

ALASKA STATE LEGISLATURE
JOINT MEETING
SENATE STATE AFFAIRS STANDING COMMITTEE
HOUSE STATE AFFAIRS STANDING COMMITTEE
February 14, 2013
8:02 a.m.

MEMBERS PRESENT

SENATE STATE AFFAIRS

Senator Fred Dyson, Chair
Senator Cathy Giessel, Vice Chair
Senator John Coghill
Senator Bill Wielechowski

HOUSE STATE AFFAIRS

Representative Bob Lynn, Chair
Representative Wes Keller, Vice Chair
Representative Lynn Gattis
Representative Shelley Hughes
Representative Doug Isaacson
Representative Jonathan Kreiss-Tomkins

MEMBERS ABSENT

SENATE STATE AFFAIRS

Senator Bert Stedman

HOUSE STATE AFFAIRS

Representative Charisse Millett

COMMITTEE CALENDAR

OVERVIEW: ALASKA CARE ACTIVE EMPLOYEE HEALTH PLAN

- HEARD

PREVIOUS COMMITTEE ACTION

No previous action to record

WITNESS REGISTER

BECKY HULTBERG, Commissioner
Department of Administration
Juneau, Alaska

POSITION STATEMENT: Presented an overview of the AlaskaCare Active Employee Health Plan.

EMILY COTTER, Strategic Initiatives Health Coordinator
Division of Retirement and Benefits
Department of Administration
Juneau, Alaska

POSITION STATEMENT: Presented information on innovative health care plan approaches.

ACTION NARRATIVE

[8:02:08 AM](#)

CHAIR FRED DYSON called the joint meeting of the Senate and House State Affairs Standing Committees to order at 8:02 a.m. Present at the call to order were Senator Giessel and Chair Dyson, and Representatives Gattis, Isaacson, Keller, Kreiss-Tomkins, and Chair Lynn.

OVERVIEW: ALASKA CARE ACTIVE EMPLOYEE HEALTH PLAN

[8:02:20 AM](#)

CHAIR DYSON announced that the only order of business would be the continuation of an overview of the Alaska Care Active Employee Health Plan. He complimented Commissioner Hultberg on her previous presentation. He appreciated the frankness and integrity of her words.

BECKY HULTBERG, Commissioner, Department of Administration, reviewed the presentation from the previous week. She said she discussed health care trends in the United States and in Alaska, and health care spending as an enterprise in Alaska. She also explained the active employee plan, its premium structure, some of the challenges of that structure, and contribution trends in the United States.

CHAIR LYNN noted the arrival of Representative Hughes.

COMMISSIONER HULTBERG began the presentation with FY 2012 medical plan expenses for the Active Employee Health Plan. She said the expenses, as well as the premiums, have grown. There was a little bit of a leveling off of expenses in FY 2010 and FY

2011, followed by an increase in FY 2012. The trend seems to be continuing in FY 2013 and is of concern.

She mentioned the depressive effect of the Affordable Health Care Plan on cost.

CHAIR DYSON asked for the reason for that effect.

COMMISSIONER HULTBERG opined that it was due to providers looking more closely at cost and deciding not to make a cost increase. There is also a general level of uncertainty regarding the economy so people tend to delay health care.

[8:08:04 AM](#)

COMMISSIONER HULTBERG discussed what drives costs in the Active Employee Health Plan. The first driver is population growth. The other two factors are unit pricing and utilization. She said the graph shows the price of medical services and how the changes in medical costs per member per month increased. From April 2010 to March 2011, compared to April 2011 to March 2012, the change in medical per member per month increased by 4 percent. However, the unit pricing increased by 9 percent, and the change in utilization decreased by 4 percent. The decline in utilization was counteracted by the 9 percent increase in pricing.

CHAIR DYSON said he has heard from the medical providers that they are in financial trouble due to marginal reimbursement rates.

COMMISSIONER HULTBERG replied that it depends on which provider one considers. There is a great deal of varied pricing structures and profit margins amongst providers. Urban hospitals are very different from rural hospitals. Specialists are very highly compensated. She concluded that compensation is relative to the type of provider. She suggested, from a customer perspective, that value must be sought.

[8:12:42 AM](#)

CHAIR DYSON thought it was counterintuitive that big providers are more expensive than small providers.

COMMISSIONER HULTBERG explained that smaller providers have to spread more cost over a smaller population.

CHAIR DYSON asked if costs are higher with urban providers.

COMMISSIONER HULTBERG clarified that profit margins are higher for the urban hospitals.

CHAIR DYSON asked about the "per unit cost."

COMMISSIONER HULTBERG said the department has not done a specific service cost comparison between rural and urban hospitals.

CHAIR DYSON inquired about the impact of having more sophisticated equipment at an urban site.

COMMISSIONER HULTBERG agreed there was a cost for that. She added that she thought more expensive equipment was one of the cost drivers. She opined that today many services are now provided in Alaska that did not previously exist. However, they become expensive over a small population base. She voiced concern about the excessive expense and where it stops.

[8:15:13 AM](#)

CHAIR DYSON agreed that a concern is that the medical profession is often doing more than is needed.

REPRESENTATIVE ISAACSON asked about the 9 percent change in unit pricing leading some to seek treatment outside of Alaska. He inquired if Commissioner Hultberg agrees that in order to decrease unit pricing, the state should pay for members to seek treatment out of state.

COMMISSIONER HULTBERG emphasized that she thinks it is a positive factor that Alaska has grown in its ability to provide medical care. She said the question is whether or not Alaska can afford to continue to provide even more medical services in Alaska. The answer depends on what the community wants to have and what they are willing to pay for, what the service is, and the financial health of the provider. Alaska is at the point, regarding cost, where it has to question whether or not there is value in continuing to bring more and more here.

She addressed the issue of out-of-state health service by informing the committee what other large insurance companies are doing. She said some employers are contracting with Centers of Excellence for certain procedures because prices are lower and outcomes are better. As an example, Walmart does that for cardiac procedures because the major medical centers do better for less cost.

She stressed that in Alaska it is important to support locally delivered health care. However, at some point, due to expense, it becomes smarter to "contract for value". She said that some procedures are billed at 36 times the usual, customary, reasonable cost (UCR) in Seattle. She hoped local medical providers would step up and correct huge margin differences.

8:20:34 AM

SENATOR GIESSEL she referred to a statement by Deputy Commissioner Barnhill where he talked about medical providers acting "rationally" in an economic sense. She agreed that there were wonderful specialists now in Alaska, but there is little, if any, competition, so the provider charges what the consumer will bear, creating an economic crisis. The fact that people are seeking services out of state creates a competitive environment that may help drive costs down.

COMMISSIONER HULTBERG agreed. She added that the state is not blaming providers. In some ways the state is part of the problem because it continues to pay 60 percent of the bill. At some point it does not make sense to continue this way; the state needs to consider if it is acting rationally, as well.

CHAIR DYSON asked about cost escalation on a national level in major cities, as compared to Alaska.

COMMISSIONER HULTBERG replied that costs tend to be lower in a competitive market. However, too much consolidation also can lead to monopolistic price increases.

She made a point about the personal nature of health care. She said she feels the state has an obligation, from a plan standpoint, to provide the best information to its employees and the best access to care from quality and cost standpoints.

8:24:58 AM

COMMISSIONER HULTBERG shared a personal story about a family member and the Mayo Clinic. She said state employees need to have the option to go to out-of-state facilities for care, especially when it is going to save the state money.

CHAIR DYSON referred to Representative Isaacson's question and asked if a preferred provider limits members' choices.

COMMISSIONER HULTBERG said no, but it makes out-of-pocket costs greater. She explained that there is a network in place in Alaska, but no penalties for those who choose to go out of the

network for services, except for the two Anchorage hospitals. Sometimes, when a member goes out of network, they may receive a bill if costs are above 90 percent of UCR.

8:28:20 AM

REPRESENTATIVE ISAACSON understood the value of choice and fiscal restraint, but also the need to induce the industry's ability to meet needs in state. Small populations don't have the medical equipment or services. He inquired if Commissioner Hultberg had considered providing more Centers of Excellence, such as those in Fairbanks and Nome.

COMMISSIONER HULTBERG agreed that it is difficult in a smaller community to have a financially sustainable medical business. She related that she has had conversations with the Alaska State Hospital and Nursing Home Association, Bartlett Hospital, and Soldotna Hospital about this topic. She said there are innovative ideas coming from some of those providers.

She related that often people do not know the difference between costs for services in state versus out of state. Some services are competitive, some are not.

REPRESENTATIVE KELLER asked about researching Centers of Excellence sources for the best treatment.

COMMISSIONER HULTBERG thought that information on quality of care has become more available recently. Quality data was available at most major medical centers, but not at all major medical centers. She suggested that providers must be encouraged to publish information on quality outcomes.

8:34:49 AM

REPRESENTATIVE HUGHES inquired about vastly differing unit pricing and how that is communicated to providers. She asked how UCR's are established and adjusted, based on information from outside providers. She asked if travel out of state for medical care is causing prices to come down.

COMMISSIONER HULTBERG said the state has had the same medical travel benefit for many years. She thought the state could do a better job of informing members of it. Right now the state is not encouraging out-of-state treatment.

She said, with respect to the pricing variation, sometimes the state will reach out to a provider through a third party administrator and network, which may ask the provider to join.

REPRESENTATIVE HUGHES suggested it might be time for the state to pro-actively act in ways to help reduce costs when there are high UCR differences.

COMMISSIONER HULTBERG reported that the conversation has begun but the plan changes have not been made. The division's current focus is hiring a new third party administrator. It is unknown what Centers of Excellence model the new administrator will bring. There are many insurance providers that bring networks to their clients. The network may or may not change.

8:39:39 AM

CHAIR DYSON said Senator Wielechowski and Senator Coghill joined the meeting.

REPRESENTATIVE ISAACSON pointed out the difference between requiring and encouraging quality data reporting, in order to prevent unintended consequences.

COMMISSIONER HULTBERG agreed. She said the provider community does not need additional mandates. The state's ability to have an impact in the market is through choices, such as contracts for value, not by regulations.

SENATOR GIESSEL discussed the constraints the state has placed on competition through a program called Certificate of Means. She said that sometimes a smaller entity, such as a surgery center, can provide lower cost, high quality care. She asked what the process is for smaller surgery centers to get into the network, even in a venue such as Anchorage.

COMMISSIONER HULTBERG replied that the best way to get into the network, currently, is through the third-party administrator. The division is considering contracting directly with smaller surgery centers.

8:43:05 AM

CHAIR DYSON asked if it would be appropriate to require no more cost shifting.

COMMISSIONER HULTBERG said Chair Dyson raises a good point about cost decisions for large medical providers. She said cost shifting is a business decision in which the state has no part. She agreed that there is a significant amount of cost shifting within hospitals, but also among payers, such as Medicare. It is a reality of the system and a decision by society that all shall

receive care. She sympathized with hospitals that have to pay for those who can't pay.

8:46:00 AM

CHAIR DYSON appreciated the quality of questions asked by members.

He asked if state employees visit emergency centers less and asked if that data could be used to receive a break on cost.

COMMISSIONER HULTBERG agreed that there could be an innovative payment structure, such as paying different rates for different groups. The state does not have a bundle payment system - one bill for all services rendered - yet, but would like to, but it is challenging. It could bring health care costs down if the medical providers are in alignment. All three entities have to be in alignment; provider, the payer, and the patient.

8:49:14 AM

REPRESENTATIVE GATTIS did not like getting bills from separate entities. She said it is difficult to determine the accuracy of the bills.

COMMISSIONER HULTBERG agreed that it is difficult to be a good consumer in that situation.

SENATOR WIELECHOWSKI said that 5 percent of the people are generating 60 percent of the costs and 15 percent of the people are generating over 80 percent of the costs. He wondered if there were ways to solve that problem.

8:51:27 AM

COMMISSIONER HULTBERG agreed that the top 5 percent drive 60 percent of the cost. She showed a graph of a typical model of health care costs. The people in the bottom band are the healthy ones and need to be kept healthy. Next two bands likely have underlying chronic conditions. The goal is to help those people manage their health issues. The higher band consists of those with high cost care needs. Here, the goal is to support those who are very ill make the best choices for their care.

REPRESENTATIVE HUGHES asked for information about strategies for the high cost care group.

8:53:34 AM

EMILY COTTER, Strategic Initiatives Health Coordinator, Division of Retirement and Benefits, Department of Administration,

explained strategies of care for the highest cost group. The third party administrator currently has a program called "Case Management," a dedicated group of employees that identifies high-cost members and helps to coordinate care for them.

REPRESENTATIVE HUGHES asked if it is a proactive health outreach.

MS. COTTER said it was, however, the patient has the option to request that service and support, also.

REPRESENTATIVE HUGHES asked if it is bringing costs down and if there is more that can be done.

MS. COTTER explained that the third-party administrator provides quarterly reports on cost savings of the program. She offered to find that information and report back to the committee.

CHAIR DYSON said it is hard to quantify cost avoidance.

[8:56:14 AM](#)

SENATOR GIESSEL shared a story of a successful coordinated cost management model used by Alaska members of the American Academy of Pediatrics. Both the patient and the provider benefit by greater cost savings and satisfaction from such a model. It does not have to be managed by the highest - cost medical professional, the physician. She said she was glad the state was pursuing this option.

COMMISSIONER HULTBERG shared information from claims data about payment comparisons by procedure. It includes the 90 percent UCR physician fee charges for Seattle and Anchorage.

COMMISSIONER HULTBERG showed information from a study the Health Care Commission did comparing price of procedures by state.

CHAIR DYSON asked for clarification regarding the percentages.

COMMISSIONER HULTBERG explained that the study compared physician charges in six states. They compared an average of the six states to each state's costs in a variety of medical specialty areas. Alaska is very much more expensive than other states in most areas. In pediatrics and family medicine the cost is about one and a half times more, but in cardiology and surgery, costs are double in Alaska. She said those are the areas the state needs to look at first.

9:01:35 AM

COMMISSIONER HULTBERG highlighted market constraints:

- Lack of alignment in interests between payer, providers, and patients
- Lack of transparency in price and quality
- Reduced competition and barriers to entry
- High percentage of government spending - 60 percent of market share.

COMMISSIONER HULTBERG referred to an Institute of Social and Economic Research (ISER) study on health care costs in Alaska done in 2011. It was discovered that government is paying about 60 percent of health care costs in Alaska. She concluded that government has to change if it expects different outcomes in the market.

REPRESENTATIVE KELLER asked how that number compares to other states.

COMMISSIONER HULTBERG did not know.

9:03:04 AM

CHAIR DYSON asked about the coordination of benefits when the employee has Medicare, Veteran's benefits, and Native Health Care benefits.

COMMISSIONER HULTBERG replied that Medicare is primary and the state retiree benefit is secondary. There is a coordination of benefits. She did not know how the other two benefit plans fit into the whole picture.

CHAIR LYNN listed all the plans he has and the confusion over coordination of benefits.

COMMISSIONER HULTBERG agreed that the coordination of benefits is complicated.

9:05:05 AM

REPRESENTATIVE KELLER requested more information about coordination of benefits. He thought that Medicaid was the first payer, before Indian Health benefits. He said that was significant because of Medicaid expansion issues. He wondered how much cost will be shifted from federal to state government. He said it is a significant question.

COMMISSIONER HULTBERG shifted to case studies. She mentioned a book called The Company that Solved Health Care that tells about a C.E.O.'s experience of controlling health care costs in a small company.

She referred to two models of innovative approaches: Value-Based Health Plan and Consumer Directed Health Plan (CDHP).

[9:08:41 AM](#)

MS. COTTER said the Value-Based Health Plan uses financial incentives to encourage healthy choices and to discourage unhealthy choices. Nebraska uses this plan.

She described the Consumer Directed Health Plan - or high deductible health care plan - as defined by the IRS in 2013 as a health plan where the deductible for an individual was \$1,250 at a minimum, and the deductible for a family was \$2,500 at a minimum. Indiana uses this plan.

She noted one of the benefits of the CDHP is that it increases price sensitivity by employees. The savings associated with both plans were attributed to the same three factors: increased use of generic medications over brand medication, decrease use of specialists and increase use of primary care physicians, and decreased use of emergency room visits.

[9:10:17 AM](#)

MS. COTTER related the components of Nebraska's Value-Based Health Plan. In 2009 Nebraska added a "Wellness Plan" to its traditional plan. It reduces employee's share of costs for wellness, preventive and high-quality services in exchange for lower premiums. It required employees and spouses to complete series of tasks during the prior 12 months. They completed a health risk assessment and a health education course and made a preventive visit to a primary care physician to assess biometrics. If employees completed those three tasks they could enroll in the Wellness Plan.

MS. COTTER listed the results of the Wellness Plan: it offered much lower premiums than traditional plans, 2010 and 2011 premium increases were less than 1 percent and the estimated return on investment was 2.7 to 1. The savings were attributed to reduced utilization of high cost services.

[9:14:35 AM](#)

MS. COTTER turned to Indiana's Consumer Driven Health Plan I (CDHP) implemented in 2006. The plan had an individual

deductible of \$2,500 and a family deductible of \$5,000. Indiana contributed 45 percent of the deductible to a Health Savings Account (HSA) which is directly connected to the high deductible health care plan.

CHAIR DYSON asked if the employee's contribution is from pre-tax dollars and can be rolled forward.

MS. COTTER said yes. The account rolls forward annually and the amount accrued can be taken with the employee. The employers can also make contributions to the account, along with employees.

She continued to explain that for an individual, the state contributed \$1,250 and for a family the state contributed \$2,500.

REPRESENTATIVE HUGHES asked if primary care was included.

MS. COTTER replied that in Indiana preventive care was covered, with no application of copay or deductible. She stressed that two of the most important factors of a plan are that the employer does contribute to the HSA, and copays and deductibles are applied to preventive care. These factors must be clearly communicated to the employees.

[9:17:41 AM](#)

MS. COTTER continued to say, in 2007, Indiana added a second CDHP plan with lower deductibles, but higher premiums. She listed the results of Indiana's plans. The state of Indiana saved money - CDHP 2010 savings were 10.7 percent, or \$17 million to \$23 million. Employees saved money - in 2010, employees saved \$7 million to \$10 million and unused funds in the HSA were over \$30 million, which is about \$2,000 for each employee. Under this plan, CDHP participants did not put off or avoid using important health care services.

[9:19:28 AM](#)

COMMISSIONER HULTBERG explained opportunities for AlaskaCare. She said the state has begun the implementation of an employee wellness program. The state is now covering preventative care at 100 percent and has implemented Weight Watchers at Work, a new Tobacco Cessation Program, and formed an employee wellness committee.

She stated that the state needs to improve consumerism and appropriate utilization of services by its members. The state also should look at plan design changes to align payer, patient,

and provider interests. It should look at contracting strategies for value. And, finally, the state must complete the procurement process for a third-party administrator.

9:22:30 AM

COMMISSIONER HULTBERG listed the barriers to success. She emphasized that change is hard. In order to transform the health care market, how people think about health care must be transformed. There is a lack of price sensitivity on the part of consumers when health care is essentially free, as it has been in the past.

She said another potential barrier is the fact that the benefit credit is bargained. Also problematic is that the state is faced with limited resources and the implementation of a new plan with limited resources.

She noted that AlaskaCare is highly visible and it operates in a political context. Changes to the plan will be highlighted.

She stressed that AlaskaCare has to be sensitive to the barriers and reach out to work with stakeholders in the process to ensure that employees are getting the best quality care at a good value.

COMMISSIONER HULTBERG concluded with the challenge, "We must lower the rate of growth of our health care spending. Our current path is not sustainable."

She stated that the state's approach is to work on the issues with the provider community and to support the delivery of high-quality, cost-effective health care in Alaska.

9:25:46 AM

SENATOR COGHILL requested information about how often the state has to renegotiate a contract with a third party administrator.

COMMISSIONER HULTBERG said the process of procuring a third-party administrator takes all of the division's capacity. By statute, the contract can only last for 5 years; a three-year contract with two optional one-year extensions. Currently, the state is in the fourth year of a contract with HealthSmart. When the contract was procured, it was with Wells Fargo, which was acquired by HealthSmart. The state elected to seek a new vendor and have some certainty on the vendor partner for next five years in order to work on strategic initiatives.

[9:27:45 AM](#)

CHAIR DYSON asked what the committee can do to help.

COMMISSIONER HULTBERG voiced appreciation for the offer, but said the division would not request more staff, it would just work smarter. She pointed out that the state health care plan is not subject to the insurance code, so she did not see a need for statutory changes. She spoke of the value of communicating issues with the legislature. She requested feedback about the plan design and support for the changes.

SENATOR WIELECHOWSKI voiced appreciation for the testimony. He suggested focusing on controlling costs, rather than increasing employee payments.

COMMISSIONER HULTBERG agreed that the core issue of cost drivers was important. They can be addressed through a regulatory approach or through health choices by consumers. She said the beauty of the consumer directed health plan is that the money is provided by the employer to an account in the employee's name, giving them a vested interest in how that money is spent.

[9:31:15 AM](#)

CHAIR DYSON said the early part of the presentation dealt with cost containment.

CHAIR LYNN thanked the presenters. He added that legislators are trying to get the best health care information as legislators, but also as consumers. He stated he has had a positive experience with state health care insurance.

[9:32:41 AM](#)

There being no further business to come before the committee, Chair Dyson adjourned the Joint Senate and House State Affairs Standing Committees at 9:32 a.m.