

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

February 5, 2016

3:18 p.m.

**MEMBERS PRESENT**

Representative Kurt Olson, Chair  
Representative Shelley Hughes, Vice Chair  
Representative Jim Colver  
Representative Gabrielle LeDoux  
Representative Cathy Tilton  
Representative Andy Josephson  
Representative Sam Kito

**MEMBERS ABSENT**

Representative Mike Chenault (alternate)

**OTHER MEMBERS PRESENT**

Representative Max Gruenberg

**COMMITTEE CALENDAR**

OVERVIEW: DEPARTMENT OF ADMINISTRATION~ HEALTH PLANS

- HEARD

**PREVIOUS COMMITTEE ACTION**

No previous action to record

**WITNESS REGISTER**

JOHN BOUCHER, Deputy Commissioner  
Office of the Commissioner  
Department of Administration  
Juneau, Alaska

**POSITION STATEMENT:** Provided a PowerPoint presentation entitled, "Alaska Department of Administration Health Plans," dated 2/5/16.

MICHELE MICHAUD, Chief Health Official  
Central Office  
Division of Retirement and Benefits  
Department of Administration

Juneau, Alaska

**POSITION STATEMENT:** Answered questions during the PowerPoint presentation entitled, "Department of Administration Health Plans," dated 2/5/16.

**ACTION NARRATIVE**

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**CHAIR KURT OLSON** called the House Labor and Commerce Standing Committee meeting to order at 3:18 p.m. Representatives Olson, Hughes, LeDoux, Tilton, Kito, and Josephson were present at the call to order. Representative Colver arrived as the meeting was in progress. Representative Gruenberg was also present.

**OVERVIEW: DEPARTMENT OF ADMINISTRATION, HEALTH PLANS**

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CHAIR OLSON announced that the only order of business would be an overview by the Department of Administration on health plans.

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JOHN BOUCHER, Deputy Commissioner, Office of the Commissioner, Department of Administration, provided a PowerPoint presentation entitled, "Alaska Department of Administration Health Plans," dated 2/5/16. Mr. Boucher informed the committee he would present an overview of AlaskaCare Health Plan, and a status report on the state's largest health care third-party administrator, Aetna. The Division of Retirement and Benefits (DRB), Department of Administration (DOA), administers a program that covers over 86,000 people of which 80 percent is enrolled in the retiree plan and 20 percent is in the employee plan; retirees and their dependents total about 70,000 people, and employees and dependents total about 16,700 people [slide 2]. Currently, the division administers ten different plans for employees and retirees. There are three employee medical and prescription drug programs, two dental programs, and one vision program, along with a flexible spending account; for retirees, there are the retiree medical prescription drug plan, an optional package for dental, vision, and audio, and a long-term care program. Soon there will be a new plan for defined contribution retirees. Mr. Boucher said all of the plans are managed by the chief health official and a staff of six, with support from DRB [slide 3]. He provided a brief history of health insurance in the state, noting that the state has been

self-insured since 1997, and the state contracts with third-party administrators to process claims and execute the health plans [slide 4].

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REPRESENTATIVE COLVER asked for the level of customer satisfaction earned by Aetna as the plan administrator, compared to the previous administrator, Wells Fargo.

MR. BOUCHER advised he would respond to that question shortly. In further response to Representative Colver, he explained that Moda is an umbrella name used for multiple companies; the state employee dental plan is a contract with Oregon Dental Service, which is a separate entity from Moda Health Plan Inc. Moda Health Plan Inc., "is in the process of being looked at by the division of insurance."

REPRESENTATIVE HUGHES asked whether the members of all of the health care plans are put into the same pool - which would reduce the cost of care - or are in separate pools, which keeps the cost higher.

MR. BOUCHER said actuarially, members are provided different rates for different risk pools within the plans, thus their premiums are dependent upon the type of plan.

REPRESENTATIVE HUGHES surmised premiums would be cheaper if all members were combined in one risk pool.

MR. BOUCHER explained that a number of factors affect the employee benefit credit. Some credits are negotiated, and some are not; in some cases it is a matter of collective bargaining.

REPRESENTATIVE HUGHES concluded that the state pays more because members are in different risk pools, and negotiated separately. She clarified that her question was to whether the state pays a higher cost, because her understanding is that larger risk pools earn better rates.

MR. BOUCHER agreed, and further explained that the retiree risk pool and the employee risk pool garner a "blended rate," which is paid by employees' and retirees' separate funds.

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REPRESENTATIVE HUGHES remarked:

Can you please clarify, is it all one risk pool and it is all the same rates? I don't think it is because you said they, they negotiate different things. I'm just trying to look at this and think how could we save money. And are we doing it in the lowest cost way, is my question.

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MR. BOUCHER responded:

The risk pool for all the employees is one risk pool; however, the amount of benefit, or the amount that the individual pays into the plan, is dependent upon the benefit that they get, and so it is considered, from an insurance prospective I believe, one risk pool for the employees, and one for the retirees. The benefit credit that the employee is allowed to provide toward buying their particular plan is, can be a negotiated item.

CHAIR OLSON further explained that the state does not buy insurance but buys reinsurance. The state is self-insured up to a certain amount, and pays for claims, except it has excess insurance to cover very expensive health issues for individuals; in fact, it is one insurance pool because insurance does not pay until costs reach "upper layers."

MR. BOUCHER added that the premiums, and reserves that have accumulated over time, pay for claims and the administration of the plan.

REPRESENTATIVE KITO questioned how the state covers costs for claims and administration, and asked for the status of the state's reserve.

MR. BOUCHER answered briefly that the state's reserves have been shrinking in the last 12 months, and he will more fully address this issue later in the presentation. He directed attention to slide 5, which illustrated the AlaskaCare Health "spend" in fiscal year 2015 (FY 15), and FY 16 through January, 2016.

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MICHELE MICHAUD, Chief Health Official, Central Office, Division of Retirement and Benefits, DOA, clarified that the AlaskaCare

Health spend illustrated on slide 5 is based on actual amounts paid for claims for this time period, rather than when the claims were incurred.

MR. BOUCHER said the total spend was about \$627.7 million for retiree and active employee claims in FY 15, and there has been a general increase for both plans. He expressed surprise in that the active employee plan appears to have increased utilization, which may be explained by uncertainty within the workforce.

REPRESENTATIVE KITO recalled that the new provider was selected because it was going to decrease health care costs; in fact, his constituents have reported that their claims and coverage have been denied, but costs continue to increase significantly.

MR. BOUCHER expressed his belief that the new third-party administrator is delivering significant network savings; he added that national trends indicate that a 9 percent increase is not uncommon. Also, he cited a significant increase in the cost of pharmaceuticals because of the introduction of new drugs.

REPRESENTATIVE LEDOUX asked what the state pays the administrator.

MR. BOUCHER answered that in FY 15 Aetna received about \$16.4 million and in FY 16 the base fee is \$15.5 million with a potential \$3.6 million "at-risk" [of being assessed penalties]. The contract calls for "either performance guarantees or earn-backs that have to be earned as part of an incentive."

REPRESENTATIVE LEDOUX asked how an administrator earns bonus points.

MR. BOUCHER explained that points are based on various benchmarks related to services, such as the call center, and there are a number of other performance guarantees that have to be met.

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REPRESENTATIVE LEDOUX surmised the administrator earns points for holding down the amount the state spends.

MS. MICHAUD said there is a claims trend guarantee.

REPRESENTATIVE LEDOUX questioned whether that provision is an incentive for the administrator to deny valid claims.

MS. MICHAUD stated that most of the performance guarantees are structured towards claims accuracy and timeliness, which would counteract denying claims to achieve the claims trend.

REPRESENTATIVE JOSEPHSON asked whether the aforementioned \$627.7 million is money for premiums paid, or charges incurred by Alaskans for medical services.

MS. MICHAUD said \$627.7 million was paid for medical services received, not including administrative fees.

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REPRESENTATIVE JOSEPHSON posed the scenario of six individuals who pay \$1,400 per month each for premiums, but do not receive services during one month. He asked whether there was a simple answer as to how Aetna used the premiums that were paid by these individuals.

MS. MICHAUD responded that Aetna would not have the money from the premiums; the state retains the premiums, Aetna pays the claims, and then bills the state for the amount of the claims incurred.

CHAIR OLSON remarked:

The money from the premium is aggregated, and then you either have a stop loss, or you have a limit where the reinsurance kicks in, say \$5 million in the aggregate, or \$10 million or whatever, and then they either get 100 percent or get a percentage, 75 or 80 percent, I suspect you guys probably get 100. But ... all the money goes in and their best guess is, whatever the insurance actually kicks in at, that they collect enough premium over the 12 months to pay the anticipated claims. ... The key is trying to get the balance, to where you collect enough premium to cover the claims, you're accurate, and that's what keeps the, ultimately keeps the rates down, is, if we have best guesses that turn out to be pretty accurate.

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MR. BOUCHER returned attention to a bar chart on slide 6, which indicated that between FY 10 and FY 13 there were significant increases in health care costs. To address this trend, the previous administration adjusted the current request for proposal (RFP); however, due to the more recent savings brought by the new third-party administrator's larger network, costs were contained, resulting in an increase in reserves available to the plan. Therefore, a policy decision was made to lower rates and gradually deplete reserves. In mid-FY 15, overall claims began to grow, and the present forecast is that FY 16 rates were set too low. He cautioned that there could be a very small reserve in the beginning of FY 17. In forecasting to determine appropriate rates, the division considers the following four "levers": plan design changes to affect cost trends; negotiating with providers on the cost of medical services; collective bargaining to address employee contributions; and adjusting employer contributions. Mr. Boucher turned the discussion to the state's third party administrator, Aetna, and informed the committee that in calendar year 2015, Aetna processed approximately 2.9 million medical and pharmacy claims, and the average turnaround time was approximately 14 calendar days. Due to a feature in the state's health care plan, approximately 46 percent of overall claims must be processed by hand, which slows processing time and adds to administrative costs. Year to date claims accuracy is estimated at approximately 97 percent, indicating there were 90,000 problems [slide 7]. He suggested that a higher percentage of auto-adjudicated claims would lead to faster processing and fewer errors.

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REPRESENTATIVE KITO asked Mr. Boucher to describe the auto-adjudicated process, and asked what percentage of challenged claims are reinstated after being reviewed by the state.

MR. BOUCHER responded that a claim can be adjudicated by a computer-generated process, or by hand. In either case, if a claim is denied, and is appealed by a member, there is an administrative review within Aetna. If there is a claims processing error, the claim is overturned by Aetna. A Level II appeal can be either an administrative-type claim, which is reviewed within Aetna, or a clinical-type appeal, which is reviewed by a three-person external review [organization] (ERO). Furthermore, Level II and Level III claims may be reviewed by the division.

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REPRESENTATIVE LEDOUX surmised the turnaround time of 14 calendar days is the period of time between the submission by the physician and the payment by Aetna to the physician.

MS. MICHAUD said yes. That is the typical time from the point that the provider submits the claim, to the time the payment is made to the provider or to the member.

REPRESENTATIVE LEDOUX asked whether the contract determines how long the state has to pay Aetna, after the state receives its claims.

MS. MICHAUD explained the division receives a billing of submitted claims daily from the third-party administrator, and must pay within ten working days.

REPRESENTATIVE LEDOUX suggested that holding the billing for ten working days would garner the state interest on its money.

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MR. BOUCHER expressed his belief that invoices are paid as promptly as possible. He directed attention to slide 8, which indicated the total number of appeals in 2015, for the retiree and employee plans:

- approximately 1,200 Level I appeals closed
- 131 Level II administrative appeals closed; 23 percent overturn rate by Aetna on Level I and Level II administrative appeals
- 52 other Level II appeals closed; 29 percent overturn rate by ERO on Level II appeals
- 21 Level III appeals to the Office of Administrative Hearings (OAH); 3 Level III appeals to superior court

MR. BOUCHER advised that all Level III appeals are first heard by the division of retirement and benefits [slide 8].

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REPRESENTATIVE LEDOUX asked why some Level II appeals are heard by Aetna and some by ERO.

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MR. BOUCHER responded that appeals to ERO may address whether a procedure is medically necessary. In further response to Representative LeDoux, he said other appeals are administrative in nature.

MS. MICHAUD further explained that a non-clinical administrative appeal that is reviewed by Aetna may be due to a math error, or a question over the coordination of benefits.

REPRESENTATIVE KITO asked for the overturn rate for Level III appeals.

MS. MICHAUD said she would provide that information.

REPRESENTATIVE HUGHES questioned whether ERO members are truly independent, or whether they receive compensation from Aetna.

MS. MICHAUD advised that Aetna contracts with three independent review organizations so that there is a rotation of ERO panels.

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CHAIR OLSON asked whether medical tourism is an option with Aetna.

MR. BOUCHER said medical tourism is not robust and most claims of that type are for procedures that are not offered within Alaska; however, employers and the state are examining that option.

CHAIR OLSON said workers' compensation carriers and major unions do utilize that option.

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REPRESENTATIVE JOSEPHSON asked for a description of the daily invoice for claims that is received by the state from the insurance provider.

MR. BOUCHER said he would provide that information. Returning to the appeal process, he noted that the number of appeals may indicate that certain benefits of the plan are not well-understood, or there are misunderstandings, and that there is an area that needs to be addressed. For example, in chiropractic and physical therapy, there is a requirement that for continued treatment after a number of visits, there must be a determination of medical necessity. Appeals in the category of

pharmacy may be because the drug is not covered, or that the prescription was filled too early.

REPRESENTATIVE LEDOUX asked, "... if somebody is seeing a doctor and the doctor prescribes physical therapy, in what situations are you going to second-guess the doctor and say that that physical therapy is not necessary?"

MS. MICHAUD answered that there is a cap on chiropractic in the employee plan; for both plans, there is a requirement that there be a significant improvement in bodily function occurring and that is expected to occur. If a member is no longer making improvement, and other responses may be appropriate, the claim may be reviewed by the second level of external review for clinical appeals. Aetna's decision, clinical evidence, and the evidence-based medicine guidelines are reviewed by an independent doctor.

REPRESENTATIVE JOSEPHSON observed that limiting coverage has always been a subject for misunderstanding about the insurance industry, and whether insurance covers "everything."

MS. MICHAUD agreed. She has heard that up to 30 percent of health care services received in the U.S. are unnecessary and potentially harmful. The state relies on its third-party administrator to ensure that evidence-based medicine is being applied.

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CHAIR OLSON asked whether said reported unnecessary procedures include those that are done to protect doctors from malpractice suits.

MS. MICHAUD was unsure.

REPRESENTATIVE LEDOUX, noting that she previously lived in a rural area, expressed her concern that insurance benefits are based on charges that are deemed usual, customary, and reasonable (UCR). She provided an example of receiving treatment in Kodiak for an amount "that's what's usual and customary in the area," but which was not paid in full by the insurance company.

MS. MICHAUD acknowledged that a provision for usual and customary fees is in the state's plan and is referred to as "a recognized charge." She advised that this is a problem

nationally, but more so in Alaska. Insurance companies rely on a non-profit company called FAIR Health which reviews billing claims from all of the payers in a geographic area and determines the prevailing charge. In further response to Representative LeDoux, she said there are five separate geographic areas in Alaska; the division hopes that Aetna will expand its network, so more rural clinics are included and can provide protection to members against a "balanced bill."

REPRESENTATIVE LEDOUX asked for the rulings from appeals stemming from refusals to pay more than [a recognized charge].

MS. MICHAUD stated that the state changed its recognized charge terminology effective in January, [2016], and has not had an appeal proceed thus far. Appeal rulings at the Aetna level have upheld the denial because the plan documents the recognized charge, and Aetna is administering to the plan document. She was unsure as to whether a Level III appeal has gone before OAH or the superior court related to the aforementioned language in the plan.

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REPRESENTATIVE HUGHES said she was hearing of problems from her constituents, and gave an example of a retiree who was referred by a doctor for physical therapy for an extended period of time. After accruing expenses of \$10,000 to \$20,000 for treatment, the member was told the visits were not covered by insurance, and was left with the responsibility to pay. She asked why notification to the doctor, patient, and physical therapist was so delayed, allowing this situation to occur.

MS. MICHAUD stated that the state's plan relies on the medical necessity determination of the third-party administrator; during the switch from one third-party administrator to another, there were changes in what is considered medically necessary. Because of the number of procedures involved, the division was not immediately aware of where differences would occur, and it did not communicate sufficiently; however, Aetna, unlike the previous administrator, posts its clinical policy bulletins - which outline what is medically necessary - online, and the bulletin can be used by the patient and provider to see how Aetna determines what is medically necessary.

REPRESENTATIVE HUGHES questioned whether, after the transition from one third-party administrator to another is complete, notification will be provided to clinics, physicians, physical

therapy clinics, and patients; further, she urged that if notification was not given during the transition, the treatment should be covered.

MR. BOUCHER offered to review this situation.

REPRESENTATIVE HUGHES seeks to ensure that all of those affected during this period of transition - or during a future period of transition - are notified by the division in order to prevent a similar situation.

MS. MICHAUD pointed out there was an article, specific to chiropractic and physical therapy, in the division's April, 2015, newsletter to all members. Further, Aetna has met with the state chiropractic association and some physical therapists to discuss its clinical policy bulletins.

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REPRESENTATIVE HUGHES stressed the importance of communicating with physicians because that seems to be where the breakdown of communication is occurring.

REPRESENTATIVE KITO gave an example of a constituent who was not informed of a pharmaceutical change until a notice of nonpayment for \$50,000 was received from their pharmacist. In a similar manner, neither the patient nor the pharmacist were notified, and he stated that all should have been notified immediately at the time of the change.

MR. BOUCHER acknowledged that the transition was not very smooth, and said the division will work through issues as they arise.

REPRESENTATIVE LEDOUX inquired as to how a change in administrator could change the terms of the insurance policy.

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MR. BOUCHER said, "And generally, it should not. I agree with you, so, but there are administrative things that happen when different people are executing our plan."

REPRESENTATIVE LEDOUX asked whether a legal opinion was sought to determine what was legally in the terms of the policy.

MS. MICHAUD relayed that there are millions of procedures and codes and each cannot be identified within a plan document. She restated that the plan document relies on terms such as medical necessity, which has historically been determined by the claims administrator. Aetna's aforementioned public clinical bulletins are issued for both pharmacy and medical, and provide a guide to the medical evidence that is used to make medical necessity determinations. In addition, the third-party administrator must keep up with changes in medical science and pharmacology.

REPRESENTATIVE LEDOUX opined that newsletters are insufficient notice of significant changes.

REPRESENTATIVE TILTON asked who determines whether a provider is in a network.

MS. MICHAUD explained that third-party administrators are affiliated with a network; for example, HealthSmart, the state's previous administrator, contracted with Beech Street to provide the previous MultiPlan network. Aetna has its own network and contracts directly with providers; however, a provider cannot be forced to join a network, but must be willing to abide by the terms of a network agreement.

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CHAIR OLSON added that his constituents have many complaints about the network.

MR. BOUCHER assured the committee that the administration was sensitive to problems with the transition to Aetna, and sought to establish a baseline of overall customer satisfaction of health care delivery through a survey. In August, 2015, DRB commissioned a study by DSS Research which surveyed over 700 residents for a statistically valid sample. The survey included 562 retirees and 151 active employee members, which reflects the membership. The survey also provided demographics, such as retirees living outside Alaska, to compare the caliber of Aetna services outside of the state. In fact, in terms of overall satisfaction, the percentage of "not too satisfied" or "not at all satisfied" varied between those living in and out of the state. Mr. Boucher suggested this could be attributed to network challenges in Alaska [slide 10].

REPRESENTATIVE JOSEPHSON returned attention to slide 5 which indicated that it costs the state four times more to cover retirees as it does to cover active employees. He surmised that

Medicare would pay 90 cents to the state's 10 cents of the benefit of a retiree 65 years old and over.

MR. BOUCHER said correct. However, [under-65 years old] retirees are very expensive to cover. Overall, the retiree plan does benefits from the number of baby boomers who are now eligible for Medicare, and that is holding down "a trend cost." Furthermore, Medicare does not cover those who live outside the U.S.

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MS. MICHAUD added that the plan is not secondary for prescriptions, thus pharmaceutical costs for retirees are high.

MR. BOUCHER advised that pharmacy has just increased to over 50 percent of the state's total spend, which is a reason for concern.

REPRESENTATIVE HUGHES asked why the percentage of members who are living in Alaska, and are dissatisfied with Aetna, is twice the percentage of members living outside of Alaska, and who are dissatisfied.

MR. BOUCHER listed a variety of reasons gleaned from a test field: how claims were processed; confusing explanation of benefit (EOB) forms, particularly for retirees coordinating coverage with Medicare; a dislike for administrative policies; and poor customer service.

CHAIR OLSON questioned whether the survey was proportioned on a population basis.

MR. BOUCHER said the survey was random, but he was unsure of the geographical representation, except for those living inside or outside of the state.

CHAIR OLSON observed that when he conducts a poll he contacts 450 to 500 residents with a margin of error at 4 percent; an aggregated survey may represent the whole state, but would underrepresent the Bush.

MR. BOUCHER stated that the survey was not intended to represent each individual geographic area within the state. He cautioned that a survey that isolated geographic areas would be very expensive. He spoke of efforts to improve the survey in the future. The survey also reported on member satisfaction with

the pharmacy plan, which indicated that levels of satisfaction were similar without regard to demographics: Between 8 percent and 10 percent of the total population was "not too satisfied" or "not at all satisfied." Regarding pharmacy, those dissatisfied reported: dissatisfaction with the benefit coverage; difficulty in using the mail order service; how claims were processed; a dislike of administrative policies; and poor customer service [slide 11]. Mr. Boucher related that the division heard the Aetna Concierge call center was not helping members, thus the survey was directed to that particular issue; in fact, 25 percent to 30 percent were unhappy with call center service. He cautioned that not all of those surveyed used the call center and the margin of error was higher [slide 12]. The Aetna Concierge call center team in Fresno, California, handles approximately 89,000 calls per year. The call center earned the following ratings: 94 percent first call resolution percentage; 98 percent quality; 1.2 percent abandonment rate; 85 percent answered within 30 seconds [slide 13]. The division was not satisfied with the call center performance, and the call center was assessed a penalty of \$546,040. In addition, the division contracted with Segal Co., to conduct a neutral party review that found that overall Aetna is providing good service; however, the customer service level is not as promised [slide 14].

CHAIR OLSON suggested that call center staff and all third-party administrator employees provide identification to members when they call.

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REPRESENTATIVE LEDOUX recalled not being able to speak to a person for the first ten minutes during a call to one of the call centers.

MR. BOUCHER expressed the division's view that the call center is the face of the plan, and a core value is for the customers to be treated well. The state, through its performance guarantees, has made clear to Aetna its expectations and in response, Aetna is providing additional customer service training. One of the complaints has been that members have to repeat calls, and then receive conflicting information, so Aetna will develop a tool to track repeat calls; he opined that the state's message is getting through to Aetna, and he gave examples of improved service.

REPRESENTATIVE KITO returned attention to the \$16.4 million paid to Aetna in FY 15, and the base fee of \$15.4 million for FY 16; he asked whether that amount is over and above the expense of their activity and if so, how Aetna's administration of the plan is paid for.

MR. BOUCHER responded:

I guess I can best describe this as: We have a base fee, and, and fees at-risk. And depending on different aspects of their performance, they would be rewarded or penalized, based upon that.

REPRESENTATIVE KITO clarified:

So ... my question really is: Is the fee, the \$15.5 million their entire cost for administering the program, or is that, the, over and above the cost of administering the program?

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MR. BOUCHER said he could not answer that question but would provide the answer if possible.

MS. MICHAUD, in response to Chair Olson, said the contract with Aetna is not finalized, but the state has a 16-page letter of agreement with Aetna and the full contract will be much larger. The letter of agreement is not confidential and is posted on the division's web site.

MR. BOUCHER turned to other performance issues with Aetna in 2014, and pointed out that the total penalties were nearly \$1.2 million. Because of that, the contract with Aetna remains unsigned and the administration is negotiating with Aetna to include additional performance guarantees for 2015 [slide 15]. Mr. Boucher restated that Aetna won the third-party administrator RFP because of the value of its network, and about 600 additional providers have been added to the network in 2014 and 2015 [slide 16].

REPRESENTATIVE JOSEPHSON recalled that in 2013, there was one orthopedic surgeon on the preferred provider list in Anchorage.

MR. BOUCHER acknowledged some providers are very reluctant to join the network. In further response to Representative Josephson, he said he did not know their motivation [to

refrain]; however, specialists' fees can be 300 percent to 400 percent higher in Alaska when compared to procedures elsewhere.

REPRESENTATIVE COLVER asked whether patients are traveling to Seattle for care because of the lack of preferred providers.

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MR. BOUCHER said he was unsure of the volume.

REPRESENTATIVE HUGHES asked whether there are preferred providers outside of the state.

MR. BOUCHER said yes. They are part of the Aetna network and also deliver care to many retirees who live outside of the state.

REPRESENTATIVE LEDOUX questioned whether a member who can show that a procedure is cheaper outside of Alaska could have their plan pay for a travel companion to care for them.

MS. MICHAUD responded that there is a provision for surgery that is less expensive elsewhere, and travel will be paid for the patient; however, the plan will not pay travel costs for a companion.

REPRESENTATIVE LEDOUX observed that if a procedure costs 400 times less elsewhere, it would be beneficial to pay for a companion.

MR. BOUCHER said the state is looking into travel for a companion; in fact, it is common to have "a wraparound package" that includes transportation from the airport at certain facilities. On the other hand, he cautioned about maintaining a balance in order to keep providers in Alaska.

REPRESENTATIVE LEDOUX expressed her belief that workers' compensation will pay for a companion's travel; she asked why the state would not.

MR. BOUCHER stated that in instances such as transplants, travel for a companion is paid. In further response to Representative LeDoux, he said a process to determine when to pay for a companion needs to be established, and the timeline for that is unknown.

REPRESENTATIVE KITO suggested that the difference in customer satisfaction between those living in- and out-of-state, might be that Outside there is a robust network. He urged, "We might need to relook at the out-of-network, in-network discussion with Aetna as we look forward to the contract."

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REPRESENTATIVE COLVER asked whether international medical travel is covered by AlaskaCare.

MS. MICHAUD said coverage is good worldwide, so a member who chooses to travel outside of the U.S. would have coverage for a medical procedure, but not for the travel expense. In further response to Representative Colver, she opined members travel for care because of the expertise available or because of lower cost. In response to Representative LeDoux, she said the travel benefit is restricted to travel within the U.S. in all circumstances.

MR. BOUCHER returned to why Aetna was selected, noting that the percentage off of billed charges in 2014 and 2015 has been about 35 percent, which reduced the state spend by approximately \$110 million each year. The previous administrator delivered approximately a 23 percent discount off billed charges; therefore, the value to members and to the plan is in the range of \$35 million to \$40 million [slide 17]. Although the division understands there are problems with Aetna, Aetna has delivered savings, and if the division continues to address customer service issues, and grows the network - given the state's fiscal situation - the state needs to continue with Aetna. Efforts by the division to address ongoing management with Aetna are as follows [slides 18 and 19]:

- meet with Aetna weekly to review performance improvement projects
- Segal Co., will perform a claims audit
- monitor appeals prior to submittal to OAH
- engage with retirees and employees to resolve customer service concerns
- evaluate travel benefits
- update Retiree Insurance Information Booklet

MR. BOUCHER continued with actions that are expected from Aetna [slide 20]:

- redesign EOB form
- improve pharmacy coordination of benefits at point of sale
- direct participation of pharmacy customer service team to supplement CVS Caremark, and inclusion of CVS Caremark in weekly meetings
- become more actively engaged with stakeholder groups

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REPRESENTATIVE KITO said:

[Regarding] the CVS Caremark relationship ... is there a clear non-directional component of that so if we have a member that is interested in getting a pharmacy benefit, they're not directed to a better price at CVS?

MR. BOUCHER answered that CVS is the administrator of the claims processing, thus from this relationship, the state has realized a significant number of pharmacy rebates.

REPRESENTATIVE KITO expressed his concern that Aetna has a direct relationship with CVS, and asked if members are directed to CVS pharmacies.

MS. MICHAUD said although there are CVS pharmacies that are part of the Aetna network, there is no incentive to utilize CVS pharmacies. The mail order program is an Aetna program and Costco is part of the mail order network, along with Diplomat Specialty Pharmacy.

REPRESENTATIVE HUGHES asked the division to respond in writing to the following question: What is happening to coordinate care to save costs, and to group purchasing for medical procedures?

MR. BOUCHER said the division is currently evaluating a relationship with "the health care coalition of Alaska."

MS. MICHAUD, in response to Chair Olson, said the state did not have network providers outside of the U.S.

[5:00:58 PM](#)

**ADJOURNMENT**

There being no further business before the committee, the House Labor and Commerce Standing Committee meeting was adjourned at 5:00 p.m.