2012 Report of the
President’s Health Care Task Force

University of Alaska

September 20, 2012
# Table of Contents

Introduction ................................................................. 3

Section 1: Educational Approaches ....................................... 5

Section 2: Financial Approaches .......................................... 8

Section 3: Approaches Not Deemed Feasible at this Time .............. 14

Appendix

  Health Care Task Force Members ...................................... A-1

  Table 1a, 2012-2013 University of Alaska UA Choice and State of Alaska
  GGU Health Trust ...................................................... A-2

  Tables 1b and 1c, and Table 1 notes ................................. A-3

  Table 2. Health Plan Comparisons—Private and Public Employers .. A-4

  Chart 1. Total 500 Plan Participants as of 8/01/2012 .................. A-5

  Chart 2. Employees Enrolled in 500 Plan Grouped by Age as of 8/01/2012 . A-6

  Chart 3. Employees Enrolled in 500 Plan Grouped by Years of Service as of 8/01/2012 . A-7

  Chart 4. Comparison of Deluxe/500 Plan Members vs. Opt-Outs as of 8/01/2012 .... A-8

  Chart 5. Total Opt-Outs by MAU as of 8/01/2012 .................... A-9

  Chart 6. Number of Opt-Outs that are Dependents on UA Plans as of 8/01/2012 .... A-10

  Chart 7. Total Opt-Outs Grouped by Age as of 8/01/2012 ................ A-11

  Chart 8. Total Opt-Outs Grouped by Years of Service as of 8/01/2012 ............ A-12
Introduction

Providing health care in Alaska is a challenge. The state has a small population inhabiting a lot of land. This simple ratio causes everything to cost more, from produce and manufactured goods to services, like health care. The higher costs of transportation and delivery—whether personnel, services or products—are compounded by a smaller pool of medical professionals in the state, especially in rural areas. The sometimes harsh realities of living and working in Alaska make it challenging to attract health care professionals to set up practice here.

Despite rising costs for health care delivery and coverage, the University of Alaska, providing quality health care to its employees has been and continues to be a priority for all involved. Employees and administration have worked together to develop and update health care options since the design of the UA2000 Plan in the late 1990s. Today, the Joint Health Care Committee (JHCC) comprises unionized and non-unionized staff and UA management in a single group to work together on the hard choices that need to be made.

The UA Choice health plan benefit currently averages out to about $16,900 per employee annually, 83% of which is paid by the university. In recent years, many programs have been proposed and enacted to help keep health care costs down without sacrificing the high standard of care. Some of these programs gave results; others did not. While it is clear that rising health care costs are not sustainable even in the short term, the University of Alaska remains committed to resolving this problem without sacrificing its current standard of care.

In May 2012, President Gamble formed the Health Care Task Force to look at alternative approaches that would maintain a valuable—yet still affordable—health care program. The charge was to think outside the box, to look at new ideas, or even consider old ideas, but in new ways. Beyond the direct approach to lower costs, the Task Force also looked at ways to raise awareness about health and health care in the UA community as well as ideas for improving the use of preventative care and wellness benefits. Keeping healthy people healthy will lower the incidence of potentially devastating illness that the plan will need to cover down the road.

The task force gathered information from the public sector, private industry, and peer institutions as well as personal and anecdotal experience. Over the summer months, with regular meetings and using a web site to collate the information, this report took shape. It is hoped that this brief summary, combined with the information organized in the website at https://sites.google.com/a/alaska.edu/2012-health-care-task-force/home, will provide UA administration and the JHCC with some options and ideas to move forward in establishing policy at UA and sustainably continue our valued health care program. From this research, the task force has made a few observations:

• The UA health plan is a good one, equal or better than that of most of its peers (see the Peer Institutions section of website)
• The costs of the plan are at or below those of comparable plans (see tables 1–2 in the appendix)
• There are many approaches beyond financial that can help maintain our health care and lower the costs to all involved

This task force report is directed to UA administration and the JHCC. Its suggestions are organized into three sections: 1. Educational approaches—larger scale initiatives that affect the wellness of the UA health care community, 2. Financial approaches dealing with the economic
nuts and bolts of health care delivery in Alaska, and 3. Suggestions that the task force felt should be mentioned but were not deemed feasible. Supplementary information and graphics are in the appendix.
Section I: Educational Approaches

Integrated Wellness Program

One approach that requires education of the UA community is that of an integrated wellness program. “Wellness program” is a small phrase that can mean a lot of different things. The University of Alaska currently has a comprehensive wellness program through Wellness Initiatives Network (WIN) for Alaska offering on-site coaching sessions, wellness breaks, screening events and fitness classes. The bulk of these on-site events are held at the three main campuses, UAA, UAF and UAS. Rural sites are able to access the online tracking site, electronic newsletters, and informational website. In addition, unused Individual Health Planning sessions (IHPs) from the main campuses are offered to the rural sites through the Rural IHP sessions, a telephonic coaching program. Wellness consultants also try to get to the larger rural locations as often as they can, usually at least twice a year.

Extending the full, in-person suite of services to the rural sites would be prohibitively expensive, so there is a need to look at tapping local resources when possible, to offer more opportunities to employees at these rural locations. For example, UA could network with local clinics or health care providers to offer flu shots or do biometric screenings at a central office location. Most communities have some sort of health clinic or medical provider presence, and efforts could be made to have these resources visit UA sites. Developing relationships with these providers would also be key to implementing a more outcomes-based plan design by increasing opportunities for employees to have biometrics recorded for preferred pricing on the health plan.

Annual Wellness Check-up and Screenings

The UA Choice health care plan (and the UA2000 Plan before it) has always had a wellness, or preventive health, benefit. Initially this benefit had an annual dollar limit ($250 at first, then $400, and later $750) before health care reform required that the benefit be unlimited. This benefit allows employees and their dependents to have preventive health care services and screenings with no deductible or coinsurance payment required. This means that even employees on the high-deductible health plan can access these screenings and services with no out-of-pocket cost to them. The list of covered services is on the web site at http://www.alaska.edu/files/benefits/preventivelist.pdf.

Many of the high-cost claims experienced by the UA Choice plan are for treatment of diseases and conditions that can usually be caught early through regular preventive screenings. As shown in the State of Alaska’s report on chronic diseases in Alaska (http://www.hss.state.ak.us/dph/chronic/pubs/assets/2012_CDBriefReport.pdf), cancer is the leading cause of death in the state. Regular preventive health screenings can detect early stage cancers, high cholesterol, high blood pressure and pre-diabetes before they become or contribute to high-cost, complex conditions.

Anecdotal reports indicate employees are hesitant to use this benefit because they believe they’d have to pay their deductible and/or coinsurance. An education campaign to promote the use of the preventive benefit is needed to encourage employees and dependents to take advantage of it. Focus should be on early detection and maintenance of health, as well as emphasis on the fact that these services, when done as routine, preventive care, carry no out-of-pocket cost to the member.
Wellness training

To promote increased awareness and knowledge about wellness, preventive benefits and healthy lifestyle choices, the University of Alaska could hold informational sessions for employees using a registration and scheduling process similar to that currently used for Safety Training. By offering a variety of topics at multiple dates and times with online and in-person sessions, employees would have increased opportunities to learn about the wellness benefits available to them. Session leaders would be available for questions and discussion in both online and in-person formats. These session notices would be distributed via e-mail with a link to the schedule, and posters or fliers announcing the sessions could be posted in common break areas.

Bring WIN to department

Expand the Wellness Break model to include information about the health plan’s preventive benefits and the importance of early detection screenings. This information could be provided by the Wellness Consultants as a required component of the Wellness Break, in addition to the subjects selected by the host department.

Overall campus wellness plan

Logically, a key component to lowering our cost of health care is improving our health. In order to do so more effectively, we must take a holistic approach and change our campus culture. A campus wellness plan that encourages and supports health and wellness is just such an approach. Strategies could include:

- Re-invigorating and expanding UAF’s Let’s Include Fitness Everyday (LIFE) program (http://www.uaf.edu/src/life-program/), and developing comparable plans at other MAUs
- Making healthier entrées and snack foods more available on campus
- Initiate or continue chancellor-sponsored health activities/competitions
- Review campus grounds for ways to make outdoor exercising more attractive
- Integrate the wellness benefit more seamlessly into campus and department cultures
- Use academic expertise to offer workshops on health-related topics (exercising, cooking, etc)

Integrate all of these strategies into a Campus Wellness Plan, and launch a campaign raising awareness of them that encourages faculty and staff to participate.

Resources:
- http://wellness.ucr.edu/wellness_programs.html
- http://healthyoregon.uoregon.edu/Home/About.aspx
- https://www.facebook.com/well.unl
- http://www.scf.edu/content/PDF/EnroServ/WellnessBookletForWeb.pdf

Patient Centered Medical Home

One of the most promising approaches to “bending the cost curve” in health care is the Patient Centered Medical Home (PCMH) model.

Momentum is growing around the concept of the primary care-based ‘medical home’ as a desirable and important strategy to: 1. Improve the quality and coordination of care, particularly for patients with chronic conditions, and 2. Slow the rate of growth in health care costs through,
for example, reductions in unnecessary or duplicative care, preventable hospital admissions, and overuse of the emergency room. The current fee-for-service payment system tends to undervalue primary care, is ineffective in rewarding quality and value, or supporting medical homes, and it serves as a potential barrier in medical-home development.

The PCMH is built upon the documented value of primary care in achieving better health outcomes, more satisfactory patient experience, and more efficient use of resources. Patients who receive care from a PCMH have continuous access to a personal physician who provides comprehensive and coordinated care for the large majority of their health care needs (from the Institute of Medicine definition of primary care).

The PCMH is responsible for all of the patients’ health care needs – acute care, chronic care, preventive services, and end of life care working with teams of health care professionals. The PCMH would coordinate the care of its patients with specialists, lab/x-ray facilities, hospitals, home care agencies, and all other healthcare professionals on the patient care team.

The PCMH adopts the principles of patient-centeredness: allowing patients free choice of physician, providing prompt appointments, reducing waiting times, delivering care based on the best evidence on clinical effectiveness, empowering patients to partner with their personal physicians on decision-making, and providing care in a culturally and linguistically appropriate manner.

The PCMH uses health information systems to provide data and reminder prompts such that all patients receive needed services.

Alaska

Alaska’s Department of Health and Social Services, Division of Health Care Services, is working to support practices across the state as they work to become medical homes. This work focuses in particular on rural/frontier, tribal, independent and non-rural providers. In early 2012, the state contracted with Public Consulting Group, a national firm, to develop a strategy to advance medical homes in the state.

Several medical practices across Alaska are working to achieve recognition as Patient Centered Medical Homes. One of the first to obtain NCQA PCMH Level 3 recognition is Providence’s Alaska Family Medicine Residency in Anchorage. The Alaska Department of Health and Social Services is also working with the Alaska Primary Care Association to launch a pilot project to create a medical home model focused on rural and frontier populations. In FY12, the Alaska State Legislature provided a capital grant to the PCA to support the transformation of a cohort of federally funded community health centers (CHCs) into medical homes. In an RFP seeking consulting services to support this initiative, the PCA reports $400,000 in state funding, which began July 1, 2011, to support practice transformation and recognition for the three CHCs selected to participate.
Section II: Financial Approaches

Eliminate the 500 Plan

The UA Choice health care program offers eligible employees a choice of one of three health plans. The three plans are: (1) the High Deductible Health Plan [HDHP], (2) the 750 Plan, and (3) the 500 Plan. The three plans offer essentially the same health care services, except that the 500 Plan provides for a lifetime maximum of $1,500 for 50% of orthodontia service.

The substantive reimbursement difference is that the 500 Plan has lower deductibles and out-of-pocket maximums. For example, on an individual basis, the 500 Plan has a 60% lower deductible and 20% lower out-of-pocket maximum compared to the HDHP. Compared to the 750 Plan, the 500 Plan has a 33% lower deductible and a 14% lower out-of-pocket maximum. That would seem to make the plan attractive, but the lower employee cost for health care service comes with a higher plan price for that same employee.

On an individual basis, the 500 Plan is significantly more expensive. For example, on a 26-payperiod cycle, the 500 Plan is 165% more expensive than the HDHP ($56 vs. $149). Compared to the 750 Plan the 500 Plan is 70% more expensive ($88 vs. $149). The difference in expense has resulted in fewer employees choosing the 500 Plan. See charts 1–3 for demographics of current 500 Plan participants.

The 500 Plan was chosen by 606 employees as recently as FY08. In FY10 there was a minor uptick in 500 Plan participation to 623 employees. Since then the reduction in 500 Plan participation has been dramatic. For FY13 only 145 (4%) employees chose the 500 Plan. That’s a 318% reduction in 500 Plan participation over a period of six years. This trend is illustrated on Chart 4. For comparative purposes, 1,868 employees chose the HDHP (48%) and 1,896 (49%) chose the 750 Plan for FY13.

The future of the 500 Plan is being decided by UA employees, who are voting with their open-enrollment selections. In a remarkable demonstration of choice, employees are saying that the 500 Plan is unnecessary. For this reason the Health Care Task Force suggests that beginning in FY14, UA should no longer offer the 500 Plan.

Opt-out options

Before 2003 all UA employees were required to participate in the university’s health care plan. In that regard UA had taken the same approach as the State of Alaska for its employees. The State still requires all eligible, full-time employees to participate in medical plan coverage.

Beginning in 2003, UA allowed eligible employees to opt out of health plan coverage as long as they provided certification of other health coverage.

The number of employees opting out of health plan coverage remained relatively flat, at about 316, until plan year FY11, when the number of opt-outs rose precipitously. Presently the number of opt-outs is 532; a 67% increase over a little more than 2.5 years (Chart 4).

Who opts out? A subset of 419 employees opted out because they claimed coverage by other insurance plans. Another subset of 113 opted out because they and their spouse were both UA employees and would otherwise have duplicate coverage. Looking at dual employment couples,
we find that 235 are from UAF (Chart 5). That is interesting because UAF has 1,390 benefit eligible employees compared to UAA’s 2,400 benefit eligible employees. A similar situation exists when examining those who opt out because they are dependents of another UA employee. Again the bulk in that category is at UAF (Chart 6).

Looking deeper into the opt-outs, we discover that they are mostly between 30 and 59 years of age. Additionally, 377 have between one and nine years of service. The median salary of opt-outs is $53,052 (Charts 7 and 8). So, the picture of opt-outs that emerges is that; (1) 79% of opt-outs claim health coverage independent of UA (not verified), (2) they are relatively young, (3) they do not have many years of service with UA, (4) they predominantly work at UAF, and (5) they are not in the upper reaches of the wage earners.

The recently enacted Affordable Health Care Act (AHCA) allows employees to decline employer provided health insurance. Under that scenario neither the employee nor employer is penalized unless the employee subsequently receives a health care subsidy through AHCA. That situation creates an uncontrollable jeopardy for the employer. Because of that provision of AHCA, employers will be incented to prohibit opt-outs. An exception would be those who opt-out for Tricare coverage. More on this can be found at; http://hardeninsight.com/Healthcare/CIAB%20FAQ.pdf

A paper published in July 2002 by David M. Cutler asserts that when employees decline coverage it drives up the cost of health insurance for those that remain in the insurance pool. The paper is a bit dated, but the concepts are still valid, and the paper can be found at; http://www.nber.org/papers/w9036.pdf

The Health Care Task Force suggests that the JHCC consider that except for dual-employment UA couples, and similarly situated dependents, the UA health plan should revert to the rule that applied prior to 2003 with regard to employee participation. That is, except for dual-employment UA couples, and similarly situated dependents, health care plan participation is mandatory.

Salary determines cost – Lockton and CC

Health care costs are a significant financial burden for lower paid employees. A small, but growing, portion of employers (8% of large employers and 5% of all employers [http://www.hreonline.com/HRE/story.jsp?storyId=4222420&query=benefits]) have asked higher paid employees to contribute more towards health care costs because it is a lower portion of their salaries. According to Lockton Dunning Benefits, a consulting firm in the Human Resources industry, the most common divisions by salary are: less than $50k, $50k to $100k, and greater than $100k. We have 469, 1,835, and 1,161 employees in these categories respectively.

Another university had equal health care rates for all employees, but offered a $40 benefit per month for employees earning below a set monthly wage.

Alternatively, at least one university charged higher health care rates to part time employees. The reasoning is that the employees are getting a full-time benefit in terms of cost to the employer, for less than full-time work.
Medical travel

Medical travel is a modern approach to health care. With the advent of electronic medical records, instantaneous communications with medical providers and insurers, and access to out-of-state centers of excellence, University employees have medical options to consider—outside of Alaska. Availability and cost are the two most common reasons for traveling out of state for medical care. Health care cost savings from the use of medical travel could reduce plan costs. Employees could get some financial relief by seeking care at less expensive hospitals or centers of excellence outside of Alaska.

On behalf of University employees, medical travel should be voluntary, should provide access to out-of-state centers of excellence, and total costs should be less than or equal to procedures available locally. In addition, there must be an organization through which employees/patients can seek recommendations on providers and costs as well as seek assistance with making the arrangements for such medical travel.

Satori World Medical is a payor-supported, employer-sponsored, consumer-choice global healthcare network that provides individuals, employers, financial sponsors, and insurers with world-class healthcare, excellent client service, and significant financial benefit. Satori’s unique Business and Care Model provides a comprehensive, one-stop shop for all services needed for individuals to obtain their medical care within their global network of International Centers of Excellence. From the first phone call to Satori, all medical and travel needs are handled. Their Nurse Patient Advocates and Travel Care Coordinators will coordinate patient care.

Rewards for healthy behavior: preferred pricing

Preventive care is effective for maintaining good health and keeping health care costs down. Studies show that health care costs relating to obesity, alcohol and tobacco use are large, and can often minimized or mitigated with preventive care. Prevention is a proactive, positive step, whereas treating illness is a reactive, often unpleasant experience. Psychologically, health care works best as a system of rewards rather than a system of punishments.

Past approaches have tried to coerce or even punish employees financially for poor decisions regarding their health care. In an academic setting, rewards are often more effective than punishment in motivating a group toward positive behavioral change. For example, past efforts to limit hiring or to raise the health care costs of people who use tobacco have met with staunch resistance. The inverse, providing a “preferred” rate for those who have healthy behaviors, does not require subscribers to conform, but rather encourages them to adopt practices that minimize their costs as well as those of the University.

Participation in wellness programs can be an important factor, but compliance with a wellness program should not provide sole eligibility for a preferred rate. With the appropriate documentation, regular visits to a primary care provider for annual physicals and management of any chronic conditions should also be included as qualifications for the preferred rate.

How would such a plan be structured at the University of Alaska? Various models exist, the details of which are beyond the scope of the task force and this document. However, a simple structure could include a series of discounts based on the number of health maintenance criteria or wellness plan options utilized by an employee and/or spouse. For example, cessation of
tobacco use would certainly qualify, though never having used tobacco might qualify more. A
regular user of tobacco would not receive a discount in this area, but may qualify for others if
the person actively participated in the UA wellness program or followed a physician-directed
regimen to mitigate another issue. The system could rapidly become very complex, but with
careful planning, a well-designed set of discounted rates could promote a healthier workforce.

Another option would be to produce a scale or table where groups of preventative measures are
combined into classes of preferred rates commensurate with the demonstrated cost savings of
each of class. For example, wellness program participation and/or regular visits to a primary
care provider to prevent or mitigate a condition would fall into the same class, and one or both
would qualify for a certain rate. A second grouping could include tobacco and alcohol usage
where cessation would yield one rate, non-usage a better preferred rate. A third group could
include dietary and lifestyle changes. A fourth group could include mental health checkups, to
ward off the effects of living at higher latitudes (which takes its toll on all of us sooner or later).
These are just suggestions, and perhaps the groupings would be different based on the impacts to
the system.

Care should be taken to design a reward system that avoids the mentality of, “Well, I gave up
smoking, and won’t get a better rate if I give up drinking, so, ‘bottoms-up!’” Each step taken
should be greeted with positive reinforcement of some kind.

For those who choose not to participate or manage their health that attentively, a standard rate
higher than current rates would apply. Though this approach may seem like people who make
poor health care choices are being fined, it is fundamentally different in three ways:

• Everyone starts with the same standard rate
• A preferred rate is earned by proactive efforts on the part of the employee or member
• Regular, documented updates would be required to maintain a preferred rate

This approach promotes buy-in from the subscriber on a regular basis, rather than beginning with
recrimination.

**Cost recovery sharing**

People are generally very good at scrutinizing the bills they get from their doctors, but when
people go to the hospital, they only receive a bill for the total cost incurred. The longer the
hospital stay, the greater the chance of mistakes. If everyone received and then checked an
itemized bill from the hospital, not only would patients be more savvy about the actual costs of
the care they received, but they might spot errors. The university just pays the bill and would
never know if an error had been made. To promote the verification of large costs, it might be
possible to have employees share in the recovery of any erroneous charges. Once the patient
receives the bill from the hospital, they need to request an itemized version. If, after receipt, they
find they were charged for items they did not receive, they have the right to question that charge.
The university might be urged to share any cost recovery with the employee 50/50 in order to
promote good bill verification. The university doesn’t want to promote frivolous inquiries that
would cost more in administrative time than the recovery is worth, but if cost recovery sharing
were limited to amounts over $50 or $100, both parties would benefit in an equitable and
valuable way.
Employee advocacy group

Employee satisfaction is a hallmark of an excellent benefits package. Regardless of the quality of benefits, if the employee cannot understand those benefits or cannot talk to someone knowledgeable when there is a problem, the package will be perceived negatively.

Inability to seek individual assistance means that even an excellent benefits package may not be fully understood, utilized, or appreciated. A patient advocacy organization would be a valuable asset. It could not only explain a complex system to people in need, but also help employees better understand the wide scope of benefits available to them. It would give employees a single source for information about their benefits, assistance in understanding problems they may encounter, and intervention with benefits vendors and health care providers. The advocacy consultants would understand the full range of benefits available and the intricacy of details like medical coding. They would employ a variety of professionals in various areas of expertise so that a call to the advocate would be a one-stop shop for information and resolution.

Patient Care is an example of such an organization and is already a player in the Alaska healthcare market, as they are currently used by the Alyeska Pipeline Service Company. Tim Adamczak, Benefits Director for Alyeska, claims that hiring Patient Care was better than hiring four full-time benefits coordinators at a fraction of the cost. Alyeska employees have been extremely satisfied with the service received from this organization.

Though the company is based out of Milwaukee, Wisconsin, Patient Care extended their hours of service to accommodate the Alaska time zone. They have indicated to University of Alaska personnel that they would be happy to extend their evening and weekend hours even further if their Alaska clientele were to increase. Mr. Adamczak said the group is responsive to the needs of both the company and its employees and is extremely satisfied with them as a vendor. Also, contracting with Patient Care or some other equally responsive employee advocacy organization would come out of HR’s consulting budget and not add to the cost of the healthcare plan. But most importantly, it would give employees a place to turn for valuable information they need to keep their lives running smoothly so that their work can also run smoothly.

Spouse-associated options

Spouses are responsible for 35.6% of the University’s health care claims although they are only 26% of the population. Therefore, decreasing the number of spouses enrolled in the University’s health care plan could be a beneficial activity. Charging a ‘spousal surcharge’ for every spouse who has other health care coverage available but waives it in favor of being on the University’s plan will assist in recovering the costs associated with the spouses on the plan.

Wellness programs reduce health care costs by working with enrollees to identify and manage risk factors before they become high-cost conditions. Currently, spouses do not participate in the University’s wellness programs. Given that spouses are responsible for a significant portion of the costs associate with the University’s health care plan, it may be beneficial to the spouses and the University to encourage spouses to participate in the University’s wellness program. At least one University surveyed required that spouses participate in a wellness program or pay a surcharge.
Preferred care sites

A relatively new concept in higher education is to offer employees easy and convenient access to primary health care services through on-site health clinics. On-site health clinics have been used in the private sector for sometime with most entities reporting the following benefits/advantages:

- Convenient access to employees to care
- A safer workplace
- Lower heath care costs through negotiated rates
- A healthier workforce (over time)

On-site health clinics in higher education usually are tied to medical program offered by those institutions. Other universities that do not have an associated medical school, including Purdue University, have also recently invested in on-site health clinics. Another consideration is whether we have the numbers necessary to justify an on-site health clinic. If the concept were explored further by UA, clinic locations would likely be limited to UAA and UAF. They also would probably need to serve the general public with special consideration or priority given to University employees.

It is the task force’s suggestion that an RFP be developed to explore interest among local health care providers in developing primary care health clinics on the Anchorage and Fairbanks campuses. It is further suggested that the RFP be designed to address the unique needs of the respective MAUs.
Section III: Approaches not deemed feasible at this time

Many universities include funded graduate students in their health care plans. The rationale is that more healthy members with fewer high-cost claims would offset the cost. This option has the added benefit of being attractive to prospective graduate students, whose demographic has changed over the years from young, single individuals to slightly older couples, often with a young child. Although the approach seems beneficial on the surface, a more detailed look at the costs involved shows that it would actually cost UA more at all levels.

Given that the average amount each employee currently pays (depending on plan choice) is almost $2,900 per year, compared to the University’s per-employee contribution of about $14,000, the problem is clear. With around 900 funded graduate students—those with stipends, or research or teaching assistantships—UA would have an additional influx of about $2.6M for health care, but accrue additional costs of potentially over $14M. Graduate students would likely cost less than the average $16,900, but they would just as likely cost more than $2,900 each year.

A further complication comes from where the employee charges would be paid. Our funded graduate students are mainly supported from the research enterprise at UAF ($114M in FY12). At a time when graduate-student costs are already rising toward that of a post-doctoral researcher, this additional cost threatens to tip the balance. Many faculty already favor post-docs instead of graduate students because they can produce funding and results the moment they begin work. This practice threatens UA’s core mission of education and has long-term implications for research in Alaska by slowing our commencement of young researchers.

Although improving health care for graduate students is a laudable goal and should be pursued, the task force concluded that adding them to the UA Choice health care plan is not viable at this time.
Health Care Task Force Members

**UAA**
John O. Riley
Jared Brandner

**UAF**
Jon Dehn
Raaj Kurapati
Cathy Cahill
Juella Sparks

**UAS**
Jill Dumesnil
Mischelle Pennoyer

**SW**
Donald Smith
Erika Van Flein
Lisa Sporleder
Table 1a
2012-2013 University of Alaska UA Choice and State of Alaska GGU ASEA Health Trust Plan Comparison

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>UA HDHP Plan</th>
<th>UA 750 Plan</th>
<th>UA 500 Plan</th>
<th>GGU ASEA Health Trust: Full Plan for Employees and Families</th>
<th>GGU ASEA Health Trust: Supplemental Plan</th>
<th>GGU ASEA Health Trust: Low Option for Employees and Families</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Deductible</td>
<td>$1,250</td>
<td>$750</td>
<td>$500</td>
<td>$250</td>
<td>None</td>
<td>$5,000</td>
</tr>
<tr>
<td>Family Deductible</td>
<td>$3,000</td>
<td>$2,250</td>
<td>$1,500</td>
<td>$500</td>
<td>None</td>
<td>$10,000</td>
</tr>
<tr>
<td>Coinsurance - In-Network (plan pays)</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
<td>20%</td>
<td>100%</td>
</tr>
<tr>
<td>Individual Out of Pocket (excludes ded)</td>
<td>$3,750</td>
<td>$3,500</td>
<td>$3,000</td>
<td>$1,000</td>
<td>N/A</td>
<td>None</td>
</tr>
<tr>
<td>Family Out of Pocket (excludes ded)</td>
<td>$8,000</td>
<td>$7,000</td>
<td>$6,000</td>
<td>$2,000</td>
<td>N/A</td>
<td>None</td>
</tr>
<tr>
<td>Lifetime Maximum Benefit</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>$10,000 per yr</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Preventive Care Benefit</td>
<td>100% Covered</td>
<td>100% Covered</td>
<td>100% Covered</td>
<td>80% no Ded</td>
<td>20%</td>
<td>80% no Ded</td>
</tr>
<tr>
<td>Primary Care Physician Copayment</td>
<td>80% after Ded</td>
<td>80% after Ded</td>
<td>80% after Ded</td>
<td>80% after Ded</td>
<td>20%</td>
<td>100% after Ded</td>
</tr>
<tr>
<td>Specialist Copayment</td>
<td>80% after Ded</td>
<td>80% after Ded</td>
<td>80% after Ded</td>
<td>80% after Ded</td>
<td>20%</td>
<td>100% after Ded</td>
</tr>
<tr>
<td>Emergency Room Copayment</td>
<td>80% after Ded</td>
<td>80% after Ded</td>
<td>80% after Ded</td>
<td>80% after Ded</td>
<td>20%</td>
<td>100% after Ded</td>
</tr>
<tr>
<td>Inpatient Copayment</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Retail Rx</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>$5</td>
<td>$5</td>
<td>$5</td>
<td>20% to $50</td>
<td>20%</td>
<td>100% after Ded</td>
</tr>
<tr>
<td>Preferred</td>
<td>$25</td>
<td>$25</td>
<td>$25</td>
<td>20% to $50</td>
<td>20%</td>
<td>100% after Ded</td>
</tr>
<tr>
<td>Non-Preferred</td>
<td>$50</td>
<td>$50</td>
<td>$50</td>
<td>20% to $50</td>
<td>20%</td>
<td>100% after Ded</td>
</tr>
<tr>
<td>Annual OOP Rx Max</td>
<td>$1,000</td>
<td>$1,000</td>
<td>$1,000</td>
<td>$500</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Monthly (12) Employee Contribution</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee</td>
<td>$122.08</td>
<td>$190.00</td>
<td>$323.83</td>
<td>$90</td>
<td>$25</td>
<td>$30</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$244.17</td>
<td>$380.00</td>
<td>$647.67</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$219.75</td>
<td>$342.00</td>
<td>$582.92</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>EE + Family</td>
<td>$341.83</td>
<td>$532.00</td>
<td>$906.75</td>
<td>$195</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Plan Enrollments</td>
<td>UA</td>
<td>GGU</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------</td>
<td>------</td>
<td>------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employees</td>
<td>3,929</td>
<td>7,993</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependents</td>
<td>5,056</td>
<td>10,412</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>8,895</td>
<td>18,405</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Plan Costs (average of all plans)</th>
<th>UA</th>
<th>GGU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employees</td>
<td>17% of $16,916 ($2,876)</td>
<td>Varied</td>
</tr>
<tr>
<td>Employer</td>
<td>83% of $16,916 ($14,040)</td>
<td>$15,960</td>
</tr>
<tr>
<td>Health Trust</td>
<td>0</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

2. Total Plan Costs for UA projected to be $16,916 per employee, per year (PEPY).
3. Other information gathered by HCTF committee members from the State of Alaska website and through telephone interviews with ASEA Health Trust administrators.
4. The State of Alaska pays a Benefit Credit each month to the ASEA Health Trust toward the cost of health insurance for each employee. For 2012-2013, that credit is $1330.
5. There are four Health Trusts providing medical insurance for their member. The Health Trusts are listed at http://doa.alaska.gov/drb/ghlb/employee/health/planDetails.html with a link to each homepage.
Table 2.
Health Plan Comparisons
Private and Public Employers

<table>
<thead>
<tr>
<th></th>
<th>Deductible - Individual</th>
<th>Deductible - Family</th>
<th>Max Out-of-Pocket (Ind)</th>
<th>Max Out-of-Pocket (Fam)</th>
<th>Coinsurance</th>
<th>Preventative Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kroger (Fred Meyer)</td>
<td>$850-$2500</td>
<td>$1700-$5000</td>
<td>$3000-$4000</td>
<td>$6000-$8000</td>
<td>20%</td>
<td>100%</td>
</tr>
<tr>
<td>Alyeska Pipeline</td>
<td>$1750</td>
<td>$3500-$5250</td>
<td>$3000</td>
<td>$9000</td>
<td>20%</td>
<td>100%</td>
</tr>
<tr>
<td>Arctic Slope Regional Corp</td>
<td>$1500</td>
<td>$3000</td>
<td>$4000</td>
<td>$9000</td>
<td>20%</td>
<td>100%</td>
</tr>
<tr>
<td>NEA Alaska</td>
<td>$100</td>
<td>$300</td>
<td>$1000</td>
<td>$3000</td>
<td>20%</td>
<td>100%</td>
</tr>
<tr>
<td>Municipality of Anchorage</td>
<td>$100-$1300</td>
<td>$300-$3000</td>
<td>$1000-$5000</td>
<td>$10000</td>
<td>20%</td>
<td>100%</td>
</tr>
<tr>
<td>UAA</td>
<td>$500-$1250</td>
<td>$1500-$3000</td>
<td>$3000-$3750</td>
<td>$6000-$8000</td>
<td>20%</td>
<td>100%</td>
</tr>
</tbody>
</table>

* data refers to in-network

1. Kroger Health Screening and HQ - and incentives to meet targets.
2. New Kroger, 2012: Centers of Excellence and Patient Centered Medical Home
3. ASRC - dropped PPO 250 plan (low deductible) this year and expects to save $2.1 million in 2012.
4. NEA Alaska (AEA): 1) dramatic 2012 dues reduction; 2) Clinics; 3) Biometrics
Chart 1.
Total 500 Plan Participants as of 8/01/2012

*Median salary for 500 Plan is $61,739.19*
Chart 2.
Employees Enrolled in 500 Plan Grouped by Age as of 8/01/2012

*Median salary for 500 Plan is $61,739.19"
Chart 3.
Employees Enrolled in 500 Plan Grouped by Years of Service as of 8/01/2012

*Median salary for 500 Plan is $61,739.19*
Chart 4.
Comparison of Deluxe/500 Plan Members vs. Opt-Outs as of 8/01/2012
Chart 5.
Total Opt-Outs by MAU as of 8/01/2012

*Median salary for Opt-Outs is $53,052.40
Chart 6.
Number of Opt-Outs that are Dependents on UA Plans as of 8/01/2012

<table>
<thead>
<tr>
<th></th>
<th>Number of Opt outs</th>
</tr>
</thead>
<tbody>
<tr>
<td>SW</td>
<td>9</td>
</tr>
<tr>
<td>UAA</td>
<td>26</td>
</tr>
<tr>
<td>UAF</td>
<td>73</td>
</tr>
<tr>
<td>UAS</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>113</td>
</tr>
</tbody>
</table>
Chart 7.
Total Opt-Outs Grouped by Age as of 8/01/2012

*Median salary for Opt-Outs is $53,052.40*
Chart 8.
Total Opt-Outs Grouped by Years of Service as of 8/01/2012

*Median salary for Opt-Outs is $53,052.40*