

**02/7 & 02/14/13
OVERVIEW:
ALASKACARE
EMPLOYEE HEALTH
PLAN BY
DEPARTMENT OF
ADMINISTRATION**

<TARGET><BILL></BILL><SUBJECT>02-7 and 02-14-13
OVERVIEW ALASKACARE EMPLOYEE HEALTH PLAN BY DEPARTMENT
OF ADMINISTRATION</SUBJECT><COMM>SSTA28</COMM></TARGET>



THE STATE
of **ALASKA**

GOVERNOR SEAN PARNELL

Department of Administration

BECKY HULTBERG, COMMISSIONER

10th Fl. State Office Building

PO Box 110200

Juneau, AK 99811-0200

Main: 907.465.2200

Fax: 907.465.2135

www.doa.alaska.gov

March 28, 2013

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

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

Dear Senator Dyson and Representative Lynn:

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

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

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

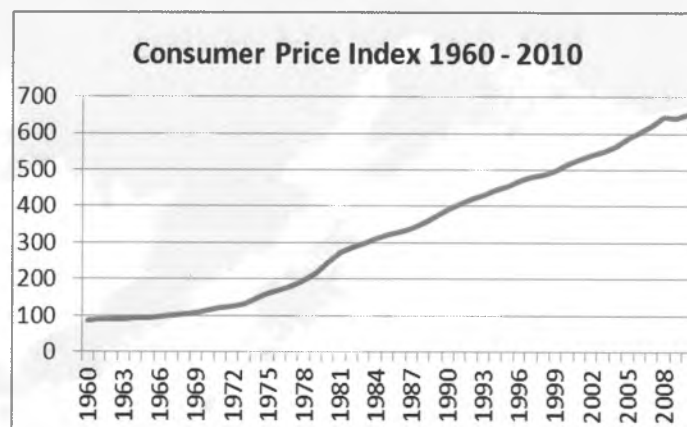
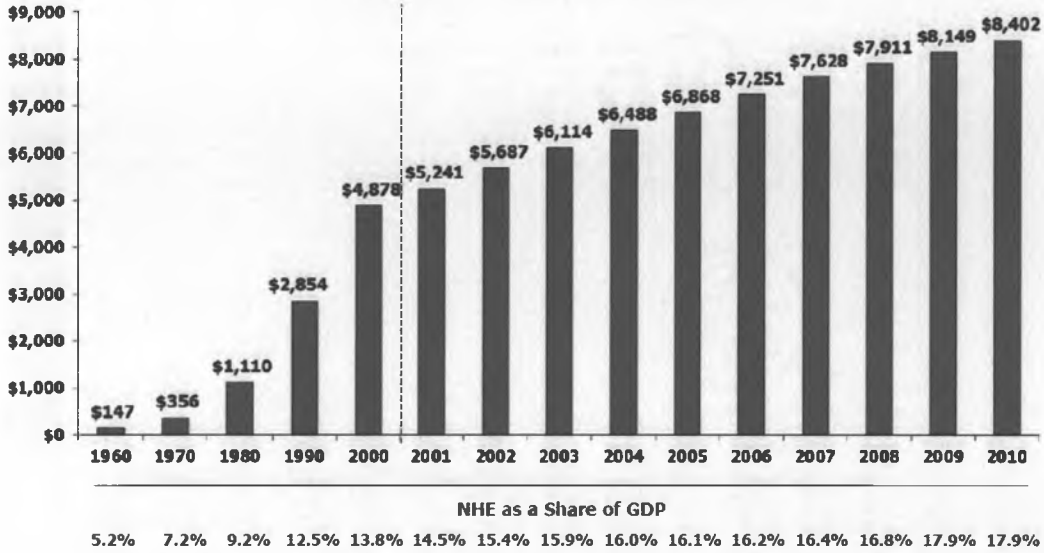


Figure 1: National Health Expenditures per Capita, 1960-2010



Notes: According to CMS, population is the U.S. Bureau of the Census resident-based population, less armed forces overseas.

Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at <http://www.cms.hhs.gov/NationalHealthExpendData/> (see Historical; NHE summary including share of GDP, CY 1960-2010; file nhegdp10.zip).



Table 127. Growth in personal health care expenditures and percent distribution of factors affecting growth: United States, 1960–2009Excel and PDF: <http://www.cdc.gov/nchs/nhis/contents2011.htm#127>.

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

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

¹Two measures of inflation are presented: economy-wide and excess medical inflation (changes in medical-specific prices in excess of those included in economy-wide inflation).

²Economy-wide inflation is calculated using the implicit price deflator (IPD) for gross domestic product (GDP). The IPD is a broad measure of the prices of the goods and services that the U.S. produces.

³Excess medical price inflation is the measured amount of medical price growth above general economy-wide price growth. This excess rate captures if medical prices have tended to rise more or less quickly than general economy-wide prices.

⁴Intensity is the residual percentage of growth that cannot be attributed to inflation or population growth. It includes changes in the use or kinds of services and supplies and captures any errors in measuring prices or total spending.

⁵Percents may not sum to 100 due to rounding.

NOTES: The inflation rates used to calculate the factors affecting growth have a base year of 2005. Starting with *Health, United States, 2010*, estimates are based on a revised methodology that incorporates available source data and methodological and definitional changes. These revisions are due to a comprehensive change in the classification structure of how estimates are defined and presented. For more information on the impact of these revisions, see:

<http://www.cms.gov/NationalHealthExpendData/downloads/benchmark2009.pdf>. See Appendix I, National Health Expenditure Accounts (NHEA) and Appendix II, Health expenditures, national: Gross domestic product (GDP). These data include revisions in health expenditures for all years and population for 2000 and subsequent years. Data have been revised and differ from previous editions of *Health, United States*.

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

Sources:

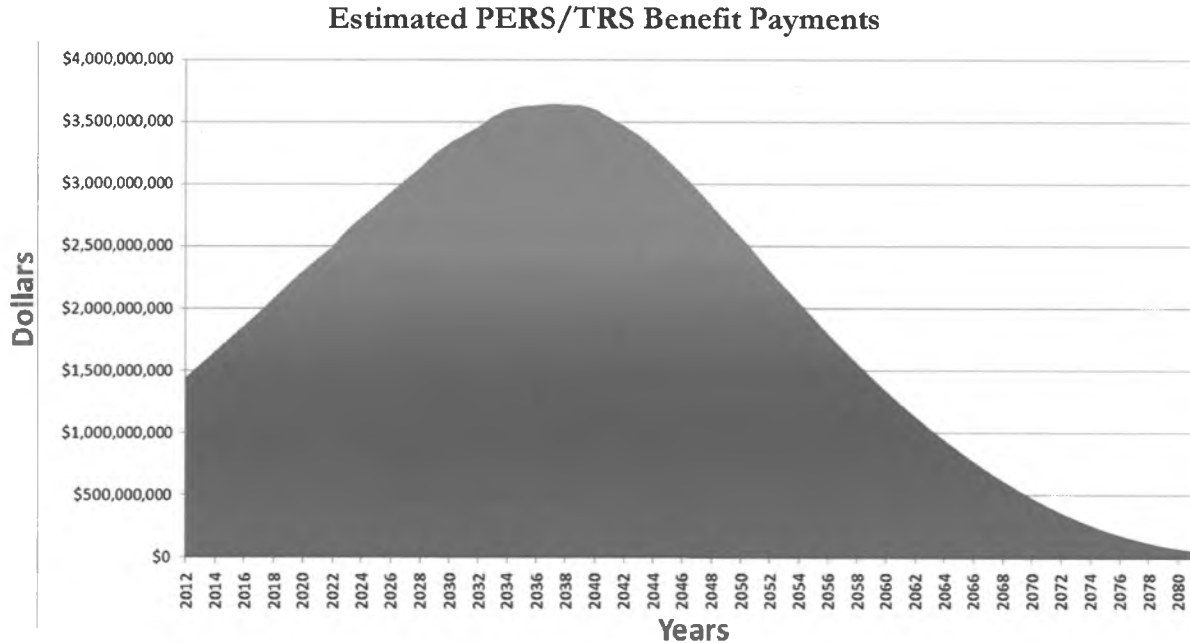
National Center for Health Statistics. (2011). Health, United States, 2011: with special feature on socioeconomic status and health. Retrieved from: <http://www.cdc.gov/nchs/data/hus/hus11.pdf>

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

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

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

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



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

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

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

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

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

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

Sources:

Master Agreement between the State of Alaska and the Public Employees Local 71 representing the Labor, Trades, and Crafts Unit. Effective July 1, 2012 through June 30, 2015. Retrieved from:

<http://doa.alaska.gov/dop/fileadmin/LaborRelations/pdf/contracts/LTC2012-2015.pdf>

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

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

Sources:

Public Safety Employees Association. Retrieved from:

<http://www.psea.net/about-psea.html>

Additional information for the bargaining unit is available at:

<http://doa.alaska.gov/dop/fileadmin/LaborRelations/pdf/buprofiles/PSEA.pdf>

- Q5:** Please provide additional details about the MM&P bargaining unit. (Sen. Dyson)
- A5:** The Masters, Mates and Pilots (MM&P) bargaining unit consists of a total of 98 positions. MM&P represents all deck officers described below:
- Regularly assigned deck officers
 - Vacation relief deck officers
 - Extra relief deck officers
 - Masters
 - Pilots
 - Chief mates
 - Second and third mates and third mate trainees

Sources:

Agreement between the State of Alaska Operating the Alaska Marine Highway System and the International Organization of Masters, Mates, and Pilots. July 1, 2008-June 30, 2011. Retrieved from:

<http://doa.alaska.gov/dop/fileadmin/LaborRelations/pdf/contracts/MMP2008-2011.pdf>

State of Alaska Workforce Profile Fiscal Year 2012. Retrieved from:

http://doa.alaska.gov/dop/fileadmin/DOP_Home/pdf/dopannualreport.pdf

- Q6:** Provide detail of what you call “the network”, basically the provider discount? What discounts do we get from the different kind of providers in what the Department refers to as “a network”? (Rep. Lynn and Sen. Dyson)
- A6:** The term “network” in the health care industry refers to a group of providers that have negotiated discounted services with an organization and have agreed not to “balance bill” a

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

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

Source:

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

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

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

Source:

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

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

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

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

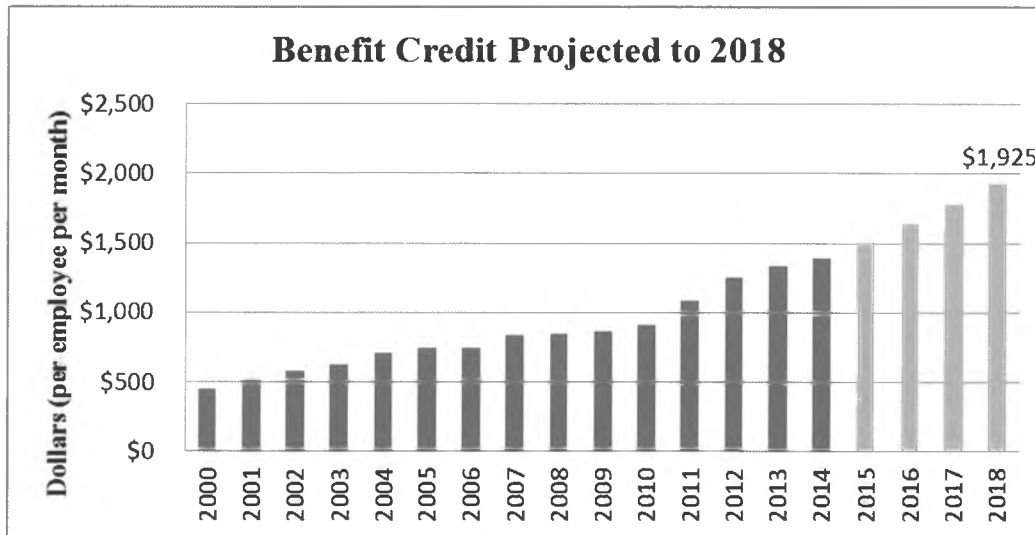
A9: The chart below provides the results of the most recent actuarial analysis of the cost Per Employee Per Month (PEPM) for each of the four plans currently offered in the AlaskaCare Employee plan during the benefit year. These are based on analysis of the FY 11 benefit year and were determined by Buck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

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

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

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

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



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

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

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

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

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

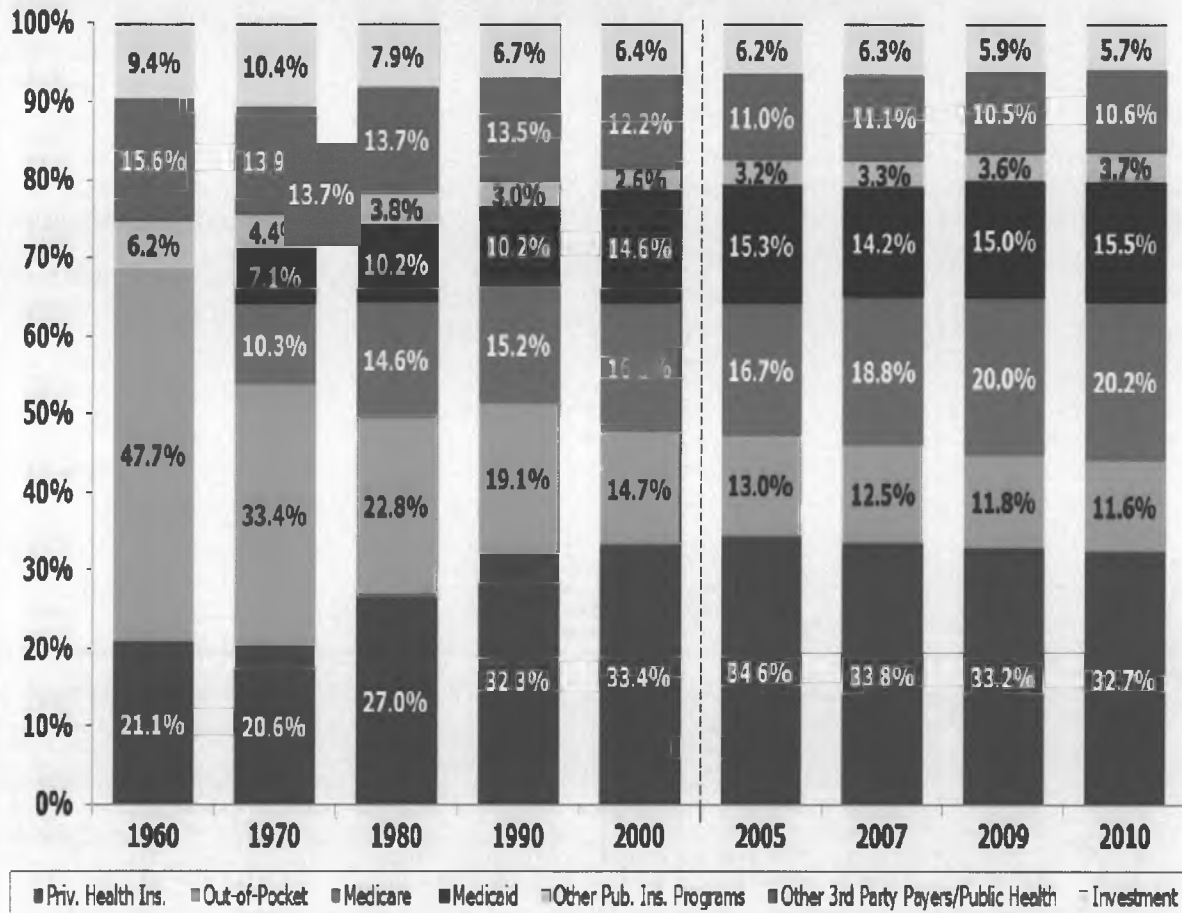
Q13: Slide 19 – What are the percentages based on? (Sen. Dyson)

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

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

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

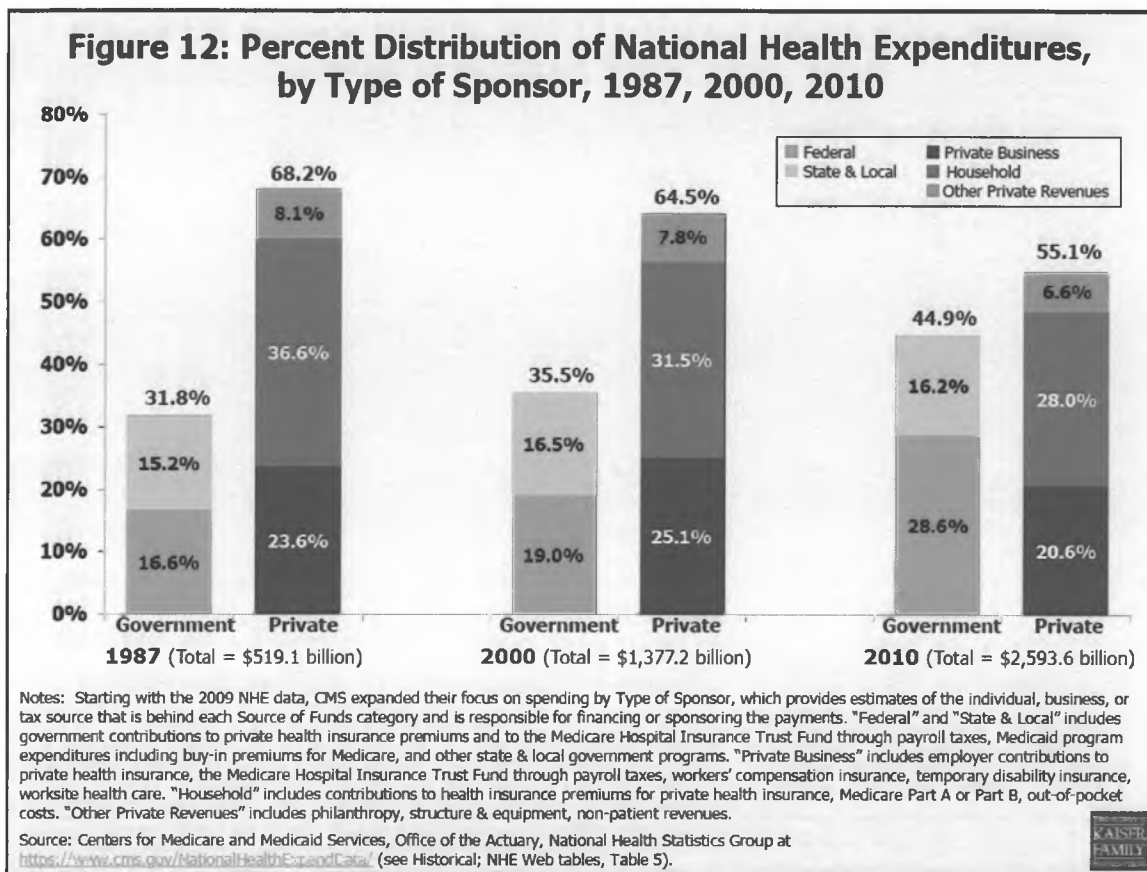
Figure 9: Percent Distribution of National Health Expenditures, by Source of Funds, 1960-2010



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

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





Sources:

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

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

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

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

March 28, 2013

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

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

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

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

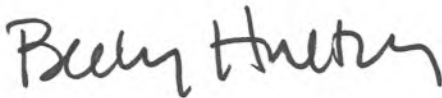
- 1) AlaskaCare Employee Plan pays 70/80/90% depending on plan selected
- 2) Medicare
- 3) TriCare
- 4) IHS

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

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

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

Sincerely,



Becky Hultberg
Commissioner

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

ALASKA DEPARTMENT OF ADMINISTRATION
ALASKACARE EMPLOYEE PLAN



Presentation to
**Joint State Affairs
Committee**

February 7, 2013

Commissioner Becky Hultberg
Deputy Commissioner Mike Barnhill

HEALTH CARE SPENDING IN THE US

National Health Expenditures (NHE) per Capita, 1960-2010



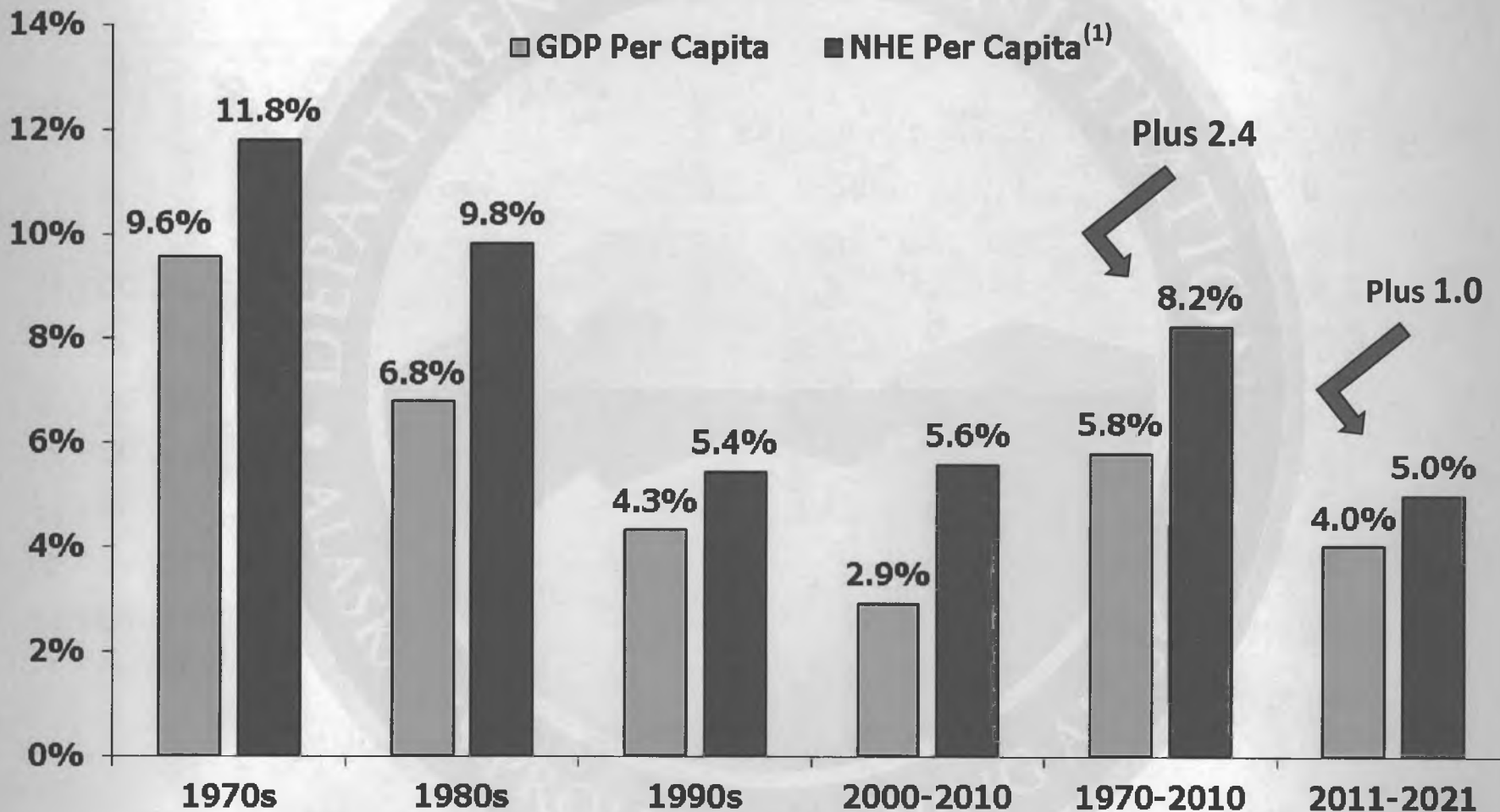
Notes: According to CMS, population is the U.S. Bureau of the Census resident-based population, less armed forces overseas and population of outlying areas, plus the net undercount.

Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at <http://www.cms.hhs.gov/NationalHealthExpendData/> (see Historical; NHE summary including share of GDP, CY 1960-2010).



HEALTH SPENDING & GDP

Average Annual Growth Rates for Health Spending and GDP Per Capita



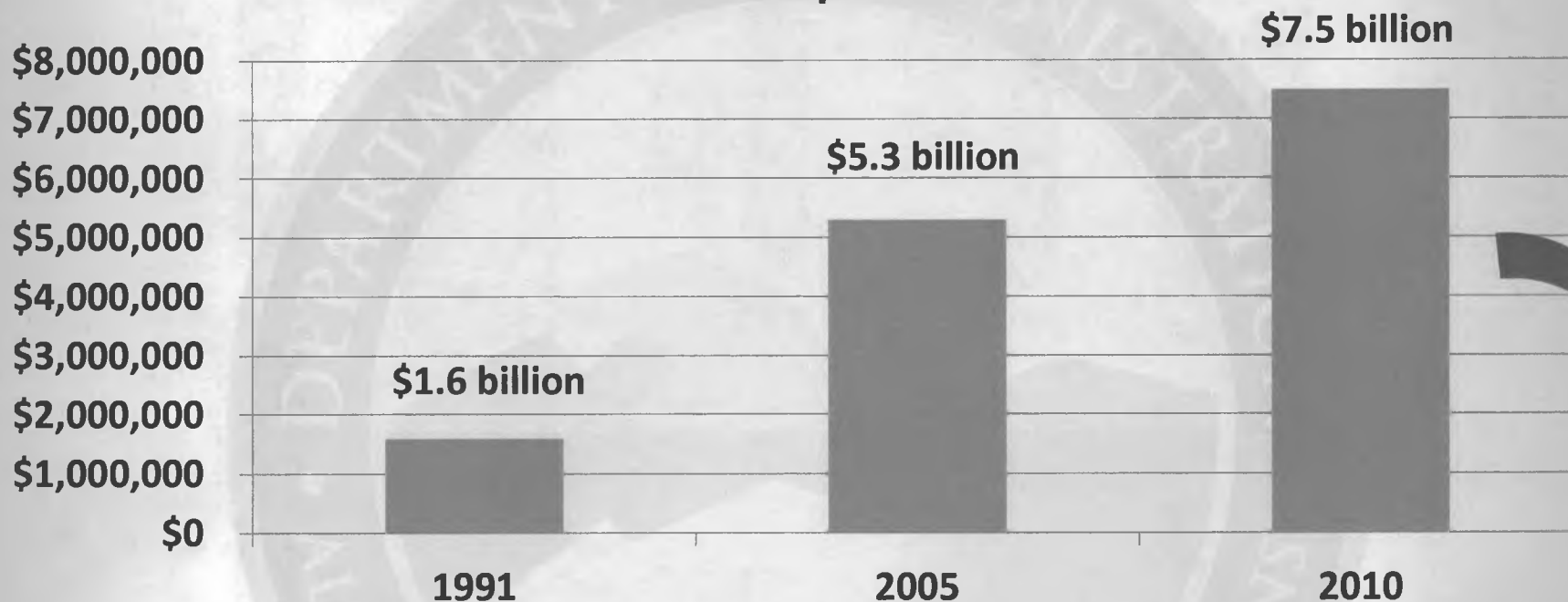
Source: Historical data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.

⁽¹⁾ NHE stands for National Health Expenditures



HEALTH CARE SPENDING IN ALASKA

Estimated Health Care Expenditures in Alaska



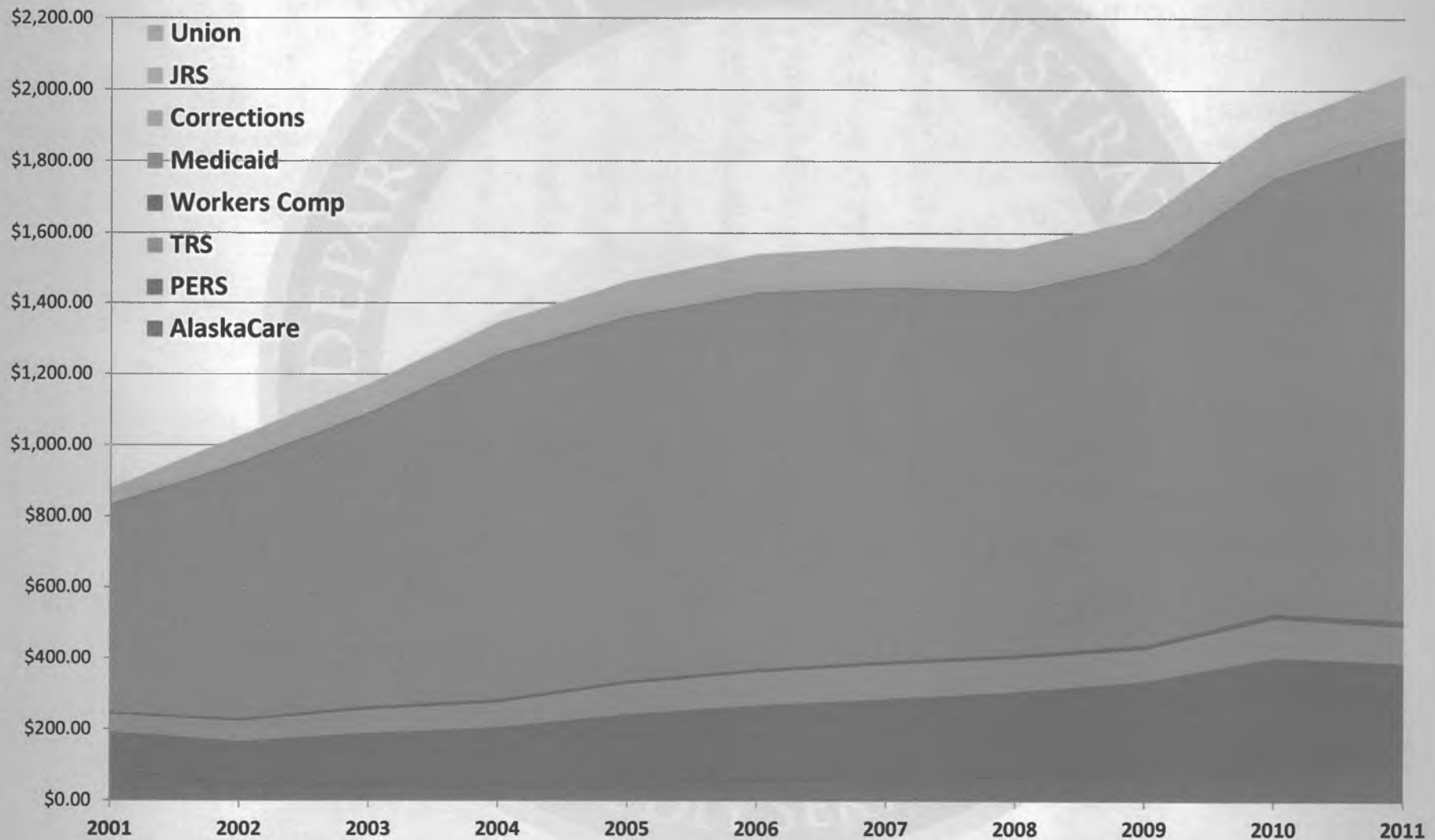
Source: Institute of Social and Economic Research (ISER), 2011

This equates to:

½ wellhead value of oil produced in AK in 2010

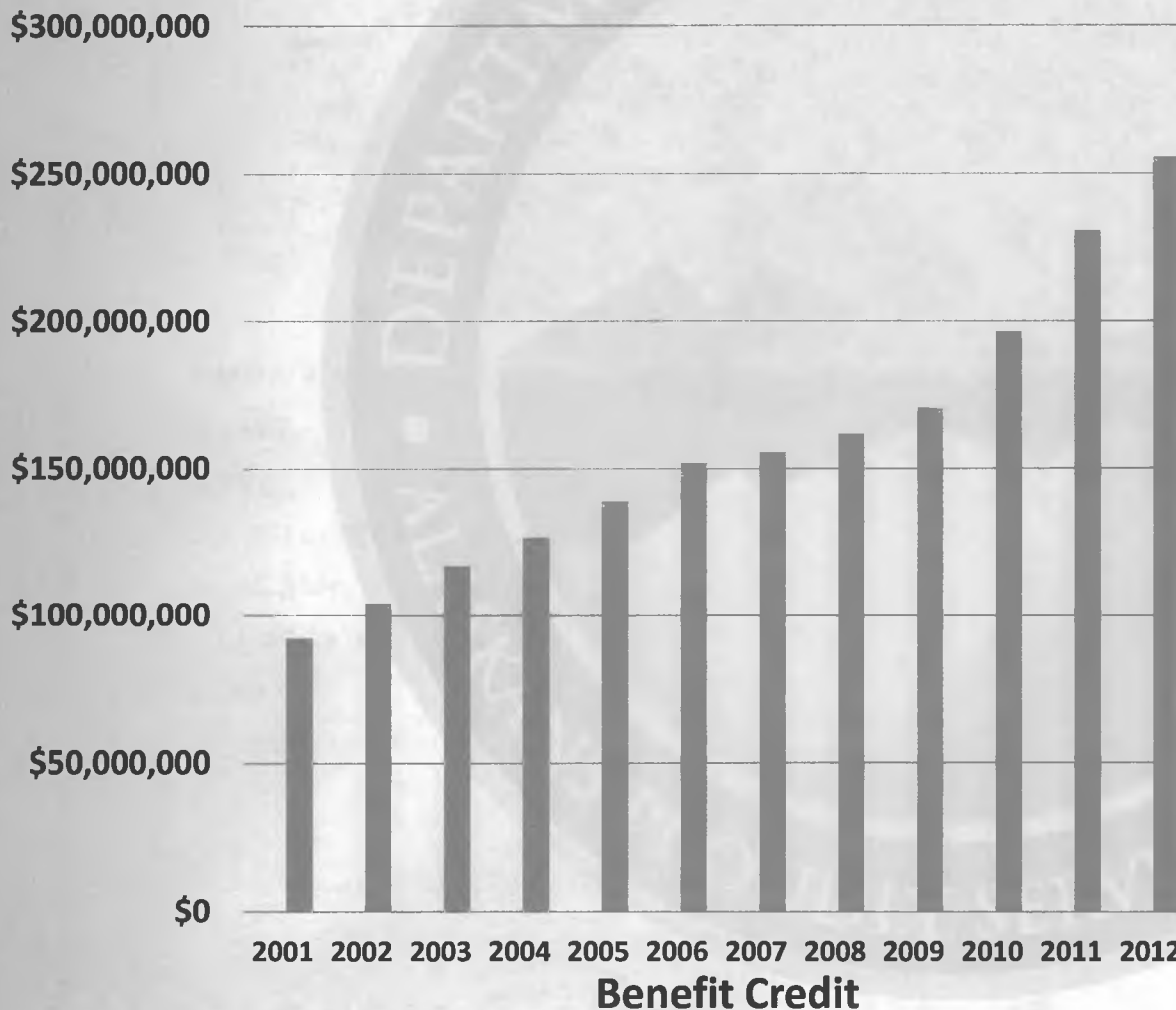
½ of Alaskan wages in 2010

HEALTH CARE SPENDING BY THE STATE



EMPLOYEE HEALTH PLAN SPENDING

State of Alaska Contributions to Active Employee Health Plans



Contributions to:

Group Health and Life Benefits Fund (AlaskaCare)

ASEA Health Trust

LTC 51 Health Trust

PSEA (3rd party insurance)

MMP Health Trust

ASCEA and TEAME (terminated in 2010)

EMPLOYEE HEALTH INSURANCE

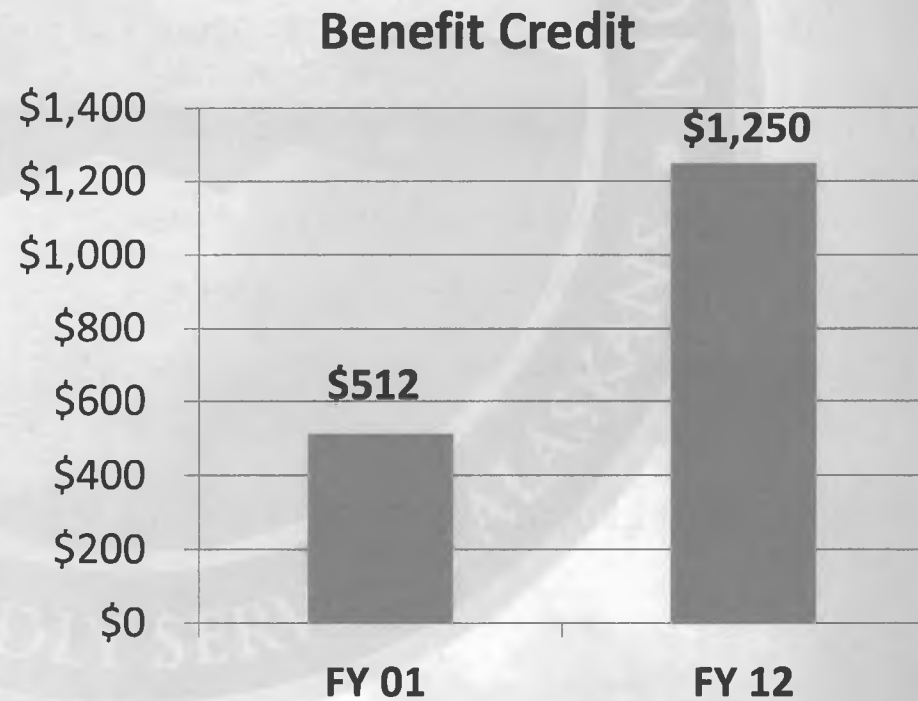
Not all State of Alaska employees receive health insurance through AlaskaCare.

AlaskaCare Health Plan	Union Health Trusts
<u>Employees: 6,400*</u>	<u>Employees: 10,500*</u>
AVTEC	General Government (GGU/ASEA)
Confidential Employees	Labor, Trades and Crafts
Correctional Officers	Public Safety Employees Association
Marine Engineers	Masters, Mates & Pilots
Mt. Edgecumbe Teachers	
Supervisory	
Inland Boatmen's Union	
Exempt/Partially Exempt Employees	

*Population counts are approximate

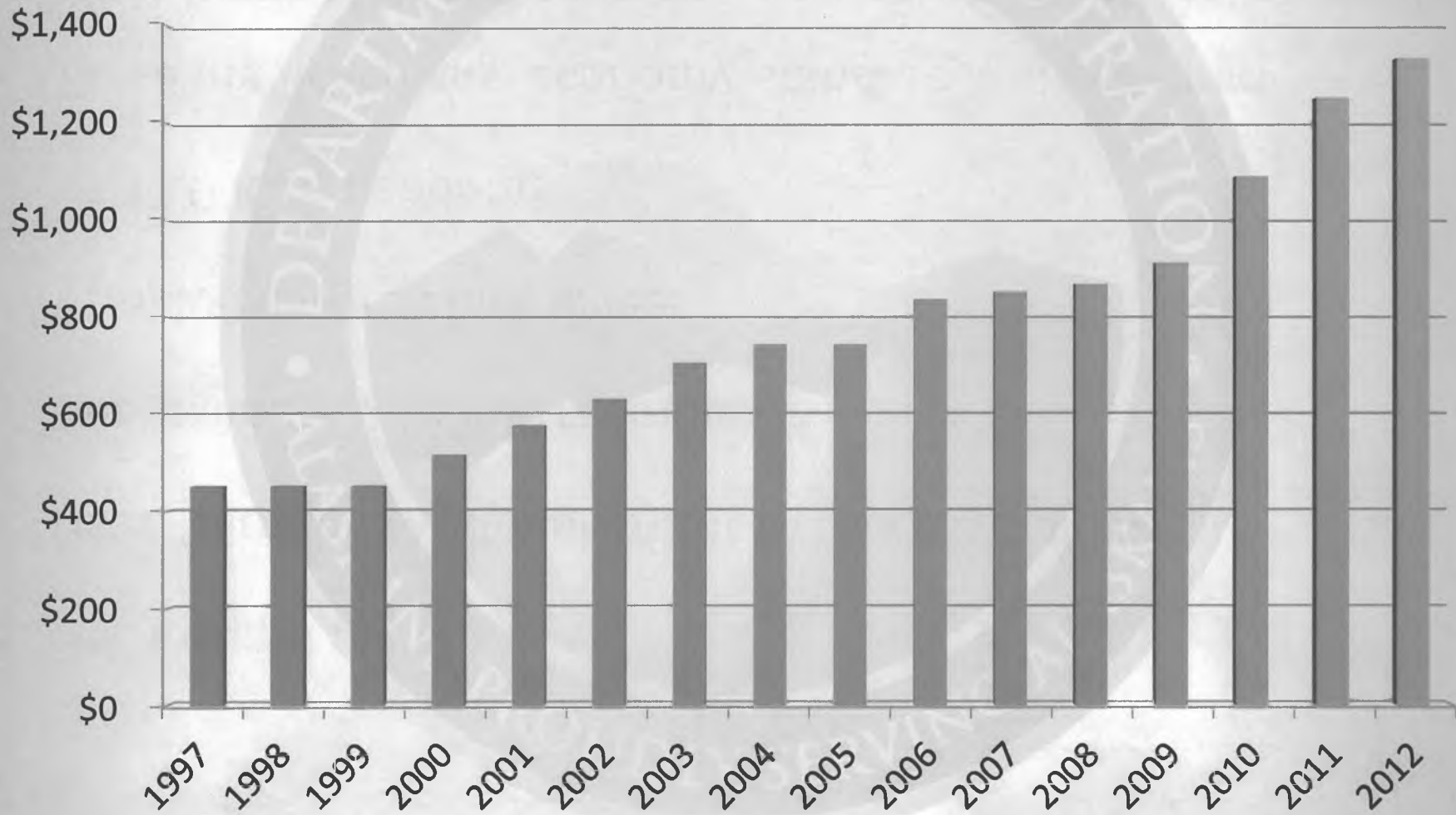
BENEFIT CREDIT

- Amount State contributes per employee per month
- Subject to negotiations
- Historically based on AlaskaCare premiums and plan experience
- FY 14 benefit credit:
 - \$1,389 per month
 - \$16,668 per year*(medical & dental)*



BENEFIT CREDIT

Benefit Credit
(medical & dental)



PLAN HIGHLIGHTS

- Self-insured plan
- Uses Third-Party Administrator to process claims
- Approximately 16,400 members
 - 6,400 covered employees
 - 10,000 dependents
- Three medical plans: economy, standard and premium
- Three types of dental coverage: preventive, standard, premium
- Two types of vision coverage: standard, managed care

PLAN HIGHLIGHTS

	Economy	Standard	Premium
Deductible	\$500 individual \$1,000 family	\$250 individual \$500 family	\$250 individual \$500 family
Coinsurance	70%	80%	90%
Annual Out-of-Pocket Maximum	\$2,000 per person after deductible	\$1,000 per person after deductible	\$300 per person after deductible
Lifetime Maximum	Unlimited		
Emergency Room	\$100 each incident for nonemergency use		
Preventive Care	Covered at 100% with no deductible		
Dependent children	Covered up to age 26		

PREMIUM RATES FY 13

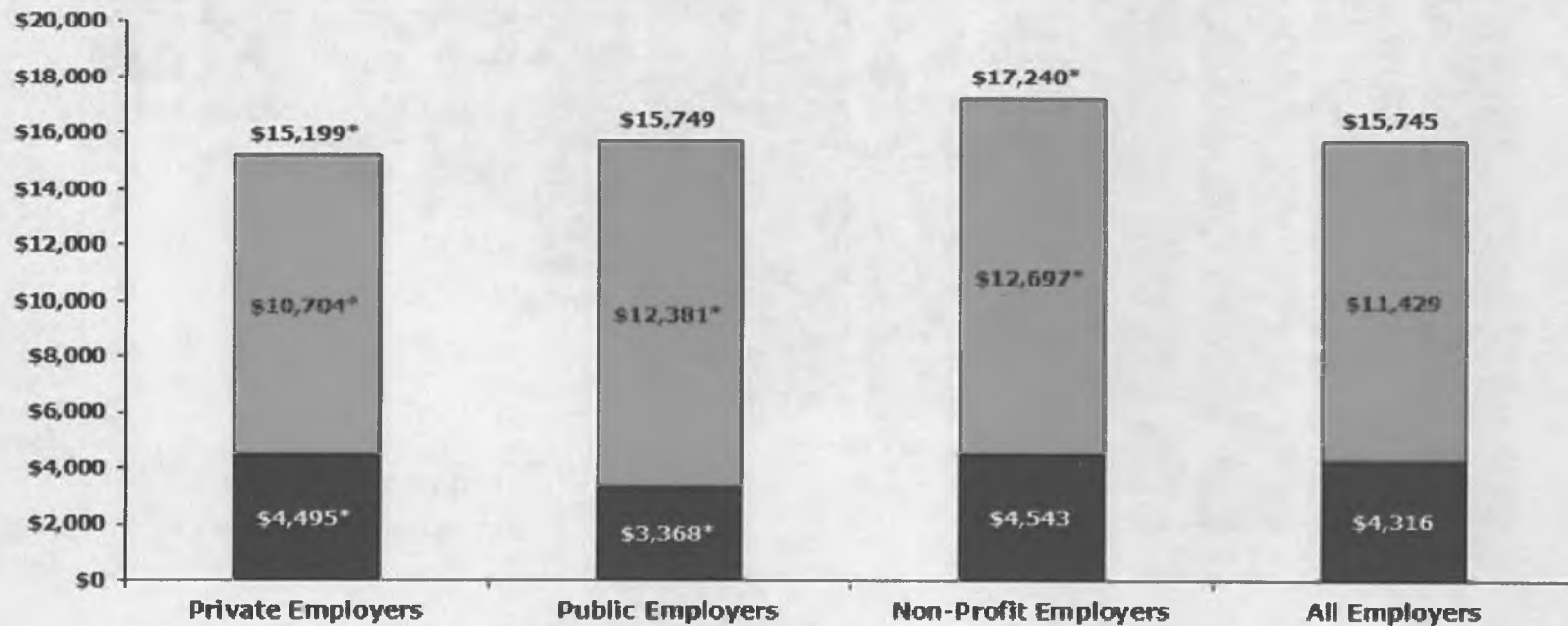
	Economy	Standard	Premium	Premium EE/ Standard Family
Medical Premium* (includes preventive dental)	\$1,330	\$1,447	\$1,945	\$1,657
State pays: (benefit credit)	\$1,330	\$1,330	\$1,330	\$1,330
Employee pays: (payroll deduction)	\$0	\$117	\$615	\$327

*Actual premiums may be higher depending on the level of vision and dental coverage selected.

- In 2012, Alaska was one of only four states to cover 100% of the premium for the lowest cost family insurance policy
Source: National Conference of State Legislatures, 2012
- The premium rates do not reflect plan experience
- Employees in the economy plan heavily subsidize those in the premium and standard plan
- Does not offer employee only coverage

US EMPLOYER & EMPLOYEE CONTRIBUTIONS

Worker and Employer Premium Contributions for Family Coverage, by Firm Ownership Category, 2012



* Estimate is statistically different from firms not in the indicated ownership category (p<.05).

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2012.

■ Worker Contribution
 □ Employer Contribution

US CONTRIBUTION TREND

Average Annual Worker and Employer Contributions to Premiums and Total Premiums for Family Coverage, 1999-2011



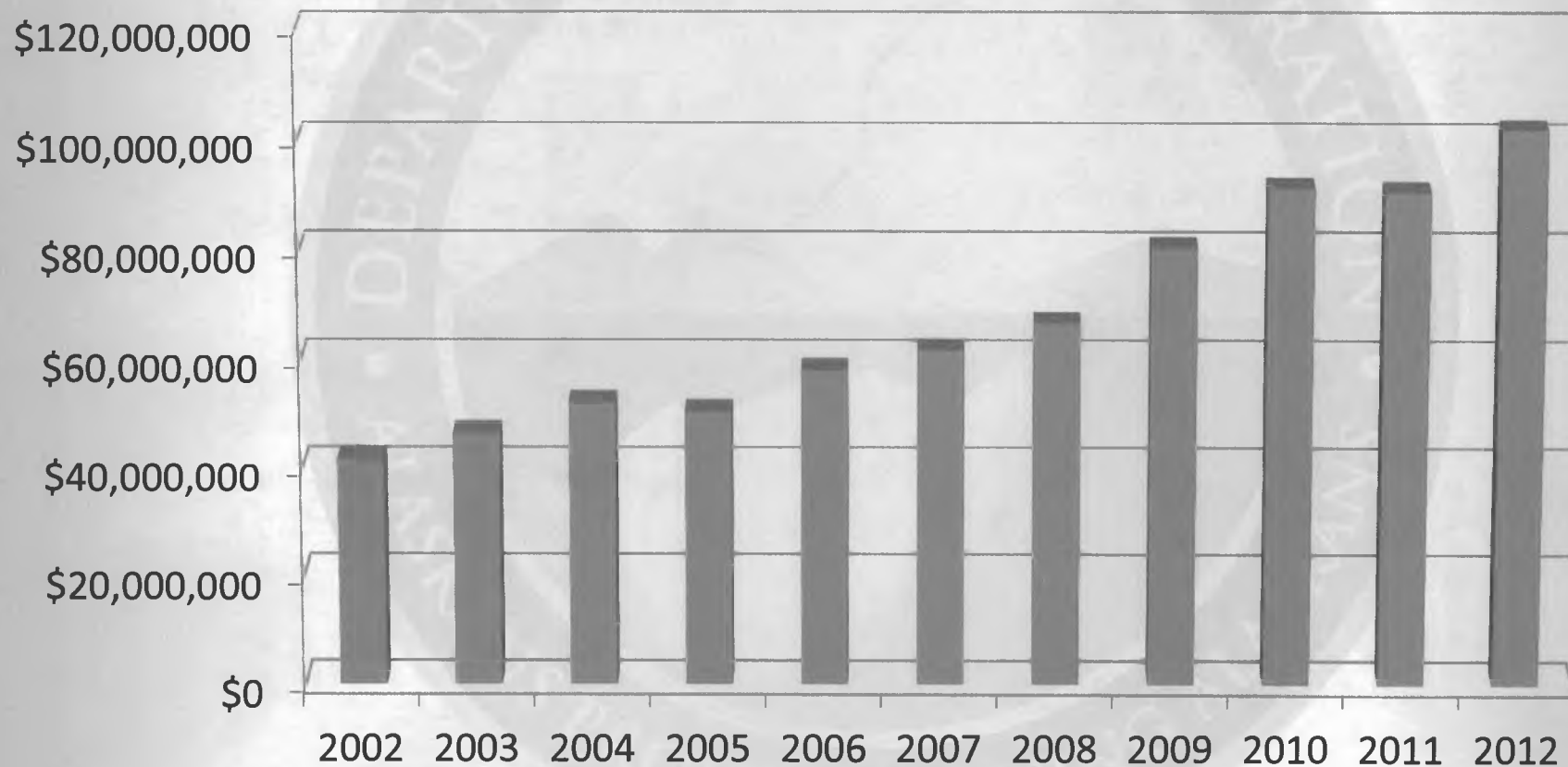
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2011.



PLAN EXPERIENCE

FY 2012 medical plan expenses were \$102,168,590



ACTIVE EMPLOYEE PRICE OF MEDICAL SERVICES

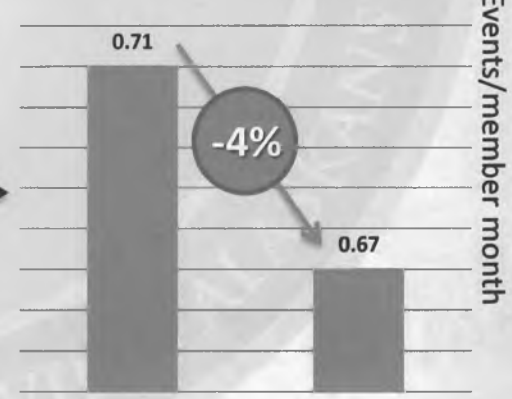
Change in Medical Per Member Per Month



Change in Unit Pricing

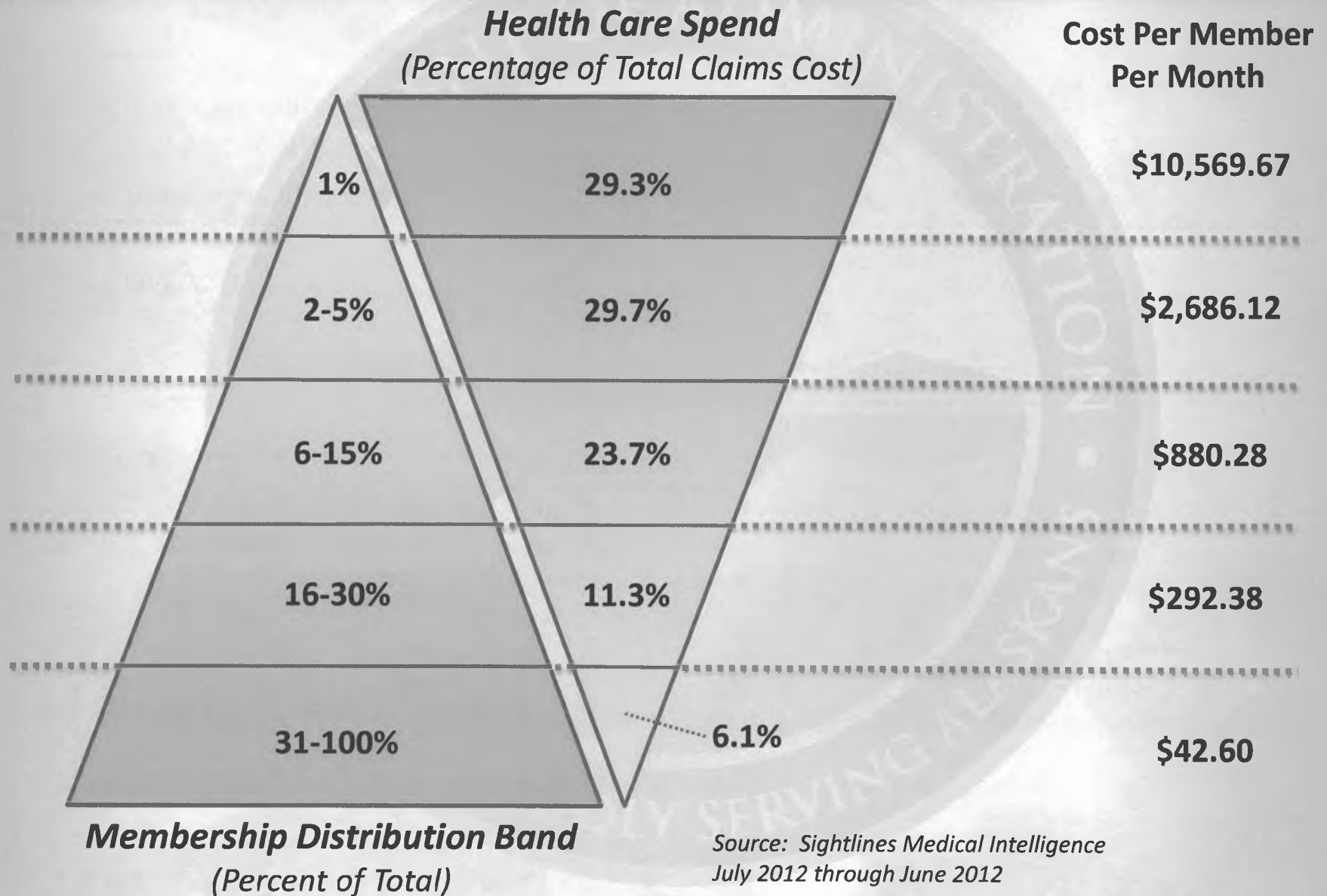


Change in Utilization



Source: Sightlines Medical Intelligence
July 2012 through June 2012

UTILIZATION OF SERVICES



PAYMENT COMPARISONS BY PROCEDURE

Procedure	Area 981 90% UCR (Washington) % Medicare	Area 995 90% UCR (Anchorage area) % Medicare
Total Hip Arthroplasty	\$5,409 305.2%	\$12,155 685.9%
Fragmenting of Kidney Stone	\$2,120 183.6%	\$8,200 710.1%
Nasal/Sinus Endoscopy, Surgery	\$871 235.4%	\$2,620 708.1%
Inject Spine L/S (CD)	\$683 312.4%	\$1,260 576.3%
RPR Umbil Hern, Reduc > 5 yr	\$1,229 232.1%	\$3,385 639.4%

Source: Ingenix claims data

PAYMENT COMPARISONS BY STATE

	AK	ID	ND	OR	WA	WY
Pediatrics	139%	91%	105%	128%	90%	86%
Family Practice	147%	96%	100%	118%	98%	88%
Internal Medicine	149%	96%	100%	117%	98%	90%
Lab	176%	89%	120%	88%	72%	131%
Ophthalmology	149%	95%	95%	122%	100%	87%
OBGYN	173%	94%	90%	112%	94%	111%
Chiropractic	172%	85%	105%	113%	89%	108%
Urology	183%	97%	95%	109%	92%	108%
Gastroenterology	191%	104%	84%	108%	87%	117%
Radiology	172%	107%	83%	88%	80%	143%
Neurology	186%	97%	100%	113%	95%	96%
Orthopedics	202%	96%	89%	104%	91%	121%
ENT	210%	98%	91%	106%	94%	109%
General Surgery	206%	95%	88%	104%	90%	125%
Cardiology	201%	98%	80%	108%	87%	124%
Cardiothoracic Surgery	N/A	N/A	N/A	106%	94%	N/A
Interventional Cardiology	474%	86%	104%	97%	84%	131%

Source: Milliman, Inc., 2011

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% of market share

Source: Institute of Social and Economic Research, UAA , 2011

The seal of the Department of Administration, State of Alaska, is centered in the background. It features a circular border with the text "DEPARTMENT OF ADMINISTRATION" at the top and "PROUDLY SERVING ALASKANS" at the bottom. Inside the circle is a stylized landscape with mountains and a river.

So is there a solution?

SERIGRAPH'S BACKGROUND

- Graphic parts manufacturing company in Wisconsin
- Costs increased 25% from 2002-2003
- Expected another 15% increase in 2004
- Used consumer driven approach to develop innovative solutions for health care

Source: The Company that Solved Health Care, 2010

SERIGRAPH'S PLATFORM

- **Consumer responsibility**

Established high deductible health care plan so employee had “skin in the game.”

- **Centers of Value**

Identified centers that provided service, quality, and competitive pricing and steered employees to those centers.

- **Prime role for Primary Care**

Developed on-site clinics to promote primary care and reduce inappropriate utilization of specialists.

Source: The Company that Solved Health Care, 2010

SERIGRAPH'S RESULTS

- Health care costs have dropped since 2004
- Cost curve averages 2.8% annual increase (parallel to inflation)

Compare to:

- National average annual increase is 7%
- AlaskaCare Employee plan average annual increase is 7% (from 2001 to 2011)

Source: The Company that Solved Health Care, 2010

INNOVATIVE APPROACHES

- Value-Based Health Plan
 - Uses financial incentives to encourage healthy choices and discourage unhealthy choices
- Consumer Directed Health Plan (CDHP)
 - Requires employee share in up-front costs
 - Provides lower monthly premiums
 - Increases price sensitivity by employees

VALUE BASED HEALTH PLAN

- In 2009, the State of Nebraska implemented the “Wellness Plan”
- Reduces employee’s share of costs for wellness, preventive and high-quality services
- Requires employees and spouses to complete series of tasks during prior 12 months
 - Health risk assessment
 - Health education course
 - Preventive visit to primary care physical

Source: Wellness Council of America, 2011

STATE OF NEBRASKA RESULTS

- Wellness plan offers much lower premiums than traditional plans
- 2010 & 2011 premium increase less than 1%
- Estimated ROI 2.7:1
- Savings attributed to reduced utilization of high cost services
- Employee participation above 30% in 2011

Source: Wellness Council of America, 2011

CONSUMER DIRECTED HEALTH PLANS

- In 2006, the State of Indiana implemented a Consumer Driven Health Plan (CDHP)
 - Individual deductible \$2,500
 - Family deductible \$5,000
 - State contributed 45% of deductible to Health Savings Account
- In 2007, a second CDHP plan was implemented with lower deductibles but higher premiums

Source: Indiana State Personnel Department

STATE OF INDIANA RESULTS

- Indiana saved money
 - CHDP 2010 savings were 10.7% or \$17-\$23 million
- Employees saved money
 - 2010 employees saved \$7-\$10 million
 - Unused funds were \$30 million
 - Average of \$2,000 per employee
- 2012 CDHP participation above 90%
- CDHP participants did not put off or avoid using important health care services

Source: Mercer Health and Benefits, 2010; National Governor's Association, 2012

OPPORTUNITIES FOR ALASKACARE

- Implementation of an employee wellness program
- Improved consumerism and appropriate utilization of services by our members
- Plan design changes to align payer, patient, and provider interests
- Contracting strategies
- Procurement of third-party administrator

BARRIERS TO SUCCESS

- Change is hard
- Benefit credit is bargained
- Implementation with limited resources
- Highly visible: operate in political context

VISION SLIDE

Our challenge:

*We must lower the rate of growth of our health care spend.
Our current path is not sustainable.*

Our approach:

- Work together with the hospital and physician community
- Support high-quality, cost-effective health care delivery in Alaska
- Develop and support innovative solutions to our health care challenges



Thank you!

Visit www.DOA.alaska.gov

for more information about our department.

Questions?