 23, 2010, are grandfathered in and not subject to the majority of the ACA, but they could benefit from the ACA program of insuring

their children up to the age of 26. The non-grandfathered (or noncompliant) plans were purchased between March 23, 2010, and January 1, 2014, she said, and they were to become compliant by 2014. Those were also the plans that the insurance companies mailed out a notice of cancelation (but then reinstated) and can be kept until October 1, 2016, if the insurer allows for it, she explained. She said January 1, 2014, [begins the] compliance-qualified health plans. "Those are the three buckets that we're talking about," she added.

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REPRESENTATIVE SADDLER asked how many Alaskans have the non-grandfathered plans.

MS. WING-HEIER said page 8 does not talk about the large employers, "but it gives you an estimate of approximately 22,000 in the individual market in 2014." For the grandfathered [plans], Premera had about 2,800 in individual markets and about 4,600 in the small groups. Moda does not have any grandfathered plans. She said to look at her slide 9.

REPRESENTATIVE JOSEPHSON asked about slide 5. At the time of the signing of the ACA, if someone had a policy it was grandfathered, so they got to keep what they had.

MS. WING-HEIER agreed, but there were some modifications, such as the children could remain on their parents' insurance until the age of 26, as well as other benefits to those with grandfathered plans, "but not the significant--the essential health benefits and others that are in the ACA compliant plans." She turned to slide 6 from 2012 and 2013, which shows all insurers in Alaska, but it does not show the self-insured. She said she has focused on Premera and Moda, because they are the two insurers that "we have released the 2015 rates for and they are the two insurers that offer products to Alaskan consumers on the Federal Facilitated Marketplace." She noted that they had about 75 percent of the market. In 2013, the numbers do not change that much, she added. She turned to slide 8, "these are all insurers--individual and small group in 2014." It includes the grandfathered plans, non-grandfathered plans, and the ACA compliant plans, but the numbers can change from day to day, she noted. Slide 9 slices the numbers a little bit differently with regard to what Premera and Moda have, as far as individual markets, small group markets, grandfathered, non-grandfathered, and ACA compliant, she explained.

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MS. WING-HEIER said her point is to show that if she added up all of the numbers for all of the individuals that she has, and if she added in the 6,000 that she thinks may be out there that have yet to enroll, the sum is 28,828. Alaska is a small market, and nothing about the ACA is going to change that. She said Alaska has extremely high health care costs, and there is not enough in the pool to spread the costs of the claims that were seen in 2014 and prior years and make it affordable. Looking at other states, the marketplace enrollment of ACA qualified plans in 2014 was about 8 million nationwide, she reported, and some states had a decrease in rates and others had rates that did not go up. She said, "California enrolled 1.4 million; Idaho, 76; [and] Washington State, 163. Some states had a little less than us. Hawaii, for one, had about 9,000. South Dakota did not have many--about 13, and North Dakota, 10." She added that those states have a lower cost of health care and, perhaps, more access to some health care.

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MS. WING-HEIER presented a slide to show where Alaska falls with enrollment [expectations], and it is "pretty much right on target" for what CMS, Avalere, and what the Kaiser Family Foundation shows us. Alaska is a little over 16,000 in all markets for enrollment, she stated. No one knows exactly how many uninsured there were in Alaska, but this is the closest number she has. She said there has been a lot of discussion over the federal exchange and the rate-review grants and why the state made the decision that it did. Regarding the federal exchange grants, the federal government awarded close to \$4 billion to 49 states to study--and in some cases, design and implement--a state-based exchange, and of those 49 states, 39 elected to participate in the federal exchange, "as Alaska did from the beginning." Recent data shows that in addition to the \$4 billion from the federal government, there was close to \$3.5 billion spent by the states themselves, she stated. In Hawaii, the average cost per enrollee of their exchange is \$23,899, and for California it is \$758. California has some of the highest enrollment numbers of any state, she added.

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MS. WING-HEIER said Alaska is part of the FFM [Federally Facilitated Marketplace], and the average cost is \$12,890 per enrollee. The lowest is Florida at \$76 and North Dakota is

\$7,089 per enrollee just to access the web site and process the application, she said.

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REPRESENTATIVE JOSEPHSON noted that Ms. Wing-Heier said that the State of Alaska spends over \$10,000 and writes a check to someone for each enrollee into the federal exchange.

MS. WING-HEIER said no. "We joined the federal exchange, the federal government is spending \$12,890 ... priced out over all of the applicants or all the enrollees," and it is an average for Alaska's share.

REPRESENTATIVE JOSEPHSON asked if that is the federal subsidy.

MS. WING-HEIER said no. "This is just the cost for you or I to go to the website and enroll through healthcare.gov to obtain insurance." She said she will find the source of that data for him. She continued and said that several states started down the path of the federal exchange grants, including Oklahoma, Louisiana, Kansas, Maine, and Wisconsin, and they returned the funding when they started to look at what the costs would be to build a state-based exchange. She said the states of Oregon and Nevada failed miserably. Oregon spent \$350 million and Nevada spent \$75 million for their exchanges in 2014, and they are joining the federal exchange in 2015. The costs are high, so states are looking to partner with each other and searching for a more economical way for people to access healthcare, she said. With a small state like Alaska, there is no way to provide the software and the commitment without the grant money running out, leaving the state to deal with the financial burden.

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MS. WING-HEIER said she has heard about the Effective Rate Review and what that means. Historically, the oversight of insurance rates has been a state responsibility, and ACA established a role for HHS [U.S. Department of Health and Human Services] by requiring that the secretary establish a process for the annual review of unreasonable rate increases in the individual and small group market. [Alaska] rates were submitted to HSS on September 4, and she said she had one conversation with HSS and "they have yet to question the data that was submitted to them or the need for the rate increase." She said that HSS will also determine if a state has an effective rate review, and she questioned what that is. She

showed a slide of the states that were granted an effective rate review status, and "we, along with 45 other states, were approved by HHS as an effective rate review." The process entails very detailed information under federal and state statutes, and "we try to point out the types of data that are submitted to us and reviewed to determine if a rate is justified," she explained. Much like the exchange, the federal government released grants to fund states to become effective rate review states, she added, and Alaska has been criticized for not accepting [these grants]. She said, "Cycle I provided \$1 million to the states to help develop or enhance a rate review process that we have already been certified as effective rate review by HHS."

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REPRESENTATIVE SADDLER asked if she is speaking of a review of effective rates or is it the system that is effective.

MS. WING-HEIER said that the intent is to determine if "our rate review process is effective and over any qualification that HHS statutory obligation or any of their processes to determine the rate to be charged to Alaska consumers."

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REPRESENTATIVE JOSEPHSON said Susan Johnson, U.S. Department of Health and Human Services, gave him something that reads:

Although Alaska meets the effective rate review standards, it does not go beyond the minimum standards in terms of their rate review process and transparency of rate review data. For example, Alaska does not have public hearings on rates; they post minimal information in a form inaccessible to consumers.

REPRESENTATIVE JOSEPHSON said that Ms. Johnson cites the Kaiser Foundation who says that Alaska is one of the least transparent states in terms of making rate review available. "Is it possible that we're complying with this minimum standard but not doing all that we could to help consumers?"

MS. WING-HEIER said, "No, sir, I believe we are going above the standard." In Alaska the concern with the transparency is that there is a statute that requires rates to be kept confidential until the effective date. "I cannot, by statute, release the rates until January 1." The statute was intended to keep

insurers from knowing what their competition was bidding to enable fair competition, she said.

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MS. WING-HEIER said there was the \$250 million over five years awarded for effective rate review grants. "In Alaska, we felt that there was adequate staffing; we thought we only qualified and we believe we only qualified for Cycle I," she said, because one of the criteria for Cycle II "is that you're trying to be an effective rate review--we already achieved that status." There are only eight healthcare insurers in Alaska, she explained, and some states have 20 to 60 insurers, so it was not clear how Alaska could spend a million dollars of federal money to enhance a process that had been working for years, she stated. She continued:

When we have taken criticism for the effective rate review, we're taking it on the individual market, because there are some significant rate increases--I don't deny that; I can't, but no one talks about that we use the same rate review, the same processes, for the group market, and that the small group went down 17 percent on the average for Moda and a slight increase of a little over 5 percent for Premera, and it's the same process we use; the same type of data; the same qualifiers.

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CHAIR OLSON recalled that Ms. Wing-Heier said that the top two companies were writing 75 percent of the premiums.

MS. WING-HEIER said, yes, Premera and Moda. She continued and said that the determination to accept funding under Cycle II was that the state had to be working towards being an effective rate review state, but Alaska had already qualified, so "we did not qualify to receive Cycle II grants." She noted that there was \$159 million awarded, and \$14 million was returned as the states could not justify how to spend the money. Ms. Wing-Heier said that the Division of Insurance does not set premium rates; insurers file their rates and the division approves or disapproves them, and rates are defined by statute and cannot be excessive, based on historical data. The rates cannot be inadequate, "we have to guarantee the solvency of the insurance companies," she said, and they cannot unfairly discriminate or

be applied unfairly for similar risks, such as age, plan, or tobacco use.

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MS. WING-HEIER noted that in 2014, when ACA came about, there was speculation across the nation as to what the pool would look like. She said there were assumptions that those who were most in need of insurance would enroll the first year, and those who are not in need of healthcare right now have yet to enroll. In 2014, there was significance loss. By reviewing the data, she found that some of it is pent up demand and that there are some very ill individuals who have needed healthcare. In certain months, the division looks at loss ratios of the premiums coming in over the claims going out. In some months the insurers were paying out over \$2.50 in claims for every \$1.00 they were taking in for premiums, and they cannot stay in business long paying out that kind of money, she stated. She said that the ACA has 10 essential benefits, and those going forward in 2014 have the benefits without any option "to roll in or roll out." Perhaps someone does not want prescription or pediatric service, for example, but the plan provides for them, she said.

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MS. WING-HEIER turned to the "medical loss ratio." She said that this appears to be a good thing for consumers, "and perhaps it is." In 2014, Premera issued checks back to consumers for \$2.6 million for their 2013 [indecipherable]. For all insurers, the medical loss ratio is "if they, basically, guess wrong on what they expect their claims were ... then the money is given back to the consumers, which is a great thing on a good year." She opined that it is unfortunate that the insurance companies cannot keep the money to spread it out over the bad years. She said if the companies guess too high on what their losses will be, the money comes back to the consumers, but that does not allow them to build up surplus money to pay future claims, and that causes a rate increase. She turned to slide 25 dealing with risk adjustment, risk corridor, and reinsurance, which are part of the ACA, and the intent was to stabilize the market, particularly for the first two years. The risk adjustment transfers money amongst the insurers to adjust for the possibility that some insurers may get more or less of their proportionate share of costly enrollees, she said. She defined reinsurance as insurance for the insurance companies. In 2014, she said, "it attached to a claim at \$45,000, but, I believe, for the first \$250,000 after that there was an 80 percent co-

insurance." She said it increases in 2015 and again in 2016, and it is done in 2017. The risk corridor, she explained, is much like the medical loss ratio, and it allows the government to claw back some of the premiums if the expected losses are lower than what the insurer predicted. The program will operate for three years, and her concern is that last week the GAO [federal Government Accountability Office] released a legal opinion that the law was not funding for 2015 unless Congress passes a clarification.

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REPRESENTATIVE SADDLER asked why it is only for three years.

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MS. WING-HEIER said that she has no clue, but she believes the intent was for things to stabilize, and at some point we would know exactly what was out there and the rates would be adequate for the population served.

REPRESENTATIVE SADDLER asked if it was not to deal with the pent up demand.

MS. WING-HEIER said it could have been to deal with the pent up demand and to see what the pool would be. Everyone knew that there were uninsured people and people needing healthcare, but there was no way to quantify the number and the pool with regard to healthcare costs.

CHAIR OLSON asked if it was written by the insurance companies.

MS. WING-HEIER said it was written into ACA. She continued. In September 2014, Secretary Sylvia Burwell wrote that while competition is working in the online marketplace, it may not work as efficiently in a high-cost market with a small population such as Alaska. That is the point Ms. Wing-Heier has been trying to push since the onset of the ACA: the concerns of a one-size-fits-all option to provide healthcare, without her division being able to be creative or think outside the box, which it is making it costly to consumers.

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REPRESENTATIVE JOSEPHSON asked what she meant by one size fits all, and if that is the state perspective, not the consumer, because consumers have some choices.

MS. WING-HEIER said the consumer can choose a gold, platinum, silver, or a bronze plan, and the consumer can choose the insurer. There are variations in the deductible "and such," but the health benefits are one size fits all.

REPRESENTATIVE JOSEPHSON said that some states with small populations, like Arkansas, saw a reduction of 2 percent and Montana's increase was only 1.35 percent. "Are we just an outlier?"

MS. WING-HEIER said part of the concern is the cost of healthcare, which is one of the highest in the nation and higher than healthcare in Arkansas. She said, "We're in a dilemma." Alaska healthcare is one of the costliest in the nation. The ACA has limited options for the products for the Alaska consumers, she added. She said the underwriting has been restrictive, and she has heard from people from all walks of life that there is a problem with the ACA in Alaska

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MS. WING-HEIER said her mission is to protect Alaska consumers and provide them with products that are financially secure and to make sure the providers are stable and accountable. She added that nothing in ACA is affordable, and the division is doing everything in its power to make healthcare affordable.

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REPRESENTATIVE SADDLER turned to slide 27, and he asked if the rates of increase are annual.

MS. WING-HEIER said the slide shows the average rates, filed by the insurance companies, of individual states for the individual market. It is the average rate of the individual markets, so it is the expected change in healthcare expenses.

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CHAIR OLSON said the original numbers he saw for Alaska were closer to 70 percent on certain types of groups.

MS. WING-HEIER said there was never a filing for a 70 percent rate increase. When the division first met with Premera, Premera indicated that it would be 70 percent, but because of its relationship in the state, their financial solvency and

stability, "we could see that they could provide a product in 2015 [with] less than a 70 percent increase and still be around in 2016." She said she does not know what Premera's testimony will be, but its rates filed with the division show the expectation of a \$5 million loss next year.

REPRESENTATIVE SADDLER asked about the 2015 rates of plus 22 percent and plus 40 percent on slide 28.

MS. WING-HEIER said, "22 percent would be the low end of one, to the high end of the other, [and] all the plans in between."

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REPRESENTATIVE JOSEPHSON noted that Ms. Johnson said that the state average premium increase was 17 percent between 2008 and 2011, so that is less than even our lower end, but Ms. Johnson notes that Premera had the largest increase of 32 percent in 2008, which would be near the middle of those numbers. Although none of this is good news, is it possible there could be some leveling, he asked, and if it is wildly inconsistent.

MS. WING-HEIER said she hopes that there is some leveling and that the rates stabilize in three to five years, but she does not know if it will level out.

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REPRESENTATIVE SADDLER said he has an interest in the coverage of young people with disabilities. He spoke of an exemption, and he asked how many in Alaska do not have coverage of mental healthcare services.

MS. WING-HEIER said she will get back to him on that.

BECKY HULTBERG, President and CEO, Alaska State Hospital and Nursing Home Association (ASHNHA), said the members of ASHNHA include hospitals and nursing homes across the state. As healthcare providers, the members know the importance of healthcare insurance, because an accident or unexpected diagnosis can tilt someone's world, and for someone without health insurance the consequences can be devastating. A functioning private insurance market is critical to providing Alaskans access to health insurance, she said. Not everyone chooses to be employed, she explained, and private insurance is a necessity, not a luxury, for those who are self-employed or those with employers who do not offer health insurance. Having

a functioning private insurance market is essential to Alaska's economy, she added.

MS. HULTBERG said, "We need entrepreneurs and we need risk takers," but without affordable health insurance this may be too much of a risk for people. Prior to the ACA, insurers could deny coverage based on pre-existing conditions, and this coverage is one of the most popular aspects of the ACA, she explained. "We're not likely, nor should we, return to a time where you could be denied coverage due to the genetic lottery or unfortunate circumstances," she stated, but the provision has changed the risk pool. She noted that in a small market, it is hard to spread risk unless premiums increase. She spoke of ASHNHA's concern about the premium increases in the private market for 2015 and that the dialogue has not been as much about finding solutions as it has been about pointing fingers. She encouraged the state, the federal government, and private insurers to sit down and discuss how to move this forward to a sustainable future. The state needs to think big, she said. Alaska is unique and here is an opportunity to demonstrate that we can find unique solutions to our unique problems. She asked the federal government to consider the flexibility and innovation that may be necessary to meet the health insurance needs of Alaskans. The problem is solvable if everyone works together--it is a math equation, she said, and people need to step out of their boxes and think differently.

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CHAIR OLSON said that when ACA was rolled out, one of the appealing points was taking pressure off of the emergency rooms, because primary care would no longer be dealt with in emergency rooms. He asked if that impact is already occurring.

MS. HULTBERG said, "Not really." Medicaid expansion is what has really changed that, so for states that have expanded Medicaid, uncompensated care costs have gone down significantly. The volume of new Alaska entrants to the exchange is not sufficient enough to see any difference in the use of emergency rooms or uncompensated care, she explained.

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REPRESENTATIVE REINBOLD asked her to describe the risk pool Alaska had prior to the ACA.

MS. HULTBERG said she is not going to claim expertise on insurance, but she believes that Alaska has had a high risk pool through ACHIA (Alaska Comprehensive Health Insurance Association), and some of the people who were in that high risk pool have transferred to the individual market. It is a matter of numbers. Alaska has a small pool, and in spreading risk over a small pool "you can see these kinds of swings," she explained.

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REPRESENTATIVE MILLETT said she is confused by Ms. Hultberg's testimony, and she asked if ASHNHA is in favor of Medicaid expansion.

MS. HULTBERG said yes, but her point today is the concern about the private insurance market and the importance in having it in Alaska to provide access to insurance and for the health of Alaska's economy. She added that ASHNHA is asking that creativity and flexibility be brought to the table.

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REPRESENTATIVE JOSEPHSON asked about any linkage between the states that have taken Medicaid expansion and cost increases.

MS. HULTBERG said she does not know, but the primary published metric involves uncompensated care, and as uncompensated care goes down, the financial performance and the ability of healthcare providers to provide services is enhanced.

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REPRESENTATIVE REINBOLD asked why ASHNHA supports Medicaid expansion and if the physicians are taking Medicaid.

MS. HULTBERG said that for many of ASHNHA's member facilities, Medicaid expansion is a moral obligation. "We believe that people have the right to healthcare," she stated. There is a population of people with no way to purchase health insurance-- it is simply beyond their reach, she explained. She said that the most fiscally responsible way to ensure healthcare coverage for that population is through accessing federal funds. Regarding the second questions, she noted that some of the member hospitals employ physicians and some do not, so it really depends on the facility.

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REPRESENTATIVE SADDLER asked Ms. Hultberg the basis for her statement that people have a right to healthcare. "Is that the state or federal constitutions, or any state law?"

MS. HULTBERG answered that this country has made the decision with the Emergency Medical Treatment and Active Labor Act that one of the things the people of the United States will provide is emergency medical care regardless of a person's ability to pay. The organization has many people with many different opinions, but it is fair to say that many of the members do believe that as a society, healthcare is one of those basic, fundamental responsibilities.

REPRESENTATIVE SADDLER asked about the Emergency Medical Treatment and Active Labor Act.

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REPRESENTATIVE MILLETT asked how many providers of ASHNHA are accepting Medicaid at this point.

MS. HULTBERG said all of the hospitals take Medicaid, and she assumes that the physicians who are employed by the hospitals take Medicaid.

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REPRESENTATIVE REINBOLD spoke of government debt and questioned this moral obligation [regarding providing healthcare to others]. She said there are "families that want to be able to support their own families--the people they've chosen." With regard to spending federal dollars, there is a large debt to pay back right now, so the "bottom line is why should people, when we have such a high debt, be forced to pay more taxes in order to take care of others when it's not a sustainable model?" She asked where these federal dollars are going to come from.

MS. HULTBERG said these dollars will be spent regardless of whether "the little bit that we would spend in Alaska on Medicaid expansion is part of the equation or not." The funds are already factored into those long-term projections, she explained.

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SHEELA TALLMAN, Senior Manager, Legislative Policy, Premera Blue Cross, said Premera provides coverage to over 100,000 Alaska residents, and it offers coverage to individuals, small employers, and large employers, as well as offering services to the larger self-funded groups. She said that Premera received approval for a 37.3 percent average rate increase for its metallic Affordable Care Act compliant plan. The actual rate increase that an individual might face will depend on age, geography, and the plan selected, she noted. The plans are offered both on and off of the exchange and will impact approximately 7,000 members starting January, 2015, and subsidies will help the lower income individuals. The 6,000 people on individual plans are members who will not be impacted, she explained. Additionally, those who obtain coverage through employer-sponsored plans are not impacted by the rate increase.

MS. TALLMAN said the individual market in Alaska has changed significantly since the implementation of ACA; guaranteed access means that all Alaskans have access to private healthcare coverage regardless of health status. The high risk pool, or ACHIA program, has decreased its enrollment by over half since the beginning of this year, she said. Additionally, the federal high risk pool, which ACHIA has administered, has also [indiscernible], so those provided coverage to some very sick individuals who could not obtain coverage in the private market.

MS. TALLMAN said the guaranteed access requirement coupled with the small size of the Alaska market has resulted in an unsustainable market. There are not enough healthy purchasers in the individual market to offset the costs of members with very high medical needs. She said that in 2014 there was a significant influx of new enrollees with very high medical costs. "We had more than \$7 million in claims from just 33 members, and that is about a third of all the claims for all 7,000 members purchasing those metallic, individual plans," she stated. On average, Premera is paying about \$723 in claims per month for members on this plan and receiving about \$500 per month in premiums. She said Premera expects to lose about \$4 million in the market in 2014. The federal "Three Rs" or the federal risk mitigation programs, were designed to minimize the effects of adverse selection in the guaranteed access environment. They are insufficient at the very high end of the claims cost and will not be able to help spread the risk in a market that is too small, she noted. Additionally, two of the programs will sunset in 2016.

MS. TALLMAN stated that the key to addressing this situation is to create a large enough pool to spread the costs of the members with significant medical needs. Even if all of the individual markets were in one pool and everyone purchased coverage, the market in Alaska is still too small to adequately spread the risk, she added. Premera suggested a policy option, which is the implementation of a supplemental state-based free insurance program, which would use the state's current high risk pool, ACHIA, to spread the highest cost conditions across the entire insured market, she said, which is how the high risk pool works today. "We believe this will help stabilize the individual market for all individual purchasers and create a more competitive market without drastic swings and premiums." She said Premera understands that the Division of Insurance is evaluating this proposal and that this is a difficult situation, especially for the impacted members, "so we are committed to working with you and other stakeholders to create a sustainable market in Alaska," she concluded.

[2:20:20 PM](#)

REPRESENTATIVE SADDLER asked about the supplemental insurance program based on ACHIA.

MS. TALLMAN said it would be a state-based solution, and the idea is to build it as a wrap-around to the federal re-insurance program. An individual would sign up for coverage with any health plan, obtaining all of the benefits and access to providers, and on the back end--much like how the federal re-insurance program works--is that once an individual hits a certain amount of medical claims costs, then those claims would be ceded to the high risk pool and spread across the entire insured market through the existing assessments that ACHIA uses today to spread the costs of the enrollees. She said there are different ways of establishing a state-based re-insurance program, like condition-based or a claims dollar amount, but the essential concept is that certain claims costs would be spread across the entire insured market.

REPRESENTATIVE SADDLER surmised that those higher costs would be borne by the state.

MS. TALLMAN agreed. "Those costs would be spread just like how ACHIA is funded today through an assessment of the entire insured market; it would function the same way," she said.

REPRESENTATIVE SADDLER said that would be to the benefit of the patient and the insurance companies, but the state would pay.

MS. TALLMAN said, "It would come at the cost of those purchasing insurance, actually, because it is an assessment that's spread across the entire insured market, so anybody that's in the individual and group market would pay that assessment."

[2:22:31 PM](#)

REPRESENTATIVE JOSEPHSON said there is some dispute about how many would be covered with Medicaid expansion; the low number is around 9,000 and the high number is 41,000--a huge difference. But if there were Medicaid expansion, he asked, "would any of those dollars translate or effectuate themselves such that Moda and Premera could meet this demand?" He referred to the \$700 in claims paid versus the \$500 in premiums, and asked if Medicaid would fix that difference by lowering the uncompensated care.

MS. TALLMAN answered that would require some additional analysis, but she said she is addressing the individual market today, and those eligible for Medicaid expansion can go into the individual market to get coverage and get subsidies, but they are eligible for separate programs, so she is not sure what impact Medicaid expansion would be on the private market.

REPRESENTATIVE JOSEPHSON asked about the rates that are set by Premera and Moda, which may be based partly on the income of the two main Alaska hospitals. "Would it seem logical to you that if, according to the high end, there was \$1.1 billion of revenue that came in covering 41,000 people, that that would trickle down and benefit some of the people in the individual market by suppressing inflation?"

MS. TALLMAN said she understands his point, but it would still be difficult to answer without doing additional analyses.

[2:25:02 PM](#)

REPRESENTATIVE JOHNSON asked if the \$4 million was across all business lines or just across those 7,000 outside of the plan. "Is that your total loss for the state, or is that just within those individual plans?"

MS. TALLMAN said the loss is just for that individual market. Premera just evaluates based on each segment, looking at the individual block and other components separately.

REPRESENTATIVE JOHNSON said, "We're looking at the state as a whole, and the state pays an awful lot of insurance being self-insured, and we provide a certain margin in that, so I would be curious to know across your total lines if that \$4 million holds true or if we're really not that bad of a market to be in."

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CHAIR OLSON asked if there any other states that are doing the supplemental rate insurance.

MS. TALLMAN said Oregon has passed a law that would establish their supplemental state re-insurance program, and a couple other states might be looking into it.

CHAIR OLSON asked if it is a violation of ACA to have a cap on benefits. He spoke of totally debilitating long-term cancer with drugs costing \$70,000 a month, "but it wouldn't be capped under ACA, is that correct?"

MS. TALLMAN said yes, so under a supplemental program, the member would still receive all of those benefits without any cap or limits, "it's just on the back end with how the claims costs are being spread. You would set some sort of attachment and build parameters to help spread the risk of the claims cost on the back end."

CHAIR OLSON asked if it would be optional or mandatory to participate.

MS. TALLMAN said it would depend on how it is designed, but it could be permissible for any insurer to participate.

CHAIR OLSON asked who pays for it.

MS. TALLMAN reiterated that it would be based on how the current high risk pool works today, which is funded through an assessment on the entire insured market. The idea would be to not increase the assessment going forward, but there are different ways of designing it, she explained.

[2:28:52 PM](#)

CHAIR OLSON asked what the assessment has been.

MS. TALLMAN said she believes that it has fluctuated over the past few years, but the average is between \$8 million to \$10 million annually. From Premera's perspective, the assessment has ranged from about \$8 to \$10 per member per month.

REPRESENTATIVE SADDLER asked how the projections of the costs to private insurers of no longer having exclusions of pre-existing conditions compare to actual costs of the past year.

MS. TALLMAN said, "If we're paying \$723 in claims per member per month compared to \$540 in premiums in 2013, and probably prior years it's been much closer to the premium amount that we've been collecting."

REPRESENTATIVE SADDLER asked about the projections.

MS. TALLMAN said she does not know, but Premera anticipated a lot more people and potentially healthier people purchasing in the pool overall, and so it has set the rates in 2014 based on that. "Now we're looking at rates based on the actual experience that we're seeing."

[2:30:23 PM](#)

JASON GOOTEE, Regional Manager, Moda Health, Alaska, said his supervisor flew to Juneau specifically for this hearing.

KRAIG ANDERSON, Senior Vice President and Chief Actuary, Moda Health, said Moda Health was known as ODS Health Plans Inc. and was a Delta Dental Plan in 1955. It is the only "Delta Dental" that does medical insurance, he noted. In the mid-2000s, Moda took over marketing rights for Delta Dental in Alaska, and between 2005 and 2007, "we rolled out individual and group dental and medical products in Alaska." Moda established an office in Anchorage in 2005, which serves as a sales office and account services, and in 2013, ODS rebranded to Moda. With the passage of health reform in 2010, there were significant market reforms, and perhaps the most significant was the impact to the individual market by the requirement of guaranteed issue and the exclusion of health statement underwriting. Prior to 2014, in order to get individual coverage in Alaska, a person had to go to an insurance company, fill out an application with health statement information, and the insurance company could either accept or decline him or her for that coverage. Another option, he said, was that the insurance company could actually rate up the policy depending on a person's health condition (but that was not a practice of Moda). "So that was the environment

before healthcare reform," he stated, and that was why the private individual market was healthier than average and had lower costs.

CHAIR OLSON asked about lifestyle choices, like smoking.

MR. ANDERSON said those people were not declined by Moda, but they may have had higher premiums.

[2:35:26 PM](#)

MR. ANDERSON said in June, 2012, a company called Lewis and Ellis did an actuarial analysis of the exchange and it factored in the impacts that healthcare would have on Alaska. The report had some interesting insights that relate to the individual market, he stated. It noted three factors of health reform that would increase rates in the individual market: eliminating age bans; health status and guaranteed issue restrictions; and minimum benefit coverage. However, he said, the primary factor is the health status and guaranteed issue restriction. He explained that the primary goal of health reform was the expansion of coverage to the uninsured, and that was to be done through the exchanges. The federal government set up a program to allow for subsidized premiums for people who earn up to 400 percent of the poverty level as long as they purchased a policy on an exchange.

MR. ANDERSON said that Lewis and Ellis estimated that the average cost of those who are currently uninsured is approximately 36% higher than the existing population in the private individual market. He reiterated that the private individual market, which was health statement underwritten and healthier on average, and the study "looked at the uninsured people that are out there in Alaska and estimated they would be 36 percent higher in costs, and those are the people that they're trying to move in to the market." Although Lewis and Ellis said that the average cost was 36 percent higher, they did not know how many of the uninsured would actually go into the private market even with the subsidies, he added. In 2013, the uninsured population in Alaska was estimated to be about 138,000. The study estimated that 54,000 of these uninsured would move into the private market, but only 16,000 people ended up being on the exchange--a very small slice of a very large pie. He said that that this small group of people who actually picked up policies in the exchanges are the ones with the highest healthcare costs.

[2:39:00 PM](#)

REPRESENTATIVE JOSEPHSON said the director talked about maybe finding 6,000 more [people to get policies in the exchanges].

MR. ANDERSON said the Lewis and Ellis report was done in 2012, so it gave a very preliminary estimate of possibly 54,000 people moving into the market. He said he thinks 22,000 is a more current estimate of the number of people expected to move into the exchange market.

CHAIR OLSON stated that of the 138,000, there is probably a significant portion that are already covered, and he spoke of Native Alaskans.

MR. ANDERSON said that is possible.

CHAIR OLSON suggested that Native Alaskans and young males are not signing up as projected. Young males think they are "bomb proof," he explained. Many of his daughters' friends do not have insurance but could; "a lot of them work on the North Slope or have the income..."

MR. ANDERSON agreed; many of the uninsured are young and healthy.

[2:41:54 PM](#)

REPRESENTATIVE MILLETT asked if he included people who had health benefits under the Indian Health Service as uninsured.

MR. ANDERSON said he did not know.

[2:42:27 PM](#)

REPRESENTATIVE REINBOLD asked who commissioned the Lewis and Ellis study.

MR. ANDERSON said he cannot recall who commissioned it.

REPRESENTATIVE REINBOLD said that a very valid source told her that 26,000 of these people were working age, childless adults who had the ability to work.

MR. ANDERSON said, "When I hear the term childless adult, what comes to mind to me are those who would have fallen in the gap of Medicaid expansion. That's what's coming to mind for me."

REPRESENTATIVE REINBOLD said the "26,000 people were adults that were completely capable of working, did not get Medicaid because they didn't have children, but it was this uncovered population, speaking of possibly these young men that are running around, you know, that feel like they're invincible. So, I just want you to address that." These are people who are not interested in taking out a plan at this time, she added.

MR. ANDERSON said he believes they would be included if they are not receiving insurance coverage. The 26,000 childless adults who do not have coverage would be within the 138,000 number that he referenced earlier.

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MR. ANDERSON noted the additional complication when, in 2013, people were allowed to keep the coverage that they had. But that population who extended their health plans from 2013 to 2014 tended to be healthier and did not enter the ACA risk pool either. So these combined factors have resulted in a higher than average risk profile for the ACA than what was predicted, he stated. Insurance companies have to price its products to the average market risk, and he said the Wakely Consulting [Group] provides that information to Moda and other insurance companies. Based on their information, Moda found that the average morbidity of the entire Alaska marketplace was 26 percent higher than what was in Moda's own pool of people, he noted, and this was the main contributing factor to Moda's rate increase.

MR. ANDERSON stated that without insurance companies participating in the exchanges, it would not work. There is no mandate for the insurance companies to join, and going into 2014, there were a number of national carriers who "sat it out in some markets." In Alaska, for the exchange to stay competitive there needs to be more than one option, "and for us to remain an option, we had to raise our rates going into 2015." He said Moda has looked at 2014 financial modeling and it indicates a loss. A big source of the loss is the transfer payment, he said, which is one of the Three Rs (or a risk adjustment component), where Moda will be making a payment to other insurance carriers because Moda has better than average risk in its population.

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MR. ANDERSON explained that there are three risk mitigation programs as mentioned earlier: reinsurance, risk adjustment, and risk corridors. The risk adjustment program is permanent, and it transfers money between insurance companies to average out the risk. It is designed so that insurance companies do not try to manipulate their risk pools. The average risk of the market is much higher than Moda's market, so Moda will have a transfer payment at the end of the year, he clarified. It is a zero-sum game, however, because there is no funding source for risk adjustment outside of the premium that is collected by the market--it is just moving that premium between carriers and it is done on a retrospective basis, he added.

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REPRESENTATIVE REINBOLD asked if the projected loss has to do with risk or does it also have to do with an increase in the number of Moda employees, bonuses, salaries, or capital improvements.

MR. ANDERSON said it is primarily a loss due to risk--"there are no expenses of the nature you mentioned that are in excess of what was planned."

REPRESENTATIVE REINBOLD asked if he was anticipating any decrease in reimbursements. [Mr. Anderson answered no.]

[2:52:18 PM](#)

REPRESENTATIVE JOSEPHSON asked if Moda believes it will capture more enrollees because the penalties on tax returns are going to escalate and because the [ACA] website is working better. Nationally there has been an increase of 10 million [enrollees], and he asked if any study suggests that there will be improvement in small states like Alaska.

MR. ANDERSON said he believes that the 8 million to 10 million represents only private insurance and does not include Medicaid expansion. His question is really the heart of the matter and the concern that Moda has. "We would anticipate more of the insured," he said. He said there were difficulties in getting people enrolled in time and there should be more enrollment. The concern is that with insurance companies raising their rates as much as they have, on average, there may be people dropping coverage.

REPRESENTATIVE JOSEPHSON asked, "Why is Moda's low-end anticipated increase 22 percent and Premera's high end 40 percent?"

MR. ANDERSON said he does not know how the two ended up with different increases; this process is confidential so he does not know what other carriers are doing in the marketplace.

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MR. ANDERSON stated that MODA is committed to the individual market in Alaska, but he is concerned that the increases necessitated by the worsening risk pool will make it more difficult for those who are uninsured to purchase policies and for those who are currently insured, to maintain those policies. The intent is to work with the Division of Insurance to come up with ideas and to provide assistance to ensure the long-term viability of the individual market, he concluded.

[2:55:58 PM](#)

REPRESENTATIVE SADDLER asked what Moda is working on with the Division of Insurance.

MR. ANDERSON said he has not had those discussions yet. In Oregon, there is a technical advisory group, which is hosted by the insurance division and brings in the carriers to work together on issues like this. One issue is the supplemental re-insurance program, and it is already in place. Ideas may result in legislation that the technical group can help draft, he said. Secondly, the pool can be expanded by putting in all the people who are in the individual market and potentially expand the pool to those that are uninsured who may qualify for significant subsidies so that they do not have a lot of out-of-pocket expense to get insurance, he stated. There are a number of Alaskans in the uninsured population, and maybe Alaska could look at merging the individual and small group markets at some point.

REPRESENTATIVE SADDLER noted that Ms. Hultberg said this is a math problem, so [indiscernible].

[2:58:41 PM](#)

CHAIR OLSON asked if Premera and Moda can talk without having the Division of Insurance in the room.

MR. ANDERSON said Moda does meet with other insurance companies but is bound by restrictions on what can be discussed. "In concept we could talk about a program as long as it wasn't related to how rates were developed."

[2:59:45 PM](#)

VINCE O'SHEA, Vice President, Pacific Seafood Processors Association (PSPA), said PSPA is a trade association with nine members companies that operate in Alaska, and seven of those operate shore-based plants, buying and processing fish. The companies employ tens of thousands of people and provide markets to Alaska fishermen. Because of ACA, insurance expenses are rising. He reminded the committee that the members of PSPA "are not price makers in the markets that we sell to." He said that 70 percent of Alaska seafood goes into the global market, and PSPA produces less than one percent of the supply. "So for us to go to our customers and say our expenses have gone up, simply means they will go to somebody else that will meet the price that they're willing to offer." He said that includes factory trawlers, which are not covered by the same rules that PSPA operates under. If labor costs go up, his members must look at new ways to reduce costs, and that will include a reduction in employees through automation and through exporting work overseas. He noted that Alaska is already sending \$1.4 billion a year worth of seafood to China, South Korea, and Southeast Asia, which then gets shipped to other markets including the United States. He said PSPA members want their workers to have health insurance, "but we also need, at the end of the day, to be able to produce fish at a price that we're able to sell for more than what it costs us to produce the fish."

REPRESENTATIVE SADDLER surmised that Mr. O'Shea's message is that there is a national desire to provide health insurance, but it might be pricing your products out of the market.

MR. O'SHEA said health insurance alone will not put his members out of the market, but it will add to the burden of competing on the global market.

[3:04:24 PM](#)

REPRESENTATIVE MILLETT asked about insurance for seasonal workers.

MR. O'SHEA said it depends on the company, but under the ACA there will be standards, and some of their workers are

benefitting from the program. He said there will be winners and losers. At least one of the companies in PSPA is covered by a union contract, so that goes into the equation, he added.

[3:05:48 PM](#)

BILL STREUR, Commissioner, Alaska Department of Health and Social Services (DHSS), noted that the committee heard a lot of numbers, which seem to be getting a little mixed up. He said that the figure for the number of uninsured, 134,000, is very close to DHSS's estimate "of about 143,000 at the outside." He added that 41,000 is very close to the total number of eligible people under Medicaid expansion, and DHSS has been using the figure of 9,000 people who would be in the gap--those who would be in need of either chronic or acute medical care (but it is a difficult number to estimate). A consulting firm estimated Alaska's Medicaid expansion to be 44,000, and of those, about 19,000 would be in the gap population, he stated. "Those are the folks that are under 100 percent of poverty level, largely childless adults, [and] not necessarily healthy. I want to clarify that because that 9,000 number that we were talking about is folks that may have an acute or chronic medical condition that prevents them from being able to work." He said that is where there has been difficulty in looking at that gap population to see what the healthcare needs would be. He offered to create a table that includes the figures that were spoken about today.

REPRESENTATIVE MILLETT asked how many people qualify for Indian Health Services out of the 143,000 uninsured people.

COMMISSIONER STREUR said he does not have that number today, but "for some reason 40 percent of that sticks in my mind." That would be the percentage of those covered under the Indian Health Services, he clarified.

REPRESENTATIVE MILLETT asked, "Between the 44,000 and the 9,000 that we're talking about that are uninsured ... have any of those been identified as being covered under Indian Health Services or are they just eligible for Medicaid expansion, whether or not they qualify for the benefits under Indian Health Services?"

COMMISSIONER STREUR said the 44,000 includes tribal members who would be eligible [for Medicaid expansion], and the 9,000 leaves out tribal members--"We're talking about folks who we believe have extremely limited access to healthcare."

REPRESENTATIVE MILLETT asked if the state is doing anything to identify those people who are covered by Indian Health Services, and getting them in contact with those benefits.

COMMISSIONER STREUR said DHSS and the Indian Health Service are working on that. In the Medicaid population alone, "we have to do a better job of ensuring that Indian Health Service members are receiving services within the IHS system." He added that about 40 percent of the total expenses "we" pay in Medicaid for tribal members is delivered in the IHS system and 60 percent is going outside the tribal system.

REPRESENTATIVE SADDLER asked about the progress of the Medicaid Reform Advisory Group.

COMMISSIONER STREUR said the meeting in October may be the last one before giving recommendations to the governor and legislature. He added that he believes the report is due in November.

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REPRESENTATIVE REINBOLD asked how the healthcare providers are doing in the marketplace.

COMMISSIONER STREUR said the United States has the highest healthcare costs in the world, and Alaska is one of the states with the highest healthcare costs in the country, so "I believe that the providers are doing well." All of the hospitals participate in Medicaid and nearly all of the physicians do. "We have incredible access, but we also pay 140 percent of Medicare," he said. Most states pay about 70 percent of Medicare, "so we're paying about double," he added.

REPRESENTATIVE REINBOLD asked if there are enough providers.

COMMISSIONER STREUR said he cannot answer that with any kind of authority. He noted that there are challenges with access to care, and that may be in regards to medical specialties, like finding a dermatologist in Southeast Alaska, but because of the innovations of the tribal partners, the development of the clinics in the rural areas, and the sophistication of the tribal health centers in rural Alaska, "we do have incredible access for the amount of road systems we have in this state."

REPRESENTATIVE REINBOLD asked if Commissioner Streur anticipates a shortage of providers because of the Affordable Care Act.

COMMISSIONER STREUR said he cannot answer that; however, he believes that with additional Alaskans getting insured, there will be a greater need for care.

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CHAIR OLSON noted that tomorrow there will be public testimony. He said he had invited Senators Begich and Murkowski today, but they did not attend.

[3:17:14 PM](#)

ADJOURNMENT

There being no further business before the committee, the House Labor and Commerce Standing Committee meeting was adjourned at 3:17 p.m.