

SENATE FINANCE COMMITTEE  
February 8, 2018  
9:02 a.m.

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CALL TO ORDER

Co-Chair MacKinnon called the Senate Finance Committee meeting to order at 9:02 a.m.

MEMBERS PRESENT

Senator Lyman Hoffman, Co-Chair  
Senator Anna MacKinnon, Co-Chair  
Senator Click Bishop, Vice-Chair  
Senator Peter Micciche  
Senator Donny Olson  
Senator Gary Stevens  
Senator Natasha von Imhof

MEMBERS ABSENT

None

ALSO PRESENT

Leslie Ridle, Commissioner, Department of Administration;  
Emily Ricci, Chief Health Care Policy Administrator,  
Department of Administration; Pat Pitney, Director, Office  
of Management and Budget, Office of the Governor.

PRESENT VIA TELECONFERENCE

Adam Reese, PRM Consulting Group; Thomas Rand, PRM  
Consulting Group; Scott Wittman, Pacific Health Policy  
Group.

SUMMARY

^PRESENTATION: HEALTH CARE AUTHORITY OVERVIEW

[9:02:57 AM](#)

LESLIE RIDLE, COMMISSIONER, DEPARTMENT OF ADMINISTRATION,  
relayed that she and her staff would provide a presentation

and then the department's consultants would present information.

EMILY RICCI, CHIEF HEALTH CARE POLICY ADMINISTRATOR, DEPARTMENT OF ADMINISTRATION, discussed the presentation, "Health Care Authority (HCA) Feasibility Study" (copy on file).

Ms. Ricci turned to turned to slide 2, "Study Overview":

- In 2016, SB 74 directed Department of Administration (DOA) to procure a study evaluating the feasibility of a Health Care Authority.
- SB 74 requires the study to:
  - Identify cost-saving strategies that a health care authority could implement;
  - Analyze local government participation in the authority;
  - Analyze a phased approach to adding groups to the health care plans coordinated by the health care authority;
  - Consider previous studies procured by the Department of Administration and the legislature;
  - Assess the use of community-related health insurance risk pools and the use of the private marketplace;
  - Identify organizational models for a health care authority, including private for-profit, private nonprofit, government, and state corporations; and
  - Include a public review and comment opportunity for employers, employees, medical assistance recipients, retirees, and health care providers.

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Ms. Ricci looked at slide 3, " Study Outline":

- Study evaluates health benefits funded directly or indirectly by the state for the following groups:
  - Medicaid
  - State of Alaska retirees (PERS, JRS and TRS)
  - Employees in the following groups:

- o State of Alaska (all bargaining groups)
  - o School districts
  - o University of Alaska
  - o State corporations
  - o Political subdivisions
  - o Other groups that would benefit from participation (e.g. individual market)
- Goal is to see if there are opportunities to create savings through greater efficiencies.
  - Evaluate opportunities for consolidated purchasing strategies and coordinated plan administration.

Ms. Ricci detailed that the Health Care Authority (HCA) feasibility study had been challenging for two reasons. Health care had gained attention at the national and statewide level because the system was fragmented, difficult to navigate, and very expensive. She considered that the existing healthcare system was complex and had been developed over decades; so there could not be a simple solution. She thought one of the largest challenges was the term "health care authority," for which there was no definition. Individuals had different and sometimes divergent ideas about the definition. She spoke about the challenging magnitude of expenditures and covered lives, which would be addressed in a later slide.

Ms. Ricci spoke to slide 4, "Study Contractors":

Contractors:

- o PRM Consulting Group (PRM) - survey collection, data analysis, phase 1 & phase 2 findings focusing on public employee benefits
- o Mark A. Foster Associates (MAFA) - peer-review, Alaska specific market analysis & opportunities
- o Pacific Health Policy Group Consulting (PHPG) - Medicaid technical assistance and analysis
- o Agnew::Beck - public comment and review process

[9:08:51 AM](#)

Ms. Ricci discussed slide 5, "Important Dates":

Timeline:

- August 30, 2017 PRM, PHPG, MAFA reports released
- September 1, 2017 Public comment process opens
- September 7, 2017 PRM webinar (12:30pm-1:30pm)
- September 11, 2017 PHPG webinar (2:00pm-3:00pm)
- September 13, 2017 MAFA webinar (2:30pm-3:30pm)
  
- October 30, 2017 Public comment process closes  
\*\*Extended to November 13, 2017\*\*
  
- December 4, 2017 Report addendum released  
\*\*Extended in conjunction with the public comment extension to December 22, 2017\*\*

Ms. Ricci detailed that the study was comprised of four different studies. The contractors had provided an overview of findings. She informed that all the report information, including the webinars, were available on the department's website.

Ms. Ricci read slide 6, "Big Picture Takeaways."

Ms. Ricci displayed slide 7, "2016 Expenditures & Covered Lives," which showed a pie chart entitled '2016 State and Federal Spend\* \$3.56 Billion,' and a bar graph entitled, 'State/Other\* Spend (\$Millions).' The bar graph showed expenditures for Medicaid, state retirees, state employees, school district employees, University of Alaska employees, and political subdivisions. She noted that the top of the slide read, "The State of Alaska & other publicly funded health benefits cover over 340,000 lives." She qualified that there was duplication in the number. The number also encompassed the AlaskaCare retiree plans, which included 40 percent of members that lived out of state.

Senator von Imhof observed that the bar graph on the right had dollar amounts for each category of spending. She wondered if there was a breakdown of the number of covered lives represented in each spending category on the bar graph. She wanted a scale of efficiency or cost per capita.

Ms. Ricci offered to provide a breakdown of the individuals represented on the graph. She thought the per capita cost would also be addressed in a later slide.

Senator Stevens asked what Ms. Ricci's definition of "health care authority."

Ms. Ricci considered that a health care authority (HCA) would be an entity that was different from what existed currently. She did not think that an HCA would be an exaggerated version of the Division of Retirement and Benefits. She thought an HCA was a different entity that had sophisticated data analytics, was empowered to engage in negotiations with providers, and managed a large pool of Alaskans. She thought one important question was who would participate in the pool.

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Senator Micciche asked if the difference of \$2.05 billion in state/other spending and \$1.51 billion in federal spending was out of pocket costs.

Ms. Ricci explained that the pie chart on slide 7 might help answer the question. The pie chart was a breakout of the \$3.56 billion in expenditures associated with the publicly funded health plans covering the 340,000 lives listed on the slide. About \$1.5 billion of the spending was associated with federal programs. The other portion of the pie chart depicted spending by the state and "other funds." She explained that the department used the term "other funds" loosely because it included local contributions. The bar chart on the right-hand side of the slide broke down the state/other spending into categories.

Ms. Ricci continued to address Senator Micciche's question. She explained that the contractors had to pick a point in time to examine in order to make equitable comparisons. The point in time chosen was September 2016. She reviewed the funding breakdown as shown on the slide.

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Senator Micciche asked about the difference between the "State/Other" spending shown on the pie chart versus the "State/Other" spending on the bar graph on slide 7.

Ms. Ricci stated that the difference had to do with Medicaid and mentioned the dental plan and the retiree plan.

Senator Micciche asked if the \$605 million in state Medicaid spending was not a state Unrestricted General Fund (UGF) cost.

Ms. Ricci informed that the slide was not broken into UGF or other funds, but rather a combination of state and local funds for the purpose of the pie chart. She thought that the Office of Management and Budget (OMB) had provided an estimate of what UGF costs were for the categories on the slide. She offered to share the information with the committee.

Ms. Ricci referenced slide 8, "Health Plan Consolidation":

- Health plan consolidation exists in the Medicaid and AlaskaCare retiree population with administrative entities covering a combined 233,000 covered lives.
- The State of Alaska, along with school districts and political subdivisions provide coverage to an estimated 44,000 benefit eligible employees through more than 100 different health insurance plans.
- This includes a mix of fully insured and self-insured plans as well as union health trusts.

Ms. Ricci stated that part of health insurance was the aggregation of risk pools. She thought pooling in volume was a fundamental concept in establishing health insurance plans. The contractors had noted that health plan consolidation did exist at higher levels that were more optimal in two areas - Medicaid and the AlaskaCare retirees and employees (which had about 80,000 lives). Reports had estimated the optimal level for pooling insurance efficiently was about 100,000 lives. She observed that there were 100 different health plans being utilized to cover different groups and included a mix of fully insured and self-insured plans. Self-insured plans were similar to AlaskaCare health plans, in which the entity providing the plan took on the risk of paying claims. In a fully insured plan, the insurer took on the risk.

Senator von Imhof hoped that further slides would refer back to slide 8. She thought you could observe in later slides that other plans were more efficient and were different in how they provided value for members.

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Ms. Ricci addressed slide 9, "Current Actions":

Implement Employee Group Waiver Plan (EGWP)

- o Increases federal subsidies for pharmacy benefits in the AlaskaCare retiree health plans through a Medicare Part D EGWP
- o Estimated savings in GF range from \$40 to \$60 million/year
- o Target implementation date is January 1, 2019

Pharmacy Benefit Management (PBM) Carve Out

- o The Division of Retirement and Benefits (the Division) issued a Request for Proposal In January for PBM services
- o Target implementation date is January 1, 2019

Travel Coordination Plan

- o The Division issued a request for proposals for travel coordination and assistance
- o Goal is to assist members seeking care outside their community through high-value, cost effective service
- o Target implementation date is July 1, 2018 for employee plan, January 1, 2019 for retirees plan

Vice-Chair Bishop looked at the estimated savings in general funds (GF) from implementing the Employee Group Waiver Plan listed on the slide.

Senator Micciche asked about estimated savings associated with travel coordination.

Ms. Ricci stated that the savings PRM identified were about \$85 per member per year across all entities. She was not certain that the amount would translate into each health plan. She would have further estimates available within 60 days' time when the department received estimates through the proposal process.

Senator Micciche assumed that the amount would be equivalent to \$85 times 44,000, or close to \$4 million per year.

Ms. Ricci stated that the amount would likely be 16,000 individuals in the employee plan and more individuals in the retiree plan. She cautioned against making estimates before learning more about the vendors that would

participate. A portion of the savings would be attributable to utilization in the program as well as the networks that the vendors were able to bring to the table with prices and quality metrics.

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Commissioner Ridle pointed to slide 10, "Next Steps":

The fiscal year 2019 budget includes funding to evaluate and implement strategies to reduce the growth of state health care spending including:

- o Implementation of contractor recommendations
  - e.g. coordinated/integrated services, data analytics, clinical guidelines;
- o Voluntary participation of pooled purchasing of services (e.g. TPA); and
- o Developing recommended options on the governance structure of a health care authority that includes representation for employees and other stakeholders

Commissioner Ridle stated that an HCA was feasible. She discussed a \$200,000 request in the Department of Administration's (DOA) budget for an effort happening in the community called "the blueprint," or "AK Reform." There was a public group including Department of Health and Social Services (DHSS), Alaska Mental Health Trust Authority (AMHTA), DOA, Division of Insurance, providers, insurers, individual doctors, members of the legislature, and others. The budget request would go toward the effort to come up with a blueprint for healthcare for Alaskans. In another part of the budget there was a \$750,000 increment to apply back to the health care authority effort. The next step was to do actuarial analysis on claims data, legal analysis, and re-engage stakeholders. She detailed that there had been public comment, but more details needed to be addressed such as implementation details, governance, and legalities.

Senator Stevens asked if both budget requests begin in the coming year.

Commissioner Ridle stated that the goal was to be done in 2018 with a plan to move forward. She believed the blueprint group had a goal to be done in December 2018, and the HCA wanted to be done by October.

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Ms. Ricci referenced slide 11, "Next Steps":

Future Exploration

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

Senator Micciche referenced the last line of the slide and asked if there had been a study from Department of Revenue (DOR) that estimated potential savings of \$125 million per year from the action of pooling the groups.

Ms. Ricci was not aware of a DOR study but recalled that there were some additional savings that the contractor had identified that might align with what Senator Micciche was suggesting.

Senator Micciche welcomed a constituent in the room.

Senator Stevens asked what power would be given to the HCA.

Ms. Ricci stated that the department wanted to outline the next steps of the HCA and to determine what kinds of things would be necessary for an HCA to manage lives in a way that was more aggressive. She thought there were benefits to the way the private sector engaged in managing the same type of circumstances. It was important for the HCA to have the tools it needed to be as effective as possible.

Ms. Ricci read slide 12, PRM "Reports I & II".

ADAM REESE, PRM CONSULTING GROUP (via teleconference), spoke to slide 14, "Purpose of the study":

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

retirees and other groups that would benefit from participation.

Phase I report focused on consolidated purchasing strategies

Phase II report focused on coordinated health plan administration

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

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Mr. Reese discussed slide 15, "Phase I Report - Consolidated Purchasing Strategies":

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

Mr. Reese addressed the three charts on the slide. He explained that annual average health care cost per household was about 60 percent greater in Alaska than for state and local governments in other parts of the country. He thought there was a significant burden to be borne by employers in the state. He referenced the chart on the bottom left and had found that there was already fairly significant organizational structure and consolidation in place. He explained the significance of the area size representing covered lives. The chart excluded Medicaid, and the largest group was AlaskaCare retirees. He thought there was a certain level of efficiencies to look to as a model for best run health plans. He listed other large pools listed on the chart.

Mr. Reese addressed the chart on the right of slide 15, "Variation in Monthly Health Plan Cost Per Household by Size of Plan." He explained that a key finding was that there was wide variation in plan cost, particularly among smaller entities (those with fewer than 500 employees).

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Mr. Reese moved to slide 16, "Phase I Report - Opportunities for consolidated purchasing efficiencies," which showed two pie charts and a table. He shared that other findings from the Phase I report identified purchasing efficiencies that could be addressed including pharmacy benefits, travel benefits, and implementing an Employer Group Waiver Plan (EGWP). He discussed the estimated savings from the efficiency opportunities identified.

Senator von Imhof referenced slide 15, and the right-hand graph. She asked if Mr. Reese had any information on the underlying demographics for each of the data points on the graph to better understand the difference in costs.

Mr. Reese answered in the affirmative. He stated that the data was a key part of the analytics. As a health actuary he was aware of the increased costs of healthcare that came with advancing age. The consultants had sought the data, received it from DOA and was able to map it to each of the entities for which it had plan design and cost information. He stated that future slides would show more detail as he had tried to adjust for the demographics for each of the health plans.

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THOMAS RAND, PRM CONSULTING GROUP (via teleconference), displayed slide 17, "Phase II Report - Consolidated Health Plan Administration":

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

Mr. Rand stated that PRM had found few other states that maintained an HCA. The two closest states models were the State of Washington and the State of Oregon. Meeting with

the states had been helpful in formulating the Phase II report, which dealt with consolidated plan administration.

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Mr. Reese referenced slide 18, "Phase II Report Observations - Wide range of health plan actuarial values," which showed two bubble charts entitled 'State Agencies and Political Subdivisions,' and 'School District Health Plans.' He stated that PRM had captured data as to the health plan actuarial value, or what proportion of covered charges would be covered by a plan. He discussed the dimensions of the two graphs.

Mr. Reese referenced an earlier question about demographics of the insurance pool population. He shared that the data on the slide was adjusted for the age and gender demographics of the underlying populations in the groups.

Mr. Reese noted that the charts were using the same scale, which helped illustrate the observation that there was a fairly wide range of actuarial values and health plans from below 75 percent to about 95 percent. The majority of the employees in state agencies were in health plans with actuarial values of 85 percent or higher; whereas the majority of school employees were in health plans with actuarial values below 85 percent.

Senator von Imhof interpreted that it would be ideal to be in the upper left-hand corner of the graphs with a higher value plan with a lower cost.

Mr. Reese agreed.

Senator von Imhof asked how the state could get most of the plans into the upper left-hand corner of the graphs.

Mr. Reese considered the graph on the left, where it was possible to see trailing smaller plans. He thought the topic that needed more study was why two plans with the same actuarial value were imbalanced in cost, even when adjusting for demographics. The topic would be addressed further in later slides.

Mr. Reese addressed slide 19, "School Districts - Comparison of Plans in Public Education Health Trust (PEHT) to those not in PEHT." The slide showed a bubble graph to

demonstrate differences in plans that participated in the public education health trust and those that did not.

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Mr. Reese pointed to slide 20, "School Districts - Comparison of Plans in Health Care Cost Management Corporation of Alaska (HCCMCA) vs not in HCCMCA." The slide showed a graph, with those participating in HCCMCA in bronze, and the blue were not.

Senator von Imhof thought the obvious conclusion was that one was better off not in a trust.

Senator Micciche referenced slide 19, and asked Mr. Reese to share some factors about the trust, so that the committee might better understand the issue.

Ms. Reese discussed the use of a composite rate, through which a health plan collected the same amount of money regardless of the number of people in a household, which could be affecting underlying costs. He thought a subsequent slide would address the matter. He discussed the uniqueness of the state, including higher healthcare costs, difficulty reaching specialty services, and the relationship with employers covering all lives in a household.

Senator Micciche thought Mr. Reese was expressing that it was the same cost to cover an employee as to cover an employee and family.

Mr. Reese answered in the affirmative. He referenced slide 19, that showed two similar plans providing the same level of benefit for vastly different costs. He thought the difference could be related to a policy of the plan sponsor with regard to the number of covered lives per household.

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Senator von Imhof asked if some of the bubbles on the slide represented a household cost that was higher versus the cost being covered by the employer or the trust.

Mr. Reese asked to advance to slide 23.

Mr. Rand spoke to slide 23, "Observation: Spousal premium requirements impact enrollment, which impacts total employer cost." He thought that there was some interaction between public funded employer-sponsored healthcare plans in Alaska, and plans provided in the private sector. He thought it was notable that about 40 percent of United States workers in the private sector were in families where both spouses were employed. Many employers were requiring significantly higher contributions for spousal and dependent coverage than for employee-only coverage. An employer that provided generous benefits, low contributions, or a composite rate would have a plan that would naturally be chosen by a couple or family.

Mr. Rand continued his remarks. He thought there was a cost shift to employers with generous plans and low or no additional contribution rates for dependents' coverage. He thought the chart and regression line on slide 23 showed the correlation between higher contributions for dependents' coverage and the percentage of participants who elected to cover family members. For every \$50 in additive contribution for spousal coverage, there was a 10 percent decline in the percentage of participants covering spouses under health plans. The plan that was more generous and less costly ended up carrying claims costs that could otherwise have been shared with other employers in dual income households.

Mr. Rand continued to discuss slide 23. He estimated that for every 1 percent decline in dependents' participation, there was a 1 percent decline in the cost of the plan. One recommendation in the Phase 2 report was that any HCA-administered plan moved away from composite rates and followed the more common practice of having dependent coverage tiers with different rates. Such tiers would not preclude a participating entity from continuing to use a composite rate, but it would highlight the issue and give some incentive for publicly funded plans in Alaska to take steps to undo the cost-shifting that was happening.

Co-Chair MacKinnon handed the gavel to Co-Chair Hoffman.

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Senator von Imhof noted that there were five public entities that had chosen to cover the entire cost of adding a spouse for coverage. She asked for confirmation that

public entities made the choice to cover the cost at the expense of other costs.

Mr. Reese answered in the affirmative. He had heard from a number of school districts that had difficulty recruiting and retaining staff and had used the spousal coverage as a recruiting tool.

Co-Chair Hoffman handed the gavel back to Co-Chair MacKinnon.

Mr. Rand stated that one of thing things PRM had noted while conducting the study was that there was a very large number of Alaskans that were covered by the federal government. The percentage of non-participation for those that were eligible for Federal Employees Health Benefits (FEHB) was about 9 percent, while in Alaska the percentage of participation approached 30 percent. He thought the number was driven by the fact that many of the individuals had spouses that worked for the state or other employers. He thought that in effect, the federal government was benefitting taxpayers by the disparity in participation rates compared to the rest of the country.

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Senator von Imhof presumed that people were choosing the more generous state employee healthcare plan over the federal plan because there was more value per dollar in the state plan.

Mr. Rand agreed. He noted that the actuarial value of federal plan was less generous than that of the state employee plans.

Senator von Imhof commented on the 9 percent of federal employees that declined coverage nationally versus 30 percent in Alaska. She concluded that the national plans seemed more similarly aligned versus the plans in Alaska, which did not seem aligned.

Mr. Rand answered in the affirmative. Private sector employees had been very aggressive in taking steps to ensure that in dual-income households the other employers plan was selected. In a recent survey reported by Willis Towers Watson, 28 percent of respondents reported that there was a spousal surcharge, which was being more

commonly used in the private sector. The surcharge required payment from employees who were eligible to identify if a spouse had access to other coverage.

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Mr. Reese spoke to slide 24, "Phase II Report - Status Quo: Expected Cost in 2021 is \$1.19 billion." The slide showed a bar graph that had started with a baseline projection of expected costs through 2021.

Mr. Reese discussed slide 25, "Coordinated Health Plan Administration Projected savings over the next five years by model." The slide showed a table of projected savings. He discussed the models depicted on the table. He observed that the second model assumed that all school districts would be in one pool and all political subdivisions and state employees would be in a separate pool. Rather than being voluntary, all plans would come at the expiration of the collective bargaining agreement. Thereby the pool size would be larger and the opportunities for coordinated plan administration savings would be larger.

Mr. Reese continued to discuss the table on slide 25. He addressed Model 3, which was a different model of state-administered captive, for those individuals that were self-insured. Model 5 included an option for individuals to gain access to a broader pool covering school districts and political subdivision, with the assumption that individuals might not have local access to a marketplace.

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Senator Micciche thought it seemed like the single risk pool would be more financially efficient in Model 1 than in Model 2. He asked if the difference was because there was an opt-out provision in Model 1.

Mr. Rand agreed and thought that he had been overly optimistic in depicting savings under Model 1. He thought the two relevant data points were the experience of the Washington and Oregon HCAs. The Oregon HCA required that all school districts participate in the HCA plan with an opt-out only available with a showing of comparable benefits in lower cost. Very few school districts had opted out. He explained that Washington had the opposite rule; both school districts and local jurisdictions were able to

elect in the plan. The percentage of participation among school districts was under 5 percent.

Mr. Rand referenced the many plans in operation in Alaska. He discussed the difference in the plans and thought consolidation could maintain development of best practices.

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Senator Micciche asked if theoretically that the plan that would deliver the greatest cost savings (a single risk pool requiring participation) was not on the chart.

Mr. Rand stated that there would be three very large risk pools, only recommended by PRM because the structure was already in place. School districts had different needs, with differing bargaining contracts. The differing needs were also reflected in earlier bubble charts. He did not think that somewhat lesser consolidation would be a significant bar to much greater efficiencies and ultimately lower costs.

Co-Chair MacKinnon asked about the reference to an ideal number of 100,000 lives covered in a pool.

Mr. Reese stated that there were some elements to the two risk pools where the rate-setting and underlying experience would be separate. There was some coordination that would be expected to take place across the plans. He used the example of a single pharmacy contract covering all covered lives. Even at the consolidated school district level there was at least 50,000 covered lives. He stated that there was not that much to be gained going from 50,000 to 100,000 lives, as most economic savings had already been achieved at the 50,000 size.

Mr. Reese moved to slide 26, "Summary Recommendations for Coordinated Health Plan Administration":

1. State of Alaska establish a Health Care Authority (HCA) with three separate pools: one pool for retirees and two pools for employees, with separate pools for school district employees and all other governmental employees.
2. All entities be required to participate in the HCA when first feasible and no later than upon the

expiration of the current collective bargaining agreement.

3. The HCA develop multiple plan options for medical, prescription drugs, dental, and vision benefits to provide a wide range in health plan choices to meet the recruitment and retention needs of the various employers and the health plan needs of their employees.

4. The HCA establish standard premium rates for the plans that reflect the expected costs of each plan option taking into account the covered population and expected health care utilization.

5. The HCA establish a tiered premium rate structure, with separate rates that vary with the size and composition of the household.

6. A Health Care Committee or Board be established to provide insight and oversight to the HCA.

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Senator Micciche asked about findings for Model 5 on slide 25 and asked if a private exchange was likely to realize a savings from the status quo.

Mr. Reese answered in the affirmative.

Vice-Chair Bishop had questions as to how the state might unwind the trust agreements inside the collective bargaining agreements.

Co-Chair MacKinnon noted that there had been a similar report with similar recommendations, and Vice-Chair Bishop was pointing out a key contention point. She referenced constitutionally guaranteed benefits for retirees, and agreement with bargaining units. The committee had previously looked at some staged approaches to working with trusts or others. She referenced a report and thought previous information matched what the administration was presenting. She thought that Vice-Chair Bishop had rightly pointed out that not all people wanted to be in the same pool.

[10:18:02 AM](#)

Ms. Ricci read slide 27, "MAFA Report," and reminded the committee that that the data being considered was from a point in time in 2016. She noted that the AlaskaCare plan had changed since that time. She did not think any changes affected the findings in a significant way.

Ms. Ricci discussed slide 28, "Overview":

Areas of focus: Public employee plans

Activities:

- o Peer review
- o Identify any additional Alaska-specific purchasing strategies

Ms. Ricci considered that the MAFA report, done by Mark Foster, had looked at opportunities for an HCA focusing on public employee groups. She summarized that the PRM Phase I report was what happened if groups pooled in the same way they did currently but came together to find products to purchase together to gain savings. The savings identified by PRM were not particularly high-magnitude at less than \$10 million after an annual \$900 million spend.

Ms. Ricci discussed Phase II of PRM's report. She thought that Phase II represented what happened when the entities made changes such as pooling differently or administering differently. There would be more significant savings given the magnitude of change. She discussed a continuum of change being contemplated and contemplated the import of the amount of change all entities were willing to undertake.

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Ms. Ricci addressed slide 29, "Key Observations/Findings":

Aggregate cost of public employee plans in 2017 will be \$956.5 million (PRM findings)

Annual inflation (8%-12%, 2014-2016) exceeds US growth rate (5%-6%, 2014-2016)

Primary driver of higher prices in Alaska is highly concentrated medical services markets

Public employer groups are highly fragmented (100 plans covering 44,000 employees)

The largest group only 3.76% of the employer health insurance market

Consolidation of public employees would expand scale to 114,000 covered lives and dramatically increase market share

Health care growth is crowding out wage growth:

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

Ms. Ricci reminded that the groups considered in the "public employee plans" listed on the slide included Alaska state employees (in and out of union health trusts), school district employees, political subdivision employees, and the University of Alaska. She discussed health care prices versus the concept of cost. The report also found that the increase in the dollars spent on health care came at a cost to other areas. She thought the last bullet on the slide had been misinterpreted that foregone healthcare costs would translate directly into a pay raise.

Ms. Ricci pointed to slide 30, "Potential Public Employee Savings Estimates":

\$655 million over 7 years

8.7% public employee spend  
o \$23 million/annually year one  
o \$127 million/annually when mature

Savings achieved through:

2.4% reduction (PRM estimate)  
o Health plan management and pooled purchasing

6.3% reduction  
o Increase collective employer purchasing power to improve health outcomes and reduce excessive costs growth

Ms. Ricci outlined strategies to achieve the 6.3 percent reduction as mentioned on the slide: accelerated health

plan tiering, value-based insurance design, and referenced-based pricing.

Ms. Ricci discussed slide 31, "Outline of Savings Estimates," which showed a table. She noted that the figures included an assumed increase in primary care utilization, along with the assumptions on savings.

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Ms. Ricci turned to slide 32, "MAFA Key Recommendations":

1. Create a health care authority for public employees
2. Allow groups to opt-out only under specific circumstances
3. Build and sustain local expertise and professional staff to support the authority
4. Consolidate health plan data analytics and procurement under the authority
5. Benchmark reference pricing and performance
6. Increase the use and development of value-based plan design

SCOTT WITTMAN, PACIFIC HEALTH POLICY GROUP (via teleconference), discussed slide 33, "Pacific Health Policy Group - Health Care Authority Feasibility Study - Medicaid Technical Assistance." He discussed his firm, which was almost exclusively engaged in working with states and the Medicaid program to develop new programs and evaluate existing programs. The firm had experience working with half the states in the country.

Mr. Wittman spoke to slide 34, "Overview":

Areas of focus:

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

Activities:

- o Provide background on national and Alaska Medicaid programs
- o Outline other states efforts to consolidate/coordinate public health plans & Medicaid

- o Describe HCA or HCA-like structures
- o Identify approaches that Alaska could consider
- o Outline a provisional governance model

Mr. Wittman summarized that his firm was hired specifically to present and evaluate Medicaid considerations as it would relate to formation of an HCA in Alaska.

[10:29:32 AM](#)

Mr. Wittman discussed slide 35, "HCAs in Other States":

Features

HCA Structure/Governance Model is Dependent on:

Role of HCA

- o Public employees only v. all state-funded health plans
- o Administration (if Authority is an "umbrella" agency)
- o Coordination/support (board with agency representation)
- o Oversight (regulatory role)
- o Development of multi-payer initiatives (commercial payer representation)
- o Advance health reform

Autonomy v. accountability

- o Benefits/risks of independence
- o Legislative control/appropriations process

Mr. Wittman discussed the table on the slide, entitled "Overview of Health Care Authorities." He pointed out that Washington and Oregon were only two states that included comprehensive healthcare health care purchasing for both public employees and Medicaid. Uniquely, the State of Oklahoma HCA was solely the Medicaid program. There were a number of other HCA's that had different roles related to health planning or regulatory activities.

Mr. Wittman moved to slide 36, "Health Care Authority Design Elements":

An Authority would have the following responsibilities

- o Strong analytic capacity to support objective analysis and capability to access health care data

- o Fiscal management and administration of health benefits for publicly-funded health programs
- o Integration and coordination of certain administrative functions
- o Development of approaches that ensure access to care
- o Monitoring and enhancement of the Alaska health care delivery system

An Authority's responsibilities, including its role as it relates to Medicaid, requires additional evaluation

Existing examples include: Permanent Fund, Mental Health Authority, Alaska Housing and Finance Corporation, etc.

Mr. Wittman discussed the slide and pondered that an HCA could include stakeholder input. He thought that generally the notion of an HCA was to create some autonomy compared to a public agency or department within state government. The authority would have an assigned role, and generally had a board structure. The legislature would generally cede some control to an authority.

[10:33:10 AM](#)

Senator von Imhof asked why Medicaid needed additional evaluation and inquired as to what type of evaluation Mr. Wittman was seeking to perform.

Mr. Wittman stated that his group would need to take a detailed look at how the state government was organized. He considered that shifting Medicaid to an HCA would be a major transformation. Shifting Medicaid from DHSS to an authority would be creating an entity that would have responsibility for all the state's healthcare funding and administration. He stated that the analysis pertaining to savings was difficult as it was a function of any reforms that were initiated.

Mr. Wittman continued to address Senator von Imhof's question, noting that there were additional analyses related to administrative costs, as Medicaid shared funding with the federal government. There was a detailed cost allocation plan that drove the number of federal Medicaid dollars that determined the number of staff in state government. It was important to consider what functions

would be transferred to an HCA to determine the impact on the administrative budget and state dollars. He thought that the evaluation was more of a question about where the state wanted to go in terms of healthcare; balanced against the fact that it was known that healthcare and other social programs were interrelated, and social deterrents to health drove healthcare costs. He suggested an argument could be made for aligning social programs with the Medicaid program. Conversely, an argument could be made that the government should align its healthcare programs. He acknowledged that there was data and fiscal analysis to be done, but more so there was importance in evaluating the priorities and objectives of what would be best for how the state administered the programs.

[10:36:23 AM](#)

Mr. Wittman displayed slide 37, "PHPG Provisional Model":

Authority would be overseen by a Board:

- o One Board Chair appointed by Governor
- o Two additional members appointed by Governor
- o One member appointed by Senate President
- o One member appointed by Speaker of House
- o Two non-voting members who are active heads of principal Alaska State government departments

Executive Director head of Authority w/three divisions

Standing & ad-hoc committees:

- o Member advisory group
- o Provider council
- o Health information technology group
- o Quality & health transformation committee

Mr. Wittman referenced the flow chart on the right-hand side of the slide. He discussed a hypothetical HCA structure in which there was still some accountability and relationship back to the elected body and the administration. He noted that as he envisioned it, all HCA employees would be state employees. The model included an executive director, under which there were committees on health care transformation, operations, and finance.

Vice-Chair Bishop observed that the standing ad-hoc committees on the slide could bring a great deal of value

and ensure the success of the board that would oversee an HCA.

[10:39:14 AM](#)

Mr. Wittman referenced slide 38, "Key Observations/Findings - Medicaid":

- Alaska Medicaid background:
  - Alaska's Medicaid program covers more than 1 in 4 Alaskans
  - Over 185,000 Alaskans were enrolled in May of 2017
  - Enrollment grew by 23% from May 2016 to 2017
  - Nearly 40% of Alaska Medicaid clients are American Indian/Alaska Native (AI/AN)
  - Federal government funds approximately 65% of the program

Mr. Wittman thought it was important to note that in exchange for the significant federal funding of Medicaid, there was complexity in the eligibility rules and how benefits were administered. He suggested that the state would need to proceed with healthcare changes within the structure of how the Medicaid program was organized.

Senator Micciche asked about existing HCAs and wondered if the authorities had success in balancing proponents of healthcare spending with more fiscally conservative priorities. He thought Alaska did not have as much financial business background focused on fiscal balance. He referenced the suggested HCA structure on slide 37.

Mr. Wittman thought other healthcare authorities had done a good job at making the best use of scarce public resources. He had worked extensively in the State of Oklahoma, which operated under an authority structure. He had not seen any particular sacrifice through lack of funds and thought the same applied with the states of Washington and Oregon. He referenced the importance of ad hoc committees as well as federal oversights as sureties that the program was not purely driven by the desire to push down programs to achieve savings. He thought the question of alignment between healthcare and social determinants could be addressed under an HCA structure, or a structure by which health and human services were combined under the same department. He thought there could be differences of

opinion and priorities but considered that there was an opportunity to align healthcare with other social programs.

[10:43:23 AM](#)

Mr. Wittman addressed slide 39, "2016 Alaska Medicaid Enrollment and Expenditures":

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

Mr. Wittman explained that the slide, as well as the following slide, illustrated that healthcare purchasing and Medicaid were quite different. Medicaid served Alaskans with complex needs, and he thought the chart helped illustrate the fact. The chart helped to amplify that 44 percent of the expenditures were for 16 percent of the eligibility group.

Mr. Wittman pointed to slide 40, "2016 Expenditures by Service Category," which showed two pie charts entitled 'Alaska Medicaid' and 'AlaskaCare Active Employees.' The charts showed the distribution of spending under the two different groups. He noted that the pharmacy component of Medicaid spending was relatively small as compared to that of the AlaskaCare active employees' amount. He pointed out items that were a significant part of Medicaid spending, while the same items were not present in spending for AlaskaCare active employees.

Mr. Wittman continued to discuss slide 40. He discussed the number of providers and the breadth of the provider network that was managed by Medicaid, as compared to the administration of a public employee plan. He spoke to the complexity of the Medicaid program and Medicaid requirements, which he thought should be acknowledged when considering consolidation of purchasing or administration.

[10:47:28 AM](#)

Mr. Wittman looked at slide 41, "Integration with Health Care Authorities:"

- Examples exist but they are limited (Oregon & Washington)

- o Differences in program requirements create complexity and challenges to integration
- o Success dependent on administrative or structural framework to support coordination

Mr. Wittman looked at the flow chart that illustrated the administrative/structure framework continuum that showed movement from interdepartmental collaboration that was informal to a more formal consolidated entity of an HCA. It had been observed in literature that sometimes less formal kinds of collaboration tended to be less effective as they were directed by the governor or legislature, which experienced turnover. Resolution of competing priorities was also more challenging in an informal structure.

Mr. Wittman turned to slide 42, "Approaches for Integration/Coordination":

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

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

Mr. Wittman discussed needs and service patterns of different populations.

[10:50:43 AM](#)

Mr. Wittman referenced slide 43, "Medicaid Considerations":

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

Additional analyses to evaluate the feasibility of the three approaches are organized within the following objectives:

- o Impact on administrative costs
- o Impact on health care expenditures and growth

- o Impact on quality of care and access to care

Mr. Wittman referenced federal rules and the Medicaid Management Information System (MMIS), which had its own set of rules. He thought it could be complex when considering consolidation across public payers. He referenced literature that stressed the importance of the role of social determinants to address both health and social needs and healthcare costs. He thought it was important for a smaller state such as Alaska that DHSS employees might function in more than one role.

Mr. Wittman continued discussing slide 43. When considering moving Medicaid, there might be opportunities for efficiencies but additionally a need might be created. He noted that individuals working in multiple roles was part of the Medicaid cost allocation plan, the mechanism by which the federal government helped to support the administrative functions of the state.

Mr. Wittman continued that he had frequently he found that Medicaid did significantly support some administrative functions that helped to administer other programs. There could be a financial impact as a result depending on what programs did transfer to an HCA. He used the example of home and community-based services as a program that could benefit from being still administered by HESS instead of transitioning to an HCA because of the complexity and overlap with federal funding sources.

Mr. Wittman continued to discuss slide 43 and referenced the bottom two bullets. He did not think there was a difference between administering a program through an authority and through a different way. Rather, the direction of the entity managing the Medicaid program would have the most effect.

[10:55:24 AM](#)

Co-Chair MacKinnon asked members to submit questions and forward to her office to submit to the administration.

Mr. Wittman looked at slide 44, "Coordinated/Integrated Purchasing":

Types of Coordinated Purchasing  
o Examples include:

- Coordinated care and payment reform (e.g., Maryland, Vermont)
- Common provider management requirements such as network adequacy and program integrity for managed care (e.g., New York)
- Designated directors or chief medical officers across agencies to facilitate coordination of quality initiatives (e.g., Oregon, Washington)
- Consolidated or coordinated provider contracts and related activities (e.g., Georgia)

Successful coordination is dependent on:

- o Structural framework
- o Sufficient resources
- o Sustained leadership/direction
- o Shared vision and values

Mr. Wittman summarized that the last two slides pertained to potentially coordinating across public departments. He stated that there was quite a bit more detail in the reports. Additionally, the slides addressed the common benefit model, which addressed a different approach to how healthcare was purchased.

Co-Chair Hoffman referenced slide 40, which listed the 2016 expenditures by service category. He asked about a total dollar amount for the categories for 2016.

Mr. Wittman stated that the figures were in the report.

Co-Chair MacKinnon asked the administration to provide her office with a dollar breakdown for the two pie charts on slide 40.

Ms. Ricci relayed that all of the webinars and reports were available online.

Co-Chair MacKinnon noted that Office of Management and Budget Director Pat Pitney was in the audience.

Senator Micciche thought it appeared as though slide 39 lined up with another document he had received.

Co-Chair MacKinnon reminded that the slide was dated for 2016. She asked the administration to follow up on the matter.

Co-Chair MacKinnon thought the presentation included information from other states and provided much information to consider.

Commissioner Ridle acknowledged the breadth of information presented. She offered to provide individual briefings for committee members.

Co-Chair MacKinnon asked if the commissioner gave the same presentation to the Senate Health and Social Services Committee.

Commissioner Ridle answered in the negative.

Co-Chair MacKinnon discussed the agenda for the following day.

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ADJOURNMENT

[11:00:59 AM](#)

The meeting was adjourned at 11:00 a.m.