Retiree Health Plan Advisory Board
Meeting Agenda

Date:	Thursday, May 4, 2023
Time:	9:00am – 03:00pm
Location:	Video Teleconference | ANC Atwood 19th Floor | JNU State Office Building 10th Floor Click here to join the meeting
Telephone Only:	(907) 202-7104 ID 889 323 200#

9:00 am	Call to Order • Roll Call and Introductions • Approval of Agenda • Approval of meeting minutes from February 9, 2023 (pg. 2-9) • Ethics Disclosure and Public Comment Script
9:15 am	Public Comment
9:30 am	Department & Division Update • End of the COVID-19 Public Health Emergency (pg. 10) • Regulations Update
10:00 am	Break
10:15 am	Modernization Topics/Priorities • Lifetime Maximum (pg 11-31) • Supplemental Non-Emergent Surgery and Travel Benefits (pg. 32-53) • Virtual Physical Therapy and Musculoskeletal Care Program (pg. 54-74)
12:00 pm	Lunch
1:00 pm	Modernization Topics Continued
2:30 pm	Public Comment
2:45 pm	Wrap up/Adjourn

The next Retiree Health Plan Advisory Board meeting is scheduled for Thursday August 10, 2023.

Retiree Health Plan Advisory Board

Quarterly Board Meeting Minutes

Date: Thursday, February 9, 2023
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
Michael Humphrey	Member	Present
Nan Thompson	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	
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	
Chris Murray	Program Coordinator, 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)	
Inmaly Inthaly	Agnew::Beck Consulting (contracted support)	
Jeanne Larson	Alaska Medicare Information Office	
Ben Hofmeister	Assistant Attorney General, Department of Law	
Annette Piccirilli	OptumRx (pharmacy third party administrator)	
Lauren Carney	OptumRx (pharmacy third party administrator)	
Naeirika Mesri	OptumRx (pharmacy third party administrator)	
Randall Burns	Retired Public Employees of Alaska (RPEA)	
Stephanie Rhoades	Retired Public Employees of Alaska (RPEA)	
Richard Ward	Segal Consulting (contracted actuarial)	
Quentin Gunn	Segal Consulting (contracted actuarial)	

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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

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Meeting Minutes

Item 1. Call to Order + Introductory Business

Chair Judy Salo called the meeting to order at 8:59 a.m. A quorum was present.

Approval of Meeting Agenda

Materials: Agenda beginning page 1 of 2/9/2023 RHPAB meeting packet

Chair Judy Salo reviewed the agenda and the board reviewed the following meeting minutes for approval:

- **September 27, 2022 RHPAB Special Meeting**
    - **Corrections:**
        - Under Item 4 in the sixth paragraph, change to "*Staff are not looking to exclude the cost of drugs in the GCIT Designated Program from accruing to the lifetime maximum benefit set in the plan."*
        - Under Item 4 at the first bullet, change "*2.5 million*" to "*2 million*"
        - Under Item 4, change "*Nan Taylor"* to "*Nan Thompson*"
        - Change headings "*Item 7. Public Comment*" to "*Item 9. Public Comment*" and "*Item 8. Closing Thoughts + Meeting Adjournmen*t" to "*Item 10. Closing Thoughts + Meeting Adjournment*"
    - No objections to the proposed corrections. Minutes approved as amended.
- **November 3, 2022 RHPAB Regular Meeting**
    - **Corrections**:
        - Under Item 3 at the second bullet, add "*if*" after "*expenses are not covered*"
    - No objections to the proposed corrections. Minutes approved as amended.
- **January 4, 2023 Modernization Subcommittee Meeting**
    - **Corrections**:
        - Add Wendy Woolf to list of attendees
        - Under Item 2 at the 4th bullet, change "*Cammy Taylor*" to "*Mauri Long*"
    - No objections to the proposed corrections. Minutes approved as amended.
- **January 23, 2023 Regulations Subcommittee Meeting**
    - **Corrections**:
        - Update title of minutes from "*Modernization*" to "*Regulations*"
        - Under Item 2 at the first discussion bullet point, change "*…Wendy noted that part missing in the proposal evaluation process*" to "*…Wendy noted that **a** part missing in the evaluation process*"
        - Under Item 2 at the first sub-bullet beginning with the word "Stakeholders", cite the regulation: 2 AAC 39.280(b)(1)(E)
        - Under Item 2 at the fifth discussion bullet point, cite the regulation: 2 AAC 39.280(d)(2)
        - Under Item 2 under the 6th sub-bullet, cite the regulation: 2 AAC 39.280(d)(3)
    - No objections to the proposed corrections. Minutes approved as amended.

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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 appreciation to the board for discussing the topics on this meeting agenda. She noted that primary care access for Medicare recipients has become challenging and while RHPAB and DRB cannot fix access for all Medicare patients, this is an issue that is critical and should be addressed for Retirees.

Item 3. Committee Reports

Modernization Subcommittee

Cammy Taylor reported that the Modernization Subcommittee focused on the three proposed changes to the plan to lifetime maximum, supplemental non-emergent surgery and travel benefits, and virtual physical therapy.

Lifetime maximum:

- The committee reviewed the following options:
  - Increasing the lifetime maximum to $4 million
  - Increasing the lifetime maximum to $8 million
  - Removing the lifetime maximum completely
- The committee recommended that the RHPAB consider the two following options:
  - Increasing the lifetime maximum to $8 million with a periodic review based on the current CPI-U, a ~$2.4 million annual cost (may vary)
  - Removing the lifetime maximum completely, a ~$2.7 million annual cost (may vary)

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Supplemental Non-Emergent Surgery, Travel Benefits + Virtual Physical Therapy

- The committee recommended that the board hold further discussion on SurgeryPlus and Hinge Health as supplemental benefits to the plan. SurgeryPlus provides travel benefits to in-network providers and recommends quality providers in cases where members are traveling to a provider that is not in-network. Hinge Health supplements personal care and members would enter this program through a SurgeryPlus referral or through information provided through membership.
- DRB staff are currently awaiting further financial analysis to be completed, after which this information will be provided to the board at its next meeting.

Betsy Wood noted the importance of reviewing plan changes that may financially impact the Medicare versus Non-Medicare populations. DRB wants to ensure that the financial costs and savings of the plan are clear. DRB staff are requesting to hold a special meeting in early March to review the financial analysis of the proposals from the Modernization Subcommittee for the board to understand the financial impacts of the proposed changes.

The board asked the following questions:

- Lorne Bretz stated that his understanding in reading the Plan Booklet is that members are not required to enroll in Medicare, and that the plan will pay the charges not paid by Medicare whether a Retiree is enrolled or not.
    - Steve Ramos clarified that if a member is enrolled in Medicare, Medicare will pay 80% of the covered benefits and AlaskaCare will pay the remaining 20% if the charges are from an in-network provider. If the provider does not accept Medicare, the provider can bill up to 100% of the charge and Medicare will still pay 80%. The AlaskaCare plan would pay up to 35% of the remaining balance owed by the member.
    - Betsy Wood added that DRB cannot compel providers to accept or not accept Medicare, and that DRB can only pay charges based on provisions of the plan.

Regulations Subcommittee

Lorne Bretz noted that the committee reviewed a set of regulations, and several suggestions were made. The public comment period on the regulations is still open, and the committee will review the feedback given by attorneys and the public before the next scheduled RHPAB meeting.

Item 4. Modernization Topics

Materials: Proposals beginning on page 44 of the 2/9/2023 RHPAB meeting packet

Betsy Wood reviewed the list of topics and highlighted the following points:

Dental - Annual Benefit Maximum: Members have given feedback that the Standard and Legacy Plans are difficult to differentiate. DRB would like to review both plans and provide a more updated plan that responds to the way people are using their dental plans today, while providing members with more value. Retirees have expressed the importance in retaining access to the Legacy Plan after retirement.

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The following proposed changes are only to the Standard plan, and all DVA members have options to choose between the Standard and Legacy Dental Plans. Betsy reviewed the following proposed changes:

Retiree Dental Plans Annual Maximum

The Standard and Legacy Dental Plans currently have a $2,000 annual maximum. Currently, there are about 1,100 members who have reached the maximum in the Standard Plan, and about 1,800 who have reached the annual maximum in the Legacy Plan through September 2022. This proposal recommends increasing the annual benefit maximum on the Standard Plan to allow members to receive coverage for more dental services annually. Staff will bring a proposal forward and the total increase amount will be discussed at the next RHPAB meeting in May.

The board held discussion and asked the following questions:

- Lorne Bretz asked about the number of members who are not using their dental benefits?
    - Betsy answered that a full overview of the number of people who did not use their dental benefits in 2022 will be provided at the May RHPAB meeting.
    - Andrea Mueca added that in a recent survey targeting 700 members, a question was added asking survey participants why they may not be using their dental benefits. The survey will be closed at the end of February, and DRB staff will bring the results to the board at the next meeting.
- Judy Salo asked if there are insurance programs that allow benefit maximums to roll over across years?
    - Richard answered that this is not a standard approach. Betsy added that DRB can be creative in its approach and that the DVA Plan is well reserved, leaving space to think about how to enhance benefits for members. She added that there should be a review to benchmark other retiree plans, and review where the AlaskaCare benefits are in comparison to those plans.

Richard added that moving to a higher threshold would not set a new standard; there is currently movement in the industry to increase the annual maximum. Betsy added that, as the cost of dental procedures increases, members are running up against the benefit maximum more frequently.

Delta Dental Preventive First Program

This proposal recommends implementing the Preventive First Program, where preventive services would no longer accrue to the benefit maximum. This program covers preventive dental services at 100% coinsurance, and services are not subject to the deductible. This program is currently offered for State Employees, and DRB believes this program should be considered for retirees, too.

The board asked the following questions:

- Judy Salo noted that non-utilization of dental benefits may tie into this proposal as the costs of dentistry continue to increase, which may prevent members from getting dental work.
- Nan Thompson requested details on the scope included within preventative care to be addressed at the May RHPAB meeting.

Item 5. Board Discussion: Medicare & Primary Care Providers in Alaska

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Due to the recent closure of the Alaska Regional Hospital Senior Clinic, the board discussed the need for Medicare providers and primary care providers in Alaska for seniors. Cammy Taylor noted that the Medicare rates in Alaska are about 35 to 40 percent higher than the rates in the Lower 48. She also noted that historically, at least during Senator Stevens' tenure and work on Alaska's rates, rates were even higher for a short period of time. However, it is unclear whether the high rates alone are the reason why primary care providers are not interested in accepting Medicare.

Cammy Taylor asked whether information is available on whether Medicaid members are also experiencing challenges in receiving care. Betsy answered that she will follow up with the board on this answer and that rates are federally set, thus the state does not have much influence on them. It has been heard that it is hard for providers to accept Medicare in large volumes as it is difficult for them to cover their own expenses.

Lorne Bretz asked about the definition of patient abandonment. Jeanne Larson answered that she is unable to speak on the definition of patient abandonment. She added that physicians and clinics must exercise caution to ensure that their patients are not being abandoned, and the state's medical board would handle any concerns about providers in the state of Alaska. There are regulations around patient abandonment; she recommended that the board review and discuss these regulations, and any potential consequences Alaska Regional Hospital could face. It would take our state Legislature being involved to grow our infrastructure. For example, the Alaska Senior Care and Providence clinics were created to provide access for the Medicare population, funded specifically by a state legislative grant. Other clinics that accept Medicare patients includes Providence Primary Care and Anchorage Neighborhood Health Center, but these clinics will likely have long wait periods for appointments, a problem likely to be exacerbated by the closure of the Alaska Regional Hospital Senior Clinic.

Jeanne continued: The Alaska Commission on Aging is working on their Senior State Plan, part of the Biden Administration's focus on equity in healthcare, to ensure seniors have accessible and culturally appropriate healthcare that allows them to stay financially independent. Access to healthcare, specifically primary care, is a way to achieve this independence. Through this focus, the Centers for Medicare and Medicaid Services (CMS) will send staff to Alaska to hold meetings about access issues; Alaska has shared with its contacts in Seattle, Washington that they should be prepared to see emergency room visits increase. The Medicare Information Office provided a recommendation in the State Plan draft to create a Medicare Ad Hoc Committee, which used to be active several years ago.

Cammy asked who is authorized to form the Medicare Ad Hoc Committee? Jeanne answered that the person who led the committee; it was based out of a senior center in the Mat-Su, but she is not sure how the committee was formed. The Alaska Commission on Aging would be the best organization to bring people together on this discussion. She recommended contacting the Commission's director as a starting point.

Betsy added that she would check on any available information that she can share with the board about this committee. She also reminded the group that as the RHPAB and DRB think of their roles, and what can be done from the Retiree healthcare plan perspective, there may not be a large role for both groups, due to the way both are structured. For example: DRB is required to act as a secondary payor to Medicare. Medicare Advantage plans are an opportunity to pay primary care differently. Aetna can do this through Value-Based Payment Arrangements with primary care providers, which still puts DRB in a

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secondary position but allows DRB to pay them separately, and potentially more to providers who have expanded their services for seniors.

Nan Thompson expressed hope that DRB will share this information in one of its regular calls with plan members and expressed appreciation to Betsy for thinking creatively about this topic. The Medicare Advantage plan would be a long-term project and a potential solution to this issue, as it would increase our leverage to make more providers want to be willing to take Medicare payments.

Item 6. 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 commented on the importance for DRB to address the statutory language that states the coverage for 65 years of age and older must be the same as those who are younger than 65. Randall would like to know what DRB thinks about this language, and how it impacts DRB's planning around this issue. Given that language, Randall asked DRB and RHPAB to consider whether DRB could make grants from its health trust to senior clinics.
- Stephanie Rhoades, RPEA. Stephanie noted that DRB is subject to AS39.35.880 that coverage for persons 65 years of age or older should be the same for persons under 65 years of age. There are several ways to explore how retirees can use the plan to gain access to primary care in areas where there is no network.

Item 7. Closing Thoughts + Meeting Adjournment

Motion by Michael Humphrey to adjourn the meeting. **Second** by Nan Thompson.
Result: No objection to adjournment. The meeting was adjourned at 10:42 a.m.

The next Retiree Health Plan Advisory Board special meeting will be on Monday, March 20, 2023. The next regular quarterly meeting will be on Thursday, May 4, 2023.

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/

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COVID-19 Public Health Emergency ends May 11, 2023

The federal government announced it will end the COVID-19 public health emergency and national emergency declarations on May 11, 2023. Here at AlaskaCare, we made temporary changes, permanent changes, and limited benefit expansions to your health plan during the public health COVID-19 response to assist you in accessing the care you needed. While the national public health emergency is set to end, your health benefits will continue to be there when you need them.

- COVID-19 Vaccines

Remains Covered. Your AlaskaCare health plan covers preventive vaccines under both the medical and pharmacy plans. AlaskaCare members receive preventive vaccines, including the COVID-19 vaccine, at no cost when received at a network pharmacy or from a network provider. Standard cost sharing provisions apply for non-preventive vaccines.

- COVID-19 Treatment

Remains Covered. Your AlaskaCare health plan covers your medically necessary treatment when diagnosed with COVID-19, the same as other covered medical expenses. You must first meet the annual deductible of $150 per person. After you meet the annual deductible, the Medical Plan pays 80% or more for covered expenses up to annual individual out-of-pocket limit of $800. When your deductible is satisfied and your out-of-pocket maximum is reached, the Medical Plan pays 100% of most covered medical expenses for the rest of the benefit year.

- COVID-19 Laboratory Testing

Remains Covered. Your AlaskaCare health plan covers laboratory testing for COVID-19, the same as other covered diagnostic testing expenses. Standard cost sharing provisions apply for COVID-19 laboratory tests (Polymerase Chain Reaction or "PCR" and antigen tests) that are deemed medically necessary under the terms of the plan.

- Over the Counter COVID-19 Testing

Temporary coverage expires on June 30, 2023. Your AlaskaCare health plan pharmacy benefit will continue to cover at-home, over the counter, FDA-authorized COVID-19 tests, 8 per month per covered person through June 30, 2023. Beginning July 1, 2023, the temporary coverage for over-the-counter COVID-19 test kits will no longer be in effect. COVID-19 laboratory testing (PCR and antigen tests) will continue to be covered per the plan provisions.

- Telemedicine Services

Remains Covered. Your AlaskaCare plan covered telemedicine before and during the COVID-19 public health emergency and will continue to cover telemedicine services delivered by your regular providers per the plan provisions. If you or your provider are unsure which telehealth services are eligible for coverage, please contact the Aetna health concierge at (855) 784-8646 for more information.

Proposal # and Title	Lifetime Maximum (R008)
Health Plan Affected	Defined Benefit Retiree Plan
Proposed Effective Date	January 1st, 2024
Reviewed By	Retiree Health Plan Advisory Board – Modernization Subcommittee
Next Review Date	May 5, 2023

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1) Background

Current Lifetime Maximum Provisions

The lifetime maximum insurance benefit is the maximum dollar amount that the AlaskaCare Defined Benefit Retiree Health Plan (Plan) will pay out during a member's lifetime for healthcare services.

The Plan currently stipulates a $2 million lifetime maximum described below and found in section *3.1.5 Lifetime Maximum* of the Defined Benefit AlaskaCare Retiree Insurance Information booklet.

> *"The maximum lifetime benefit for each person for all covered medical expenses is $2,000,000.*
>
> *At the end of each benefit year, up to $5,000 of medical benefits used is automatically restored regardless of your physical condition. If you have received more than $5,000 of covered medical benefits, your full annual spent maximum may be restored when you submit proof of good health satisfactory to the claims administrator within the following year. This provision will not provide benefits for covered expenses incurred before the date the maximum is restored."*[1]

Prescription drug expenses billed through the pharmacy plan do not count toward the lifetime maximum. However, medical pharmacy expenses, such as injections or other prescription medications provided when a member is inpatient at the hospital, are counted toward the lifetime maximum. Beginning on January 1, 2023, the cost of Gene-based, Cellular, and other Innovative Therapies (GCIT) products obtained through the medical claims administrator's GCIT Designated Network program does not accrue towards the plan's lifetime maximum.[2]

Once a member becomes Medicare-eligible, the Plan becomes supplemental to Medicare.[3] Claims costs are then limited by Medicare's fee schedule, and the Plan's responsibility is limited to amounts not covered by Medicare. Any amount paid by the Plan continues to accrue to a member's lifetime maximum, however the majority of their expenses are covered by Medicare, typically leaving a much smaller amount to be considered by AlaskaCare.

Lifetime Maximum History

The lifetime maximum provision currently in the plan represents an increase from the initial plan provision which set the limit at $250,000. In 1985, the $250,000 lifetime max was increased to $1 million, and in 1999 it was increased again to the present limit of $2 million.

[1] https://drb.alaska.gov/docs/booklets/DB-RetireeInsuranceBooklet_WEB.pdf
[2] Retiree Insurance Information Booklet, *Section 3.3.26 Gene-based, Cellular, and other Innovative Therapies (GCIT)*, January 2023. pg. 71-72. https://drb.alaska.gov/docs/booklets/DB-RetireeInsuranceBooklet_WEB.pdf
[3] Retiree Insurance Information Booklet, *Section 3.1.7 Effect of Medicare*, January 2023. pg. 21-22. https://drb.alaska.gov/docs/booklets/DB-RetireeInsuranceBooklet_WEB.pdf

A lifetime maximum provision of $2 million may have been sufficient to cover most individuals' medical care over 20 years ago, however it is now causing serious hardship for a small but growing number of members. Removing or increasing the lifetime maximum would represent a valuable gain for members with chronic and catastrophic conditions. If the current lifetime maximum had adjusted in keeping with inflation, based solely on the Consumer Price Increase for All Urban Consumers (CPI-U) for Medical Services, then it would have increased by approximately 220% to $4.4 million based on inflation from 1999 to 2022.[4] This estimation does not account for cost pressures specific to Alaska.

In 2009, the Patient Protection and Affordable Care Act (PPACA) required most health plans to remove any lifetime maximum, and as a result these provisions are becoming increasingly uncommon in health plans. There are very few group plans remaining with similar limits on lifetime benefits due to the Affordable Care Act, these are limited to retiree only plans.

On June 17, 2010, the Internal Revenue Service, U.S. Department of Labor, and U.S. Department of Health and Human Services issued joint interim final regulations clarifying that stand-alone retiree plans are exempt from the insurance mandates of PPACA. Thus, the State's retiree health plan is excluded from the ACA insurance mandates, including the prohibition of lifetime maximums.

The Defined Contribution Retiree Health Plan does not have a lifetime benefit maximum. The AlaskaCare Employee Health Plan was not initially subject to the ACA insurance requirements due to having grandfathered status. However, the employee plan forfeited grandfathered status in 2015 and eliminated the lifetime maximum at that time. A number of other changes were made to the employee plan at the same time, such as direct contracting with Regional Hospital and preventive care coverage, which makes determining the impact of just the removal of the lifetime maximum difficult to determine. However, this change did not threaten the employee plan's solvency.

Options for Members Approaching or Reaching the Lifetime Maximum

The impact of the current lifetime maximum limit varies depending on a member's individual circumstances. A major factor that will determine the severity of the impact is whether the member is eligible for Medicare.

Medicare Members

Members with Medicare as their primary coverage who have reached the AlaskaCare lifetime maximum can still receive coverage for their health care services through Medicare. Medicare does not have a lifetime maximum limit on benefits. If the member uses services that Medicare covers, and the services are deemed to be medically necessary, they can continue to use as

[4] *Removal of the Retiree Plan Lifetime Maximum – Focus on Actuarial and Financial Impact for the Retiree* Plan (Updated), Segal Consulting memo dated January 9, 2023.

many as needed, regardless of the cost accumulated, in any given year or over a lifetime. Their secondary AlaskaCare coverage will still be limited by the lifetime maximum, but their Medicare coverage will continue.

Non-Medicare Members

Members not eligible for Medicare who are facing extraordinarily high health care costs are disproportionately impacted by the current lifetime maximum as they do not have guaranteed access to other health insurance the way Medicare-eligible members do.

Options for members who are not eligible for Medicare are limited to the following:

1. Medicaid - for those who meet certain eligibility or income thresholds.[5]
2. Federally Facilitated Marketplace - members may qualify for coverage and enroll during a special enrollment period; but the $5,000 reinstatement creates complexity for members requiring special approval and/or review.
3. Alaska Comprehensive Health Insurance Association (ACHIA)[6] – this has been a resource for some members who have reached their lifetime maximum. Premiums range depending on age and the deductible selected. In 2023, an individual who is 60 years of age would have a monthly premium of $2,876 for a plan with $1,000 deductible and $1,106 for a plan with a $15,000 deductible.[7]

An unintended consequence of the $5,000 annual reinstatement provision is that even after a member reaches their lifetime maximum, they are considered by other plans to have insurance which meets minimum essential coverage provisions limiting their ability to qualify for other forms of insurance. Because of this, some members who have met their lifetime maximum but who are not yet Medicare eligible may not be able to access other health coverage options.

Even members who have not reached their lifetime maximum may be impacted by the lifetime maximum provision. The Division is aware of at least one circumstance where providers have withheld care or delayed treatment until the member comes up with enough monetary deposit because they are concerned the recommended treatment course will exceed the remainder of their plan benefit despite having over $1 million left.

Another individual has indicated he must delay a necessary procedure for 2 years, until he reaches Medicare eligibility, because his remaining plan benefits are not sufficient to cover the service.

[5] Alaska Department of Health and Social Services [DHSS], Division of Public Assistance, Medicaid Eligibility Standards: http://dpaweb.hss.state.ak.us/POLICY/PDF/Medicaid-Standards.pdf
[6] Alaska Comprehensive Health Insurance Association [ACHIA]: http://www.achia.com/premiums.asp
[7] ACHIA 2023 Monthly Individual Premiums Rates: https://www.achia.com/docs/ACHIA%202023%20Non-Medicare%20Premium%20Rates.pdf

Often, members are not necessarily aware of the lifetime maximum plan provision and retire confident that they have health insurance for themselves and their dependents for the remainder of their lives. When they do reach the maximum, they are generally extraordinarily sick and highly vulnerable.

2) Goals and Objectives

1. Ensure members retain access to health insurance during a catastrophic health event.
2. Implement strategies to prudently utilize the funds that support the AlaskaCare Retiree Health Plan.

3) Summary of Proposed Change

This proposal considers two options. The first is to increase the lifetime maximum to $8 million and remove the reinstatement of benefits provisions related to the lifetime maximum. The second is to remove the lifetime maximum limit. A change implemented under either option would be prospective from the effective date, and would not be applied retroactively. Claims incurred prior to the effective date of the change will not be adjusted.

The Division also reviewed increasing the lifetime maximum to $4.4 million, which is equivalent to an inflationary increase since the lifetime maximum was last updated. This option is not being put forward in favor of the two options listed below.

Option 1: Lifetime Maximum Increased to $8 million

Coverage for all members, including those who have already reached the current $2 million lifetime maximum benefit, would be updated to reflect the new $8 million limit, and the annual reinstatement provision would be removed. The lifetime maximum would be reviewed by the Division at least every 5 years for indexing to the consumer price index (CPI) and any other information relevant to the evaluation. Any future changes to the lifetime maximum would not be automatic, but would be evaluated after such a review. An $8 million limit reflects a value that is roughly equivalent to the financial impact of removal of the lifetime maximum and maintains some cost control measures for the plan.

The annual $5,000 reinstatement provisions would be removed to eliminate the complication it causes members around minimum essential coverage provisions limiting their ability to qualify for other forms of insurance. If a member were in the plan for 30 years, they could potentially have $150,000 reinstated, which is a significantly smaller amount than the $6 million increase in the lifetime maximum, which would therefore be an enhancement.

The retiree plan annual individual out-of-pocket maximum, benefit maximums and other cost sharing provisions would remain unchanged. Pharmacy benefits do not accumulate toward the lifetime maximum and would not be impacted by this change.

Option 2: Lifetime Maximum Removed

Coverage for all members, including those who have already reached the current $2 million lifetime maximum benefit, would be updated to reflect the removal of the lifetime maximum. The annual reinstatement provisions would no longer be needed.

The retiree plan annual individual out-of-pocket maximum, benefit maximums and other cost sharing provisions would remain unchanged. Pharmacy benefits do not accumulate toward the lifetime maximum and would not be impacted by this change.

4) Analysis

While the number of individuals impacted by the existing lifetime maximum is small (see member impact below); those who are impacted find themselves without an avenue for affordable health insurance at an extremely vulnerable time. Without a change to this plan provision, it is likely that an increasing number of individuals will reach the lifetime maximum given the growing cost of health care and advances in medical technology.

This is a priority item for the Division, which sees the devastating impacts on members approaching their lifetime maximum. More members are reaching the lifetime maximum due to the significant growth of health care costs over the past decade. The growth in health care costs is due to a variety of factors including access to new technological advancements. These medical advancements bring relief to patients, but plan sponsors have a fiduciary responsibility to ensure that they are properly used and prudently reimbursed. Targeted programs intended to manage costs and incentivize quality care (*e.g.*, the GCIT designated network program for complex, high-cost therapies implemented in the Plan in January 2023) are an important tool to protect the Plan against ballooning costs, while at the same time providing access to necessary medical treatments.[8]

An increase or the removal of the lifetime maximum may ease the financial barriers to health care that members experience once the current $2 million maximum is reached, potentially improving their clinical outcomes. Lack of health insurance coverage or high out of pocket costs may negatively affect health[9] and lead members to delay or forgo needed care. However, it is likely that most members exceeding this cost threshold have very serious, critical health issues.

Any fixed amount lifetime maximum will impact more members over time, as costs continue to increase. Predicting future claims activity for individuals can be challenging given the limited information on health risks and current treatment plans for each individual.

[8] Ibid.
[9] Institute of Medicine (U.S.) Committee on Health Insurance Status and Its Consequences. (2009). *America's uninsured crisis: Consequences for health and health care*. National Academies Press.

5) Impacts

It is important to note that the true value of this benefit enhancement will vary and fluctuate annually, potentially to a substantial degree. Even with over 70,000 members, the claims data are not a credible source for the analysis, given the relatively small number of individuals who currently reach the lifetime maximum limit.

Actuarial Impact to AlaskaCare | Increase

Decrease | Neutral | Increase

The actuarial impact of this proposal will vary depending on the option selected for implementation. These impacts are discussed in the attached Segal Consulting memorandum.[10]

Table 1. Actuarial Impact

Option	Actuarial Impact
Option 1: Lifetime Maximum Increased to $8 million	0.35% increase
Option 2: Lifetime Maximum Removed	0.40% increase

Financial Impact to AlaskaCare| | Cost Increase

Decrease | Neutral | Increase

Projected Annual Financial Impact

The annual financial impact of this proposal will vary depending on the option selected for implementation and may deviate from the projected impacts below depending on actual claims experience. Because a relatively small number of members are likely to be impacted when compared to the total membership, it is difficult to use past claims data to predict future experience.

The impact to the plan will also vary depending on whether members with claims over $2 million are eligible for Medicare or not. The Plan pays secondary to Medicare for more than 70% of members currently, with the expectation that this percentage will continue to grow as the group is aging at a rate greater than that for new retirements. Medicare pays roughly 80% of all medical costs, which includes more routine cases as well as high-cost treatments and technologies. This provides protection for the Plan against expected market trend increases as well as increases associated with medical advancements.[11]

The projections outlined in Table 2 below are based on the retiree medical and pharmacy claims projection of $646,600,000 for 2023 (as of September 2, 2022) and trended forward at 6% to $685,400,000 for 2024 and are discussed in the attached Segal Consulting memorandum.[12]

[10] *Removal of the Retiree Plan Lifetime Maximum – Focus on Actuarial and Financial Impact for the Retiree* Plan (Updated), Segal Consulting memo dated January 9, 2023.
[11] Ibid.
[12] Ibid.

Table 2. Annual Financial Impact

Option	Financial Impact
Option 1: Lifetime Maximum Increased to $8 million	$2.4 million annual increase
Option 2: Lifetime Maximum Removed	$2.74 million annual increase

Projected Long-Term Financial Impact

The cost increase associated with the proposed benefit alteration may have long-term impacts to the healthcare Actuarial Accrued Liability (AAL) [13] and to the Additional State Contributions (ASC)[14] associated with the Plan.

Because the financial impact to the plan will vary depending on whether individuals with claims over $2 million are enrolled in Medicare or are not yet Medicare-eligible, the future cost projections contemplate two scenarios:

- 10% of the cost impact attributable to Medicare members / 90% attributable to non-Medicare members.
- 20% of the cost impact attributable to Medicare members / 80% attributable to non-Medicare members.

In an illustrative example, the tables below summarize the estimated increase in healthcare AAL for the Public Employees Retirement System (PERS), Teachers Retirement System (TRS), and Judicial Retirement System (JRS) combined and the estimated increase in the ASC for FY25. These estimates, along with the projected impact on the ASC through 2039 if this change had been reflected in the June 30, 2022, valuations are discussed in the attached Buck memorandum.[15] Each of the implementation options and Medicare impact scenarios described above are considered in these projections.

It is important to note that the June 30, 2022 valuations and FY25 contribution rates (which determine the FY25 ASC) have not yet been formally approved by the Alaska Retirement Management Board (Board). The June 30, 2022 valuation results are expected to be approved during the June 2023 Board meeting, and the FY25 contribution rates will be adopted during the September 2023 Board meeting. Impacts are also shown as a percentage increase/(decrease).[16]

The projected healthcare AAL for the defined benefit retiree systems combined (PERS, TRS, and JRS) as of the June 30, 2022, valuation is $9,117.7 million. Under impact scenarios contemplated if the plan's lifetime maximum benefit was eliminated or increased, the illustrative impact on the AAL is an increase between $22.9-29.3 million, or by 0.25-0.32%.

[13] AAL: The health Actuarial Accrued Liability is equal to the total accumulated cost to fund the postemployment benefits arising from service in all prior years.
[14] Employer contributions to retirement payments were capped in FY08. Since then, the state makes additional assistance contributions to help cover the accrued unfunded liability associated with participating employers.
[15] *Impact of Potential Increase or Elimination of Lifetime Maximum for AlaskaCare Retiree Health Plan,* Buck Consulting Memo dated March 3, 2023.
[16] Ibid.

Table 3. FY22 Healthcare AAL Illustrative Impact on Combined PERS/TRS/JRS DB if Lifetime Maximum ("LTM") Increased ($ millions)

Lifetime Maximum (LTM) Scenario		Current Healthcare AAL for Combined DB as of 6/30/2022	Increase in 6/30/2022 AAL	% Increase in 6/30/2022 AAL
1	$8 million	$9,117.7	$22.9	0.25%
2	$8 million	$9,117.7	$25.6	0.28%
3	Unlimited	$9,117.7	$26.5	0.29%
4	Unlimited	$9,117.7	$29.3	0.32%

The ASC is a mechanism for the State to provide payment assistance to participating employers' Actuarially Determined Contribution (ADC). The ADC is determined by adding the normal cost[17] to the amount needed to offset the amortization of any existing unfunded accrued liability over a period of 25 years.

Under all impact scenarios contemplated, increasing or eliminating the plan's lifetime maximum benefit is expected to increase the calculated ASC associated with future healthcare costs by $300K or 0.06%.[18]

Table 4. FY25 Impact on Combined PERS/TRS/JRS DB Contributions if Lifetime Maximum ("LTM") Increased ($ millions)

Lifetime Maximum (LTM) Scenario		Pension and Healthcare Current FY25 Contributions for Combined DB	Increase in FY25 Additional State Contributions if Hinge Health Added	% Increase in FY25 Contributions
1	$8 million	$486.9	$0.3	0. 06%
2	$8 million	$486.9	$0.3	0. 06%
3	Unlimited	$486.9	$0.3	0. 06%
4	Unlimited	$486.9	$0.3	0. 06%

The illustrative increase to the FY25 ASC is associated with the normal cost only. The current overfunded status of retiree health care liabilities has eliminated the immediate need for amortization payments to offset any health care unfunded liability. It is important to note that long-term funded status of the trusts is subject to change in response to market volatility and many other factors.

Member Impact | Enhancement

An increase to or the removal of the lifetime maximum would provide financial relief and continued health coverage for members who have met or are approaching the current lifetime limit. This change would also provide additional reassurance that future health care costs will be covered for members who are not currently approaching the lifetime maximum.

[17] The normal cost represents the present value of benefits earned by active employees during the current year.
[18] The increases are the same for all scenarios due to rounding.

AlaskaCare retiree plan members who are at or near the lifetime maximum as of Quarter 1 of 2023:

- **Between $1.5-$1.7 Million**: 11 members
- **Between $1.7-$1.9 Million**: 4 members
- **Above $1.9 Million**: 16 members
  - 6 are under $2 million
  - 10 have reached $2 million

It is unknown exactly how many members have reached this maximum limit over the lifetime of the plan, as the records for individuals who have "termed," or who are no longer covered by the plan, are not retained in perpetuity.

Operational Impact (DRB)| Neutral

Decrease | Neutral | Increase

Operational impacts to the Division will be minimal. The Division will follow the standard process for making plan changes per 2 AAC 39.390 and provide direction to the Third-Party Administrator to implement the change and ensure members are reinstated. Once the implementation activities are complete the Division does not anticipate any additional operational impact.

Operational Impact (TPA) | Neutral

Decrease | Neutral | Increase

An increase or the removal of the lifetime maximum provision will bring the retiree health plan in-line with other, mainstream, health plan provisions and will require less effort for the TPA once the initial change is completed. The TPA will need to assist in identifying and informing members who would benefit from having their plan benefits reinstated and will need to update the claim adjudication processes and systems to update the lifetime accumulators. These activities will be a one-time effort that should not require significant work by the TPA.

Provider Impact | Minimal

Provider impact is estimated to be both minimal and positive as this removes a potential barrier to care for their patients.

6) Clinical Considerations

An increase in or the removal of the lifetime maximum will ease existing impediments to care that members experience potentially improving their clinical outcomes; however, it is likely that most members exceeding this cost threshold have very serious, critical health issues.

7) Implementation and Communication Overview

Division staff will follow the standard process for making changes to the Defined Benefit retiree plan, which includes completion of the following:

- Proposal analysis and stakeholder input
- Plan Amendment
- Public comment periods
- Commissioner of Administration determination
- Any needed updates to the Retiree Insurance Information Booklet
- Education outreach to benefit recipients

8) Proposal Recommendations

DRB Recommendation

The Division recommends…

RHPAB Board Recommendation

The RHPAB board voted on ##/##/## to recommend/not to recommend Option XX

Commissioner of Administration Recommendation

The plan administrator made the determination on ##/##/## to …

Description	Date
Proposal Drafted	08/10/2018
Reviewed by Modernization Subcommittee	08/10/2018, 09/28/2018, 10/30/2018, 04/23/2019, 06/12/2019, 01/04/2023
Reviewed by RHPAB	08/29/2018, 11/28/2018, 02/06/2019, 05/08/2019, 08/07/2019, 02/09/2023, 05/04/2023

9) Plan Language

January 2023 Plan Booklet Language	Proposed Plan Booklet Language
3.1.5 Lifetime Maximum The maximum lifetime benefit for each person for all covered medical expenses is $2,000,000. At the end of each benefit year, up to $5,000 of medical benefits used is automatically restored regardless of your physical condition. If you have received more than $5,000 of covered medical benefits, your full annual spent maximum may be restored when you submit proof of good health satisfactory to the claims administrator within the following year. This provision will not provide benefits for covered expenses incurred before the date the maximum is restored. EXAMPLE: Assume you have used $3,000 of medical benefits during the year and your lifetime benefit is decreased to $925,000. At the end of the year, the $3,000 would be restored and your maximum lifetime benefit available would be $928,000. If you had used $6,000 of medical benefits, your maximum lifetime benefit would be reset to $930,000, unless you submitted proof of your good health and were approved for a full reinstatement.	TBD – Depending on which Option is selected for implementation

Memorandum

To: Ajay Desai, Director, Division of Retirement and Benefits

From: Richard Ward, FSA, FCA, MAAA

Date: January 9, 2023

Re: Removal of Retiree Lifetime Plan Maximum – Focus on Actuarial and Financial Impact for the Retiree Plan *(Updated)*

The State currently provides retiree coverage up to a lifetime maximum of $2,000,000, with an annual $5,000 reinstatement once the limit is reached.

The Plan applies the general benefit provisions, such as deductible, coinsurance and out-of-pocket limits, to determine any portion of the costs that are the member's responsibility. If the member has additional coverage, such as Medicare or other employer provided coverage, any portion of the costs covered by that plan is also considered. Below is a table outlining the current benefits offered under the Plan:

Deductibles	
Annual individual / family unit deductible	$150 / up to 3x per family
Coinsurance	
Most medical expenses	80%
Most medical expenses after out-of-pocket limit is satisfied	100%
Second surgical opinions, Preoperative testing, Outpatient testing/surgery • No deductible applies	100%
Out-of-Pocket Limit	
Annual individual out-of-pocket limit • Applies after the deductible is satisfied • Expenses paid at a coinsurance rate other than 80% do not apply against the out-of-pocket limit	$800
Benefit Maximums	
Individual lifetime maximum • Prescription drug expenses do not apply against the lifetime maximum	$2,000,000
Annual reinstatement once lifetime maximum is reached	$5,000
Individual limit per benefit year on substance abuse treatment without precertification. Subject to change every three years	$12,715
Individual lifetime maximum on substance abuse treatment without precertification. Subject to change every three years	$25,430

Prescription Drugs	Up to 90 Day or 100 Unit Supply	
	Generic	Brand Name
Network pharmacy copayment	$4	$8
Mail order copayment	$0	$0

Actuarial Value

We reviewed claims data through mid-October 2022 provided by Aetna for retirees over and under 65 who are currently active on the plan and identified:

- 30 claimants with claims totaling over $1.5 million
- 17 claimants with accumulated claims over $1.70 million; and
- 10 claimants with at least $1.99 million

Any fixed amount lifetime maximum will impact more members over time, as costs continue to increase.

Predicting future claims activity for individuals can be challenging given the limited information on health risks and current treatment plans for each individual. The true value of this benefit enhancement will likely vary and fluctuate annually, potentially to a substantial degree. Even with over 70,000 members, the claims data are not a credible source for the analysis, given the relatively small number of occurrences.

Based on information provided by the State, the initial plan provisions set the limit at $250,000 before an increase in 1985 to $1 million and another increase 1999 to the current amount of $2 million. If the lifetime maximum was increased based solely on the Consumer Price Increase for All Urban Consumers (CPI-U) for Medical Services, then it would have increased by approximately 220% to $4.4 million based on inflation from 1999 to 2022.

However, this would not necessarily account for the unique inflationary pressures for Alaska and may by understated. Additionally, on a forward-facing basis there are increasingly more expensive treatments, such as gene therapy, that may have more total charges than the current lifetime maximum.

As these treatments emerge, it is anticipated there will be targeted programs available in the industry to manage costs for quality care. A recent example is the gene therapy center of excellence (COE) network developed by Aetna. It would be prudent for the Division to continue to evaluate and consider targeted programs and options as they become available in the industry in order to manage the high costs associated with certain specialized treatments, while still providing access to high quality care.

There are very few group plans remaining with similar limits on lifetime benefits. Due to the Affordable Care Act, these are limited to retiree only plans. The trend we observe in the market is to remove these lifetime limits. The cost differential between increasing the limit and removing the limit is generally considered to be relatively minor, and provides additional coverage for members with the greatest needs.

Due to the challenges regarding analyzing removing the lifetime maximum using the State's data, our updated analysis utilizes the Optum Comprehensive Benefit Pricing Model[1], along with the previously completed work using the Apex Actuarial Rate Modeling System[2], to determine the impact of removing the lifetime maximum as well as increasing the maximum to different levels. The model was calibrated to account for the current membership's demographics, geography, and overall cost structure. Our results are representative of the average anticipated increase for a typical year under typical circumstances.

There are a few distinct types of options available:

- Eliminate the Lifetime Maximum
- Increase the Lifetime Maximum to another fixed amount
- Incorporate an indexing element that provides a market benchmark used to assess a fixed amount into the future.

This third option was recently discussed by the Retiree Health Plan Advisory Board's (RHPAB) Modernization Committee. This approach would review the Lifetime Maximum every five years against the accumulated increase in the Consumer Price Increase for All Urban Consumers (CPI-U) for Medical Services.

At the Division's request, we have modeled an $8,000,000 Lifetime Maximum subject to this every-five-year review. For reference, the annual CPI-U increase from 1999 to 2022 was approximately 3.5%. Over a five-year period, this accumulates to an 18.8% increase, or an increase from $8,000,000 to $9,500,000.

The following table summarizes the impact of this option, and three additional options:

New Lifetime Maximum	Impact on Actuarial Value
$4,000,000	0.25%
$8,000,000	0.35%
$8,000,000 (indexed by medical CPI)	0.38%
Unlimited	0.40%

The impact on actuarial value is determined based on the average aggregate impact to a given year and is therefore the effect over the long-term. The annual impact on plan experience may vary based on large claim activity and the introduction of new technologies and medical advancements.

The Plan pays secondary to Medicare for more than 70% of members currently, with the expectation that this percentage will continue to grow as the group is aging at a rate greater

[1] The Optum Comprehensive Benefit Pricing Model provides comprehensive plan design and rate modeling capabilities and is widely utilized throughout the industry by insurance carriers and consulting actuaries. Segal held an annual license to utilize this model at the time the analysis was conducted.

[2] The Apex Actuarial Rate Modeling System provides comprehensive plan design and rate modeling capabilities and is widely utilized throughout the industry by insurance carriers and consulting actuaries. Segal held an annual license to utilize this model at the time the analysis was conducted.

than that for new retirements. Medicare pays roughly 80% of all medical costs, which includes more routine case as well as high cost treatments and technologies. This provides protection for the Plan against expected market trend increases as well as increases associated with medical advancements.

Financial Impact

The financial impact is based on the most recent retiree medical and pharmacy claims projection of $646,600,000 for 2023 (dated September 2, 2022), and trended forward at 6% to $685,400,000 for 2024.

The following table summarizes the impact for the same four options:

New Lifetime Maximum	Annual Financial Impact
$4,000,000	$1,710,000
$8,000,000	$2,400,000
$8,000,000 (indexed by medical CPI)	$2,400,000
Unlimited	$2,740,000

The Annual Financial Impact is based on the projected 2024 claims costs and considers the benefit design that would be in place for 2024. For purposes of this analysis the Lifetime Maximum would be $8,000,000 in the indexed scenario for 2024 and, therefore, the projected financial impact will be the same in 2024 as for the scenario with the same, but not indexed, Lifetime Maximum.

Over the long-term, however, the financial impact of the indexed $8,000,000 Lifetime Maximum would be very close to removing the Lifetime Maximum completely.

Additional Notes

The data used for this analysis was reviewed, but not audited, and found to be sufficient and credible.

The above projection is an estimate of future cost and is based on information available to Segal at the time the projection was made. Segal has not audited the information provided. A projection is not a guarantee of future results. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, change in demographics, overall inflation rates and claims volatility. Projection of retiree costs takes into account only the dollar value of providing benefits for current retirees during the period referred to in the projection. It does not reflect the present value of any future retiree benefits for active, disabled, or terminated employees during a period other than that which is referred to in the projection, nor does it reflect any anticipated increase in the number of those eligible for retiree benefits, or any changes that may occur in the nature of benefits over time.

The Coronavirus (COVID-19) pandemic continues to evolve and will likely continue to impact the 2022 and 2023 US economy and health plan claims projections for most Health Plan Sponsors. Unanticipated changes in the pandemic may impact the retirees' ability to utilize this program and result in experience that deviates from these projections.

cc: Betsy Wood, Division of Retirement and Benefits
Andrea Mueca, Division of Retirement and Benefits
Noel Cruse, Segal
Eric Miller, Segal
Quentin Gunn, Segal

March 3, 2023

Ms. Betsy Wood
Acting Chief Health Administrator
Division of Retirement and Benefits
State of Alaska
P.O. Box 110203
Juneau, AK 99811-0203

Impact of Potential Increase or Elimination of Lifetime Maximum for AlaskaCare Retiree Health Plan

Dear Betsy:

As requested, we have estimated the impact of the following changes that are being considered for the AlaskaCare Retiree Health Plan members participating in the PERS/TRS Defined Benefit Plans (for those hired prior to July 1, 2006) and JRS:

- **Increase of Lifetime Maximum** – Currently the AlaskaCare Retiree Health Plan has a lifetime maximum of $2,000,000 (excluding prescription drugs), with $5,000 automatically restored at the end of each benefit year. The change being considered is to increase this lifetime maximum to $8,000,000 and review this maximum every five years against the accumulated increase in the Consumer Price Index for All Urban Consumers (CPI-U) for Medical Services.
- **Elimination of Lifetime Maximum** – An alternative change being considered is to eliminate the lifetime maximum.

Segal provided a memo dated January 9, 2023 which modeled the increase or elimination of the current lifetime maximum. Assuming the change would be effective January 1, 2024, they estimated that increasing the Lifetime Maximum to $8,000,000 would increase the retiree health plan cost during 2024 by $2,400,000, and that eliminating the Lifetime Maximum would increase the retiree health plan cost during 2024 by $2,740,000. Their total projected cost during 2024 prior to adopting either of these options was $685,400,000, which is within 3.0% of the projected cost in our most recent actuarial valuations as of June 30, 2022. Therefore, to estimate the financial impact of these changes on PERS/TRS/JRS, we reflected the increases during 2024 provided by Segal and used the June 30, 2022 valuation assumptions to project future annual cost increases. Because this change would affect both pre-Medicare and Medicare members, we modeled two scenarios to illustrate the sensitivity of assuming what percentage of Medicare members would be impacted. This is an important assumption because the more Medicare members are assumed to be impacted, the greater the increase will be in the Actuarial Accrued Liability (AAL) and Additional State Contributions (ASC).

As mentioned in Segal's memo, there is limited data available to predict the number of people who are expected to reach the current lifetime maximum. Members who are eligible for Medicare are generally less likely to reach the lifetime maximum since Medicare provides primary coverage and the AlaskaCare plan provides secondary coverage (for those benefits that are not covered by Medicare). As mentioned above, the overall cost to the plan is sensitive to the attribution of the cost between pre-Medicare / Medicare members. To illustrate the impact of the attribution, we modeled the following two scenarios:

- 10% of the cost impact attributable to Medicare members / 90% attributable to non-Medicare members
- 20% of the cost impact attributable to Medicare members / 80% attributable to non-Medicare members

Shown in the table below is a summary of the estimated increase in healthcare Actuarial Accrued Liability (AAL) for PERS, TRS, and JRS combined, the projected increase in Additional State Contributions (ASC) for FY25 if this change had been reflected in the June 30, 2022 valuations, and the projected increase in ASC through 2039. It is important to note that the June 30, 2022 valuations and FY25 contribution rates (which determine the FY25 ASC) have not yet been formally approved by the Alaska Retirement Management Board (Board). The June 30, 2022 valuation results are expected to be approved during the June 2023 Board meeting, and the FY25 contribution rates will be adopted during the September 2023 Board meeting. Impacts are also shown as a percentage increase/(decrease). See Appendix A for the impacts split by plan.

FY22 Healthcare AAL Impact on Combined PERS/TRS/JRS DB if Lifetime Maximum ("LTM") Increased ($ millions)					
Scenario	(LTM) Lifetime Maximum	% of LTM Cost Assumed for Non-Medicare	Current Healthcare AAL for Combined DB as of 6/30/2022[1]	Increase in 6/30/2022 AAL if LTM Increased[2]	% Increase in 6/30/2022 AAL
1	$8M	90%	$9,117.7	$22.9	0.25%
2	$8M	80%	$9,117.7	$25.6	0.28%
3	Unlimited	90%	$9,117.7	$26.5	0.29%
4	Unlimited	80%	$9,117.7	$29.3	0.32%

FY25 Impact on Combined PERS/TRS/JRS DB Contributions if Lifetime Maximum ("LTM") Increased ($ millions)					
Scenario	(LTM) Lifetime Maximum	% of LTM Cost Assumed for Non-Medicare	Pension and Healthcare Current FY25 Contributions for Combined DB[1]	Increase in FY25 Contributions if LTM Increased[2,3]	% Increase in FY25 Contributions
1	$8M	90%	$486.9	$0.3	0.06%
2	$8M	80%	$486.9	$0.3	0.06%
3	Unlimited	90%	$486.9	$0.3	0.06%
4	Unlimited	80%	$486.9	$0.3	0.06%

FY25-39 Impact on Combined PERS/TRS/JRS DB Contributions if Lifetime Maximum ("LTM") Increased ($ millions)					
Scenario	(LTM) Lifetime Maximum	% of LTM Cost Assumed for Non-Medicare	Pension and Healthcare Current FY25-39 Contributions for Combined DB[1]	Increase in FY25-39 Contributions if LTM Increased[2]	% Increase in FY25-FY39 Contributions
1	$8M	90%	$8,697.0	$1.7	0.02%
2	$8M	80%	$8,697.0	$1.7	0.02%
3	Unlimited	90%	$8,697.0	$2.0	0.02%
4	Unlimited	80%	$8,697.0	$2.0	0.02%

[1] Current AAL shown includes only Healthcare. Current and projected contributions include both Healthcare and Pension reflecting State as an Employer and Additional State Contributions.

[2] All of the data, assumptions, methods and current plan provisions used in the above calculations are documented in the actuarial valuation reports as of June 30, 2022.

[3] The increases are the same due to rounding. Because the healthcare portions of these plans are currently overfunded, the increases in FY25 ASC for PERS and TRS reflects the increase in Normal Cost only. If the healthcare portions of these plans were not overfunded and the increases in AAL were to be amortized over 25 years according to the Board's current funding policy, the total increases in FY25 ASC would be approximately $1.8M under Scenario 1, $1.9M under Scenario 2, $2.0M under Scenario 3, and $2.2M under Scenario 4.

Additional Notes

Except as noted above, the data, assumptions, methods and plan provisions used in our analysis are the same as those described in the June 30, 2022 actuarial valuation reports.

The Retiree Health Plan Advisory Board (RHPAB), staff of the State of Alaska and the Board may use this letter for purposes of analyzing the potential impact of the benefit change described above. Use of this letter for any other purpose or by anyone other than the RHPAB, staff of the State of Alaska or the Board may not be appropriate and may result in mistaken conclusions because of failure to understand applicable assumptions, methods or inapplicability of the letter for that purpose. Because of the risk of misinterpretation of actuarial results, Buck recommends requesting its advanced review of any statement to be based on information contained in this letter. Buck will accept no liability for any such statement made without its prior review.

Future actuarial measurements may differ significantly from current measurements presented in this letter due to plan experience differing from that anticipated by the actuarial assumptions, changes expected as part of the natural operation of the methodology used for these measurements, and changes in plan provisions or applicable law. In particular, retiree group benefits models necessarily rely on the use of approximations and estimates and are sensitive to changes in these approximations and estimates. Small variations in these approximations and estimates may lead to significant changes in actuarial measurements. An analysis of the potential range of such future differences is beyond the scope of this letter.

Actuarial Certification

This letter was prepared under our supervision and in accordance with all applicable Actuarial Standards of Practice. We are Associates of the Society of Actuaries and Members of the American Academy of Actuaries. We meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinions contained herein.

If there are any questions, Stephen can be reached at (215) 586-1227 and Christian can be reached at (717) 308-8981.

Respectfully submitted,

Stephen Oates, ASA, EA, MAAA, FCA
Principal, Health
Buck

Christian Hershey, ASA, MAAA
Senior Consultant, Health
Buck

Appendix A – Summary of Impacts Split by Plan

	$8M Lifetime Maximum			
	Scenario 1 10% Medicare / 90% non-Medicare		Scenario 2 20% Medicare / 80% non-Medicare	
($ millions)	$ Impact	% Impact[1]	$ Impact	% Impact[1]
Increase in Healthcare AAL as of June 30, 2022[2]				
PERS	$16.6	0.25%	$18.6	0.28%
TRS	6.3	0.26%	7.0	0.29%
JRS[3]	0.0	0.20%	0.0	0.24%
Total	$22.9		$25.6	
Increase in FY25 ASC[2, 4]				
PERS	$ 0.2	0.06%	$ 0.2	0.06%
TRS	0.1	0.05%	0.1	0.05%
JRS[3]	0.0	0.00%	0.0	0.00%
Total	$ 0.3		$ 0.3	
Increase in ASC through FY39[2]				
PERS	$ 1.3	0.02%	$ 1.3	0.02%
TRS	0.4	0.02%	0.4	0.02%
JRS[3]	0.0	0.00%	0.0	0.00%
Total	$ 1.7		$ 1.7	

[1] Increase in Healthcare AAL as a percentage of the June 30, 2022 Healthcare AAL. Increase in FY25 ASC as a percentage of the FY25 Contributions for Pension and Healthcare. Increase in ASC through FY39 as a percentage of the projected Contributions for Pension and Healthcare through FY39. Current and projected Contributions include both Healthcare and Pension reflecting State as an Employer and Additional State Contributions.

[2] All of the data, assumptions, methods and current plan provisions used in the above calculations are documented in the actuarial valuation reports as of June 30, 2022.

[3] The amount rounds to less than $0.1M where $0.0 is shown.

[4] The increases are the same due to rounding. Because the healthcare portions of these plans are currently overfunded, the increases in FY25 ASC for PERS and TRS reflects the increase in Normal Cost only. If the healthcare portions of these plans were not overfunded and the increases in AAL were to be amortized over 25 years according to the Board's current funding policy, the total increases in FY25 ASC would be approximately $1.8M under Scenario 1 and $1.9M under Scenario 2.

	Elimination of Lifetime Maximum			
	Scenario 3 10% Medicare / 90% non-Medicare		Scenario 4 20% Medicare / 80% non-Medicare	
($ millions)	**$ Impact**	**% Impact[1]**	**$ Impact**	**% Impact[1]**
Increase in Healthcare AAL as of June 30, 2022[2]				
PERS	$19.2	0.29%	$21.2	0.32%
TRS	7.3	0.30%	8.0	0.33%
JRS[3]	0.0	0.23%	0.1	0.28%
Total	$26.5		$29.3	
Increase in FY25 ASC[2, 4]				
PERS	$ 0.2	0.07%	$ 0.2	0.07%
TRS	0.1	0.06%	0.1	0.06%
JRS[3]	0.0	0.00%	0.0	0.00%
Total	$ 0.3		$ 0.3	
Increase in ASC through FY39[2]				
PERS	$ 1.5	0.02%	$ 1.5	0.02%
TRS	0.5	0.02%	0.5	0.02%
JRS[3]	0.0	0.00%	0.0	0.00%
Total	$ 2.0		$ 2.0	

[1] Increase in Healthcare AAL as a percentage of the June 30, 2022 Healthcare AAL. Increase in FY25 ASC as a percentage of the FY25 Contributions for Pension and Healthcare. Increase in ASC through FY39 as a percentage of the projected Contributions for Pension and Healthcare through FY39. Current and projected Contributions include both Healthcare and Pension reflecting State as an Employer and Additional State Contributions

[2] All of the data, assumptions, methods and current plan provisions used in the above calculations are documented in the actuarial valuation reports as of June 30, 2022.

[3] The amount rounds to less than $0.1M where $0.0 is shown.

[4] The increases are the same due to rounding. Because the healthcare portions of these plans are currently overfunded, the increases in FY25 ASC for PERS and TRS reflects the increase in Normal Cost only. If the healthcare portions of these plans were not overfunded and the increases in AAL were to be amortized over 25 years according to the Board's current funding policy, the total increases in FY25 ASC would be approximately $2.0M under Scenario 3 and $2.2M under Scenario 4.

Proposal # and Title	Supplemental Non-Emergent Surgery and Travel Benefits (R001)
Health Plan Affected	Defined Benefit Retiree Plan
Proposed Effective Date	TBD (January 2024-December 2024)
Reviewed By	Retiree Health Plan Advisory Board – Modernization Subcommittee
Review Date	May 5, 2023

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1) Background

Many AlaskaCare Defined Benefit retiree health plan (Plan) members travel to access medical care. A large portion of the membership lives in Alaska or rural areas where they do not always have local access to the medical care they require. As a result, these members may have no choice but to travel outside their community to obtain certain types of medical care. For others, they may prefer to travel to obtain care that is less expensive than the care available in their community, or to obtain care from a specific provider or facility located outside their community.

Current Travel Coverage

The Plan provides members limited coverage for certain travel costs when members need to travel away from their home to obtain care. The expenses eligible for coverage and the portions of covered travel costs vary depending on the qualified travel circumstances but are typically limited to airfare costs only. Lodging, per diem expenses, and travel for a companion are rarely eligible for coverage.

The Plan currently covers member health related travel costs within the contiguous limits of the United States, Alaska, and Hawaii. Coverage is limited to the member receiving care, unless a companion benefit is clearly stated or authorized by the plan administrator (e.g. a travel companion for a minor) and includes:[1]

a) Transportation to the nearest hospital by professional ambulance.
b) Round-trip transportation, not exceeding the cost of coach class commercial air transportation, to the nearest professional treatment.
c) Documented travel expenses for ground transportation including fares, mileage, food and lodging for the most direct route if ground transportation and the most direct one-way distance exceeds 100 miles. This applies only while the member is in transit and ends once they arrive at the location of treatment.

The plan provides coverage in the following circumstances:

a) Emergencies
b) Treatment not available locally. Treatment must be received for travel to be covered.
c) Second surgical opinions which cannot be obtained locally.
d) Surgery provided less expensively in another location.

In most circumstances, travel costs do not include the following:

a) Travel for a companion
b) Lodging
c) Food
d) Other transportation costs

Currently, in order to enable the Plan's claims administrator to determine the maximum payable airfare benefit, travel in most circumstances must be precertified. If travel is not precertified, eligible travel expenses will be paid up to $500 (not to exceed actual eligible costs). The plan does not pay for travel costs up front, the member is required to front those costs and submit them for reimbursement following completion of the trip.

[1] For full travel coverage details, see: Retiree Insurance Information Booklet, *Section 3.3.18 Travel*, January 2023. pg. 56-60. https://drb.alaska.gov/docs/booklets/DB-RetireeInsuranceBooklet_WEB.pdf.

Members traveling to seek care may see the provider of their choice. Except for transplant and Gene-based Cellular and Other Innovative Therapies (GCIT) services, the plan does not currently passively or actively steer members to providers or facilities who have demonstrated they meet certain quality or outcome metrics or offer members access to decision support tools to seek out high-quality providers and facilities.

Supplemental Non-Emergent Surgery & Travel Programs

Recognizing that traveling to seek care often enables members to visit providers best suited to meet their health needs, many health plans, including the AlaskaCare Employee Health Plan (employee plan) have implemented programs to ease the burden of travel, and to incentivize use of providers who meet certain quality and cost metrics. Plans report benefits from this model including avoided unnecessary procedures, reduced complication and readmittance rates, and discounted costs.[2]

These programs are intended to support members when accessing care outside their community by streamlining the travel process, expanding eligible travel expenses in specific circumstances, providing care coordination support, connecting members to a network of high-quality providers, and ensuring services are provided at cost-effective prices.

2) Goals and Objectives

1. Connect members with specialists that may not be available locally, and who have been vetted against stringent quality measures.
2. Expand travel expenses eligible for Plan coverage in certain circumstances.
3. Streamline the administrative and coordination tasks for members requiring non-emergent surgery.
4. Enhance patient outcomes through reduced complication rates based on the quality of providers available to members through specialized networks.
5. Drive value through competitive pricing.

3) Summary of Proposed Change

This proposal considers adding an optional supplemental travel program coupled with access to a narrow, high-quality network of providers and facilities delivering non-emergency surgical services to the Plan. This proposal does not contemplate changing or updating the standard travel benefits detailed in *Section 3.3.18 Travel* in the AlaskaCare Retiree Insurance Information Booklet.[3] The proposed program would be supplemental to all existing benefits.

The proposed program would:

1. Provide access to dedicated care advocates to assist members with provider selection, care coordination, and travel arrangements.
2. Provide access to a high-quality network of providers.

[2] Jonathan R. Slotkin, Olivia A. Ross, M. Ruth Coleman, and Jaewon Ryu. *Why GE, Boeing, Lowe's, and Walmart Are Directly Buying Health Care for Employees.* Harvard Business Review. June 08, 2017. https://hbr.org/2017/06/why-ge-boeing-lowes-and-walmart-are-directly-buying-health-care-for-employees

[3] Retiree Insurance Information Booklet, *Section 3.3.18 Travel*, January 2023. pg. 56-60. https://drb.alaska.gov/docs/booklets/DB-RetireeInsuranceBooklet_WEB.pdf.

3. Ease the travel process by coordinating and pre-paying the travel itinerary for the member and a traveling companion for services provided through the program.
4. Bring savings to the Plan through discounted rates.

Currently, the Division has contracted with SurgeryPlus to act as a Third-Party Administrator (TPA) and administer this program for active employee plan members. This proposal contemplates implementing the proposed change by expanding the SurgeryPlus service offering to retiree plan members. As with all AlaskaCare contracted TPA services, the contract currently held by SurgeryPlus will be periodically competitively bid, and a different TPA may administer this program in the future based on the outcome of the procurement process.

SurgeryPlus Overview

SurgeryPlus has developed a network of providers across the United States that meet certain stringent quality criteria, both objective and subjective. These criteria include verification of licensure, board certification, completion of a fellowship, no state sanctions, a reputational review, passage of a comprehensive malpractice review, and a demonstrated complication rate of less than 1% over the past five years. SurgeryPlus negotiates deeply discounted case rates with these high-quality providers for specific non-emergent services and procedures.

SurgeryPlus' care advocates serve as a single point of contact for members. When members require an elective surgery, they can contact SurgeryPlus to see if the procedure they are seeking is offered through the SurgeryPlus network. If so, a dedicated care advocate will assist the member.

Member's lodging will be covered for a necessary duration as determined by the surgeon. After the member completes the procedure and travels home, follow up care can be provided through their primary care physician or other appropriate local providers, combined with telehealth services as needed. If necessary, the member can travel back to the surgeon for needed follow up care.

Advantages of using the SurgeryPlus benefit include:

- A dedicated care advocate.
- Recommendations to SurgeryPlus network providers, and to Medicare accepting SurgeryPlus network providers.
- Better outcomes with procedure volume requirements and lower complication rates.
- Coordinated travel itinerary.
- Hotel and flights are booked and pre-paid by SurgeryPlus.
- Debit card with applicable travel funds.
- Accessing care from high-quality providers who have agreed to competitive rates brings cost savings to the member and to the plan.

Episode of Care

An episode of care under the SurgeryPlus benefit can be considered in two categories:

1. Care Coordination and Travel: Includes quality provider recommendations and care coordination from a dedicated Care Advocate, all travel expenses for travel arrangements made through SurgeryPlus (see "Travel Benefits" section below for more detail).

2. Medical Expenses: Includes all services and treatments administered from admission to discharge at the selected venue for a procedure, as well as the pre-operative and post-operative consultations with the SurgeryPlus provider. Any medical services received outside of the episode of care would be covered under the other provisions of the medical plan.

For non-Medicare-eligible members, a SurgeryPlus episode of care includes both the care coordination/travel expenses, and the medical expenses associated with the procedure.

For Medicare-eligible members, a SurgeryPlus episode of care includes the care coordination and travel expenses. To ensure appropriate coordination with Medicare, the medical expenses associated with the procedure will pay under the standard medical benefit and must first be submitted to Medicare before consideration by AlaskaCare.

Member Cost Share

All expenses included in a Surgery Plus Episode of Care will be subject to the Plan's standard cost share.

Table 1. AlaskaCare Retiree Health Plan Member Cost Share[4]

Deductible	Coinsurance	Out-Of-Pocket Maximum
$150	80%	$800; applies after the deductible is satisfied

While a review of other plans' experience with similar benefits has shown that there is a correlation between higher member participation in a travel surgical program and lower member cost share for the associated services, this proposal maintains the plans' current standard cost share provisions due to this program being offered as an optional benefit.

SurgeryPlus Covered Services and Procedures

SurgeryPlus provides coverage for non-emergent procedures, including but not limited to the common procedures listed below. The full list of procedures available will vary based on the current capabilities of SurgeryPlus' network of providers, or any future TPA's network of providers.

Table 2. Common SurgeryPlus Covered Services and Procedures

AREA	PROCEDURE TYPES	
KNEE	• Knee Replacement • Knee Replacement Revision	• Knee Arthroscopy • ACL/MCL/PCL Repair
HIP	• Hip Replacement • Hip Replacement Revision	• Hip Arthroscopy
SHOULDER	• Shoulder Replacement • Shoulder Arthroscopy	• Rotator Cuff Repair • Bicep Tendon Repair
FOOT AND ANKLE	• Ankle Replacement • Bunionectomy • Hammer Toe Repair	• Ankle Fusion • Ankle Arthroscopy

[4] Retiree Insurance Information Booklet, *Section 1.1 Medical Benefits*, January 2023. pg. 2-4. https://drb.alaska.gov/docs/booklets/DB-RetireeInsuranceBooklet_WEB.pdf.

SPINE	• Laminectomy/Laminotomy • Anterior Lumbar Interbody Fusion • Posterior Lumbar Interbody Fusion	• Anterior Cervical Disk Fusion • 360 Spinal Fusion • Artificial Disk
WRIST AND ELBOW	• Elbow Replacement • Elbow Fusion • Wrist Fusion	• Wrist Replacement • Carpal Tunnel Release
GENERAL SURGERY	• Gallbladder Removal • Hernia Repair	• Thyroidectomy
GASTROINTESTINAL	• Colonoscopy • Endoscopy	
GYNECOLOGY	• Hysterectomy • Bladder Repair	• Hysteroscopy
BARIATRIC	• Gastric Bypass • Laparoscopic Gastric Bypass	• Laparoscopic Sleeve Gastrectomy
EAR/NOSE/THROAT	• Ear Tube Insertion (Ear Infection) • Septoplasty	• Thyroidectomy • Sinuplasty

Care Coordination

After a member reaches out to SurgeryPlus to access their benefit, SurgeryPlus care advocates provide an initial list of providers who are best suited to perform the procedure. For Medicare-eligible members, the care advocates will provide recommendations for SurgeryPlus-contracted providers who accept Medicare.

When a member selects one of the SurgeryPlus-recommended providers, their care advocate will work with the member to arrange for the transfer of the member's medical records to the selected provider who will review the case. Upon review, if the provider accepts the case, SurgeryPlus will begin to schedule the procedure and make arrangements for the member's travel. The member will receive assistance with everything from scheduling to billing, with the intent to make the experience easier at every step. This care advocate will continue to assist the member through their end-to-end surgical journey and into recovery.

Travel Benefits

Members utilizing the SurgeryPlus benefit would receive plan coverage for additional travel expenses beyond what is covered under the standard benefit, including coverage for a companion's travel expenses.

Only travel arrangements made through the SurgeryPlus Care Advocate are eligible for coverage under the SurgeryPlus benefits. The specific travel benefit depends on the procedure, the provider and the distance between the provider and a member's residence.

Covered expenses may include the following as arranged by SurgeryPlus:

1. Roundtrip coach class commercial air transportation for patient.
2. Roundtrip coach class commercial air transportation for one companion.
3. Assistance with transportation costs to and from the airport to appointments.
4. Lodging away from home while traveling to receive pre-operative consult services, procedures covered under the SurgeryPlus benefits, and post-procedural consults. Lodging away from home

will be covered until such time as the provider has advised that the patient is cleared to travel and does not require a near term in-person visit with the treating provider, or in any case where the member does not have easy access to primary care.

5. Pre-loaded debit card to cover $25 per patient per day ($50 per day for patient & companion) for meals and incidental expenses while traveling away from home to receive services covered under the SurgeryPlus benefits, during the stay to obtain a SurgeryPlus Episode of Care, and to assist with travel expenses from the place of care to the member's place of residence.
6. When a member uses ground transportation in lieu of air travel, and the most direct one-way distance:
    a. is less than 100 miles from the member's residence, the member receives a pre-loaded debit card of $25 to help with fuel,
    b. exceeds 100 miles but is less than 200 miles from the member's residence, the member receives a pre-loaded debit card of $50 to help with fuel,
    c. exceeds 200 miles from the member's residence, the member receives a pre-loaded debit card of $100 to help with fuel.

Limitations

Certain examinations, tests, treatments or other medical services may be required prior to, or following, a planned medical procedure with a SurgeryPlus provider. Any medical services performed by anyone other than a SurgeryPlus provider, including pre- and post-care, will be subject to the coverage provisions and other terms of the medical plan.

SurgeryPlus Episode of Care does not cover:

1. diagnostic testing in advance to determine whether a procedure is necessary;
2. convenience expenses;
3. procedures or care that are not medically necessary; and
4. treatment for any complications that arise during an episode of care that requires the member to be discharged from the facility and transported via ambulance to an appropriate venue (*e.g.*, Emergency Room).

After an Episode of Care, if a member needs emergency care for any reason, that care would be covered under the standard terms of the Plan.

SurgeryPlus travel benefits may not be used in conjunction with other AlaskaCare travel benefits provided by the Plan. SurgeryPlus travel benefits cannot be combined with travel benefits provided by other plans, and these benefits do not coordinate with other primary or secondary plans.

Coverage Scenarios

Coverage Scenario 1 – SurgeryPlus Network Provider

If a member receives services from a SurgeryPlus network provider, the member will be eligible for SurgeryPlus benefits. For common procedure types provided in locations most utilized by Alaska-based members, overlap between the SurgeryPlus provider network and Medicare is 100%.

Coverage Scenario 2 - Surgical Care Outside of the SurgeryPlus Program

Members have the right to obtain care from any provider they choose. If a member elects to seek surgical care outside of the SurgeryPlus program, standard plan provisions apply. A member is ***not eligible***

for the additional benefits provided by this program if they elect not to see a SurgeryPlus network provider or SurgeryPlus approved provider, or do not schedule or obtain their services through SurgeryPlus.

4) Analysis

The expansion of covered travel costs in certain circumstances will benefit the membership and will ease the process for people who need to seek care outside of their community. The addition of a supplemental, narrow, travel-related network will provide members with access to surgeons who demonstrate they meet and maintain a combination of objective and subjective quality metrics. For Medicare-eligible members, the additional support and provider recommendations will help them to identify the Medicare-accepting provider best suited to deliver the care they need.

Note: These benefits are available to be added based on services being offered by a third-party provider (currently SurgeryPlus). The ability to continue to offer them is dependent on the continued availability of third-party service providers offering these or similar services. If this service model changes in the future, the plan benefit will be impacted.

Members Traveling Now for Care

The Division estimates that utilization of travel benefits provided through SurgeryPlus will increase from travel claims today. However, it is difficult to predict with certainty what the actual usage will be.

Member requested travel reimbursement has been trending down. Due to COVID-19, there was a decline in in-person medical services and elective surgeries during 2020 and 2021 as well as a decline in members seeking travel reimbursement.

Table 3. AlaskaCare Retiree Health Plan Travel Expense Claims

Year	Number of Travel Claims	Total Spend on Travel Claims
2022 (Q1 and Q2 only)	224	$45,698
2021	444	$100,780
2020	402	$77,483
2019	624	$115,994
2018	822	$92,851

The above table may not fully reflect the volume of members traveling to receive care. Factors that can impact member utilization of travel benefits include:

A. Members may have traveled to receive care, but were denied coverage for their travel expenses due to a failure to precertify their travel;
B. Members may have traveled to receive care and not realized their travel expenses were eligible for coverage and therefore did not apply for reimbursement;

Employee Plan Experience with SurgeryPlus

SurgeryPlus benefits were implemented on August 1, 2018 for the AlaskaCare employee plan and have been quite successful. From 2018 through 2022, 166 procedures were completed, resulting in combined

savings of nearly $6 million[5].

Table 4. AlaskaCare Employee Plan: SurgeryPlus Highlights

Lifetime Utilization Metrics	166 completed procedures
Lifetime ROI	7.51X
Lifetime Savings Metrics	$5,989,257 in Procedure Savings $527,824 in Avoided Procedures $900,093 in Avoided Complications
SOA Member Survey Results	Overall rating on the benefit: *Very Positive* How likely are you to recommend the benefit: *10/10* Most important factor to choosing SurgeryPlus: *Cost and Care Advocacy*

5) Impacts

Actuarial Impact | Neutral

Decrease | Neutral | Increase

The proposed program would result in enhancements to the plan that are favorable for members and promote efficient utilization of services. However, as this proposal does not suggest changes to how a member's cost share for medical services is calculated, the actuarial impact will be neutral. This impact is discussed in the attached Segal Consulting memorandum.[6]

Financial Impact | Cost Decrease

Decrease | Neutral | Increase

Projected Annual Financial Impact

Based on book of business data provided by SurgeryPlus, it is estimated that approximately 400 procedures (20% of eligible procedures) annually will be provided through the SurgeryPlus program, resulting in savings due to the utilization of lower cost providers and fewer associated complications. Offset by contractual administrative expenses and assuming an average of $3,000 per procedure in travel costs, it is estimated there will be approximately $2,800,000 in annual savings to the Plan associated with the SurgeryPlus program. This estimate is discussed in the attached Segal Consulting memorandum.[7]

Projected Long-Term Financial Impact

The cost decrease associated with the proposed benefit additions may have long-term impacts to the healthcare Actuarial Accrued Liability (AAL)[8] and to the Additional State Contributions (ASC) associated with the Plan.

In an illustrative example, the tables below summarize the estimated impact on the healthcare AAL for the Public Employees Retirement System (PERS), Teachers Retirement System (TRS), and Judicial

[5] SurgeryPlus utilization 2018 through year-to-date November 2022.
[6] Segal Consulting Memorandum, *Travel Benefits Focus on Actuarial and Financial Impact for the Retiree Plan*, December 21, 2022.
[7] Ibid.
[8] AAL: The health Actuarial Accrued Liability is equal to the total accumulated cost to fund the postemployment benefits arising from service in all prior years.

Retirement System (JRS) combined and the estimated impact on the ASC for FY25. These estimates, along with the projected impact on the ASC through 2039 if this change had been reflected in the June 30, 2022, valuations are discussed in the attached Buck memorandum.[9]

It is important to note that the June 30, 2022, valuations and FY25 contribution rates (which determine the FY25 ASC) have not yet been formally approved by the Alaska Retirement Management Board (Board). The June 30, 2022, valuation results are expected to be approved during the June 2023 Board meeting, and the FY25 contribution rates will be adopted during the September 2023 Board meeting. Impacts are also shown as a percentage (decrease).[10]

The projected healthcare AAL for the defined benefit retiree systems combined (PERS, TRS, and JRS) as of the June 30, 2022, valuation is $9,117.7 million. Contemplating a scenario where SurgeryPlus was implemented for the retiree plan, the illustrative impact on the AAL is a decrease of $14.4 million. This represents a -0.16% impact on the overall AAL.

Table 5. FY22 Healthcare AAL Illustrative Impact on Combined PERS/TRS/JRS DB if SurgeryPlus Implemented ($ millions)

Scenario		Current Healthcare AAL for Combined DB as of 6/30/2022	(Decrease) in 6/30/2022 AAL	% (Decrease) in 6/30/2022 AAL
1	SurgeryPlus Implemented	$9,117.7	($14.4)	(0.16%)

The ASC is a mechanism for the State to provide payment assistance to participating employers' Actuarially Determined Contribution (ADC). The ADC is determined by adding the normal cost[11] to the amount needed to offset the amortization of any existing unfunded accrued liability over a period of 25 years.

Contemplating a scenario where SurgeryPlus was implemented for the retiree plan, the illustrative impact on the ASC for FY25 was a decrease of $300k, representing a -0.07% percent change.

Table 6. FY25 Impact on Combined PERS/TRS/JRS DB Contributions if SurgeryPlus Implemented ($ millions)

Scenario		Pension and Healthcare Current FY25 Contributions for Combined DB	(Decrease) in FY25 Additional State Contributions if Hinge Health Added	% (Decrease) in FY25 Contributions
1	SurgeryPlus Implemented	$486.9	($0.3)	(0. 07%)

The illustrative decrease to the FY25 ASC is associated with the normal cost only. The current overfunded status of retiree health care liabilities has eliminated the immediate need for amortization payments to offset any health care unfunded liability. It is important to note that the long-term funded status of the trusts is subject to change in response to market volatility and many other factors.

[9] Buck Memorandum, *Impact of Adding an Optional Supplemental Travel Program through SurgeryPlus for AlaskaCare Retiree Health Plan*, March 3, 2023.
[10] Ibid.
[11] The normal cost represents the present value of benefits earned by active employees during the current year.

Member Impact | Enhancement

Members would benefit from the addition of this program, as it would provide additional financial assistance in covering the cost of travel for themselves and a companion. It will facilitate access for members requiring care from specialists that are not available locally. It may also result in better outcomes through reduced complication rates due to the provider quality of the SurgeryPlus network. It can be difficult to identify the best physician or surgeon for a procedure and tools to do so are limited. The physician credentialing and recommendations along with the scheduling assistance and care coordination can assist members in navigating that process.

- SurgeryPlus does not currently have any Alaska-based providers in their network. Any Alaska-based member using SurgeryPlus to receive care would need to travel out of state.[12]
- Members utilizing SurgeryPlus would not have to pay out of pocket for their eligible travel expenses and seek reimbursement later. While the travel benefits available to members under this program would be different from the current travel coverage offered under the Plan, the addition of this program does not represent a change to covered medical expenses.

Non-Medicare Eligible Members

Members who are not eligible for Medicare will benefit from the expanded coverage for travel expenses, the care coordination services, and from the anticipated positive outcomes associated with high quality care from the SurgeryPlus network of providers.

Members will be required to pay any applicable deductible and coinsurance to SurgeryPlus prior to receiving care, but then all travel and medical costs will be covered by SurgeryPlus. The member will not have to pay bills after their procedure and will not have to cover the cost of their travel up front and submit for reimbursement after the fact.

Medicare Eligible Members

Under normal plan provisions Medicare eligible members can seek services from any provider that accepts Medicare, and any services provided would be subject to Medicare's fee schedule.

However, if the member seeks care from a SurgeryPlus network provider that also accepts Medicare, the member will be able to utilize SurgeryPlus for travel arrangement and care coordination. SurgeryPlus' care advocates can offer Medicare-accepting provider recommendations from within the providers who participate in the SurgeryPlus network.

As detailed in Figure 1, for the common procedure types for markets most utilized by Alaska-based members, overlap between the SurgeryPlus provider network and Medicare is 100%. This information is not representative of all markets where SurgeryPlus' provider network is active, rather it is meant to provide an overview of key markets with direct flights from areas where AlaskaCare members are concentrated. SurgeryPlus has confirmed that within each covered procedure category, the network has providers that can accept Medicare primary patients.

[12] SurgeryPlus is willing to begin contracting discussions with any Alaska-based providers that meet the credentialing requirements.

Figure 1. Medicare Accepting Providers in Current Surgery Plus Network; Key Markets

Geo-Access Case Study for Medicare

Medicare Accepting Providers in Current SurgeryPlus Network

	Joint	Spine	General	Cardiac
Seattle	100% Accept Medicare	100% Accept Medicare	100% Accept Medicare	100% Accept Medicare
Phoenix	100% Accept Medicare	100% Accept Medicare	100% Accept Medicare	100% Accept Medicare
Los Angeles	100% Accept Medicare	100% Accept Medicare	100% Accept Medicare	NA
Chicago	100% Accept Medicare	100% Accept Medicare	100% Accept Medicare	NA

Medicare does not cover travel, so the expansion of travel coverage beyond the standard benefit to include costs for a member and companion will provide a better benefit to members who are Medicare eligible.

Operational Impact (DRB) | Neutral

Decrease | Neutral | Increase

The Division anticipates moderate operational impacts initially during the implementation process, with minimal ongoing impact as the SurgeryPlus program is already provided to Employee Plan members. The combined teams have completed a successful implementation and transition to operations. Though all parties (the Division, SurgeryPlus, Aetna) currently coordinate to cover care for Employee Plan members, scaling operational tasks to include the retiree population will require a greater degree of collaboration and fine tuning of existing processes.

Staff will need to oversee expansion of SurgeryPlus' services offering to the retiree plan population, resulting in a minor increase to the routine work to administer and monitor the benefit including quality control, reporting, billing, responding to eligibility questions, and communications.

Operational Impact (TPA) | Increase

Decrease | Neutral | Increase

The impact to the medical Third-Party Administrator (TPA), Aetna is anticipated to be high for several reasons:

- Aetna will need to enhance and streamline the coordination activities with an external vendor (SurgeryPlus) to share member accumulator data, eligibility, and claims data.
- Aetna will provide eligibility to the external vendor.
- Aetna will need to maintain its existing process for travel claims administration in parallel with the additional services provided by the external vendor.

The impact to the current supplemental travel and non-emergent surgery benefit administrator (SurgeryPlus) is anticipated to be high for several reasons:

- SurgeryPlus will need to enhance and streamline the coordination activities with the medical TPA to share member accumulator data, eligibility, and claims data.
- SurgeryPlus will need to scale its operations to effectively service a larger population than it does today for the State.

6) Considerations

Clinical Considerations

These changes are anticipated to result in overall better quality of care for members. Surgery Plus drives value and positive patient outcomes by only contracting with providers that meet strict quality standards. Not only must providers be licensed, board certified, fellowship trained, have no state sanctions, and pass reputational and malpractice reviews, but they and the facility they practice at must meet additional quality metrics related to procedure-specific volume, patient support programs, complication, outcome, and readmission rates, and more.[13]

Across their book of business, SurgeryPlus reports a <1% complication rate for joint, spine, bariatric, and general procedures, while the industry complication rate for the same procedure categories ranges from 8 – 15%.[14]

Provider Considerations

The expansion of travel benefits, particularly the SurgeryPlus program, could create additional competition in the Alaska medical marketplace as providers compete with those offering the same services outside of their community. This could result in reduced costs and better services as providers work to remain competitive. Alternatively, as members in small communities seek care elsewhere, any fixed cost for providing those services could be spread across a smaller number of patients increasing costs for those who receive care at home.

7) Implementation and Communication Overview

Division staff have already worked with SurgeryPlus to successfully implement this program beginning August 1, 2018 for the AlaskaCare employee plan.

The travel and surgery coverage benefit is not dependent on alignment with the start of a plan year, and could be added mid-year. Of note is a seasonal trend of when more surgical procedures are typically performed, which is in the fourth quarter of the year.

Division staff will follow the standard process for making changes to the Defined Benefit retiree plan, which includes completion of the following:

- Proposal analysis and stakeholder input
- Public comment period(s)
- Any needed language updates to the Retiree Insurance Information Booklet
- Education outreach to benefit recipients

[13] SurgeryPlus presentation to RHPAB. Transforming Access to Excellent Care. November 3, 2022. p 9.
[14] Ibid. p 10.

Due to the level of coordination and integration required between the current medical Third-Party Administrator and the supplemental non-emergent surgery and travel benefit administrator, the implementation process will be critical to ensure smooth service delivery. The effective date of this benefit addition will be dependent on the implementation process and will be set once all parties have scoped the work and timeline to ensure a successful launch. Implementation is initially targeted for the first half of 2024.

8) Proposal Recommendations

DRB Recommendation

The Division recommends/does not recommend implementation of the supplemental non-emergent surgery & travel programs.

RHPAB Board Recommendation

The RHPAB board voted on ##/##/## to recommend/not to recommend implementation of the supplemental non-emergent surgery & travel programs.

Commissioner of Administration Recommendation

The plan administrator made the determination on ##/##/## to recommend/not to recommend implementation of the supplemental non-emergent surgery & travel programs.

Description	Date
Proposal Drafted	07/20/2018
Reviewed by Modernization Subcommittee	08/10/2018, 09/28/2018, 10/30/2018, 04/23/2019, 06/12/2019, 1/4/2022
Reviewed by RHPAB	08/29/2018, 11/28/2018, 02/06/2019, 05/08/2019, 08/07/2019, 05/04/2023

9) Plan Language

New language for the Retiree Health Plan will need to be drafted.

Memorandum

To: Ajay Desai, Director, Division of Retirement and Benefits

From: Richard Ward, FSA, FCA, MAAA

Date: December 21, 2022

Re: Travel Benefits – Focus on Actuarial and Financial Impact for the Retiree Plan

The AlaskaCare Retiree Plan currently reimburses for coach airfare associated with select services and treatments. Precertification is required and travel is restricted to the treatment facility. The Plan does not reimburse members if airline miles are used to purchase tickets, nor does it reimburse for the cost of food, lodging, or local ground transportation such as airport shuttles, cabs or rental cars.

The Plan applies the general benefit provisions, such as deductible, coinsurance and out-of-pocket limits, to determine any portion of the costs that are the member's responsibility. If the member has additional coverage, such as Medicare or other employer provided coverage, any portion of the costs covered by that plan is also considered.

Below is a table outlining the current benefits offered under the Plan:

Deductibles	
Annual individual / family unit deductible	$150 / up to 3x per family
Coinsurance	
Most medical expenses	80%
Most medical expenses after out-of-pocket limit is satisfied	100%
Second surgical opinions, Preoperative testing, Outpatient testing/surgery • No deductible applies	100%
Out-of-Pocket Limit	
Annual individual out-of-pocket limit • Applies after the deductible is satisfied • Expenses paid at a coinsurance rate other than 80% do not apply against the out-of-pocket limit	$800
Benefit Maximums	
Individual lifetime maximum • Prescription drug expenses do not apply against the lifetime maximum	$2,000,000
Annual reinstatement once lifetime maximum is reached	$5,000

Individual limit per benefit year on substance abuse treatment without precertification. Subject to change every three years	$12,715	
Individual lifetime maximum on substance abuse treatment without precertification. Subject to change every three years	$25,430	
Prescription Drugs	Up to 90 Day or 100 Unit Supply	
	Generic	Brand Name
Network pharmacy copayment	$4	$8
Mail order copayment	$0	$0

The Department of Administration is contracting with SurgeryPlus to provide enhanced travel benefits, which include a per diem for lodging and meals, companion airfare, and concierge-level member services to coordinate travel arrangements with medical care. The scope of covered services and procedures eligible for travel benefits will also be expanded to include the following:

Circumstance	Current Benefit	Proposed Benefit
Emergency travel	Transportation to nearest hospital by professional ambulance	No change
Transplant via Aetna Institute of Excellence	-Member and companion -Overnight stay: -$50 per person/night -$100/night maximum -Companion expense: -$31/night	No change
Travel for minor	-Minor and companion -Transportation covered	-Add overnight lodging benefit of $80/night up to 14-day maximum -Add per diem benefit of $31 per patient/day; or $62 per patient & companion/day
Second surgical opinion	-Transportation covered for member only	-Add lodging and per diem benefit as described above
Treatment and diagnostic services not available locally	-Transportation, lodging and per diem covered for member only -Limited to treatment only -Limited to the following visit per benefit year: -1 treatment for condition -1 for follow-up -1 pre- or post-natal care -1 for maternity delivery -1 pre- or post-surgery -1 per surgical procedure -1 per allergic condition	-Restrict to services received from a network provider -Add lodging and per diem benefit as described above to cover the member’s entire length of stay subject to medical necessity -Allow for both pre- and post-op visit coverage if post-op received within 60-days of discharge -Add companion benefit if procedure requires general anesthesia

Circumstance	Current Benefit	Proposed Benefit

Surgery and diagnostic services in other locations less expensive	-Only applicable for surgery
	-Transportation covered for member only
	-Total cost may not exceed the recognized charge for same expenses received locally
	-Total cost must include:
	    -surgery
	    -hospital room and board
	    -travel to another location
		-Restrict to services received from a network provider
		-Add “if not available through the SurgeryPlus program”
		-Add coverage for companion if procedure requires general anesthesia
		-Add lodging and per diem benefit as described above to cover the member’s entire length of stay subject to medical necessity

SurgeryPlus Program	-Not currently available to retiree members	-All travel includes member and companion -Travel costs arranged for and covered up front by SurgeryPlus -Hotels arranged and paid for by plan -$31 per diem for member/$62 with companion -Members receive pre-loaded debit card in advance of trip

Additionally, the Division would maintain prior-authorization requirements and add new requirements for prior-authorization if a member is seeking less expensive treatment and intend to have travel arranged through SurgeryPlus.

The Division is considering the standard SurgeryPlus benefits, as described above, for non-Medicare members. The current consideration for the Medicare members is to provide access to the travel coverage, provider recommendations and care coordination component of the SurgreyPlus offerings. The Division has indicated that they are planning to undertake additional negotiations to ensure that the plan will still coordinate with Medicare with no impact to the member or the plans status as a secondary coverage.

Actuarial Value

While these enhancements are favorable for the member, there will be no impact on actuarial value. These changes promote efficient utilization of medical services, which helps manage program costs. However, there are no changes to how the cost share is determined and therefore, the enhanced travel benefits do not affect the actuarial value of the program.

Additional incentives that affect cost sharing (such as waiving deductibles and/or coinsurance) would likely result in an increase to actuarial value.

Financial Impact

While there is no impact on the Plan's actuarial value, there would be a financial impact.

Based on previous analysis utilizing Book of Business data from SurgeryPlus, it is estimated that 20% of eligible procedures will result in about 400 procedures accessing the SurgeryPLus network and associated travel benefit annually, resulting in savings due to the utilization of lower cost providers and fewer associated complications. Offset by contractual administrative expenses and assuming $3,000 per procedure in travel costs, it is estimated there will be approximately $2,800,000 in annual savings to the Plan associated with the SurgeryPlus program.

Segal reviewed the assumptions used by SurgeryPlus and consider them to be reasonable. For budgeting purposes, to be conservative in projecting the impact of a new program, Segal's analysis utilizes a 20% margin.

Additional Notes

The data used for this analysis was reviewed, but not audited, and found to be sufficient and credible.

The above projection is an estimate of future cost and is based on information available to Segal at the time the projection was made. Segal has not audited the information provided. A projection is not a guarantee of future results. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, change in demographics, overall inflation rates and claims volatility. Projection of retiree costs considers only the dollar value of providing benefits for current retirees during the period referred to in the projection. It does not reflect the present value of any future retiree benefits for active, disabled, or terminated employees during a period other than that which is referred to in the projection, nor does it reflect any anticipated increase in the number of those eligible for retiree benefits, or any changes that may occur over time.

The Coronavirus (COVID-19) pandemic continues to evolve and will likely continue to impact the 2022 and 2023 US economy and health plan claims projections for most Health Plan Sponsors. Unanticipated changes in the pandemic may impact the retirees' ability to utilize this program and result in experience that deviates from these projections.

cc: Betsy Wood, Division of Retirement and Benefits
Andrea Mueca, Division of Retirement and Benefits
Noel Cruse, Segal
Eric Miller, Segal
Quentin Gunn, Segal

March 3, 2023

Ms. Betsy Wood
Acting Chief Health Administrator
Division of Retirement and Benefits
State of Alaska
P.O. Box 110203
Juneau, AK 99811-0203

Impact of Adding an Optional Supplemental Travel Program through SurgeryPlus for AlaskaCare Retiree Health Plan

Dear Betsy:

As requested, we have estimated the impact of the following change that is being considered for the AlaskaCare Retiree Health Plan members participating in the PERS/TRS Defined Benefit Plans (for those hired prior to July 1, 2006) and JRS:

- **Addition of Optional Supplemental Travel Program through SurgeryPlus** – Currently the AlaskaCare Retiree Health Plan provides limited coverage for certain member health related travel costs associated with select services and treatments. Qualified expenses are typically limited to airfare costs only and require precertification. Lodging, per diem expenses, and travel for a companion are rarely eligible for coverage. The change being considered is to add an optional supplemental travel program coupled with access to a narrow, high-quality network of providers and facilities delivering non-emergency surgical services to the Plan.

Segal provided a memo dated December 21, 2022 which modeled the addition of the supplemental travel program through SurgeryPlus. The travel cost for each procedure is assumed to be $3,000. Based on follow-up discussions with Mr. Richard Ward of Segal, medical claims savings of $30,000 for each pre-Medicare surgical procedure performed is expected due to the utilization of lower cost providers who have a demonstrated ability to achieve fewer associated complications for their patients. Experience from active members already using SurgeryPlus benefits supports this assumption. No medical savings were considered for Medicare members, but Mr. Ward indicated that there is likely an opportunity for some medical savings due to this initiative. Segal estimated the SurgeryPlus network and associated travel benefit will be accessed for 133 pre-Medicare and 267 Medicare procedures annually, resulting in net annual savings of $2.8M.

The undersigned actuaries have relied on Mr. Ward's utilization assumptions as summarized above, as we are not able to assess the reasonableness of this assumption for the purpose of this measurement without a significant amount of additional research and effort beyond the scope of this engagement. We note that SurgeryPlus estimated more utilization by pre-Medicare members relative to Medicare members than what was assumed by Mr. Ward. This suggests that Mr. Ward's assumption is more conservative as net plan savings are only expected for pre-Medicare members.

The proposed effective date is yet to be determined. We have assumed this change would be effective January 1, 2024. To estimate the financial impact of this change on PERS/TRS/JRS, we reflected the costs and savings provided by Segal to our projected cost during 2024 based on our most recent actuarial valuations as of June 30, 2022. Future net annual cost/saving increases were projected using the June 30, 2022 valuation assumptions.

Shown in the table below is a summary of the estimated (decrease) in healthcare Actuarial Accrued Liability (AAL) for PERS, TRS, and JRS combined, the projected (decrease) in Additional State Contributions (ASC) for FY25 if this change had been reflected in the June 30, 2022 valuations, and the projected (decrease) in ASC through 2039. It is important to note that the June 30, 2022 valuations and FY25 contribution rates (which determine the FY25 ASC) have not yet been formally approved by the Alaska Retirement Management Board (Board). The June 30, 2022 valuation results are expected to be approved during the June 2023 Board meeting, and the FY25 contribution rates will be adopted during the September 2023 Board meeting. Impacts are also shown as a percentage increase/(decrease). See Appendix A for the impacts split by plan.

FY22 Healthcare AAL Impact on Combined PERS/TRS/JRS DB if SurgeryPlus Implemented ($ millions)

Current Healthcare AAL for Combined DB as of 6/30/2022[1]	(Decrease) in 6/30/2022 AAL[2]	% (Decrease) in 6/30/2022 AAL
$9,117.7	($14.4)	(0.16%)

FY25 Impact on Combined PERS/TRS/JRS DB Contributions if SurgeryPlus Implemented ($ millions)

Pension and Healthcare Current FY25 Contributions for Combined DB[1]	(Decrease) in FY25 Contributions[2,3]	% (Decrease) in FY25 Contributions
$486.9	($0.3)	(0.07%)

FY25-39 Impact on Combined PERS/TRS/JRS DB Contributions if SurgeryPlus Implemented ($ millions)

Pension and Healthcare Current FY25-39 Contributions for Combined DB[1]	(Decrease) in FY25-39 Contributions[2]	% (Decrease) in FY25-FY39 Contributions
$8,697.0	($2.1)	(0.03%)

[1] Current AAL shown includes only Healthcare. Current and projected contributions include both Healthcare and Pension reflecting State as an Employer and Additional State Contributions.

[2] All of the data, assumptions, methods and current plan provisions used in the above calculations are documented in the actuarial valuation reports as of June 30, 2022.

[3] Because the healthcare portions of these plans are currently overfunded, the changes in FY25 ASC for PERS and TRS reflects the decrease in Normal Cost only. If the healthcare portions of these plans were not overfunded and the decreases in Actuarial Accrued Liability (AAL) were to be amortized over 25 years according to the Board's current funding policy, the total FY25 Additional State Contributions (ASC) would decrease by approximately $1.2M (an additional $0.9M reduction beyond the normal cost reduction of $0.3M).

Additional Notes

Except as noted above, the data, assumptions, methods and plan provisions used in our analysis are the same as those described in the June 30, 2022 actuarial valuation reports.

The Retiree Health Plan Advisory Board (RHPAB), staff of the State of Alaska and the Board may use this letter for purposes of analyzing the potential impact of the benefit change described above. Use of this letter for any other purpose or by anyone other than the RHPAB, staff of the State of Alaska or the Board may not be appropriate and may result in mistaken conclusions because of failure to understand applicable assumptions, methods or inapplicability of the letter for that purpose. Because of the risk of misinterpretation of actuarial results, Buck recommends requesting its advanced review of any statement to be based on information contained in this letter. Buck will accept no liability for any such statement made without its prior review.

Future actuarial measurements may differ significantly from current measurements presented in this letter due to plan experience differing from that anticipated by the actuarial assumptions, changes expected as part of the natural operation of the methodology used for these measurements, and changes in plan provisions or applicable law. In particular, retiree group benefits models necessarily rely on the use of approximations and estimates and are sensitive to changes in these approximations and estimates. Small variations in these approximations and estimates may lead to significant changes in actuarial measurements. An analysis of the potential range of such future differences is beyond the scope of this letter.

Actuarial Certification

This letter was prepared under our supervision and in accordance with all applicable Actuarial Standards of Practice. We are Associates of the Society of Actuaries and Members of the American Academy of Actuaries. We meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinions contained herein.

If there are any questions, Stephen can be reached at (215) 586-1227 and Christian can be reached at (717) 308-8981.

Respectfully submitted,

Stephen Oates, ASA, EA, MAAA, FCA
Principal, Health
Buck

Christian Hershey, ASA, MAAA
Senior Consultant, Health
Buck

Appendix A – Summary of Impacts Split by Plan

	Addition of SurgeryPlus	
($ millions)	$ Impact	% Impact[1]
(Decrease) in Healthcare AAL as of June 30, 2022[2]		
PERS	($10.4)	(0.16%)
TRS	(4.0)	(0.17%)
JRS[3]	(0.0)	(0.05%)
Total	($14.4)	
(Decrease) in FY25 ASC[2, 4]		
PERS	($0.2)	(0.07%)
TRS	(0.1)	(0.06%)
JRS[3]	0.0	(0.00%)
Total	($0.3)	
(Decrease) in ASC through FY39		
PERS	($1.6)	(0.03%)
TRS	(0.5)	(0.02%)
JRS[3]	0.0	(0.00%)
Total	($2.1)	

[1] (Decrease) in Healthcare AAL as a percentage of the June 30, 2022 Healthcare AAL. (Decrease) in FY25 ASC as a percentage of the FY25 Contributions for Pension and Healthcare. Increase in ASC through FY39 as a percentage of the projected Contributions for Pension and Healthcare through FY39. Current and projected Contributions include both Healthcare and Pension reflecting State as an Employer and Additional State Contributions.

[2] All of the data, assumptions, methods and current plan provisions used in the above calculations are documented in the actuarial valuation reports as of June 30, 2022.

[3] The amount rounds to less than $0.1M where $0.0 is shown.

[4] Because the healthcare portions of these plans are currently overfunded, the changes in FY25 ASC for PERS and TRS reflects the decrease in Normal Cost only. If the healthcare portions of these plans were not overfunded and the decreases in Actuarial Accrued Liability (AAL) were to be amortized over 25 years according to the Board's current funding policy, the total FY25 Additional State Contributions (ASC) would decrease by approximately $1.2M (an additional $0.9M reduction beyond the normal cost reduction of $0.3M).

AlaskaCare Retiree Health Plan

Proposal # and Title	Virtual Physical Therapy and Musculoskeletal Care Program (R027)
Health Plan Affected	Defined Benefit Retiree Health Plan
Proposed Effective Date	TBD (January 2024 – December 2024)
Reviewed By	Retiree Health Plan Advisory Board – Modernization Subcommittee
Review Date	May 5, 2023

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1) Background

Current Rehabilitative Care Telehealth Coverage

The AlaskaCare Defined Benefit Retiree Health Plan (Plan) currently provides coverage for physical therapy (PT) and other outpatient rehabilitative care services designed to restore and improve bodily functions lost due to injury or illness.[1] Most rehabilitative care services are commonly delivered in person; however some rehabilitative care services can be delivered remotely, via telemedicine by providers practicing within the scope of their license.

The Plan covers services when delivered via telehealth in accordance with the AlaskaCare third-party administrator's (Aetna) policies. These policies are actively managed and updated by Aetna to reflect standard care delivery practices. For example, some care may be appropriately delivered via a telephone connection, while other services may require an audiovisual connection.

Virtual Physical Therapy

Virtual PT is a method of providing physical therapy or musculoskeletal (MSK) care services where instead of traveling to a provider for an in-person visit, patients communicate with a provider via phone call or videoconference and attend the appointment from home.

Telehealth has been used across different PT specialties, and is frequently a fit for members who would not necessarily require physical touch from the therapist. For example, virtual sessions might be used to help educate patients, or to supplement in-person sessions.

While different from traditional services, telehealth physical therapy has multiple benefits.

- Virtual physical therapy is accessible to more people. For those who live in rural areas far from the nearest PT clinic—or who don't have access to transportation—attending online sessions may be considerably more feasible than traveling to in-person appointments. This is particularly valuable to our retiree members who may live in rural areas.
- Virtual physical therapy is generally more comfortable for rehabilitation patients. While recovering from surgery or an acute injury, a patient may not be able to drive to an in-person appointment. Telehealth PT allows them to make progress on their recovery without needing to leave home.
- Allowing members to self-manage their symptoms in their own homes can grant them a greater sense of independence, making them feel more in control of their recovery process. It may also be helpful to conduct virtual sessions in the same area of the home where members would be practicing exercises on their own. That way, the therapist can provide guidance on using rehabilitative equipment and features of the home (such as walls, doorways, and furniture) within certain exercises.
- Virtual PT sessions may be easier for patients to fit into their busy lives since they don't have to drive to the PT clinic. For busy retirees, an at-home appointment can offer a welcome level of convenience.

AlaskaCare Retiree Health Plan Musculoskeletal Spend

A large cost driver in the Plan is treatment of MSK conditions including osteoarthritis, fractures, neck pain, mechanical joint disorders, and back pain. From January through December 2021, the Plans' costs

[1] Retiree Insurance Information Booklet, *Section 3.3.12 Rehabilitative Care*, January 2023. pg. 52-53. https://drb.alaska.gov/docs/booklets/DB-RetireeInsuranceBooklet_WEB.pdf

associated with MSK treatments for 8,141 members totaled $30.7 million, making up approximately 18.6% of the plan's overall paid medical expenses.[2]

AlaskaCare Employee Health Plan Virtual PT Experience

The AlaskaCare Employee Health Plan has contracted with a virtual MSK care provider organization to offer virtual-only MSK care and physical therapy since July of 2021. The benefit is administered by Hinge Health, an affiliate of the supplemental travel and non-emergency surgery benefit administrator, SurgeryPlus.

2) Goals and Objectives

1. Offer members a cost-effective, easy-to-access, highly personalized MSK care and treatment option.
2. Support members in achieving MSK condition prevention, surgical avoidance, and better surgical recovery outcomes.
3. Facilitate access to a wider range of medical providers for consultations and advice.
4. Drive value through cost-effective care.

3) Summary of Proposed Changes

This proposal considers providing Plan members with access to a virtual MSK care and support program as an additional care and treatment option for MSK conditions. This proposal does not contemplate changing or updating the standard rehabilitative care benefits detailed in *Section 3.3.12 Rehabilitative Care* in the AlaskaCare Retiree Insurance Information Booklet. The proposed program would be supplemental to all existing benefits.

Such a program would focus on prevention, acute care for members experiencing an acute MSK condition, such as a pulled muscle or sprained ankle, and chronic care designed to treat ongoing MSK conditions, such as arthritis or chronic back pain.

This proposal contemplates implementing the proposed change by expanding the Hinge Health service offering to retiree plan members. As with all AlaskaCare contracted services, the contract currently held by SurgeryPlus and Hinge Health will be periodically competitively bid, and a different TPA may administer this program in the future based on the outcome of the procurement process. Changes or updates to the program may be necessary based on future service offering availability.

Hinge Health Overview

Hinge Health's services are made up of four care pathways:

1. **Prevention**
   The prevention program is offered free of charge to all plan participants. To participate, members download a free software application to their smart device where they can access customizable exercise programs and lifestyle educational materials designed by physical therapists and physicians.
2. **Acute**
   The acute program is available to members experiencing an acute MSK condition, such as a sprained ankle or tendonitis. The program combines use of the Hinge Health software application with one-on-one video visits with a physical therapist to work through a treatment program. Participants in the

[2] Aetna Consultative Analytic Impact Report, State of Alaska Retiree Plan, May 4, 2022.

acute program can have a limited number of physical therapy sessions before they will be referred to in-person care. Should the member require surgery, the Hinge Health physical therapist will provide the member with information about their benefit options. If SurgeryPlus is implemented in the Plan, Hinge Health physical therapists can refer members to that program.

3. Chronic
   The chronic program is meant for members grappling with an ongoing MSK condition, such as arthritis or chronic back pain. Hinge Health will send program participants wearable body movement sensors and a linked tablet that provide real time feedback to physical therapists during video visits and tracks the patient's progress and adherence to their program of care. Program participants are also matched with a dedicated health coach to provide tailored educational information as well as to assist in developing the program of care. Should the member require surgery, the Hinge Health physical therapist will provide the member with information about their benefit options. If SurgeryPlus is implemented in the Plan, Hinge Health physical therapists can refer members to that program.
4. Surgery
   If a member requires surgery or decides to move forward with surgery after participating in the acute or chronic care programs, Hinge Health offers pre and post-operative rehabilitation. Though members are free to use the surgeon of their choosing through the current medical benefits, if the Surgery Plus program is expanded to retiree health plan members, Hinge Health's providers would ensure that members were aware of the option to schedule their procedure through SurgeryPlus.

Hinge Health's services are available at no cost to members. The cost of this service to the plan depends on the level of care received by the member.

1. Preventive services, including expert medical opinions, exercise therapy, and education, are offered free of charge to all plan participants.
2. Acute care for recent injuries, including video visits with a physical therapist is $250 per engaged participant per year.
3. Chronic care for high-risk individuals or pre and post-surgical rehabilitation is $995 per engaged participant per year.

The plan will never be charged for members who do not engage in the program, and the plan will never be charged more than $995 per engaged participant per year. For example, if a person begins in the acute care program but transitions into a post-surgical rehabilitation course of care, the maximum cost to the plan for that person for the year will be $995.

Hinge Health offers a 1.5:1 Return-on-Investment (ROI), based on reduction in member's pain and avoided surgical interventions.

4) Analysis

Currently, the Plan will cover virtual PT and MSK care visits if the provider is practicing within the scope of their license, in alignment with Aetna's Clinical Policy Bulletins (CPB), and in alignment with the terms of the Plan. However, members do not currently have access to a specific virtual MSK care and support program. The addition of such a program should benefit the membership and allow for greater choice, improved accessibility, and additional convenience when seeking this type of care.

Note: These benefits are available to be added based on services being offered by a third-party provider. The ability to continue to offer them is dependent on the continued availability of the service provider. If this service model changes in the future, the plan benefit will be impacted.

Employee Plan Experience with Hinge Health

This benefit was implemented in July 2021 for the AlaskaCare Active employee plan and has been quite successful. From inception through April 2022, 308 members participated in the chronic program and 98 members in the acute program. Participants in the chronic program reported a 52% reduction in pain and surgery likelihood decreased by 59%. In the acute program, participants reported a 63% reduction in pain over the first three weeks of therapy and a 28% reduction in pain during weeks four through six.[3]

Recent enrollment in the program has been robust, with 563 new users enrolled in 2022.

5) Impacts

Actuarial Impact to AlaskaCare | Neutral

The proposed program would result in enhancements to the plan that are favorable for members, offer access to a supportive MSK care program, and promote efficient utilization of medical services. However, providing access to this care program will not have an actuarial impact on the plan. This is discussed in the attached Segal Consulting memorandum.[4]

Financial Impact to AlaskaCare | Cost Decrease

Projected Annual Financial Impact

The financial impact of this change is ultimately dependent on the number of members who choose to engage with the program and whether program participants are Medicare-eligible or not. The annual fee for Hinge Health to the plan is up to $995 per engaged participant per year. This fee is offset by plan savings due to improvements in members' pain management and avoided future high-cost medical care. Hinge Health estimates that a 1 percent improvement equates to $71.09 in saved claims cost for a typical employer. Hinge Health helps to protect the plan financially by offering a return on investment (ROI) of 1.5:1 for the non-Medicare eligible retirees with a prorated refund if the ROI is not met. The savings associated with avoided future care for Medicare-eligible retirees will be split between Medicare (as the primary payor) and AlaskaCare (as the secondary payor), therefore the guaranteed ROI for Medicare retirees will be less than for AlaskaCare primary members.

However, due to a number of Alaska and AlaskaCare-retiree health plan specific factors, the actual ROI for AlaskaCare retiree health plan members are likely to be greater than the ROI guaranteed by Hinge Health. Commercial health care costs in Alaska are higher than in the rest of the country by as much as 40-80%. The majority (~60%) of retiree plan members reside in Alaska. The Plan's population is, on average, older than that of a typical employer. An older population typically has higher claims costs, and therefore increased savings opportunities when considering avoided future medical care. Additionally, the plan would benefit primarily from any savings associated with avoided future prescription medications (*e.g.*, pain medication).

[3] SurgeryPlus Q4 2021 Utilization Report, January 28, 2022

[4] *Addition of Hinge Health – Focus on Actuarial and Financial Impact for the Retiree Plan (Updated),* Segal Consulting memo dated April 20, 2023.

Based on the AlaskaCare employee plan's participation rate (3.85%), Segal estimates that among the approximately 76,000 retiree members, approximately 2,900 members would engage with Hinge Health. This would result in a plan cost of approximately $2.9 million annually.

After considering the Alaska and AlaskaCare retiree health plan-specific factors, and after reviewing actual reported pain reduction in the first 12 months of engagement in the Employee Plan, Segal has estimated that annual savings, net of program costs, could total $2.5 million. A more conservative estimate based solely on the Hinge Health guaranteed ROI indicates that that annual savings net of program costs could total $1.4 million in net annual savings after accounting for program fees. These estimates are discussed in the attached Segal Consulting memorandum.[5]

Projected Long-Term Financial Impact

The proposed benefit addition may have long-term impacts on the healthcare Actuarial Accrued Liability (AAL)[6] and to the Additional State Contributions (ASC)[7] associated with the Plan.

Buck performed an analysis contemplating the long-term impacts of adding Hinge Health to the retiree health plan. [8] Because the long-term financial impacts are dependent on the gross cost savings associated with avoided future medical care, and these savings can vary based on many factors, Buck's analysis considers three different scenarios to serve as the baseline for future cost impact projections:

1. **Scenario 1** started with Hinge Health's guaranteed ROI of 1.5:1 and then assumed that 100% of claims savings for pre-Medicare retirees and 20% of Medicare eligible retiree claims savings will be realized by the Plan while 100% of administrative costs will be borne by the Plan. In such a scenario, Buck estimates that the addition of Hinge Health would result in an annual net cost to the plan of $1.2 million.
2. **Scenario 2** used data from a peer-reviewed Hinge Health study to estimate the savings associated with pre-Medicare and Medicare-eligible participants. The results of this analysis estimated that the Plan would realize net savings of $269K annually.
3. **Scenario 3** uses a Medicare ROI of 0.76:1, based on information Hinge Health provided from two Hinge Health clients that are of similar makeup to the AlaskaCare retiree health plan membership. The pre-Medicare ROI for this scenario is the same as for scenario 2. This scenario shows that the plan would experience savings of $758K annually.

In an illustrative example, the tables below summarize the estimated impact on the healthcare AAL for the Public Employees Retirement System (PERS), Teachers Retirement System (TRS), and Judicial Retirement System (JRS) combined and the estimated impact on the ASC for FY25. These estimates, along with the projected impact on the ASC through 2039 if this change had been reflected in the June 30,

[5] Ibid.
[6] AAL: The health Actuarial Accrued Liability is equal to the total accumulated cost to fund the postemployment benefits arising from service in all prior years.
[7] Employer contributions to retirement payments were capped in FY08. Since then, the state makes additional assistance contributions to help cover the accrued unfunded liability associated with participating employers.
[8] *Impact of Adding the Hinge Health Digital Musculoskeletal Care Program as a Benefit for AlaskaCare Retiree Health Plan,* Buck Consulting Memo dated March 6, 2023.

2022, valuations are discussed in the attached Buck memorandum.[9] Each of the three scenarios described above are considered in these projections.

It is important to note that the June 30, 2022, valuations and FY25 contribution rates (which determine the FY25 ASC) have not yet been formally approved by the Alaska Retirement Management Board (Board). The June 30, 2022, valuation results are expected to be approved during the June 2023 Board meeting, and the FY25 contribution rates will be adopted during the September 2023 Board meeting. Impacts are also shown as a percentage increase/(decrease).10

The projected healthcare AAL for the defined benefit retiree systems combined (PERS, TRS, and JRS) as of the June 30, 2022, valuation is $9,117.7 million. Under the scenarios contemplated, if Hinge Health was implemented for the retiree plan, the illustrative impact on the AAL could range from an increase of $27 million to a decrease of $500k. This represents a .30% to -0.01% impact on the overall AAL.

Table 1. FY22 Healthcare AAL Illustrative Impact on Combined PERS/TRS/JRS DB if Hinge Health Implemented ($ millions)

Scenario		Current Healthcare AAL for Combined DB as of 6/30/2022	Increase in 6/30/2022 AAL	% Increase in 6/30/2022 AAL
1	Hinge Health 1.5:1 ROI	$9,117.7	$27.0	0.30%
2	Study-Based	$9,117.7	$9.0	0.10%
3	Self-Reported Medicare	$9,117.7	($0.5)	(0.01%)

The ASC is a mechanism for the State to provide payment assistance to participating employers' Actuarially Determined Contribution (ADC). The ADC is determined by adding the normal cost[11] to the amount needed to offset the amortization of any existing unfunded accrued liability over a period of 25 years.

Contemplating a scenario where Hinge Health was implemented for the retiree plan, the illustrative impact on the ASC for FY 25 ranged from an increase of $100k to a decrease of $100k, representing between 0.03% to -0.02% percent change.

Table 2. FY25 Impact on Combined PERS/TRS/JRS DB Contributions if Hinge Health Implemented ($ millions)

Scenario		Pension and Healthcare Current FY25 Contributions for Combined DB	Increase in FY25 Additional State Contributions if Hinge Health Added	% Increase in FY25 Contributions
1	Hinge Health 1.5:1 ROI	$486.9	$0.1	0.03%
2	Study-Based	$486.9	($0.0)	(0.01%)
3	Self-Reported Medicare	$486.9	($0.1)	(0.02%)

The illustrative increase to the FY25 ASC is associated with the normal cost only. The current overfunded status of retiree health care liabilities has eliminated the immediate need for amortization payments to

[9] Ibid.

[10] Ibid.

[11] The normal cost represents the present value of benefits earned by active employees during the current year.

offset any health care unfunded liability. It is important to note that the long-term funded status of the trusts is subject to change in response to market volatility and many other factors.

Member Impact | Enhancement

Providing members access to a virtual PT and MSK support service will enhance the services available to all Plan members. The proposed program is not a covered service under Medicare, so members' AlaskaCare coverage will be primary, regardless of the member's Medicare eligibility status. If, in the future, Medicare changes coverage to include these types of services, Medicare's coverage would become primary for Medicare-eligible members.

Members may benefit from lower out-of-pocket MSK-related costs and positive health outcomes.

Operational Impact (DRB)| Initial: Moderate Ongoing: Minimal

The Division anticipates moderate operational impacts associated with implementation and member communication as follows:

- Division staff would need to review and distribute communications to educate and increase awareness of the implementation of the virtual PT program.
- Division staff would need to coordinate and oversee implementation of the program to ensure that the addition is implemented correctly, the process is running smoothly, and that member questions and/or concerns are responded to.

After implementation, and once members are accustomed to the programs, the ongoing operational impacts are anticipated to be minimal.

Operational Impact (TPA) | Initial: Moderate Ongoing: Minimal

The initial impact to the current virtual PT and MSK support provider (Hinge Health) is anticipated to be moderate for several reasons:

- Hinge Health will collaborate with the Division's staff to scale operations to effectively service a larger population than it does today for the State.
- Hinge Health will need to undertake a member outreach campaign in advance of the implementation.
- Hinge Health will need to produce reports on the impacts and savings associated with the program.

After implementation, the ongoing operational impacts are anticipated to be minimal and will include maintenance of the program and ongoing outreach efforts.

6) Considerations

Clinical Considerations

Participation in this program is anticipated to often result in positive clinical outcomes and reduced pain for members.

In April 2022, a study on the impacts of participation in the Hinge Health program on individuals who also participate in Medicare was released. The study found that in the 12 months after the program start date, the monthly MSK-specific medical costs for non-Hinge Health participants were $221.27 higher on average than participants in the program. Accounting for program fees, this would result in a 2.7x ROI.

The study found that main savings drivers were related to decreased hospital inpatient and outpatient facility utilization, and decreased utilization of professional services from specialists.[12]

Provider Considerations

Providing members with access to a virtual PT and MSK support provider could create additional competition in the Alaska medical marketplace as providers compete with those offering similar services outside of their community. This could result in reduced costs and better services as providers work to remain competitive. Alternatively, as members in small communities seek care elsewhere, any fixed cost for providing those services could be spread across a smaller number of patients, increasing costs for those who receive care from local providers.

The virtual PT and MSK support program offered by Hinge Health is meant to supplement and complement services provided in a more traditional setting. If a Hinge Health program participant is unable to progress beyond a certain point, they may be referred to or recommended to in-person MSK care.

7) Implementation and Communication Overview

Division staff have already worked with Hinge Health to successfully implement this program beginning July 2021 for the AlaskaCare employee plan.

Division staff will follow the standard process for making changes to the Defined Benefit retiree plan, which includes completion of the following:

- Proposal analysis and stakeholder input
- Public comment period(s)
- Any needed language updates to the Retiree Insurance Information Booklet
- Education outreach to benefit recipients

8) Proposal Recommendations

DRB Recommendation

The Division recommends/does not recommend providing Plan members with access to a virtual MSK care and support program as an additional care and treatment option for MSK conditions.

RHPAB Board Recommendation

The RHPAB board voted on ##/##/## to recommend/not to recommend providing Plan members with access to a virtual MSK care and support program as an additional care and treatment option for MSK conditions.

[12] Patrick Curran, Heidi Laughlin. *Hinge Health Medicare Cost and Utilization Study*. April 28, 2022. https://assets.ctfassets.net/cad7d5zna5rn/6BN7T0unYTlqPcEFDmNw54/8a16f0f497294d25f9838871b7b053c2/Hinge_Health_Medicare_Cost_and_Utilization_Study.pdf

Commissioner of Administration Recommendation

The plan administrator made the determination on ##/##/## to recommend/not to recommend providing Plan members with access to a virtual MSK care and support program as an additional care and treatment option for MSK conditions.

Description	Date
Proposal Drafted	1/4/2023
Reviewed by Modernization Subcommittee	1/4/2023
Reviewed by RHPAB	2/9/2023, 05/04/2023

9) Plan Language

New language for the Retiree Health Plan will need to be drafted.

Memorandum

To: Ajay Desai, Director, Division of Retirement and Benefits

From: Richard Ward, FSA, FCA, MAAA

Date: April 20, 2023

Re: Addition of Hinge Health – Focus on Actuarial and Financial Impact for the Retiree Plan

The State is considering offering the Hinge Health Digital Musculoskeletal Care program as a benefit for the Retiree Plan.

The Plan applies the general benefit provisions, such as deductible, coinsurance and out-of-pocket limits, to determine any portion of the costs that are the member's responsibility. If the member has additional coverage, such as Medicare or other employer provided coverage, any portion of the costs covered by that plan is also considered. Below is a table outlining the current benefits offered under the Plan:

Deductibles	
Annual individual / family unit deductible	$150 / up to 3x per family
Coinsurance	
Most medical expenses	80%
Most medical expenses after out-of-pocket limit is satisfied	100%
Second surgical opinions, Preoperative testing, Outpatient testing/surgery • No deductible applies	100%
Out-of-Pocket Limit	
Annual individual out-of-pocket limit • Applies after the deductible is satisfied • Expenses paid at a coinsurance rate other than 80% do not apply against the out-of-pocket limit	$800
Benefit Maximums	
Individual lifetime maximum • Prescription drug expenses do not apply against the lifetime maximum	$2,000,000
Annual reinstatement once lifetime maximum is reached	$5,000
Individual limit per benefit year on substance abuse treatment without precertification. Subject to change every three years	$12,715
Individual lifetime maximum on substance abuse treatment without precertification. Subject to change every three years	$25,430

Prescription Drugs	Up to 90 Day or 100 Unit Supply	
	Generic	Brand Name
Network pharmacy copayment	$4	$8
Mail order copayment	$0	$0

Actuarial Value

While the inclusion of this program for the Plan can be viewed as an enhancement favorable for the member, there will be no impact on actuarial value. This change provides an additional option for members and helps to promote efficient utilization of medical services, which can in turn help manage program costs.

Financial Impact

The annual fee for Hinge Health to the plan will be $995 per participant per year per engaged member. However, this fee is offset by plan savings due to improvements in pain management by the members. Hinge Health estimates that a 1 percent improvement equates to $71.09 in saved claims cost. This correlation is based on analysis of multiple years of data across their book of business.

The financial impact is dependent on the number of members who choose to engage with Hinge Health. A member's Medicare status will also affect the financial impact to the Plan. Since the Plan pays secondary to Medicare for medical expenses, savings associated with improved health and reduced utilization will be shared between the Plan and Medicare.

The $71.09 savings per percentage reduction in pain is based on national average healthcare costs for a typical employer. The AlaskaCare Retiree Plan differs from this typical employer in a number of regards.

Commercial Healthcare costs in Alaska are reported to be between 40% and 80% higher than in the Lower 48[1]. Approximately 40% of retirees reside in the Lower 48, with the majority residing in Washington. Combining these factors, we estimate that costs for non-Members are approximately 20% higher than the national commercial average.

Non-Medicare members are approximately 62 years old on average. Compared to an average assumed age of 42 for a typical employer, and assuming 1.5%[2] in increased morbidity per age, this equates to a 35% higher claims costs, and therefore assumed savings, per member.

Applying this against the $71.09 Hinge Health assumption yields $115 in savings per non-Medicare member.

[1] The 2010 Annual Report for the Alaska Health Care Commission reported that physician costs were 60% higher than the national average and hospital costs were 40% higher. A 2017 analysis by Primera Blue Cross determined that payments to physicians and facilities in Alaska exceeded the national average by 76%. Kaiser, more recently in 2020 estimates tat Health Care spending per capita in Alaska exceeds the national average by 34% and is 47% higher than those in Washington.

[2] Assumed morbidity assumptions are based on the most recent actuarial valuation by Buck Consultants of the State's retiree health liability.

Segal recently reviewed medical costs in the Alaska Employee Plan and determined that, on average, the allowed commercial market charges in the Employee Plan are about 270% of Medicare. We are utilizing the same rate in this analysis.

Medicare members are approximately 72 years old on average. Assuming an additional 2.0%[3] in increased morbidity per age, this equates to a 64% higher claims costs, and therefore assumed savings, per member, when compared with a typical active employee.

Applying this to the $71.09 Hinge Health assumption yields $52 in savings per Medicare member.

Additionally, the Plan, paying secondary to Medicare, will share the savings with Medicare. A typical share in medical expenses has Medicare assuming 80% of the costs and 20% for the Plan. For Pharmacy, the Plan would benefit from the majority of the savings. For simplicity, we are assuming the Plan will benefit from 20% of the assumed savings. This equates to $10 in savings per point in reported pain reduction.

In the first 12 months of engagement with the Employee Plan, members reported an average reduction of 51%. This translates to annual claims cost reductions of $5,852 per non-Medicare member and $528 per Medicare member.

The Plan's Hinge Health costs will be $995 regardless of Medicare eligibility, resulting in $4,857 net savings per non-Medicare participant and a $467 net ***cost*** per Medicare participant.

Currently, the State's Employee plan offers Hinge Health as a benefit. Through the start of November 2022, there were 540 enrolled users out of approximately 14,000 members. Assuming a similar engagement rate of 3.85% among the approximately 76,000 retiree members, Segal would estimate about 2,900 members would engage with Hinge Health.

Currently, the plan's membership is approximately 75% Medicare. Assuming Hinge Health utilization will follow this distribution results in 727 non-Medicare participants and 2,173 Medicare participants.

Applying these to the per participant net savings and cost estimates results in an aggregate savings of $2,500,000.

Hinge Health helps to protect the plan financially by offering a return on investment (ROI) of 1.5:1 with a prorated refund if the ROI is not met. Our initial analysis from December 2022 was based on this guarantee applying to all members and resulted in an annual net savings of $1,400,000.

Hinge Health has subsequently refined the ROI guarantee to be 0.30:1 for the Medicare membership and the same 1.5:1 for the non-Medicare membership.

Given these additional considerations and refinements, we consider the initial $1,400,000 annual savings estimate to be reasonable, and conservative, and will be utilized in our next budget projection and rate setting analysis should Hinge Health be implemented for the Retiree

[3] Assumed morbidity assumptions are based on the most recent actuarial valuation by Buck Consultants of the State's retiree health liability.

Plan. While the more refined analysis indicates greater savings may be realized, the analysis is heavily based on a number of assumptions. While these assumptions are considered reasonable individually and in aggregate, the actual savings will vary and be dependent upon a number of factors, including where participants live and their aggregate Medicare status. As a result we favor the simpler, more conservative estimate.

The current estimate for 2024 claims costs is $685,400,000. Both estimates are less than 0.4% of this figure.

Additional Considerations and Comments

The net savings per non-Medicare participant ($4,857) is approximately 10x the net cost per Medicare participant ($467). Therefore, the plan should achieve net savings in aggregate when the Medicare participants are less than 90% of the total Hinge Health participants.

The Plan’s membership is trending towards an increasing portion being Medicare eligible, but it will still be a number of years before the membership is expected to be 90% Medicare.

Claims costs, and associated gross savings, are expected to trend at 5-6% annually. The Hinge Health fee is expected to trend at a lower rate, resulting in the net savings per non-Medicare participant to trend at a higher rate and the net cost per Medicare participant to decrease over time.

To what extent claims trend exceeds the increases in Hinge Health costs will affect the ratio of net savings per non-Medicare participant to net cost per Medicare participant, which will impact the 90% threshold noted above. Higher claims trends will lead to higher break-even threshold levels.

This is not anticipated to be an issue for several years and projecting the anticipated timeframe for when the net aggregate impact of Hinge Health may become a cost is beyond the scope of this analysis.

Additional Notes

The data used for this analysis was reviewed, but not audited, and found to be sufficient and credible.

The above projection is an estimate of future cost and is based on information available to Segal at the time the projection was made. Segal has not audited the information provided. A projection is not a guarantee of future results. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, change in demographics, overall inflation rates and claims volatility.

Projection of retiree costs takes into account only the dollar value of providing benefits for current retirees during the period referred to in the projection. It does not reflect the present value of any future retiree benefits for active, disabled, or terminated employees during a period other than that which is referred to in the projection, nor does it reflect any anticipated increase

in the number of those eligible for retiree benefits, or any changes that may occur in the nature of benefits over time.

The Coronavirus (COVID-19) pandemic continues to evolve and will likely continue to impact the US economy and health plan claims projections for most Health Plan Sponsors. Unanticipated changes in the pandemic may impact the retirees' ability to utilize this program and result in experience that deviates from these projections.

cc: Betsy Wood, Division of Retirement and Benefits
Andrea Mueca, Division of Retirement and Benefits
Noel Cruse, Segal
Eric Miller, Segal
Quentin Gunn, Segal

March 6, 2023

Ms. Betsy Wood
Acting Chief Health Administrator
Division of Retirement and Benefits
State of Alaska
P.O. Box 110203
Juneau, AK 99811-0203

Impact of Adding the Hinge Health Digital Musculoskeletal Care Program as a Benefit for AlaskaCare Retiree Health Plan

Dear Betsy:

As requested, we have estimated the impact of the following change that is being considered for the AlaskaCare Retiree Health Plan members participating in the PERS/TRS Defined Benefit Plans (for those hired prior to July 1, 2006) and JRS:

- **Addition of Hinge Health** – Currently the AlaskaCare Retiree Health Plan provides coverage for physical therapy and other outpatient rehabilitative care services designed to restore and improve bodily functions lost due to injury or illness. The change being considered is to offer virtual musculoskeletal (MSK) care and physical therapy through Hinge Health. The program would be supplemental to all existing benefits.

Segal provided a memo dated December 21, 2022 which modeled the addition of Hinge Health. The annual fee for Hinge Health is $995 per engaged participant per year. Hinge Health offers a 1.5:1 Return-on-Investment (ROI), based on the average reduction in members' self-reported pain, with 100% of their fees at risk. Hinge Health estimates that a 1 percent improvement in pain equates to $71.09 in avoided claims costs. Hinge Health is currently offered through the State's Employee plan. Segal estimated that 2,900 retiree members would engage with Hinge Health, resulting in claims savings of $4.3M and plan costs of $2.9M, resulting in annual savings of $1.4M.

The proposed effective date is yet to be determined. We have assumed this change would be effective January 1, 2024. To estimate the financial impact of this change on PERS/TRS/JRS, we reflected the costs and savings provided by Segal to our projected cost during 2024 based on our most recent actuarial valuations as of June 30, 2022. Future net annual cost/saving increases were projected using the June 30, 2022 valuation assumptions. For members who are eligible for Medicare, Medicare provides primary coverage and the AlaskaCare plan provides secondary coverage (for those benefits that are not covered by Medicare). As such, it is our understanding that 80% of gross savings for Medicare members would go to Medicare while the remaining 20% would be received by the Plan. However, 100% of the cost for Medicare members that engage in this program will be covered by the Plan. Accounting for the reduced savings the Plan will receive for Medicare members, we estimate that the program would result in annual claims savings of approximately $1.7M, resulting in a net annual cost of $1.2M to the Plan. The tables on the following page provide a summary of how Hinge Health is expected to impact costs on a gross and net plan basis.

As noted, it is our understanding that the Hinge Health guaranteed ROI is offered on an estimated gross claims avoidance basis, without considering that the Plan pays secondary for Medicare members, as follows:

Retiree Group	**Number of Members Engaged**	**Annual Cost $995 per Engaged Member**	**Gross (Savings) Guaranteed 1.5 ROI per Engaged**	**Annual Gross Cost (Savings)**
Pre-Medicare	727	$723,365	($1,085,048)	($361,683)
Medicare	2,173	$2,162,135	($3,243,203)	($1,081,068)
Total	**2,900**	**$2,885,500**	**($4,328,251)**	**($1,442,751)**

In this second table, savings for Medicare members reflect an expectation that only 20% of the estimated gross claims costs avoided will generate savings for the Plan on a net basis.

Scenario 1 Retiree Group	Number of Members Engaged	Annual Cost $995 per Engaged Member	Net Plan (Savings) Guaranteed 1.5 ROI per Engaged	Annual Net Plan Cost (Savings)
Pre-Medicare	727	$723,365	($1,085,048)	($361,683)
Medicare	2,173	$2,162,135	($648,641)*	$1,513,494
Total	**2,900**	**$2,885,500**	**($1,733,689)**	**$1,151,811**

*Gross Medicare (savings) of ($3,243,203) are assumed to be shared 80/20 between Medicare and the Plan: ($2,594,562) to Medicare with the balance of ($648,641) to the Plan.

We relied on Segal's estimate that 2,900 retired members would engage with Hinge Health. Actual retiree utilization could be higher or lower. We expect more retired members to have a need for the service than active employees would, as older retired members are expected to have a higher prevalence of MSK issues. However, some older retirees might encounter technological, health or other barriers that could dampen utilization. Higher utilization among the pre-Medicare population can be expected to deliver the best savings opportunity for the Plan, as some members may defer costly surgeries until they are Medicare-eligible, when Medicare would cover most of the costs. Higher utilization for the Medicare population would pose a cost risk to the Plan, as indicated by an expected ROI below 1 on a net Plan basis. This is an important assumption to consider because the more Medicare members who participate, the greater the increase will be in the Actuarial Accrued Liability (AAL) and Additional State Contributions (ASC). We note that as the Plan population ages, it is becoming more prominently Medicare-eligible. At June 30, 2018, there were 2 Medicare members per 1 pre-Medicare member. Four years later at June 30, 2022, there were 3 Medicare members per 1 pre-Medicare member.

Founded in 2014, Hinge Health is a relatively new point solution. A number of studies have supported their assertion that the program delivers meaningful gross cost savings through avoided medical care. But as more experience develops over time, expectations could change.

We consider the Hinge Health guaranteed ROI assumption set as the most reasonable "baseline" for required GASB (Governmental Accounting Standards Board) cost reporting purposes. Results under two additional assumption sets offer alternative and more optimistic data points regarding this solution's potential. The "Study-Based" scenario uses peer-reviewed or independent studies to estimate the ROI for pre-Medicare and Medicare participants:

Scenario 2 Retiree Group	Number of Members Engaged	Annual Cost $995 per Engaged Member	Net Plan (Savings) Study-based ROI per Engaged	Annual Net Plan Cost (Savings)
Pre-Medicare	727	$723,365	($2,000,704)*	($1,277,339)
Medicare	2,173	$2,162,135	($1,153,863)**	$1,008,272
Total	**2,900**	**$2,885,500**	**($3,154,567)**	**($269,067)**

*per "Hinge Health 136 Employer Study" (page 14): $2,752 PMPY (per member per year)
**per "Hinge Health Medicare Cost and Utilization Study": $221.27 X 12 X 20% = $531 PMPY

The "Self-Reported Medicare" scenario uses a Medicare ROI of 0.76:1, based on information Hinge Health provided from two Hinge Health clients that are similar to Alaska. The pre-Medicare ROI for this scenario is the same as for the "Study-Based" scenario:

Scenario 3 Retiree Group	Number of Members Engaged	Annual Cost $995 per Engaged Member	Net Plan (Savings) Study-based and Self-reported ROI per Engaged	Annual Net Plan Cost (Savings)
Pre-Medicare	727	$723,365	($2,000,704)*	($1,277,339)
Medicare	2,173	$2,162,135	($1,642,788)**	$519,347
Total	**2,900**	**$2,885,500**	**($3,643,492)**	**($757,992)**

*per "Hinge Health 136 Employer Study" (page 14): $2,752 PMPY (per member per year)
**per Hinge Health's self-reported information from two clients that are similar to Alaska with Medicare ROI of 3.8 X 20% X $995 = $756 PMPY

Shown in the table below is a summary of the estimated increase in healthcare Actuarial Accrued Liability (AAL) for PERS, TRS, and JRS combined, the projected increase/(decrease) in Additional State Contributions (ASC) for FY25 if this change had been reflected in the June 30, 2022 valuations, and the projected increase/(decrease) in ASC through 2039. It is important to note that the June 30, 2022 valuations and FY25 contribution rates (which determine the FY25 ASC) have not yet been formally approved by the Alaska Retirement Management Board (Board). The June 30, 2022 valuation results are expected to be approved during the June 2023 Board meeting, and the FY25 contribution rates will be adopted during the September 2023 Board meeting. Impacts are also shown as a percentage increase/decrease). See Appendix A for the impacts split by plan.

FYE22 Healthcare AAL Impact on Combined PERS/TRS/JRS DB if Hinge Health Implemented ($ millions)

Scenario		Current Healthcare AAL for Combined DB as of 6/30/2022[1]	Increase in 6/30/2022 AAL[2]	% Increase in 6/30/2022 AAL
1	GASB Baseline	$9,117.7	$27.0	0.30%
2	Study-Based	$9,117.7	$ 9.0	0.10%
3	Self-Reported Medicare	$9,117.7	($ 0.5)	(0.01%)

FY25 Impact on Combined PERS/TRS/JRS DB Contributions if Hinge Health Implemented ($ millions)

Scenario		Pension and Healthcare Current FY25 Contributions for Combined DB[1]	Increase/ (Decrease) in FY25 Contributions[2,3,4]	% Increase/ (Decrease) in FY25 Contributions
1	GASB Baseline	$ 486.9	$ 0.1	0.03%
2	Study-Based	$ 486.9	($ 0.0)	(0.01%)
3	Self-Reported Medicare	$ 486.9	($ 0.1)	(0.02%)

FY25-39 Impact on Combined PERS/TRS/JRS DB Contributions if Hinge Health Implemented ($ millions)

Scenario		Pension and Healthcare Current FY25-39 Contributions for Combined DB[1]	Increase/ (Decrease) in FY25-39 Contributions[2]	% Increase/ (Decrease) in FY25-39 Contributions
1	GASB Baseline	$8,697.0	$ 0.7	0.01%
2	Study-Based	$8,697.0	($ 0.4)	(0.00%)
3	Self-Reported Medicare	$8,697.0	($ 0.7)	(0.01%)

[1] Current AAL shown includes only Healthcare. Current and projected contributions include both Healthcare and Pension reflecting State as an Employer and Additional State Contributions.

[2] All of the data, assumptions, methods and current plan provisions used in the above calculations are documented in the actuarial valuation reports as of June 30, 2022.

[3] The amount rounds to less than $0.1M where $0.0 is shown.

[4] Because the healthcare portions of these plans are currently overfunded, the increases in FY25 ASC for PERS and TRS reflects the increase in Normal Cost only. If the healthcare portions of these plans were not overfunded and the increases in AAL were to be amortized over 25 years according to the Board's current funding policy, the total increases in FY25 ASC would be approximately $1.8M for the Baseline scenario and $0.5M for the Study-Based scenario, and ($0.1M) for the Self-Reported Medicare scenario.

Additional Notes

Except as noted above, the data, assumptions, methods and plan provisions used in our analysis are the same as those described in the June 30, 2022 actuarial valuation reports.

The Retiree Health Plan Advisory Board (RHPAB), staff of the State of Alaska and the Board may use this letter for purposes of analyzing the potential impact of the benefit change described above. Use of this letter for any other purpose or by anyone other than the RHPAB, staff of the State of Alaska or the Board may not be appropriate and may result in mistaken conclusions because of failure to understand applicable assumptions, methods or inapplicability of the letter for that purpose. Because of the risk of misinterpretation of actuarial results, Buck recommends requesting its advanced review of any statement to be based on information contained in this letter. Buck will accept no liability for any such statement made without its prior review.

Future actuarial measurements may differ significantly from current measurements presented in this letter due to plan experience differing from that anticipated by the actuarial assumptions, changes expected as part of the natural operation of the methodology used for these measurements, and changes in plan provisions or applicable law. In particular, retiree group benefits models necessarily rely on the use of approximations and estimates and are sensitive to changes in these approximations and estimates. Small variations in these approximations and estimates may lead to significant changes in actuarial measurements. An analysis of the potential range of such future differences is beyond the scope of this letter.

Actuarial Certification

This letter was prepared under our supervision and in accordance with all applicable Actuarial Standards of Practice. We are Associates of the Society of Actuaries and Members of the American Academy of Actuaries. We meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinions contained herein.

If there are any questions, Stephen can be reached at (215) 586-1227 and Christian can be reached at (717) 308-8981.

Respectfully submitted,

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Principal, Health
Buck

Christian Hershey, ASA, MAAA
Senior Consultant, Health
Buck

Appendix A – Summary of Impacts Split by Plan

	Scenario 1 Hinge Health (“GASB Baseline”)		Scenario 2 Hinge Health (“Study-Based”)		Scenario 3 Hinge Health (“Self-Reported Medicare”)	
($ millions)	**$ Impact**	**% Impact[1]**	**$ Impact**	**% Impact[1]**	**$ Impact**	**% Impact[1]**
Increase (Decrease) in Healthcare AAL as of June 30, 2022[2]						
PERS	$19.6	0.29%	$ 6.6	0.10%	($ 0.3)	0.00%
TRS	7.3	0.30%	2.4	0.10%	(0.2)	(0.01%)
JRS[3]	0.1	0.34%	0.0	0.16%	0.0	0.04%
Total	$27.0		$ 9.0		($ 0.5)	
Increase (Decrease) in FY25 ASC[2, 4]						
PERS[3]	$ 0.1	0.03%	$ 0.0	(0.01%)	($ 0.1)	(0.02%)
TRS[3]	0.0	0.02%	0.0	(0.01%)	0.0	(0.02%)
JRS[3]	0.0	0.00%	0.0	0.00%	0.0	0.00%
Total[3]	$ 0.1		$ 0.0		($ 0.1)	
Increase (Decrease) in ASC through FY39						
PERS	$ 0.5	0.01%	($ 0.3)	0.00%	($ 0.5)	(0.01%)
TRS	0.2	0.01%	(0.1)	0.00%	(0.2)	(0.01%)
JRS[3]	0.0	0.00%	0.0	0.00%	0.0	0.00%
Total	$ 0.7		($ 0.4)		($ 0.7)	

[1] Increase in Healthcare AAL as a percentage of the June 30, 2022 Healthcare AAL. Increase in FY25 ASC as a percentage of the FY25 Contributions for Pension and Healthcare. Increase in ASC through FY39 as a percentage of the projected Contributions for Pension and Healthcare through FY39. Current and projected Contributions include both Healthcare and Pension reflecting State as an Employer and Additional State Contributions.

[2] All of the data, assumptions, methods and current plan provisions used in the above calculations are documented in the actuarial valuation reports as of June 30, 2022.

[3] The amount rounds to less than $0.1M where $0.0 is shown.

[4] Because the healthcare portions of these plans are currently overfunded, the increases in FY25 ASC for PERS and TRS reflects the increase in Normal Cost only. If the healthcare portions of these plans were not overfunded and the increases in AAL were to be amortized over 25 years according to the Board’s current funding policy, the total increases in FY25 ASC would be approximately $1.8M for the Baseline scenario, $0.5M for the Study-Based scenario, and ($0.1M) for the Self-Reported Medicare scenario.