Retiree Health Plan Advisory Board
Meeting Agenda

Date:	Thursday, February 9, 2023
Time:	9:00am – 11:00am PLEASE NOTE TIME CHANGE OnlinePublicNotices
Location:	Video Teleconference | ANC Atwood 19th Floor | JNU 10th Floor Click here to join the meeting
Telephone Only:	(907) 202-7104 ID 335 590 312#
Board Members:	Judy Salo (chair), Lorne Bretz, Dallas Hargrave, Paula Harrison, Cammy Taylor, Michael Humphrey and Nanette Thompson

9:00 am Call to Order – Judy Salo, Board Chair
- Roll Call and Introductions
- Approval of Agenda
- Ethics Disclosure and Public Comment Script

9:10 am Public Comment

9:20 am Committee Reports
- Modernization subcommittee
- Regulations subcommittee

9:30 am Modernization Topics
- Dental: Annual Benefit Maximum
- Dental: Preventive First

10:00 am Board Discussion
- Medicare and Primary Care Providers in Alaska

10:45 am Public Comment

11:00 am Wrap up/Adjourn

The next Retiree Health Plan Advisory Board meeting is tentatively scheduled for early March 2023.

Retiree Health Plan Advisory Board

Quarterly Board Meeting Minutes

Date: Tuesday, September 27, 2022 9:00 a.m. to 3:00 p.m.
Location: Atwood Building, Anchorage; HSS Building, Juneau; WebEx (virtual)

Meeting Attendance

Name of Attendee	Title of Attendee	
Retiree Health Plan Advisory Board (RHPAB) Members		
Judy Salo	Chair	Present
Cammy Taylor	Vice Chair	Present
Lorne Bretz	Member	Present
Dallas Hargrave	Member	Present
Paula Harrison	Member	Present
Nan Thompson	Member	Present
Michael Humphrey	Member	Present
Mauri Long	Modernization Committee Member (RPEA)	Present
Wendy Woolf	Regulations Committee Member (RPEA)	Present
State of Alaska, Department of Administration Staff		
Ajay Desai	Division Director, Retirement + Benefits	
Emily Ricci	Chief Health Policy Administrator, Retirement + Benefits	
Betsy Wood	Deputy Health Official, Retirement + Benefits	
Teri Rasmussen	Program Coordinator, Retirement + Benefits	
Andrea Mueca	Health Operations Manager, Retirement + Benefits	
Steve Ramos	Vendor Manager, Retirement + Benefits	
Michael Gamble	Member Liaison, Retirement + Benefits	
Chris Murray	Program Coordinator, Retirement + Benefits	
Christina Fantasia	Appeals Specialist, Retirement + Benefits	
Elizabeth Hawkins	Appeals Specialist, Retirement + Benefits	
Others Present + Members of the Public		
Ben Hofmeister	Assistant Attorney General, Department of Law	
Noel Cruse	Segal Consulting (contracted actuarial)	
Stephanie Messier	Segal Consulting (contracted actuarial)	
Richard Ward	Segal Consulting (contracted actuarial)	
Kautook Vyas	Segal Consulting (contracted actuarial)	
Inmaly Inthaly	Agnew::Beck Consulting (contracted support)	
Randall Burns	Public Member	
Delisa Culpepper	Public Member	
Dorne Hawxhurst	Public Member	

Common Acronyms

The following acronyms are commonly used during board meetings and when discussing the retiree health plan generally:

- ACA = Affordable Care Act (formal name: Patient Protection and Affordable Care Act)
- ARMB = Alaska Retirement Management Board
- CMO = Chief Medical Officer
- CMS = Center for Medicare and Medicaid Services
- COB = Coordination of Benefits
- COVID-19 = Novel Coronavirus Disease (identified 2019), also known as SARS-CoV-2
- DB = Defined Benefit plan (for Tier 1, 2, 3 PERS employees and Tier 1, 2 TRS employees)
- DCR = Defined Contribution Retirement plan (Tier 4 PERS employees, Tier 3 TRS employees)
- DOA = State of Alaska Department of Administration
- DRB = Division of Retirement and Benefits, within State of Alaska Department of Administration
- DVA = Dental, Vision, Audio plan available to retirees
- EGWP = Employer Group Waiver Program, a federal program through Medicare Part D that provides reimbursement for retiree pharmacy benefits
- EOB = Explanation of Benefits, provided by the plan administrator detailing claims coverage
- HIPAA = Health Insurance Portability and Accountability Act (1996)
- HRA = Health Reimbursement Arrangement account, a mechanism for the employer to reimburse high-income Medicare enrollees for any premium charge for their plan (IRMAA)
- IRMAA = Income Related Monthly Adjustment Amount, a surcharge from CMS for a Medicare plan for individuals or households earning above certain thresholds
- MA = Medicare Advantage, a type of Medicare plan available in many states
- MAGI = Modified Adjusted Gross Income, based on an individual or household's tax returns and used by CMS to determine what if any premium must be paid for a Medicare plan.
- OAH = Office of Administrative Hearings, a quasi-judicial body that hears some types of appeals
- OPEB = Other Post Employment Benefits; an accounting term used to describe retirement benefits other than pension benefits, and the retiree health trust
- OTC = Over the counter medication, does not require a prescription to purchase
- PBM = Pharmacy Benefit Manager, a third-party vendor that performs claims adjudication and network management services
- PEC = proposal evaluation committee (part of the procurement process to review vendors' bids)
- PHI = protected health information, a term in HIPAA for any identifying health or personal information that would result in disclosure of an individual's medical situation.
- PMPM = Per member per month, a feature of capitated or managed-care plans
- PPO = Preferred Provider Organization, a type of provider network
- RDS = Retiree Drug Subsidy program (a federal pharmacy subsidy program)
- ROI = Return on Investment
- RFP = Request for Proposals (a term for a procurement solicitation)
- RHPAB = Retiree Health Plan Advisory Board
- TPA = Third Party Administrator
- USPSTF: U.S. Preventive Services Task Force

Meeting Minutes

Item 1. Call to Order + Introductory Business

Chair Judy Salo called the meeting to order at 9:03 a.m. A quorum was present. Cammy Taylor introduced Mike Humphrey as a new Board member, filling the seat representing the Retired Public Employees of Alaska (RPEA).

Approval of Meeting Agenda

Materials: Minutes beginning page 3 of 9/27/22 RHPAB meeting packet

- **Motion** by Lorne Bretz Taylor to approve the agenda as presented. **Second** by Mike Humphrey.
    - **Discussion**: None.
    - **Result**: No objection to approval of agenda as presented. Agenda is approved.

Approval of Previous Meeting Minutes

- **Motion** by Cammy Taylor to approve minutes of the May 5, 2022 regular Board meeting; July 20, 2022 Modernization Subcommittee meeting; and September 8, 2022 Modernization Subcommittee meeting. **Second** by Lorne Bretz.
    - **Corrections**: In the May 5, 2022 regular Board meeting minutes, page 6 (page 22 in packet) under the second bullet, change "out-of-" to "out-of-network provider."
    - **Result**: No objection to approval of minutes as amended. Minutes approved.

Ethics Disclosure

Vice Chair Cammy Taylor requested that Board members state any ethics disclosures in the meeting and reminded members of the disclosure form available from staff, to keep any necessary disclosures on file.

- No disclosures were stated by Board members.

Item 2. Public Comment

Before beginning public comment, the Board established who was present on the phone or online, and who intended to provide public comments. Individuals were asked to state their full name for the record, and that if there are several people wishing to provide comment, comments will be limited to 3 minutes per person, at the discretion of the chair. Chair Salo also reminded Board members and members of the public of the following:

1) A retiree health benefit member's retirement benefit information is confidential by state law;
2) A person's health information is protected by HIPAA;
3) Testimony will be posted on the Board's website and will be publicly available, including both written comments and statements made verbally in meetings and recorded in the minutes;
4) By giving public testimony on those subjects, the person will be treated as having waived their right to confidentiality regarding the subject of their testimony;
5) An individual cannot waive this right on behalf of another individual, including spouse or family member;
6) The chair will stop testimony if any individual shares protected health information.

Members of the public who provide comments are also encouraged to submit their comments in writing to the Retiree Health Plan Advisory Board: rhpab@alaska.gov.

Public Comments

- Dorne Hawxhurst expressed concerns on two items:
    - There is perceived age discrimination with precertification. If a member who is age 63, and not yet Medicare-eligible, goes to Alaska Regional for a hospitalization, Alaska Regional is responsible for receiving precertification as an in-network provider for Aetna. If Alaska Regional does not receive precertification, the claim may be denied in whole or in part, but the member is held harmless. This is not the case for the special population of members age 65 and older who are ineligible for Medicare Part A (e.g., only ever working for the State of Alaska) and did not earn enough Medicare Part A credits. When a member of this population goes to Alaska Regional for a hospitalization, the member is responsible for receiving precertification and will be billed for any denied claims. Dorne was informed by an Aetna representative that there are no in-network providers for members age 65 and older, and was informed these members have a different health plan. Dorne requested that health plan through a power-of-attorney and the plan has since not been provided for her review. If the precertification rules are going to be revised, the plan should clearly indicate they only apply to members of a certain age group.
    - Dorne also expressed opposition for the proposed travel cap, and for the Division's failure to cover travel for diagnostic testing. While the plan would cover travel on the Alaska Marine Highway System, that only covers a member's passage, not their vehicle. For example, if the ferry drops a member off in Whittier or Valdez, the member will have to find their way to Anchorage, which is costly. The round-trip cost of the member's passage and their vehicle is equal to the cost of a round trip commercial flight.

Item 3. Department of Administration + Division of Retirement & Benefits Updates

Chair Salo asked Emily Ricci to share updates.

Legal + Regulatory Updates

Emily Ricci introduced the topic of a recent ruling with a case heard at the Alaska Supreme Court, involving a member who believed that certain services should have been paid for and wanted assurances that the services would be paid for in the future. Assistant Attorney General Ben Hofmeister explained the case further:

- The case, filed in August, involves an appeal of a decision on Aetna's coverage of services. In this case, a member appealed a claim denial related to lack of medical documentation to support ongoing massage therapy service.
- The member made a series of appeals were made to Aetna. The Division of Retirement and Benefits, which has authority to make a determination on appeals, decided to pay the claim and educate the appellant that additional documentation would be needed for future claims. The appellant rejected that decision.
- The Division decided not to send the case to the Office of Administrative Hearings (OAH) as Alaska law allows for OAH to consider decisions made by state agencies that are adverse to the beneficiary. In this case, the bill was paid, and it was determined the decision was not adverse to the beneficiary.
- The appellant objected and ultimately filed a claim in superior court.
- The Division made the same argument in the superior court, which affirmed the Division's decision.

Health Fairs

Chris Murray gave a brief update on health care events:

Health fairs ceased for the last two years due to the pandemic; this year, health fairs have been scheduled around the state for retirees and employees. Recently, two health fairs were held in Palmer and Fairbanks. Most attendees were retirees; over 800 labs were administered, and over 400 flu shots were given. Overall, the events were well-organized with a positive response, and have given opportunities for face-to-face interactions with members. There are upcoming events in more locations, including in Anchorage and Juneau, throughout October.

- Is there a tracking system for people who are attempting to register, but are not able to sign up, since it is past the deadline?
    - Chris answered he does not know the answer to this question, as the coalition who hosts these events determines availability of its appointments and manages the preregistration process. When the coalition determines availability, they begin planning the venue, staffing, and review historical data. The historical data and variables determine the number of slots available at each location. Slots are added as additional capacity becomes available.

DVA Open Enrollment

Andrea Mueca gave a brief update on Dental Vision, and Audio (DVA) open enrollment:

Enrollment begins on October 12, 2022 and ends on November 23, 2022. The enrollment guide will be mailed out with a comparison document, members should receive the materials on the week of October 10, 2022. A reminder postcard will also be sent halfway through the open enrollment period. All members are encouraged to participate in open enrollment to verify their plans and review any revisions that should be made to reduce or increase coverage. Information is on the Division of Retirement and Benefits website and includes the enrollment guide with instructions and a comparison document. This information will be sent to the Board as well for reference.

Plan Booklet Updates for 2023

Teri Rasmussen gave a brief update on the Plan Booklet updates for 2023:

Each fall, reviews to the Plan Booklet are made for necessary changes (including typos and changes to standards of care), then public processes are in place to provide a public comment and review period for the plan amendments.

This coming year, the planned changes include some clarifications of the plan language. (e.g., reimbursement submission language is further clarified to help members understand the reimbursement request process).

The public comment period will begin in mid-October and end in mid-November and will be a 30-day period. The public comment period will be announced in three newspapers, through emails to retirees, in a newsletter, in an online public notice, in retiree meetings and a teleconference, and on the Division's website. Along with the announcement, there will be a marked version of the Plan Booklet highlighting proposed changes in each section, as well as a 1 to 2-page summary. The electronic version of the Plan Booklet will be available before January 1, 2023 and paper copies of the Plan Booklet will be available after that date as it usually takes longer to get printed copies made.

Emily Ricci noted the importance of holding discussions on plan changes earlier in the year moving forward (usually held in September), considering the consistent timing conflict with the DVA open enrollment period (usually in October to November), which happens simultaneously during the public comment process for Plan Booklet updates.

The board agreed with the Division staff's approach. Staff confirmed that they would move forward with this approach in the coming year, which should resolve some operational issues.

Inflation Reduction Act and Impact on Medicare Part D

Emily Ricci outlined the impact of the federal Inflation Reduction Act on Medicare Part D plans:

The Inflation Reduction Act was passed by Congress and signed into law on August 16, 2022 and has a number of relevant provisions. The act will not impact members' coverage experience for prescription drugs but may impact their health plans.

The Division does not expect plan changes in 2023, as most items impacting members and plans will not take effect until later years. The rules have not been promulgated yet, but it is anticipated that members will have low impact from the act overall. There have been changes to federal subsidies, specifically to the thresholds to subsidy payments for the plan. This information is only preliminary, as staff are still not sure how the act will be operationalized. There may be some other offsets that occur because of the pricing negotiations. The larger question is whether the offsets will be enough to cover the change in subsidies.

- Judy Salo asked that if the subsidy reduction got to a certain level, would it be best to have the Medicare Part D plan differently constructed to return to the RDS approach?
    - Richard Ward answered there is a threshold that could make sense, but current subsidies are upwards of $60 million; a $13 million reduction would become $47 million. There are also indications other subsidies would be enhanced, which could offset the lowering of the subsidy threshold. RDS subsidies are estimated to be in the range of $20 to $25 million.

EGWP Opt-Out Plan Update

Emily Ricci noted that members are required to provide certain information (e.g., contact information) for EGWP plan eligibility. Staff have attempted to contact various members over long periods of time to obtain this information which has prevented enrollment into the EGWP plan.

Andrea Mueca gave a brief update on the Division's changes relative to the EGWP plan:

In 2019, the "Age 65 Letter" was implemented for retirees who are turning age 65, to be notified three months before their 65th birthday about how Medicare interacts with the retiree plan. The notice includes a Medicare information brochure, information on IRMAA, and a Medicare enrollment verification form which requests a Medicare ID number from members. Without this number, members cannot be enrolled into EGWP. There is an average 30% response rate to these letters. For further context, there are about 350 members turning age 65 per month.

If there is no response received to the initial letter, a reminder notice will be sent out. If a member fails to reply to the reminder notice after 30 days, the member will be placed into the Pharmacy Opt-Out Plan, which has a different co-pay structure. In this case, if the member has a pharmacy visit, they will have a different experience than they are used to under their prior plan, which will likely result in a call to the Division. Staff will use this call to obtain their Medicare ID number and make retroactive payments. Staff plans to implement this letter and follow-up process in January 2023.

Item 4. GCIT – Final Proposed and Recommendation Vote

Materials: GCIT Network Benefits proposal on page 34 in 9/27/22 RHPAB Meeting packet

Betsy Wood noted that more gene therapies are being released on the market as treatment options, resulting in the need for the plan to be prepared with fair coverage guidelines for members. Staff are looking for a vote from the Board at this meeting in order to implement the GCIT Network Benefits in the medical plan on January 1, 2023.

Betsy Wood reviewed the proposal:

Gene-Based, Cellular, and other Innovative Therapies (GCIT) are complex courses of treatment. With GCIT's being new areas of treatment, it can be difficult to understand if the therapy is a drug, in-patient administered drug, or a medical service. These therapies are highly specific and typically engineered using genetic material.

The Division's goals are the following:

1. Ensure members maintain access to necessary treatments as needed
2. Provide members with logistical and clinical support needed for serious conditions
3. Reduce member and plan risk by adding cost controls for emerging high-cost treatments

Staff proposes adding Aetna's GCIT Designated Network program to the AlaskaCare retiree plan, which would provide coverage for specific drugs and therapies included in the program list (*page 42 of the 9/27/2022 RHPAB meeting packet*) through designated network providers who have been manufacturer-approved to administer the drugs. Members would also be provided a clinical team at Aetna who has experience with these specific types of gene therapies.

Travel would be covered as follows: $50 per night per person for lodging, and up to $10,000 per course of treatment for the member and a companion, if the care must be administered away from the patient's home.

Staff proposes to clarify the plan's language to note services will be covered under the medical plan, rather than the pharmacy plan. This would be done through implementation of OptumRx through the Medical Benefit Specialty Vigilant Drug Program Exclusion List, which details which treatments are not covered under the plan. OptumRx has developed a definition of drugs to fit into this category: drugs designated as an orphan drug, or exhibit gene therapy technology with annual cost of $500K; not self-administered, and requires a medical provider to give the first dose; and must be administered in a patient setting. For products meeting these criteria, they have defined these be a medical benefit, which ensures these services are covered under the medical plan instead.

Staff proposes to exclude expenses for products included in the GCIT Designated Network Program from accruing to the lifetime maximum benefit set in the plan. At this time, staff are only looking to exclude the cost of the drug for drugs included in the Medical Benefit Specialty Vigilant Drug Program Exclusion List. However, it is still a priority of the Division to adjust the lifetime maximum from a holistic perspective; this will be separately addressed from this proposal.

The following are anticipated impacts of this proposal:

For members, current utilizers of impacted GCIT services on the medical and pharmacy plans can continue their current treatments and would not be adversely impacted by the addition of the GCIT Designated Network program.

Staff would like new utilizers to be aware that they have additional travel coverage and clinical support. There are currently no facilities or providers in Alaska that participate in the GCIT network, which means members residing in Alaska will likely travel to receive care. Aetna will continue to negotiate single-case agreements for members if this program is implemented.

The financial impact is difficult to project, since treatments are very rare. Information is included in the detailed proposal about what potential savings to expect, based on the wholesale price. Aetna projects the plan would save about 17% below the Average Wholesale Price (AWP) for drugs included in the program, which may also include rebates. Staff anticipates that cost controls will be put in place to protect the plan from inflated costs associated with already-expensive medications. However, financial savings is not the main motivator for the proposal. Staff want to provide protection, additional support, and access to complex treatments in a safe and responsible environment.

There is no anticipated actuarial impact to the plan. There is minimal anticipated impact to operations, other than staff reviewing and distributing communications to educate and increase awareness of the GCIT Network program, updating the Plan Booklet language, and coordinating implementation of operational changes with Aetna. Most of this effort will take place during initial implementation.

Prior to moving forward to the resolution, Chair Judy Salo formally appointed Mike Humphrey to the Modernization Subcommittee.

Questions and discussion about the proposal, including review of the draft resolution:

- Paula Harrison: If the cost of therapy could be up to $2.5 million, how does this impact the $2.0 million lifetime cap for retirees? Would the drug costs be exempt from the inclusion from the cap, but not the travel costs and lodging?
    - Betsy Wood confirmed this is correct. The cost of the product drives total costs associated with these treatments; these would be excluded from the $2.5 million lifetime maximum. Staff acknowledge the lifetime maximum should be addressed as a broader policy.

Resolution 2022-01 (*page 49 of the 9/27/2022 RHPAB meeting packet*) was drafted for the Board to consider and vote as an advisory recommendation. Betsy Wood reviewed the draft resolution with the Board; the group discussed the following amendments:

- On the 7th "WHEREAS," make this into two "Whereas" statements:
    - "WHEREAS, the Plan's current Third-Party Administrator (TPA) offers a GCIT Designated Network program which provides price protection, specialized clinical support and care coordination; and"
    - "WHEREAS, additional eligible travel benefits of up to $10,000 per course of treatment will be available to members seeking GCIT designated network services; and"
- On the 9th "WHEREAS," change "FDA pipeline therapies" to "emerging GCIT products identified by the FDA."
- On the 10th "WHEREAS," change "limited pharmacy exclusions" to "specific pharmacy exclusions."

Emily Ricci brought a public comment from Wendy Woolf to the Board's attention, in which she expressed concern about implementing the Optum Rx Medical Benefit Specialty Vigilant Drug Program Exclusion List. The proposal indicates drugs on the list will no longer be covered under the pharmacy plan, but instead under the medical plan. Moving these drugs would count against this against retirees' $2.0 million lifetime maximum. Wendy Woolf recommended excluding all the drugs on the list that would count against retirees' $2.0 lifetime maximum.

Emily Ricci noted that staff reviewed the comment; from the Division's perspective, it is unclear whether the drugs Wendy referenced are covered under the pharmacy plan; these are drugs provided as a medical service in a medical environment, not drugs that are obtained through a pharmacy. Additionally, Emily Ricci stated that the administrative burden to carve an increasingly high number of items out of the lifetime maximum sets a policy precedent the Division is uncomfortable with, and is unrealistic to maintain. The Division prefers not to craft policies to work around the lifetime maximum; they would like to address the lifetime maximum directly as a future policy change. For these reasons, the Division believes the proposal does not need further modifications and does not recommend action on this.

- **Motion** by Nan Taylor to approve Resolution 22-01 as amended during the meeting. **Second** by Cammy Taylor.

  Discussion: No further discussion.

  Vote: Motion passes.

Bretz	Hargrave	Harrison	Humphrey	Salo	Taylor	Thompson
Yes	Yes	Yes	Yes	Yes	Yes	Yes

The Board took a break at 11:16 a.m., and returned to the meeting at 11:25 a.m.

Item 5. Remove Precertification Penalty – Final Proposal and Recommendation Vote

Materials: Proposal to remove precertification penalty on page 51 of 9/27/2022 RHPAB meeting packet:

Emily Ricci reviewed the proposal and outlined the following:

Staff propose to remove penalties currently applied to members who do not receive precertification and use an out-of-network provider. This can happen when a member goes to an out-of-network provider and receives services requiring precertification by the plan which are determined to be medically necessary. The plan currently pays for coverage but assesses a $400 penalty to the member. Staff proposes eliminating this penalty so that, if a member sees an out-of-network provider and does not get a precertification for a service that is eligible for coverage, the member would still receive the full coverage benefit and no longer be assessed the $400 penalty.

From an administrative perspective, if a member travels, and does not get precertification, then submits a claim later, it is difficult for the Aetna concierge and claims processing team to determine what the recognized charge would have been for that travel. For this reason, and due to complex travel coverage provisions, staff want to encourage members to have travel precertified. Additionally, it is difficult for the Aetna team to look back 6 to 8 weeks later to determine what airfare would have been at that time. When looking at the average reimbursement for tickets, it was found that the average was a $400 reimbursement. It was determined that travel could be reimbursed up to $500 cash if the travel was not precertified, allowing plan consistency and benefits to the member.

The plan's policy has not been updated since 2014, and the Division is looking to make updates on a more regular basis. Staff proposes to remove the existing precertification list from the Plan Booklet and reference the third-party administrator's precertification list, which is publicly accessible and will be updated to reflect changes in practice and terms, so the plan can utilize a more regularly-updated list.

Staff anticipate that the proposed changes will have minimal impact to members, and will be an overall positive change, as it would make it easier for members to access their benefits and submit claims, and remove a penalty. There is a risk members currently face if they go to an out-of-network who does not seek precertification: a post-service review may determine that the service was not medically necessary. If a network provider fails to precertify, and there is a subsequent determination that the service was not medically necessary, members are held still harmless.

- Cammy Taylor: she hears members are concerned about precertifications, because they believe the national precertification list is subject to change at any time, and changes will occur without their knowledge.
    - Emily Ricci confirmed that the national precertification list does change periodically, but the change is not always negative for members.
- Emily Ricci shared back a comment by Wendy Woolf, which indicates support for removing the precertification penalties. In her comment, Wendy also asks why travel benefits are capped at $500 if the member has not precertified travel, rather than the full travel benefit. Wendy also requested that the proposal clearly outline that travel precertification is required, and retirees are responsible for precertifying travel, regardless of the network provider being in-network or out-of-network. She further commented that the statement at the top of page 7 of the proposal is unnecessary, as it does not matter that the Aetna's standard does not require precertification for travel, as it is still an AlaskaCare requirement.
    - Emily addressed Wendy's comments, stating that under the current provisions, travel would not be covered at all, and covering the travel up to $500 is a benefit to the member compared to the current policy. Additionally, Wendy Woolf's comments have been addressed during discussion of the proposal at this meeting.
- Cammy noted at the last meeting, several questions asked during public comment were answered by Aetna (e.g., turnaround time for requests and information on the different mechanisms used by providers to receive approvals). Cammy reminded the Board this discussion was prompted by a settlement negotiation; the precertification list for medical services has a different process than travel, and is a uniquely different process than a medical process. Cammy reviewed the quarterly reports as the available data on the number of people who failed to precertify, which was about 10%. In the meantime, she noted the Division can work to educate members and remove the penalty.

Betsy Wood reviewed Resolution 22-02 (page 94 of the 9/27/2022 RHPAB meeting packet) with the Board.

- **Motion** by Nan Taylor to approve Resolution 22-02 as presented. **Second** by Cammy Taylor.

  Discussion: No further discussion.

  Vote: Motion passed.

Bretz	Harrison	Humphrey	Salo	Taylor	Thompson
Yes	Yes	Yes	Yes	Yes	Yes

The Board took a lunch break at 11:55 a.m., and returned to the meeting at 1:00 p.m.

Item 6. Member Support: Orphan Drug Program

Materials: Presentation slide deck on page 96 of the 9/27/2022 Board meeting packet

Sara Guidry noted the Orphan Drug Program is no longer identified as an opportunity for AlaskaCare, and is instead in the implementation phase. The program will be in place effective November 1, 2022. The program has no negative impact to members, but rather is an additional program for members on rare medications for rare conditions. A decision has already been made to put the program into place.

Sara Guidry outlined the following in the presentation:

- Slide 2: The term "orphan drug" came from the Orphan Drug Act, put in place by the U.S. FDA. Orphan drugs are medications for rare conditions. When there is lower utilization of these drugs, the costs are higher for these products over time, because they are not produced at large scale. High-cost products treat about 7,000 rare conditions that impact 1 in 10 Americans. Of the new FDA approvals in 2019, 44% were orphan drugs.
- Slide 3: The Orphan Drug Program includes the following support services: a medication action plan, dedicated support from board-certified pharmacists who specialize in orphan drugs, a comprehensive medication review, and one-on-one coaching.
- Slide 4: The program delivers personalized care, an optional benefit that members can opt out of. If concerns are identified, a pharmacist can contact a provider to discuss concerns and interventions.
- Slide 5: A member's story is highlighted, speaking to the importance of early detection to ensure receival of the right medication.
- Slide 6: A member's story is highlighted, speaking to the advantage of having personalized support through the program.
- [Slide 7: *Missing in slide deck*]
- Slide 8: There is a projected plan savings of $132,000, net of the program cost, based on medication-specific program savings with other clients using this program. The table shows between January and March, there was a total of 28 retirees on a medication that is part of the Orphan Drug Program. In 2021, there was a total of 36 retirees; these numbers can fluctuate. The program is priced in a way that only pays for members who are actively participating in the program and who participate in at least one consultation. Eligible members are contacted; if they do not respond or opt out, they will not be charged for the plan. If a member is interested and participates in at least one consultation, there is a $300 charge per program year.

- Cammy Taylor asked if the projected plan savings are based on drug interactions, or drugs that members are otherwise steered from because of the orphan drugs?
    - Sara Guidry answered the savings are calculated through a variety of prior studies showing the cost of certain medical emergencies. This medical data is used to determine that cost that could have occurred; the savings projection is based on clients who are part of the program, and the savings they've experienced through the program.

- Slide 9: Monthly, quarterly, and year-end reporting details include information on member information and consultations, provider information, drugs identified for members, activities on

engagement, enrollment, consults, outreaches, and provider communication, and total specific interventions, discontinued therapies, and plan paid savings.

- Slides 10-11: List of currently targeted medications for the Orphan Drug Program. Three to four additional medications will be added on November 1, 2022. There is currently no utilization rate for retirees which will not change the project program cost or savings.

Item 7. Premium Rates for Plan Year 2023

Materials: Presentation slide deck on page 107 of the 9/27/2022 meeting packet

Richard Ward gave some context prior to presenting the 2023 plan rates and noted that when the analysis is being done to provide recommendations for premium rates for any given year, there is a focus on covering claims costs and administrative expenses. Also, short term needs are balanced with long-term considerations.

Richard presented on the premium rate development and outlined the following:

- Slide 2: Analyses are done to provide recommendations and develop premium rates for a given year, with a focus on covering claims, administrative, and operational costs. Some plans are considered over a multi-year period, while others are short-term. The primary objective is to focus on the overall financial health and viability of the plan, balancing short- and long-term needs.
- Slide 3: On a net combined basis, expenses are compared against current premium rates and the revenue produced, to see how well they align. The intent is to collect enough revenue (through premiums) to cover the anticipated costs of the plan over time, based on prior expenses and the trend in anticipated expenses. The retiree health liability is well funded.
- Slide 4: In 2023, it is projected that there will be a ~$40 million difference funding gap. The rates are sufficient for the bottom line at this time.
- Slide 5: Segal does not recommend any changes to the CY2023 contributions.
- Slide 6: Comparisons of Medicare and non-Medicare retiree claims show that a Medicare primary participant costs about 50 to 65 percent less than a non-Medicare primary participant.
- Slide 7: Recent claims experiences inform projected claims for the next year for DVA plans. Administrative and operational costs are used to project claims and determine the monthly premium.
- Slide 8: The Legacy Dental Plan was re-introduced in January 2020, replicating the Standard Dental Plan in effect before January 2014. The total difference in costs (plan design, network configurations, charge methodology) between the Legacy and Standard plans is 14.3%. COVID-19 has impacted the plan utilization and thus has insufficient credibility in the 24-month lookback experience period to be rated individually at this time.
- Slide 9: The CY23 Dental, Vision, and Audio funding rates are lower than the Standard. The proposed options of holding rates for the Standard Plan would reduce the Legacy premiums, bringing them in line with the Standard Plan for CY23.
- Slide 10: Assuming Legacy rates are reduced to Standard rates in 2023, Segal projects that there will be a ~$6.33 million funding gap.
- Slide 11: Further spend-down is projected but there will still be a cushion in the existing fund. In future years, there are plans to manage the spend-down to prevent a sharp increase when this cushion of funding is fully spent down. Emily encouraged the Board to think about long-term

considerations, such as policy changes at the federal level, that will impact the DVA plan, and to take a holistic approach when reviewing how the Standard and Legacy plans could be changed.

- Slide 12: The Long-Term Care (LTC) plan benefits are paid out well after premiums are paid, so a long-term view is necessary. Segal recommends maintaining the current premium rates through the next actuarial valuation in June 2023.
- Slide 13: LTC plan valuation results through June 30, 2021; current trends show in 2019, the plan was 121% funded; this has since increased to 154% in 2021, primarily due to investment returns.

Item 8. Subcommittee Reports

Modernization Subcommittee Report

Materials: Proposed updated bylaws on page 121-125 of the 9/27/2022 RHPAB meeting packet.

Teri Rasmussen reported on behalf of Dallas Hargrave, and noted the reason for updating the subcommittee's bylaws is due to Administrative Order #56 initiated by Governor Dunleavy on June 6, 2022. As a result, the Board's bylaws have proposed updates, outlined as follows:

1. Board composition increased from 7 to 8 members, with a seat added for an RPEA member.
2. Quorum number updated to reflect what constitutes a majority of members.
3. Regulations Subcommittee added.
4. RPEA seat added to Modernization and Regulations Subcommittees.
5. Ethics statute number corrected.
6. Version history table updated

Motion by Nan Thompson to adopt the proposed changes to the RHPAB bylaws. **Second** by Lorne Bretz.

- **Discussion:** None.
- **Result**: Bylaws updates unanimously approved as presented.

Item 7. Public Comment

See Item 2 in the meeting minutes for public comment guidelines.

Chair Salo reminded meeting attendees of the guidelines for public comments provided in the meeting and invited anyone who wishes to provide public comment at this time to speak.

- Randall Burns, RPEA. Randall asked for clarification on the report given by Segal Consulting on the premium rate development and asked if the DVA plan calculations included calculations resulting from having all new members in the Standard plan beginning in 2020. Richard Ward confirmed the calculations did include this.

Item 8. Closing Thoughts + Meeting Adjournment

Motion by Nan Thompson to adjourn the meeting. **Second** by Lorne Bretz.
Result: No objection to adjournment. The meeting was adjourned at 2:18 p.m.

The next Retiree Health Plan Advisory Board meeting will be Thursday, November 3rd, at 9:00 a.m.

Check RHPAB's web page closer to the meeting to confirm the schedule, location and to download materials for upcoming meetings. https://drb.alaska.gov/retiree/rhpab/

Retiree Health Plan Advisory Board

Quarterly Board Meeting Minutes

Date: Thursday, November 3, 2022, 9:00 a.m. to 3:00 p.m.
Location: Atwood Building, Anchorage; HSS Building, Juneau; Zoom (virtual)

Meeting Attendance

Name of Attendee	Title of Attendee	
Retiree Health Plan Advisory Board (RHPAB) Members		
Judy Salo	Chair	Present
Cammy Taylor	Vice Chair	Present
Lorne Bretz	Member	Present
Dallas Hargrave	Member	Present
Paula Harrison	Member	Present
Nan Thompson	Member	Present
Michael Humphrey	Member	Present
Retiree Health Plan Advisory Board (RHPAB) Subcommittee Members		
Mauri Long	Modernization Subcommittee	Present
Wendy Woolf	Regulations Subcommittee	Present
State of Alaska, Department of Administration Staff		
Ajay Desai	Division Director, Retirement + Benefits	
Emily Ricci	Chief Health Policy Administrator, Retirement + Benefits	
Betsy Wood	Deputy Health Official, Retirement + Benefits	
Teri Rasmussen	Program Coordinator, Retirement + Benefits	
Andrea Mueca	Health Operations Manager, Retirement + Benefits	
Steve Ramos	Vendor Manager, Retirement + Benefits	
Michael Gamble	Member Liaison, Retirement + Benefits	
Chris Murray	Program Coordinator, Retirement + Benefits	
Christina Fantasia	Appeals Specialist, Retirement + Benefits	
Elizabeth Hawkins	Appeals Specialist, Retirement + Benefits	
Erika Burkhouse	Assistant Vendor Manager, Retirement + Benefits	
Kathy O'Leary	Administrative Support, Retirement + Benefits	
Others Present + Members of the Public		
David Broome	Aetna (medical third-party administrator)	
Michael Dorward	Aetna (medical third-party administrator)	
Shellie Gansz	Aetna (medical third-party administrator)	
Blythe Keller	Aetna (medical third-party administrator)	
Kimberly Krebs	Aetna (medical third-party administrator)	
Sonja Rogers	Aetna (medical third-party administrator)	
Richard Ward	Segal Consulting (contracted actuarial)	
Annette Piccirilli	OptumRx (pharmacy third party administrator)	
Alecia Bradley	OptumRx (pharmacy third party administrator)	
Inmaly Inthaly	Agnew::Beck Consulting (contracted support)	
Randall Burns	Public Member	

Common Acronyms

The following acronyms are commonly used during board meetings and when discussing the retiree health plan generally:

- ACA = Affordable Care Act (formal name: Patient Protection and Affordable Care Act)
- ARMB = Alaska Retirement Management Board
- CMO = Chief Medical Officer
- CMS = Center for Medicare and Medicaid Services
- COB = Coordination of Benefits
- COVID-19 = Novel Coronavirus Disease (identified 2019), also known as SARS-CoV-2
- DB = Defined Benefit plan (for Tier 1, 2, 3 PERS employees and Tier 1, 2 TRS employees)
- DCR = Defined Contribution Retirement plan (Tier 4 PERS employees, Tier 3 TRS employees)
- DOA = State of Alaska Department of Administration
- DRB = Division of Retirement and Benefits, within State of Alaska Department of Administration
- DVA = Dental, Vision, Audio plan available to retirees
- EGWP = Employer Group Waiver Program, a federal program through Medicare Part D that provides reimbursement for retiree pharmacy benefits
- EOB = Explanation of Benefits, provided by the plan administrator detailing claims coverage
- HIPAA = Health Insurance Portability and Accountability Act (1996)
- HRA = Health Reimbursement Arrangement account, a mechanism for the employer to reimburse high-income Medicare enrollees for any premium charge for their plan (IRMAA)
- IRMAA = Income Related Monthly Adjustment Amount, a surcharge from CMS for a Medicare plan for individuals or households earning above certain thresholds
- MA = Medicare Advantage, a type of Medicare plan available in many states
- MAGI = Modified Adjusted Gross Income, based on an individual or household's tax returns and used by CMS to determine what if any premium must be paid for a Medicare plan.\
- NDC = National drug code
- OAH = Office of Administrative Hearings, a quasi-judicial body that hears some types of appeals
- OPEB = Other Post-Employment Benefits; an accounting term used to describe retirement benefits other than pension benefits, and the retiree health trust
- OTC = Over the counter medication, does not require a prescription to purchase
- PBM = Pharmacy Benefit Manager, a third-party vendor that performs claims adjudication and network management services
- PEC = proposal evaluation committee (part of the procurement process to review vendors' bids)
- PHI = protected health information, a term in HIPAA for any identifying health or personal information that would result in disclosure of an individual's medical situation.
- PMPM = Per member per month, a feature of capitated or managed-care plans
- PPO = Preferred Provider Organization, a type of provider network
- RDS = Retiree Drug Subsidy program (a federal pharmacy subsidy program)
- ROI = Return on Investment
- RFP = Request for Proposals (a term for a procurement solicitation)
- RHPAB = Retiree Health Plan Advisory Board
- RPEA = Retired Public Employees of Alaska
- TPA = Third Party Administrator
- USPSTF: U.S. Preventive Services Task Force

Meeting Minutes

Item 1. Call to Order + Introductory Business

Chair Judy Salo called the meeting to order at 9:03 a.m. A quorum was present.

Approval of Meeting Agenda

Materials: Agenda beginning page 1 of 11/3/22 RHPAB meeting packet

- **Motion** by Cammy Taylor to approve the agenda as presented. **Second** by Nan Thompson.
  - **Discussion**: None.
  - **Result**: No objection to approval of agenda as presented. Agenda is approved.

Ethics Disclosure

Chair Judy Salo requested that Board members state any ethics disclosures in the meeting and reminded members of the disclosure form available from staff, to keep any necessary disclosures on file.

- No disclosures were stated by Board members.

Item 2. Public Comment

Before beginning public comment, the Board established who was present on the phone or online, and who intended to provide public comments. Individuals were asked to state their full name for the record, and that if there are several people wishing to provide comment, comments will be limited to 3 minutes per person, at the discretion of the chair. Chair Salo also reminded Board members and members of the public of the following:

1) A retiree health benefit member's retirement benefit information is confidential by state law;
2) A person's health information is protected by HIPAA;
3) Testimony will be posted on the Board's website and will be publicly available, including both written comments and statements made verbally in meetings and recorded in the minutes;
4) By giving public testimony on those subjects, the person will be treated as having waived their right to confidentiality regarding the subject of their testimony;
5) An individual cannot waive this right on behalf of another individual, including spouse or family member;
6) The chair will stop testimony if any individual shares protected health information.

Members of the public who provide comments are also encouraged to submit their comments in writing to the Retiree Health Plan Advisory Board: rhpab@alaska.gov.

Public Comments

- Stephanie Rhoades, RPEA. Stephanie expressed interest in hearing about the Surgery Plus travel benefits and noted that precertification travel is commonly misunderstood among most retirees, so it is important to educate retirees on airfare coverage. Second, RPEA is interested in removing the lifetime maximum cap. While the costs to remove the cap seem to be minimal, the impacts for the few people who are near the cap may be catastrophic, so it important to take a balanced approach. Third, retirees are interested in a review of the rehabilitative care services next, as therapy is needed for conditions affecting balance and other critical issues for elders; clear service limits must be provided on this. Fourth, Stephanie suggested the addition of exercise coverage for preventative care because as retirees are moving into aging, physical movement is necessary.

- Wendy Woolf expressed appreciation for the topics discussed on modernization and looks forward to the dental preventative services discussion topic.

Item 3. Department of Administration + Division of Retirement & Benefits Updates

DVA Open Enrollment

Andrea Mueca reported that open enrollment is currently active, beginning on October 12th and ending on November 23rd. Currently, the Division is midway through the enrollment period. Postcard reminders for open enrollment will be sent to members soon. To date, there have been approximately 700 participants who have made elections. Of the 700 participants, 330 selected the Standard plan, 170 selected the Legacy plan, and 270 have chosen to keep their current election.

- Chair Judy Salo asked if there is data on the number of calls requesting information on the plans?
    - Andrea Mueca answered she currently does not have the information requested, but will follow up. Betsy Wood added that some examples were put together to compare services between each plan; this information is available on the Division's website, and has been referred to by Delta Dental's point of contact for member services when members are inquiring on information on the available plans.

Retiree Insurance Information Booklet Public Comment Period

Materials: AlaskaCare Retiree DB Insurance Information Booklet beginning page 2 of 11/3/22 RHPAB meeting packet

Teri Rasmussen reported that the Retiree Insurance Information Booklet public comment period is open October 14th through November 18th. The public is welcome to submit comments in writing to the Division through the email address listed on the website. Notice of the public comment period has also been posted in an online public notice, social media, and the Division's newsletter. The Retiree Insurance Information Booklet updates are grouped into three categories: 1) General cleanup and additional language clarification, 2) RHPAB Resolution 22-01 approving the addition of the GCIT Network, and 3) RHPAB Resolution 22-02 approving the removal of the precertification penalty.

- Cammy Taylor suggested adding language to clarify that expenses are not covered a service is determined to be not medically necessary after a post-service review. Additionally, Cammy pointed out that in the updated Plan Booklet, "prescription drugs" are defined differently than it is currently defined and asked if the definition excludes any products that members are currently receiving now. Cammy also noted that the medical foods that are currently covered do not have an NDC identifier, and asked if it is known whether any other products may be questioned under coverage by medical substances.
- Betsy Wood answered that the Division's intent was not to change coverage, but to clarify the language on coverage. The Division staff worked with OptumRx to walk through various scenarios to ensure that coverage would not be changed but rather, to clarify that for a product to be considered for coverage, it must have a NDC identifier. Regarding the question on medical foods, Betsy will contact OptumRx for more information. Cammy Taylor asked if "non-emergent" means that if there is an emergency, members must precertify.
    - Betsy Wood answered that there is no intent to change the practice and that this area of the Booklet will likely be updated on an annual basis.

- Cammy Taylor asked for language clarification to be added in the body of the Plan Booklet on travel and lodging coverage for transplant services.
    - Emily Ricci answered that for travel coverage for transplant services, follow-up services within a certain period would be covered under the $10,000 travel cap as part of the transplant program. Betsy Wood noted that she would contact Aetna to clarify parameters for this type of travel and follow up with the Board.

2023 Meeting Dates

Materials: 2023 meeting dates beginning page 12 of 11/3/22 RHPAB meeting packet

Teri Rasmussen shared that the list of meeting dates in 2023 in the RHPAB meeting packet have a couple errors, specifically on day of the week referenced for some of the meetings, but the dates are correct. After this meeting, Teri will send calendar invites to the Board members.

Betsy Wood noted that Division staff have found that considering proposals at the November meeting is too late in the year to implement new decisions in a timely manner, considering the public comment periods that are required following each decision made. The schedule of 2023 meeting dates reflects past meeting schedules; however, the board should anticipate an additional meeting in late summer or early fall 2023 to allow timely implementation of new changes in 2024.

Item 4. Inflation Reduction Impact on AlaskaCare Retiree Plans

Materials: Inflation Reduction Act slide deck beginning on page 13 in 11/3/22 RHPAB Meeting packet

Emily Ricci noted that the federal Inflation Reduction Act will have an impact to Medicare Part D plans. The intent behind the presentation by Richard Ward (Segal Consulting) is to provide context on the impacts of the federal Inflation Reduction Act.

Richard Ward presented on the impacts of the Inflation Reduction act on AlaskaCare retiree plans:

Slide 1: Title slide

Slide 2: The Inflation Reduction Act was signed into law on August 16, 2022. Initial analysis shows that there will be impacts to Medicare drug coverage, with an emphasized impact on Medicare Part D plans. There is still more to be determined by the federal government.

Slide 3: There are several changes slated for the next ten years; changes listed on the slide are not all inclusive. One significant change is a cap on insulin costs beginning in 2023. One of the primary effects to focus on is the underlying cost structure for basic Part D plans. This structure generates calculated EGWP subsidies to AlaskaCare, and it will be important to focus on how these changes could affect subsidies. One effect seems to be a reduction in catastrophic insurance paid every year, but this has yet to be determined, as the rules and regulations are being finalized. Additionally, in 2025 there will be an out-of-pocket annual maximum of $2,000 for Part D plans.

- Nan Thompson asked if the Inflation Reduction Act identifies the ten drugs which prices will be negotiated on in 2026.
    - Richard Ward answered that these drugs have not yet been named, but guidance has been given on drug selection, which will start with a top-down approach. A small number of drugs can affect a portion of the overall spend.

Slide 4: The Direct Contribution (DC) plan will have minimal impact in 2023. The changes include limiting copays for insulin and eliminating cost-sharing for adult vaccines. The current AlaskaCare benefits provisions already meet these requirements for outpatient medications. The act also includes a provision that limits member premium increases to be no more than 6% for the next few years.

Slide 5: Initial observations of the act's impact on AlaskaCare retiree plans include lower outpatient insulin costs for some DC Plan retirees (depending on how the Medicare formula determines the member cost share) and a potential increase to net group plan EGWP costs due to changes in the basic Part D coverage and EGWP subsidies. Overall, the impact to DB Plan retirees is anticipated to be minimal.

The Board took a break at 10:03 a.m., and returned to the meeting at 10:30 a.m.

Item 5. Modernization Topics/Priorities

Materials: AlaskaCare Retiree Health Plan Modernization Topics on page 19 of 11/3/2022 RHPAB meeting packet:

Betsy Wood noted that a list of modernization topics that includes the division's and the board's priorities is included in the packet. There are a few additions that require a review. Section 2 lists some of the topics pended for future discussion. Section 3 lists our accomplishments to date.

Betsy Wood reviewed the list of topics and requested that the RHPAB hold an open discussion on whether the listed topics are priorities that are aligned between the Board and the Division. Betsy highlighted the following:

Remove or increase lifetime maximum: The work to implement the GCIT Network highlighted the need to address the lifetime maximum which has been a Division and Board priority. The Division would like to begin addressing this topic with the Modernization Subcommittee, and then with the full Board. There are a couple approaches to adjusting the lifetime maximum and the Division would like to explore all the impacts of these options. The Division is acutely aware that most members do not reach the lifetime benefit maximum but if they do, the impacts are highly adverse for members. Thus, this item would be prioritized.

Enhance travel benefits, add health concierge: The Division would like to explore the addition of an enhanced benefit around travel for plannable surgeries and increasing the travel coverage in those instances. This proposal would also consider additional items outside of the scope of SurgeryPlus services. The approach could be starting with Surgery Plus first, and then looking at the additional pieces such as the health concierge later. The employee plan has been working with Surgery Plus, and we have found a lot of value in the program.

Virtual musculoskeletal condition treatment (Hinge Health): This has been added to the Employee Plan through a partnership with SurgeryPlus. The Division has found it to be incredibly successful and believes it represents an important opportunity for retirees incorporate musculoskeletal prevention activities and maintain activity levels.

- Nan Thompson asked what a virtual musculoskeletal condition treatment entails?
    - Betsy Wood answered that it is similar to virtual physical therapy. Hinge Health provides health coaches to help members work through conditions. For example, if a member has knee pain and physical therapy will help, Hinge Health connects members with a provider

that will create a care program and walk the member through physical therapy exercises. This program can be completed in a member's home and at their convenience.

DVA Standard Plan annual benefit maximum: The Division would like to begin considering how to modify the DVA Standard Plan to make it more modern and flexible for members. Members want to maintain access to the Legacy Plan as is, which is why changes would only be made to the Standard plan. For the Standard Plan we want to look at the $2,000 annual dental benefit maximum.

Add "Preventive First" coverage to DVA Standard Plan: The "Preventive First" coverage is a program in place with Delta Dental in the Employee Plan. The program does not change the coverage benefit, but it means that preventive services do not accrue to the annual benefit maximum. For example, if you get a cleaning, it would still be covered the same way, but it would not accrue toward the $2,000 annual benefit maximum, which leaves more room for other care in the benefit maximum.

Medicare Advantage: Considering the number of people who will be entering the Medicare age eligible group, Medicare Advantage could be an important tool for providing options to Medicare age eligible members. We are still a ways out from being in a position where we are able and prepared to explore Medicare Advantage offerings. We should keep this as a priority and continue to look at it.

Review DVA Standard Plan audio benefits: Members have given feedback for the Division to review the vision and audio benefits in the DVA Standard Plan. There are acute needs for the dental benefits which could be addressed first and following that the vision and audio benefits could then be reviewed for possible changes to the benefits.

The Board held a discussion:

- Cammy Taylor asked if there is a recommendation for the order of topics to be prioritized for recommendation by the Board?
    - Betsy Wood recommended that the enhanced travel for plannable surgeries with Hinge Health be addressed simultaneously with the lifetime maximum. The dental topics could be reviewed separately; both items may have an effect on the member premiums. Emily Ricci added there should be a broader discussion on the DVA Plan reserve levels, and how this impacts premiums. Emily also noted that the DVA Plan has high reserve levels.
- Mike Humphrey noted that pharmacy costs are staggering and recommended that the Board and Division explore this as pharmacy changes have immediate impacts on the plan costs.
- Lorne Bretz requested that prior to changing benefits, the Division should identify reasons for why members are not utilizing parts of the plan.
- Cammy Taylor asked if there is a way of knowing if members that are not utilizing the dental plan are also not utilizing the audio and visual parts of the plan?
    - Staff confirmed they can share this information.
- Mauri Long (Modernization Subcommittee member) noted that reviewing member premiums requires a review of the dental, vision, and audio (DVA) plans. Particularly for the aging population, vision and audio benefits will be important to review, as Mauri feels the payments are not keeping up with the costs. Some significant changes to these programs could be useful and these changes should not be made separately. Mauri requested that this item be prioritized sooner.

Item 6. SurgeryPlus Overview

Materials: Presentation slide deck in supplemental materials for 11/3/22 meeting

John Zutter noted that the goal for SurgeryPlus is to transform access to care for low frequency medical cases with high severity and costs. John Zutter presented on the SurgeryPlus program and highlighted the following:

Slide 1: Title slide

Slide 2: Presentation overview

Slide 3: Centers of Excellence (COE) are important for plannable surgeries, as they address challenges in quality of care, affordability, and patient experience. The program gives members access to providers with a less than 1% surgical complication rate, covering procedures for members with limited to no cost share, and guided access to quality care. Complication rates can be high for surgeries (8 to 10% of patients have complications), but these rates can be reduced by choosing doctors with a more rigorous set of standards. Considering that surgeries can be the largest source of bankruptcy for insured Americans, SurgeryPlus' s practice of contracting for these procedures at much lower prices results in savings and incentives for several members.

Slide 4: Some Employer Direct Healthcare results from the last five to six years show that SurgeryPlus members have grown to 3.5 million, with over 300 employers utilizing the program and with two national health plan partnerships in place.

Slide 5: Outcomes, cost impact, accessibility, and traction are factors that are considered when evaluating a COE.

Slide 6: SurgeryPlus is a leading solution, as it is the only COE with enough volume to analyze and report based on their own outcomes. The company is the market leader for increased savings, is highly accessible, and has a large membership and client base.

Slide 7: Transition slide

Slide 8: SurgeryPlus' medical advisory board is comprised of clinical leadership, clinical quality advisors, and a surgical advisory board. Leading doctors over the nation in their specific fields are selected to be on the board.

Slide 9: The stages for determining a member's plan of care includes pre-screening, interviews/on-site interviews, and facility evaluation. The medical advisory board uses verifiable data and industry expertise to select surgeons.

Slide 10: Compares SurgeryPlus complication rates, versus industry average complication rates. This comparison shows that SurgeryPlus complication rates are less than 1%, while the industry average for complication rates are between 8% to 15%.

Slide 11: Compares the percentage of surgeons from four example hospitals that are COEs in carrier networks and shows how surgeon selection matters. By completing four of the six pre-screening criteria, over 60% of surgeons are eliminated as qualifying for this program.

Slide 12: Transition slide

Slide 13: Shows the wide network coverage of SurgeryPlus across the United States, with facilities in over 470 hospitals and over 1,500 covered procedures.

Slide 14: Transition slide

Slide 15: Due to having a highly selective network, SurgeryPlus can negotiate much lower reimbursement rates.

Slide 16: Comparison of metrics for AlaskaCare active employee population from 2019 through September 2022.

Slide 17: Transition slide

Slide 18: Process overview of the SurgeryPlus "ecosystem" beginning with patient need, ending at billing.

Slide 19: SurgeryPlus is in process of establishing a partnership with Aetna, and has a partnership with Hinge Health as of 2021.

Slide 20: Overview of the member experience in the SurgeryPlus program.

Slide 21: Transition slide

Slide 22: SurgeryPlus provides a dedicated in-house Care Advocate team. For each member relationship, a care advocate is assigned; members are 100% supported.

Slide 23: SurgeryPlus solutions include providing a dedicated Care Advocate, thoughtful selection of surgeons, coordinated travel assistance, and protection to members from high out-of-pocket costs.

Slide 24: SurgeryPlus provides services to all AlaskaCare Retirees, regardless of coverage. Non-Medicare Retirees receive access to full benefits for eligible surgeries, access to concierge services for medical services, and their scope of coverage is aimed to making travel attainable.

Slide 25: End slide

Betsy Wood noted that the timeline for implementing this program in the AlaskaCare Retiree plan should be discussed in the Modernization Subcommittee, along with review of the lifetime benefit maximum. SurgeryPlus is not implemented on a benefit-year basis. The Division is unclear on what the timeline for implementation would be, but they are interested in moving this forward and implementing it within the next six to twelve months. John Zutter noted that about half of SurgeryPlus clients have implemented the program off-cycle.

The Modernization Subcommittee agreed to meet in early January 2023 to discuss this further.

The Board took a lunch break at 11:55 a.m., and returned to the meeting at 1:00 p.m.

Item 7. Education Session: Value-Based Arrangements & Medicare Advantage Plan

Materials: Presentation slide deck on page 23 of the 11/3/2022 meeting packet

Blythe Keller introduced presenters Shellie Gansz and Michael Dorward, who presented on Value-Based Arrangements and Medicare Advantage Plan as the educational topic for the meeting.

Slide 1: Title slide

Slide 2: Presentation agenda overview

Slide 3: Image slide

Slide 4: Subtitle slide

Slide 5: To transform how healthcare is delivered, a focus on advanced strategy must be done through value-based arrangements. The overall goal is to create affordability and accessibility for Alaskans, through investing in primary care, expanding the network, building on successes, and making impactful outcomes through new capabilities and innovations.

Slide 6: Compares the difference between today's approach to care, versus the enhanced approach. Today's approach is provider-centric, payer-led, focuses primarily on sick patients, lacks comprehensive care coordination, and focuses on discounts only. The enhanced approach is member-centric, collaborates between providers and payers, focuses on the population health, has robust care coordination, is data-driven, and has a competitive total cost of care. However, outside of this type of plan, the fee-for-service environment for health care services will continue.

Slide 7: There is a need to improve the patient experience. Providers and payers are currently working siloed, with little communication, resulting in challenging member experiences.

Slide 8: Value-based arrangements allow additional data and information to be shared with providers, with the goal of making the member experience easier. Providers are incentivized to deliver and improve quality care at a lower cost by setting certain quality metrics and efficiency targets. Benchmarks are set and monitored for performance, while looking for ways to collaborate on improvement. More data is shared with providers to help them understand the population they serve.

Slide 9: Provides data on the overview of AlaskaCare membership attribution. When a provider participates in a value-based arrangement, they become accountable for a certain population. This population is determined through attribution. Value-based arrangements happen behind the scenes, and do not impact the way members access care. Providers are only engaging in a different way through value-based arrangement contracts.

Slides 10-11: List of 2022 quality measure examples, usually centered around preventative care and diabetes.

Slide 12: Clinically Integrated Network (CIN) is defined with care, connectivity, and contracting. A CIN consists of care coordination, data sharing, population health management, physician engagement, and wellness and health promotion. The goal is to ensure that there is a fundamental shift in thinking about fee for value, instead of fee for service.

Slide 13: Subtitle slide

Slide 14: Aetna met with Envoy to develop a commercial arrangement that began in January 2022. The value-based arrangement model being used is a pay for performance attribution model.

Slide 15: Aetna has had an arrangement with Pinnacle Integrated Medicine since October 2016. The value-based arrangement model being used is a patient centered medical home attribution model.

Slide 16: Aetna has had an arrangement with Providence since January 2021, using a pay for performance model.

Slide 17: Aetna has had an arrangement with Pinnacle Women's Health OBGYN since January 2018, using a pay for performance model.

Slide 18: Some organizations that will have potential commercial arrangements (currently under negotiation) are the Alaska Health Alliance, Fairbanks Memorial Hospital, Valley Medical Center, and Central Peninsula Community Hospital.

Slide 19: Aetna is focused on ways to innovate and bring in new providers. Vera Whole Health is a provider focused on primary care, with two clinics in Anchorage. They are eager to serve the Alaska retiree population with a bridged approach, by being available to under-65 retirees to start, and expansion to all Medicare eligible members in Anchorage in 2024.

Slide 20: Subtitle slide

Slide 21: Aetna's goal is to expand Medicare Advantage to Alaska as of 2024. To do this, there are Aetna representatives in Anchorage to secure a CMS adequate network by the end of 2022 for the Medicare bid filing that will happen in the first quarter of 2023. Recruitment efforts are currently underway.

Slide 22: The Medicare Advantage value proposition includes performance-based reimbursement, collaborative care management, and sharing of analytics and data.

Slide 23: Subtitle slide

Slide 24: Subtitle and image slide

Slide 25: Section agenda overview slide

Slide 26: Subtitle slide

Slide 27: There are three types of providers in relation to Medicare Advantage: 1) Providers who accept Medicare assignments, 2) Providers that charge the Medicare limiting charge, and 3) Providers who have opted out of the federal Medicare program. About 1% of providers across the country have opted out of Medicare. The Medicare Advantage program requires that members must see providers who accept Medicare.

Slide 28: Subtitle slide

Slide 29: Breakdown of Medicare Plans (Parts A through D and supplemental plans): Medicare Part A and B plans are government plans; Medicare Parts C and D, and supplemental plans, are private plans.

Slide 30: Medicare Advantage provides additional benefits beyond what the original Medicare plan provides such as health advocacy programs and personalized nurse support at no extra cost. Additionally, there is an annual limit on out-of-pocket costs for covered medical services.

Slide 31: The data in this slide shows an increase in national Medicare Advantage membership growth.

Slide 32: This slide shows that there are only 16 states in the United States that do not offer Medicare Advantage plan yet.

Slide 33: Subtitle slide

Slide 34: The traditional Medicare coordination of benefits (COB) plan has a payment process with several steps, requires two medical ID cards, more paperwork, and multiple bills and Explanation of Benefits.

Slide 35: The Medicare Advantage plan provides simplicity through ease of use, one medical ID card, more benefits than the Original Medicare Part A and Part B plans, and one monthly Explanation of Benefits for medical services.

Slide 36: This slide compares the claims payment process and shows that the Medicare Advantage plan is reduced by three steps, in comparison to the Medicare Secondary benefit plan. To be eligible for a Medicare Advantage plan, a member must be retired.

- Paula Harrison asked if a member was retired from the State of Alaska but works for a private employer, if they would still be eligible to enroll in Medicare Advantage.
    - Aetna staff confirmed that a member must be retired to be eligible during which they could select the Group Medicare Advantage plan.
    - Emily Ricci and Betsy Wood noted that this is the beginning of the Division exploring the Medicare Advantage plan for retirees, and there are still several scenarios to consider and understand. The scenario Paula mentioned will be further discussed.

Slide 37: Subtitle slide

Slide 38: Additional features of Medicare Advantage plans pay include preventive services (eye and vision exams, annual physicals, etc.); wellness services (healthy home visits, 24/7 nurse line, telehealth, etc.); and support services (mental wellbeing resources, chronic health condition support, etc.).

Slide 39: "Thank you" slide

Slide 40: Disclaimer slide

Slide 41: End slide

The Board asked the following questions:

- Mauri Long asked that if a member receives services from a provider that is included in the Envoy and Pinnacle programs, if they automatically become their patient?
    - It was confirmed that value-based arrangements happen behind the scenes, and invisible to the member. Envoy and Pinnacle are relatively new programs.
- Mauri Long noted that it seems as if it would be challenging to provide an analysis to determine if this program would be beneficial for retirees.
    - Michael Dorward answered that the federal government pays Aetna a fixed amount of money per month, regardless of the number of claims. Aetna must utilize the federal funds given and are financially responsible for members. Also, Michael has seen that their clinical programs have shown an estimated savings of $120 to $160 per member; Aetna can typically show savings of about 30% to 50% of an employer's health plan in comparison to the secondary Medicare plan. Varying factors are the amount of federal government subsidies (which differ from state to state, and county to county), geographic distribution of the membership, and current claims utilization.
    - Betsy Wood answered that back in 2020, the Division issued a Request for Information (RFI) to offer Medicare Advantage. The estimates given show that if every Medicare-eligible member shifted to the Medicare Advantage program, there would be about $25 million to $27 million in savings. The Division believes the savings would be beneficial

for members, but it was acknowledged that the Division is in the beginning stages of exploring this option.

- Mauri Long asked if the Medicare Advantage plan includes a prescription drug plan?
    - Emily Ricci answered that this piece would be decided when releasing a request for proposal for a Medicare Advantage plan.

Item 8. Public Comment

See Item 2 in the meeting minutes for public comment guidelines.

Chair Salo reminded meeting attendees of the guidelines for public comments provided in the meeting and invited anyone who wishes to provide public comment at this time to speak.

- No public comment.

Item 8. Closing Thoughts + Meeting Adjournment

Motion by Nan Thompson to adjourn the meeting. **Second** by Cammy Taylor.
Result: No objection to adjournment. The meeting was adjourned at 2:59 p.m.

The next Retiree Health Plan Advisory Board meeting will be Thursday, February 9, 2023, at 9:00 a.m.

Check RHPAB's web page closer to the meeting to confirm the schedule, location and to download materials for upcoming meetings. https://drb.alaska.gov/retiree/rhpab/

Retiree Health Plan Advisory Board

Modernization Committee Meeting Minutes

Date: Wednesday, January 4, 2023 9:00 a.m. to 12:00 p.m.

Location: Microsoft Teams (virtual)

Meeting Attendance

Name of Attendee	Title of Attendee	
Retiree Health Plan Advisory Board (RHPAB), Modernization Committee Members		
Cammy Taylor	Committee Chair (RHPAB)	Present
Nanette (Nan) Thompson	Committee Member (RHPAB)	Present
Mauri Long	Committee Member (RPEA)	Present
Mike Humphrey	Committee Member (RPEA)	Present
Judy Salo	Board Member	Present
Paula Harrison	Board Member	Absent
Dallas Hargrave	Board Member	Absent
Lorne Bretz	Board Member	Absent
State of Alaska, Department of Administration Staff		
Betsy Wood	Acting Chief Health Policy Administrator, Retirement + Benefits	
Teri Rasmussen	Program Coordinator, Retirement + Benefits	
Chris Murray	Program Coordinator, Retirement + Benefits	
Andrea Mueca	Health Operations Manager, Retirement + Benefits	
Kathy O'Leary	Administrative Support, Retirement + Benefits	
Erika Burkhouse	Vendor Management, Retirement + Benefits	
Michael Gamble	Healthcare Economist, Retirement + Benefits	
Others Present + Members of the Public		
Kimberly Krebs	Aetna (medical third party administrator)	
Carrie Sather	OptumRx (pharmacy third party administrator)	
John Zutter	SurgeryPlus	
Megan Cunningham	SurgeryPlus	
Kristin Kelley	Hinge Health	
Austin Weaver	Hinge Health	
Noel Cruse	Segal Consulting (contracted actuarial)	
Richard Ward	Segal Consulting (contracted actuarial)	
Inmaly Inthaly	Agnew::Beck Consulting (contracted support)	
Randall Burns	Public Member	
Stephanie Rhoades	Public Member	

Common Acronyms

The following acronyms are commonly used during board meetings and when discussing the retiree health plan generally:

- ACA = Affordable Care Act (formal name: Patient Protection and Affordable Care Act)
- ARMB = Alaska Retirement Management Board

- CMO = Chief Medical Officer
- CMS = Center for Medicare and Medicaid Services
- COB = Coordination of Benefits
- COVID-19 = Novel Coronavirus Disease (identified 2019), also known as SARS-CoV-2
- DB = Defined Benefit plan (for Tier 1, 2, 3 PERS employees and Tier 1, 2 TRS employees)
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- OPEB = Other Post Employment Benefits; an accounting term used to describe retirement benefits other than pension benefits, and the retiree health trust
- OTC = Over the counter medication, does not require a prescription to purchase
- PBM = Pharmacy Benefit Manager, a third-party vendor that performs claims adjudication and network management services
- PEC = proposal evaluation committee (part of the procurement process to review vendors' bids)
- PHI = protected health information, a term in HIPAA for any identifying health or personal information that would result in disclosure of an individual's medical situation.
- PMPM = Per member per month, a feature of capitated or managed-care plans
- PPO = Preferred Provider Organization, a type of provider network
- RDS = Retiree Drug Subsidy program (a federal pharmacy subsidy program)
- ROI = Return on Investment
- RFP = Request for Proposals (a term for a procurement solicitation)
- RHPAB = Retiree Health Plan Advisory Board
- RPEA = Retired Public Employees of Alaska
- TPA = Third Party Administrator
- USPSTF: U.S. Preventive Services Task Force

Meeting Minutes

Item 1. Call to Order + Introductory Business

Chair Cammy Taylor called the committee meeting to order at 9:04 a.m.

Approval of Meeting Agenda

Materials: Agenda packet for 1/4/23 RHPAB Modernization Committee Meeting

Cammy Taylor asked the committee if there was any objection to approval of the agenda as presented. There was no objection to approval of the agenda as presented. Agenda is approved.

Ethics Disclosure

Cammy Taylor requested that committee members state any ethics disclosures in the meeting.

- No members made ethics disclosures.

Item 2. Working Session

Proposed Change: Lifetime Maximum

Materials: Proposal beginning on page 2 of 1/4/2023 agenda packet

Betsy Wood reviewed background information and the proposed changes to the Lifetime Maximum section of the Plan: The Division is working to address the Plan's current provision containing a $2 million lifetime maximum on the Defined Benefit Retiree Plan. The Plan language currently notes that there is a $2 million lifetime maximum and at the end of each benefit year, up to $5,000 of medical benefits are automatically restored regardless of physical condition. If a member has received more than $5,000 of covered medical benefits, the full annual spent maximum may be restored upon submission of proof of good health to the claims administrator within the following year. Betsy noted that prescription drug expenses billed through the Pharmacy Plan do not count toward the lifetime maximum but medical pharmacy expenses billed through the Medical Plan do count toward the lifetime maximum except Gene-Based Cellular and other Innovative Therapies (GCIT) and products obtained through this program.

Once a member becomes Medicare-eligible, the Plan becomes supplemental to Medicare and the claim costs are limited by Medicare's fee schedule. Any amount paid by the Plan in a Medicare-secondary position continues to accrue towards a member's lifetime maximum.

The lifetime maximum on the Plan initially consisted of a $250,000 limit which increased to $1 million in 1985 and then to $2 million in 1999. It has been over 20 years since there has been a change in the lifetime maximum limit. Based on the Consumer Price Increase for All Urban Consumers (CPI-U) for Medical Services, the limit would have increased to about $4 million from 1999 to 2022; this does not account for cost pressures that are specific to Alaska.

If a member is eligible for Medicare and they are approaching the lifetime maximum, they can still receive coverage for services through Medicare which does not have a lifetime maximum benefit. Therefore, the AlaskaCare Plan would have no impact on Medicare coverage. Members who are not eligible for Medicare and are approaching the lifetime maximum may be eligible for other health

coverage such as Medicaid if they meet certain eligibility requirements and income thresholds and/or may qualify for coverage on the Marketplace during a special enrollment period.

Staff have considered the following options for the committee's consideration:

- Doubling the lifetime maximum to $4 million
    - $4 million annual maximum
    - .25% increase to actuarial value of plan
    - $1.7 million additional cost for annual impact
- Increasing the lifetime maximum to $8 million
    - $8 million annual maximum
    - .35% increase to actuarial value of plan
    - $2.4 million additional cost for annual impact
- Removing the lifetime maximum
    - .4% increase in actuarial value of plan
    - $2.7 million additional cost for annual impact

Richard Ward provided insight on the actuarial value and annual impact noting that the three estimates are average expectations. The annual additional cost could be $0 for several years and then increase in future years where members have needs with higher costs. The Employee Plan accounts for potential cost impacts associated with not having a lifetime maximum in the funding and reserving process conducted on an annual basis. An analysis on the impact to the retiree healthcare trust fund is expected to be completed by the February RHPAB meeting.

For the options to increase the lifetime maximum, staff recommend removal of the reinstatement provisions, which will be beneficial to members who are approaching the limit by ensuring they maintain access to other coverage options. Additionally, staff are considering the reason for the lifetime maximum being included in the Plan; it is a financial protection for the plan. DRB would like to work with the committee to determine the appropriate limit and whether to include the lifetime maximum in the Plan. If the lifetime maximum is removed, the Plan would be open to a greater financial spend; it is important for the Plan to have a strategy in place to move members to appropriate sites of care while also putting cost restricts on the spend.

Over the entire lifetime of the Plan, records for individuals who are no longer covered by the Plan are not retained in perpetuity, therefore staff cannot report on how many members, since the plan began, have approached the lifetime maximum. Page 9 of the 1/4/2023 agenda packet shows a snapshot of members who are currently being tracked.

Overall, there would be minimal operational impact and removing the limit or increasing the limit would be minimal. Staff would communicate the change to members and make changes within the Aetna system.

The following questions and comments were given from committee members:

- Cammy Taylor asked what the purpose of the lifetime maximum is.
    - Richard answered the purpose of the lifetime maximum is to provide financial protection for the Plan. Richard noted that there are pension plans with maximum

benefits or disability plans that provide income replacements to a certain level; these measures help manage the liability and exposure for the Plan.
    - The lifetime maximum in the Plan does not exist in the statute.
    - Betsy will confirm that the $2 million lifetime maximum was raised prior to self-insurance of the Plan.
- Mauri Long asked if any studies on the financial impact to the Plan were completed prior to the lifetime maximum being raised in past years.
    - Betsy answered that she would complete a review of past records.
- Mauri Long asked if the actuary financial impacts that were estimated prior to the removal of the lifetime maximum in the employee plan were proved to be correct.
    - Betsy will follow up with this information and noted that, to her understanding, when the change was made, there were several other changes occurring simultaneously that required the employee plan to give up the grandfathered status under the Affordable Care Act; this resulted in the removal of the lifetime maximum among other changes.
    - Richard Ward gave additional insight and confirmed there were several other changes occurring when the employee plan lifetime maximum was removed, and non-grandfathered plans needed to expand preventive coverage. Richard added the change did not severely impact the financial solvency of the Employee Plan.
- Cammy asked if it is possible to identify a number or percentage of members in the employee plan whose claims have exceeded $2 million during a period of time.
    - Richard believes this data can be given, but only one instance comes to mind right away.
- Mauri referred to page 13 of the packet that outlines the annual financial impact to each of the three options, specifically the $1.7 million additional cost if the lifetime maximum was increased to $4 million. Mauri asked if the average expectations that were identified included all spend, or only the anticipated increased spend?
    - Richard answered the average expectation included the increased spend. The $1.7 million associated with the $4 million lifetime maximum increase reflets the expected average cost for an increase between $2 to $4 million. The current $2 million is already included in the $685 million that is projected as the forward trend in 2024.
- Mauri asked what the operational impacts for the Division staff and third party administrator would be if the Board proposed an adjustment to the lifetime maximum of $4 million, which represents the CPI-U change since the last increase, followed by the Division completing a review annually or bi-annually to automatically increase the lifetime maximum based on the CPI-U?
    - Betsy answered this would add another task for each round. A calculation and coding in the system would have to be completed. Overall, the impact would not be substantial.
- Cammy asked if the system identifies people who are eligible for coverage as Tier 1 through 3 members who might have reached their lifetime maximum, but do not show up on the currently displayed list?
    - Andrea Mueca answered if a member hits their annual lifetime maximum, they would not be terminated from AlaskaCare, but their claims would stop being paid. Members can still receive pharmacy coverage and any dental, visual, and audio elections they've made.

- Nan Thompson asked for clarification on the purpose of the reinstatement provision, and how the provision works.
    - Betsy answered she has not seen anything that clearly articulates why this provision was included. If the lifetime maximum is increased, the Division staff are recommending removal of the reinstatement provision and ideally, if the lifetime maximum is increased, it would be increased high enough that members would not come close to reaching the lifetime maximum.
    - Andrea added that the "good health" reinstatement provision operates when Aetna is contacted by Division staff requesting reinstatement, and reinstatement is also requested on an annual basis. Aetna may be monitoring members who may need reinstatements.

The Division will complete its normal process to obtain public comment. Betsy requested committee members to inform staff of additional information to research and follow up at the February RHPAB meeting.

The committee discussed the three options presented for consideration:

- Nan expressed interested in the option to increase the lifetime maximum annually or bi-annually based on a review of the CPI-U at the time. Nan expressed concern for removing the lifetime maximum limit, as no adjustment could be made after the removal.
- Mauri expressed support for the second option to increase the lifetime maximum to $8 million, with an annual financial impact of $2.4 million, with an attachment to the CPI-U.
- Mauri asked if the ACA removed the lifetime maximum limit, can we find out if it has bankrupted any other health insurance coverage plans?
    - Richard answered that generally, smaller plans carry stop loss coverage which has affected their stop loss premiums, changing the exposure for stop loss carriers who may have been providing coverage prior for plans that had a lifetime maximum. Then, stop loss carriers' exposure was limited by the lifetime maximum; removal of the lifetime maximum increases exposure of the stop loss carrier, reflected in the premium of the plans. Larger plans that have removed the lifetime maximum have generally reviewed their reserving policies and thresholds, then increased to self-insure against their former lifetime maximum. Richard is not aware of any plans that have become financially insolvent due to removal of the lifetime maximum.
- Cammy expressed concern about a $4 million lifetime maximum option being enough to capture the data seen with members who have already reached the $2 million maximum.
    - Betsy answered an alternative option could be to split the difference between $8 million and $2 million limits, for a $6 million limit that could be indexed to the CPI-U over about 5 to 6 years; this would be a reasonable pace for staff.
- Judy Salo expressed support for a $6 million lifetime maximum, with a periodic analysis that considers the current and future financial landscape. Judy asked why other plans are removing the lifetime maximum if it is a financial guardrail.
    - Richard noted in his work with other organizations discussing the same topic, policymakers usually conclude that eliminating the lifetime maximum does not provide a significantly different exposure than it would to increase it to a significant amount. Secondly, they find value in resolving the issue permanently by removing the limit altogether. Richard added one option is not necessarily better than the other.

- Judy referred to the $5,000 annual reinstatement and asked that if the reinstatement was eliminated to avoid unintended consequences, there might be legal jeopardy in terms of the non-diminishment clause? If the limit was increased significantly from $2 million, then it would unlikely be that a member would be concerned about the presence of the $5,000 reinstatement.
    - Cammy answered the committee will review the whole proposal package, with consideration of the beneficial offsets for items that are changed in the Plan.

Additionally, Betsy acknowledged Judy's sentiments in evaluating the overall impacts and noted that the overall benefit maximum is being considered for an increase. The $5,000 reinstatement over fifty years works out to be $250,000 of added benefit during that time period. When looking at the actual dollar value, the $250,000 is far less in what is being considered for increase to the lifetime maximum.

At the February RHPAB meeting, the Board will consider the following options:

- Removal of the lifetime maximum.
- Increasing the lifetime maximum to $8 million, with a review every 2 to 4 years based on the current CPI-U.

Division staff will review the financial implications, complete a long-term financial forecast, and aims to have this information ready for the February RHPAB meeting.

The Board took a break at 10:40 a.m., and returned to the meeting at 10:48 a.m.

Supplemental Non-Emergent Surgery & Travel Benefits (SurgeryPlus)

Betsy Wood noted the Division works with Hinge Health to provide virtual physical therapy and musculoskeletal benefits which have been positive for the Employee Plan. SurgeryPlus currently holds the contract; the Division will need this contract to be released for a public bidding process in the future.

Megan Cunningham (SurgeryPlus and Employer Direct Healthcare) presented to the committee and gave an overview of SurgeryPlus, noting that SurgeryPlus can provide services to all AlaskaCare Retirees regardless of whether they are covered by Medicare. Megan reviewed the service coverage differences between retirees with Medicare and retirees without Medicare and noted two deviations in coverage from the SurgeryPlus benefits for Medicare Retirees: 1) Claims are paid by Medicare instead of SurgeryPlus and 2) Several Medicare Retirees usually have established providers they see regularly, so Medicare Retirees only have SurgeryPlus coordinate their travel and/or provide quality in-network provider recommendations. Megan asked the committee for feedback on medical necessity checks for Medicare Retirees since SurgeryPlus does not pay their claims, therefore, there is no way to complete a medical necessity check.

Betsy Wood added that Medicare Retirees who have Medicare as a primary insurance provider would not have to await authorization from Aetna as their claims would be paid through Medicare primarily with Aetna being a secondary payor. The Division intends to keep that process in place with SurgeryPlus being willing to support that process, too. The Division looks forward to having SurgeryPlus help with moving members to high quality, affordable care by giving recommendations to members for quality in-network providers. This proposal does not contemplate changing the current travel provisions and is only supplemental to the current travel provisions.

John Zutter described how SurgeryPlus would ensure that members with Medicare coverage are being moved to high quality providers: SurgeryPlus can complete this in a variety of ways, subject to direction given by the Board with consideration on how they would like the service administered. John noted there is overlap with doctors accepting Medicare for musculoskeletal care. When looking at other categories, this may change materially depending on other specifics; there are a few options:

1. SurgeryPlus can only pay and support travel for the member if they are seeing an in-network provider that meets their standards and accepts Medicare.
2. SurgeryPlus will recommend providers they believe to be high quality with the amount of detail they have from a review, which only consists of two-thirds of the qualification process, due to limitations from not being contracted with the provider.
3. If a member prefers a specific provider and does not want to see another in-network provider recommended by SurgeryPlus, the Board must determine whether they will support this.

Betsy noted the Division would like the committee's sense of where limitations should be placed and the approach to the population of Medicare Retirees. The committee agreed that it would be helpful to understand where the provider overlap is and what the access looks like; John noted this information would be a point-in-time analysis as providers go in and out of contract.

Betsy reiterated the goal of this committee meeting is to hold a work session on the proposals with the committee to identify outstanding questions to address between now and the February RHPAB meeting, in order to make an informed recommendation on the proposals from the committee to the full Board. The May RHPAB meeting will consist of a full review of the proposed Plan changes, with a potential recommendation vote by the Board. Following that, the proposed changes will undergo the approval process with the Commissioner. All three proposed changes discussed during this meeting will require Plan amendments and changes to the Plan language; this will launch another 30-day public comment period. Betsy anticipates that implementation of the proposed changes would occur in July or August 2023 at the earliest and that it is not necessary to implement the changes within the Plan year.

The committee agreed to only consider the first two options presented by John Zutter. Betsy and the Division staff will work with the SurgeryPlus team to develop a proposal that clearly articulates the guardrails for these two options and manages expectations.

Betsy highlighted the 19th page of the agenda packet which outlines the member cost share where all expenses included in a SurgeryPlus Episode of Care would be subject to the Plan's standard cost share. The Division staff recommend the Plan changes have the normal cost share applied, then reviewing and adjusting in the future as needed. The financial impact to these proposed changes estimates an annual savings of $2.8 million to be associated with the SurgeryPlus program, but this may change depending on utilization and where members seek care.

Virtual Physical Therapy and Musculoskeletal Care Program (Hinge Health)

Betsy Wood noted that SurgeryPlus and Hinge Health are partners, but are two separate programs and offerings. Hinge Health is accessible through various avenues but the Division has accessed Hinge Health through their partnership with SurgeryPlus. The Division has evaluated offering Hinge Health to employees as part of their relationship with Aetna and SurgeryPlus and concluded that they would access Hinge Health through SurgeryPlus, due to the space they are both operating in. Several services

can be coordinated through the SurgeryPlus. A plannable surgery tends to consist of musculoskeletal issues – a large part of what SurgeryPlus coordinates for their members. The Division feels that the addition of this program is a good fit into the Plan.

Kirsten Kelley (Hinge Health) presented to the committee and gave an overview of Hinge Health:

Slide 1: Title slide
Slide 2: Gives an overview of Hinge Health, a digital solution that personalizes care for seniors across several services outside of musculoskeletal (MSK) services with key principles to reduce pain, improve safety, and keep active.
Slide 3: Gives an overview of the suite of services for MSK for complex care that includes high risk management, app based MSK therapy, surgical networks, pain relief devices, and fall prevention.
Slide 4: Gives an overview of how SurgeryPlus and Hinge Health partner to provide personalized care to seniors. When surgery is appropriate, SurgeryPlus provides full service surgical concierge to coordinate a surgeon and help manage appointments with a nationwide network of top-quality surgeons and pre-negotiated bundled rates. When surgery is avoidable, Hinge Health provides digital MSK clinics, provides MSK programs for every body part to prevent pre/post-op surgery care, and personalized care through a clinical care team and app.
Slide 5: Gives an overview of the referral process between Hinge Health and SurgeryPlus that aims to improve member experience and outcomes
Slide 9 (*did not review Slides 6-9*): Shows the journey through MSK services provided by SurgeryPlus and Hinge Health for Hinge Health members interested in surgery, SurgeryPlus members scheduled for surgery, and SurgeryPlus members who have surgeries that are not recommended.

The following questions and comments were given from committee members:

- Mauri Long asked about the access points to Hinge Health.
    - Kirsten answered that there are a few different access points:
        - A referral through SurgeryPlus
        - A marketing campaign about Hinge Health letting retirees know of this new benefit which drives interested members to a customized landing page where an online clinical screener can be completed
- Mauri asked for clarity on whether a member must have a medical necessity evaluation completed and how the service is billed.
    - Betsy answered that Hinge Health is a separate program offering meant to supplement the care received by a brick-and-mortar rehabilitative care provider. Any services that members receive that fit within the window of musculoskeletal services are delivered by a Hinge Health provider. Charges are billed to the Plan depending on how the members engage; there is no charge for preventive care, but acute and chronic programs are care require different costs to be assessed to the Plan. Aetna will not conduct medical necessity reviews and the service is not billed through Aetna, since Hinge Health is a separate program.

Betsy noted this program does not have an actuarial impact to the Plan, as it is supportive care that does not fit into the bucket of medical services. Regarding the financial impact, return on investment is calculated based on reduction on an individual's pain, and how this can end up financially. Hinge Health has additional information on how this return on investment is calculated. The Division believes keeping members active and setting them up to achieve better outcomes results in a return on investment. The

Division anticipates a net savings on an annual basis, based on improved outcomes by members who participate in this program. There will be additional financial information available at the February RHPAB meeting on the long-term financial analysis.

Item 4. Public Comment

Before beginning public comment, the Chair established who was present on the phone or online, and who intended to provide public comments, and reiterated reminders about these comments being part of the public record, and that commenters cannot share protected health information (PHI).

- Stephanie Rhoades: she expressed support for the removal of the lifetime maximum, as it providers greater parity and other plans have also removed the lifetime maximum limit. Stephanie also mentioned that RPEA has submitted a letter through RPEA President, Randall Burns. Stephanie hopes the Modernization Subcommittee will review the letter and noted that RPEA has a strong stance on the entire Plan being reviewed with other items being prioritized for modernization.
- Randall Burns: he stated the health trust has been overfunded, and there have been discussions on legislation to determine a way to increase funding to the underfunded pension with funds from the health trust. Randall suggested that RHPAB recommend a way forward to support the reduction of the health trust fund and elimination of the lifetime maximum limit.

Item 5. Closing Thoughts + Meeting Adjournment

Upcoming meetings:

- The next Retiree Health Plan Advisory Board quarterly meeting is scheduled for Thursday, February 9, 2023.

1. **Motion** by Mauri Long to adjourn the meeting. **Second** by Cammy Taylor.
    - **Result**: No objection to adjournment. The meeting was adjourned at 12:33 p.m.

Retiree Health Plan Advisory Board

Modernization Committee Meeting Minutes

Date: Thursday, January 12, 2023, 10:00 a.m. to 12:00 p.m.

Location: Atwood Building, Anchorage; HSS Building, Juneau; Teams (virtual)

Meeting Attendance

Name of Attendee	Title of Attendee	
Retiree Health Plan Advisory Board (RHPAB), Modernization Committee Members		
Lorne Bretz	Committee Chair (RHPAB)	Present
Nanette (Nan) Thompson	Committee Member (RHPAB)	Present
Wendy Woolf	Committee Member (RPEA)	Present
Cammy Taylor	Board Member	Present
State of Alaska, Department of Administration Staff		
Betsy Wood	Acting Chief Health Policy Administrator, Retirement + Benefits	
Teri Rasmussen	Program Coordinator, Retirement + Benefits	
Andrea Mueca	Health Operations Manager, Retirement + Benefits	
Elizabeth Hawkins	Lead Appeals Specialist, Retirement + Benefits	
Christina Fantasia	Appeals Specialist, Retirement + Benefits	
Kathy O'Leary	Administrative Support, Retirement + Benefits	
Ajay Desai	Division Director, Retirement + Benefits	
Others Present + Members of the Public		
Inmaly Inthaly	Agnew::Beck Consulting (contracted support)	
Randall Burns	Public member	
Fred Traber	Public member	

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- DRB = Division of Retirement and Benefits, within State of Alaska Department of Administration
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- RHPAB = Retiree Health Plan Advisory Board
- RPEA = Retired Public Employees of Alaska
- TPA = Third Party Administrator
- USPSTF: U.S. Preventive Services Task Force

Meeting Minutes

Item 1. Call to Order + Introductory Business

Chair Lorne Bretz called the committee meeting to order at 10:01 a.m.

Approval of Meeting Agenda

Materials: Agenda packet for 1/12/2023 RHPAB Regulations Committee Meeting

- **Motion** by Wendy Woolf to approve the agenda as presented. **Second** by Nan Thompson.
  - **Result**: No objection to approval of agenda as amended. Agenda is approved.

Ethics Disclosure

Lorne Bretz requested that committee members state any ethics disclosures in the meeting.

- No members made ethics disclosures.

Chair Bretz stated intent to include public comment at the end of the meeting before adjournment, if any members of the public join the meeting before adjournment.

Item 2. Working Session: Draft Regulations

Materials: Documents beginning on page 2 of the 1/12/2023 agenda packet

Betsy Wood introduced the working session for the subcommittee to discuss the Division's proposed regulations. In a settlement agreement between State of Alaska and RPEA, the state committed to drafting regulations articulating the process for considering and making changes to the AlaskaCare defined benefit retiree health plan. During this meeting, the Division staff are requesting input from the RHPAB, through the Regulations Subcommittee, on proposed regulations to this effect that have been released for public comment. Plan members have expressed that it is critical for them to review changes being considered and to have opportunities to provide public comment. A set of proposed regulations were released in December 2022 and are currently available for public comment through the end of February. So far, no public comments have been submitted. Staff will share the regulations again at another town hall and place the public comment period information in upcoming issues of the Retiree newsletter.

Staff believe there are more opportunities to update other regulations, specifically the appeals process and developing a regulations package for long-term care plans.

The proposed regulatory changes include the following:

1. 2 AAC 39.280 will be amended to include new language and new subsections that describe the process for proposing changes to the benefits provided by the retiree DVA insurance coverage and the process for amending the description of DVA insurance coverage published in the plan booklet. The intent is to outline the considerations the Plan Administrator may evaluate when developing a proposed change or plan amendment and describe the public notice process and opportunity to comment on proposed changes.
2. 2 AAC 39.290 will be amended to further define the term "administrator" and to define the terms "dental-vision-audio insurance coverage" and "plan booklet."'
3. 2 AAC 39.390 will be amended to include new language and new subsections that describe the process for proposing changes the benefits provided by the retiree major medical insurance coverage and the process for amending the description of major medical insurance coverage published in the plan booklet. The intent is to outline the considerations the Plan Administrator may evaluate when developing a proposed change or plan amendment and describe the public notice process and opportunity to comment on proposed changes.
4. 2 AAC 39.399 will be amended to further define the term "administrator" and to define the terms "major medical insurance coverage" and "plan booklet."

Discussion

- Wendy Woolf commented on the citations used for authorities and noted that the Division should review these citations: the two authorities that should be cited were not cited. Wendy noted that the authorities should be specific to its corresponding regulation, rather than global healthcare plans in general. Additionally, Wendy noted that part missing in the proposal evaluation process is the definition of the RHPAB's role. Wendy stated the language incorporated in the settlement agreement said the regulations should encapsulate the Division's current process for making changes. For RPEA, an essential feature of this process is that the

RHPAB provide input. This RHPAB/stakeholder input should be separated into its own regulation in this package, to clearly identify who the stakeholders are. It was also suggested in the past to have a stakeholder group in absence of the RHPAB.

- Nan Thompson stated that overall, the presented draft outlines a clear process, but agreed with Wendy that an overall review of the regulations should be completed.
- Lorne thanked Wendy for her comments and noted the presented process was written well.
- The committee discussed the importance of defining specific terms such as the following:
    - **Stakeholders:** Wendy recommended that definitions be added to the process, such as for "stakeholders." Additionally, Line E states "input from stakeholders, if applicable;" should have the phrase "if applicable" removed, as it indicates stakeholder input may not apply when stakeholder input is always applicable.
    - **Benefit Clarification:** The benefit clarification is viewed as an opportunity to provide more information on how a benefit is administered, therefore, it would not undergo the Plan change process. Wendy recommended that the term "benefit clarification" be defined to prevent potential lawsuits.
    - **Actuarial Impact:** The actuarial impact analysis is completed by a third party.
        - Betsy noted that currently, while the Division does contract with a third party to complete actuarial impact analyses, and does not foresee that work being brought in-house, there could be an in-house actuary in the future.
        - Wendy recommended that, while the definition of "actuarial impact" may not include that the analysis is done by a third party, the definition "actuarial impact" should still be included.
    - **Outreach:** Wendy recommended that the type of outreach to retirees should be clarified through defining this term to give members an understanding of what outreach is to protect the Division.
        - Betsy added that outreach methods change overtime, and minimum notice requirements are included in the proposed regulations. Current notice methods may include, a periodic newsletter that is mailed twice per year to members, a monthly newsletter email, the DRB website, the state's online notice system, statutorily required announcements in newspapers, and mailings (this is substantially expensive and takes time to put a mailing together as it requires releasing a Request for Qualifications (RFQ) to select a vendor to complete the mailing.
        - Wendy noted that the minimum outreach expectations should be through website postings and email announcements.

- Wendy noted that on page 4 of the agenda packet consisting of the draft regulations on the line referring to adopting emergency amendments, particularly the line stating, "emerging technology or medical treatments and services; or", the intent is unclear without commas, and it should be outlined clearly. Wendy recommended deleting this line as it is unclear what is constituted as an emergency.
    - Betsy answered that it is emerging technology or medical treatments and services that are new and need to be acted on quickly to protect the financial health of the Plan. Releasing an emergency amendment would allow the Division to define how to receive coverage on new technologies and medical treatments. This preserves the plan

administrator's ability and flexibility to make current decisions on unforeseen emergences. Betsy acknowledged the language should be revised further clarified.
    - Wendy recommended rewording that line to the following: "emerging technology or emerging medical treatments or emerging medical services; or […]."
    - Wendy asked for clarification on the third listed item, "a need for the immediate preservation of the orderly operation of the dental-vision-audio insurance plan."
        - Betsy answered that this refers to an unforeseen circumstance. The Division believes in the importance of the Plan Administrator having the ability and flexibility to make quick changes in emergency scenarios.
    - Wendy asked about the term "orderly operation," does this mean DRB handling the item, or the third-party administrator? If the third-party administrator goes bankrupt, for example, how would that change the plan?
        - Betsy responded this does not change the plan, per se.
- Wendy will provide further recommendations in writing.
- Wendy recommended that the Division give another 30-day public comment period after the regulations are revised. She asked if the Division responds to comments in writing upon receive and review of the comments?
    - Betsy answered the Division may respond, depending on the nature of comments received.
    - Teri added that all public comments are compiled and posted publicly on the DRB website and provided to the RHPAB.

With the public comment period still active, the Division will complete intake of the public comments, review and compile the comments, and Betsy will notify the committee once that is complete. If changes are made to the proposed regulations, DRB staff will make a recommendation on whether another 30-day public comment period should be released, based on the magnitude of the public comments received and recommended changes.

Item 3. Public Comments

Before beginning public comment, the Chair established who was present on the phone or online, and who intended to provide public comments, and reiterated reminders about these comments being part of the public record, and that commenters cannot share protected health information (PHI).

- Randall Burns, RPEA, referred to the first page of the regulations 2 AAC 39.280(b)(1) and recommended language that could incorporate the RHPAB, or another separate stakeholder group:

  "(b) To change the benefits provided under dental-vision-audio insurance coverage, the administrator shall

  1) propose changes to the coverage; in drafting [THE] **a proposal and pursuant to Retiree Health Plan Advisory Board's charge to facilitate regular engagement, communication, and cooperation related to the health plans of the state's retirement health systems**, the administrator**, in accordance with the RHPAB,** shall […]."

  Randall emphasized it was the RPEA's intent in settling the litigation with the State of Alaska, that there was an understanding an independent advisory board that

would participate with the DRB in drafting and discussing changes. If the regulations cannot specifically reference the RHPAB because they were created through an executive order, then there should be a reference indicating that the proposal would happen in coordination with a separate stakeholder group and then defining the stakeholder group. Randall will also submit written comments.

Item 4. Closing Thoughts + Meeting Adjournment

- **Motion** by Wendy Woolf to adjourn the meeting. **Second** by Nan Thompson.
  - **Result**: No objection to adjournment. The meeting was adjourned at 2:20 p.m.

Upcoming meetings:

- The Retiree Health Plan Advisory Board's next quarterly meeting on Thursday, February 9, 2023.

Executive Summary	**Retiree Dental Plans Annual Maximum (RXXX)**
Health Plan Affected	Defined Benefit Retiree Plan
Proposed Effective Date	TBD
Reviewed By	Retiree Health Plan Advisory Board
Review Date	February 9, 2023

1) Background

Upon retirement, AlaskaCare retirees may choose to participate in a voluntary Dental-Vision-Audio (DVA) plan to provide coverage for themselves and their eligible dependents. The AlaskaCare retiree Dental plan is fully funded by members' monthly premium payments, and the Division works hard to maximize the benefits members receive while keeping premiums affordable. Effective in plan year 2020, AlaskaCare began offering two retiree dental plan options, the Legacy Dental Plan, and the Standard Dental Plan which each have different dental coverage provisions. The Division contracts with Delta Dental of Alaska to assist in administration of both dental plans. Currently, both plans include a maximum annual benefit amount (annual maximum) of $2000.00. The Division has committed to maintaining the Legacy plan (the DVA plan that was in place prior to 2014) as an option for members to choose during open enrollment. To ensure the Legacy Plan maintains fidelity to the plan that was in place prior to 2014, the Division is considering updates and changes to the Standard Plan only.

One of the most frequent requests the Division receives from members is a desire for improvement and modernization of the retiree dental plans. Costs for dental services, along with healthcare costs in general, continue to increase throughout Alaska and the United States, meaning more members are reaching their annual maximum. In 2021, 7.4% (2,537 individuals) of Legacy Plan members met their annual maximum, up from 5.5% in 2020; while 6.1% (1,629 individuals) of Standard Plan members met their annual maximum; up from 5.0% in 2020.

The AlaskaCare retiree Dental Plans are designed to help retirees offset the cost of their dental care and to support them in maintaining good overall oral health. And as currently designed, all dental service costs in both plans are applied toward the annual maximum. This includes less expensive preventive types of services as well as more complicated and expensive oral health procedures such as treatment of diseases of the gums, fillings, oral surgeries, crowns, dentures and bridges, and other covered dental services. With all dental procedures and care being applied toward the annual maximum, members can reach their annual benefit limit very quickly.

2) Objectives

a) Support members in maintaining their dental health.
b) Promote high-value care.
c) Provide a dental plan option that is more in line with current dental procedure costs.

3) Summary

The Division is interested in exploring the idea of increasing the Standard Plan's annual benefit maximum. Doing so would allow members participating in the Standard Plan to receive Plan coverage for a more dental services each year, bringing the annual benefit maximum more in line with present day dental costs.

4) Actuarial and Financial Impacts of Proposed Change

To be determined.

Executive Summary	Delta Dental Preventive First Program (RXXX)
Health Plan Affected	Defined Benefit Retiree Plan
Proposed Effective Date	TBD
Reviewed By	Retiree Health Plan Advisory Board
Review Date	February 9, 2023

1) Background

Upon retirement, AlaskaCare retirees may choose to participate in a voluntary Dental-Vision-Audio (DVA) plan to provide coverage for themselves and their eligible dependents. The AlaskaCare retiree Dental plan is fully funded by members' monthly premium payments, and the Division works hard to maximize the benefits members receive while keeping premiums affordable. Effective in plan year 2020, AlaskaCare began offering two retiree dental plan options, the Legacy Dental Plan, and the Standard Dental Plan which each have different dental coverage provisions. The Division contracts with Delta Dental of Alaska to assist in administration of both dental plans. The Division has committed to maintaining the Legacy plan (the DVA plan that was in place prior to 2014) as an option for members to choose during open enrollment. To ensure the Legacy Plan maintains fidelity to the plan that was in place prior to 2014, the Division is considering updates and changes to the Standard Plan only.

One of the most frequent requests the Division receives from members is a desire for improvement and modernization of the retiree dental plans. Preventive dental care can help members avoid potentially painful and costly restorative treatments down the road. In 2021, 63% of Legacy Plan members received preventive cleanings, up from 57% in 2020; while 69% of Standard Plan members received preventive cleanings; up from 65% in 2020.

The AlaskaCare Standard Dental Plan is designed to help retirees offset the cost of their dental care and to support them in maintaining good overall oral health. Oral health maintenance is why it's so important to focus on preventive care to catch signs and symptoms of dental disease early. Currently, the Plan allows for preventive dental services to be covered at 100% coinsurance with no deductible. However, claims for preventive services do count toward a member's annual maximum benefit of $2000.00. Implementing Delta Dental's *Preventive First* program (program) for the Standard retiree dental plan would provide additional coverage for dental care by exempting preventive services from accruing to the annual benefit maximum.

2) Objectives

a) Support members in maintaining their dental health.
b) Promote high-value care.
c) Provide a dental plan option that is modernized and more in line with current dental procedure costs.

3) Summary

Delta Dental's Preventive First program covers preventive dental services at 100% coinsurance, and the services are not subject to the deductible, just as these services are covered today. Covered preventive services would not change; services in this category include periodic exams, x-rays, sealants, and fluoride treatment.

The program differs from current practice in that any preventive services paid by the Plan would not count toward a member's $2,000.00 annual allowance for dental services. This drives value for the member by freeing up dollars that would normally be applied towards preventive services and allow those monies to be used for more complicated oral health procedures such as treatment of diseases of the gums, fillings, oral surgeries, crowns, dentures and bridges, and other covered dental services.

4) Actuarial and Financial Impacts of Proposed Change

To be determined.