

ALASKA LEGISLATURE SPECIAL COMMITTEE/SUBJECT FILES 8672

3086 SCOMM 142: HOUSE SPECIAL COMMITTEE ON WAYS & MEANS 2005-2006

**Regularly Commissioned Public Safety Officers Unit (AA & AP)**

(AA) Classified, nonsupervisory employees of the Department of Public Safety who have primary responsibility for the prevention and detection of crime and the enforcement of State laws (i.e., fish and game, penal, traffic, or highway) and require certification as a police officer by the Alaska Police Standards Council.

(AP) Classified, nonsupervisory employees of the Department of Transportation and Public Facilities who have primary responsibility for international airport safety and fire protection and require certification by the Alaska Police Standards Council. The Public Safety Employees Association represents employees in both these bargaining units.

Health coverage through PSEA Health & Welfare Trust.

Health eligible members: 422



## AlaskaCare Health Plan Information

There are two health plans available to eligible employees and retirees of the State of Alaska.

The **Retiree AlaskaCare** (retired members) health plan covers medically necessary expenses at 80% of usual, customary, and reasonable charge after a \$150 individual, \$450 per family deductible. Routine services are not covered. Expenses for travel round trip to the nearest available medical treatment facility is available with pre-certification. Retail prescription drug copays are \$4 generic and \$8 brand for a 90-day or 100-unit supply. Mail order drugs have no copay. Mental health benefits are available at 50% without pre-certification and 80% with pre-certification.

Certain services require pre-authorization in order to be covered or pre-certification to receive the highest benefit. Coverage offers a network of participating providers and hospitals.

The **Select Benefits AlaskaCare** (active employees) health plan covers medically necessary expenses at one of the three options of coverage: 70%, 80%, or 90% of the usual, customary, and reasonable charge. The deductibles range from \$250 individual, \$500 family to \$500 individual, \$1,000 family. One routine annual exam is covered per year. Expenses for travel round trip to the nearest available medical treatment facility is available with pre-certification.

Retail prescription drug copay for a 30-day supply is 20% of the total cost of the drug with a minimum of \$8 and maximum of \$50. Copay for a 90-day supply is 20% of the total cost of the drug with a minimum of \$16 and maximum of \$100. Mail order drugs have a \$20 brand, \$8 generic copay for a 90-day supply. There is an annual maximum drug copay of \$1,000 per individual, \$2,000 per family after which drugs are purchased with no copay charged.

Mental health benefits are available at 50% without pre-certification or at the selected option's copay of 70%, 80%, or 90% with pre-certification. Certain services require pre-authorization in order to be covered or pre-certification to receive the highest benefit. Coverage offers a network of participating providers and hospitals with steerage to Providence Alaska Medical Center. Benefits are reduced by 20% for inpatient hospitalization at a facility other than Providence Alaska Medical Center in Anchorage and for any inpatient services provided in the remaining 49 states at nonparticipating hospitals.

Both AlaskaCare health plans became self-funded in 1997. NYLCare Health Plans Northwest was the first Third Party Administrator from 1997-2000. Aetna is the current Third Party Administrator from 2000-present.

## I. Population Demographics

| ACTIVE AlaskaCare Health Cost Analysis<br>June 2001-April 2005 |                            |       |       |       |                                   |
|----------------------------------------------------------------|----------------------------|-------|-------|-------|-----------------------------------|
| Demographics of active membership                              |                            |       |       |       |                                   |
|                                                                | June<br>2001-<br>Dec. 2001 | 2002  | 2003  | 2004  | January<br>2004-<br>April<br>2005 |
| Number of Employees                                            | 4,550                      | 5,582 | 5,563 | 5,513 | 5,505                             |
| Number of Dependents                                           | 8,617                      | 9,775 | 9,316 | 9,049 | 8,954                             |
| Ratio of Dependents to Employees                               | 1.9                        | 1.8   | 1.7   | 1.6   | 1.6                               |
| Percent Male Members                                           | 49.8%                      | 49.9% | 50.1% | 49.9% | 49.8%                             |
| Percent Female Members                                         | 50.2%                      | 50.1% | 49.9% | 50.1% | 50.2%                             |
| Average Age – Employee                                         | 45                         | 44    | 44    | 45    | 45                                |

| RETIREE AlaskaCare Health Cost Analysis<br>June 2001-April 2005 |                            |        |        |        |                                   |
|-----------------------------------------------------------------|----------------------------|--------|--------|--------|-----------------------------------|
| Demographics of retiree membership                              |                            |        |        |        |                                   |
|                                                                 | June<br>2001-<br>Dec. 2001 | 2002   | 2003   | 2004   | January<br>2004-<br>April<br>2005 |
| Number of Retirees                                              | 22,463                     | 23,967 | 25,345 | 26,672 | 27,485                            |
| Number of Dependents                                            | 22,830                     | 22,881 | 23,299 | 24,668 | 24,709                            |
| Ratio of Dependents to Retirees                                 | 1.0                        | 0.95   | 0.92   | 0.92   | 0.90                              |
| Percent Male Retirees                                           | 47.1%                      | 47.1%  | 47.0%  | 47.1%  | 46.9%                             |
| Percent Female Retirees                                         | 52.9%                      | 52.9%  | 53.0%  | 52.9%  | 53.1%                             |
| Average Age – Retiree                                           | 63                         | 63     | 64     | 64     | 64                                |

## II. Cost Drivers in Alaska

In July 2005, Commonwealth North issued a report titled, "Alaska Primary Health Care: Opportunities and Challenges." Highlights of the report conclude the following (attached):

- Approximately 110,000 Alaskans have no health insurance coverage.
- Thousands are turning to hospital emergency rooms as a source of primary care many without ability to pay.
- Inadequate health care in remote areas is a significant logistical, financial and educational challenge.
- Alaska health care costs are approximately 40% higher than Seattle (per Premiera, corroborated by Providence and Alaska Regional).
- Alaska hospitals are losing tens of millions of dollars from uncollectible accounts arising from excessive emergency room use and they are unable to reduce the amount of emergency room care provided due to Federal law (see attached).

### III. Cost Drivers Specific to AlaskaCare Health Plans

Growth in enrollment: Retirees increased from 45,293 members to 52,194 from December 2001 to April 2005. Medical enrollment increased 5.3% and Dental-Vision-Audio (DVA) enrollment increased 6.2% on a year over year basis. Most of the growth represents retirees who are under the age of 65. This population often receives a richer benefit as a retiree than they had as an active employee. Between 1,800 to 2,000 members retire annually and receive system-paid medical benefits for themselves and eligible dependents.

Active membership increased from 13,167 members to 14,459 from December 2001 to April 2005.

Increase in claim costs: There continues to be an increase in claims per employee/retiree. The lines of coverage that hold the largest increase in claim dollars from one fiscal year to the next are medical services and prescription drugs. Claims per employee/retiree increased 5.5% for medical and 13.1% for prescriptions, annually, trended after growth has been factored out. The plan's experience continues to be lower than the national trend averages across the board.

The retiree plan's increase can be broken down into the following categories:

|          |                        |
|----------|------------------------|
| \$15.7M  | Medical                |
| \$ 0.4M  | Mental Health Services |
| \$11.9M  | Prescription Drugs     |
| \$ 1.2M  | Dental                 |
| \$ 0.2M  | Vision                 |
| -\$0.09M | Hearing                |

Utilizing network providers can reduce medical costs, however, Alaska has relatively few providers who participate. Prescription drug costs can be decreased by many different mechanisms. The active population pays a percentage of their drug costs, which provides incentive for them to choose the most cost-effective method to purchase their drugs. The retirees have little incentive to control their drug costs due to minimal copay combined with coordination of benefits (COB) which also reimburses the retiree for the copay amount as well. Retirees do not pay anything for their prescriptions if they use the mail order pharmacy service or if both retiree and spouse cover each other under dual AlaskaCare retiree plans.

As technological advances in medicine are made, the increase in medical costs is proportionate to the new technology's utilization.

The accrued liability to the retirement systems for medical costs to retirees represents 37% for PERS and 31% for TRS.

Seventy-five percent of the retiree medical costs are incurred for pre-65 members. The costs are reduced to 25% for post-65 medical costs because this is when the AlaskaCare Plan coordinates with Medicare.

## IV. Authority

### Active Health Plan--Authority Source

#### AS 39.35.090 Group Life and Health Insurance

(a) The Department of Administration may obtain a policy or policies of group insurance covering State employees, persons entitled to coverage under AS 14.25.168, AS 22.25.090, AS 39.35.535 or former AS 39.37.145, employees of other participating governmental units, or persons entitled to coverage under AS 23.15.136, subject to the following conditions:

- (1) A group insurance policy shall provide one or more of the following benefits: life insurance, accidental death and dismemberment insurance, weekly indemnity insurance, hospital expense insurance, surgical expense insurance, dental expense insurance, audiovisual insurance, or other medical care insurance.
- (2) Each eligible employee of the State, the spouse and the unmarried children chiefly dependent on the eligible employee for support shall be covered by the group policy, unless exempt under regulations adopted by the commissioner of administration.

#### 1978 AG Opinion File No. J-66-444-78

##### Health and Retirement Bargainability

It was determined that AS 39.30.090 does not specify what levels of coverage or benefits must be included in the policy (or policies) obtained, we believe the issue of group life and health insurance benefits is negotiable under PERA. The labor relations section for the State of Alaska does not bargain the plan design changes. The only provision that is bargained deals with the increased premium amounts for the active health plan (Select Benefits). Health care plan design changes are the purview of Scott J. Nordstrand, Commissioner of Administration.

The active employee "Select Benefits" Health Plan is referred to as the Commissioner's Plan. The Commissioner has authority to determine and make plan changes.

### Retiree Medical Plan--Authority Source

#### PERS - AS 39.35.535 Medical Benefits

(a) Except as provided in (d) of this section, the following persons are entitled to coverage if a benefits recipient elects major medical insurance coverage under this section:

- (1) a person receiving a monthly benefit from the system.

- (2) the spouse of a person receiving a monthly benefit from the system.
- (3) a natural or adopted child of a person receiving a monthly benefit from the system, if the dependent child as defined in AS 39.35.680.

#### TRS – AS 14.25.168 Medical Benefits

- (b) Except as provided in (c) of this section, the following persons are entitled to coverage if a benefits recipient elects major medical insurance coverage under this section:
  - (4) a person receiving a monthly benefit from the system
  - (5) the spouse of a person receiving a monthly benefit from the system
  - (6) a natural or adopted child of a person receiving a monthly benefit from the system, if the dependent child as defined in AS 14.25.220.

The Commissioner of Administration has the authority to determine and make changes to the retiree "AlaskaCare" Health Plan.

#### **Legal Constraints Regarding Making Changes – Retiree Health Plan**

Alaska State Constitution, Article 12 Section 7.

Membership in employee retirement systems of the State or its political subdivisions shall constitute a contractual relationship. Accrued benefits of these systems shall not be diminished or impaired. Retired State workers are protected by this section from the loss or reduction of retirement benefits due them.

In 1999, the Commissioner approved seven changes to the retiree health plan. Each of the changes had advantages with corresponding disadvantages to the benefits for the retiree membership. The changes were intended to be offsetting and cost neutral to the plan. RPEA (Retired Public Employees' Association), ASEA and NEA brought suit regarding the plan design changes.

In 2003, the Alaska Supreme Court held that (1) health insurance benefits are benefits protected from diminishment or impairment by the Alaska Constitution; (2) Constitution protects health insurance benefits themselves rather than the costs of those benefits; and (3) when determining if changes were reasonable to pass constitutional muster, *comparative analysis of disadvantages and compensating advantages of changes to health insurance benefits must be made* [Emphasis added] by focusing on the entire group of employees rather than the individuals.

This case has been remanded back to the Superior Court to analyze the plan changes based on the Supreme Court's ruling and determine damages, if any, regarding these changes (scheduled for trial in January of 2006).

## V. Cost Containment Initiatives

The Division works has a task force that reviews and recommends cost containment initiatives for the Select Benefits and Retiree AlaskaCare health plans. This task force is the Health Benefit Evaluation Committee, a labor taskforce consisting of union members selected who meet in accordance with Article 28 of the Supervisory Contract on a quarterly basis to discuss options for decreasing health costs to the Select Benefits plan.

The Health Benefit Subcommittee was a subcommittee of the PERB and TRB boards. This group would discuss options regarding the Retiree AlaskaCare plan, until June 30 when their duties were dissolved by SB 141 legislation. For example, this group initiated the generic drug campaign, which has been successful in reducing drug costs by moving members to generic drugs from Brand name drugs. The Alaska Retirement Management Board, which replaced the PERB and TRB, has decided to have a Health Subcommittee.

### Active AlaskaCare Plan Initiatives

**2003** - Increase in prescription drug copay to a percentage of the total cost of the drug rather than a flat dollar amount for active employees. Utilizing this type of benefit rather than a dollar copay amount, regardless of the price of the drug purchased, provides incentive for the member to choose carefully when deciding whether to purchase a brand drug versus a less expensive generic equivalent, if their provider is in agreement that the generic is sufficient to treat their condition. Aetna estimated the savings at \$8-9 per employee per month. This plan provision change has demonstrated its success associated with cost containment for rising prescription drugs.

**2003** - Coordination of Benefits methodology was revised. This was initiated as a result of State Health Trusts offering a 30% plan to their employees who had secondary coverage. The implication of this offering is that costs would be shifted from the Health Trust plans to another plan covering the family. Where the normal course would be for the primary plan to pay their portion and the coinsurance amount would be paid by the secondary plan, these 30% plans would have paid only 30% of a primary benefit and the secondary plan (many are AlaskaCare members) would have been burdened with the 70% cost remaining. Regulations were amended to curtail this cost shifting to the active plan's population. Estimated savings at \$750,000 in transferred claims.

**2004** - The active plan took several steps to reduce health care expenditures last year. Treatment guidelines for morbid obesity were revised to more restrictive requirements. Aetna estimated the savings based on 35 patients per year to be approximately \$350,000 annually.

Effective July 1, 2005, a hospital-only preferred provider agreement was made effective for hospital services in the Municipality of Anchorage and in the remaining 49 states. A 20% reduction in benefits for utilizing a nonpreferred hospital was an incentive to receive services from a preferred hospital. This steerage has produced plan savings. Deloitte estimated the savings to be approximately \$400,000 to \$600,000 annually.

**2005** – Elimination of the coordination of benefit savings bank occurred this year. Although a dollar figure was not provided in potential savings, there will undoubtedly be savings realized. COB savings was a mechanism that rationalized if an AlaskaCare plan was a secondary plan, yet a member was paying a full premium for a small percentage of benefit, then members were not realizing a full benefit of the premium amount paid. As claims processed through the plan, a portion of the realized savings were "banked" and then rebated back to the member to repay the deductible and coinsurance amounts charged by the plan. The amount of "banked" savings paid the member additional dollars over and above the original charge for the medical services. When Deloitte conducted its audit in 2004, one recommendation included that the COB savings bank be eliminated.

In May and June positive open enrollment was conducted for all members of Select Benefits AlaskaCare. This required all members to positively enroll and provide documentation proving that the dependents enrolled are in fact eligible dependents. Industry standards estimate that plans that undertake this initiative find that on average 15% of the plan's covered members are unable to provide the necessary documentation.

The State has never had a positive open enrollment for its Select Benefits Plan. Additionally, as a tax qualified health plan, the Division must be able to provide documentation ensuring that only qualified members receive benefits under this plan. Positive open enrollment will be scheduled at regular intervals in the future.

The preliminary results of the positive open enrollment for the Select Benefits Plan indicate 1,243 or 13.6% of dependents previously enrolled were not enrolled as of July 1, 2005. This represents baseline information as of July 1, 2005, and is subject to change as eligibility documentation is verified. The Division is allowing a 60-day grace period, through August 30, for employees to provide necessary documentation, with coverage retroactive to July 1, 2005. Based on the above figures, it is estimated that the cost savings to the plan will be approximately \$3 million annually.

Deloitte Consulting has been requested to provide an analysis of implementing a high deductible health plan combined with a health savings account component as requested in introduced legislation, namely SB94. The Division awaits this analysis to provide further potential cost savings information.

Noted below are the premium Increases, trend projections and Aetna Corporate Trends:

|                                         | <b>FY05</b>          | <b>FY06</b>                 | <b>FY07</b>              |
|-----------------------------------------|----------------------|-----------------------------|--------------------------|
| Plan Actual Percentage Premium Increase | 5.7%                 | 10.5%                       | 2.0%                     |
| Active AlaskaCare Trend                 | 7% Medical<br>20% RX | 10-14% Medical<br>12-15% RX | 2-6% Medical<br>6-12% RX |
| Aetna Corporate Trend                   | 13% Medical<br>15 RX | 16% Medical<br>15% RX       | 18% Medical<br>14.5% RX  |

Noted below are the active plan claims costs for FY 2005 through FY 2000.

| <b>Health Claims Cost by Fiscal Year</b> | <b>Amount</b> |
|------------------------------------------|---------------|
| FY2005                                   | \$49 Million  |
| FY2004                                   | \$49 Million  |
| FY2003                                   | \$45 Million  |
| FY2002                                   | \$44 Million  |
| FY2001                                   | \$80 Million  |
| FY2000                                   | \$64 Million  |

### **AlaskaCare Retiree Health Plan**

The AlaskaCare Retiree plan faces challenges in containing health care costs due to the provisions noted under Section III. Some initiatives have been undertaken due to mandatory State and federal regulatory compliance.

**2004** - Retiree AlaskaCare members were required to submit proof of full-time student status at an accredited educational or technical institution recognized by the Department of Education and Early Development for their dependents between the ages of 19 and 23. Prior to this date, coverage was extended to dependents up to age 23 regardless of full time student status. Approximately 1,000 dependents were removed from eligibility on January 1, 2005, when members failed to provide supporting student documentation. The potential savings to the plan based on \$3,034.20 claim dollars paid per dependent in FY04 is \$3.03M.

**2005** – Gastric Bypass Surgery criteria was amended in order to require members to meet stricter standards prior to the surgery being pre-authorized. Aetna estimated the savings based on 35 patients per year to be approximately \$350,000 annually.

**2005** - Elimination of the coordination of benefit savings bank occurred this year. Although a dollar figure was not provided in potential savings, there will undoubtedly be savings realized. COB savings was a mechanism that rationalized if an AlaskaCare plan was a secondary plan, yet a member was paying a full premium for a small percentage of benefit, then members were not realizing a full benefit for the premium

amount paid. As claims processed through the plan, a portion of the realized savings would be "banked" and then rebated back to the member to repay the deductible and coinsurance amounts charged by the plan.

This amount of "banked" savings would often pay additional monies over and above the original charge for the medical services. In the case of retirees who have Medicare as their primary health plan, the AlaskaCare plan's reimbursement for COB savings occasionally included monies paid to the retiree over and above the amount charged by the provider and in excess of the amount Medicare authorizes the provider to collect on behalf of the retiree. When Deloitte conducted its audit in 2004, one recommendation included that the COB savings bank be eliminated.

**2005 - Retiree Eligibility Verification** is scheduled to begin November through January 2006 and become effective January 2006. The State has never required dependent eligibility verification for retirees covered under the AlaskaCare Plan. It is estimated that this initiative will result in annual cost savings of \$16 million.

**2005 - Subrogation of third party liability claims** is being undertaken for both the active and retiree plans. Previous to this method being used, there was little or no oversight of these health care dollars that may have been the responsibility of a third party, such as with medical claims incurred due to an automobile accident or personal property settlements. The cost to the plan is 27% of any monies collected, however, that represents 73% more than the plan realized previously in subrogated claims payments.

**Generic Drugs** - Generic drug utilization versus Brand name drugs increased from 36% for the active plan in 2001 to 48% in 2005. For the retiree plan, generic drug utilization increased from 35% in 2001 to 45% in 2005 (most plans do not rise above 50% for generic drug usage). Continued education and encouragement to the membership to utilize generic equivalent drugs is an ongoing campaign. For the retiree plan every 1% movement from Brand name drugs to generic represents a \$1 million savings to the plan.

**Network Savings** - Aetna as the Third Party Administrator for the State of Alaska's health plans has established a comprehensive network system with providers and health facilities. Members who receive services from preferred providers or facilities that are in the network system-represent millions of dollars of savings to both plans each year. The State has negotiated with Aetna to meet certain performance guarantees through the use of network providers and facilities in order to increase the savings amount.

**Medicare Part D** - The Retiree Drug Subsidy, part of the Medicare Modernization Act of 2003, will provide a 28% subsidy of qualified retiree drug costs back to the plan if the plan maintains the same level of drug benefit available today. Because the AlaskaCare health plan provides a better benefit than Medicare's Part D drug plan, CMS will pay the State up to 28% of eligible costs for maintaining prescription drug coverage for Medicare participants.

The electronic application process became available on August 1. The Division has been successfully approved to participate in the subsidy program and payments back to

the retiree health trust fund are expected to begin in February of 2006. As retiree's drug expenses alone in 2005 were \$96M, the potential if a mere 10% of the plan's drug expenditures for this population qualifies for the subsidy, the payment back to the plan is projected to be \$7M annually.

Noted below are the retiree health plan premium increases, trend projections, and Aetna corporate trends:

|                                         | CY04                  | CY05                       | CY06                      |
|-----------------------------------------|-----------------------|----------------------------|---------------------------|
| Plan Actual Percentage Premium Increase | 12.0%                 | 5.5%                       | 3.0%                      |
| Retiree AlaskaCare Plan                 | 13% Medical<br>15% RX | 6-10% Medical<br>12-14% RX | 3-5% Medical<br>20-22% RX |
| Aetna Corporate Trend                   |                       | 15-16% Medical<br>15% RX   | 18% Medical<br>14.5% RX   |

Noted below are the retiree plan claims costs for FY 2005 through FY 2000:

| Health Claims Cost by Fiscal Year | Amount        |
|-----------------------------------|---------------|
| FY2005                            | \$256 Million |
| FY2004                            | \$226 Million |
| FY2003                            | \$205 Million |
| FY2002                            | \$148 Million |
| FY2001                            | \$128 Million |
| FY2000                            | \$106 Million |

*How do these initiatives impact the overall costs for the health plans?*

These initiatives act to reduce the claims cost for each of the plans, which in turn reduces the percent of increase in the annual premium amount established for the active and retiree health plans. To calculate the annual premium increase for each of the plans, Deloitte uses the prior year *claims cost*, national trend, and cost savings measures to arrive at the premium increase for that fiscal (active plan) and calendar year (retiree plan).

For example, beginning on July 1, 2005, the active plan implemented a Preferred Provider Option (PPO) and changed the criteria associated with gastric bypass surgeries to be more stringent. As a consequence, Deloitte estimated 4.0% savings to the health plan from the two changes. This reduced the FY05 premium increase to 5.7%. In the absence of the two plan changes the premium increase as recommended by Deloitte would have been 10% for FY05.

For the retiree plan, the claims cost for CY04 was lower than that projected by Deloitte, which resulted in a premium increase of 5.5% for CY05 as compared with 12% for CY04. In summary, plan changes and dependent verification for the active and retiree

health plans act to reduce the annual year-after-year premium cost increases and *help slow the escalation of health care costs* [emphasis added] associated with these health plans.

*How does the Alaska Retiree Health Plan compare with other state retiree health plans?*

The short answer is "favorably." The retained actuary conducted a robust analysis in 2004 as part of the Tier redesign study associated with the medical plan and the resultant costs to provide medical coverage to eligible retirees. The actuary concluded that the benefits provided to retirees are "rich" when compared to their other clients. 37% of the PERS accrued unfunded liability is attributed to medical costs. This amount is 31% for TRS.

Workplace Economics conducted a study that was issued in 2004. The study reviewed 50 states regarding retiree medical coverage. The report (attached) indicates what percentage of states and what level of retiree medical coverage is provided. The percentage noted below are for the pre-65 health care coverage:

- 24% of states provide access only to health care; the retirees must pay 100% of the premium
- 44% of state's cost share with employees (i.e., low plan \$159 per month to \$925 per month)
- 32% of states pay all of the premium

## **Trends by National Government and Employers / Plans to Reduce Claims Costs**

On a federal or national level there are things like EMR/EHR (Electronic Medical/Health Records - CMS is giving physicians free software), and review/accreditation organizations trying to provide information (AHRQ, NCQA-HEDIS, JCAHO, URAC, Leapfrog, eValue8, etc).

On an Employer/Plan perspective, some initiatives would include:

- Prescription Drug Initiatives
  - Increase generic usage via education or voucher programs\*
  - Specialty drug network for serious/chronic conditions, typically injectables
  - Step Therapy or prior approval for certain drugs \*\*
  - Further restricting formulary \*\*
- High Deductible Health Plan (HDHP) with Health Savings Accounts \*\*
- Disease Management and enhanced disease management (expanding conditions managed) for active members \*\* can be part of HDHP
- Incentives for Wellness Programs (i.e., Health Risk Assessments) \*\* can be part of HDHP
- Centers of Excellence (Transplant, Cardiac, Bariatric Surgery, Cancer)\*\*
- Further restricting networks (most often using Tiered Networks)
- Health Advocate Programs
- Consumer Education (Transparency of Costs) \*\*

The State of Alaska has implemented the items identified above by \*. Further, the items identified above as \*\* are in the process of being researched/studied for possible future implementation.

# **COMMONWEALTH NORTH**

## **Alaska Primary Health Care: *OPPORTUNITIES & CHALLENGES***

Approved by the Board of Directors on June 7, 2005  
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## **EXECUTIVE SUMMARY**

### **Why Alaska health care issues must be addressed and solved**

Health care is not a goal or end in itself. The ultimate goal of health care and of this study is health and wellness for Alaskans. Alaskans must identify and improve the aspects of health care that are under our control. Many health care issues are national, that Alaskans cannot affect. Therefore, it is even more important to address and solve issues we can do something about. Furthermore, the demographics of an aging population will put foreseeable pressure on all fronts.

### **ACCESS**

- Approximately 110,000 Alaskans have no health insurance coverage.
- Many others have minimal or inadequate coverage.
- Thousands are turning to hospital emergency rooms as a source of primary health care, often without ability to pay.
- Adequate health care in remote areas is a significant logistical, financial and educational challenge.

### **QUALITY**

- Based on the 2004 National Healthcare Quality Report, Alaska has low rankings in several key measures of cancer, heart disease, maternal and child health, respiratory diseases, and nursing and home health care.
- Many Alaskans are in high-risk health categories, many are not receiving adequate care.

### **COST**

- Alaska health care costs are approximately 40% higher than Seattle (per Premera, corroborated by Providence and Alaska Regional)
- Medicaid costs to the State of Alaska are rising dramatically, to over \$1 billion in 2005. It is placing a strain on the state budget.
- Health care insurance premiums are also rising dramatically, creating a significant burden on employers and employees.
- Alaska hospitals are losing tens of millions of dollars from uncollectable accounts arising from excessive emergency room use and they are unable to reduce the amount of emergency room care provided due to Federal law.

### **What can we do?**

There are four major interrelated factors driving primary healthcare in Alaska today:

1. Health and wellness of the population
2. Availability of care and insurance
3. Affordability of care and insurance
4. Financial health of the stakeholders, such as employers, providers and individuals

These drivers are currently interacting in a "cost spiral" that is creating a very serious situation nationally and in Alaska. The rate of increase in the cost of health care is unsustainable—if unchecked health care increases will price employers out of the market. Already industries such as automobiles are threatened. We need to avoid similar impacts in Alaska.

We believe that with focus and coordination Alaskans can impact this "cost spiral" positively through specific actions in the four areas mentioned above:

1. Lifestyle and prevention: Raise public awareness and increase personal responsibility for wellness
2. Access: Make services and insurance more widely available
3. Quality: Continue improving quality of care that is delivered
4. Costs: Reduce costs of service delivery and insurance to make them more affordable

There are many health care initiatives already underway in these areas by various governmental and non-governmental entities. Some have proven to be effective and cost-efficient. Others show significant promise. Health care reform is complex and controversial, with multiple players and competing interests. Inconsistent tracking and trending create significant factual disputes about healthcare systems. Any major reform has potential to create both winners and losers.

Given this environment, the Study Group came to three overarching conclusions:

1. The Study Group process itself has been enlightening, educational and productive.
2. Every aspect of health care is complex. Understanding the system and improving it is beyond the capacity of any one element within the system.
3. The Study Group recommends that an ongoing body be established to continue and deepen this Group's work.

The time to act is now. Involvement of Alaskans in the health care debate is vital. Reform of some sort is inevitable, and Alaskans should control it as much as possible to our own benefit. Since there is no single forum today where the disparate players can come together to agree on facts, share solutions and craft a win-win for our unique Alaskan conditions, this Study Group recommend formation of—

### **The Alaska Health Care Roundtable ("Roundtable")**

The goals of the Roundtable are to continue communication and foster action among parties that have a long-term vested interest in health care reform. It must set a standard of credibility and create timely actionable ideas that can gather bipartisan support, get quick approval and become part of a long-term fiscal plan for Alaska. It would be a sounding board and facilitator for ideas and recommendations, with a focus on lifestyle and prevention, access, quality and cost.

The core membership in the Roundtable would be self-selecting, comprised of members with a long-term compelling interest in improving the Alaska health care system. Examples of core members would be major employers at risk, health care providers and local foundations. A wide variety of other potential members, resources and ad hoc participants could be included as needed. Funding would be by voluntary contributions by the participants and the community.

## INTRODUCTION

### The big picture: National background issues and the state of health in the U.S.

While the focus of this study is factors controllable in Alaska, it is important to understand the national context in which we operate. The United States spends more on health care than any other country, measured either as a percentage of gross domestic product, or in terms of money spent per person. The OECD, or Organization for Economic Cooperation and Development, is a group of industrialized nations that are an appropriate benchmark for U.S. expenditures and performance.

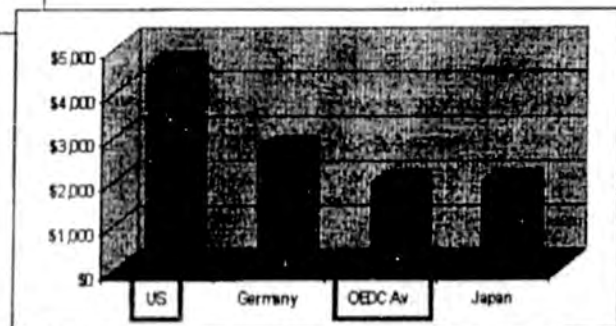
## The National Situation - Spending



Source: Commonwealth Fund

OECD—Organization for  
Economic Cooperation and  
Development

Per capita health care expenditures by country



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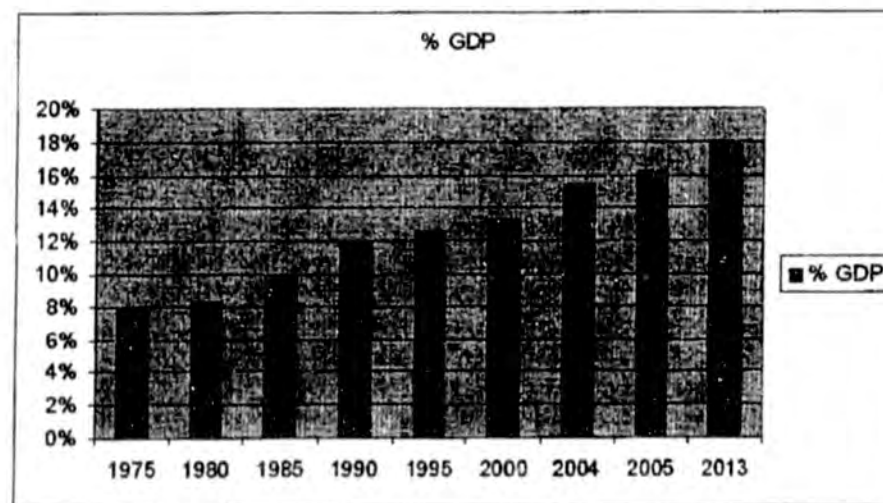
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Health care spending has risen dramatically in recent years, increasing from about 8 % of the gross domestic product in 1975 to over 16% today. The Commonwealth Fund, a private nonpartisan foundation that supports independent research on health and social issues, projects that by 2013 the U.S. will be spending 18% of GDP on health care.

Many factors contribute to these increases. Often cited are huge costs caring for the last three months of life, advertising driven consumerism, high cost of technology, defensive medicine practiced to avoid malpractice suits, malpractice insurance, a fractionated payment system and massive cost shifting to those able to pay caused by inadequate or no health insurance for many Americans (and Alaskans). The crushing cost of health care threatens whole industries and affects our worldwide ability to compete economically.

## The National Spending Situation: Trend in Healthcare Costs as a % of GDP



Source: Commonwealth Fund

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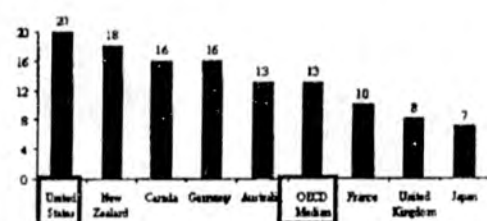
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The **Commonwealth Fund** is a foundation specializing in health care issues.

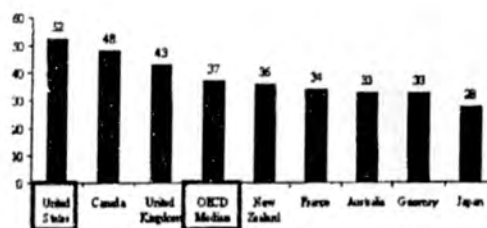
In terms of outcomes, the United States has obtained poor results from the massive amounts invested. By many measures, the U.S. trails other industrialized nations, as represented by Organization of Economic Cooperation and Development averages. We also have a higher percentage of uninsured than most advanced countries, which tend to have centralized health care systems.

## The National Situation: Outcomes



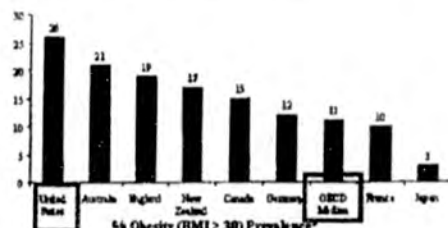
Age-Standardized Mortality Rates for Diabetes Mellitus per 100,000 Population in 1999<sup>34</sup>

### DIABETES



Age-Standardized Mortality Rates for Lung Cancer per 100,000 Population in 1999

### LUNG CANCER



### OBESITY

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And, the U.S. ranks only

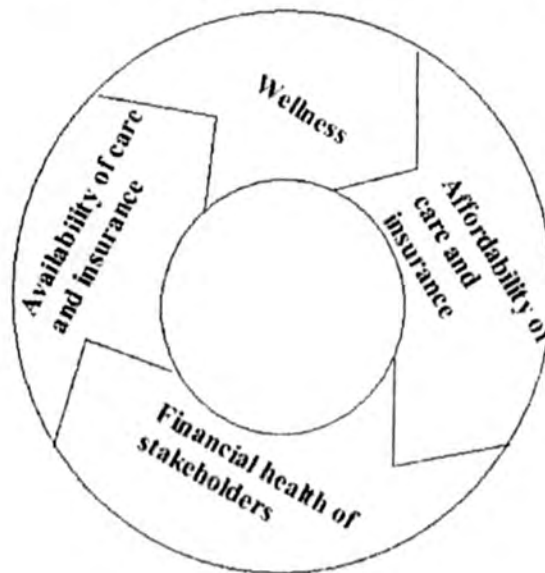
- #28 overall in infant mortality
- #24 in life expectancy

Sources: OECD Health Data 2002,  
March of Dimes Data Center 2002  
World Health Organization 2000

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A conceptual framework of four primary healthcare factors can help us understand how all the different factors are interrelated.

## Four Primary Healthcare Factors and how they are interrelated



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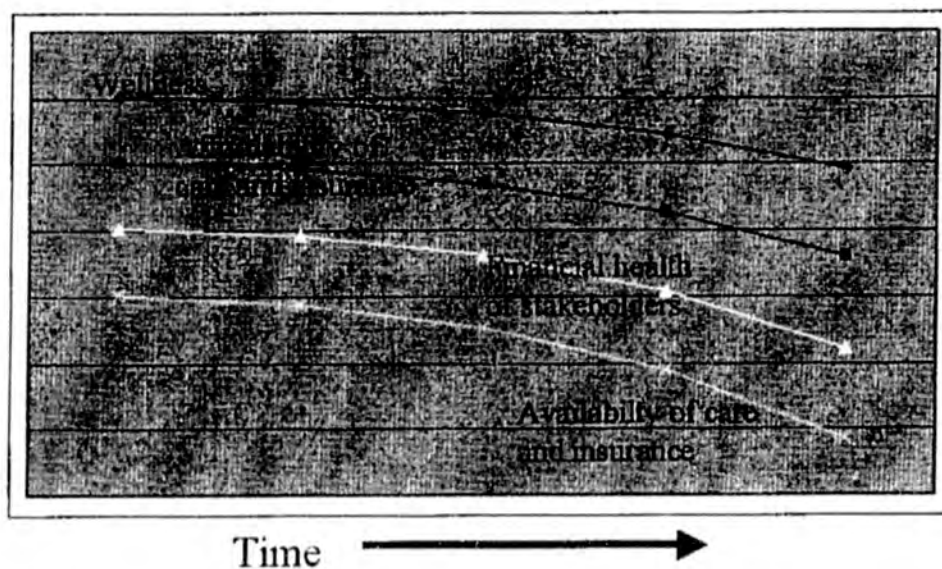
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- Wellness of the population
- Affordability, coordination and quality of care and insurance
- Availability of care and insurance
- Financial health of stakeholders including:
  - Health care providers (physicians, clinics, hospitals)
  - Companies, institutions and government

These factors are all part of a complete cycle. Each factor affects the other. Therefore they are portrayed in a circle.

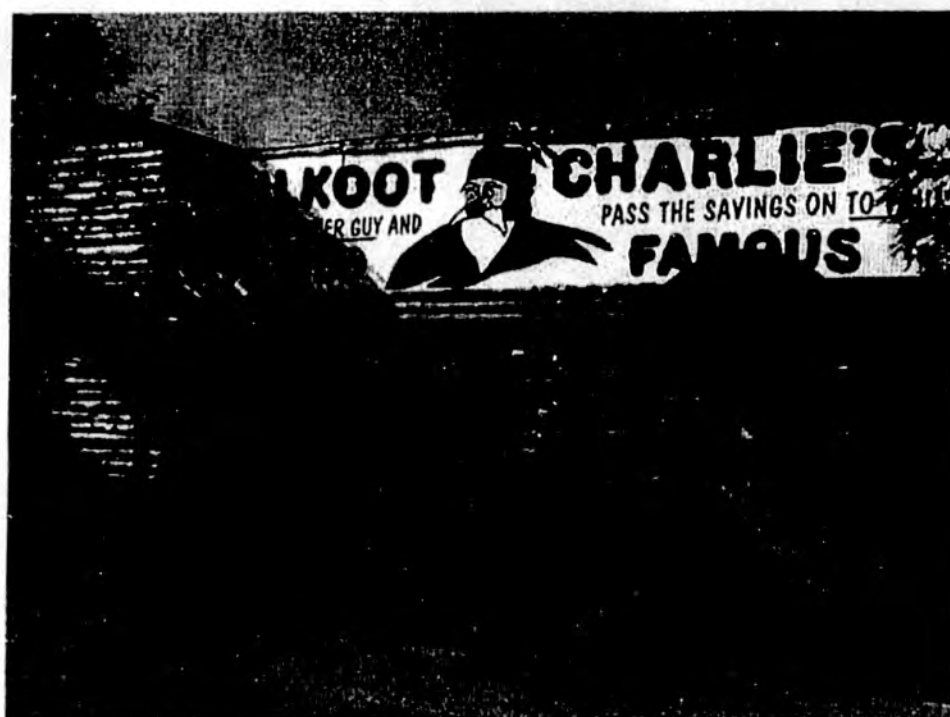
As time goes on, each of these factors influences the others, with the ultimate result of either undermining or improving the health and wellness of our people.

## The conceptual crux of the problem



A significant problem is a de facto dynamic in our current U.S. health care policy.

The motto of a popular Alaska establishment embodies this unintended and unwanted de facto policy, to wit—



“We cheat the other guy and pass the savings on to you!”

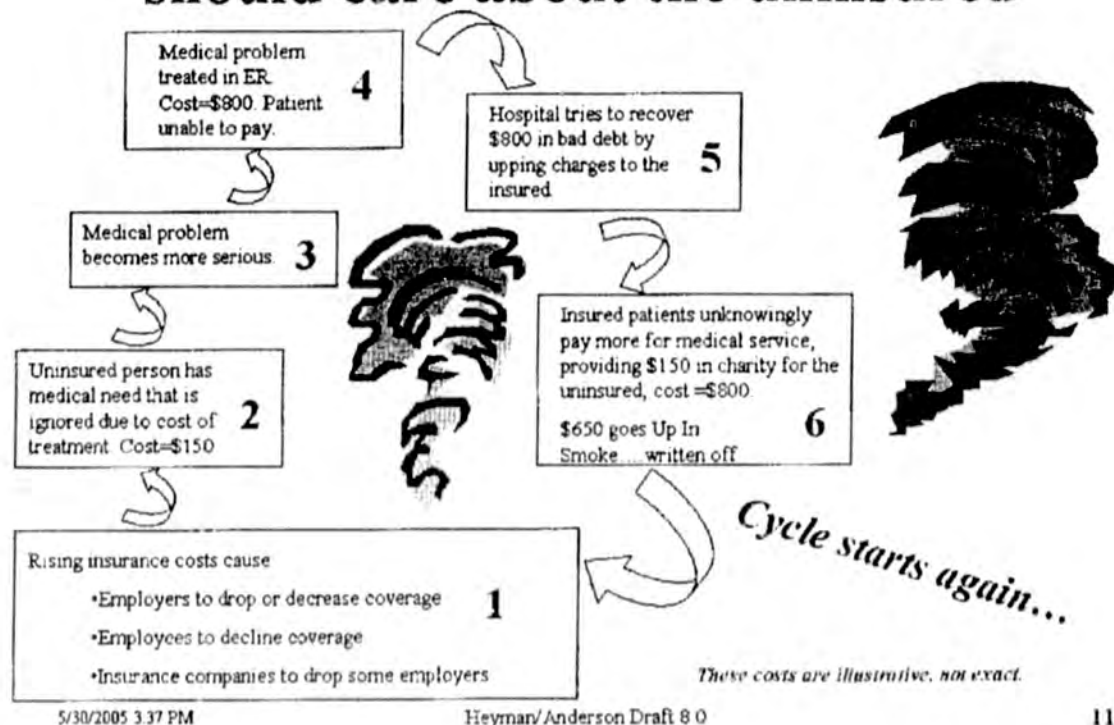
This phenomenon has impacts both nationally and in Alaska, and Alaskans are not always the beneficiary, creating serious cost shifting and economic dislocations.

## A SIGNIFICANT ISSUE FOR HEALTH CARE IN ALASKA

The focus of this study is what can be done in Alaska. It does not address national issues such as a single payer system, rationing of health care or national structural issues. However, the following conceptual illustration is both a national and Alaska problem.

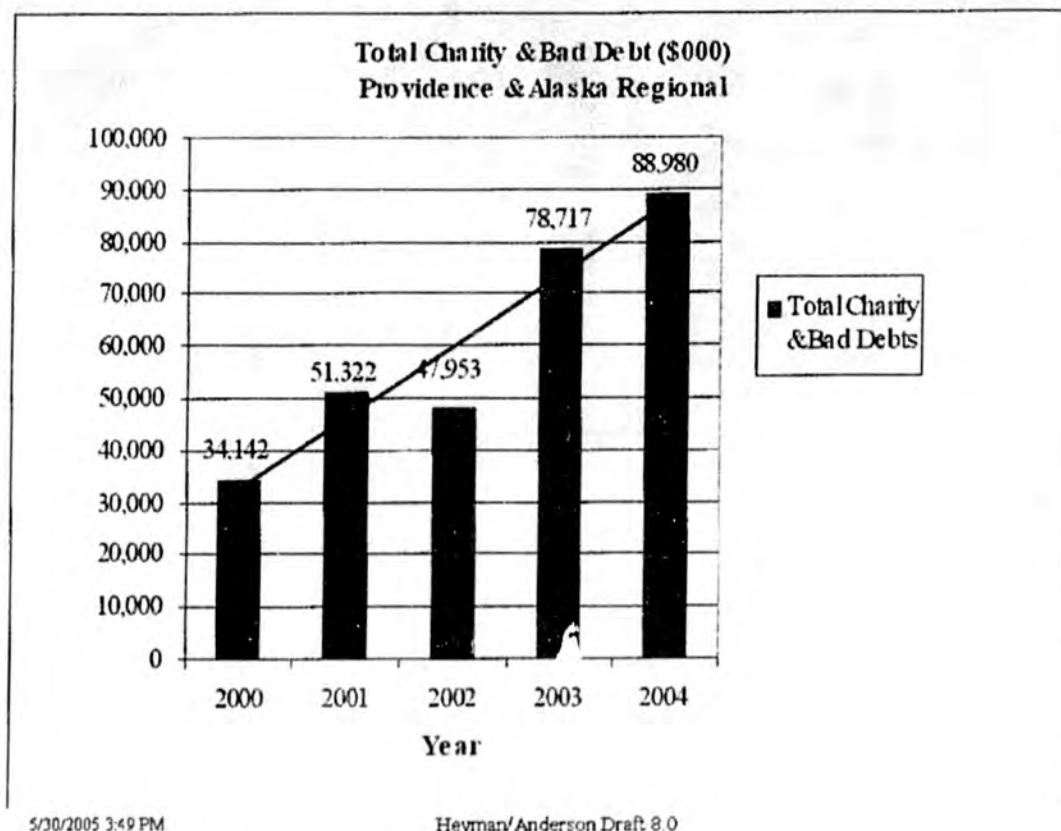
It shows how the high cost of health care causes people to postpone needed care, which increases ultimate costs of treatment, frequently and reluctantly performed by practitioners at unneeded and inappropriate levels. Often the emergency room of a hospital becomes a highly expensive primary care facility. If treated earlier, medical conditions could have better outcomes at a lower cost.

### Why even a non-compassionate insured should care about the uninsured

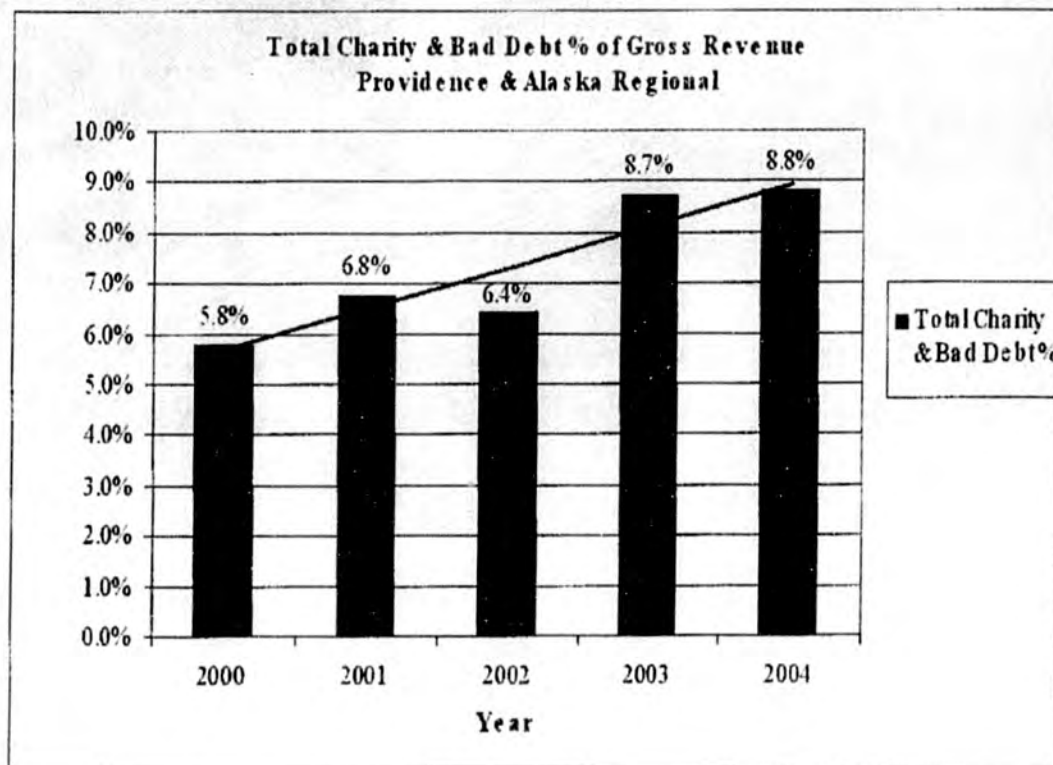


A federal law, the Emergency Medical Treatment and Active Labor Act ("EMTALA") requires that hospital emergency rooms treat and not turn away any patients who show up, regardless of ability to pay.

**Emergency rooms** are becoming primary care treatment centers for those without access to, or awareness of, alternatives. Current waits can be up to two hours, especially during high traffic times like early evenings or weekends. This creates inefficient use of specially trained staff and is enormously expensive. Many ER patients have no insurance coverage or other means to pay their bill. The financial burden then falls on the hospital to write off uncollectible accounts.



Note: the numbers above are in thousands of dollars. E.g. 88,980 = \$88,980,000



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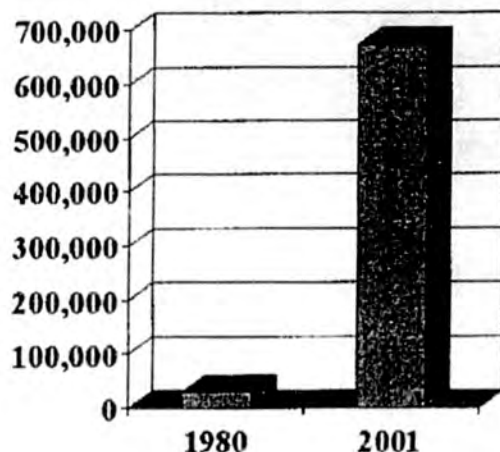
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The financial impact on hospitals is even more acute than the slide above suggests. While the percentage of charity and bad debt compared to gross revenue has increased dramatically in recent years, the bottom line impact is significantly greater because actual hospital cash collections are much less than the gross revenue billings used in the chart above.

Hospitals are not the only ones affected. Individuals unable to pay medical expenses are filing for bankruptcy at staggering rates. Although Alaska data are not available, national data are noted below.

## Personal Bankruptcies due to Health Care Costs-U.S.



- Between 1980 and 2001 medically driven bankruptcies increased 23 times
- 60% skipped doctors visits
- 47% skipped prescription medicines

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Source: American Medical Association 2/05 and a Harvard Law School/Medical School 2/05 studies.

70% of these debtors had some form of health insurance at the start.

Main factors cited for declaring bankruptcy were:

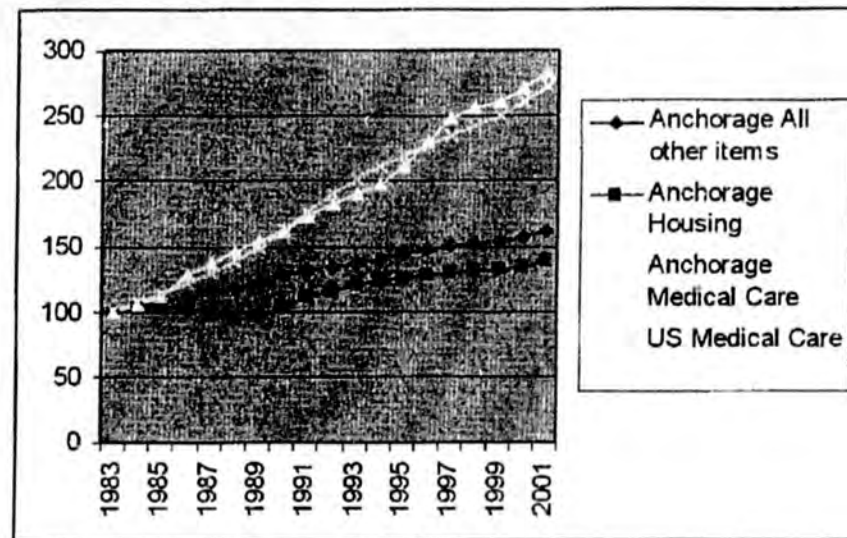
|                         |     |
|-------------------------|-----|
| Hospital costs          | 42% |
| Prescription drug costs | 21% |
| Doctor bills            | 20% |

## Cost: What do Alaskans pay? Why?

The impact of **bad debt** on the health care system has been clearly illustrated in the preceding charts.

# Increasing Cost of Medical Care in Alaska

Anchorage CPI-U for selected components 1982-2001



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Source: Alaska Economic Trends / June 2004

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Premiera, Alaska's largest health care insurer, reports that their **Alaska costs are about 40% higher than Seattle**. General observations by resource people have referenced a 40% differential overall, more in some specialties, less in others. Local hospitals have corroborated this differential. Other information points to even larger discrepancies on reimbursement rates for physicians. The Alaska Division of Medical Assistance Health Care Cost Analysis Report placed Alaska in the top five states in terms of the cost of medical and surgical procedures.

**Small practices** and increasing personnel costs contribute to the high cost of medicine in Alaska. Also there is general, but not substantiated, belief that the **Alaska population is too small to support HMOs**. Any discussion of managed care has been resisted by medical providers.

**Dependence on "Fair Share" and other sources** of federal dollars place about \$800 million potentially at risk, an important share of current health care funding to Alaska. Alaska also faces **competition from other states** for willing providers. Furthermore, **reimbursement**

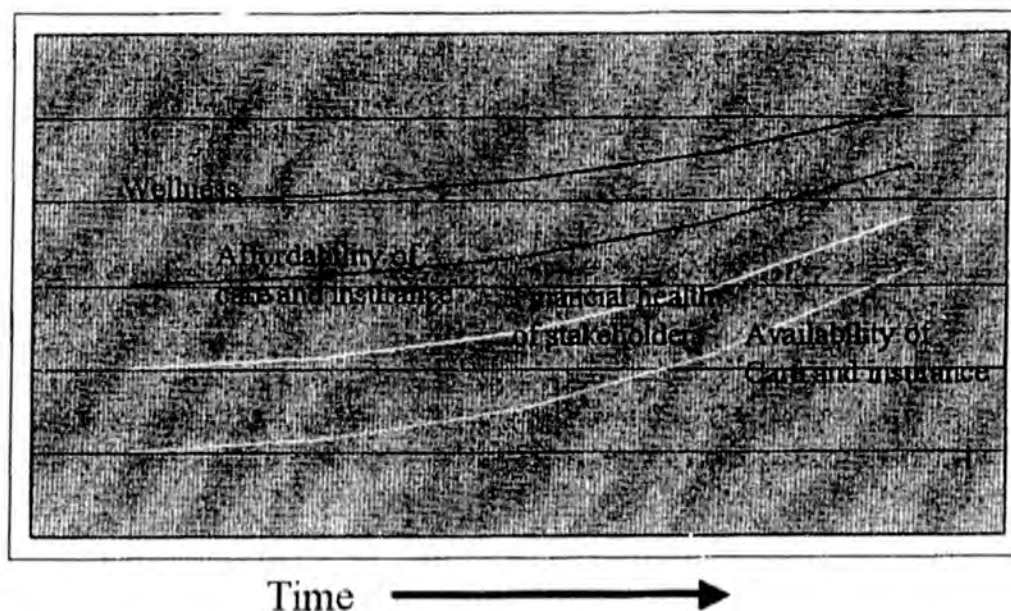
**formulas are going down.** The state is now paying over one billion dollars annually to pay Medicaid expenses.

**Cost of health insurance**—there is no public oversight of health care insurance rates by the Division of Insurance as there is in some other states. They are a result of negotiations between insurance companies and large groups.

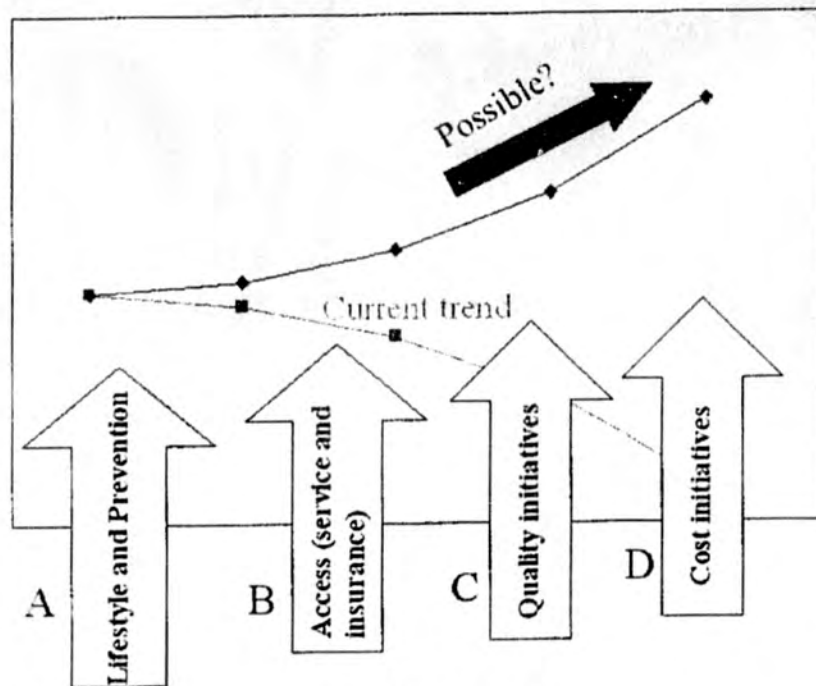
The **Certificate of Need** situation needs to be objectively analyzed and considered as a component in a comprehensive statewide health care plan. Critics of the Certificate of Need claim the process stifles competition and innovation. Supporters claim it prevents unnecessary duplication of facilities and allows more rational allocation of assets.

**The impact of tort issues on health care.** The cost of malpractice insurance and defensive medicine is hard to quantify, but is deemed to be substantial. OB/GYN liability insurance is \$60-65k/year. SB 67 puts a 250k cap on non-economic suffering. The California experience with a similar cap since 1975 has been positive. Alaska has only two traditional liability carriers. However, compared to U.S. averages, malpractice insurance costs in Alaska are middle of the pack.

## Is a trend reversal possible in Alaska?



Perhaps, with coordinated and focused effort



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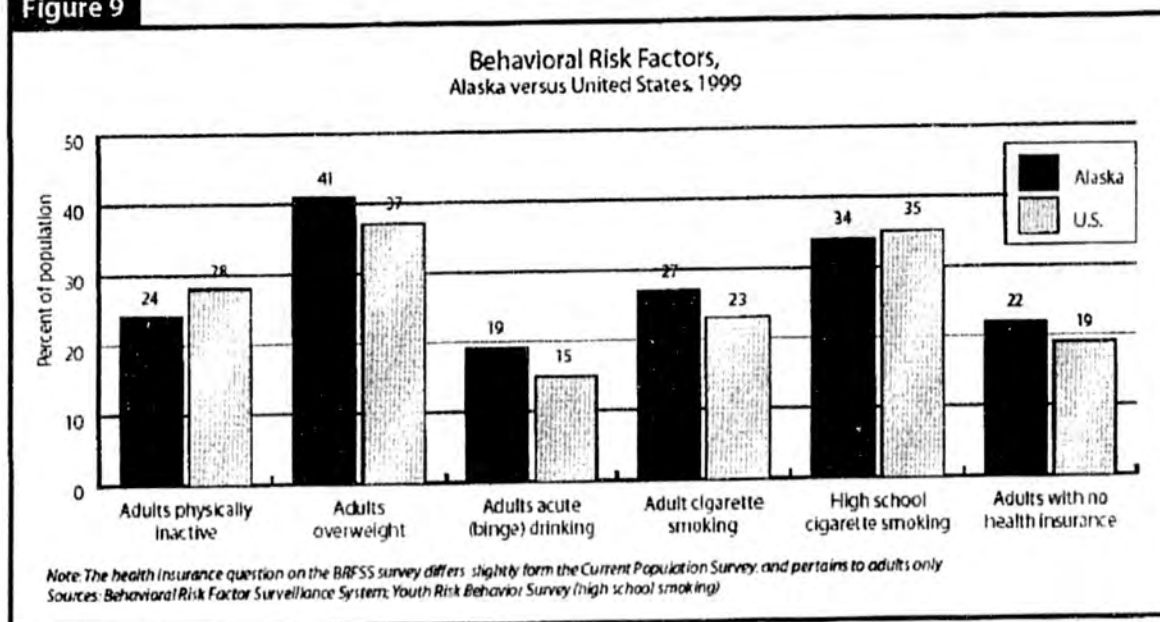
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Quality of Alaska's health: Based on the 2004 National Health Care Quality Report of 100 measures of health care quality, Alaska is about average for the U.S. However, as the charts on page 7 indicate, the U.S. trails many other industrialized nations.

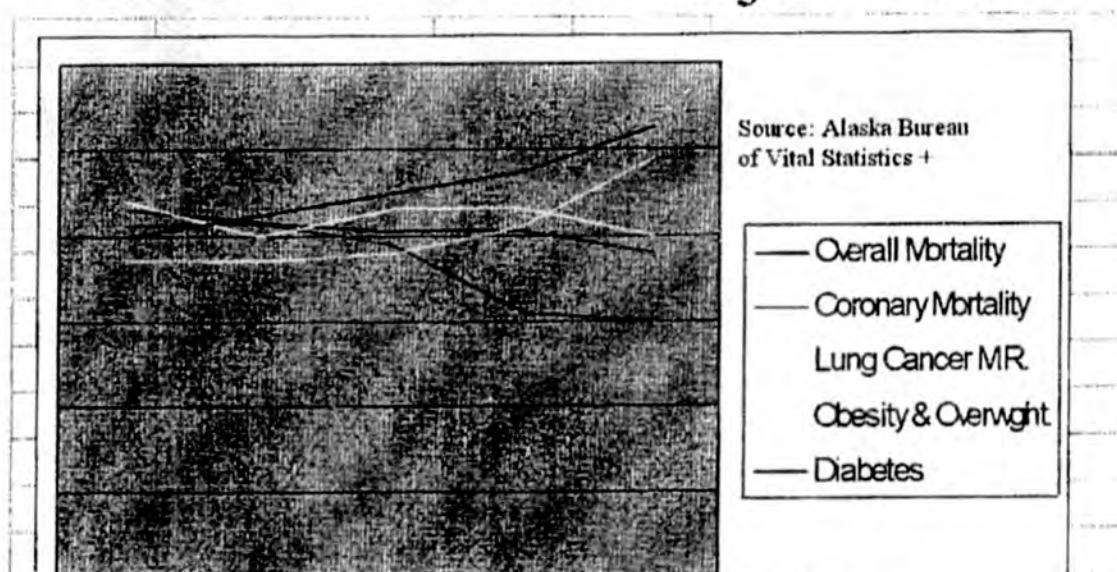
## Unfortunately, Alaska mirrors poor National behavioral risk factors

**Figure 9**





## Alaska Trends in major disease



**Trends only—not incidence rates**

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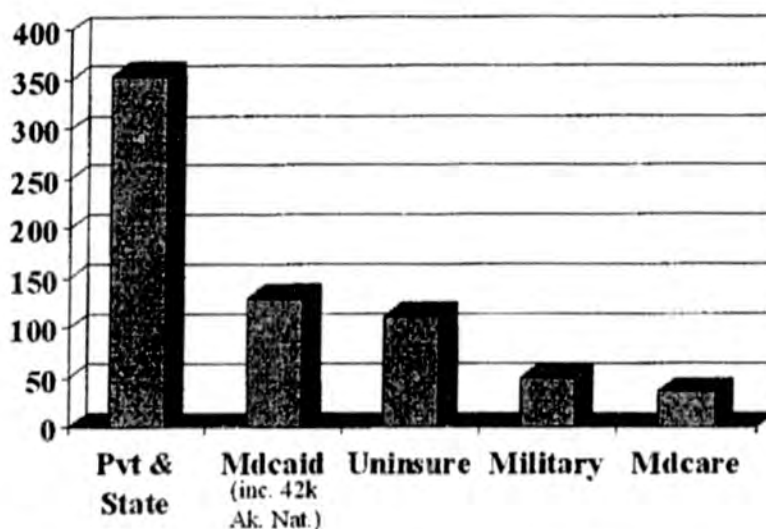
(Vertical axis is rates of disease, horizontal axis is time)

While progress has been made in heart and lung disease, obesity and diabetes have negative trends.

## How is Alaska's health care being paid? What about those without coverage?

Currently about 110,000 Alaskans do not have health care insurance. Approximately 82% of Alaskans have some type of insurance coverage, as illustrated by the chart below. The column for private and state coverage includes state employees. Medicaid covers over 40,000 Alaska Natives, the remainder of which are covered under federal programs. Military and Medicare coverage rounds out the picture. However, an unquantified, but suspected to be substantial, number of people have inadequate insurance coverage.

### Alaska's Insurance Coverage



Source: Navigant Consulting, Ak. Journal of Commerce

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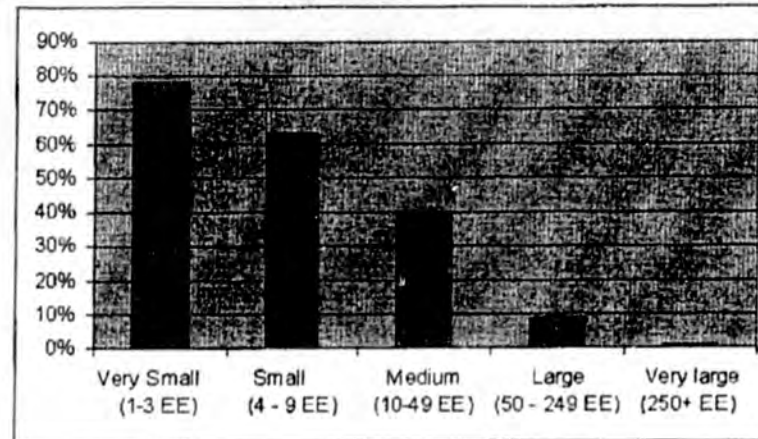
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The majority of Alaskans without insurance work for smaller businesses.

## Alaskan firms NOT offering health insurance



And only 0.00% of Alaskans were employed in firms with over 50 employees...

Source: Alaska Dept. of Labor and Workforce Development, 2002

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### Safety net providers

There are 34 federally sponsored Community Health Centers (CHCs) in Alaska. They see all patients and charge a sliding fee schedule based upon income. Although there are the Neighborhood Health Center in Anchorage and the Interior Community Health Center in Fairbanks (both federally sponsored CHCs), a large number of uninsured patients receive their care in the city's emergency rooms.

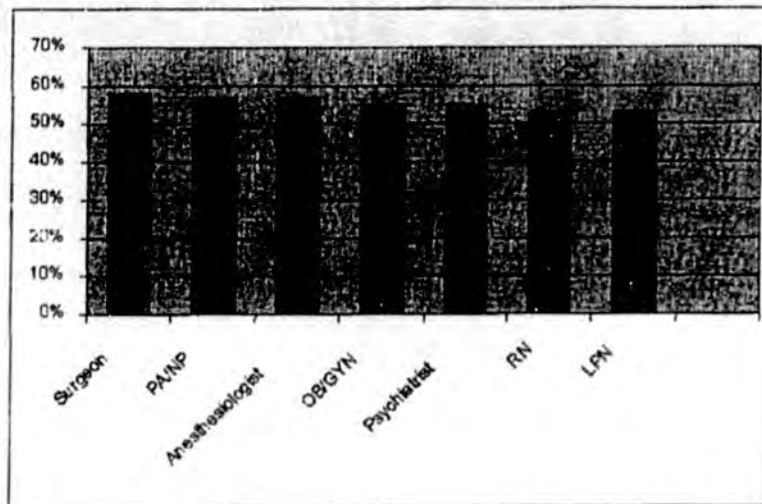
Under federal law, patients who visit the emergency rooms must be seen regardless of their ability to pay. This results in the uncompensated care that was referenced previously.

Although not safety net providers, the Alaska Native Health system provides care to an estimated 125,000 Alaska Natives through an extensive network of community health aid clinics, regional hospitals and a major referral center.

# Healthcare Provider Shortages are Projected for Alaska



PERCENT OF PROVIDERS CURRENTLY MORE THAN 45 YEARS OF AGE:



Sources: AK Department of Labor

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**Shortage of doctors:** ½ doctors in Alaska are over 50. Fewer doctors are practicing than are licensed. Compared to the rest of the U.S., Alaska has 17-30% fewer doctors per capita, partly because we have a relatively younger population. However Alaskans are aging, and the need will increase. Today Alaska needs 472 more doctors than it has. The shortage will increase in the future. Statewide Alaska has a 25-30% shortage of physicians. Physicians are practicing fewer hours and retiring younger than in past decades. As a result it may require more than one new physician to replace a retiring one. 70% of doctors in the lower 48 practice near where they did their residency. The rate of return on a medical education is diminishing compared to other professions. Medical students average \$100,000 of debt; specialties can be \$250,000 with an average of 8 years post-graduate education. Similarly, graduating dentists average nearly \$200,000 in debt. In contrast, graduating attorneys and MBA's begin earning money faster and with less debt.

**Nurse Practitioners and Physician Assistants** provide care to Alaskans in a wide variety of settings, including rural and urban primary care clinics, urban specialty practices, and remote critical access hospitals that were historically difficult to staff with other providers. There are over 200 physician assistants and 420 nurse practitioners working in Alaska. This gives Alaska one of the highest ratios of nurse practitioners per capita in the nation.

As in 25 other states nurse practitioners are licensed to practice autonomously. A recent Columbia University study (JAMA, 2000) and another from Yale University (1992), compared physician and nurse practitioner practice. They found that patients expressed a high degree of satisfaction with the care they received, that accuracy of diagnosis and health outcomes were equivalent, and that Nurse Practitioners provide quality, cost-effective care to their patients.

**The role and extent of coverage of complementary and alternative medicine** (chiropractic, acupuncture, etc.) in Alaska is undefined, but substantial. As of May 25, 2005, the Alaska Division of Occupational licensing listed the following numbers of active licenses for the following types of doctors:

|                             |       |
|-----------------------------|-------|
| Allopathic doctors (M.D.)   | 2,377 |
| Chiropractic doctors (D.C.) | 227   |
| Osteopathic doctors (D.O.)  | 183   |
| Podiatrist (D.P.M.)         | 20    |

## **SPECIFIC ALASKAN RECOMMENDATIONS FOR IMPROVEMENT**

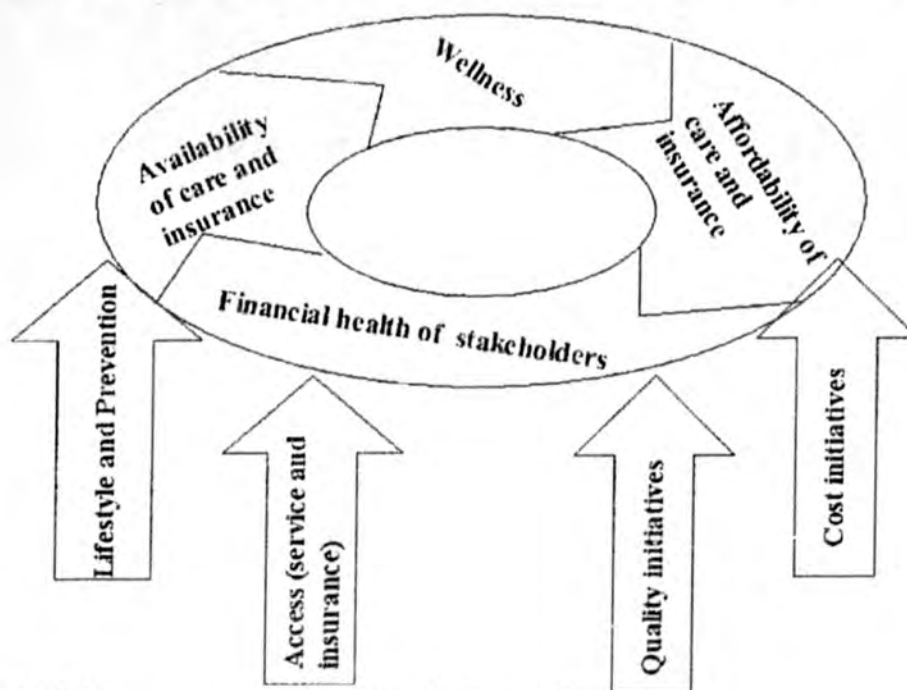
This Study Group has identified a continuum of challenges, many of which are interrelated to each other. While they may all be part of a whole, the Study Group identified discrete categories to more readily focus on how each recommendation may be best implemented. A chart below summarizes the recommendations and identifies which parties are affected by, or responsible for, each recommendation.

However, in the process of assessing health care in Alaska, and looking for improvements, the Study Group developed consensus on three overarching conclusions:

- 1. The Study Group process itself, which includes representatives of all key components of the health care system in Alaska, has been enlightening, educational and productive. For the first time in recent years, key players have been able to share experiences and ideas in a supportive and cooperative environment.**
- 2. Every aspect of health care is complex. Education, technology, funding, social and demographic factors, economics, federal and state laws and regulations all have many interrelated facets. Understanding the health care system, and improving it, are beyond the capacity of any one element within the system.**
- 3. Therefore, a fundamental recommendation of the Study Group is that an ongoing body be established to achieve multiple goals:**
  - a. Continue the communication process started by this Study Group among the key elements in the Alaska health care system and the broader Alaska community.**
  - b. Create a body that will have a long-term vested interest in understanding and improving the system. Some solutions are immediate, others will take generations. But without consistent advocacy, the system is unlikely to make needed fundamental changes.**
  - c. Through the quality of its participants, and the comprehensiveness and depth of its vision, the body will set a standard of credibility that will sustain its ongoing operations and facilitate implementation of its recommendations.**

**In that spirit, this Study Group offers the "Yarmon Plan" as a starting point for structuring such a body.**

# The Roundtable Proposal (The Yarmon Plan)



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## The Alaska Health Care Roundtable

**Goals:** a, b, c on the previous page. Create a timely, actionable package that will gather bipartisan political support, get quick approval, and become a significant part of a long-term fiscal plan for Alaska.

**Focus:** Access, quality and cost. Function as both a sounding board and facilitator for ideas and recommendations.

**Structure:** Create the "Alaska Health Care Roundtable"

**Membership in the Roundtable:** Self-selecting. Must have a core of members who have a long-term compelling interest in improving access, quality and cost of health care in Alaska. Examples of potential members would be:

- a. Major employers
- b. Providers
- c. Foundations
- d. Other participants as invited by the Roundtable

**Funding:** Voluntary contributions by the participants.

**Strategic relationships:** Form a research relationship with the **University of Alaska/Institute of Social and Economic Research (ISER)**. The Roundtable itself could focus on strategic policy and political analysis. UA would provide in-depth research as needed on a contract basis.

**Tactics:** Secure the support of major employers and secure their interest in funding such a Roundtable. There is no point in CWN issuing a major recommendation that will fall flat on its face. Get seven or more CEOs of major employers to make a financial commitment to the project and be present at its unveiling.

Create a package of recommendations that will be dynamic, compelling and politically impossible not to accept. Create a "win-win" atmosphere so all participants can claim victory.

Local or regional Roundtables can address "nuts and bolts" issues of cooperation, implementation, sharing and efficiency.

**Potential resources, ad hoc participants or additional members:** Business leaders of large businesses, business leaders of small businesses, Alaska Natives, labor, non-profit (Foraker Group), education, military, insurance industry, state government (legislature, administration), health care providers, Medicare, Medicaid

### Summary table of recommendations with affected and responsible parties

The following chart summarizes various recommendations that were suggested in the course of our study. They are a starting point of menu items for the Roundtable to analyze and prioritize.

**A = Parties affected by or benefiting from the listed Recommendation**

**R = Parties responsible for implementing the listed recommendation**

| Recommendation                            | Individuals | Legislature | Governor | Local Governments | Private Sector | Health Care Professionals & Institutions | Universities (or schools) | Insurance Companies |
|-------------------------------------------|-------------|-------------|----------|-------------------|----------------|------------------------------------------|---------------------------|---------------------|
| <b>Lifestyle &amp; Prevention</b>         |             |             |          |                   |                |                                          |                           |                     |
| 1. Walkable community                     | AR          |             |          | AR                | AR             | AR                                       | AR                        | AR                  |
| 2. Public Health role                     | A           | R           | R        | AR                | A              | A                                        | AR                        | A                   |
| 3. School phys ed                         | A           | R           | R        | AR                | A              | AR                                       | R                         | A                   |
| 4. Schools nix bad foods                  | AR          | R           | R        | AR                | A              | AR                                       | AR                        | A                   |
| 5. Incentivize behaviors                  | AR          | AR          | AR       | AR                | AR             | A                                        | AR                        | AR                  |
| 7. Rural dentistry                        | A           | A           | A        | AR                | A              | AR                                       | AR                        | AR                  |
| 8. Drug/psych facilities                  | A           | AR          | AR       | AR                | A              | AR                                       | A                         | AR                  |
| 9. U.S. preventive health recommendations | AR          | AR          | AR       | AR                | AR             | AR                                       | AR                        | AR                  |
| 10. Circumpolar health studies            | A           | AR          | AR       | AR                | A              | A                                        | A                         | A                   |
|                                           |             |             |          |                   |                |                                          |                           |                     |

| <b>Access</b>                                       | <b>Indiv.</b> | <b>Legis.</b> | <b>Gov.</b> | <b>Loc Gv</b> | <b>Private</b> | <b>HC</b> | <b>Univ/Sc</b> | <b>Ins. Cos</b> |
|-----------------------------------------------------|---------------|---------------|-------------|---------------|----------------|-----------|----------------|-----------------|
| 1a. Expand WWAMI                                    | A             | R             | R           | A             | A              | AR        | AR             | AR              |
| 1b. Market AK To MDs                                | A             | R             | R           | AR            | AR             | AR        | A              | AR              |
| 2. Cut liability ins. Cost factors                  | A             | R             | R           | A             | A              | AR        |                | AR              |
| 3. Cover uninsured                                  | AR            | AR            | AR          | AR            | AR             | AR        | AR             | AR              |
| 4. Pool small cos.                                  | A             | R             | R           | AR            | AR             | A         |                | AR              |
| 5. Promote lower cost centers                       | A             | AR            | AR          | AR            | AR             | AR        | A              | A               |
| 6. Same day non ER alternatives                     | A             | R             | R           | AR            | A              | AR        | A              | AR              |
| 7. Examine other state models e.g. UT, ME           | A             | R             | R           | A             |                | R         | R              | AR              |
| 8. More GME \$ for family practice                  | A             | R             | R           | A             | A              | AR        | AR             | A               |
| 9. Improve MD reimbursements                        | A             | R             | R           | A             | A              | AR        |                | AR              |
| 10. Medicare licensing requirement                  | A             | R             | R           | A             | A              | A         | A              | A               |
| 11. Public insurance hearings                       | A             | R             | R           | A             | A              | A         | A              | AR              |
| <b>Quality</b>                                      |               |               |             |               |                |           |                |                 |
| 1. Evidence based prevention, Intervention          | AR            | AR            | AR          | AR            | AR             | AR        | AR             | AR              |
| 2. Use bench-marks                                  | A             | R             | R           | AR            | AR             | AR        | AR             | AR              |
| 3. Measure, disclose quality info                   | AR            | AR            | AR          | AR            | AR             | AR        | AR             | AR              |
| <b>Costs</b>                                        |               |               |             |               |                |           |                |                 |
| 1. Prevention education, intervention               | AR            | AR            | AR          | AR            | AR             | AR        | AR             | AR              |
| 2. Electronic medical records                       | A             | AR            | AR          | AR            | AR             | AR        | AR             | AR              |
| 3. Drug formularies                                 | AR            | AR            | AR          | AR            | AR             | AR        | A              | AR              |
| 4. Health care <> State fiscal plan                 | A             | AR            | AR          | AR            | AR             | AR        | AR             | AR              |
| 5. Disclose fees clearly                            | A             | R             | R           | A             | A              | AR        | A              | AR              |
| 6. Community duplication dialogue                   | A             |               |             | AR            | AR             | AR        |                | AR              |
| 7. Joint purchasing                                 | A             |               |             | AR            | AR             | AR        |                | A               |
| 8. Allocation & rationing                           | A             | AR            | AR          | AR            | A              | AR        | AR             | AR              |
| 9. Fee transparency legislation                     | A             | R             | R           | AR            | A              | AR        | AR             | AR              |
| 10. Legislative ins., reimbursement, tort solutions | A             | R             | R           | AR            | AR             | AR        | AR             | AR              |

## **The impact of lifestyle and prevention**

First and foremost, this is an issue of individual responsibility. This means that each of us is ultimately responsible for our own health, how we eat, exercise and live. Nevertheless, many collective societal educational and social efforts can help further acceptance of this individual responsibility through application of sound health maintenance principles.

Our society is not used to facing the facts of collective issues. They are not part of the national or state non-Native psyche. Currently, the health care industry plugs holes in the dike that are the result of unhealthy lifestyles. We need to go way upstream and focus on prevention.

Fortunately, we can learn from the positive example of reduction of smoking in America. Much remains to be done. Today's limited but meaningful success is the result of a long-term effort that lasted over a generation. Extensive public education, warning labels, laws banning smoking in public places and a consistent message from the health care community ultimately resulted in societal changes that now appear to have gained a self-reinforcing life of their own.

### **1. Plan a "walkable community."**

- a. Land use designed to facilitate walking and biking can encourage cardiovascular health. Maintaining safe municipal trail systems, seasonal bike paths, and cleared wintertime walkways permit citizens to practice healthful life habits year around.
- b. Enlightened city planning and architecture can promote a more active lifestyle.
- c. As public demand for exercise opportunities grow, their inclusion in real estate development and city planning can improve property values.

### **2. The role of public health as community educator and provider.** Municipal health departments need to serve many more people than those who seek care at the clinic. Promoting wellness and healthful living habits to the entire community is an essential part of the public health mission. This portion of the mission needs to be funded adequately in the budget.

### **3. The importance of physical education in the schools— (not a "frill")** It is important to teach children about the relationship between health, diet and exercise. Not every child will want to join a sports team, but learning to be responsible for their own health by incorporating physical activity into their daily lives is an important health lesson that cannot be ignored.

### **4. Eliminate internal inconsistencies and conflicts between programs and objectives.** For example, eliminate financial incentives in schools to promote unhealthy foods. Provide a financial alternative to schools that have come to rely upon income from selling junk foods in the schools.

5. **Incentivize healthy behaviors through workplace activities.** Convince the Top 49 Alaska businesses to educate their employees on healthy lifestyles and offer healthful workplace activities. The Top 49 businesses would represent a large percentage of the Alaska population not already covered by Federal or Alaska Native health care systems. Encourage a **Top 49 Health Summit** to facilitate understanding and participation of these large Alaska businesses.
6. Develop intervention programs for **promoting the traditional rural diet.**
7. **Reconsider rural access to dentistry as part of the study.** Many rural communities lack a sufficient population to support construction of a simple dental facility to house a full time dental practice. The investment required to maintain a facility for use by an itinerant dentist would likely need to be made by the community, possibly partnering with the state. Lack of roads prevents the use of mobile dental clinics that are used in other remote locations worldwide.
8. **Reduce the critical shortage of facilities for alcohol and drug detox, and psychiatric facilities. The lack of services these facilities provide can increase costs in the long run.** Persons affected by alcohol and drug use, and the accidents they cause, account for a significant portion of the population needing care in hospital emergency rooms and psychiatric facilities. Yet Alaska has too few beds to treat those in need of drug and alcohol recovery. As a result we are forced to tolerate that burden of higher healthcare costs. Detox beds make good economic and health policy sense.
9. Find ways to incorporate **U.S Task Force on Preventive Health** recommendations into medical practices, schools, work environments and homes.
10. **Continue the Institute of Circumpolar Health Studies** to analyze common problems and look for solutions that will work for all circumpolar peoples. Similar environments and cultures may result in shared knowledge that can benefit those in northern latitudes. Many health issues in Alaska relate to weather, the environment, subsistence food quantity and quality, potable water and sanitation issues. These are issues shared by other circumpolar peoples. Alliances with other circumpolar countries, and organizations like the Institute for Circumpolar Health Studies may provide new insights in resolving some of these issues.

### **Access improvement recommendations**

1. **Workforce development issues**
  - a. **Expand the WWAMI program.** Improve the supply of primary care providers (family practice physicians, internists, nurse practitioners, physician's assistants), especially outside of Anchorage. Current or potential shortages can be identified in specific specialties.
  - b. **Market the Alaska lifestyle to Outside doctors.** JV with tourism, the State Medical Board, ASMA. Create a dog and pony show.

2. **Investigate and modify the factors that influence the cost of professional liability insurance**
3. **Reduce the number of uninsured Alaskans**— A non-government designed system is probably preferable to a government-operated system.
4. **Investigate pooling smaller companies a la the Foraker Group in an effort to reduce premium costs.**
5. **Promote lower cost models such as neighborhood health centers where appropriate**
6. **Educate the public and promote same day access to alternatives other than hospital emergency rooms.** This involves creation of more readily available and timely access to primary care. Alternatives could include increasing the number of primary care providers and clinics, establishing a variety of disincentives for visits for minor complaints, and establishing a system for care for the uninsured. Emergency rooms themselves may need to be reorganized and redesigned to separate life-threatening emergencies from routine medical needs.
7. **Examine uninsured models elsewhere; e.g. Utah, Maine and Florida.**
8. **Adjust the Medicare (GME) reimbursement formula for Family Practice Residency programs.**
9. **Ensure adequate government reimbursement to doctors, hospitals, community health centers, mid-level practitioners and community health aides without unreasonable bureaucratic burdens.**
10. **Consider making accepting Medicare patients a condition of licensure in Alaska.** This has been done in Massachusetts. Weigh the advantages of increased access for Medicare patients against the negative effect of attracting practitioners to Alaska.
11. **Consider public hearings for health care insurance and professional liability insurance rates** to facilitate price transparency. Currently insurance rates are largely negotiated between large institutional users and insurance carriers. As private contracts, the resulting rates are not disclosed. Individuals have little or no negotiating power and either have to accept or reject rates offered to them. The thought is that greater transparency could result in more favorable, or at least understandable, rates for individual consumers.

### **Quality improvement recommendations**

1. **Promote and encourage primary prevention, early intervention, and evidence based practices by providers and payers of health care.**
2. **Use meaningful benchmarks; e.g. the Alaska 20/20 example.**
3. **Measure quality of service and make the information publicly available.**

### **Cost reduction recommendations**

1. **Prevention through Public health education, and early intervention** Preventing illness will save more lives, more lost work time and more healthcare dollars than any other option available to us as a community. Consider the adage "the cheapest health insurance is healthcare you don't need." Measures include flu shots when they are recommended and vaccinations against common diseases. Encourage the following behaviors: weight control, regular exercise, avoiding cigarettes and excessive alcohol, fat, salt, and sugar, adequate water consumption, and controlling blood pressure.
2. **Encourage and promote the establishment of an Electronic Medical Record** with a common interface as a means to improved safety and efficiency of health care.
3. **Drug formularies**—utilize where appropriate and effective.
4. **Promote the strong interrelationship between cost of health care and a state fiscal plan** as a means of putting health and budget decisions in perspective.
5. **Fee and billing transparency.** Mandatory disclosure of fees in advance of treatment and "understandability" standards for medical billing.
6. **Encourage local cooperation and sharing of services and facilities.** Promote community by community dialogue on the cost of duplication
7. **Analyze the possibility of saving money by joint purchasing** by appropriate parties.
8. **Allocation and rationing** might be considered if other measures fail to stabilize health care costs.
9. **Suggest legislation to mandate fee transparency**
10. **Consider legislative solutions to tort and liability issues.** Quantify professional liability insurance, patient reimbursement and tort issues—are there legislative solutions? Look at tort reform experiences Outside, such as MICRA, for ideas that might apply to Alaska.

## **SUCCESS STORIES AND PROMISING PROGRAMS**

**Alaska has a number of programs that have proven to be successful:**

### **Lifestyle and prevention**

- The South Central Foundation Primary Care Clinics place great emphasis on prevention. This results in some of the best state data for immunization rates, colorectal screening, mammograms and other standard preventive health interventions.

### **Access**

- Anchorage Neighborhood Health Center
- Other community health centers
- Health aides in rural Alaska
- South Central Foundation has programs that have established same day access. Utilization rates for emergency room use and specialty services have fallen dramatically. Utilization rates of primary care services have also had a modest decrease.

### **Quality**

- Hospital quality control programs have been established in all the major hospitals in Alaska with excellent results. For example, Providence Hospital received national recognition for reducing surgical site infections after joining a national collaborative focus on this issue. Alaska Regional Hospital was recognized for reducing pneumonias after intubations. The Alaska Native Medical Center has developed a national reputation for quality improvement activities working in close association with the Institute for Health Care Improvement. All of our major hospitals have joined the national initiative known as the "100,000 Lives Campaign" to save this many lives in U.S. hospitals by June 2006.

### **Costs**

- The Alaska Federal Health Care Partnership, consisting of the DOD, VA, Coast Guard and the Alaska Native Health System, have been able to reduce costs by bulk purchasing and the sharing of clinical resources.

### **Other programs show promise:**

- The State of Alaska has developed benchmarks for population health improvement targets in a document called "Healthy Alaskans 2010."

### **Lifestyle and prevention**

- The Anchorage Daily News and a growing number of businesses are discussing wellness incentives in an effort to reduce health care costs. Generally all of these approaches are similar. Employees who agree to join this effort receive personal health care improvement plans and personalized coaching on a regular basis. Some companies offer health care premium discounts as an incentive to participate.

## **APPENDIX**

### **Key ideas in the 1994 CWN study "Health Care: Finding an Alaskan Solution"**

1. The health care reform debate is complex and controversial, with multiple players with competing interests.
2. There are significant factual disputes about the health care system.
3. Health care reform creates winners and losers.
4. The most important conclusion for Alaskans: Involvement of Alaskans in the health care debate is vital. Some type of reform is inevitable and Alaskans must work to ensure that reform is responsive to our unique Alaskan conditions.

### **Study Group Participants**

Co-chairs: Thomas Nighswander, M.D and Marvin Swink

Editor: Duane Heyman

Hartig Fellow: Dan Kiley, DDS

Kathy Anderson, Eleanor Andrews, Sergei Bogojavlensky, MD, PC, Steven Boyd, Sharon Cissna, Bill Dann, Fred Dyson, Mark Foster, Alice Galvin, Ed D, Catherine Giessel, FNP-CS, Scott Goldsmith, Ph D, Joe Griffith, Parry Grover, Carolyn Heyman-Layne, David Hudspeth, Jewel Jones, Nancy King, Jonathan Kumin, Edward Lamb, Grace Long, Ph.D, John Patrick Luby, Tana Myrstol, Rebecca Parker, Al Parrish, Joanne Partain-Phelan, Jeff Ranf, Noel Rea, Tessa Rinner, David Snyder, MD, Greg Thies, Lawrence Weiss, Ph D, MS, Heather Wheeler, RD, Tim Wiepking, Kevin Wiley, Joan Wilson, James Yarmon

### **2004-2005 Commonwealth North Officers and Board of Directors**

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| Nancy Bear Usera                    | Senior Vice President, Corporate Relations, Alaska USA Federal Credit Union  |
| David Wight                         | President & CEO, Alyeska Pipeline Service Company                            |
| Eric Wohlforth                      | Attorney, Wohlforth, Vassar, Johnson and Brecht                              |
| James Yarmon                        | CEO, Yarmon Investments, Inc.                                                |
| Duane Heyman                        | Executive Director, Commonwealth North                                       |

## **The Charge**

### **Alaska Primary Health Care – Opportunities & Challenges**

**Approved by the Commonwealth North Board on July 20, 2004**

#### **1. Questions to be addressed:**

- a) How is primary health care currently being delivered to Alaskans?
- b) Are Alaskans receiving quality health care under the current scenario?
- c) What does the future hold for health care in Alaska?
- d) Are there ways to do a better job, such as by bridging the current multiple systems?

#### **2. Scope of study:**

The intention of this study is to focus on primary care – the need for Alaskans to receive basic health care. Recognizing there are a number of health care areas which merit similar attention such as long-term care, behavioral health, dental care, etc., the focus of this particular study is to address the past, present and future of primary health care in Alaska. The study will include an update/compilation of previous reports to provide a context.

- The study will briefly explore the historical delivery of health care and how that history impacts the present challenges Alaska faces. In providing this background, the study will also look at the health status of Alaskans – is it above/below that of other states or are we keeping pace?
- The study will explore the “drivers” behind the cost of health care in Alaska and will assess its impact, if any, upon economic development in the State. Access and quality of care/services are a critical determinant of cost within the various health systems in Alaska.
- This study will identify principal health care entities and look at the current multiple health systems – what are the benefits and challenges? Are they sustainable? What impact, if any, do these multiple systems have on the cost and quality of health care?
- There are a number of challenges facing health care providers and recipients. This study will identify those challenges and where possible, potential solutions.
- There are a number of examples where health care entities are collaborating. The study will highlight the best practices and identify additional areas of collaboration. The study will also take into account lessons learned from other states.

#### **3. Nature of report to be issued (Technical, Analytical, or Opinion):**

This report will analyze issues, identify a process for addressing them and suggest guiding principles. The report will provide background, current status and recommendations for change or further study. While the report will largely express opinions, it will address technical issues that are necessary aspects of the larger picture.

#### **4. Conflict of interest standards:**

The intent of the study is to represent a balance between the geographic, demographic, ethnic and economic interests in Alaska. It is expected that persons with interests in the outcome of the study will be members of the study group and will participate in its deliberations. Study group leaders should request that study group members identify their interests relative to specific points they advocate.

#### **5. Measure of success:**

This study will succeed by generating a greater understanding of and insight into health care issues in Alaska and areas in which health providers can work together for the mutual benefit of all Alaskans.

## **Resource People Interviewed**

- 9.23.04 Ed Lamb, Al Parrish—Hospital perspectives
- 9.30.04 Barbara Russell—Premera
- 10.07.04 Alex Spector—VA, Lt. Col. Vic Rosenbaum—Elmendorf Hospital, Maj. Ward Hinger-  
-TRICARE
- 10.14.04 Commissioner Joel Gilbertson
- 10.21.04 Paul Sherry—Alaska Native Tribal Health Consortium
- 10.28.04 Tessa Rinner—Denali Commission
- 10.28.04 The Maine Plan (Sergei Bogojavlensky, MD)
- 11.11.04 Norman Wilder MD, MBA (Regional), Roy Davis MD (Providence)—Quality and cost  
control initiatives
- 11.18.04 Rod Betit—State Hospital & Nursing Home Association
- 12.02.04 Catherine Schumacher MD—Access to health care in Anchorage
- 12.09.04 Cathy Giessel, MS, FNP-CS—The role of nurse practitioners
- 12.09.04 Harold Johnston, MD— Program Director, Alaska family Practice Residency
- 1.06.05 Joan Fisher – Executive Director, Anchorage Neighborhood Health Center and Medical  
Director, Dr. Tom Hunt and Beverly Wooley, Director, Anchorage Municipal Health  
Department
- 1.27.05 Janet Trautwein – VP Government Affairs, National Assn of Health Underwriters
- 1.28.05 (Forum) panel discussion with Commissioner Joel Gilbertson, Al Parrish, Randall  
Burns—Alaska Small Hospital Performance Improvement Network, Dr. David Snyder—  
Alaska Native Medical Center
- 2.03.05 James Jordan, Executive Director, Alaska State Medical Association
- 3.10.05 Ann Conway, Maine Center for Public Health
- 3.25.05 Joseph Ditre, Executive Director, Consumers for Affordable Health Care Foundation  
(Maine)

# **State of Alaska**

**2006-2007**

**Select Benefits**

**Renewal Report**

**October 13, 2005**

## EXECUTIVE SUMMARY

Deloitte Consulting LLP (Deloitte Consulting) has been retained by the State of Alaska to provide recommended funding rates for its Select Benefits medical, dental, and vision benefit plans. The State currently contracts with Aetna and VSP to administer the plans on a self funded basis. The State currently offers three medical and dental plans (Premium, Standard and Economy) and two vision plans (Standard and Managed Care).

Deloitte Consulting calculated the funding rates using commonly accepted underwriting methodologies and assumptions. This report outlines our approach and observations from our analysis and projection.

The State of Alaska has also requested that Deloitte Consulting perform a study regarding offering a high deductible health plan that would permit the individual to participate in a federally qualified health savings account. If a high deductible health plan were offered on an optional basis, these rates may need to be adjusted to reflect the impact of adverse selection of healthier individuals moving to the new plan. That analysis is being performed and will be provided under a separate report.

### Renewal Process

Deloitte Consulting has reviewed three years of claims experience, enrollment, trends, premium data; administrative fees and other information provided in order underwrite these benefits. The results of our analysis were discussed with the Division of Retirement and Benefits prior to finalizing the recommended funding levels. Based on our analysis, we are recommending that the FY07 funding levels for the period 7/1/06 – 6/30/07 increase 2% for the medical plan with no increase for the dental and vision plans.

### FY07 Funding Levels

|                         | Economy – Single/Family |         |                  |
|-------------------------|-------------------------|---------|------------------|
|                         | Medical                 | Dental  | Medical & Dental |
| Total FY06 Funding Rate | \$775.00                | \$45.00 | \$820.00         |
| Renewal Change          | 2.0%                    | 0.0%    | 1.8%             |
| Total FY07 Funding Rate | \$790.00                | \$45.00 | \$835.00         |

## **UNDERWRITING PROCESS**

In order to project needed premium levels for the State's benefit plans we reviewed claims experience, trends, current premium levels, administrative fees, applicable benefit or plan changes and reserve fund levels. These processes will be discussed below.

### **Claims Experience**

Aetna HealthCare provided Deloitte Consulting State specific paid claims experience by month for the most recent 36 months. In this case we were able to obtain data from 8/1/2002 through 7/31/2005. The claims were separated into medical, prescription drugs (Rx), dental and vision. Deloitte Consulting used this paid claim experience to project monthly incurred claims using an actuarial completion factor methodology.

The most recent 12 months of claims experience has been much better than expected and is exhibiting trends lower than being experienced by other employers or insurance carriers. Some factors contributing to better than average experience include:

- Significant reduction in the number of catastrophic cases (> \$50,000 per individual per 12 months). Catastrophic cases comprised 34.4% of paid claims in 2003 and fell to 30.5% in 2004.
- Reduction in emergency room visits by 14.3% (2004 vs. 2003).
- Lower than expected prescription drug costs:
  - 2.1% increase in generic drug utilization resulting in reduced brand drug costs.
  - The revised coinsurance with minimum/maximum limits which leverages cost sharing as cost inflation increases.

Although not directly considered in our rate setting analysis, we must note that Deloitte was notified of a high cost claim incurred in July 2005 (not in the experience period analyzed) which is expected to exceed \$750,000. The Division also completed its positive enrollment project in July 2005 that resulted in a reduction of dependents covered by nearly 10%.

The most recent 12, 24 and 36 months of claims experience was reviewed to determine the effect on the needed premiums. After applying trend and other underwriting adjustments (described later), all of these time periods produced similar results with calculated premium changes of -0.4% to 2.0%. Historically the most recent 12 months of claims experience has been used in renewal calculation. Due to recent variations in claim experience, we believe it would be prudent to put more credibility on the 24-month and 36-month analysis resulting in a recommended rate increase of 2% for the medical while continuing with no rate increase for dental and vision. The overall result is an increase of 1.8%.

### **Trend Assumptions**

In order to determine the appropriate trend rate used to project claims for FY07 we review State specific claims trend along with industry norms provided by Aetna. The experience trend is

determined by reviewing the rolling 12-month per employee per month costs. The chart below shows this analysis.

|                                            | Medical | Rx       | Dental  | Vision  |
|--------------------------------------------|---------|----------|---------|---------|
| Experience Trend                           | 2 to 6% | 6 to 12% | 0 to 2% | 0 to 3% |
| Aetna Corporate Trend (Alaska & NW Region) | 18%     | 14.5%    | 9%      | NA      |
| Applied Trend                              | 9%      | 12%      | 3%      | 3%      |

These trends are applied to the State's historical incurred claim amounts in order to project future claims using a midpoint to midpoint trend calculation.

#### **Current Premium Levels**

Deloitte Consulting calculated aggregate current premium levels for Medical/Rx, Dental and Vision using a membership weighted average of the various plan levels. This approach arrives at one overall Medical/Rx increase percentage to be applied for all plans and not a separate increase for Premium/Standard/Economy plans. The actuarial value of the three plans and premiums would continue in the current relationship.

#### **Administrative Fees**

Based on the most current contract between the State and Aetna the administrative fee for the Select Benefits group for FY06 is \$43.02. In order to project this fee into FY07 we have increased the fee 5% to \$45.17. The final fee has not yet been negotiated with Aetna.

The administrative fee includes Aetna administrative fees, network access fees, Informed Health Line, VSP fees and payment for Magellan Behavior Health. In addition, the Aetna contract also includes provisions around operational performance guarantees, network savings guarantees and prescription drug rebates being refunded to the State.

#### **Reserve Adjustment & Contingency Margin**

The current cash fund balance for the Group Health and Life Fund is estimated to be about \$18.6 million as of June 30, 2005. We assume that the entire net fund balance is available to pay plan claims as necessary.

A reasonable objective would be to maintain a net fund balance equal to 15% to 25% of annual plan incurred claims as a hedge against future adverse experience. The net fund balance as of June 30, 2005, is approximately 30.0% of projected FY07 incurred claims. Year-to-year fluctuations in medical costs and utilization can occur even for a program of this size.

We believe this fund balance is in the reasonable range and are not recommending any explicit adjustments to the renewal to adjust the level of the reserves.

### **Benefit or Plan Changes**

In order to forecast future claim levels we need to account for historic changes in the plan design and abnormal occurrences such as non-recurring catastrophic claims. We have made two adjustments to the historical claims for this projection.

Prescription drug plan change - Beginning 7/1/03 the prescription drug benefit changed from a \$5 generic and \$10 brand copay structure to a 20% generic and 30% brand coinsurance structure with an \$8 minimum and \$50 maximum copay. The value of this change has been estimated at 15.0% savings (applied to the prescription drug claims only). When adjusting for this change in the renewal projections, 15% savings was applied to claims incurred prior to 7/1/03 to adjust the claims to the same benefit level.

Medical plan changes – beginning 7/1/04 Aetna implemented a PPO program and advised that they had modified their process for handling gastric bypass surgeries. We estimated 4.0% savings due to these changes. In addition, Aetna notified Deloitte that there was a catastrophic claim in 2003 that was not expected to affect future claims resulting in a 1.1% favorable adjustment.

The Division has requested that Deloitte perform a study of the feasibility of offering a high deductible plan that would permit an employee or the State to make a contribution to a federally qualified Health Savings Account (HSA). If such a plan were offered on an optional basis, the rates developed may need to be adjusted to reflect the impact of the additional offering.

### Rate Recommendations

Deloitte reviewed a couple different approaches when determining the final rate recommendations. Based on the past year's favorable experience and placing additional credibility on the 24-month and 36-month experience periods, Deloitte recommends the following premium rate structure for FY07:

| Medical/Audio/Rx |                                 |            |          |          |
|------------------|---------------------------------|------------|----------|----------|
|                  | Premium<br>(Standard<br>Family) | Premium    | Standard | Economy  |
| FY06 Rates       | \$980.00                        | \$1,156.00 | \$898.00 | \$775.00 |
| Renewal Change   | 2.0%                            | 2.0%       | 2.0%     | 2.0%     |
| FY07 Rates       | \$1,000.00                      | \$1,179.00 | \$916.00 | \$790.00 |

| Dental         |          |          |            |
|----------------|----------|----------|------------|
|                | Premium  | Standard | Preventive |
| FY06 Rates     | \$175.00 | \$105.00 | \$45.00    |
| Renewal Change | 0.0%     | 0.0%     | 0.0%       |
| FY07 Rates     | \$175.00 | \$105.00 | \$45.00    |

| Total Economy Plan      | Single/Family |
|-------------------------|---------------|
| Total FY06 Funding Rate | \$820.00      |
| Renewal Change          | 1.8%          |
| Total FY07 Funding Rate | \$835.00      |

| Vision         |          |              |
|----------------|----------|--------------|
|                | Standard | Managed Care |
| FY06 Rates     | \$33.00  | \$22.00      |
| Renewal Change | 0.0%     | 0.0%         |
| FY07 Rates     | \$33.00  | \$22.00      |

# **State of Alaska**

**2006**

**Retiree Benefits**

**Renewal Report**

**October 31, 2005**

## EXECUTIVE SUMMARY

Deloitte Consulting LLP (Deloitte Consulting) has been retained by the State of Alaska to provide recommended funding rates for its Retiree medical, dental, and vision benefit plans. The State currently contracts with Aetna to administer the plans on a self funded basis. The State currently offers medical and dental/vision/audio (DVA) plans.

Deloitte Consulting calculated the funding rates using common underwriting methodology and assumptions. This report outlines our approach and observations from our analysis and projection.

### Renewal Process

Deloitte Consulting reviewed three years of claims experience data, enrollment, trends, premium, administrative fees and other information provided in order underwrite these benefits. This process is detailed in this report. This analysis was discussed with the Division of Retirement and Benefits prior to the final setting of the recommended funding levels. Based on our analysis, we are recommending that the calendar year 2006 (CY06) composite rate levels should increase 3.0% for the medical plan and 0.0% for the DVA plan (See detailed rating exhibits). It should be noted that the overall medical plan increase would have needed to be 7.8% if we had not adjusted our rating for improved drug rebates and the Medicare Part D subsidy.

### FY06 Funding Levels

|                           | Medical  | DVA     |
|---------------------------|----------|---------|
| Total CY05 Composite Rate | \$850.15 | \$87.26 |
| Renewal Change            | 3.0%     | 0.0%    |
| Total CY06 Composite Rate | \$875.65 | \$87.26 |

In arriving at our recommended increase we rated this group in 4 ways. Results of each method are shown below.

In addition, we looked at projections using 12, 24 and 36 months of experience. All of these time periods produced similar results.

In past years we have not made an explicit adjustment for drug rebates and performance guarantees. It was assumed that rebates along with performance guarantees would provide reserve and contingency funding. If we were to continue rating in this manner the medical and drug rate increase would be 7.8%.

Due to the growth in drug rebates, we performed a rating with an explicit adjustment for rebates. Rebates are received monthly for a negotiated amount and used to offset Aetna administrative fees. There is also an annual additional amount received to reconcile actual rebates to amount

already received for the year. If we were to rate the retirees with this adjustment the medical and drug rate increase would be 6.1%.

This year we also could incorporate the value the of the Medicare Part D subsidy the State of Alaska will be receiving by continuing to provide prescription drug coverage to their retirees. It has been determined that the State of Alaska will qualify for the 28% subsidy and an explicit factor for this adjustment is included in this rating. It should be noted that the actual receipt of subsidy payments will be many months after claims have been paid. However, these reimbursements will be made and can be used to offset rates. This adjustment would reduce the increase to 4.7%

Due to the adequacy of the current fund balance, we are recommending that the rates reflect both the improved drug rebates and eventual receipt of the subsidy payments. These two adjustments result in a calendar year 2006 (CY06) composite rate level increase of 3.0% for the medical plan and 0.0% for the DVA plan.

## **UNDERWRITING PROCESS**

In order to project needed premium levels for the State's benefit plans we review claims experience, trends, current premium levels, administrative fees, applicable benefit or plan changes and reserve fund levels. These processes will be discussed below.

### **Claims Experience**

Aetna HealthCare provides Deloitte Consulting State-specific paid claims experience by month for the most recent 36 months. In this case we were able to obtain data from 8/1/2002 through 7/31/2005. The claims are separated into medical, prescription drugs (Rx), dental and vision. Deloitte Consulting uses this paid claim experience to project monthly incurred claims using an actuarial completion factor methodology. Due to the credible size of this group, we concentrated on the most recent 12 months of claims experience.

The most recent 12 months of experience has been better than forecasted last year and slightly lower than being experienced by other employers and insurance carriers. Some factors contributing to the better than average experience include:

- Average length of hospital stays down 8.7%
- This reduction in length of stay kept inpatient costs to a reasonable 5.8% increase
- In-Network utilization improved 5-7%
- Ancillary unit costs such as lab services improved dramatically (up to 22%)
- Generic utilization improved from 41.3% to 45%

### **Trend Assumptions**

In order to determine the appropriate trend rate used to project claims for CY06 we reviewed State specific claims trend along with industry norms provided by Aetna. The experience trend is determined by reviewing the rolling 12-month and 3-month per retiree per month (PRPM) costs. The chart below shows this analysis.

|                       | Medical | Rx       | Dental | Vision  | Audio       |
|-----------------------|---------|----------|--------|---------|-------------|
| Experience Trend      | 3 - 5%  | 20 - 22% | 3 - 4% | 0 to 3% | -10 to -20% |
| Aetna Corporate Trend | 18%     | 14.5%    | 9%     | NA      | NA          |
| Applied Trend         | 7%      | 21%      | 4%     | 2%      | 0%          |

These trends are applied to the State's historical incurred claim amounts in order to project future claims using a midpoint to midpoint trend calculation. Due to the credible size of this group, we concentrated on the most recent 12 months of claims experience.

We have used a slightly higher trend than the experience suggests for medical to account for the impact the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) will have on Alaska providers. Under MMA, there is a special provision affecting physicians in Alaska that resulted in more than a 52% increase in average Medicare physician fee schedule payments for 2004. It is our understanding that most Aetna providers in the State of Alaska accept Medicare payments and since only approximately 45% of State of Alaska retirees are eligible for Medicare the affect of the MMA on Alaska is adequately reflected in a slight increase in trend over the observed experience trend.

#### **Administrative Fees**

Based on the most current contract between the State and Aetna the FY06 (7/1/05 - 6/30/06) administrative fee for the Medical plan is \$29.22 and \$4.43 for the DVA plan. We used a 5% trend to forecast the FY07 (7/1/06 - 6/30/07) administrative fee. The final fee has not yet been negotiated with Aetna.

The administrative fee includes Aetna administrative fees, network access fees, VSP fees and payment for Magellan Behavior Health. In addition, the Aetna contract also includes provisions around operational performance guarantees, network savings guarantees and prescription drug rebates to be refunded to the State.

#### **Reserve Adjustment & Contingency Margin**

The current cash fund balance for the Retiree Health Fund is estimated to be about \$126.0 million for Medical as of June 30, 2005. This indicates a growth of approximately 51.9% over the June 30, 2004 Retiree Health Fund for Medical of approximately \$83.0 million. We assume that the entire net fund balance is available to pay plan claims as necessary.

A reasonable objective would be to maintain a net fund balance equal to 15% to 25% of annual plan incurred claims as a hedge against future adverse experience. The net fund balance as of June 30, 2005, is estimated to be between 42.2% and 44.2% of projected CY06 incurred claims for the Medical plan. Year-to-year fluctuations in medical costs and utilization can occur even for a program as large as this.

We believe this fund balance for the Medical plan is adequate and are not recommending an explicit adjustment to the renewal to adjust the level of the reserves.

The current cash fund balance for the Retiree Health Fund is estimated to be about \$10.5 million for DVA as of June 30, 2005. This indicates a growth of approximately 9.3% over the June 30, 2004 Retiree Health Fund for DVA of approximately \$9.6 million. The net fund balance as of June 30, 2005, is estimated to be 50.8% of projected CY06 incurred claims for the DVA plan.

We believe this fund balance for the DVA plan is sufficiently adequate and we recommend no increase for the DVA plan.

#### **Benefit or Plan Changes**

In order to forecast future claim levels we need to account for historic changes in the plan design. We have made adjustments to the historical claims for this projection for the DVA plan.

**Dental plan change** - Beginning 1/1/03 the dental benefit changed from 80% to 100% for preventive services. The value of this change has been estimated at 9.4% cost. When adjusting for this change in the renewal projections, 9.4% of additional cost was applied to claims incurred prior to 1/1/03 to adjust the claims to the same benefit level.

**Vision plan change** - Beginning 1/1/03 the vision plan added coverage for anti-reflective, polycarbonate and scratch resistant lenses. The value of this change has been estimated at 8.4% cost. When adjusting for this change in the renewal projections, 8.4% of additional cost was applied to claims incurred prior to 1/1/03 to adjust the claims to the same benefit level.

**Audio plan change** - Beginning 1/1/03 the audio maximum benefit increased from \$800 to \$2,000 every three consecutive benefit years. The value of this change has been estimated at 36.4% cost. When adjusting for this change in the renewal projections, 36.4% additional cost was applied to claims incurred prior to 1/1/03 to adjust the claims to the same benefit level. In 2003 and 2004 we observed a significant increase in audio claims due to the increase in this benefit. It should be noted that for this upcoming year (2006) the annual benefit maximum for the majority of participants will "reset".

### Rate Recommendations

In order to meet expected claims experience, Deloitte recommends the following premium rate structure for CY06.

| Medical              |         |                    |
|----------------------|---------|--------------------|
|                      | 2005    | 2006 - Recommended |
| Retiree Only         | \$573   | \$590              |
| Retiree & Spouse     | \$1,146 | \$1,179            |
| Retiree & Child(ren) | \$809   | \$833              |
| Retiree & Family     | \$1,382 | \$1,423            |

| DVA                  |       |                    |
|----------------------|-------|--------------------|
|                      | 2005  | 2006 - Recommended |
| Retiree Only         | \$54  | \$54               |
| Retiree & Spouse     | \$108 | \$108              |
| Retiree & Child(ren) | \$97  | \$97               |
| Retiree & Family     | \$152 | \$152              |

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**State Government Retiree Health Benefits:  
Current Status and Potential Impact of New  
Accounting Standards**

by  
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Lorel Wisniewski, Ph.D.  
Workplace Economics, Inc.**

The AARP Public Policy Institute, formed in 1985, is part of the Policy and Strategy group at AARP. One of the missions of the Institute is to foster research and analysis on public issues of importance to older Americans. This publication represents part of that effort. The views expressed herein are for information, debate, and discussion, and do not necessarily represent formal policies of AARP.

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## Foreword

The likelihood that an employer offers retiree health benefits varies by size of employer, region, and industry. State and local governments continue to offer retirees health coverage at a higher rate than any other industry. While there are some common factors that influence health benefit decisions of employers in both the public and private sectors, there are also factors that distinguish public and private sector employers.

One such distinction is that state and local governments follow accounting standards for financial reporting different from those followed by private companies. State and local governments follow standards set out by the Governmental Accounting Standards Board (GASB), whereas private companies follow those of the Financial Accounting Standards Board (FASB). In the early 1990s, FASB implemented accounting standards for retiree health benefits that changed how a company's costs for retiree health benefits have to be reported. The standards required a change from reporting the expense of retiree health benefits on the basis of the cost of benefits in the period in which they are paid to reporting the cost of benefits as they are earned, which involves estimating and accruing both the future cost of these commitments and current spending for these commitments. This change has been widely cited as one factor, along with rising cost of these benefits, that has led companies to revise their retiree health benefit programs. Although GASB did not implement similar standards at the same time, it is now issuing new standards for state and local governments to report the costs of their Other Postemployment Benefits (OPEB), i.e., benefits other than pensions. The new standards raise the question of how their implementation will affect retiree health benefits in the future.

The AARP Public Policy Institute commissioned Workplace Economics, Inc. to conduct this research on retiree health benefits in state governments. In addition to providing a snapshot of state government retiree health benefits under existing accounting rules, the report gives an overview of current accounting practices for these benefits and of the changes that the new standards require. Based on this information, the report discusses potential issues that the new standards may raise for governments, taxpayers, and retirees. For example, reports based on the new accounting standards will make information on the long-term costs of retiree health benefits to state and local governments more readily available. Such information may focus attention on the challenge of honoring past and future commitments for retiree health benefits.

We hope this report will help inform debates that implementation of the new GASB standards may stimulate.

Gerry Smolka  
Senior Policy Advisor  
AARP Public Policy Institute

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## Executive Summary

### Purpose

The Governmental Accounting Standards Board (GASB) issued an Exposure Draft<sup>1</sup> early in 2003, and a revision to the draft in early 2004, detailing proposed new accounting standards for state and local government retiree health care and other non-pension benefits. The Board adopted Statement No. 43, *Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans*, in May 2004 and a related Statement, *Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions*, in June 2004. The earliest these will go into effect is for fiscal years starting in December 2006. To the extent that the new GASB standards require changes in assumptions or methods currently used by public sector entities to account for and report the costs of retiree health care, decision-makers' consideration of the more comprehensive information developed may result in changes in behavior and practices by both providers and users of retiree health benefits. To assess the potential impact of the new GASB standards on public policy, this paper examines retiree health care benefits currently provided in state government employment by the 50 states excluding the District of Columbia and practices employed by state governments to account for and finance their retiree health benefit obligations. The results can be used as a baseline against which to gauge the implications of the changes in accounting standards.

### Background

Current practices used by state governments to account for and report their retiree health benefit obligations diverge from private sector practice and are shaped by existing accounting standards such as GASB 12, 25, 26, and 27. The new standards for governmental employer reporting of OPEB are broadly similar to standards applicable to the private sector issued by the Financial Accounting Standards Board (FASB) in 1990; they understand that OPEB is deferred compensation and their objective is to achieve accrual of benefit costs and liabilities during periods when employees render services. However, the new GASB standards are modeled after previous GASB standards on employers' reporting of pension benefits and include differences from FASB requirements designed to address the accounting and reporting practices of the public sector. For many states, the new OPEB standards will require accrual accounting for such benefits for the first time.

### Methodology

To provide a current snapshot of health benefits for retired employees, Workplace Economics, Inc. analyzed information in its proprietary database on benefits provided to state government employees in all 50 states (the District of Columbia is not part of the state government database). To provide the overview of current state financial reporting practices, Workplace Economics analyzed state governments' annual financial reports.

<sup>1</sup> Standards for "Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions" and "Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans" can be ordered from GASB at its internet website ([www.gasb.org](http://www.gasb.org)).

## Findings

1. Many states play a substantial role in the provision of retiree health benefits. Current retiree health care programs available to state government retirees vary significantly by key plan characteristics such as number and type of plans offered; premium costs; cost-sharing features such as copayments, coinsurance, and deductibles; and prescription drug plan features. For example, total monthly premiums for individual coverage for pre-Medicare retirees range from \$159.92 for the lowest-cost plan offering available among the 50 states to \$925.42 for the highest-cost plan offered in any state. For Medicare-eligible retirees, total monthly premiums for single coverage range from \$46.40 for the lowest-cost available plan to \$448.52 for the highest-cost plan offered in any state.
2. State financial statement reports provide some insight into the dimensions of retiree health insurance programs and their aggregate cost. Significantly, 41 states report providing some contribution towards defraying the cost of state retiree health insurance through programs covering more than 1.7 million retirees. Of the 41 states that reported providing some contribution towards retiree health insurance, 30 finance the state costs on a pay-as-you-go basis, while only 11 reported a prefunding arrangement. In the aggregate, state spending on OPEB approximated \$4.4 billion in FY2001. About \$3.8 billion was financed on a pay-as-you-go basis.
3. There are currently four GASB standards that provide guidance for existing state government accounting and reporting for postemployment health insurance benefits. GASB 12, *Disclosure of Information on Postemployment Benefits Other Than Pension Benefits by State and Local Government Employers*, became effective June 15, 1990 and requires that all employers who finance all or some portion of their retiree health insurance should provide: (1) a description of the benefits provided, employee groups covered, and the employer and participant obligations to contribute; (2) a description of the statutory, contractual, or other authority under which the benefit provisions and obligations to contribute are established; (3) a description of the accounting and financing or funding policies followed for those benefits; and (4) the expenditures/expenses for those benefits recognized for the period. These disclosures are typically accomplished through a note to the governmental entity's financial statement. However, unlike the new OPEB standards, GASB 12 does not require that particular practices be employed in recognizing and measuring retiree health insurance benefits. Subsequently, three additional GASB standards were implemented which affected the treatment of retiree health care benefits when provided through a public employee retirement system. First, GASB 27, *Accounting for Pensions by State and Local Governmental Employers*, issued in late 1994 but not effective until mid-1997, provides guidance to employers that elect to apply their pension accounting standards to retiree health care. In June 1996, GASB 25, *Financial Reporting for Defined Benefit Pension Plans and Note Disclosures for Defined Contribution Plans*, and GASB 26, *Financial Reporting for Postemployment Health Care Plans Administered by Defined Benefit Pension Plans*, became effective. GASB 25 and GASB 26 have delineated the applicable standards, not only for retiree health care plans that are advance funded through a public employee retirement system, but, more broadly, for any retiree health care plan administered by a governmental defined benefit pension plan, regardless of whether the health care plan is funded on an actuarially determined basis or by some other mechanism. In its OPEB project, the Board decided to apply the same overall approach adopted in GASB 25 and GASB 27 to the reporting of OPEB by employers and plans, with such modifications as the Board considered necessary to reflect differences between pension benefits and OPEB.

4. While GASB's new OPEB standards are similar to FAS 106 in requiring those government employers to accrue the costs of postretirement health insurance during the years of service of their employees just as private sector employers are required to accrue the costs of such benefits, it appears likely there will be some significant differences in the standards as well as differences in the impact of the standards.

### **Impact and Implications**

Employer-sponsored retiree health care provided by public employers is an important component of our nation's system of health care insurance for retirees. Therefore, any significant changes to state government employer retiree health care insurance resulting from the new OPEB standards or from the impact of underlying cost drivers necessarily will call for a response from policymakers if insurance gaps arise.

1. The private sector experience with FAS 106 provides mixed lessons for trying to anticipate the outcome of the new OPEB standards as formulated by GASB.
2. State government employers are typically large employers, and large employers generally provide postemployment benefit programs that remain relatively stable over time.
3. The financial information produced by the application of the new OPEB standards may encourage state governments to think about reducing retiree health benefit programs in the future in order to avoid liabilities. Yet, while the new OPEB standards may result in the consideration of changes that would minimize adverse accounting effects on public budgets, health benefit program changes seem more likely to be prompted by the availability of a drug benefit through Medicare and the underlying cost drivers, e.g., health care inflation, an expanding retiree population relative to active employees.
4. The new OPEB standards may encourage greater prefunding of retiree health care benefits. Because prefunding typically produces higher short-term costs as compared to pay-as-you-go financing, it may add to state government financial obligations at an inopportune time for those states and may, therefore, prompt a reconsideration of the level of state commitments for future retirees. At the same time, states which do begin prefunding (and those already prefunding) may find that their direct employer costs will be lower in the long run and that their credit rating may be bolstered.
5. To the extent the new OPEB standards may encourage greater prefunding of retiree health care benefits, they may produce greater intergenerational equity for taxpayers. This is because each generation, at least in theory, can assure itself that it is paying only for the personnel costs associated with the services provided by employees active during the taxpayer's lifetime, not previous lifetimes.

### **Conclusion**

Economic and demographic factors are putting upward pressure on the cost of retiree health insurance provided by state public employers and, unless adequately prefunded, increasing

retiree health insurance costs may result in mounting deferred liabilities for state employers with the potential for an adverse impact on credit ratings. The concern over the future potential effect of such liabilities has prompted an examination of current governmental accounting standards for financial reporting to determine if such reporting achieves a sufficient consideration of the impact of providing retiree health care benefits on overall government operations. However, the implementation of new governmental accounting standards concerning retiree health insurance and other postemployment benefits, while adding to short-term pressures on government employees, appears unlikely to change what are typically the stable benefit provision patterns of large state employers, unless coupled with significant health care cost inflation for the foreseeable future and a continued deterioration of the active-to-retiree workforce ratio.

## Introduction

It is the widespread practice of state governments to provide health benefits to former employees when they retire. In fact, the share of public sector employers offering retiree health benefits remains high in comparison to private employers.

The Governmental Accounting Standards Board (GASB) issued an Exposure Draft early in 2003 detailing proposed new accounting standards for state and local government retiree health care and other non-pension benefits; the Board adopted Statement No. 43, *Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans*, and a related statement, *Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions*, in June 2004. The new standards for employer reporting of Other Postemployment Benefits (OPEB) are broadly similar to standards applicable to the private sector issued by the Financial Accounting Standards Board (FASB) in 1990; they understand that OPEB is deferred compensation and their objective is to achieve accrual of benefit costs and liabilities during periods when employees render services. However, the new GASB standards are modeled after previous GASB standards on employers' reporting of pension benefits and include differences from FASB requirements designed to address the accounting and reporting practices of the public sector. Some additional differences from private sector requirements are associated with GASB's simplified alternative measurement method for small plans, e.g., single employer OPEB plans with fewer than 100 members.

To the extent that the new GASB standards require changes in assumptions or methods currently used by public sector entities to account for and report the costs of retiree health care, the introduction of these new standards may result in changes in behavior and practices by both providers and users of retiree health benefits. Faced with more comprehensive financial information and revised expectations regarding current and future health care costs, it is generally assumed that public employers, retiree health care plans, plan participants (including both retiree participants and actively employed future participants) and policymakers may alter their decision-making regarding the structure and level of postretirement health benefits.

Organization of Paper. This paper begins with a description of how retiree health care benefits are provided in state government employment in fiscal year 2003. This "current" state of retiree health care benefits provided by state government employers then can be used as a baseline against which the impact of any policy changes can be assessed. Next, this paper reviews the current practices used by state governments to account for and finance their retiree health benefit obligations. This involves a review of existing accounting standards, such as GASB 12, 25, 26, and 27, where relevant, and a delineation of how these standards have set the stage for movement to new OPEB standards. Then, this paper examines the potential impact of the new OPEB standards on accounting practices and contrasts the standards' likely effect with the impact of the adoption of FASB 106, highlighting the major similarities and differences between the standards. Finally, this paper concludes with an assessment of the potential impact of the new OPEB

standards on current and future state government retirees, public employers, taxpayers, and policymakers.

Methodology. In order to provide an overview of current state government retiree health insurance benefits, Workplace Economics, Inc. analyzed information in its proprietary database, developed over 15 years, on benefits provided to state government employees in all 50 states (the District of Columbia is not part of the state government database). The database is the product of an annual survey of state governments on their employee benefits as well as an analysis of state employee health insurance plan documents; the database includes information on health benefits for retired employees. The information in Appendix A comes from this database. To provide the overview of current state financial reporting practices and the information in Appendix B, Workplace Economics analyzed state governments' annual financial reports.

The discussions of the current and new standards are based on the authors' knowledge of the two sets of standards, and the section on the impact reflects the authors' own assessment of some of the potential effects of the implementation of new GASB accounting standards.

## Overview of Current State Government Retiree Health Benefits

In order to properly assess the impact of any new OPEB standard, both the depth and breadth of retiree health care benefits received by state government retirees needs to be determined. That is, it is important to identify the scope of such state programs and to understand the share of the financial burden borne by each state government for such benefits. To shed light on these issues, Workplace Economics, Inc. undertook two data analyses in this paper: (1) an examination of the key plan characteristics of state retiree health care programs and (2) a review of state government annual financial reports on the scope and aggregate annual cost of state OPEB spending.

### Key Characteristics of State Retiree Health Care Plans

Fiscal year 2003 data for each state were examined in order to determine: (1) the actual dollar amount of premiums paid for retiree health care coverage by the state and by the retiree, respectively; (2) the deductibles, coinsurance, physician co-payments, and out-of-pocket maximums associated with the plans reviewed; and (3) the key characteristics of any prescription drug plans offered as part of the retiree health care program. When more than two plans were offered, the lowest-cost and the highest-cost plans were included in the analysis.<sup>1</sup> As summarized below, retiree health care programs available to state government retirees varied significantly in design.

Plan Offerings. In fiscal year 2003, all 50 state government employers surveyed offered health care benefits for retirees under the age of 65, and 48 states—all but Indiana and Nebraska—offered health care benefits to retirees age 65 and older. (See Appendix Table A1.) Roughly one in five states offered a single plan statewide, while some others offered as many as 10 or more plans. However, in states with multiple options, generally no more than three or four plans were available statewide, while additional offerings—usually HMOs—were available only in limited service areas. A retiree therefore typically had no more than three or four options available, based on the location of his or her residence.

In a number of cases, health coverage options offered to pre-Medicare retirees were the same as or similar to those available to active employees. In some cases, pre-Medicare and/or Medicare-eligible retirees selected from either additional or different options offered by the state and the retirement system. In Arizona, for example, retirees could

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<sup>1</sup> Because some states offer a large number of pre-Medicare and Medicare retiree health care plans that would make a complete inventory of the key characteristics of all such plans unwieldy, this analysis was limited to providing information on the key plan characteristics of the lowest-cost and highest-cost plans offered to retirees, where "lowest-cost" and "highest-cost" refers to the retiree premium cost in dollars for retiree-only coverage. These plans were selected for analysis because they set the lower and upper bounds for the premium costs for all available plans and because such plans often attracted the largest enrollments among available plans. For example, a survey of state plan sponsors revealed that, for 72% of the responding states, the retiree health plan with the largest enrollment was either the "lowest-cost" plan or the "highest-cost" plan that was described for that state in Appendix A.

select from separate sets of plans offered by the retirement system and by the state Department of Administration.

Upon reaching age 65, when retirees become eligible for Medicare, plan payment and/or coverage changed. Retirees of the states of Indiana and Nebraska were no longer covered under the state's health plan after age 65 and had to seek individual coverage elsewhere to supplement Medicare. In the remaining 48 states, many retirees were able to continue coverage in the same health plan that they had while working or as an early retiree, but in 20 states they were also offered options for Medicare supplement plans.<sup>2</sup> A few states offered only Medicare supplement plans to retirees over the age of 65. In either case, Medicare was the primary payer for retirees age 65 and over, so individuals had to sign up for Medicare as soon as they became eligible. Comprehensive plans were not explicitly designed to complement Medicare as were the supplement plans, but they all coordinated coverage with Medicare to avoid duplicate payment for services covered by both plans.<sup>3</sup>

The majority of states offered the two groups of retirees—pre-Medicare and Medicare eligible—the same number of plan options. Nevertheless, 14 states offered fewer options, and seven states offered more options to retirees age 65 and over than their younger counterparts.

Eligibility for Retiree Health Benefits. In most states, individuals eligible for pensions based on their years of service could opt for continued health care coverage, although 17 states had additional requirements such as some minimum number of years of active service with the state or prior coverage in the health plan as an active employee. (See Appendix Tables A2 and B1.) States also differed as to when the retiree could opt for coverage. A dozen states required the individual to enroll within a limited time period—usually 30 to 90 days—surrounding the retirement date. A few allowed the retiree to defer enrollment in specific situations, such as when the retiree was already covered as a dependent under a state-sponsored plan but later lost that coverage upon the spouse's death, or when an employee terminated employment prior to retirement but with specified service credit.

Premium Contribution. Eligibility requirements for state subsidization of the premium frequently differed from requirements for participation in the plan, i.e., a retiree who was eligible to participate in the health plan may not have been eligible for a premium

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<sup>2</sup> The Centers for Medicare and Medicaid Services (CMS) and the National Association of Insurance Commissioners (NAIC) have defined 10 standardized "Medicare supplement" or "Medigap" plans that may be offered to Medicare-eligible retirees. Employers that offer Medicare supplement plans to retirees over age 65 conform to one of these types. The plans (designated "A" through "J") are designed to complement Medicare coverage by paying for varying degrees of deductibles, coinsurance, prescription drugs and other services not covered by Medicare.

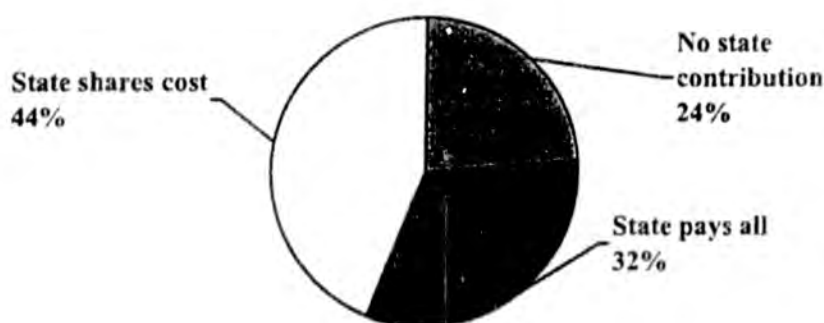
<sup>3</sup> Retirees who do not enroll in Medicare are effectively treated by state government health plans "as if" they were enrolled. Some plans make allowances for individuals not eligible for Medicare because their employer did not pay taxes into the program to retain some level of coverage. See Appendix Table A2.

subsidy. (See Appendix Tables A2 and B1 for details about eligibility for subsidies from health plan documents and financial reports, respectively, and also the notes to Tables A3 and A4 on premium costs for early retirees and Medicare-eligible retirees.) Almost one-third of states varied the portion of the subsidy based on the individual's years of credited service at retirement, with long-service employees (typically with 20 to 30 years) eligible for the maximum subsidy.

Figure 1 summarizes how states shared premium costs with pre-Medicare retirees for single coverage assuming the individual was eligible for the maximum subsidy.<sup>4</sup> For pre-Medicare retirees, 16 states (32%) paid the full amount of the premium for at least the lowest-cost plan offered and, in 12 states (24%), the retiree paid 100 percent of the premium.

Figure 2 summarizes premium cost-sharing requirements for Medicare-eligible retirees for single coverage assuming the individual was eligible for the maximum subsidy. Seventeen states (34%) paid the full premium for at least the lowest-cost plan offered to eligible retirees over the age of 65, while Medicare-eligible retirees in 11 states (22%) paid the full amount of the premium themselves. Of the remaining states, 20 states (40%) shared premium costs for individual coverage between the state and the retiree (shown in Appendix Tables A3 and A4), and two states (4%) had no plan.

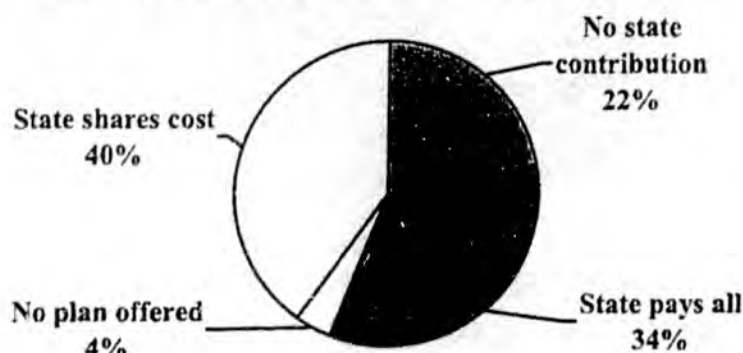
**Figure 1. Premium Cost Sharing For Pre-Medicare Retirees, FY 2003**



Note: Data are for single coverage and assumes maximum subsidy. Other conditions may apply, e.g., enrollment in the lowest-cost plan.  
Source: Workplace Economics

<sup>4</sup> The information cited and provided in the Appendix tables applies to individual coverage for the retiree only. States vary in their practices regarding coverage and the extension of subsidies to dependents.

**Figure 2. Premium Cost Sharing For Medicare-Eligible Retirees, FY 2003**



Note: Data are for single coverage and assumes maximum subsidy. Other conditions may apply, e.g., enrollment in the lowest cost plan.  
Source: Workplace Economics

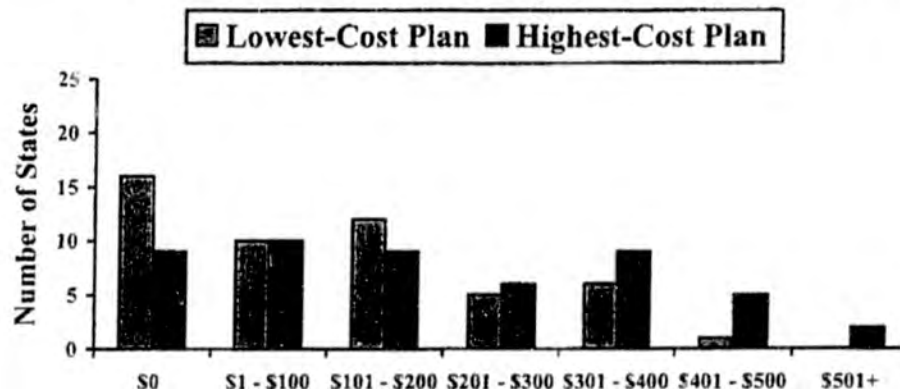
Across all 50 states, total monthly premiums for individual coverage for pre-Medicare retirees ranged from \$159.92 in South Dakota for the state's low-option preferred provider plan (PPO) to a high of \$925.42 for a PPO plan in Arizona. Among the 34 states where the pre-Medicare retiree paid either all or some portion of the premium costs, the monthly payment varied from \$5.01 in Utah for an HMO to \$795.40 for an indemnity plan in Wisconsin, assuming the retiree qualifies for the maximum subsidy. Figure 3 shows the distribution of pre-Medicare retiree premium contributions in \$100 increments. The figure includes the highest-cost plan and the lowest-cost plan for each of the 50 states.

For Medicare-eligible retirees, total monthly premiums for single coverage ranged from \$46.40 for an HMO in New Mexico to \$464.23 for a regional HMO in New York. Among plans requiring retirees to pay all or a portion of premium costs, the monthly premium share for individual coverage paid by Medicare-eligible retirees varied from \$10.00 in Georgia for a Medicare HMO to \$448.52 for Iowa's open access plan, assuming the retiree qualifies for the maximum subsidy. Figure 4 shows the Medicare-eligible retiree premium contribution within \$100 increments. The figure includes the highest-cost plan and the lowest-cost plan for each of the 50 states.

These findings clearly show the substantial role played by many states in the provision of retiree health care benefits in terms of the dollar amount of premium contributions that they made. It should also be noted that, in many cases, the health insurance premium applicable to pre-Medicare retirees might have been the same premium applicable to active employees. This may have been the case particularly where pre-Medicare retirees continued to be pooled for health insurance together with active employees. As a result, the premiums reported in such cases may have understated the actual claims costs incurred on behalf of the pre-Medicare participants. While such pooling of individuals

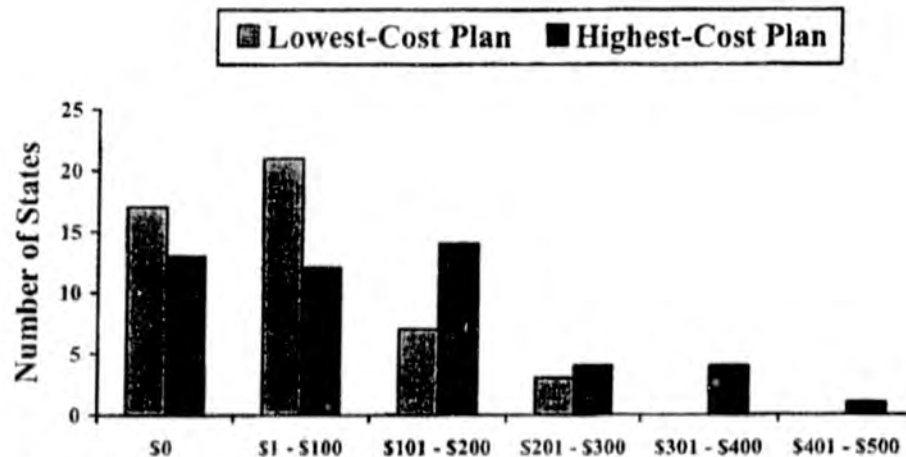
who are offered the same benefits (even though they may have different health or age characteristics) is at the heart of the insurance principle of spreading the risk, a few states took the position in their plan reporting that they were providing an implicit premium subsidy to their pre-Medicare retirees.

**Figure 3. Premium Contributions Paid by Pre-Medicare Retirees by State, FY 2003**



Note: Data are for single coverage and assumes maximum subsidy.  
Source: Workplace Economics

**Figure 4. Premium Amounts Paid by Medicare-Eligible Retirees by State, FY 2003**



Note: Data are for single coverage and assumes maximum subsidy.  
Source: Workplace Economics

Types of Plans and Cost-sharing Features. Key features of the lowest-cost and highest-cost plans available to retirees in each state are detailed in Appendix Tables A5 (pre-Medicare retirees) and A6 (Medicare-eligible retirees). Note that plan types in the tables — for example, HMO, PPO, and point-of-service (POS) — reflect the terminology of the particular state, i.e., the terms are not uniformly defined from state to state. Furthermore, the traditional distinctions between plan types have blurred as providers, plan administrators, and the state employers or retirement systems that offer the plans have altered plan features and added options to both minimize costs and provide alternatives.

Most common among the plans offered to pre-Medicare state retirees were plans that offer a different level of coverage and out-of-pocket payment depending on whether the member chooses to obtain care from in-network providers or out-of-network providers. Deductibles were common in most plans, except plans that only offer benefits when network providers were used. Many plans required copays that vary by the type of service obtained (e.g., specialty physicians, mental health, laboratory, physical therapy). Though not widespread, some plans (such as those that do not have deductibles) required hospital copays, typically from about \$100 to \$300 per admission, after which the plan paid all or most covered charges. A majority of plans reviewed had out-of-pocket maximums to limit the annual expenses paid by members. The per person maximums (using in-plan services where provider networks are part of the plan design) varied from \$400 to \$10,000 per year, but typical maximums were \$1,000 or \$2,000. Nonetheless, nearly a third of plans reviewed had no out-of-pocket maximum. Deductibles, copays, coinsurance and out-of-pocket maximums could vary considerably within a plan depending on whether the individual has obtained care from in-network or out-of-network providers.

Plan options available to Medicare-eligible retirees either were the same or similar in structure and characteristics to the options offered to pre-Medicare retirees, or were Medicare supplement plans (see Appendix Table A6). Yet plans without an out-of-pocket maximum were more likely in offerings to Medicare-eligible retirees. Plans that were not Medicare supplements differed from those described in the preceding paragraph only in how the benefit payment was calculated. Because Medicare was the primary payer, remaining charges were submitted to the insurance plan, which paid in accordance with the features of the plan. Copayments and out-of-pocket limits still applied (and, where applicable, continued to vary depending on whether the provider was part of the plan network). Medicare supplement plans, as noted previously, were explicitly designed to pay certain covered charges that are not paid by Medicare, such as all or part of the deductibles required under Medicare, or the retiree's 20 percent share of coinsurance for physician services.

In general, the lowest-cost plans were those requiring the retiree to pay the greatest share of covered benefits in the form of higher deductibles, copays or out-of-pocket maximums. In addition, plans with the greatest restrictions on where and how a member receives care tended to have lower premium costs.

**Prescription Drug Benefits.** Almost all of the highest- and lowest-cost state plans reviewed included some level of prescription drug coverage (see Appendix Tables A7 (pre-Medicare) and A8 (Medicare-eligible)). Since Medicare currently does not cover prescription drugs, this benefit was of particular importance to retirees over the age of 65. The majority of states offered the same drug benefit to early retirees and retirees on Medicare. However, in one state (South Dakota), both the lowest-cost and highest-cost Medicare-eligible plans did not include a drug benefit, although this benefit was available for early retirees. In a few other states, a drug benefit may have been available in one, but not both, of the plans examined in this study.

Many states offered a single prescription drug benefit as part of all (or most) of the health plans. Generally, under these plans, the retiree made a payment when purchasing the drug at a participating retail pharmacy. The vast majority of plans required copayments of a certain dollar amount, but a dozen or so plans required retirees to pay coinsurance of a certain percent of the drug price; the plan paid the balance. Some of these plans had a minimum or maximum coinsurance amount. Plans may have had different levels of copayments or coinsurance. The levels typically differed depending on whether the drug was classified as generic, brand name/formulary, or nonformulary. Of state government drug benefits reviewed, a small share had a single copayment level and a slightly larger share had two copayment levels. The majority had three levels of copayment. Among the plans reviewed, typical copayments were \$5 or \$10 for the lowest level; \$15, \$20, or \$25 for the second level; and \$30, \$35, or \$40 for a third level. The copays typically applied to a 30-34 day supply, and many plans offered further discounts for retirees who purchased maintenance or other medications by mail order (e.g., a requirement of two copays for a 90-day supply is typical). In addition, a few plans required a drug deductible or limit out-of-pocket payments for drugs. Limits on out-of-pocket payments be limited to generic and preferred drugs and drugs purchased in the plan's network. While benefits commonly included a mail order pharmacy option, this option was not included in at least one plan in about a dozen states.

#### **State Retiree Health Care Program Financial Report Data**

The analysis of health plan documents in the previous section provides information on the availability of, premiums for, and nature of benefits offered to state retirees. While that is an important part of the picture of current state retiree health benefits, it does not describe the current size, funding, or costs of these benefits to the state. To develop a picture of these aspects of state retiree health benefit plans and because, ultimately, any change in the OPEB accounting standards is most likely to be reflected in the comprehensive annual financial report (CAFR) of the state or the entity through which the benefit is provided (e.g., state retirement plan), each state's most recently available CAFR was reviewed with respect to OPEB reporting.

Each state's relevant annual reports were examined for the following categories of information: (1) the number of eligible retirees reported (generally as of mid-year