



MEMORANDUM

DATE: February 24, 2015

TO: Representative Dan Saddler, Chairman
House Health and Social Services Finance Sub-Committee

FROM: Sana Efird 
Assistant Commissioner

SUBJECT: Health Care Commission House Finance Committee Presentation Follow-Up

On February 11, 2015, the Department of Health and Social Services received the following questions from you regarding the Health Care Commission Finance Committee Presentation. The following is submitted in response:

1. Is Medicaid already paying for certain services in a bundled rate? (Rep. Saddler)

The Alaska Medicaid Program currently does not pay for any services through a bundled rate for episodes of care. This methodology would pay a single rate covering all hospital, physician, and associated services for specific types of health care episodes, such as all medical maternity care associated with a delivery, or hip or knee replacements.

However, the Medicaid Program does pay a daily encounter rate for certain types of providers for certain categories of services. For example, hospitals and nursing homes are paid single daily rates for all inpatient service (hospitals) and long term care services (nursing homes) provided during a stay. Federally Qualified Health Centers (FQHCs) are paid a single daily encounter rate for all primary care services provided during a Medicaid beneficiary patient visit, i.e., a single encounter rate is reimbursed regardless of how many tests and/or other procedures are provided associated with the primary care clinic visit on a given day. Also, Tribal Health Organizations are paid a single daily encounter rate set by the Centers for Medicare and Medicaid Services for all dental services or all behavioral health services provided during a Medicaid patient's visit.

2. *What has the Commission learned about Medical Malpractice Insurance as a cost driver in Alaska, and why haven't they made related recommendations? (Rep. Thompson)*

The Commission studied this issue in 2012 and found that the reforms enacted by the Alaska legislature in 1997 under the Alaska Tort Reform Act, and in 2005 under the Alaska Medical Injury Compensation Reform Act, made a positive impact on the cost of medical liability coverage for Alaska's medical sector. The Commission learned that medical professional liability rates for physicians in Alaska had been twice as high as those in northern California (considered the "gold standard" in liability reform) in 1996, and had fallen to be in line with the rates in northern California by 2012. These findings were included in the Commission's 2012 Annual Report, and links to reference documents are posted on the Commission's website on the "Malpractice Reform" references page at:

<http://dhss.alaska.gov/ahcc/Pages/focus/malpracticereform.aspx>

More information, including links to reference documents, is provided in the attachment on the Commission's findings regarding medical malpractice reform.

3. *What has the Commission learned about health care costs and pricing in Alaska, and what are the drivers of higher prices here? (Rep. Guttenberg)*

The Commission's work has primarily focused on the cost of acute medical services in Alaska over the past few years. The Commission's recommendations aim to contain health care cost growth through removal of regulatory barriers that limit flexibility in payment structures and negotiations; increasing transparency for patients, providers, payers, and policy makers; and improving value in health care payment, delivery, and care models.

A compilation of the Commission's official Findings Statements regarding health care costs in Alaska is attached. Important studies on this topic conducted for the Commission and on which these Findings are based are available on our website at:

<http://dhss.alaska.gov/ahcc/Pages/focus/healthcarecosts.aspx>.

The most significant of these studies includes a series of reports conducted for the Commission by an international health care actuarial firm, Milliman, Inc., comparing reimbursement levels for the most utilized medical procedures for various specialties between Alaska and a number of comparison states, and for six different payers, including commercial insurers, Medicaid, Medicare, Workers' Compensation, TRICARE, and the VA. The studies also include analyses comparing payment levels for hospitals, pharmaceuticals, and durable medical equipment. A separate report by Milliman also identifies the drivers of costs that are higher in Alaska than other states.

The Commission presented a summary of what we had learned so far about health care costs, pricing and cost drivers in Alaska to HFIN HSS on December 2, 2013. That presentation is available in the legislative archives at:

http://www.legis.state.ak.us/basis/get_documents.asp?session=28&docid=14603

4. *How much has the Commission spent on contracts and RSAs for the various studies? (various committee members)*

The Commission has spent a total of \$396.6 on consultant contracts for special studies over the past five years, as follows:

- Impact of the Affordable Care Act on Alaska; ISER/UAA; 2010: \$31,718
- Economic Analysis of Health Care Spending in Alaska; ISER/UAA; 2011: \$63,251
- Actuarial Analyses of Physician, Hospital, Prescription Drug, and Durable Medical Equipment Prices Compared to other States and between Payers, including analysis of cost drivers of price differentials; Milliman, Inc.; 2011 & 2012: \$140,000
- All-Payer Claims Database Study; Freedman HealthCare, LLC; 2013: \$84,120
- Survey of Alaskan Employer Health Benefit Practices; AK Department of Labor & Workforce Development; 2013-2014: \$22,000
- Analysis and Reports on Alaskan Employer Health Benefit Practices; ISER/UAA; 2013-2014: \$55,490

5. *What are the costs associated with implementing the Commission's legislative recommendations? (Rep. Wilson)*

Certain of the Commission's recommendations would cost state government nothing to implement, for example, enacting legislation to:

- Strengthen state seizure laws and/or require bonding of certain provider types that pose a higher risk of fraudulently billing Medicaid and being unable to compensate the State.
- Require hospitals and physicians to provide patients with price information when asked and to post prices for procedures that are most utilized and that generate the highest revenue.
- Change commercial insurance regulations that are inherently inflationary.

Estimates of costs of other recommendations include:

- Creation and on-going operation of a statewide All-Payer Claims Database for increasing understanding of and ability to improve costs and utilization of services, and to increase transparency: \$750.0 start-up followed by \$750.0/year was the initial estimate, however a recent report released this week documented smaller population states' such as Alaska's requiring just \$350.0/year. Anticipate at least 50% federal funding, with other financing mechanisms available as well. Potential savings could be significant. A recent study published in the Journal of the American Medical Association found that increasing transparency reduced employers' health benefit costs by 14%. If this transparency tool were implemented and resulted in a savings of just 1% it would save Alaskan payers – public and private – a total of \$100 million/year.
- Enhancement to near real-time and on-going maintenance of the Prescription Drug Monitoring Database (PDMP): \$105.0/year, which could be fully funded with a fee mechanism that would not require state general funds. PDMPs are effective tools at combatting the growing prescription drug abuse epidemic, which now kills more people than heroin and cocaine combined and is also an important factor in Medicaid fraud and abuse. PDMPs are proving effective at improving clinical decision-making and patient care as reported by prescribing clinicians, as well as in helping with the identification and

reduction in doctor-shopping practices, and in reducing drug and medical costs related to inappropriate prescribing. More information on PDMP effectiveness research is available from the Brandeis PDMP Center of Excellence at:
<http://www.pdmpexcellence.org/>

It is important to note too that the majority of the Commission's recommendations are directed at State agencies, and many of those recommendations are cost-neutral. A cost analysis on all legislative recommendations will be provided in the coming weeks.

6. *Will the Commission conduct an evaluation of the effectiveness of behavioral health services provided through Division of Behavioral Health grants? (Rep. Neuman)*

The former Commission Chair declined to conduct this analysis in the past for a number of reasons:

- It was outside the scope of his professional medical expertise.
- There are currently no members of the Commission with mental health or substance abuse treatment expertise (one seat designated for the Mental Health Trust Authority is currently filled by an administrator of a community-based resource service organization for the developmentally disabled).
- It was outside the scope of the Commission's focus on acute medical services, which costs Alaskan employers, public programs, and individuals a total of approximately \$7 billion/year, of which the State of Alaska's share is over \$1.7 billion/year.

The current Commission Chair is investigating opportunities for facilitating implementation of this study by an entity better qualified to evaluate mental health and substance abuse treatment.

7. *Please provide a listing of all the States in the State Rankings referred to on slide #6 (Rep. Neuman)*

Please see the attached "State Health Rankings" document, which includes an update of the position of Alaska relative to other states for Life Expectancy, Access to Primary Care, and Per-Capita Health Care Spending based on the most current data available.

8. *What are the "Rules of Engagement" for Commission interaction with the Legislature? (Rep. Saddler). Has the Commission made recommendations or had conversations that are "secret" or have not been shared with the Legislature?*

- Public transparency of Commission operations:
 - All meetings of the Commission are open to the public; a teleconference line is provided for those members of the public interested in listening-in who are unable to attend in person.
 - Agendas, presentations, and meeting handouts are all posted on the Commission's website.
 - All meetings of the Commission are recorded and transcribed. The full transcripts of all Commission meetings are posted on the Commission's website.

- A draft of the Commission's annual findings and recommendations and plans for the coming year are released each November for public comment before finalization and approval.
- The Commission is allowed to and does communicate with and interact with the Legislature. For example, the Commission:
 - Includes ex-officio representation from the House and Senate in its membership as provided in statute. Legislative representatives have been/are Sen. Donny Olson and Sen. John Coghill, and Rep. Wes Keller and Rep. Pete Higgins.
 - Provides Annual Reports on the activities and recommendations of the Commission on January 15 of each year.
 - Presents to Legislative Committees when invited on topics the Commission has studied and policy recommendations the Commission has made, including on:
 - 02/03/2010 to Senate HSS
 - 03/30/2010 to a House HSS-hosted legislative forum on the Affordable Care Act
 - 02/07/2011 to Senate HSS
 - 02/08/2011 to House HSS
 - 02/16/2011 to House Finance HSS
 - 02/16/2011 to Senate Finance HSS
 - 02/01/2012 to Senate HSS
 - 02/07/2012 to House HSS
 - 02/20/2013 to House Finance HSS
 - 02/28/2013 to House HSS
 - 03/14/2013 to House HSS on the Affordable Care Act
 - 06/07/2013 to House Finance HSS
 - 06/25/2013 to the Admin Reg Review Committee on the Affordable Care Act
 - 12/02/2013 to House Finance HSS
 - 01/24/2014 to House Finance HSS
 - Responds to inquiries concerning topics the Commission has studied and policy recommendations the Commission has made.
 - Provides feedback on draft bills directly related to Commission recommendations through the mark-up process.
- Limitations:
 - As an agency within DHSS, the Commission Chair and Director have required prior approval from the Governor's Office in the past for:
 - Actual drafting of legislation, either for sponsorship by the Governor or a legislator
 - Taking a formal position on proposed legislation
 - Providing testimony on proposed legislation
 - The Commission has not accepted requests of individual legislators to conduct special studies that fall outside of the scope of the Commission's expertise and focus.

9. *How has the Commission communicated findings and recommendations to the Legislature? (Rep. Neuman)*

Commission membership includes two representatives from the legislature — one each from the House and from the Senate. Legislative members have served as liaisons helping the Commission understand how to best communicate with and support the legislature, have hosted Commission presentations to legislative committees, and have sponsored legislation based on findings and recommendations of the Commission. Most recently Senator Coghill, the current Commission member from the Senate, has arranged to host and lead a Lunch & Learn forum on the Commission and about health care in Alaska for legislators and staffers on February 26, 2015.

The Commission submits an annual report to the legislature each year on January 15. The 2014 Annual Report was submitted January 15, 2015 and read across the floor of the House January 21 and the Senate on January 22.

Commission leaders have testified on numerous bills related to Commission recommendations. In addition, Commission presentations have been made numerous times to legislative committees on findings and recommendations, and also on the Affordable Care Act, including on:

- 02/03/2010 to Senate HSS
- 03/30/2010 to a House HSS-hosted legislative forum on the Affordable Care Act
- 02/07/2011 to Senate HSS
- 02/08/2011 to House HSS
- 02/16/2011 to House Finance HSS
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- 02/28/2013 to House HSS
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- 06/25/2013 to the Admin Reg Review Committee on the Affordable Care Act
- 12/02/2013 to House Finance HSS
- 01/24/2014 to House Finance HSS

10. *Can the Commission provide model legislation for an All-Payer Claims Database? How much would an All-Payer Claims Database cost to set up and operate, and how would personal health information be protected?*

Model legislation for state All-Payer Claims Databases (APCDs) does not currently exist, and so the Commission prepared a Policy Brief this past year for interested legislators, which describes key provisions that should be included in Alaska APCD legislation. The Policy Brief includes suggested provisions for maximizing privacy and security of data, and also describes the estimated costs. The Brief is included in the 2014 Annual Report, and is also available on-line at:

<http://dhss.alaska.gov/ahcc/Documents/2014ReportAPPENDIX%20B.pdf>

In addition, on February 12, the West Health Policy Center and the national APCD Council released a guide for states for developing an APCD. Based on information provided in this guide the cost of maintenance of an APCD for Alaska may be much less than originally estimated due to Alaska's small population and relatively few number of commercial insurers, and because standardized reporting systems are being developed in the public domain. The development guide may be accessed via this website:

<http://www.prnewswire.com/news-releases/west-health-policy-center-and-apcd-council-launch-new-guide-to-create-all-payer-claims-databases-and-accelerate-healthcare-price-transparency-300035119.html>

The Commission initially estimated approximately \$750.0 in start-up costs that could most likely be covered at 50% by federal funds, and depending on federal grant availability could potentially receive 100% federal funding for start-up. On-going annual operations were estimated initially by the Commission in the Policy Brief at between \$545.0 - \$900.0 based on other states' experience, but based on information provided in the recently released development guide that estimate might drop to as low as \$350.0. On-going annual operations may be able to receive 50% federal support as well.

The Commission's Policy Brief recommends state legislation for Alaska apply our stringent public health data privacy and security provisions outlined in AS 18.15.360-365 or AS 18.23.300, which include criminal penalties for inappropriate use or release of data. The Brief also advises that legislation direct the department to establish rules governing monitoring systems to ensure data system security and regarding protection of patient and community privacy. The Brief also advises requirements for rigorous formal data use application processes. Additional potential concerns legislators and others may have and suggested solutions are included in a table on page 3 of the Policy Brief. Recommended provisions for legislation are outlined on pages 4 through 7.

If you have any additional questions regarding this issue, please contact Sana Efird at 465-1630.

cc: Amanda Ryder, Fiscal Analyst, Legislative Finance
Adam Bryan, Capital Budget Coordinator, Office of Management and Budget
Valerie Davidson, Commissioner
Jay Butler, Chief Medical Officer
Jon Sherwood, Deputy Commissioner
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Melissa Ordner, Budget Manager
Anthony Newman, Legislative Liaison
Wilda Laughlin, Deputy Legislative Liaison

Alaska Health Care Commission
Findings Regarding Medical Malpractice Liability Reform in Alaska

The Commission studied the question of the need for medical malpractice liability reform in 2012, and found that the medical malpractice environment is relatively stable in Alaska compared to other states.

The Commission heard testimony from Jim Jordan, then Executive Director of the Alaska State Medical Association, and top executives of Alaska's two medical liability carriers (Andy Firth, CEO of MIEC, and Neil Simons, Vice President of NORCAL). The Commission found that the reforms enacted by the Alaska legislature in 1997 under the Alaska Tort Reform Act, and in 2005 under the Alaska Medical Injury Compensation Reform Act, made a positive impact on the cost of medical liability coverage for Alaska's medical sector.

The Commission's official findings from their analysis are below, followed by reference documents reviewed at the time.

Findings:

- ▶ Alaska's medical malpractice environment is relatively stable, supported by:
 - The 1997 Alaska Tort Reform Act
 - The 2005 Alaska Medical Injury Compensation Reform Act
 - Alaska Civil Rule 82
- ▶ Clinicians in two of Alaska's three medical sectors, the Tribal Health System and the Department of Defense/Veterans Affairs, are covered for medical liability under the Federal Tort Claims Act (FTCA) and are not subject to state tort law when acting within the scope of their official duties.
- ▶ Alaska's malpractice reforms to-date appear to have made an impact on the cost of medical liability coverage for Alaska's private medical sector.
 - In 1996 medical professional liability rates for physicians in Alaska were approximately two times those in northern California (considered the "gold standard" in liability reform)
 - Today, in 2012, Alaska's medical liability costs are in line with those in northern California.
- ▶ Alaskan health care administrators report anecdotally a positive impact on physician recruitment due to the positive malpractice environment in the state.
- ▶ Cost savings associated with defensive medicine practices are more difficult to identify because there are other contributors to these practices beyond the threat of litigation. Other factors that may influence defensive medicine practices include physician training and culture, fee-for-service reimbursement structures, and financing mechanisms that insulate patients from the cost of health care services.

Reference Documents (access link by clicking with the ctrl key):

- [Firth, Holmes. "Malpractice Relief: Lower Premiums, Tort Reform Add to Alaska's Appeal." Alaska Medicine, Sept 2009](#)
- [2011 Malpractice Coverage Premium Comparisons](#)
- [Alaska Legislative Research Memo on Impact of Tort Reform. January 27, 2012](#)
- [Massachusetts Medical Society 2011 Physician Practice Environment Report](#)

Findings on Health Care Cost, Pricing and Reimbursement in Alaska¹

Excerpted from Annual Reports of the Alaska Health Care Commission

2011 Findings on Cost of Health Care in Alaska (2011 Annual Report)¹

- **Health care spending in Alaska continues to increase faster than the rate of inflation.**
 - Total spending for health care in Alaska reached \$7.5 billion in 2010, a 40% increase from 2005. At current trends it is projected to double to more than \$14 billion by 2020.
 - By comparison, the wellhead value of oil produced in Alaska was \$16.4 billion in 2010, and is projected to be \$18.6 billion in 2020.
 - Also by comparison, total wages earned by Alaskan employees was \$15.4 billion in 2010.

- **Health care is becoming increasingly unaffordable for U.S. and Alaskan employers and families.**
 - The cost of health insurance premiums in the U.S. increased by 160% between 1999 and 2011, compared to an overall rate of inflation of 38% during that same period.
 - American workers' contributions to health insurance premiums increased 168% between 1999 and 2011, compared to a 50% increase in workers' earnings during that same period.
 - Since 1982 the Anchorage Consumer Price Index increased 95%, while the CPI for medical care in Anchorage over that time period increased 320%.
 - Alaska is number one in the nation for the cost of employee health benefits based on a newly released survey by United Benefits Advisors, which found that Alaska employers are paying an average of \$11,926 per employee each year for health insurance – nearly twice as much as the least expensive state.
 - Fewer Alaskan employers are offering employee health benefits in 2010 than in 2003.
 - The percentage of large employers in Alaska (those with more than 50 employees) offering coverage dropped from 95% in 2003 to 93% in 2010.
 - The percentage of small employers offering coverage dropped from 35% to 30% during that same period.
 - Alaskan employees' share in the cost of their insurance premiums increased from 11% to 14% for single coverage and from 17% to 22% for family coverage between 2003 and 2010.
 - The average cost of a health care premium increased 51% for single coverage and 35% for family coverage between 2003 and 2010.
 - The average annual premium cost for family coverage in Alaska was \$14,230 in 2010.

- **Cost shifting occurs between commercial and public payers.** Cost per unit of service is significantly higher for commercial payers relative to provider operating costs and compared to the two largest public payers, Medicaid and Medicare. For example, commercial reimbursement rates are 110% higher than Medicare reimbursement for hospital services in Alaska. Also, as spending has increased over time for all payers in Alaska, it increased at a higher rate for individuals and private employers compared to government employers and public programs.
 - Because of the cost shifting that occurs through rate disparities, rate reductions by public payers may result in higher rates charged to commercial insurers and translate into higher premiums for individuals who purchase private insurance and for employers who provide employee health benefits.

¹ Note that "Findings" Statements are vetted through public comment and commission members vote to approve Findings in final form for inclusion in Annual Reports

- While the major public payers appear to under-reimburse providers compared to private payers, they provide additional financial support for health care through other mechanisms. For example, Medicare subsidizes physician residency training, Medicare and Medicaid provide Disproportionate Share Hospital (DSH) payments to hospitals that see a high proportion of Medicare and Medicaid patients, and the federal government through the Indian Health Service and Alaska Tribal Health System has funded much of the development of the rural health infrastructure in Alaska.
 - The existence of public insurance programs helps spread health care system fixed costs among more payers and beneficiaries.
- **Commercial insurance premiums in Alaska are roughly 30% higher relative to five comparison states, which are higher than the national average. Commercial insurance premiums are primarily a factor of utilization and price for health care services.**
- **Alaska's health care utilization rates do not appear to be a major driver behind higher premium rates relative to comparison states based on financial analysis of the private health care system. Utilization of health care services in Alaska is roughly in line with comparison states, and is lower than the nationwide average.**
 - Alaska uses 13% fewer services than the nationwide average to treat a similar Medicare patient.
 - Alaskan Medicare enrollees have fewer hip replacement surgeries and roughly the same number knee and shoulder replacement surgeries (rate per 1,000 enrollees).
 - For the commercially covered population, inpatient bed days are higher overall in Alaska, but lower in urban Alaska than the comparison states. Emergency room visits are higher, outpatient visits are about the same, and medication prescriptions are lower.
- **Health care prices paid in Alaska are significantly higher than in comparison states.**
 - Reimbursement for physician services in Alaska is 60% higher than in comparison states for all payers based on a weighted average; and 69% higher for commercial (private insurance) payers.
 - The difference in reimbursement for physician services varies significantly depending on the specialty. For example, pediatricians in Alaska are reimbursed at rates 43% higher on average than pediatricians in the comparison states, and cardiologists in Alaska are reimbursed at rates 83% higher than cardiologists in the comparison states.
 - Commercial reimbursement for private sector hospital services is 37% higher in Alaska than in the comparison states. Medicare fees paid for private sector hospital services are 36% higher in Alaska than in the comparison states.
- **Medical prices are driven by two components: 1) operating costs associated with delivering medical services, and 2) operating margins. Following are attributes of medical prices in Alaska's private health care sector:**
 - Operating costs for health care providers are higher in Alaska relative to the comparison states. There is insufficient data available to fully analyze and compare physician practice operating costs, but analysis of publicly available hospital cost reports found Alaska private sector hospital operating costs are 38% higher overall and 86% higher for Alaska's private sector rural hospitals. Higher operating costs in Alaska for hospitals and physician practices are driven by:

- The cost of living, which is 20-30% higher in Alaska than in comparison states (overall, not accounting for rural/urban differences).
 - Medical salaries for health care workers, which are 0% - 10% higher in Alaska (excluding self-employed physicians).
 - Health benefit costs for hospital and physician practice employees, which in Alaska are higher than any other state in the nation.
 - 11% - 15% utilization of “travelling” temporary staff, who typically are paid at a higher rate and whose employment results in other inefficiencies in delivery of health care services;
 - Administrative burdens associated with government regulation and compliance with payer requirements, including documentation requirements, fraud and abuse audits, licensing and certification requirements, and employee background checks.
 - Drivers of higher operating costs in Alaska specific to the private sector hospital system include:
 - RN staffing ratios, which average 29% higher than comparison states.
 - Occupancy rates, which on average are lower at 49.9% in Alaska relative to 58.1% in comparison states.
 - In 2010 the average all-payer operating margin for Alaska’s private sector hospital system was 13.4% compared with the average of comparison states’ hospital systems of 5.7%. Operating margins for individual Alaska facilities vary widely within these averages, ranging from -9.2% to 29.4%. For Medicare patients, the operating margin is 2.6 percentage points less than the comparison state average, at -11.5% in Alaska compared to -8.9% in the comparison states, causing upward pressure on commercial premiums in order to offset hospital losses.
 - Physician discounts are low in Alaska relative to the comparison states, an indication that physicians in Alaska have more market power relative to pricing.
- **Utilization for health care services in Alaska, while similar to the comparison states and low relative to the U.S. and other industrialized nations, is still a critically important factor to consider in containing cost growth and improving quality of care and health outcomes.** Utilization of health care resources is highly inefficient. The estimated level of wasted health care spending in the U.S. is between 30% and 50%, leaving significant room for improvement in the effectiveness and efficiency of health care delivery.
 - **Market forces affecting pricing for health care services are impacted by state laws and regulations in Alaska.** There are state laws and regulations in place that influence the market in such a way as to drive prices higher for the consumer.
 - Lower physician discounts in Alaska can be at least partly explained by the relative lack of competition among providers, particularly for specialty care. In many areas, including Anchorage, there are a limited number of providers in any given specialty (sometimes only one provider group). As a result, physicians can largely dictate the fees they are paid by commercial payers.
 - Relative provider leverage may be further exacerbated by Alaska’s regulation requiring usual and customary charge payment to be at least equal to the 80th percentile of charges by geographic area. Since many providers have over 20% of their market share, this implies that those providers can ensure that their charges are below the 80th percentile and therefore, receive payment for their full billed charges.

- A separate state law requires payers to reimburse non-contracted providers directly instead of through the patient, removing incentives typically used by payers to encourage providers to join their networks.
- **The average payment for durable medical equipment (DME) in Alaska is 21% higher for all payers relative to the average comparison state payment level.** DME consists of non-pharmaceutical items ordered by a provider for a patient. By payer, the average reimbursement for DME is:
 - 23% higher for commercial payers in Alaska relative to the average across commercial payers in the comparison states
 - The same in Alaska for Medicare and TRICARE as the comparison states' Medicare and TRICARE average
 - 180% higher for the VA in Alaska relative to the average VA payment across the comparison states
 - 55% higher for the Alaska Medicaid program relative to the average Medicaid program payment across the comparison states (excluding N. Dakota)
 - 98% higher for the Alaska Workers' Compensation program relative to the average of N. Dakota and Washington states' Workers' Comp payment level (Idaho, Oregon and Wyoming not available)

2012 Findings on Cost of Health Care in Alaska – Pharmaceuticals (2012 Annual Report)ⁱⁱ

- Prices for pharmaceuticals do not appear to be a significant driver of higher health care costs in Alaska relative to the comparison states of Idaho, Washington, Oregon, Wyoming, and North Dakota.²
- Worker's Compensation payment rates for pharmaceuticals are higher in Alaska than the average of the Worker Compensation rates of the five comparison states by approximately 17%.³
- Medicare and Medicaid dispensing fees for Alaska are higher than Medicare and Medicaid dispensing fees in all the comparison states.
- There is significant variation in reimbursement levels between payers within Alaska. For example, Medicaid pays 15% more on average than the all-payer average within Alaska, while TRICARE pays 7% less on average.
- Price, while similar in Alaska on average relative to comparison states, and utilization of pharmaceuticals are critically important factors to consider in containing cost growth and improving quality of care and health outcomes.

² Milliman, Inc., *Pharmaceutical Reimbursement in Alaska and Comparison States*, October 16, 2012.

³ Workers' compensation reimbursement for pharmaceuticals is estimated to be 0.4% of total reimbursement by all payers combined based on national prescription drug expenditure data.

2013 Findings on Cost of Health Care in Alaska – Workers’ Compensation (2013 Annual Report)

- **Workers’ compensation costs in Alaska are the highest in the nation, primarily due to high medical benefit costs.** The number of occupational injuries in Alaska has declined by 4-5% per year over the past 15 years, most recently decreasing 7% between 2011 and 2012; however, Alaska’s worker’s compensation premiums have been increasing and were the highest in the U.S. in 2012.⁴
 - Alaska’s workers’ compensation premiums ranked 28th highest in the U.S. in 2000 and had increased to second highest in the nation by 2004. Since 2004 Alaska has ranked either first or second every year for the highest workers’ compensation premium cost in the U.S.
 - At 76% of total claim costs, the proportion of medical claims costs is substantially higher in Alaska than the national average of 59%. Alaska’s average medical claim cost is \$48,200 per case compared to the national average of \$28,000.
 - Alaska’s allowable workers’ compensation medical fees are the highest in the nation, according to a 2012 survey of workers’ compensation medical fee schedules conducted by the Workers’ Compensation Research Institute.
 - Alaska’s workers’ compensation medical fee schedule demonstrates an inefficient allocation of resources. The current fee schedule based on usual and customary billed charges is inherently inflationary and interferes with market function that might otherwise contain cost growth.
 - Prescription drug costs comprised 19% of total workers’ compensation medical claims costs in Alaska in 2011. A 2011 National Council on Compensation Insurance report on Alaska’s workers’ compensation program identified over-prescription of opioid narcotics and drug repackaging by physicians as the primary cost drivers of pharmaceutical costs.
 - Application of medical treatment guidelines has demonstrated improved patient outcomes and cost reduction in other state workers’ compensation programs that have adopted this practice.

⁴ “Alaska Division of Workers’ Compensation 2012 Annual Report,” Department of Labor & Workforce Development; National Council on Compensation Insurance 2012 Alaska State Advisory Forum; “2012 Workers’ Compensation Premium Rate Ranking Summary,” Oregon Department of Consumer and Business Services, October 2012.

Background information on Commission Health Care Cost & Pricing Studies and Findings

2011 Studies: The Commission contracted for two studies this year to learn more about the cost of health care in Alaska. One was an economic analysis conducted by the Institute for Social & Economic Research (ISER)/MAFA on spending for health care services in Alaska, including estimates of total spending levels by payer and types of services. The other was a financial analysis conducted by Milliman, Inc., an international health care actuarial consulting firm, on health care pricing for hospital and physician services.

The purpose of these studies was to provide information regarding health care cost drivers in Alaska to inform future policy recommendations aimed at improving affordability and access to care. Hospital and physician services were the first two areas selected for study because they represent the highest proportion of spending for health care in Alaska at 31.5% and 28% (respectively), compared to 9% for prescriptions and equipment, 3% for nursing home and home health care services, 5.5% for dental services, 10% for administrative costs, and 13% for all other services. The Commission plans to study pricing for prescription medication during the coming year.

The economic analysis conducted by ISER/MAFA identified trends in levels of spending, who is paying the bills and how cost shifting occurs between payers, the services Alaskans are buying, the numbers of Alaskans with health insurance, and the proportion of employers offering health care coverage to their employees. This study, published in August, is included as Appendix A of this report and is available on the Commission's website at: <http://www.hss.state.ak.us/healthcommission/2011commissionreport.htm>.

The financial analysis of physician payment rates conducted by Milliman, Inc. compares health care prices for the top 25 utilized procedure codes for each of 17 physician specialties in Alaska with five other states: Washington, Oregon, Idaho, Wyoming, and North Dakota. This analysis includes a comparison of billed and allowed charges for commercial payers, and fees for Medicare, Medicaid, Workers' Compensation, the Veteran's Health Administration, and TRICARE. The report on physician payment rates also includes a comparison of the average reimbursement level for durable medical equipment (DME) overall and by payer.

The hospital payment rate analysis compares payment levels in Alaska's non-federal facilities with non-federal facilities in the same five comparison states plus Hawaii. Hawaii was added at the request of the state hospital association because it has logistical challenges somewhat similar to Alaska's, such as those associated with transportation costs, and because of the similarly high cost-of-living. This analysis was restricted to non-federal hospital facilities due to data limitations, and because federal facilities serve a defined beneficiary population, have unique federal funding streams, and operate under differing rules than non-federal facilities. Additionally, the commission's recommendations are primarily targeted at state government policy leaders and will have more limited influence on federal and tribal policies.

The hospital analysis includes 100% of the non-federal acute care facilities and 74% of licensed acute care beds in Alaska (federal tribal and military hospitals support 19% and 7% respectively of total licensed beds). The commission may choose to conduct a separate analysis of reimbursement levels and cost drivers for federal tribal and military hospital services at some point in the future if analysis of potential strategies related to affordability, cost of care and sustainability of the health care system require this additional information.

The analyses of hospital and physician payment rates and cost drivers are presented in three reports from Milliman, Inc. and are included in Appendix B of this report (available on the commission's website at: <http://www.hss.state.ak.us/healthcommission/2011commissionreport.htm>). Note that these reports are systems-level analyses and are not intended to be utilized as an evaluation of individual facilities or physician practices. Statistics for individual facilities vary widely within the systems-level averages presented, and conclusions should

not be drawn about specific facilities from these data without review of each individual facility's financial and cost reports.

ⁱⁱ **2012 Studies:** The Commission began an in-depth analysis of the cost of health care in Alaska during 2011 to better understand cost drivers and inform policy recommendations aimed at improving affordability and access to care. These studies began with an economic analysis conducted by the Institute of Social & Economic Research (ISER)/MAFA of health care spending in the state, including estimates of total spending levels by payer and types of services. That same year Milliman, Inc., an international health care actuarial consulting firm, conducted an analysis comparing prices paid for hospital and physician services and for durable medical equipment in Alaska with a number of other states.

Hospital and physician services were the first two areas selected for actuarial study because they represent the highest proportion of spending for health care in Alaska at 31.5% and 28% (respectively), compared to 9% for prescriptions and equipment, 3% for nursing home and home health care services, 5.5% for dental services, 10% for administrative costs, and 13% for all other services. These are also the two main components of spending for acute medical care. The commission continued the price comparison analysis of acute medical spending this year with a study (also conducted by Milliman) of prescription drug reimbursement levels.

The 2012 actuarial analysis of pharmaceutical payment rates compares average prices paid for the top 50 prescribed (on a per-unit basis) generic drugs, top 50 brand named drugs, and a select group of 20 specialty drugs in Alaska with five other states: Washington, Oregon, Idaho, Wyoming, and North Dakota. The analysis includes a comparison of allowed charges for commercial payers and fees for Medicare, Medicaid, Workers' Compensation, the Veteran's Health Administration, and TRICARE. The following findings statements are based on the Milliman analysis, which concluded that for all payers combined, Alaska's pharmaceutical reimbursement is 1% higher on average than the comparison state average. The Milliman analysis is included as Appendix B in this report.

State Health Rankings

Per Capita Health Care Spending by State		
2009 Data (most recent available)		
Rank	State	Per Capita Spending
1	Massachusetts	\$9,278
2	Alaska	\$9,128
3	Connecticut	\$8,654
4	Maine	\$8,521
5	Delaware	\$8,480
6	New York	\$8,341
7	Rhode Island	\$8,309
8	New Hampshire	\$7,839
9	North Dakota	\$7,749
10	Pennsylvania	\$7,730
11	West Virginia	\$7,667
12	Vermont	\$7,635
13	New Jersey	\$7,583
14	Maryland	\$7,492
15	Minnesota	\$7,409
16	Wisconsin	\$7,233
17	Florida	\$7,156
18	Ohio	\$7,076
19	South Dakota	\$7,056
20	Nebraska	\$7,048
21	Wyoming	\$7,040
22	Missouri	\$6,967
23	Iowa	\$6,921
24	Hawaii	\$6,856

avg.	United States	\$6,815
25	Louisiana	\$6,795
26	Washington	\$6,782
27	Kansas	\$6,782
28	Illinois	\$6,756
29	Indiana	\$6,666
30	New Mexico	\$6,651
31	Montana	\$6,640
32	Michigan	\$6,618
33	Kentucky	\$6,596
34	Oregon	\$6,580
35	Mississippi	\$6,571
36	Oklahoma	\$6,532
37	North Carolina	\$6,444
38	Tennessee	\$6,411
39	South Carolina	\$6,323
40	Virginia	\$6,286
41	Alabama	\$6,272
42	California	\$6,238
43	Arkansas	\$6,167
44	Colorado	\$5,994
45	Texas	\$5,924
46	Nevada	\$5,735
47	Idaho	\$5,658
48	Georgia	\$5,467
49	Arizona	\$5,434
50	Utah	\$5,031

Downloaded 2-14-15 from Kaiser State Health Facts:

<http://kff.org/other/state-indicator/health-spending-per-capita/>

Sources: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. National Health Expenditure Data: Health Expenditures by State of Residence, 2011. U.S. Population by State, 1991-2009 obtained from the U.S. Bureau of the Census February, 2011.

Definitions Health Spending Per Capita includes spending for all privately and publicly funded personal health care services and products (hospital care, physician services, nursing home care, prescription drugs, etc.) by state of residence (aggregate spending divided by population). Hospital spending is included and reflects the total net revenue (gross charges less contractual adjustments, bad debts, and charity care). Costs such as insurance program administration, research, and construction expenses are not included in this total.

Life Expectancy at Birth		
From Measure of America 2013-2014 Dataset		
2010 Estimates using 2009 Data		
Rank	State	Life Expectancy
1	Hawaii	81.30
2	Minnesota	81.05
3	Connecticut	80.82
4	California	80.77
5	Massachusetts	80.52
6	New York	80.48
7	Vermont	80.45
8	New Hampshire	80.32
9	New Jersey	80.28
10	Utah	80.20
11	Colorado	80.02
12	Wisconsin	79.98
13	Washington	79.92
14	Rhode Island	79.87
15	Nebraska	79.84
16	Iowa	79.71
17	Arizona	79.64
18	North Dakota	79.55
19	Oregon	79.52
20	Idaho	79.49
21	South Dakota	79.47
22	Florida	79.45
23	Maine	79.19

24	Virginia	79.01
25	Illinois	78.96
	UNITED STATES	78.86
26	Maryland	78.80
27	Kansas	78.72
28	Pennsylvania	78.50
29	Montana	78.49
30	Texas	78.45
31	New Mexico	78.43
32	Delaware	78.36
33	Wyoming	78.34
34	Alaska	78.29
35	Michigan	78.23
36	Nevada	78.05
37	North Carolina	77.81
38	Ohio	77.75
39	Indiana	77.61
40	Missouri	77.54
41	Georgia	77.23
42	South Carolina	76.95
43	Tennessee	76.30
44	Kentucky	75.97
45	Arkansas	75.96
46	Oklahoma	75.88
47	Louisiana	75.71
48	Alabama	75.42
49	West Virginia	75.40
50	Mississippi	74.96

Note: Alaska dropped from 29th ranking reported in 2011 dataset

Data downloaded from Measure of America 2013-2014 Report :

http://www.measureofamerica.org/measure_of_america2013-2014/

Primary Care Physicians		
Number of primary care physicians per 100,000 population. 2014 Ranking based on 2012 Data		
Rank	State	Value
1	Massachusetts	200.8
2	Maryland	178.5
3	Rhode Island	177.0
4	Vermont	170.9
5	New York	167.3
6	Connecticut	166.7
7	Minnesota	145.2
8	New Jersey	143.7
9	Hawaii	140.2
10	New Hampshire	135.7
11	Illinois	133.9
12	Oregon	131.5
13	Pennsylvania	130.3
14	Maine	130.2
15	Washington	126.7
16	Virginia	125.8
17	Ohio	125.0
17	Wisconsin	125.0
19	Tennessee	124.4
	UNITED STATES	123.5
20	Louisiana	123.7
21	North Dakota	123.6
22	California	122.2

22	Michigan	122.2
24	Colorado	120.7
25	Nebraska	118.5
26	North Carolina	117.9
27	New Mexico	115.6
28	South Dakota	113.5
29	Alaska	113.2
30	Delaware	112.8
31	Missouri	111.8
32	Florida	110.0
33	South Carolina	107.9
34	West Virginia	107.8
35	Kansas	106.6
36	Georgia	105.4
37	Indiana	104.2
38	Kentucky	103.0
39	Arkansas	102.6
40	Alabama	101.9
41	Montana	99.7
42	Texas	98.8
43	Arizona	98.4
44	Utah	90.8
45	Wyoming	90.0
46	Iowa	85.7
47	Nevada	85.3
48	Oklahoma	84.8
49	Mississippi	81.8
50	Idaho	80.1

Downloaded from America's Health Rankings 2-14-15:

<http://www.americashealthrankings.org/ALL/PCP#>

Primary Care Physicians is a measure of access to primary care for the general population as measured by the number of primary care physicians per 100,000 population. Primary care physicians include all those who identify themselves as Family Practice physicians, General Practitioners, Internists, Pediatricians, Obstetricians, or Gynecologists. The 2014 ranks are based on 2012 data from the American Medical Association's publication Physician Characteristics and Distribution in the United States, 2014 Edition. Data used with permission.