# AK HCA Position Paper Executive Summary

An Alaska government takeover of health care in the Last Frontier could grow Alaska's budget, while shrinking innovation and creating a state run health care system that would increase costs, provide less flexibility and lead to less effective care.

It is called the Alaska Health Care Authority (HCA) which creates a structure that expands the size of Alaska's bureaucracy at a time when Alaska's government is struggling to fund public education, infrastructure and are cutting the permanent fund dividend.

The State of Alaska has scheduled two public meetings, on August 9 and 30, 2018, to discuss the governance structure of the proposed HCA, facilitated by the Pacific Health Policy Group (PHPG).[1] This is remarkably premature, as no unbiased, reliable studies have been completed to establish that a Health Care Authority is appropriate for Alaska.

In 2016, Senate Bill 74 passed, directing the Alaska Department of Administration (DOA) to examine whether creating an Alaska HCA is feasible and can serve as an effective tool to reduce costs, improve quality, and maintain benefits and access for individuals whose health benefits are funded directly or indirectly by the state. This would include State of Alaska retirees and employees, state corporations, University of Alaska employees, school district employees, and, potentially, political subdivision employees. [2]

In 2017, three studies were completed: 1) by PHPG, focused on a potential Medicaid component, 2) by PRM Consulting Group, focused on public employee and retiree health plans, and 3) by Mark A. Foster & Associates focused on Alaska Market analysis. All three studies concluded that an HCA could save healthcare costs for the State of Alaska if all publicly funded entities are required to participate in the program.

However, these studies neglect to mention important facts. For example, **health care authorities in other states are dealing with mismanagement and dramatic cost overruns.**

In 2016, Washington State lawmakers discovered the Washington HCA miscalculated and underfunded its budget by $463 million.[3] In November, 2017, an Oregon Secretary of State audit found approximately 41 percent of the Medicaid enrollees in the Oregon HCA were ineligible, resulting in $88 million in avoidable

---

[1] http://doa.alaska.gov/HCA/

[2] https://stateofreform.com/wp-content/uploads/2017/09/Health-Care-Authority-Feasibility-Study.pdf

[3] http://thelens.news/2016/03/09/almost-half-a-billion-off-healthcare-authority-budgeting-goofs-rankle/

expenditures from March 1 to Aug. 31, 2017. While the audit was underway, *The Oregonian* and *The Portland Tribune* reported an additional total $186 million of improper payments were made.[4]

**The Alaska State-funded studies miss other important facts.** For example, despite PRM study claims to the contrary, Oregon school districts are not presently allowed to opt out of participation in their HCA program. Further, the PRM study fails to report that those Oregon school districts that did timely opt out offer better benefits at lower administrative costs and co-payments, thereby saving the school districts funds to use for better pay for their employees. The districts that were able to opt out are more successful in attracting quality teachers than the school districts required to participate in the Oregon HCA.

PHPG falsely reports the Hawaii Health Authority "is responsible for health planning."[5] Although the Hawaii Health Authority was created in 2009 and charged with designing a universal health care system covering all residents of Hawaii,[6] it has been inactive since 2015. Given other providers and agencies already offer the same proposed services, the Hawaii Health Authority has no staff, no budget, and the terms of all appointed board members expired in 2015.[7] Regardless, the State of Alaska continues to publish that the Hawaii Health Authority is a functioning entity.[8]

Rather than addressing these and other important deficiencies in its State-funded study reports, the State of Alaska simply cites the reports as justification for proceeding with the HCA concept for Alaska.[9]

Any HCA established in Alaska should adopt practices already successfully incorporated into the private-sector purchaser coalitions such as the Public Education Health Trust and the Pacific Health Coalition (PHC). PHC is comprised of over 45 member health benefit plans in Alaska and the Pacific Northwest. These member funds represent over 100,000 employees and their dependents in Alaska, and 150,000 covered lives in the Pacific Northwest. As such, PHC has already

---

[4] https://www.oregonlive.com/politics/index.ssf/2017/10/oregon_overpays_more_than_74_m.html

[5] http://doa.alaska.gov/pdfs/ak-doa-hca-feasibility-study-presentation-phpg-09-11-17.pdf?_ga=2.199662830.1314435202.1530457439-470483966.1521391601, at slide 20;

[6] http://www.pnhp.org/news/2015/march/hawaii-health-authority-could-reduce-health-costs-if-empowered-to-do-so; http://hha.hawaii.gov/new-2011-update-to-health-futures-task-force-report/

[7] http://hha.hawaii.gov/about-hawaii-health-authority/

[8] See, e.g., http://mhtrust.org/mhtawp/wp-content/uploads/2017/11/HandOut-HealthCareAuthorityFeasibilityStudy-DOA-Presentation.pdf, at slide 29; http://www.commonwealthnorth.org/download/action_groups/health-care-coalition/2015/2017/DOA-HC-Feasability-Study-Emily-Ricci-111717.pdf, at slide 28.

[9] If you find the associated footnote links fail to work, and you need a copy of the original studies, let us know and we can provide them.

achieved the number of covered lives needed to negotiate cost savings without unduly limiting access to quality health care providers.

PHC is insulated and protected from political interference. The governing board is elected by its participating member plans, not appointed by the governor or other politicians. The governing board of PHC is nimble, able to make quick decisions to take advantage of innovative and economic opportunities. Moreover, the participating plans are allowed to select from among the menu of optional plan services offered by PHC, and they can opt out of PHC altogether at any time with reasonable notice.

Finally, PHC's participating member funds are able to actively engage their employees, which is an essential element of medical cost containment. PHC's member funds, including Boroughs and School Districts, work hard at communicating the direct connection between how their local employees use the plan and the overall cost of coverage. For example, if an employee uses a less expensive provider or medication, or if an employee tries conservative treatment instead of moving immediately to expensive tests or surgery, the resultant savings will accrue to the employee's Trust or employer plan, and the employee will benefit from the savings.

Without the ability to institute these common-sense private sector features, the Alaska HCA concept should be scrapped, and the $750,000 appropriated for additional studies should be returned to the State Treasury, or otherwise used to influence adverse Federal healthcare policies.