Retiree Health Plan Advisory Board Meeting Materials

February 6, 2019

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Retiree Health Plan Advisory Board
Meeting Agenda

Meeting: Advisory Board
Date: February 6, 2019
Time: 9:00am - 4:00pm
Location: **Anchorage**: Atwood Building, 550 W 7th, 19th Floor Conf. Room
Juneau: State Office Building, 10th Floor Conf. Room
Teleconference: **1-650-479-3207 / Access Code:** 807 655 246
WebEx Link:
https://stateofalaska.webex.com/stateofalaska/onstage/g.php?MTID=e87948a4eff2842768de5fab4f6ee535b

Committee Members: Judy Salo (chair), Joelle Hall, Gayle Harbo, Dallas Hargrave, Mauri Long, Cammy Taylor, and G. Nanette Thompson

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February 6, 2019

9:00 am **Call to Order – Judy Salo, Board Chair**
- Roll Call
- Introductions
- Approval of Agenda*
- Ethics Disclosure
- Approve Previous Meeting Minutes*
    - November 28, 2018

9:10 am **Public Comment**

9:30 am **Department Update**
- Administration Updates
- Third-Party Administrator Procurement Update
- Review of Tele-Townhall

10:00 am **Break**

10:15 am **OptumRx Transition Update**
- Implementation
- EGWP

10:45 am **Modernization Process Outline**

- Timeline Options
- Communications Strategy

12:00 pm **Lunch on Your Own**

1:15 pm **Review Modernization Topic Analyses**

- DRB Presentations

3:30 pm **Public Comment**

3:50 pm **Final Thoughts**

- Next meeting: May 8, 2019

4:00 pm **Adjourn**

Retiree Health Plan Advisory Board

Board Meeting Minutes

Date: Wednesday, November 28, 2018 9:00 a.m. to 4:00 p.m.

Location: State Office Building 333 Willoughby Avenue 10th Floor, Juneau, AK 99801 and Robert B. Atwood Building 550 West 7th Avenue, 12th Floor, Anchorage, AK 99501

Meeting Attendance

Name of Attendee	Title of Attendee	
Retiree Health Plan Advisory Board (RHPAB) Members		
Judy Salo	Chair	Present
Cammy Taylor	Vice Chair	Present
Joelle Hall	Member	Present
Gayle Harbo	Member	Present
Dallas Hargrave	Member	Present
Mauri Long	Member	Present (phone)
Nan Thompson	Member	Present
State of Alaska, Department of Administration Staff		
Leslie Ridle	Commissioner, Alaska Department of Administration	
Michele Michaud	Deputy Director of Retirement + Benefits	
Emily Ricci	Health Care Policy Administrator, Retirement + Benefits	
Andrea Mueca	Health Operations Manager, Retirement + Benefits	
Betsy Wood	Deputy Health Official, Retirement + Benefits	
Shane Francis	Health Care Economist, Retirement + Benefits	
Vanessa Kitchen	Administrative Assistant, Office of the Commissioner	
Others Present + Members of the Public		
Lynda Gable	Aetna	
David Broome	Aetna	
Daniel Dudley	Aetna	
Hali Duran	Aetna	
Brianna Hoeppner	OptumRx	
John Zutter	SurgeryPlus	
Richard Ward	Segal Consulting	
Noel Cruse	Segal Consulting	
Quentin Gunn	Segal Consulting	
Linda Johnson	Segal Consulting	
Wendy Woolf	Retiree Public Employees Association (RPEA)	

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
- CMS = Center for Medicare and Medicaid Services
- COB = Coordination of Benefits
- DB = Defined Benefit plan (for Tier 1, 2, 3 PERS employees and Tier 1, 2 TRS employees)
- DCR = Defined Contribution Retirement plan (for Tier 4 PERS employees and 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 Medicare plan (IRMAA)
- IRMAA = Income Related Monthly Adjustment Amount, a surcharge from CMS for a Medicare plan for individuals or households earning above certain thresholds
- 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.
- OPEB = Other Post Employment Benefits; an accounting term used to describe retirement benefits other than pension benefits
- 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.
- RDS = Retiree Drug Subsidy program (a federal pharmacy subsidy program)
- RFP = Request for Proposals (a term for a procurement solicitation)
- RHPAB = Retiree Health Plan Advisory Board
- TPA = Third Party Administrator

Meeting Minutes

Item 1. Call to Order + Introductory Business

Chair Judy Salo called the meeting to order at 9:00 a.m.

Approval of Meeting Agenda

Materials: Agenda packet for RHPAB Meeting 11/28/18

- **Motion** by Gayle Harbo to approve the agenda as presented. **Second** by Joelle Hall.
  - **Discussion**: None.
  - **Result**: No objection to approval of agenda as presented. Agenda is approved.

Ethics Disclosure

Judy Salo reminded the Board members that they must complete the required form if there are any updates to their ethics disclosures. Board members should contact DRB staff for a copy of this form.

Introduction of New Board Member

Last month, the Board welcomed Nanette (Nan) Thompson as the newest appointment to the Retiree Health Plan Advisory Board, following her appointment in October 2018.

Approval of Previous Meeting's Minutes

Materials: Draft minutes from RHPAB Meeting 8/29/18

- **Motion** by Gayle Harbo to approve the 8/29/18 minutes as presented. **Second** by Cammy Taylor.
  - **Discussion**: None
  - **Result**: No objection to approval of minutes as presented. Minutes are approved.

2018-2019 Meeting Dates

Materials: Meeting Dates in 11/28/18 meeting agenda packet

The 2019 quarterly RHPAB meeting dates were finalized at the August 29 meeting. The Board still needs to determine the location for the in-person meeting for August 7 and 8, 2019. Board members expressed an interest in meeting with DRB staff in person, most of whom are based in Juneau.

- **Motion** by Gayle Harbo to hold the August 8, 2019 meeting in Juneau. **Second** by Cammy Taylor.
  - **Discussion**: None
  - **Result**: The board voted to approve the motion.

Hall	Harbo	Hargrave	Long	Salo	Taylor	Thompson
Yes	Yes	Yes	Yes	Yes	Yes	Yes

Motion passes, the August 2019 meeting will be in Juneau.

Item 2. Public Comment

Before beginning public comment, the board established who was present in Anchorage and Juneau, 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. Judy 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.

Public Comments

- **Charles Bill, CEO of Bartlett Regional Hospital.** He expressed Bartlett Hospital's concerns about the proposed travel benefit program. He is concerned about the impacts on Alaska-based health businesses, who represent a significant portion of the economy and tax revenue for the State. He shared that Bartlett is considered a small rural hospital and is different than an urban hospital, and the hospital's profit margin last year was 1.1%. They provide behavioral health services and an array of other services for a small community, and their "bread and butter" business helps cover the costs of these other services that are not reimbursed at a robust level. This policy for medical travel will impact rural hospitals in particular. He noted that the packet references orthopedic services in Juneau, and if there is more out of state competition for this service, he anticipates Bartlett may lose their existing orthopedic specialists including those in their emergency room, and would have to pay more to bring someone in to provide services.
    - Judy Salo thanked Charles for his testimony, and invited him to view the presentation from SurgeryPlus scheduled for today's meeting if possible.

Item 3. Department of Administration Update – Leslie Ridle, Commissioner

Commissioner Leslie Ridle thanked the Board for participating in today's meeting. She commented that this meeting is her last as Department of Administration Commissioner, and working with RHPAB has been one of the highlights of her tenure with the Department. She is glad the Board has been established and appreciates the work of each member. As a state retiree herself, she believes this board is very important for retirees, and is happy that the Board will continue in this work. She thanked the Board for their service, and thanked the staff for their hard work, as well as their expertise in this subject. She noted that the health plan's design is old and there are important changes that can benefit retirees and the plan. She advised staff to continue the great progress they are making on the health plans and maintain positive momentum.

She provided updates on several items:

Review of Tele Town Hall

- The November 15 Tele Town Hall focused on the Dental, Vision and Audio plan, but staff also fielded other questions about the retiree health plan and the pharmacy plan transition.
- DRB staff are extremely knowledgeable in answering questions, even without written notes!

- The next Tele Town Hall will be December 20, 2018, and will continue monthly as long as there is good participation from retirees, indicating that people have questions. They have been well attended by several hundred people each month, and seem to be informative for members.

Housekeeping Items

- Commissioner Ridle is preparing a transition report and met with the new Commissioner of Administration to discuss some of the work the Department is doing.
- Michele Michaud and Emily Ricci will be presenting to the Retired Public Employees Association on December 12 about the pharmacy benefit manager (PBM) transition.

Transition to New Pharmacy Benefits Manager

- This item is addressed below.

Item 4. PBM Transition and EGWP Update

Andrea Mueca shared that OptumRx now has access to individual members' information and can assist members with their plan information. The welcome kits will be mailed to all members by the end of this week, including the new ID card, required notices and other information. Some members are being contacted directly to address any issues specific to their situation. Overall, there are approximately 42,000 members to be enrolled in EGWP. Of those, only 900 members were identified as not matching CMS records, and are being directly contacted via a letter and phone call to address this discrepancy.

Brianna Hoeppner shared that OptumRx is working through the pre-implementation audit, their internal quality control processes have been completed.

- Judy Salo asked for the OptumRx concierge service number, for any members who need to call. She noted that Board members often get questions from other retirees and having information like this is helpful to refer people to the right place.
  - Michele Michaud stated that the concierge service number is (855) 409-6999.

Emily Ricci added that historically, members have shared that the required communications received each fall from CMS (annual notices and other letters) are often confusing, so this time period is often the busiest time of the year and risk of members being frustrated or having trouble understanding the communications. Staff are aware of this and working to prepare responses to common issues, if several people share the same concern that topic is a good candidate for an FAQ or specific follow-up.

- Judy Salo asked where Board members should refer people when questions arise, should they provide the OptumRx or DRB contact number?
  - Emily Ricci responded that generally, the OptumRx concierge service is the first point of contact for members on most issues. That number is (855) 409-6999.
- Judy also asked, having not attended the most recent Town Hall on 11/15/18, were there a lot of questions about the pharmacy transition?
  - Commissioner Ridle added that the featured topic was the Dental, Vision and Audio plan, which was the top choice in the audience poll given during the previous Town Hall event, retirees were asked what topics they would like future Town Halls to focus on.
- Joelle Hall asked whether this transition information has been spread to retiree groups, and active employee local unions, to share information if they get questions from their members

and other contacts? She recommends providing this information for their members, as they will likely also get questions about the transition.
    - Emily Ricci responded that DRB staff has not done this yet, but agrees this is a great idea, staff will follow up to provide this information.
    - Commissioner Ridle suggested that staff brief the new contact in the Governor's office who is tasked with constituent relations, so they also have this information.
- Joelle also asked whether this information will be provided to legislators' offices, as this is another place that constituents often contact for information?
    - Commissioner Ridle shared that staff have provided this information previously to the sitting legislators, but will need to do this again. Staff will provide this information to the incoming legislators' staff, when the new staff are in place.
- Cammy Taylor requested that DRB staff add Joelle Hall, as the public member who is not a retiree, to the mailing list for materials sent to retirees? (Other Board members suggested adding Dallas Hargrave as well, and suggested non-beneficiary legislators be added to the list).
    - Staff will follow up with staff when the new legislative offices are in place.

Because the Board was significantly ahead of schedule on the agenda, the 15-minute morning break was shifted to 9:30 a.m. The Board resumed at 9:45 a.m.

Item 5. Presentation by SurgeryPlus

Materials: SurgeryPlus Overview Presentation in 11/28/18 meeting agenda packet

John Zutter thanked DRB staff and the Board for inviting him to present, and for the opportunity to provide travel benefits to the State of Alaska. The presentation included in the packet provides an overview of the services they are currently providing for active employees, and the proposed services for retirees. He invited questions from the Board throughout the presentation.

See page 36 of the packet for an overview of the procurement process: the RFP process began in January 2018, and SurgeryPlus was awarded that contract in August. They began providing travel benefit services for active employees, and the contract allows for the possibility to extend similar services to retirees and dependents covered under the retiree health plan, which is the topic of discussion today.

SurgeryPlus and DRB staff are discussing, in addition to the standard SurgeryPlus services for some non-emergency surgeries, offering additional travel benefit services for other procedures, which they have prepared a cost estimate for. There is a range of options, to be presented later today.

SurgeryPlus has three primary values:

1. Provide surgeons of excellence: including quality providers and skilled practitioners.
2. Employee satisfaction: providing high quality service to members, having a good relationship and consistent support throughout the process
3. Clear savings and return on investment (ROI): because they focus on very specific services, they can also focus on achieving cost savings without giving up quality.

He provided an example of the market of orthopedic surgeons in Tampa, Florida, and how they selected their providers, all of whom are top of field, and the additional qualifications they must have: Board certified, have completed a specialized fellowship, do not have any sanctions or disciplinary actions

against them in any state, and do not have any criminal charges related to malpractice. It is surprising how many providers do not meet all of these criteria. SurgeryPlus conducts a thorough background check for each provider in their network, in each state because most actions against medical providers are at the state level and must be researched individually.

Facilities are also closely evaluated, looking at standard quality metrics for each facility in addition to the individual providers. SurgeryPlus looks at both the individual surgeon and the facility to determine which providers will provide the highest quality service.

- Cammy Taylor asked whether SurgeryPlus also looks at the success rate and volume of procedures as a measure?
  - Yes, SurgeryPlus looks at frequency and volume of procedures done each year, as well as specific expertise per procedure (for example, experience in hand surgery is different than general joint surgery). It is important to find providers who have done a high volume of procedures to ensure they are skilled and experienced with that work.
- Judy Salo referred back to the public comment earlier in the meeting from Bartlett Hospital, and anticipates that other rural hospitals and providers have the same concerns. She asked John Zutter to speak to this issue of perceived competition with in-state providers, as well as whether it is possible to certify Alaska-based providers in the network?
  - John responded that in any market, there are certainly economic and political considerations for providing travel benefits. He noted that they work with a variety of public employers and have experience with controversial discussions on this topic. He stated that SurgeryPlus is open to adding any provider to the network, provided that they meet 1) quality and 2) cost standards, because they cannot compromise on those two metrics and continue to provide the services they intend to provide.
  - He noted that the available national data shows that in general, there is higher cost and lower quality health care in rural areas, which can be attributed to the lower population density in the market, difficulties in recruitment and getting supplies to rural areas. He also stated that Alaska has higher reimbursement than most of the U.S., which is challenging when comparing with providers in many other states.
- Commissioner Ridle asked why there are no participating centers in New York, as an example?
  - John responded that the map in the packet is current as of March 2018, and since that time they have added additional network providers, including in New York City and Rochester, NY. They began in Boston and are currently located in Texas, but they generally look for business in large urban areas, where most of the U.S. population lives, and to build strong options in those communities. Their primary focus is large metro areas, where there are typically the most providers including specialists.
  - Looking at Alaska's retirees across the lower 48, he believes they have a strong network to serve that population. He noted that most procedures are likely to happen in Seattle as well as in California. One of the providers in Seattle is Virginia Mason, they have a very good reputation and record. Another is CHOMP (Community Hospital of Monterey Peninsula) in northern California, the top-rated organization in that field.

John continued: their goal is not only to provide assistance, but to provide high quality service. They recruit employees with a high degree of empathy to build a relationship with the customer; they provide education to members about the available options and how they should evaluate their choices; they

research and give three options for the member to choose a provider, with ample information about each to allow the member to do their own research before making a decision. Their goal is not to steer someone to one provider, but to give sufficient information for the member to decide. He noted that typically, people get specialist referrals from a primary care provider, friends and family recommendations, and online searches; none of these sources are necessarily sufficient to evaluate quality and whether that specialist provider is a good choice. He added that trust is very important, building trust with the customer and ensuring that they trust the provider doing their procedure. They also get recommendations from customers to add a doctor to their network, and can build that network over time with providers who meet their criteria.

SurgeryPlus also provides logistical support in scheduling, dealing with medical records, and other services that can be stressful for a patient to do on their own when arranging for care. The goal is to connect someone with a staff member ASAP, and help them navigate the process. Care advocates also provide follow-up and additional care coordination services, ensuring that people also get post-surgery treatments such as physical therapy, which aids in recovery and helps ensure a successful procedure.

- Commissioner Ridle asked what is included in the 35-day average from beginning to end, does this include the member's decision-making process?
    - Yes, this is an average of all services, for all customers. Some can be handled within 10 or 20 days (typically not lower than that), others may be scheduled far in advance. The goal is to move through the process efficiently and get the member the procedure they need as soon as possible, or when they choose to schedule it.

Page 43 includes an example of cost comparison for SurgeryPlus cost for a total hip replacement (including all the services needed for that procedure), compared with other providers' costs. There is a great deal of variety in quality, and not correlated with cost. SurgeryPlus is consistently below the national average, and overall can demonstrate higher quality outcomes than average. Venue selection is a factor as well, in both quality and cost. Page 44 provides a comparison of typical Alaska rates for some procedures, compared with SurgeryPlus average costs. Additionally, the significant cost savings for these procedures are not only beneficial to the plan, but also for the member, who will pay less out of pocket for a high-quality procedure.

SurgeryPlus currently does not cover some procedures: oncology, brain procedures, births (maternity care), dental and vision, and any emergency surgeries, which are not planned in advance. They are working to add oncology and brain procedures in 2019, after working through the logistical issues.

Proposed Expansion of Travel Services

John shared that DRB staff approached the company with some possible parameters for additional services and asked the company for their thoughts on how to provide these services, and at what cost. He noted that Alaska is an especially unique health care market, and the "off the shelf" services they provide need to be customized to meet the needs that the State defined.

The State's objectives are:

1. Broaden the scope of travel services provided.
2. Provide best possible experience for plan members.

3. Provide education and advocacy to make informed decisions (quality, access, appropriateness, and cost).
4. Increase utilization of travel services for some procedures.
   .

- Nan Thompson noted that "travel" in Alaska often means great distances in state for care. Have any Alaska providers been added to the service? And would broadening the scope of services include services from Alaska providers?
    - No, there have not been any Alaska providers added to the SurgeryPlus network to date. However, broadening the scope can certainly involve Alaska providers.

Page 49 includes multiple options for consideration, on a continuum from status quo to full service:

- The status quo includes travel services provided by Aetna, and specific travel benefits for the procedures covered by SurgeryPlus.
- A limited expansion could be some policy changes such as including a companion in more circumstances, depending on the procedure and medical necessity, and an increase in the lodging and travel reimbursement. This would still involve multiple vendors, but would provide some additional benefits compared with the status quo; it would likely be primarily a reimbursement model so the member has less upfront cost.
- A concierge travel service would provide more proactive services, including flight and hotel booking, and payment upfront rather than reimbursement. This also gives the State more control over the process and what travel benefits are provided, potentially fewer denied claims after the fact if someone did not choose something fully covered by the plan, while leaving the care decisions to the member for their procedure.
- Finally, a concierge medicine service would provide a broader scope of services, including travel and other arrangements, and can help coordinate travel to go to a high-quality provider either in state or out of state. The service would include research and information to help the member choose a high-quality provider, essentially a member advocate for their health care needs. This would be especially helpful for the highest utilizers of services: the top 1% of patients incurs about 30% of costs, and the top 5% incurs about 50% of costs. Helping this group in particular could manage costs, and helping the larger group more generally with travel arrangements.
- Dallas Hargrave asked which of the options presented is currently offered to active employees?
    - Currently, the "limited expansion" model is being offered to active employees, including the standard services for SurgeryPlus and some other travel benefits.
- Emily Ricci noted that staff are envisioning this travel benefit to help people in state, particularly in rural areas with limited access to specialty procedures, as well as out of state. Someone in Bethel or Nome, for example, could use SurgeryPlus to coordinate travel to Anchorage or Fairbanks to get a procedure they need.
    - John added that under the concierge medicine model, their staff would be able to help research options for the member, and help that member make a decision for local care.
- Cammy Taylor asked for clarification, this concierge medicine model would include services not in the SurgeryPlus network?
    - John responded that yes, the travel coordination services could be utilized for any medical service from any provider, not just those who are in the SurgeryPlus network.

- Cammy also asked, given that 70% of retirees are eligible for Medicare, how does this impact the services provided?
    - John responded that most of their network providers accept Medicare, so they would still be able to access the same provider options.
    - Regarding the logistics and decision process, for Medicare eligible members, SurgeryPlus would still do the coordination but would not pay, since Medicare has lower rates and would therefore be the payer.
    - The rest of the services would still be available, and SurgeryPlus would still be able to help someone find a quality Medicare provider to provide that service.
- Joelle Hall asked for clarification: for the active employees' plan, were the options available for this plan as well, and what was the decision process for offering the more limited expansion of services for those employees?
    - John clarified that the new options, concierge travel and concierge medicine, were developed over recent months, after the services for the active employee plan were put in place. The same or a variation on these services could be offered to active employees as well, if the State wants to expand that contract.
- Judy Salo asked about the concierge travel services and the process of adding new providers: is it possible to complete the credentialing process relatively quickly, for example if someone's preferred provider was added to the network?
    - John noted that credentialing can be quick, but contracting takes time, as this requires negotiation with the provider, there needs to be two willing parties to enter the contract. However, their intent is not to compete with Aetna and Medicare pricing, for example, and would look at available options within their current network(s) so that members are considering options within their network.
- Judy also asked about outpatient surgery centers as a relatively lower cost option for surgery, compared to traditional hospitals. How are surgery centers evaluated for quality?
    - John responded that unlike hospitals, outpatient surgery centers are not regulated by CMS, so there is less available data about these facilities, including quality measures. However, SurgeryPlus still evaluates these facilities for the network, looking at credentialing information, relying on the expertise of the medical advisory board, and conducting a site visit to evaluate the facility onsite. Some of SurgeryPlus's staff has expertise in this area of evaluating quality.
    - Some procedures are not necessarily appropriate for outpatient surgery centers, including risk of complications and potential for needing to be admitted to the hospital if something goes wrong. SurgeryPlus may find that even if an outpatient facility is licensed to perform a particular procedure, it is not necessarily the best fit. For example, some procedures such as spinal cervical fusions should be done inpatient because of serious risk of throat swelling and therefore need for intubation. They may recommend not using an outpatient setting for that procedure in that circumstance.
- Emily Ricci asked for clarification about the role of providers in reviewing the patient's medical record, and the decision process used by SurgeryPlus, their providers and the patient?
    - John responded that the provider's judgment and advice is an important aspect of the process, they offer a determination whether the patient would be a good fit. Including the care coordinator/advocate, provider and the patient in the decision process can

ensure better outcomes and encourage asking the right questions. For example, a provider reviews the patient's medical records and may suggest a procedure is not a good fit based on other aspects of their health.

There are different tiers of members' needs:

1. The top tier is a small group needing the most attention and case management for complex, high risk issues. While much of the case management functions would be filled by the primary plan carrier, in this case Aetna, SurgeryPlus would also provide some of these services in the context of these procedures.
2. The next highest tier is individuals that may have one or more high cost episodes, such as a serious injury and rehabilitation, but their utilization is more infrequent and/or is mainly associated with one episode of care.
3. The third tier represents most of the plan's members, those who do not frequently access high-cost care, or who do not have a high-cost care episode. This group would still benefit from travel coordination and any non-emergency surgeries needed over time, but will utilize these services less than those in the other two tiers.

- Mauri Long asked what the qualifications are for care advocates?
    - Care advocates are not clinical staff, but have college or graduate level education, are passionate about health, and have good communication and empathy skills. Many have a social work background. These are the day to day contacts for members. Care advocates are not intended to be clinical staff and provide medical advice, but to give recommendations and information to members to make decisions.
    - The SurgeryPlus medical advisory board includes medical professionals with expertise in a number of specialties.
    - The company also has a highly experienced chief medical officer, with clinical experience, who is available for consultation. The advisory board members are also available for consultation as needed.
- Mauri also asked how long SurgeryPlus has been in business?
    - John responded that SurgeryPlus is the name of their primary product, the company name is Employer Direct Healthcare and has been operating since 2011. The current ownership group has been in place for 3 years. John is the CEO and is also part of the ownership group.
- Mauri also asked whether the statistics provided are based on data since 2011, or what is the timeframe for this performance record?
    - John noted that the company was formed in 2011, but most reliable statistics begin in 2013 as the company grew, so their performance numbers presented represent a 5-year time period. The company continues to grow, including providing services to several public sector employers across the U.S.
- Mauri commented that in her experience with out of state travel, if a person travels out of state to get a procedure and needs follow-up later, she has found that local providers may be unwilling to take on the case because they did not perform the procedure. How would SurgeryPlus address this issue?

- John responded that in terms of complications, there are two typical categories: first, a complication that happened during the episode of care; second, a complication that occurred after discharge, possibly after some time has passed.
    - For the first situation, the complication is addressed while the person is at the facility.
    - For the second situation, the person must go to the emergency department and cannot be refused care, those are typically emergent situations like infections.
    - The situation Mauri described is a third scenario, which may involve sending the person back to the original doctor, or requiring finding another provider to deal with the complication. In their experience, they have not had complaints about providers not accepting a patient to deal with a complication. He also noted that in 2018 so far, their complication rate is 0.5%, below the national average.
- Judy Salo asked what medical expertise they have in house to oversee operations?
    - John responded that they have specialists in several fields, including general surgery, ear nose and throat, orthopedic and musculoskeletal. He provided examples of the advisory board members' qualifications. He also noted that some board members are specialists in revisions, which means analyzing and addressing complications in procedures, specifically procedures done by another provider.
    - They take care to recruit qualified and experienced medical professionals, and this significantly reduces complications for these procedures. It is not realistic to assume that a provider will never have complications, but it is important that the provider knows how to respond to this, and has likely had to deal with complications for that procedure over the years with a variety of patients.
    - If there is a provider that has a complication, SurgeryPlus will investigate and review the case, including the member and doctor's notes, interviews with the member and the provider, and will remove that doctor from the network temporarily until the case is resolved. There may be a "small c" complication, meaning that it was an unavoidable outcome which happens from time to time, or a "big C" complication, meaning it was an error or misjudgment by the doctor. If the complication was unavoidable, the doctor will be returned to the network; if the complication was the fault of the provider, they have a "1 strike" policy and that doctor cannot return to the network.

Page 52 includes an example, a rotator cuff surgery, and the cost difference between an outpatient surgery center versus a hospital (in this example, it is about $7,000 more expensive in an inpatient setting, as well as potential risk of infection or complication from being in a hospital).

SurgeryPlus also focuses on value by looking at appropriateness of diagnosis as well as incidence of complications, looking at avoided complications but also avoided procedures if there is a more appropriate treatment than the surgery proposed. This helps avoid unnecessary surgeries, which can save cost but also ensure that patients get the right treatment and therefore better health outcomes; even if the appropriate procedure is more expensive, it would still result in better health outcomes because it is the best treatment for that situation. Proactive follow-up also improves health outcomes.

Page 55 includes potential travel policies regarding coverage of flights, hotels, ground transportation and per diem. The goal is to find the most appropriate solution, including when travel is or is not appropriate for that procedure. This would include the cheapest but also most efficient option, which would include an economy flight with minimal connections; a reasonably priced and quality hotel near

the surgery location; reimbursement for ground transportation; and per diem during travel days. Regarding companion travel, the company looks at medical necessity as well as practical necessity: for example, if a procedure requires general anesthesia or significant recovery time, a companion can help. If the person is a minor, one or both parents should be able to accompany the child. Additionally, the policy allows some flexibility in terms of additional travel needs (for example, traveling earlier to see family before the procedure), but if it is not medically necessary, the member would be billed for those additional charges, such as extra hotel nights or a differential in flight cost to accommodate a personal visit or other business.

- Judy Salo asked DRB staff to report how well this service is operating now for the active employee plan, recognizing that it has only been in place since August 2018, and also about the timeline to implement this for retirees if this recommendation moves forward.
    - Andrea Mueca shared that so far the experience has been positive, there have been approximately 6 procedures done already, and 2 which are still in progress. One member provided a thorough review of the process and had a very positive experience; this member was able to pay for most services with a prepaid card to cover expenses.
    - John shared that they have received 80 unique callers, 56 wanted to open a case to determine if it is a good fit. Of those, 6 were completed and there are 28 actively in the queue. Within the 28 in process, 7 are transferring medical records; 2 are waiting for a procedure scheduled in the future; 2 have scheduled consults; 6 scheduled procedures in the next few weeks; and some are actively evaluating their provider choices.
    - Emily Ricci added that overall, they have gotten positive feedback from members, and have gotten inquiries about other procedures that are not covered now but people want travel coordination for these services. There has been a learning curve, a few members have expressed frustration of the general complexity of traveling for medical care.
    - John shared that their experience has also been positive, they are learning a great deal about Alaska's unique market, and are learning from their mistakes to improve care.
- Emily Ricci commented that during the process, some members do use this service but end up deciding to stay locally for the procedure. She believes the largest reason for a member initiating the process and not using the benefit is because the person opts to stay local for the procedure. She sees this as a success either way, as people have choices for their care.
    - John added that their staff compensation and performance is not based on the volume of surgeries they coordinate, but the quality of care and members' feedback, so quality of customer service is the basis of their compensation. This ensures that the incentive is not to provide as many surgeries as possible.
- Gayle Harbo asked John Zutter his qualifications?
    - John shared that he grew up in New York, attended Colgate University and studied Middle Eastern Political Science. He previously worked as an investment banker, including helping make a company public, and then moved to Texas and worked with another founder of the company to buy the company. He has been CEO of the company for 2 years and involved in day to day operations now. He has found his non-medical background to be both helpful and a barrier to this work, but overall still a good fit.
- Mauri Long asked how active the medical advisory board is in day to day operations?
    - John responded that the two board chairs are compensated with equity in the company, and do not receive a salary but have an incentive for long-term success of the company.

They have multi-year contracts. Other board members are case by case, they may be paid hourly as needed, for example. The chief medical officer is a salaried employee.

- Mauri also asked when was the SurgeryPlus service first offered, and how has it changed?
  - The core service has been offered since 2011, but they have expanded their care advocacy services more recently. He also noted that the proposed additional services (medical concierge services) are beyond the scope of what they offer today, but they are working on offering this to a few other clients with similar needs, and he sees it as consistent with the services they already offer. Offering this for services other than the surgeries they focus on would be a broadening of scope.
  - He added that in 2019, they anticipate having 1.25 million members in this network and have access to the services they provide.
- Mauri also asked how many completed procedures they have done?
  - John did not have the exact number, but estimated that the company has completed approximately 10,000 procedures since 2011.

Board members thanked John Zutter for his presentation, and indicated that many of their questions will be for DRB staff regarding timeline and the process for reviewing this proposal.

Item 6. Board Member Volunteers

Note: this item was originally scheduled for 3:00, but was shifted to earlier in the day because the Board was ahead of schedule.

There are two volunteer needs for RHPAB members:

1. Participation in the proposal evaluation committee (PEC) for the third party administrator (TPA) procurement process in 2019, for the plan year starting January 1, 2020.
   - Cammy Taylor expressed interest, but wanted to know what the schedule would be.
   - Nan Thompson also expressed interest, and is available based on the schedule shared by staff. She is not experienced or expert in this area, she anticipates having a lot to learn!
   - Judy Salo commented that she did not have experience when she participated in the procurement process for the pharmacy plan, but found the entire process to be extremely informative and valuable. She encouraged Nan to participate.
   - Commissioner Ridle added that staff bring a great deal of expertise to the process and can help educate the committee members who do not have this expertise. Additionally, it is very valuable to have a non-health-care-expert participate to bring that perspective to the process, and ask questions that others may not think of.
   - Emily Ricci shared that the deadline for proposals is December 18, 2018, with the goal of having a PEC meeting on January 28-29, 2019. The committee will score proposals, with the top scoring vendors scheduled for interviews. There will be separate interviews for the medical vendor and the dental, vision and audio vendor, essentially two concurrent processes for those plans. The interviews are tentatively scheduled for Thursday and Friday, February 7-8, 2019, following the quarterly RHPAB meeting on Tuesday and Wednesday, February 5-6, so this would be a busy week. Interviews may go into the following week. There will be preparation time reviewing the proposals and scoring them individually. Staff

estimate at least 40 hours of work, including meetings and other preparation time, but it may be slightly more.

- The group discussed where interviews should take place; it is likely logistically easier to hold them in Juneau, and this is the interview location stated in the RFP.

- **Motion** by Cammy Taylor to appoint Nan Thompson to the proposal evaluation committee (PEC) for the medical, dental, vision and audio plan procurement process. **Second** by Joelle Hall.
    - **Discussion**: None.
    - **Result**: The board voted to approve the appointment.

Hall	Harbo	Hargrave	Long	Salo	Taylor	Thompson
Yes	Yes	Yes	Yes	Yes	Yes	Yes

Appointment of Nan Thompson to the PEC approved.

2. With the departure of Mark Foster from the Board in October, a third modernization committee member is needed. Cammy Taylor is the chair, and Joelle Hall is one of two committee members. The group discussed who is interested and available to serve on this committee.
    - Betsy Wood clarified that in the previous meeting, Cammy Taylor was already selected as chair by a vote of the Board, so there is no additional action needed in this meeting.
    - Judy Salo indicated that as the Board chair, she still intends to participate as much as possible to track what is being discussed and learn the detail shared in those meetings.
    - Mauri Long volunteered to serve on this committee, she hesitated previously because of other time commitments she could not control. Her only caveat is that she will not be able to participate in person for every meeting, but is willing to serve and will call in if not available in person.
    - The group agreed that in person participation is not necessary, they would very much appreciate Mauri serving on the committee.

- **Motion** by Judy Salo to appoint Mauri Long as the third member of the modernization committee. **Second** by Cammy Taylor.
    - **Discussion**: None
    - **Result**: The board voted to approve the appointment.

Hall	Harbo	Hargrave	Long	Salo	Taylor	Thompson
Yes	Yes	Yes	Yes	Yes	Yes	Yes

Appointment of Mauri Long to the modernization committee approved.

The Board took a lunch break at 11:55 a.m., and returned to the meeting at 1:15 p.m.

Item 7. Modernization Committee Report + Review Modernization Table

Materials: Modernization Table and related materials in 11/28/18 meeting agenda packet

Judy Salo called the meeting to order and again thanked staff for their work on the packet, particularly the table on page 57 that summarizes the list of proposals being considered.

Cammy Taylor also thanked staff for their work, and shared that while the modernization committee does not have any specific recommendations or action to bring to the Board today, they are continuing to review and discuss the proposals. She noted that the table includes, at the Board's request, the fiscal and actuarial impact if it has been researched. For example, while the proposal to change the plan to incentivize in-network care was intended to generate cost savings, the research by staff and Segal Consulting found that because out of pocket maximum is relatively low, most members meet that maximum each year so there would not be as much financial impact as anticipated, and in fact a slightly higher financial impact to the plan because in-network services would be paid at a higher percentage.

- Judy Salo asked for clarification about the impact matrix (page 59 in the packet): for example, enhanced travel benefits show a net zero actuarial impact, but a fiscal impact of cost savings.
  - Cammy Taylor explained that the two axis, actuarial and fiscal impact, show whether it has a positive, negative or neutral impact in either category.
- Judy also asked why the actuarial value of the plan is net zero for the enhanced travel benefit?
  - Richard Ward responded that the actuarial value only changes if the fundamentals of the plan change (co-pays, co-insurance rates, etc.). The enhanced travel benefits proposal provides more access to care and more efficiencies in terms of cost, but does not change those fundamentals in the plan.
  - Richard also shared that the team is working on a dynamic tool for assessing combinations of the different proposals, for example looking at whether one is adopted or not adopted, and the net impact of multiple suggestions. This will be available in the next meeting.
- Cammy Taylor commented that the intent of looking at these proposals as a whole is to determine the additional costs of including additional benefits that members have asked for,
- Emily Ricci noted that one proposal not on the list, but could be considered as part of the discussion of offsets.
  - Emily also pointed to #5, out of network reimbursement (recognized charge) should be discussed as a potential offset.
  - Additionally, she is interested in researching services that people are utilizing at a higher rate than average, to understand why these services are being utilized and what if any plan design changes could be made to address that need.
- Dallas Hargrave asked, regarding #17 "add medically necessary treatment of gender dysphoria, including surgery." He recalls this item being brought up in the previous meeting, and noted that the individual who testified submitted follow-up public comments, asking what if anything has been done on that topic since the August 29 meeting. He also noted that the individual participated in today's meeting in Juneau. What is the status of this, and could this be added?
  - Michele Michaud responded that the analysis has not been done yet, but it does not look more difficult or complicated than the others.
  - Richard Ward added that his firm has done analysis of this service for other plans, he can draw on the work already done to complete this analysis.
- Cammy Taylor highlighted the drug-related proposals (#12, #13, #14) regarding pharmacy benefits, and asked if these should be considered together?
  - Emily Ricci responded that regarding #14 about compounded pharmacy products, staff are working with independent pharmacies and have been working on an agreement for

participation in the plans. Staff are still working on this, but will bring it back to the Board when it is further along. She also noted that item #3 (high-value pharmacy network for some members) could be discussed with #14.
    - Emily further noted that #11 and #12 should potentially be discussed together, as both would directly impact members, and it would be a sensitive topic for members. The change to a 3-tier pharmacy system was done in the active employee plan 2 years ago.
    - Emily further noted that #13 is not a high priority, as it could be a good change to the plan but they do not anticipate this being as important as some other items on the list at this item.
    - Richard Ward noted that #12 could have some steerage/cost control implications because they would incentivize use of generic drugs and certain brands, depending on how the tiers are defined.
- Cammy Taylor commented that retirees will want to understand what the net impacts of these proposals would be, particularly what the offsets would be if additional benefits are added as proposed. This will help retirees evaluate the trade-offs. The spreadsheet discussed earlier will be value for looking at these together.
    - Emily Ricci agreed, this will be a helpful tool and helps inform the conversation about the net enhancements or diminishments to the plan.
    - Richard Ward added that it is also important to not assume that the impacts are additive, some are related proposals or may have inter-related impacts.
- Cammy Taylor noted that the group has also discussed adding other types of services, such as rolfing, as well as wellness programs. Is there an update on any of these discussions?
    - Michele Michaud responded that in the case of paying for some health benefits via a reimbursement account, for example, paying part or all of the cost of a gym membership, staff researched this question but found that it is a taxable benefit, not non-taxable, even if done through a reimbursement account.
- Dallas Hargrave asked for clarification, for the active employee plan, are the wellness benefits offered in that plan taxable?
    - Emily Ricci responded that the benefit is actually a voluntary discount offered by certain gyms and other facilities, and not a taxable reimbursement, so this is the way to avoid the tax implications of a reimbursement (cash) transaction. This approach may be more feasible for active employees, as they all or mostly live in state.
- Cammy Taylor asked staff and the Board for their priorities for the December 12 modernization committee, for staff to prepare analysis in advance of the meeting?
    - #3 (implement a high-value pharmacy network with lower copays for chronic meds, medical synchronization, counseling, and packaging options for participating members) and #14 (limit compound coverage to high-quality, narrow network of pharmacies) will not be ready in December, Emily suggested these for a January meeting.
    - Joelle Hall commented that she would like the committee to review one or more of #5 (out of network reimbursement), #11 (increase deductible and out-of-pocket maximum) and #16 (in-network enhanced clinical review of high-tech imaging and testing). There are only two weeks before that meeting, she recognizes the amount of time needed to prepare these proposals.

- Emily Ricci suggested that discussion of #11 (increase deductible and out of pocket maximum) would be the easiest to prepare in the short time before the next meeting.
    - Cammy Taylor agreed, this would be useful to evaluate, knowing that it would be one of the more controversial items on the list.
    - Commissioner Ridle commented she agrees that it is better to share all of the proposals upfront if they are to be considered as part of the package for discussion, this ensures transparency and gives members time to consider the potential tradeoffs on the table.
- Mauri Long asked for clarification on #6, co-payment for primary care?
    - Emily Ricci explained that this proposal would allow for a simple co-payment, rather than including this under the deductible and co-insurance, for primary care. This is intended to incentivize primary and preventive care. She noted that plan members are using specialty care at a higher rate than comparable other plans, it is worth reviewing how to better incentivize primary care and reduce the financial burden on members to seek this care.
- Mauri Long asked for clarification about the actuarial and fiscal impact for a new program: would offering a new program have an impact on actuarial value, if it is not offered in the plan today?
    - Richard Ward clarified that it would depend on whether we are discussing care and services, or other benefits with financial impact. There are two different categories, one is care and services (actual services the member can access, and at what amount) and other benefits, such as the travel benefit, that are not a specific service but have a financial impact.
    - Commissioner Ridle also clarified that there can be carveouts or exceptions to the general policies in the plan.
- Mauri commented that in order to incentivize preventive care, for example, if the goal is to manage costs, then this should also focus on in-network providers.
    - Michele Michaud agreed, there may be overlap in these proposals, and also it may be beneficial to incorporate network steerage into any other proposal to incentivize in-network care, including for any new benefits or programs offered.
- Mauri also commented that she appreciates the in-depth analysis for each individual proposal, including impacts to members, operations and clinical implications, and impacts to retirees versus the plan. She understands the purpose of summarizing the fiscal and actuarial impacts on the table, but suggests that it would be helpful to also see impacts to the retirees on this table, so retirees can see what impacts would be to them individually as well as to the plan.
    - Judy Salo agreed that it is important to consider impacts on retirees. She noted, however, that this is a complicated question: would it be a minor impact to many members, or a significant impact but to a few members? For example, rehabilitative benefits are likely to be of great interest to some retirees, but most people do not utilize these services up to the annual maximum. This would be difficult to measure overall impact to members, and could change depending on the number of visits or otherwise limit on that service. She appreciates staff's

efforts to characterize impacts to retirees by the level of impact on an individual retiree, as well as the number or portion of retirees who would be impacted.
        - Cammy Taylor agreed that this will be helpful information, particularly when analyzing proposals, but will be more useful when looking at the proposals together and making tweaks to the various options to find the right balance.
    - Cammy Taylor commented that for preventive services, as more people are eligible for Medicare over time (it has changed from 60% to 70% since she began working on this project), how will that change over time per the projected population changes and the mix of Medicare eligible retirees in the plan?
        - Richard Ward responded that this is a good question, and the number who are eligible for Medicare does have a big impact on the per capita costs of the plan, this is something they do track and consider for long-term planning. He noted that the analysis is focused on a 1-year timeframe (comparing the proposal to actual recent costs), but this should be considered over a longer time frame.
        - Judy Salo also noted that changes in state law will result in fewer people retiring before age 65, so relatively more people will be eligible for Medicare on retirement. Additionally, people are working longer (later in their life) and are more likely to be eligible for Medicare when they retire.
        - Richard Ward agreed, and noted this is a national trend, as people work later in their life and relatively fewer people are eligible to enroll in Medicare. The net effect for some proposals and aspects of the plan design may result in less cost to the plan as more people are enrolled in Medicare, but other provisions may also disproportionately impact Medicare enrollees such as coordination of benefits. These impacts will also change over time as well,
- Cammy Taylor summarized the topics for the December 12 modernization committee meeting, or the January 2019 committee meeting:
    - #1, Enhanced travel benefits (continued discussion)
    - #11, Increase deductible and out of pocket maximum (initial discussion)
    - #12, Implement 3-tier pharmacy benefits, Segal Consulting will begin this analysis but it will be complicated to determine, and DRB staff are still working with the independent pharmacists to finalize the proposal. This should be discussed in January.
    - #17, Medically necessary treatment for gender dysphoria should be covered in January.
    - #18, Clarify reimbursement policies for surgical assistants in the plan booklet.
        - Emily Ricci explained that this is a new item, it is one of several “housekeeping” items that are not likely to represent a controversial change in the plan itself, but would clarify the specific benefit. There are several of these type of items that members have asked about over time.
        - Nan Thompson asked for more information about this item.
        - Michele Michaud commented that often, there is a surgeon and an assistant during a procedure, often the assistant’s services are also billed. This would clarify that the plan will cover the assistant’s time as a percentage of the surgeon’s bill rate, and would not allow for balance billing for the assistant’s services. This is a not-uncommon issue with the plan.

Item 8. Discuss Modernization Process and Timeline

Goal: by February 2019 meeting, have a finalized list of topics that will be considered.

The group reviewed the proposed timeline on page 61. Emily Ricci emphasized that while there are defined public comment periods listed in the timeline document, this does not mean that public comment is limited to those periods—public comment is accepted at any time, and is not limited to these periods. The listed time periods would be the official public comment periods for those proposals.

Emily also noted that implementing the changes selected would be a multi-year process, with not all of the changes made at once. Staff identified an end date and implementation period, and worked backwards from that point to develop the rest of the timeline. The intent is to define overall what the plan changes would be, i.e. a plan amendment listing all the changes, as well as effective dates which may be different for different plan changes. This provides a clear framework for the overall changes, so they can be assessed as a group. Staff proposed the quarterly RHPAB meetings as good milestones for this process:

- February 2019 RHPAB meeting, the list of proposals being considered would be finalized, indicating what is or is not being considered in the project.
- The list of proposals would be discussed at the modernization committee, with the goal of bringing back the full list. Some of the work has already been done on the proposals, and others would have analysis take place.
- May 2019 RHPAB meeting, all individual proposals would be finalized as review drafts for discussion by the group as a whole.
- The group would then look at the package as a whole and discussion of which individual proposals would be in the package. The modernization committee would continue discussion and public comments would be solicited on the individual proposals and the package.
- August 2019 RHPAB meeting would review the package and finalize what is included in that package. The meeting would include an advisory vote on what is included in the package.
- In fall 2019, staff would prepare the draft plan amendment document so that people can review the actual language to be used to describe these concepts.

Emily added that this timeline is admittedly tight, there is not much slack time for slipped deadlines as they move forward. There is also a specific risk of not meeting the November 2019 deadline, as many of the plan changes would need to take effect January 1, 2020 on signing a new contract with the third party administrator, whether it is the same or a new vendor.

- Dallas Hargrave commented that this timeline seems tight, at what points would the public be informed and invited to give comments? What outreach would occur?
    - Emily Ricci responded that it is always difficult to get the public's attention on any item, but the intent is to do several months of public outreach in advance as the project progresses, beginning with the work of the modernization committee to work through the details and document questions and concerns for staff to research further.
- Judy Salo commented that the timing and sequencing of the proposals should also be considered, this will be an important policy decision as well.

    - Emily Ricci agreed, and noted that during a previous plan update, some of the additional benefits were implemented first, giving additional time to educate members about the other offsets made in the plan, but allowing for members to benefit from the enhancements to the plan first.
- Commissioner Ridle commented that staff should consider an official briefing of the ARMB (Alaska Retirement Management board) about the proposed changes.
    - Gayle Harbo responded that she does provide an update to the Board in their regular meetings, but a more detailed presentation from staff would be useful as well, she will follow up with the board.
- Judy Salo asked staff to consider whether three phases are needed to implement, or if this can be done in two phases.
- Emily Ricci also commented that in terms of timing, staff will be also busy during legislative session from February to May, as well as the timing coinciding with the clarification period of the procurement process for the third party administrator. This is the most challenging period in terms of demand on staff time.
- Cammy Taylor asked whether all of the proposals need to be done on January 1, or could any of these be done mid-year? She noted that given all the demands on staff time, RHPAB members are available to help and support this process, and are open to the timeline changing if staff need additional time.
    - Michele Michaud responded that some changes should be done at the beginning of the plan year, but others could be done mid-year. It is possible that some of the changes would be done starting mid-year in 2020.
- Judy Salo also noted that between meetings, Board members can submit written questions or comments (consistent with the terms of the Open Meetings Act and the spirit of transparency) if staff would like feedback or input.
    - Commissioner Ridle noted that the Board is advisory, but still subject to the terms of the Open Meetings Act. A vote cannot take place during a meeting. She also advised transparency by sharing back the content of communications
    - Dallas Hargrave commented that the Board cannot discuss items via email as a group, but staff can send a question to all Board members, to which they can respond individually and the record is shared as public information.
- Mauri Long asked whether any of the items on the list need to be determined before selection of the third party administrator?
    - Emily Ricci responded that as the plan sponsor, the State reserves that right in their contracts, which allows for plan changes in the future under that contract. She also noted that there may or may not be a third party administrator depending on the outcome of the procurement process, staff does not pre-determine that. This will allow for inclusion of any future plan changes, even after the TPA contract has been signed.

Judy Salo recommended that the Board take a break, then conclude discussion of the modernization process before returning to public comment.

The board took a 15 minute break at 2:28, and returned at 2:45.

Item 8 (continued). Discuss Modernization Process and Timeline

Judy Salo reconvened the meeting and invited any additional comments or questions about the modernization project.

- Dallas Hargrave, regarding the matrix on page 59, asked about the number provided for the enhanced travel benefits (expected savings of $2.8 million) and what version of services this would be, given the presentation of the options by SurgeryPlus about additional services? Which of these does that estimate represent?
    - Emily Ricci responded that the cost savings and actuarial value includes the status quo services, and approximately half of the services under "limited expansion" (not the first two bullets), and not the two columns to the right. The additional services are not included in that analysis, and would depend on the level of service fees from SurgeryPlus and on utilization.
- Dallas also asked whether staff anticipates more or less savings to the plan with the implementation of these additional proposed services from SurgeryPlus?
    - Emily responded that the actual cost to the plan is to be determined, as it will depend on the negotiated fees with SurgeryPlus to provide these benefits. However, she anticipates that overall, adding these services for members could generate greater savings because they offer members a way to select high-quality, reasonable cost care which would also save the plan money in the long run. However, this analysis needs to be refined further, and incorporate consideration of the fees. Emily also noted that there is no co-insurance for employees for the SurgeryPlus benefit, because it would have created a negative incentive because they would owe the 20% of the service upfront, which would be challenging for most people to pay. By removing co-insurance, this slightly but not significantly increased actuarial value and cost to the plan, but is beneficial for members.

Item 9. Public Comment

See Item 2 in the minutes for public comment guidelines.

Public Comments

- **Wendy Wolf, Retired Public Employees Association.** She is Southcentral chapter chair at RPEA, but will provide comments as an individual. She looks forward to the presentation by DRB staff (Emily and Michele) at their chapter meeting in December.
  She commented that typically, RPEA chapters adjourn for the summer and do not meet during the summer. They do meet in June, the Fairbanks and Juneau chapters meet monthly and the Southcentral chapter meets quarterly. She recommends that staff send information before the chapters' June meetings, so they can be reviewed and distributed out before the summer break and help get more input. She also suggested that staff send out a survey to all retirees regarding the modernization proposals, asking for their input on the individual proposals, and potentially their thoughts on priorities or what they most or least support in the package overall.
  She appreciates the process and allowing RPEA to be involved, she looks forward to continuing this work with RHPAB and DRB staff.
    - Cammy Taylor asked staff as a follow-up about the results of the annual employee and retiree survey fielded to all AlaskaCare members, when these would be available, and in

particular what the responses were to the question “What services should be added to the plan?”
    - Michele shared that staff are waiting for the report from the survey contractor, but will share this information with the Board when available.
  - Judy Salo suggested a survey of retirees only could be helpful, and should include a question about what additional benefits or changes to the plan they would like to see in the future.
    - Commissioner Ridle noted that there are monthly Tele Town Hall that include a simple poll feature, this is another good opportunity to ask questions of retirees or get feedback on a question.

Item 10. Meeting Adjournment

- The next RHPAB quarterly board meeting is February 6, 2019. The quarterly AlaskaCare meeting with the vendors will be the previous day, February 5, 2019. The next modernization committee meeting is Wednesday, December 12, 2018.
- Joelle Hall commented that there is a great deal of uncertainty in Alaska’s policy landscape as well as nationally, she wanted to thank Commissioner Ridle and her staff for all of their work and taking the initiative to move the plan modernization work forward, which has been needed for many years. As a public member and a Board member, she very much appreciates all of this work and looks forward to continuing the work under the new administration.
- Cammy Taylor echoed Joelle’s appreciation for Commissioner Ridle and her staff.
- Judy Salo thanked Nan Thompson for volunteering to serve on the proposal evaluation committee, and believes it will be a great learning experience for her and introduction to this work.
- Gayle Harbo shared best wishes for the holidays to everyone.

- **Motion** by Cammy Taylor to adjourn the meeting. **Second** by Gayle Harbo.
  - **Discussion**: None.
  - **Result**: No objection to adjournment. The meeting was adjourned at 3:00.

Retiree Health Plan Advisory Board
Public Comment Guideline

Public Comment	
Purpose	The public comment period allows individuals to inform and advise the Retiree Health Plan Advisory Board about policy-related issues, problems or concerns. It is not a hearing and cannot be used to address health benefit claim appeals. The protected health information of an identified individual will not be addressed during public comment.
Protocol	Individuals are invited to speak for up to three minutes. • A speaker may be granted the latitude to speak longer than the 3-minute time limit only by the Chair or by a motion adopted by the Full Advisory Board. • Anyone providing comment should do so in a manner that is respectful of the Advisory Board and all meeting attendees. The Chair maintains the right to stop public comments that contains Private Health Information, inappropriate and/or inflammatory language or behavior. **<u>Members providing testimony will be reminded they are waiving their statutory right to keep confidential the contents of the retirement records about which they are testifying. See AS 40.25.151.</u>**

Protected Health Information
Protected Health Information (PHI) submitted to the Board in writing will be redacted to remove all identifying information, for example, name, address, date of birth, Social Security number, phone numbers, health insurance member numbers. If the Board requests records containing protected health information, the Division will redact all identifying information from the records before providing them to the Board.

Retiree Health Plan Advisory Board
Public Comment Guideline

Frequently Asked Questions	
How can someone provide comments?	**IN PERSON** - please sign up for public comment using the clipboard provided during the meeting. **VIA TELECONFERENCE** – please call the meeting teleconference number on a telephone hard line. To prevent audio feedback, do not call on a speaker phone or cell phone. You may use the mute feature on your phone until you are called to speak, but do not put the call on hold because hold music disrupts the meeting. If this occurs, we will mute or disconnect your line. **IN WRITING** – send comments to the address or fax number below or email AlaskaRHPAB@alaska.gov. For written comments to be distributed to the Advisory Board prior to a board meeting they must be received thirty days prior to the meeting to allow time for distribution and identifying information will be redacted (see "Protected Health Information"). **PRIVATE HEALTH INFORMATION**: The state must comply with federal laws regarding Private Health Information. Written information submitted for public comment which contains identifying information will be redacted to ensure compliance with privacy laws. **Address**: Department of Administration, Attn: RHPAB, 550 W 7th Avenue, Ste 1970, Anchorage, AK 99501 Fax: (907) 465-2135
Can I bring my questions or concerns about a claim or medical issue to the Board?	The Board does not have authority to decide health benefit claim appeals. Members should call Aetna at 1-855-784-8646 to address their question and/or concern. After contacting Aetna, members can also contact the Division of Retirement and Benefits at 1- 800-821-2251 or 907-465-8600 if in Juneau.
For additional information:	For additional information please call 907-269-6293 or email AlaskaRHPAB@alaska.gov if you have additional question.

AlaskaCare Health Plan

PBM Transition Post Go-Live Highlights

100% of previously utilized pharmacies contracted with OptumRx and added to the network by 1/1/19

41,380 Medicare eligible retirees successfully enrolled into EGWP
378 in EGWP Holding Plan (pending enrollment)

Employee January Claims Processing Stats

- 2,926 utilizing members
- 6,576 total paid claims
- 82.5% generic dispensing rate
- 93% filled at retail
- 7% filled at mail
- 100 specialty claims
- $1,150,663 Total Plan Paid
- $174.98 Avg Plan Paid/Rx

EGWP January Claims Processing Stats

- 23,831 utilizing EGWP members
- 82,338 total paid claims
- 79,010 Part D paid claims
- 3,328 Enhanced wrap claims
- 81% generic dispensing rate
- 84% filled at retail
- 16% filled at mail
- 691 specialty claims
- $14,955,759 Total Plan Paid
- $181.64 Avg Plan Paid/Rx

Non Med D Retiree January Claims Processing Stats

- 8,447 utilizing members
- 24,226 total paid claims
- 80% generic dispensing rate
- 87% filled at retail
- 13% filled at mail
- 372 specialty claims
- $5,263,874 Total Plan Paid
- $217.28 Avg Plan Paid/Rx

AlaskaCare Health Plan

PBM Transition Post Go-Live Highlights

Member Services January Call Stats
13,270 Calls Received
13,198 Handled
13 second Avg Speed to Answer
0.54% Abandonment Rate
11 min 48 sec Avg Handling Time
85.5% Service Level

Navigator - Top 5 by Call Type

100 %
80 %
60 %
40 %
20 %
0 %

MAIL ORDER
CLAIMS PROCESSING
BENEFITS & COVERAGE
MEMBER MATERIAL
ELIGIBILITY

AlaskaCare Health Plan

PBM Transition Post Go-Live Highlights

CMS Part D EGWP Subsidies – January

926 Gap Discount claims

$1,159,571 in reported coverage gap discounts (paid quarterly)

$90,847 in direct subsidies (paid monthly)

$16,774 in LIPS (paid monthly)

$1,495,984 in prospective reinsurance amount (paid monthly)

CMS Part D EGWP Subsidies

- **All CMS subsidies are passed through from OptumRx to its self-funded EGWP clients via either Automated Clearing House (ACH) transfer or physical check**

	Direct Subsidy	Low-Income Premium Subsidy (LIPS)	Low-Income Cost Sharing Subsidy (LICS)	Coverage Gap Discounts	Catastrophic Reinsurance
Frequency of Payment	Monthly	Monthly	Annually	Quarterly	Prospective PMPM payments Monthly, and CMS Reconciled amount Annually
Timing for Payment to Client	Generally mid-month for that month's payment	Generally mid-month for that month's payment	Approx. 12 Months after end of plan year	Approx. 90-180 days after end of each Quarter	Prospective PMPM payments paid each month, and then CMS reconciled amount either paid or recouped approx. 12 Months after end of plan year
Reported to Clients via	CMS MMR (Monthly Membership Report)	CMS MMR (Monthly Membership Report)	Annual Catastrophic Reinsurance and LICS Report	Quarterly Coverage Gap Discount Report	MMR for monthly prospective Reinsurance payments, and Annual Catastrophic Reinsurance/LICS Report for reconciled Reinsurance
Method of Payment	Automated Clearing House (ACH) or Check	Automated Clearing House (ACH) or Check	Automated Clearing House (ACH) or Check	Automated Clearing House (ACH) or Check	Automated Clearing House (ACH) or Check
CMS Data Source / Tool to reconcile payments to	MMR	MMR	CMS Annual Payment Reconciliation reporting	Quarterly Gap Discount Reporting	MMR and CMS Annual Payment Reconciliation reporting
CMS Calculation Methodology	The National Average Monthly Part D Bid Amount is multiplied by the individual's risk score. This amount is then reduced by the National Base Beneficiary Premium (rounded to nearest $0.10 increment)	Calculated as the lesser-of the National Base Beneficiary Premium (rounded to nearest $0.10 increment) or Low-Income Premium Subsidy regional benchmark	Calculated as the difference between the normal plan cost share amount minus the LIS cost share amount	Calculated as 70% of all brand name drug costs in the Standard Part D Coverage Gap	Calculated as 80% of drug costs (net of Direct and Indirect Renumeration) above the TrOOP threshold

Employer Group Waiver Program (EGWP)

2019 Updated Analysis

February 6, 2019

AlaskaCare

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Summary Comparison—RDS vs. EGWP

	RDS	EGWP
OPEB Reduction	**No**	**Yes**
Annual Application	Yes	No
Plan Year	Any	Should be Calendar Year
Network	Commercial	CMS Requirements, but can be customized – separate contract/terms
Benefits	No requirements, with Actuarial Attestation	CMS Requirements, but can replicate current benefits
Formulary	Commercial	Minimum CMS Requirements; can replicate current
Prior Authorizations	**No Requirement**	**Part B/D and Part D/not covered, but can utilize wrap to replicate current**
Subsidies	**Claims dependent; capped for catastrophic**	**Base subsidy for all members; Subsidies increase with costs**
IRMAA	**No**	**Yes**
Out of Country/other MA/EGWP coverage	Yes	No, but can cover in RDS plan that replicates benefits
Plan Fiduciary	State	State
Federal Subsidies - Initial	**$20M**	**$40M ($20M net of RDS)**
Federal Subsidies - Updated	**$20M**	**$48M ($30M net of RDS)**

Financial Analysis

	Initial (2018)	Updated (2019)
EGWP		
Base Subsidy	$10.0M	$4.0M
Coverage Gap Discount	+ $23.0M	+ $28.0M
Catastrophic Reinsurance	+ $14.0M	+ $22.0M
= Total Subsidies	**= $47.0M**	**= $54.0M**
Additional Admin Fees	- $6.8M	- $5.2M
IRMAA	- $0.2M	- $0.8M
= Net EGWP	**= $40.0M**	**= $48.0M**
RDS Subsidy	**$20.0M**	**$18.0M**
Estimated Savings	**$20.0M**	**$30.0M**

- **CMS Base Subsidy has declined since 2016**
- **Coverage Gap Discount Match (CGDM) has increased from 50% to 70%**
- **CGDM change results in more members hitting the TrOOP, increasing the Catastrophic Reinsurance**
- **IRMAA updated based on 2019 applications**

Thank You! Questions?

DRAFT

AlaskaCare Retiree Health Plan Modernization Process

Action	Timeline A	Timeline B Date	Timeline C
Step 1			
Finalize DRAFT proposals list	Feb 6, 2019	Feb 6, 2019	Feb 6, 2019
Step 2			
Review each proposal			
Staff analysis + revisions	Late Feb 2019	Late Mar 2019	Late Sep 2019
Modernization committee review 1	Mid Mar 2019	Mid Apr 2019	Mid Oct 2019
Member education/outreach	Feb-May 2019	May-Aug 2019	Oct 2019-Feb 2020
Public comment	Mar-May 2019	May - Aug 2019	Oct 2019-Feb 2020
Modernization committee review 2	Mid Apr 2019	Mid Aug 2019	Mid Feb 2020
Staff review proposals	Late Apr 2019	Late Aug 2019	Late Feb 2020
Finalize DRAFT 1 of proposals under consideration	May 8, 2019	Mid Sept 2019	Mid Mar 2020
Step 3			
Draft modernization package			
Modernization committee review 1	Mid June 2019	Mid Oct 2019	Mid Apr 2020
Member education/outreach	May-July 2019	Nov 2019-Jan 2020	Apr-July 2020
Public comment	May-July 2019	Nov 2019-Jan 2020	Apr-July 2020
Modernization committee review 2	Mid July 2019	Mid Jan 2020	Mid July 2020
Staff review draft modernization proposal package	Late July 2019	Late Jan 2020	Late July 2020
RHPAB board review of proposals/possible recommendation vote	Aug 7, 2019	Early Feb 2020	Early Aug 2020
Step 4			
Draft plan amendment			
Member education	Aug-Oct 2019	Feb-Apr 2020	Aug-Oct 2020
Public comment	Aug-Oct 2019	Feb-Apr 2020	Aug-Oct 2020
Update plan amendment	Late Oct 2019	Late Apr 2020	Late Oct 2020
RHPAB: Final advisory vote	Nov 6, 2019	May 2020	Nov 2020
Issue final plan amendment	Mid-Nov 2019	Mid-May 2020	Mid-Nov 2020
Step 5			
Implementation			
Staff + vendor implementation start date	Nov 2019	May 2020	Nov 2020
Member education	Nov 2019-Jan 2020	May-July 2020	Nov 2020-Jan 2021
Go-live phase 1	Jan 1, 2020	Jul 1, 2020	Jan 1, 2021
Member education	May-July 2020	Nov 2020-Jan 2021	May-July 2021
Go-live phase 2	Jul 1, 2020	Jan 1, 2021	Jul 1, 2021
Member education	Nov 2020-Jan 2021	May-July 2021	Nov 2021-Jan 2022
Go-live phase 3	Jan 1, 2021	Jul 1, 2021	Jan 1, 2022

Alaska Retiree Health Plan Modernization Project Timeline

REVIEW DRAFT 1/30/19

LEGEND

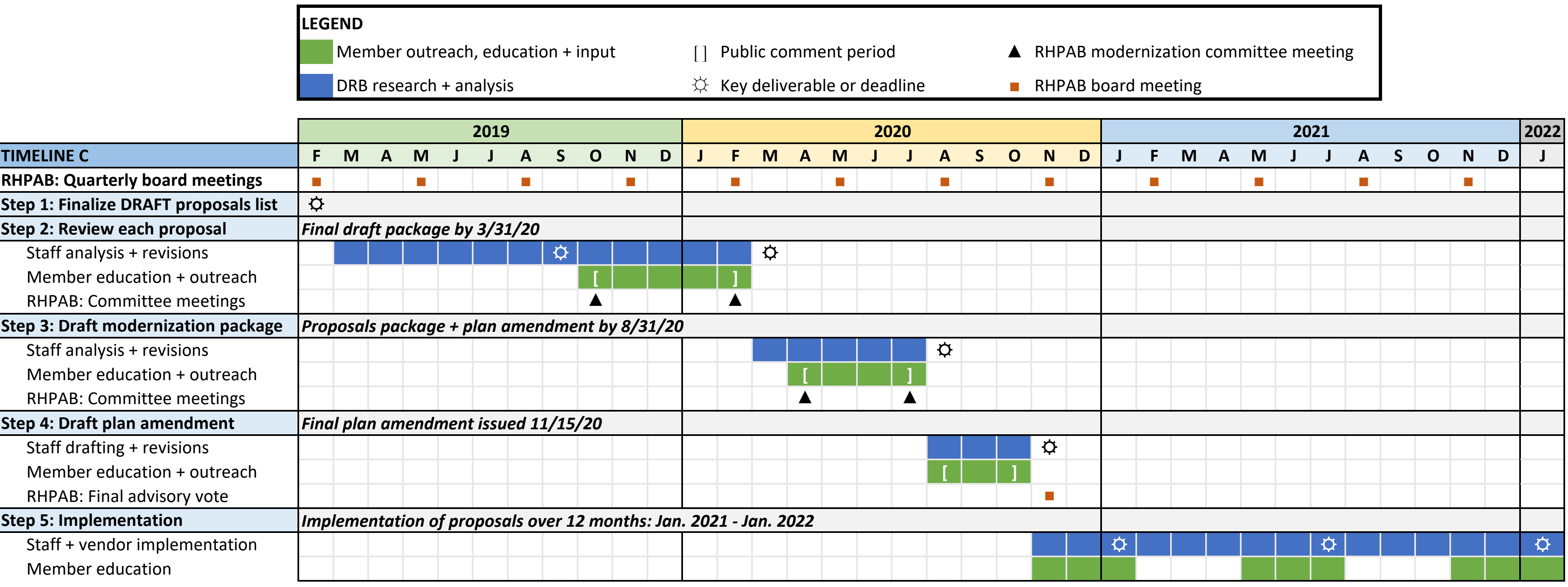
Member outreach, education + input	[ ] Public comment period	▲ RHPAB modernization committee meeting
DRB research + analysis	☼ Key deliverable or deadline	■ RHPAB board meeting

	2019											2020												2021												2022
TIMELINE A	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J
RHPAB: Quarterly board meetings	■			■			■			■			■			■			■			■			■			■			■			■		
Step 1: Finalize DRAFT proposals list	☼																																			
Step 2: Review each proposal	***Final draft package by 5/31/19***																																			
Staff analysis + revisions	☼			☼																																
Member education + outreach		[		]																																
RHPAB: Committee meetings		▲	▲																																	
Step 3: Draft modernization package	***Proposals package + plan amendment by 8/31/19***																																			
Staff analysis + revisions							☼																													
Member education + outreach				[		]																														
RHPAB: Committee meetings					▲	▲																														
Step 4: Draft plan amendment	***Final plan amendment issued 11/15/19***																																			
Staff drafting + revisions										☼																										
Member education + outreach							[		]																											
RHPAB: Final advisory vote										■																										
Step 5: Implementation	***Implementation of proposals over 12 months: Jan. 2020 - Jan. 2021***																																			
Staff + vendor implementation												☼						☼						☼												
Member education																																				

	2019											2020												2021												2022
TIMELINE B	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J
RHPAB: Quarterly board meetings	■			■			■			■			■			■			■			■			■			■			■			■		
Step 1: Finalize DRAFT proposals list	☼																																			
Step 2: Review each proposal	***Final draft package by 9/31/19***																																			
Staff analysis + revisions		☼						☼																												
Member education + outreach				[			]																													
RHPAB: Committee meetings			▲				▲																													
Step 3: Draft modernization package	***Proposals package + plan amendment by 2/28/2020***																																			
Staff analysis + revisions													☼																							
Member education + outreach										[		]																								
RHPAB: Committee meetings									▲			▲																								
Step 4: Draft plan amendment	***Final plan amendment issued 5/15/20***																																			
Staff drafting + revisions																☼																				
Member education + outreach													[		]																					
RHPAB: Final advisory vote																■																				
Step 5: Implementation	***Implementation of proposals over 12 months: Jul. 2020 - Jul. 2021***																																			
Staff + vendor implementation																		☼						☼						☼						
Member education																																				

Alaska Retiree Health Plan Modernization Project Timeline

REVIEW DRAFT 1/30/19



DRAFT Communications Strategy: Retiree Health Plan Modernization Project

- **Educate** and **inform** retirees about the health plans, proposed plan changes as part of the modernization project, and (during implementation) about upcoming changes as they are implemented.
- **Listen** and **respond** to retirees' questions, concerns and ideas for improving the plan.
- **Communicate** and **collaborate** with retirees and stakeholders to protect, improve and sustain Alaska's retirement benefit system for current and future generations of retirees.

Channels: How should messages be shared?

Website: Project Page

One page, or a set of pages, with information about the Modernization Project, contact info, upcoming outreach events (if any), how to submit comments, FAQ sections, summaries and analysis of proposed changes.

Handouts + Print Materials

- Overview of DRB and current retiree health plan
- Fact sheets (What is the Modernization Project? How Will I Benefit from the Modernization Project?)
- Fiscal implications: long-term sustainability of the health trust
- Components of modernization project:
- Basic legislative update, key numbers to understand (membership, costs, etc.). Do we want to have a targeted piece just for the legislators, or can we reuse existing materials?
- Send mailers to unions, etc.?

Retiree E-newsletter

- Monthly e-newsletter for retirees, typically published third week.
- Include updates on this project in each e-newsletter.

HealthMatters (mailed) newsletter

- Regular issues in October and May; October issue typically includes all required plan information for the coming calendar year.
- Can also produce special editions at other times. A special edition later in the process, summarizing the complete set of changes in the proposed plan amendment, may be a good use of this tool.
- Relatively costly to produce and mail, should be used primarily to inform about the project and push readers to website for details.

RHPAB Meetings, Modernization Subcommittee Meetings

The Board has a Modernization Committee to review and discuss proposals in detail, request more information or research, and provide feedback or guidance on which direction to pursue. The Board can and does receive both written and verbal public comment.

The Board will get updates on the project at their quarterly meetings.

Channels: How should messages be shared?
Tele-town Halls General town hall about the process (get involved, we want to hear from you, etc.), then more info as individual proposals are vetted and the full proposed package is developed.
In-person events, hosted by DRB TBD: requires logistics planning, public notice, outreach and invitations to attract attendees
In-person events, hosted by other organizations • **Legislators' constituent events** Meet and greet events, mini town halls, constituent meetings • **AARP Alaska Seminars** Tele town hall format or in-person meetings • **RPEA chapter meetings** • **Presentations to Public or Other Key Partners** Ideas for presentations to interested audiences, via other organizations or public events: o Regular board or member meetings of other orgs. o Conferences, annual meetings and gatherings o Senior Centers o Others?
Health Fairs Share project overview and materials (flyers) at upcoming health fairs. Host possible event or session.
Social Media • Use social media (Facebook) to send updates about the project, push interested people to the DRB website for details, and give notice of upcoming outreach events. • Post links to information about the project periodically, such as before or after an RHPAB meeting. • Polls: difficult to send only to target audience, but could be used with followers of a page or group
Surveys and Polls • Online surveys can be targeted, e.g. e-news subscribers • Statistically-valid polling can provide representative sample based on demographics, geographic location, etc.
Explainer Video(s) • Focus on specific, complex topic that would benefit from an animated explanation • May be best used later in the process to educate about pending changes. Example: EGWP explainer video.

DRAFT

Key Contacts	Audience(s)
Retiree e-newsletter subscribers	Retirees and dependents, in Alaska and outside
Tele town hall participants	Retirees and dependents, in Alaska and outside
Legislators + staff in legislative offices	Legislators (information and updates about the process) Constituents with questions
AARP: Alaska chapter	Retirees in Alaska
RPEA: statewide and regional chapters	Retirees in Alaska + elsewhere
Senior centers (Anchorage, Eagle River, Fairbanks, Juneau, others)	Retirees in Alaska
Pioneer Homes?	
Public employees' union offices	Members / former members with questions
Medical providers who serve retirees	Providers, billing specialists, administrative staff
Other providers who serve retirees in a health care capacity	Pharmacists, care coordinators

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Retiree Health Plan Modernization Topics*

#	Current or Upcoming Topics for Analysis	Actuarial Impact	Fiscal Impact
1a.	Enhance travel benefits	+0.00%	-$2,800,000/yr
1b.	Enhance travel benefits, add health concierge	+0.00%	-$2,500,000/yr
2.	Network steerage: 70% out-of-network and 90% in-network	+0.14%	+$800,000/yr
3.	Increase deductible and out-of-pocket maximum	-0.50% -1.60%	-$2,900,000/yr -$9,300,000/yr
4.	In-network enhanced clinical review of high-tech imaging and testing		
5.	Implement high-value pharmacy network with lower copays for chronic meds, medical synchronization, counseling, and packaging options for participating members.		
6.	Add wellness benefits such as gym membership or program like Silver Sneakers - *public comment proposal*		
7.	Out-of-network reimbursement		
8.	Copayment for primary care		
	Previously Discussed Topics (Analysis may be on-going)		
9.	Expand preventive coverage to add full suite of preventive services	+0.75%	+$5,000,000/yr
10.	Remove or increase lifetime limit (currently $2M)	+0.40%	+$2,700,000/yr
11.	Implement clear service limits for rehabilitative care such as chiropractic, physical therapy, occupational therapy, etc.	-0.035%	-$325,000/yr
12.	Expand rehabilitative services to include Rolfing, Acupuncture, and Acupressure – *public comment proposal*	Minor enhancement	Minor Expenditure Increase
	Topics for Potential Future Analysis		
13.	Implement 3-tier pharmacy benefit; change out-of-network pharmacy benefits		
14.	Exclude coverage for drugs with over-the-counter (OTC) equivalents		
15.	Limit compound coverage to high-quality, narrow network of pharmacies		
16.	Exclude implants related to periodontal disease from medical plan and cover under dental plan		
17.	Add medically necessary treatment of gender dysphoria including surgery – *public comment proposal*		
	Plan Housekeeping Items		
18.	Clarify reimbursement policies for surgical assistants in the plan booklet		

*These are subject to change as the proposals evolve through additional analysis and committee guidance and discussion.

Updated for: February 6, 2019

DRAFT-Summary of Responses to Proposed Plan Design Change

Proposed change: Enhancing travel benefits

Plans affected: DB Retiree Plan

Reviewed by: Retiree Health Plan Advisory Board

Proposed implementation date: TBD

Review Date: ~~October 30~~February 6, 2018

Table 1. Plan Design Changes

	Member	Actuarial	DRB Ops	Financial	Clinical	TPA	Provider
No impact							
Minimal impact		X	X	X			
High impact	X				X	X	X
Need Info							

DRAFT

Description of proposed change:

Amend the plan booklet to expand travel benefits for members as follows:

1) Add the SurgeryPlus travel program to the retiree plan which arranges and coordinates travel for a member and their companion to a network of surgeons and facilities that meet rigorous quality metrics for deeply discounted prices.
2) Cover travel for diagnostic procedures not covered by the SurgeryPlus travel program and either not available locally or less expensive in other locations.
3) Cover travel for a companion when a member receives treatment or a diagnostic procedure that requires general anesthesia.
4) Provide lodging and per diem benefits for the length of stay for second opinions, or when treatment or diagnostic procedures are not available locally or less expensive in other locations (subject to certain limitations described below).
~~4)~~5) Expand travel coordination services to include prospective travel arrangement paid and coordinated by SurgeryPlus for services that are not part of their network but meet the expanded criteria outlined in points 3 to 5 above.

The fiscal impact to the plan is estimated to be $2.8 million a year in savings associated with the SurgeryPlus travel program. The additional financial impact for expanding other travel services is under development. There is no anticipated actuarial impact to the plan.[1]

[1] See attachment A; Segal Consulting Memorandum, July 25, 2018.

The increase in covered travel costs will benefit the membership and will increase their options for treatment. The addition of the SurgeryPlus network will provide members with access to surgeons who demonstrate they meet and maintain a combination of objective and subjective quality metrics.[2] The expansion of travel benefits for diagnostic services will address an unmet need among the membership as well the expansion of lodging and per diem expenses for the member and companion as applicable.

These changes will require additional administrative work by the Third-Party Administrator(s) and the Division.

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.

Background:

The AlaskaCare retiree defined benefit health plan currently provides reimbursement for certain travel expenses in the following circumstances:

1) In emergency situations[3]
2) For a minor (under 18 years of age) with a parent/legal guardian[4]
3) For certain transplant services at an Aetna Institute of Excellence (IOE) with a companion and lodging[5]
4) Second surgical opinions[6]
5) Treatment not available locally[7]
6) Surgery in other location if provided less expensively[8]

The current plan language regarding travel costs is confusing and covered expenses are narrow in most circumstances. The portions of covered travel costs vary depending on the

[2] See attachment B for a list of SurgeryPlus provider metrics.
[3] Page 42, AlaskaCare Retiree Health Insurance Information Booklet, 2003: http://doa.alaska.gov/drb/pdf/ghlb/retiree/RetireeInsuranceBooklet2003with2018amendment.pdf
[4] Page 41, Ibid.
[5] Page *xxxvii-xl*. Ibid.
[6] Page 43, Ibid.
[7] Page 42, Ibid.
[8] Page 44, Ibid.

qualified circumstance above. Generally, unless otherwise specified, travel costs include the following:

- Round-trip transportation, not exceeding the cost of coach class commercial air transportation, to the nearest professional treatment. This is limited to the member unless a companion benefit is clearly stated (e.g. travel for a minor, transplant IOE).
- 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.
- In most circumstances, travel costs do not include the following:
  - Travel for a companion
  - Lodging (with the exception of transplants at IOE, travel via ground transportation, and travel in certain circumstances where treatment is not available locally[9])
  - Food (with exceptions including transplants at IOE and travel via ground transportation)
  - Other transportation costs (e.g. taxis, etc.)

All travel, excluding emergency travel and surgery less expensive in other locations, require pre-authorization. If travel is not-preauthorized members are not eligible for reimbursement. -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.

Table 2: Comparison of current and proposed changes ~~1, below, outlines the proposed changes.~~

Circumstance	Current	Proposed
Emergency travel[10]	Transportation to nearest hospital by professional ambulance	No change
Transplant via Aetna IOE[11]	-Member and companion -Overnight stay: -$50 per person/night -$100/night maximum -Companion expense: -$31/night	No change

[9] Page 42-43, Ibid.
[10] Page 42, Ibid.
[11] Page *xxxvii*, Ibid.

DRAFT

Circumstance	Current	Proposed
Travel for minor	-Minor and companion -Transportation covered[12]	-Add overnight lodging benefit ~~of $80/night~~ of 3-star or above hotel within 30 minutes of appointments, up to 14-day maximum; -Add per diem benefit ~~of $31 60 per patient/day; or $62 120 per patient & companion/day~~ to reflect State of Alaska per diem rates.[13] ~~per diem rates for state employees during work travel.~~
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 ~~(as well as minors, or members with physical disabilities requiring a travel companion (requires medical necessity)~~or when appropriate or necessary (e.g. minors, members with physical disabilities, etc. subject to medical necessity)~~.~~

[12] This includes either airfare or round-trip transportation and associated costs (including $80/day for lodging) if distance exceeds 100 miles one-way.

[13] See Attachment C: State of Alaska Per Diem Rates Revised 12/10/2018

DRAFT-Summary of Responses to Proposed Plan Design Change

Circumstance	Current	Proposed
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. -Restrict to services over $2,000 locally (including 2nd opinions) measured using EDH data and floor of 200% of Anchorage Medicare. -Add "if not available through the SurgeryPlus program." -Add coverage for companion ~~if procedure requires general anesthesia~~as described above. -Add lodging and per diem benefit as described~~-~~ above. ~~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. -State of Alaska per diem rate for meals & incidentals. -Companion travel covered if medically necessary as described above. ~~$31~~ 60 ~~per diem for member/$120~~62 ~~with companion~~ -Members receive pre-loaded debit card in advance of trip.
Long-term stay		~~Requires additional review. Suggested per diem rate of $33.~~ -Defined as more than 30 days. -Long term lodging and meals and incidental rates apply as

Circumstance	Current	Proposed
		outlined in State of Alaska Per Diem Rates.
Maximum Reimbursement	None	-No more than $10,000 per diagnosisepisode of care.[14]

SURGERYPLUS BACKGROUND: The Division competitively bid travel coordination and administrative services in the first half of 2018. The selected bidder was SurgeryPlus. Extensive details are available in Attachment B, but an high level overview of SurgeryPlus services follows:

- SurgeryPlus develops a network of providers across the United States that meet certain quality criteria, both objective and subjective.
- SurgeryPlus negotiates discounted, case rates for services.
- SurgeryPlus advocates serve as a single point of contact for members.
- When members seek an elective surgerysurgery, they can contact Surgery Plus to see if the procedure they are seeking is offered through the SurgeryPlus network and to be provided a list of three surgeons who are best suited to perform the surgery.
- If the member selects a physician, SurgeryPlus arranges for a transfer of the member's medical records to the selected physician who will review the case.
- Upon review, if the surgeon accepts the case SurgeryPlus will begin arrangements for the members' travel.
- When the member is ready to travel they will receive a copy of their itinerary in advance in a format of their preference.
- At admission (or check in) they will present their SurgeryPlus card.
- Their lodging will be covered for a duration necessary as determined by the surgeon.
- Following discharge, a SurgeryPlus advocate will follow up telephonically with the member.
- After the member travels home, follow up care can be provided through their primary care physician combined with telehealth services.
- If necessary, the member can travel back to the surgeon for necessary follow up care.

SurgeryPlus will also provide travel administration services for members who are Medicare-eligible and are not using the SurgeryPlus network along with members

[14] Reflects current limit for travel costs related to transplant occurrence.

seeking care in other circumstances (e.g. treatment not available locally or surgery and/or diagnostic services less expensive elsewhere and not otherwise covered by the SurgeryPlus network).

Members who do not want to use the SurgeryPlus travel administration services to book travel can also use the current method and submit receipts for reimbursement to the Third-Party Administrator.

It is not anticipated that the deductible or cost share would be waived under any of these scenarios.

Member Impact:

Members would benefit from this change, as it would provide additional financial assistance in covering the cost of travel for themselves and a companion. It may facilitate increased access for members requiring care from specialists that are not available locally and the overall number of members seeking care outside of their community. It may also result in better outcomes through reduced complication rates based on the provider quality of the SurgeryPlus network.

WHO IS IMPACTED:

Members traveling now for care: Approximately 1,200 AlaskaCare retiree members received reimbursement for covered travel in 2017. This number should be viewed with caution in predicting member utilization for several reasons:

1) Members may not have realized pre-authorization is required and be denied coverage as a result;
2) Members may have traveled and not realize they were eligible for services and therefore did not apply for reimbursement;
3) Administrative challenges may have resulted in member's claims not processing correctly.

Given this, the Division estimates utilization of a travel benefits under the proposal will be higher than is experienced today; however it is difficult to predict with certainty what actual usage will be.

In reviewing claims data, SurgeryPlus estimates utilization at around 400 procedures per year.[15]

Members who are Medicare-eligible: Medicare does not cover travel, so the expansion of the standard travel coverage and per diem for a member and companion will be of benefit to members who are Medicare eligible.

Medicare-eligible members will not fully benefit from the provider network offered through the SurgeryPlus travel program, which is pre-empted by Medicare's own provider network. However, they will be able to utilize SurgeryPlus for travel arrangement.

Members who are not Medicare-eligible: Members who are not Medicare-eligible will benefit fiscally and through anticipated positive outcomes associated with high quality care from the SurgeryPlus network of providers and the travel arrangement and coordination offered. Members will also benefit from the expansion of the standard travel coverage.

Members will be required to pay their deductible and co-insurance to SurgeryPlus prior to receiving care unless coinsurance is waived; which may pose a financial burden to some as these bills are generally received following surgery..

Actuarial Impact

Neutral / Enhancement / Diminishment

Table 2: Actuarial Impact

	Actuarial Impact
Current	N/A
Proposed	No actuarial impact[16]

DRB Operational Impacts

The Division anticipates minimal operational impacts as follows:

- Staff will need to manage another vendor and the routine work associated with that including quality control, reporting, billing, responding to eligibility questions, and communications.
- Staff will need to review and distribute communications to educate and increase awareness of the new plan benefit.
- A plan amendment will need to be developed, put forward for public comment, and published before the benefit takes effect.
- Staff will need to coordinate and oversee implementation including plan education and cultural training for the SurgeryPlus team, ensuring coordination between

[16] See Attachment A **This will be updated to include the wrap services**

DRAFT

SurgeryPlus and the Third-Party Administrator are working smoothly, coordinating eligibility, and responding to member questions and/or concerns.

Division staff have already been working with SurgeryPlus on implementing this program beginning August 1, 2018 for the AlaskaCare employee plan, so many of these items are already being worked through. The addition of the retiree plan will require some additional work to ensure the program is being properly administered, but the majority of coordination has already occurred.

Financial Impact to the plan:

The financial impact to the plan for the addition of the SurgeryPlus travel network and services is estimated to be savings of $2.8 million annually. This is based on members using the SurgeryPlus network for 400 procedures per year. The total savings is net of the administrative costs for SurgeryPlus and the estimated cost per member per trip of $3,000.[17] ~~The fiscal impact of the expanded travel wrap is under analysis.~~

Expanding other travel services is anticipated to add an addition $300,000 in expense to the plan.[18] ~~The financial impact needs to be updated to reflect the additional changes described in this document.~~

Clinical Considerations:

These changes are anticipated to result in overall better quality of care for members.

Access to SurgeryPlus program- Provider quality is a distinguishing feature of the SurgeryPlus network which reports complication rates of 0.82% among members using their network[19] compared to the 14.1% average for AlaskaCare retirees living in Alaska but seeking care outside of the state in 2017 (13.8% for professional services, 17.1% for outpatient care and 27.6% for inpatient care.

Third Party Administrator (TPA) operational impacts:

The impact to the TPA is anticipated to be high for several reasons:

- The TPA will need to coordinate with an external vendor (SurgeryPlus) including sharing prior-authorizations; member accumulator data, eligibility, and claims data.

[17] See Attachment A

[18] Ibid.

- The TPA will need to retain the ability to pre-authorize travel even if an external vendor is coordinating that travel on behalf of the member.
- The TPA will provide eligibility to the external vendor.
- The TPA will need to maintain its existing process for travel claims administration in parallel with the additional services provided by the external vendor.
- The TPA will need to ensure its staff are trained and knowledgeably about the new benefits to accurately answer members travel-related questions and appropriately transfer members to the external vendors.

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.

Documents attached include:

Document Name	Attachment	Notes
Segal Memorandum; ~~July 25, 2018~~January 31, 2019	A	This analysis has been updated to reflect the addition of expanded travel services.
SurgeryPlus Overview Updated	B	This presentation has been updated to reflect the presentation provided to the board on November 28, 2018
State of Alaska Per Diem Rates	C	Online at http://doa.alaska.gov/dof/travel/resource/rates.pdf
Current AlaskaCare Travel Utilization - Retiree	D	
Public Comments	~~C~~E~~D~~	TBD

DRAFT-Summary of Responses to Proposed Plan Design Change

Proposed change: Enhanced~~ing~~ travel benefits with health concierge services

Plans affected: DB Retiree Plan

Reviewed by: Retiree Health Plan Advisory Board

Proposed implementation date: TBD

Review Date: ~~October 30~~February 6, 2018

Table 1. Plan Design Changes

	Member	Actuarial	DRB Ops	Financial	Clinical	TPA	Provider
No impact							
Minimal impact		X	X	X			
High impact	X				X	X	X
Need Info							

DRAFT

Description of proposed change:

Amend the plan booklet to expand travel benefits for members as follows:

1) Add the SurgeryPlus travel program to the retiree plan which arranges and coordinates travel for a member and their companion to a network of surgeons and facilities that meet rigorous quality metrics for deeply discounted prices.
2) Cover travel for diagnostic procedures not covered by the SurgeryPlus travel program and either not available locally or less expensive in other locations.
3) Cover travel for a companion when a member receives treatment or a diagnostic procedure that requires general anesthesia.
4) Provide lodging and per diem benefits for the length of stay for second opinions, or when treatment or diagnostic procedures are not available locally or less expensive in other locations (subject to certain limitations described below).
5) Expand travel coordination services to include prospective travel arrangement paid and coordinated by SurgeryPlus for services that are not part of their network but meet the expanded criteria outlined in points 3 to 5 above.
~~4)~~6) Provide members access to the SurgeryPlus credentialing and physician recommendations, records transfer, scheduling assistance, and follow-up and adherence support for services received locally as well as those covered under the expanded criteria in points 3 – 5 above.

The fiscal impact to the plan is estimated to be $2.8 million a year in savings associated with the SurgeryPlus travel program. The additional financial impact for expanding other

travel services ~~is under development~~ is estimated to result in additional annual costs of $300,000. The overall financial impact of adding the health concierge services is under analysis. There is no anticipated actuarial impact to the plan.[1]

The increase in covered travel costs will benefit the membership and will increase their options for treatment. The addition of the SurgeryPlus network will provide members with access to surgeons who demonstrate they meet and maintain a combination of objective and subjective quality metrics.[2] The expansion of travel benefits for diagnostic services will address an unmet need among the membership as well the expansion of lodging and per diem expenses for the member and companion as applicable.

The addition of coordination for members seeking care from providers outside of the SurgeryPlus network, including those available locally, will benefit members in finding a provider, transferring records, and scheduling procedures.

These changes will require additional administrative work by the Third-Party Administrator(s) and the Division.

Background:

The AlaskaCare retiree defined benefit health plan currently provides reimbursement for certain travel expenses in the following circumstances:

1) In emergency situations[3]
2) For a minor (under 18 years of age) with a parent/legal guardian[4]
3) For certain transplant services at an Aetna Institute of Excellence (IOE) with a companion and lodging[5]
4) Second surgical opinions[6]
5) Treatment not available locally[7]
6) Surgery in other location if provided less expensively[8]

The current plan language regarding travel costs is confusing and covered expenses are narrow in most circumstances. The portions of covered travel costs vary depending on the

[1] See attachment A; Segal Consulting Memorandum, ~~July 25, 2018~~January 31, 2019.
[2] See attachment B for a list of SurgeryPlus provider metrics.
[3] Page 42, AlaskaCare Retiree Health Insurance Information Booklet, 2003: http://doa.alaska.gov/drb/pdf/ghlb/retiree/RetireeInsuranceBooklet2003with2018amendment.pdf
[4] Page 41, Ibid.
[5] Page *xxxvii-xl*. Ibid.
[6] Page 43, Ibid.
[7] Page 42, Ibid.
[8] Page 44, Ibid.

qualified circumstance above. Generally, unless otherwise specified, travel costs include the following:

- Round-trip transportation, not exceeding the cost of coach class commercial air transportation, to the nearest professional treatment. This is limited to the member unless a companion benefit is clearly stated (e.g. travel for a minor, transplant IOE).
- 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.
- In most circumstances, travel costs do not include the following:
  - Travel for a companion
  - Lodging (with the exception of transplants at IOE, travel via ground transportation, and travel in certain circumstances where treatment is not available locally[9])
  - Food (with exceptions including transplants at IOE and travel via ground transportation)
  - Other transportation costs (e.g. taxis, etc.)

All travel, excluding emergency travel and surgery less expensive in other locations, require pre-authorization. If travel is not-preauthorized members are not eligible for reimbursement. -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.

Table 2: Comparison of current and proposed changes ~~1, below, outlines the proposed changes.~~

Circumstance	Current	Proposed
Emergency travel[10]	Transportation to nearest hospital by professional ambulance	No change
Transplant via Aetna IOE[11]	-Member and companion -Overnight stay: -$50 per person/night -$100/night maximum -Companion expense: -$31/night	No change

[9] Page 42-43, Ibid.
[10] Page 42, Ibid.
[11] Page *xxxvii*, Ibid.

DRAFT-Summary of Responses to Proposed Plan Design Change

Circumstance	Current	Proposed
Travel for minor	-Minor and companion -Transportation covered[12]	-Add overnight lodging benefit ~~of $80/night~~ of 3-star or above hotel within 30 minutes of appointments, up to 14-day maximum; -Add per diem benefit ~~of $31~~ 60 ~~per patient/day; or $62~~ 120 ~~per patient & companion/day~~ to reflect State of Alaska per diem rates.[13] ~~per diem rates for state employees during work travel.~~
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 ~~(as well as minors, or members with physical disabilities requiring a travel companion (requires medical necessity)~~ or when appropriate or necessary (e.g. minors, members with physical disabilities, etc. subject to medical necessity)~~.~~

[12] This includes either airfare or round-trip transportation and associated costs (including $80/day for lodging) if distance exceeds 100 miles one-way.

[13] See Attachment C: State of Alaska Per Diem Rates Revised 12/10/2018

DRAFT-Summary of Responses to Proposed Plan Design Change

Circumstance	Current	Proposed
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. -Restrict to services over $2,000 locally (including 2nd opinions) measured using EDH data and floor of 200% of Anchorage Medicare. -Add "if not available through the SurgeryPlus program." -Add coverage for companion ~~if procedure requires general anesthesia~~as described above. -Add lodging and per diem benefit as described~~-~~ above. ~~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. -State of Alaska per diem rate for meals & incidentals. -Companion travel covered if medically necessary as described above. ~~$31~~ ~~60~~ ~~per diem for member/$120~~~~62~~ ~~with companion~~ -Members receive pre-loaded debit card in advance of trip.
Long-term stay		~~Requires additional review. Suggested per diem rate of $33.~~ -Defined as more than 30 days. -Long term lodging and meals and incidental rates apply as

DRAFT

Circumstance	Current	Proposed
		outlined in State of Alaska Per Diem Rates.
Maximum Reimbursement	None	-No more than $10,000 per diagnosisepisode of care.[14]

SURGERYPLUS BACKGROUND: The Division competitively bid travel coordination and administrative services in the first half of 2018. The selected bidder was SurgeryPlus. Extensive details are available in Attachment B, but an high level overview of SurgeryPlus services follows:

- SurgeryPlus develops a network of providers across the United States that meet certain quality criteria, both objective and subjective.
- SurgeryPlus negotiates discounted, case rates for services.
- SurgeryPlus advocates serve as a single point of contact for members.
- When members seek an elective surgerysurgery, they can contact Surgery Plus to see if the procedure they are seeking is offered through the SurgeryPlus network and to be provided a list of three surgeons who are best suited to perform the surgery.
- If the member selects a physician, SurgeryPlus arranges for a transfer of the member's medical records to the selected physician who will review the case.
- Upon review, if the surgeon accepts the case SurgeryPlus will begin arrangements for the members' travel.
- When the member is ready to travel they will receive a copy of their itinerary in advance in a format of their preference.
- At admission (or check in) they will present their SurgeryPlus card.
- Their lodging will be covered for a duration necessary as determined by the surgeon.
- Following discharge, a SurgeryPlus advocate will follow up telephonically with the member.
- After the member travels home, follow up care can be provided through their primary care physician combined with telehealth services.
- If necessary, the member can travel back to the surgeon for necessary follow up care.

SurgeryPlus will also provide travel administration services for members who are Medicare-eligible and are not using the SurgeryPlus network along with members

[14] Reflects current limit for travel costs related to transplant occurrence.

seeking care in other circumstances (e.g. treatment not available locally or surgery and/or diagnostic services less expensive elsewhere and not otherwise covered by the SurgeryPlus network).

Members who do not want to use the SurgeryPlus travel administration services to book travel can also use the current method and submit receipts for reimbursement to the Third-Party Administrator.

It is not anticipated that the deductible or cost share would be waived under any of these scenarios.

In addition to their traditional travel and network access services, SurgeryPlus can also provide prospective travel coordination and support for members eligible to travel under the expanded criteria listed in Table 2 even if those services are not available through the traditional SurgeryPlus network. Prospective support would include booking tickets and hotel rooms along with providing a card with per diem in advance of the member's travel. This would be available for members traveling outside of their community, which could include travel both in and outside of Alaska.

Supplemental to the prospective travel arrangement, members could also access SurgeryPlus for assistance with finding a physician for their specific procedure, as well as scheduling, records transfer, and follow up after the procedure. This could be available to members independent of their decision to travel. Meaning members could use this service to find providers within their community, and to gain assistance in records transfer and scheduling. For example, a member in the Anchorage area who seeks an orthopedic procedure could call SurgeryPlus for assistance in finding a board certified provider in Anchorage, and get assistance in scheduling and records transfer as well as follow up after the procedure.

Member Impact:

Members would benefit from this change, as it would provide additional financial assistance in covering the cost of travel for themselves and a companion. It may facilitate increased access for members requiring care from specialists that are not available locally and the overall number of members seeking care outside of their community. It may also result in better outcomes through reduced complication rates based on the provider quality of the SurgeryPlus network. The additional physician credentialing and recommendations along with scheduling assistance and records transfer can greatly assist members who are seeking care both within their community as well as outside. It can be extremely difficult to identify the best physician or surgeon for a procedure and tools to do so are limited. This is one way to assist members in navigating that process.

WHO IS IMPACTED:

Members traveling now for care: Approximately 1,200 AlaskaCare retiree members received reimbursement for covered travel in 2017. This number should be viewed with caution in predicting member utilization for several reasons:

1) Members may not have realized pre-authorization is required and be denied coverage as a result;
2) Members may have traveled and not realize they were eligible for services and therefore did not apply for reimbursement;
3) Administrative challenges may have resulted in member's claims not processing correctly.

Given this, the Division estimates utilization of a travel benefits under the proposal will be higher than is experienced today; however it is difficult to predict with certainty what actual usage will be.

In reviewing claims data, SurgeryPlus estimates utilization at around 400 procedures per year.[15]

Members receiving care locally: Members receiving procedures locally will have an additional resource to assist in finding a provider, transferring records, and scheduling procedures.

Members who are Medicare-eligible: Medicare does not cover travel, so the expansion of the standard travel coverage and per diem for a member and companion will be of benefit to members who are Medicare eligible.

Medicare-eligible members will not fully benefit from the provider network offered through the SurgeryPlus travel program, which is pre-empted by Medicare's own provider network. However, they will be able to utilize SurgeryPlus for travel arrangement.

Medicare-eligible members will also be able to use SurgeryPlus to assist with finding a physician, coordinating records, and scheduling procedures for services they receive either inside or outside of their community.

Members who are not Medicare-eligible: Members who are not Medicare-eligible will benefit fiscally and through anticipated positive outcomes associated with high quality care from the SurgeryPlus network of providers and the travel arrangement and coordination offered. Members will also benefit from the expansion of the standard travel coverage and from the ability to access Surgery Plus to assist with finding a physician,

coordinating records, and scheduling procedures for services they receive either inside or outside of their community..

Members will be required to pay their deductible and co-insurance to SurgeryPlus prior to receiving care unless coinsurance is waived; which may pose a financial burden to some as these bills are generally received following surgery..

Actuarial Impact

Neutral / Enhancement / Diminishment

Table 2: Actuarial Impact

	Actuarial Impact
Current	N/A
Proposed	No actuarial impact[16]

DRB Operational Impacts

The Division anticipates minimal operational impacts as follows:

- Staff will need to manage another vendor and the routine work associated with that including quality control, reporting, billing, responding to eligibility questions, and communications.
- Staff will need to review and distribute communications to educate and increase awareness of the new plan benefit.
- A plan amendment will need to be developed, put forward for public comment, and published before the benefit takes effect.
- Staff will need to coordinate and oversee implementation including plan education and cultural training for the SurgeryPlus team, ensuring coordination between SurgeryPlus and the Third-Party Administrator are working smoothly, coordinating eligibility, and responding to member questions and/or concerns.

Division staff have already been working with SurgeryPlus on implementing this program beginning August 1, 2018 for the AlaskaCare employee plan, so many of these items are already being worked through. The addition of the retiree plan will require some additional work to ensure the program is being properly administered, but the majority of coordination has already occurred.

[16] See Attachment A **This will be updated to include the wrap services**

Financial Impact to the plan:

The financial impact to the plan for the addition of the SurgeryPlus travel network and services is estimated to be savings of $2.8 million annually. This is based on members using the SurgeryPlus network for 400 procedures per year. The total savings is net of the administrative costs for SurgeryPlus and the estimated cost per member per trip of $3,000.[17]

Expanding other travel services is anticipated to add an addition $300,000 in expense to the plan.[18] The fiscal impact of adding health concierge services is under analysis. The fiscal impact of the expanded travel wrap is under analysis.

Clinical Considerations:

These changes are anticipated to result in overall better quality of care for members.

Access to SurgeryPlus program- Provider quality is a distinguishing feature of the SurgeryPlus network which reports complication rates of 0.82% among members using their network[19] compared to the 14.1% average for AlaskaCare retirees living in Alaska but seeking care outside of the state in 2017 (13.8% for professional services, 17.1% for outpatient care and 27.6% for inpatient care.

Assisting members in finding a provider, transferring records, and scheduling appointments can improve the quality of care a member receives by directing them to high-quality providers either in, or outside of, their community. This can also support members quality of care by assisting them in adhering to their treatment plan.

Third Party Administrator (TPA) operational impacts:

The impact to the TPA is anticipated to be high for several reasons:

- The TPA will need to coordinate with an external vendor (SurgeryPlus) including sharing prior-authorizations; member accumulator data, eligibility, and claims data.
- The TPA will need to retain the ability to pre-authorize travel even if an external vendor is coordinating that travel on behalf of the member.
- The TPA will provide eligibility to the external vendor.
- The TPA will need to maintain its existing process for travel claims administration in parallel with the additional services provided by the external vendor.

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[17] See Attachment A
[18] See Attachment A

- The TPA will need to ensure its staff are trained and knowledgeably about the new benefits to accurately answer members travel-related questions and appropriately transfer members to the external vendors.

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.

Documents attached include:

Document Name	Attachment	Notes
Segal Memorandum; ~~July 25, 2018~~January 31, 2019	A	This analysis has been updated to reflect the addition of expanded travel services.
SurgeryPlus Overview Updated	B	This presentation has been updated to reflect the presentation provided to the board on November 28, 2018
State of Alaska Per Diem Rates	C	Online at http://doa.alaska.gov/dof/travel/resource/rates.pdf
Current AlaskaCare Travel Utilization - Retiree	D	
Public Comments	~~C~~ED	TBD

330 North Brand Boulevard Suite 1100 Glendale, CA 91203-2308
T 818.956.6700 www.segalco.com

MEMORANDUM

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

From: Richard Ward, FSA, FCA, MAAA

Date: January 31, 2019

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	
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.

Circumstance	Current Benefit	Proposed Benefit
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.
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.

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 the experience with their book of business, SurgeryPlus estimates that 20% of eligible procedures will result in about 400 procedures 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. An expansion to the current benefits is estimated to result in additional annual costs of $300,000.

This analysis is based on medical claims data from December 2016 through November 2017, which was summarized specifically to analyze the opportunity for an enhanced travel benefit. The data was reviewed, but not audited, and found to be sufficient and credible for this analysis.
Segal reviewed the assumptions used by SurgeryPlus and consider them to reasonable. For budgeting purposes, in order to be conservative in projecting the impact of a new program, Segal's analysis utilizes a 20% margin.

Please note that the projections in this report are estimates of future costs and are based on information available to Segal at the time the projections were made. Segal Consulting has not audited the information provided. Projections are 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, trend rates, and claims volatility. The accuracy and reliability of projections decrease as the projection period increases. Unless otherwise noted, these projections do not include any cost or savings impact resulting from The Patient Protection and Affordable Care Act (PPACA) or other recently passed state or federal regulations.

cc: Michele Michaud, Division of Retirement and Benefits
Emily Ricci, Division of Retirement and Benefits
Linda Johnson, Segal
Michael Macdissi, Segal
Noel Cruse, Segal
Dan Haar, Segal

Uniquely positioned to meet the State’s evolving needs

Executive Summary

- On January 30th, 2018 Alaska issued a RFP for travel and supplemental health services focused on ensuring Plan Participants had adequate access to high-quality, appropriately priced healthcare
  - Employer Direct Healthcare LLC, with its SurgeryPlus offering, won this contract award
  - The SurgeryPlus benefit was launched for the active employee population on August 1st, 2018, and since that launch Employer Direct has opened over 50 cases for the State
  - As part of that contract, the State may choose to make SurgeryPlus available to the retiree population as well
- We understand that the State is interested in evaluating a broader range of services including:
  - Expanded travel benefits, including for services beyond non-emergent surgeries
  - Greater customer service to advocate on behalf of member's health needs
- Employer Direct and SurgeryPlus are able to meet these requirements

Employer Direct and SurgeryPlus are uniquely positioned to meet the State's needs immediately and can be deployed in less than 60 days

SurgeryPlus Overview

A supplemental benefit for non-emergent surgeries that provides top-quality care, a better experience and lower costs

Our **Differentiators**

Surgeons of EXCELLENCE

Rigorous Screening &
Reduced Complications

Employee SATISFACTION

Better User Experience
We Handle It All

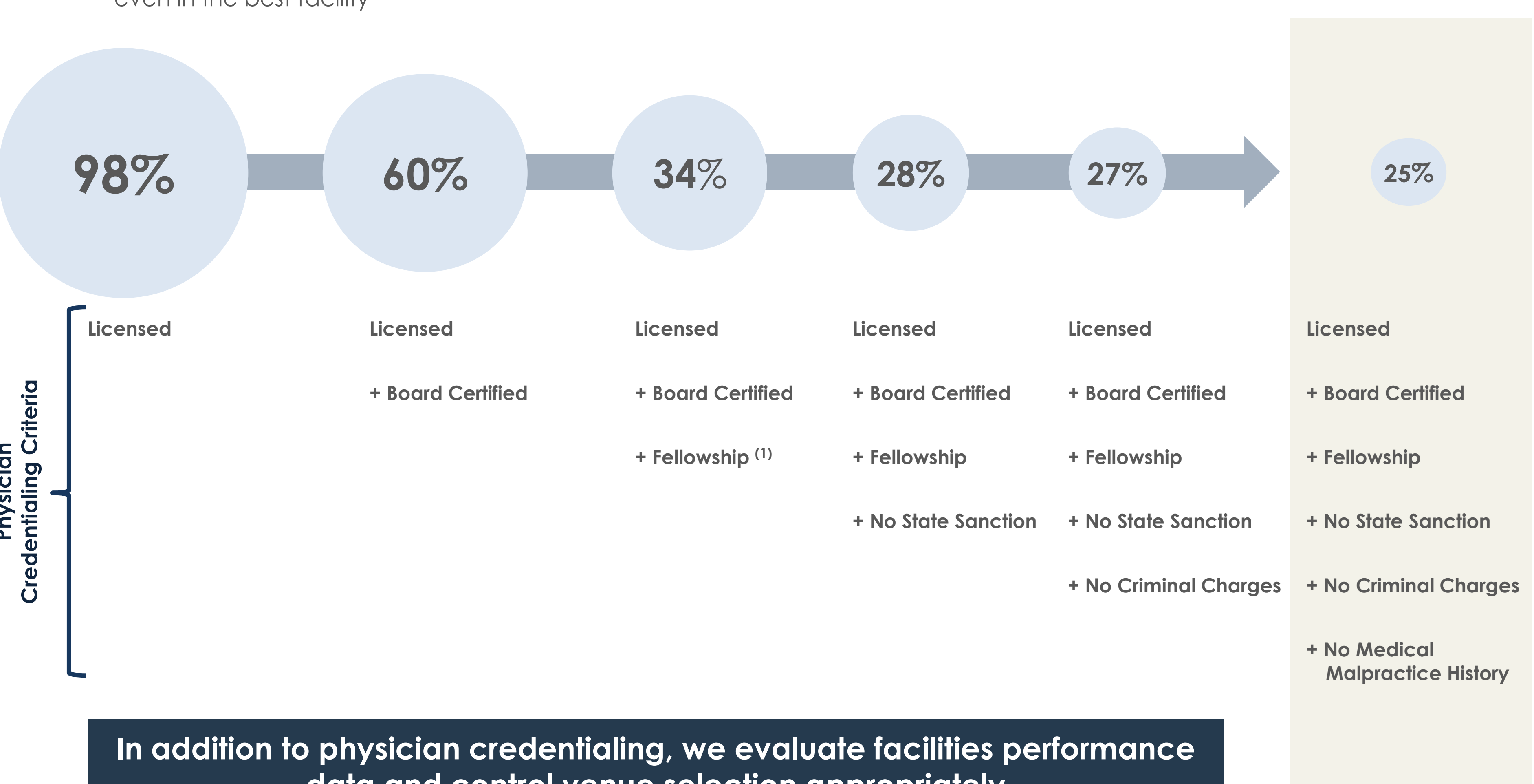
Hard-Dollar ROI SAVINGS

Pre-Negotiated Bundled Rates
Reduced Employer & Employee Costs

How We Evaluate Physician Quality

A More Comprehensive Evaluation Process

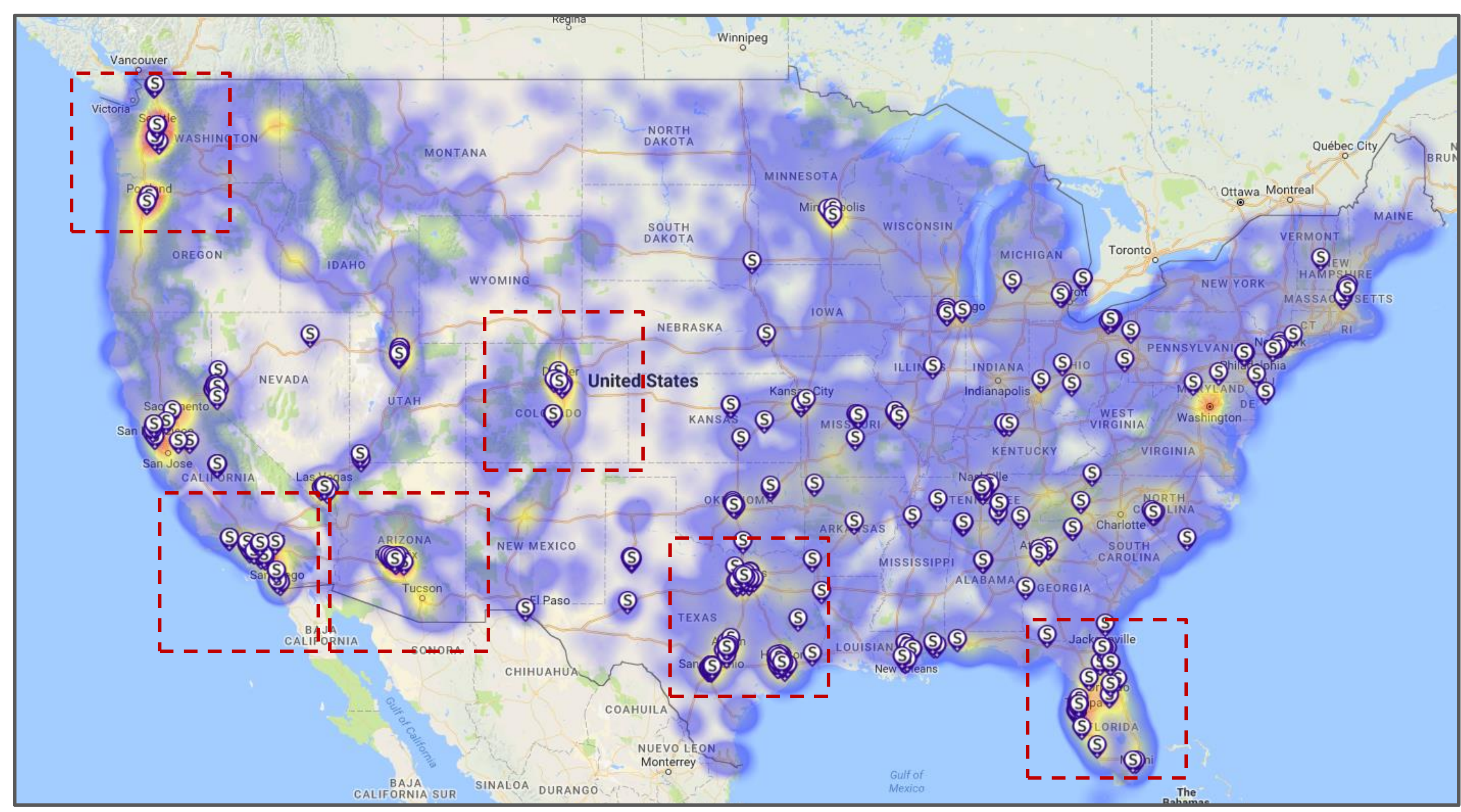
- Unlike some of our peers, our quality starts with the physician; a poor doctor will lead to a poor result even in the best facility



(1) Where appropriate, category dependent.

SurgeryPlus Provider Network

State of Alaska Member Population



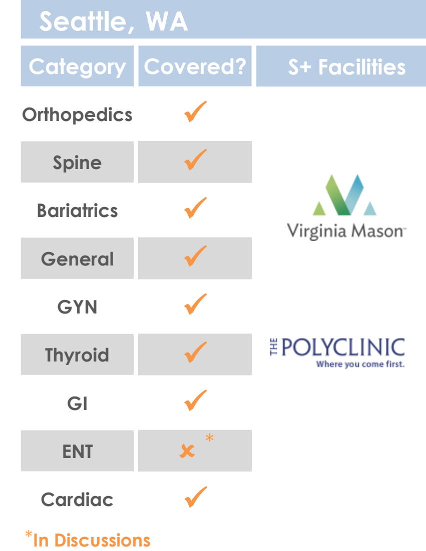
Legend: SurgeryPlus Provider

73

Source: SurgeryPlus Provider Network as of March 23, 2018.

SurgeryPlus Provider Network

Seattle / Portland



Seattle, WA		
Category	Covered?	S+ Facilities
Orthopedics	✓	
Spine	✓	
Bariatrics	✓	Virginia Mason
General	✓	
GYN	✓	
Thyroid	✓	THE POLYCLINIC Where you come first.
GI	✓	
ENT	✗ *	
Cardiac	✓	

*In Discussions

Provider Spotlight

Virginia Mason

- Performed over 15,000 surgical procedures in 2016
- COE for Walmart, Boeing, FedEx
- Recognized 5 consecutive years by US News & World as a national high performer in Orthopedics

Legend: SurgeryPlus Provider

74

Source: SurgeryPlus Provider Network as of March 23, 2018.

Care Advocates Handle It All

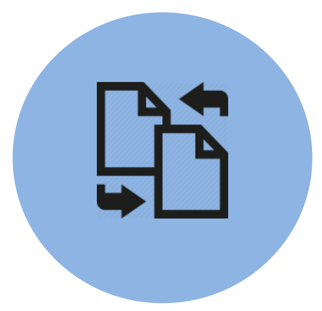
Full-Service Concierge Creates a Better Member Experience

Locate

Find best fitting Surgeon of Excellence

Schedule

Book timely appointments & manage logistics



Coordinate

Bundle service providers & transfer records

Follow Up

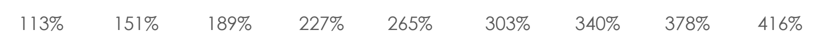
Ensure complete member satisfaction

Managed by the Metrics for Scalability

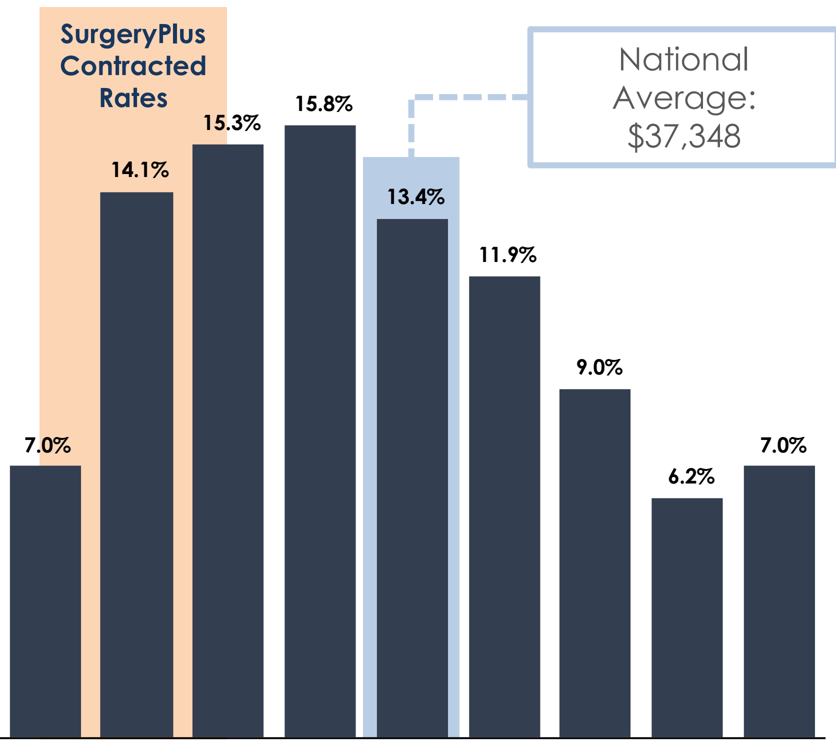
Wait Time	First-Time Call Length	Time to Consult	% of Calls to Cases	% of Cases to Procedures	Time to Procedure
~5 seconds	~4 minutes	~21 days	~52.4%	~50.7%	~35 days

Healthcare Today: Price Volatility

SurgeryPlus' Bundled Rates Provide Consistent and Lower Costs



(% of Total Claims)



Market Rates Exhibit Tremendous Volatility

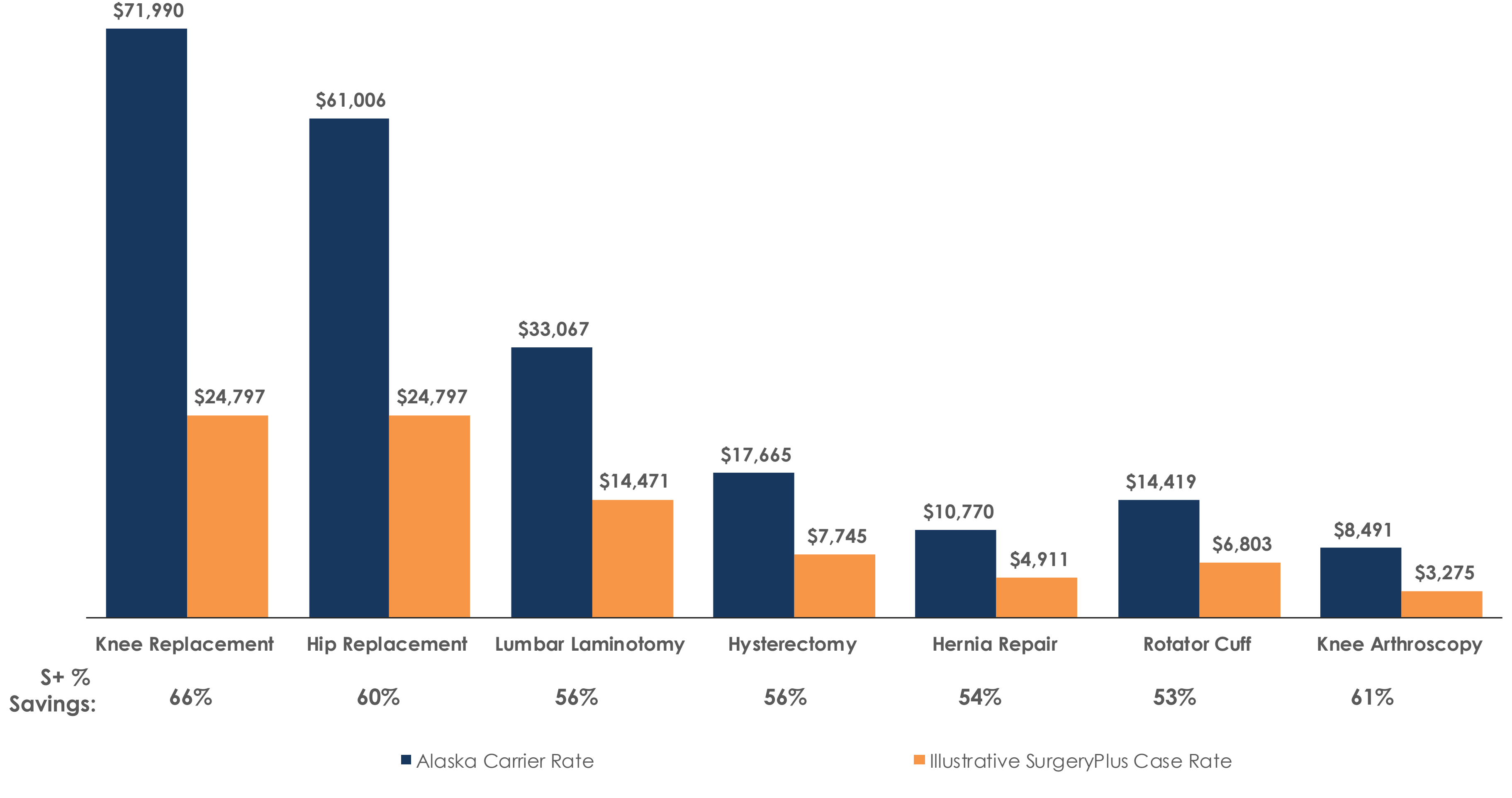
Little transparency or incentive for member around cost

76

Source: Select data from SurgeryPlus claims database as of March 14, 2018.

Illustrative SurgeryPlus Savings Examples

Common SurgeryPlus Procedures vs. Carrier Rates



Notes: Alaska carrier case rates based on estimated case rates in the Juneau, AK MSA. 77
Illustrative SurgeryPlus case rate based on best existing contracts in the Seattle, WA MSA. Outpatient case rates shown where available and applicable.
Procedure pricing can vary substantially based on specific codes billed and physician / facility used.

Savings for Clients and Members

Plan Design Illustration: Waived Coinsurance

	Plan	SurgeryPlus By EmployerDirect Healthcare Cost	SurgeryPlus By EmployerDirect Healthcare Savings	
Illustrative Knee Replacement Example				
Replacement Surgery	$40,000	$20,000	$20,000	
Employee Costs:				
- Deductible	$150	$150	–	
- Coinsurance	$800	– *	$800 *	Savings resulted from SurgeryPlus' pre-negotiated bundled rates
Total Employee Costs	$950	$150	$800 *	
Plan Net Cost to State	**$39,050**	**$19,850**	**$19,200**	Total employer savings after waived coinsurance

* If coinsurance is waived similar to the AlaskaCare employee plan design.

Most Common Covered Procedures

Commonly Covered Procedures by Category

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 & Ankle:

- Ankle Replacement
- Bunionectomy
- Hammer Toe Repair
- Ankle Fusion
- Ankle Arthroscopy

Spine:

- Laminectomy / Laminotomy
- Anterior Lumbar Interbody Fusion (ALIF)
- Posterior Lumbar Interbody Fusion (PLIF)
- Anterior Cervical Disk Fusion (ACDF)
- 360 Spinal Fusion
- Artificial Disk

Wrist & Elbow:

- Elbow Replacement
- Elbow Fusion
- Wrist Fusion
- Wrist Replacement
- Carpal Tunnel Release

General Surgery:

- Gallbladder Removal
- Hernia Repair (inguinal, ventral, umbilical, and hiatal)
- Thyroidectomy

GI:

- Colonoscopy
- Endoscopy

GYN:

- Hysterectomy
- Bladder Repair (Anterior or Posterior)
- Hysteroscopy

Bariatric:

- Gastric Bypass
- Laparoscopic Gastric Bypass
- Laparoscopic Sleeve Gastrectomy

Cardiac:

- Defibrillator Implant
- Permanent Pacemaker Implant
- Pacemaker Device Replacement
- Valve Surgery
- Cardiac Ablation

ENT:

- Ear Tube Insertion (Ear Infection)
- Septoplasty
- Sinuplasty

Note: Detailed list of procedures by CPT code is available upon request.

Expansion of Travel Health Concierge Services

Employer Direct and SurgeryPlus are ideally positioned to immediately deliver best-in-class health concierge services to the State

State of Alaska Objectives

- Broaden the scope of services included under the travel program
- Seek to provide the best possible experience for plan participants
- Provide education and advocacy to allow members to make the most informed decisions about their healthcare
  - Quality
  - Access
  - Appropriateness
  - Cost
- Increase utilization of the services
- Consolidate vendors to the extent possible for operational efficiency

Program Design

Scope of Services Should Inform Vendor Selection and Design

	Status Quo	Limited Expansion of Services	Concierge Travel	Concierge Medicine
Description	▪ Reimbursement for qualified expenses — Limited in scope — Limited utilization ▪ Requires verification retrospectively that conditions were met — Potentially unreasonable burden on member given lack of healthcare transparency	Same as Status Quo, but: ▪ Allow travel companion for appropriate situations (e.g. any service including general anesthesia, minors, or members with physical disabilities requiring a travel companion [requires medical necessity]) ▪ Pay for 100% of lodging & reasonable per diem ▪ Provide full SurgeryPlus offering including its travel benefits to retirees for SurgeryPlus procedures	▪ Prospective travel arrangement paid by state/vendor with member contribution as needed ▪ 24/7 support for travel related issues ▪ Provide full SurgeryPlus offering including its travel benefits to retirees for SurgeryPlus procedures	Same as Concierge Travel, but: ▪ Credentialing and doctor recommendations on all services (local or travel) ▪ Care Advocacy & Concierge Medicine Services — Records transfer — Scheduling — Venue selection — Adherence support — Follow-up and continuity communications
Vendor Choices	Aetna / primary administrator	Aetna / primary administrator AND / OR Employer Direct (SurgeryPlus)	Employer Direct (SurgeryPlus) OR Pure travel vendor + Employer Direct (SurgeryPlus)	Employer Direct (SurgeryPlus & CarePlus)
Pros + Cons	**+ No additional bandwidth required** – No benefits realized	**+ Potentially limited increase in non-SurgeryPlus utilization** **+ Potential strong improvement for SurgeryPlus events** **+ Limited additional administrative costs** – Does not impact quality – Not full solution	**+ Superior experience on all travel** **+ Better control for state** **+ Reduction of vendors for service** – No impact on care side	**+ Quality of care** **+ Member experience** **+ Cost containment** – New offering design (bandwidth, creation & perfection of offering, etc.)

What We Do For Members

Full-Concierge Service Creates a Better Member Experience

1 ENGAGE + EDUCATE

Many high-cost patients were not in that category the prior year. Our focus is to proactively identify prospective high-cost claimants before diseases or conditions reach advanced stages, or for existing conditions, help ensure patients receive and follow the best treatment paths.

2 LOCATE

Identify best-in-class, high-quality providers and/or venues specific to the member's needs, whether that may be driven by geographic, socioeconomic, or demographic needs.

3 ARRANGE + SCHEDULE

Schedule appointments and follow-up visits

Transfer medical records

Arrange travel (e.g. flights, hotels, car services)

Manage logistics on case-by-case basis

4 GUIDE

Our focus is to always improve the quality of care for the member. Our holistic approach focuses on medical, behavioral, financial and other aspects of each individual, not just their health condition. We ensure all of the member's needs are being met throughout their journey.

5 MEMBER COMMUNICATION + ADVOCACY

Our top priority is to ensure members are staying on track to meet their healthcare goals.

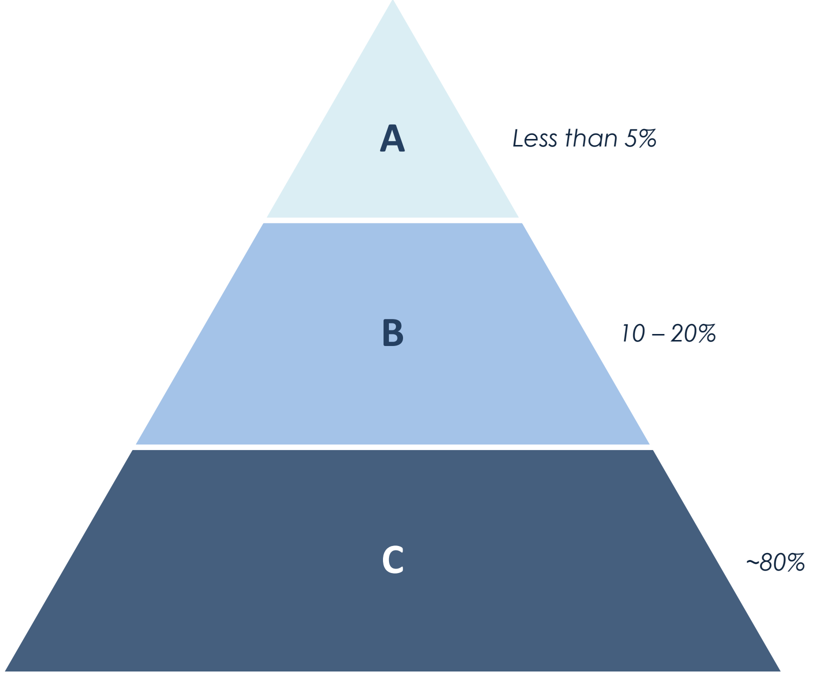
6 FOLLOW-UP

Our advocates are there every step throughout the recovery process – including treatment and medication needs. We are there to address any concerns a member may have post-discharge and focus on compliance/adherence to their recovery plan.

[CarePlus] for Alaska

Identifying Population Segments

Alaska Membership by Profile Tier



Description of Tiers

A — **Chronic high-risk, high-cost members**

- 1:1 care advocacy & concierge medicine services
- Outreach efforts where appropriate
- High touch and ongoing
- Focus on care advocacy & concierge medicine services and plan adherence in conjunction with treating physicians

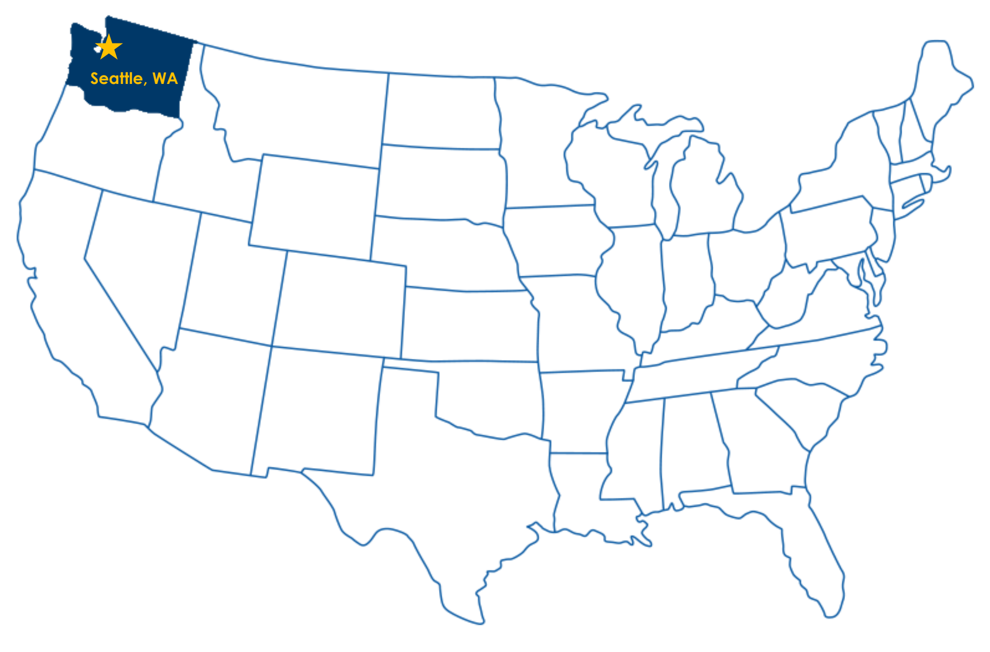
B — **High-risk, high-cost but more episodic**

- 1:1 care advocacy & concierge medicine services
- Outreach based on expected episodes, where appropriate
- Inbound call & episode-driven
- Focus on doctor selection, venue selection, and continuity of care

C — **Low-risk, low-cost members**

- Focus on customer service only
- Passive communication efforts

Value Generation – Impact of Venue Selection



Rotator Cuff Case Study

Procedure Setting	ASC	Hospital
% of Frequency Observed in Claims	38.8%	61.2%
Illustrative Carrier Rate	$13,075	$20,075
Carrier Price Difference ($)	$7,000	
Carrier Price Difference (%)	153.5%	
Memo: Average S+ Rate	*$6,803*	*NA [1]*

(1) SurgeryPlus does not contract or medically steer this procedure to hospitals, unless deemed medically necessary.

Value Impact

Appropriate Diagnosis

Accessing Care and Second Opinions

- Second opinions are welcomed, at minimum they only confirm initial diagnoses
- About 25 percent of treatment plans change based on second opinions from additional pathology teams
- Second opinions help identify new innovative therapies that may not be available with member's primary provider, geography, etc.

Clinical Evaluation and Diagnosis

- Stage and the anatomical extent of the tumor will guide surgical, radiation and medical oncologists on how to approach treatment
- Our top-quality, rigorously credentialed providers will provide their recommended treatment plan and explain the recovery process

Holistic Treatment Plan

- Following a treatment plan can be difficult and time-consuming once a patient leaves a facility, but it's crucial to complete remission
- Advocate has full transparency around chemotherapy, specific drugs used, treatment cycles completed, surgeries done, future-check ups, and any additional treatment given to member

How [CarePlus] Can Help

- Identify a high-quality, credentialed oncology provider and coordinate all scheduling, medical records transfer and travel logistics
- All-encompassing resource for all medical or financial related questions member may have
- Assist member post-discharge (e.g., follow-up visits, fitness monitoring, Rx support, etc.)
- Monitor treatment plan progress

Source: MD Anderson Cancer Center

[CarePlus]: What We Aren’t

What We Aren’t	Our Perspective
An outsourced status quo prior authorization vendor	We believe prior authorization can be more efficient and nuanced
A traditional insurance call center experience	We believe in advocacy
A purely clinical case management offering	Our focus is on avoiding industry pitfalls and making educated decisions
A limited scope travel agency	Health travel is more complicated and we rise to that challenge

Employer Direct and SurgeryPlus have the capability to positively impact Alaska’s plan members

Proposed Coverages for Concierge/Planned Travel

Coverage Option	Proposed Policy Guideline
Care Advocacy and Concierge Services	Available on-demand to all plan participants
Travel Expenses	Paid, subject to Travel Policy limitations
Travel Policy:	
Flights	Cheapest, most-direct economy route within 24 hours, avoiding overnight stay where possible
Hotel	Cheapest within estimated 30 minutes of appointments at 3-star level or above
Car / Other	Consistent with SurgeryPlus, will reimburse for ground transportation to/from airport and facility (e.g. taxi)
Per Diem	Flexible at the discretion of the State
Travel Eligible Services	Procedures/services with cost estimate of at least $2,000 locally (includes 2nd opinions), measured using EDH data and floor of 200% of Anchorage Medicare, or where care is not available locally
Companion Travel	When appropriate or necessary (e.g. any service including general anesthesia, minors, or members with physical disabilities requiring a travel companion [requires medical necessity])
Buy-up	Member can upgrade services with their money through the program

The above guidelines are solely recommendations for consideration

State of Alaska Per Diem Rates

		Alaska				Contiguous U.S., Hawaii, & Foreign					
		M&IE		**Lodging**		**M&IE**		**Lodging**			
Bargaining Unit		**Short-Term**	**Long-Term**	**Short-Term (30 days or less)**	**Long-Term (more than 30 days)**	**Short-Term**	**Long-Term**	**Short-Term**	**Long-Term**	**First and Last Day of Travel ****	**Travel Less Than 24 Hours**
AAM **KK – CEA** **GC - ACOA** **XE - Executive** **TA - AVTECTA** **EE - Excluded** **TM - TEAME** **NG – Nat'l Guard** **Boards & Commissions** **General Government (GG/GY/GP/GZ)** Contract eff. July 1, 2016 through June 30, 2019 **SS – Supervisory (SU)** Contract eff. July 1, 2016 through June 30, 2018 **AA, AP - State Troopers and Airport Police** Contract eff. July 1, 2014 through June 30, 2017		$60	$33	Actuals *OR* $30 noncommercial option	$45 for commercial *OR* $30 noncommercial option	Federal M&IE rate	55% of federal M&IE rate	Actuals *OR* $30 non-commercial option	55% of federal lodging rate	75% of the Daily M&IE Amount (see TABLE A on next page for proration)	75% of the Daily M&IE Amount (see TABLE A on next page for proration) if more than 12 hours and at least 2 hours longer than normal work hours
BB - Marine Engineers Beneficial Assoc. (MEBA) Contract effective 7/1/2014 – 6/30/2017 **CC - International Organization of Masters, Mates, and Pilots (MMP)** Contract effective 7/1/2014 – 6/30/2017 **MM - Inlandboatmen's Union (IBU)** Contract effective 7/1/2014 – 6/30/2017	Cash Allowance for Subsistence and Quarters when not provided by the State	AAM*		Greater of $95 Peak (May 16 - Sept. 15), $85 Off-peak (Sept. 16 - May 15) *OR* Actuals		AAM*		Greater of $95 Peak (May 16 - Sept. 15), $85 Off-peak (Sept. 16 - May 15) *OR* Actuals		AAM*	AAM*
	Travel due to relief at other than port of engagement or between temporary assignments	Actuals									
	Travel between regular assignments (if change port is not the same as the residence port)	Deadheading only									
LL – Labor, Trades, and Crafts (LTC) Contract effective 7/1/2015 – 6/30/2018		AAM*	AAM*	Lodging Allowance in LTC Alaska Lodging Rates by Region Chart below *OR* Actuals (with advance approval) *OR* If utilizing a bunkhouse with heat, light, adequate cooking, sleeping and lavatory facilities, members are paid lodging allowance less $10 *OR* Commuting allowance (See Notes)		AAM*	AAM*	AAM*	AAM*	For Travel Within Alaska the Prorated M&IE based on time of travel applies (see TABLE B on next page for proration) For Travel Outside of Alaska the AAM* policy applies	50% of the daily or the prorated meal allowance, whichever is greater and not less than $30, (see TABLE B on next page for proration), if more than 10 hours in travel status

***** See first row for description of AAM Per Diem Rates. These are the current rates and also those that were effective July 1, 2010.
****** The M&IE rates for Alaska and the contiguous United States (CONUS) are prorated on the next page. If total daily amount does not equal a CONUS amount listed in table, you may manually calculate meal period prorated amounts based on the percentages supplied. The Standard CONUS Rate ($55) applies to all cities or counties not listed on the Federal GSA table.

State of Alaska Per Diem Rates

MEALS & INCIDENTAL EXPENSES (M&IE) PRORATION

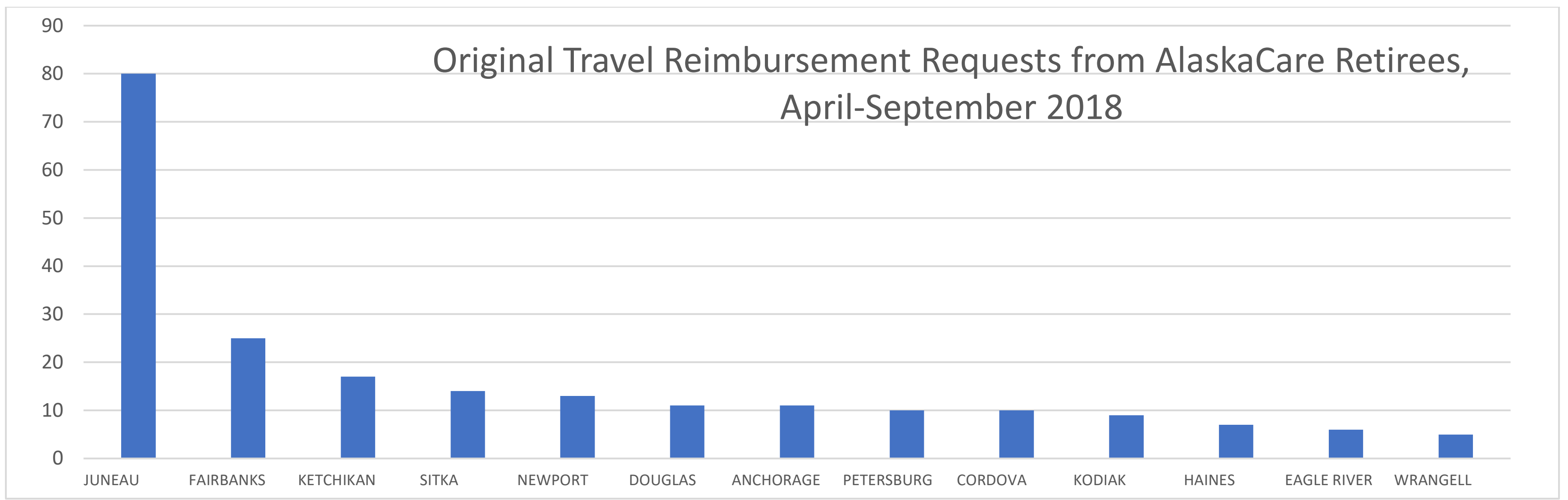
TABLE A. AAM RATES														
Rates effective 07/01/2018 – 09/30/2018														
	AK Short-Term	AK Long-Term	Outside Alaska Short-Term (CONUS)						Outside Alaska Long-Term (CONUS)					
Total Daily Amount	**$ 60**	**$ 33**	**$ 74**	**$ 69**	**$ 64**	**$ 59**	**$ 54**	**$ 51**	**$ 41**	**$ 38**	**$ 35**	**$ 32**	**$ 30**	**$ 28**
Pro-Rated Amount (75%)	**$ 45**	**$ 24.75**	**$ 55.50**	**$ 51.75**	**$ 48**	**$ 44.25**	**$ 40.50**	**$ 38.25**	**$ 30.75**	**$ 28.50**	**$ 26.25**	**$ 24.00**	**$ 22.50**	**$ 21.00**
Rates effective 10/01/2018														
	AK Short-Term	AK Long-Term	Outside Alaska Short-Term (CONUS)						Outside Alaska Long-Term (CONUS)					
Total Daily Amount	**$ 60**	**$ 33**	**$ 76**	**$ 71**	**$ 66**	**$ 61**	**$ 56**	**$ 55**	**$ 41**	**$ 38**	**$ 35**	**$ 32**	**$ 30**	**$ 28**
Pro-Rated Amount (75%)	**$ 45**	**$ 24.75**	**$ 57**	**$ 53.25**	**$ 49.50**	**$ 45.75**	**$ 42.00**	**$41.25**	**$ 30.75**	**$ 28.50**	**$ 26.25**	**$ 24.00**	**$ 22.50**	**$ 21.00**

TABLE B. MEAL PERIODS AND PRORATED M&IE AMOUNTS															
Rates effective 07/01/2018 – 09/30/2018															
	Meal Period %	AK Short-Term	AK Long-Term	Outside Alaska Short-Term (CONUS)						Outside Alaska Long-Term (CONUS)					
Midnight-10:00 AM	Breakfast (21%)	$ 12	$ 7	$ 17	$ 16	$ 15	$ 13	$ 12	$ 11	$ 9	$ 9	$ 8	$7	$ 7	$6
10:00 AM-3:00 PM	Lunch (26%)	16	9	18	17	16	15	13	12	10	9	9	8	7	6
3:00 PM-Midnight	Dinner (53%)	32	17	34	31	28	26	24	23	19	17	15	14	13	13
	Incidentals	included above	included above	5	5	5	5	5	5	5	3	3	3	3	3
	Total Daily Amount	**$ 60**	**$ 33**	**$ 74**	**$ 69**	**$ 64**	**$ 59**	**$ 54**	**$ 51**	**$ 54**	**$ 38**	**$ 35**	**$ 32**	**$ 30**	**$ 28**
Rates effective 10/01/2018															
	Meal Period %	AK Short-Term	AK Long-Term	Outside Alaska Short-Term (CONUS)						Outside Alaska Long-Term (CONUS)					
Midnight-10:00 AM	Breakfast (21%)	$ 12	$ 7	$ 18	$ 17	$ 16	$ 14	$ 13	$ 13	$ 9	$ 9	$ 8	$7	$ 7	$6
10:00 AM-3:00 PM	Lunch (26%)	16	9	19	18	17	16	15	14	10	9	9	8	7	6
3:00 PM-Midnight	Dinner (53%)	32	17	34	31	28	26	23	23	19	17	15	14	13	13
	Incidentals	included above	included above	5	5	5	5	5	5	3	3	3	3	3	3
	Total Daily Amount	**$ 60**	**$ 33**	**$ 76**	**$ 71**	**$ 66**	**$ 61**	**$ 56**	**$ 55**	**$ 41**	**$ 38**	**$ 35**	**$ 32**	**$ 30**	**$ 28**

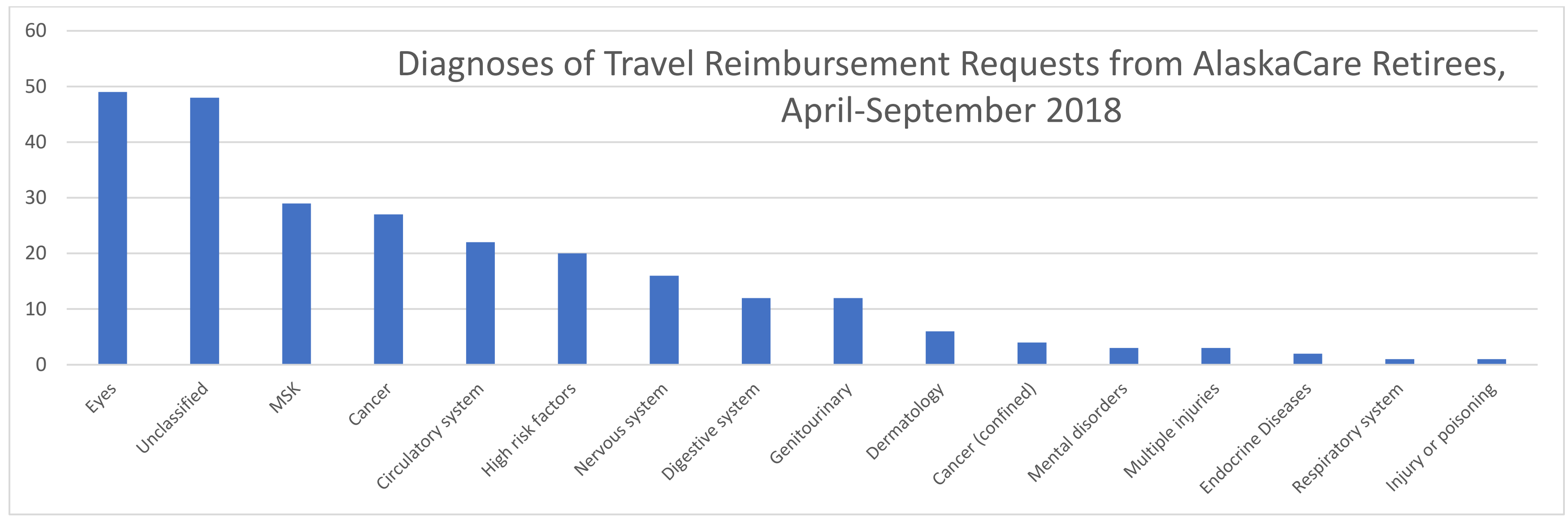
LTC ALASKA LODGING RATES BY REGION NOTES

See Community-Region Listing for the locations in each region				
Region	**Peak Season (5/16 - 9/15)**		**Off Season (9/16 - 5/15)**	
	Short-Term = First 30 days	**Long-Term = Days 31-Travel Completion**	**Short-Term = First 30 days**	**Long-Term = Days 31-Travel Completion**
1 - Southeast Alaska	$ 74.00	$ 44.40	$ 64.00	$ 38.40
2 - Southcentral Alaska	$ 79.00	$ 47.40	$ 59.00	$ 35.40
3 - Interior Alaska	$ 64.00	$ 38.40	$ 54.00	$ 32.40
4 - Southwest Alaska	$ 64.00	$ 38.40	$ 60.00	$ 36.00
5 - Barrow, Kotzebue	$ 64.00	$ 38.40	$ 60.00	$ 36.00

1. Actuals refers to reimbursable expenses supported by receipts.
2. All M&IE payments in excess of federal M&IE rates are reported as taxable compensation. In addition, M&IE payments for trips without overnight lodging are taxable compensation.
3. All lodging allowance payments (including LTC commuting allowance) in excess of submitted receipts are reported as taxable compensation.
4. Boards & Commission members receive Administrative Manual rates, except for at-home meetings during which, in general, they are not allowed lodging per diem.
5. LTC members assigned to work more than 50 miles from their permanent duty station are entitled to a commuting allowance if they return to their residence on their own time (e.g., weekends). The commuting allowance is 90% of lodging allowance (see chart) plus applicable M&IE.



- The distribution is expected, given Juneau's high retiree population and status as a medically-underserved area
    - Where diagnosis is specified, 41% of Juneau travelers are seeking ophthalmology care.



- 256 Unique Claims, or $651 in travel-based (transportation, lodging, meals) expenditures per Claimant
- This will rise on a per-claimant basis as restrictions on travel companions are loosened, and additional travel expenses are incurred on their behalf.

Travel Reimbursements (Retirees, April-September 2018)	**Amount**
A0140 Non-emergency transportation and air travel (private or commercial) intra or inter state.	$ 144,771
A0180 Non-emergency transportation: ancillary: lodging – recipient	$ 10,045
A0170 Transportation: ancillary: parking fees, tolls, other	$ 2,931
A0110 Non-emergency transportation and bus, intra, or inter state carrier	$ 2,886
A Other Travel Expense Not Otherwise Specified	$ 1,558
A0200 Non-emergency transportation: ancillary: lodging – escort	$ 1,518
A0090 Non-emergency transportation, per mile - vehicle provided by individual (family member, self, neighbor) with vested interest.	$ 1,284
A0190 Non-emergency transportation: ancillary: meals – recipient	$ 1,048
A0120 Non-emergency transportation: mini-bus, mountain area transports, or other transportation systems	$ 438
A0100 Non-emergency transportation; taxi	$ 245
Total	$ 166,723

DRAFT-Summary of Responses to Proposed Plan Design Change

Proposed change: Increase deductible and OOP limit

Plans affected: DB Retiree Plan

Reviewed by: Retiree Health Plan Advisory Board

Proposed implementation date: TBD

Review Date: ~~December 12, 2018~~February 6, 2019

Table 1: Plan Design Changes

	Member	Actuarial	DRB Ops	Financial	Clinical	TPA	Provider
No impact							
Minimal impact			X		X	X	
High impact	X	X		X			X
Need Info							

DRAFT

As the Division and the Retiree Health Plan Advisory Board (RHPAB) consider different proposals to modernize the health plan by including provisions that add benefits to the plan, the RHPAB and the Division must also seek to maintain the overall existing actuarial value of the plan. To achieve this, the Division and the board are considering several different types of changes to offset the addition of new benefits.~~.~~ Increasing member's cost share, defined here as the deductible and out-of-pocket (OOP) limit, is the most direct way to achieve a comparable offset.

In this initial draft proposal, the Division has identified three different options for consideration by the RHPAB and membership. Similar to other proposals, these options serve as a starting point for discussion and can be designed differently than proposed here depending on input from the board and membership.

Description of proposed change:

Increase the deductible and OOP limit in the defined benefit retiree health plan as follows:

Option 1 – Increase deductible by $50 per individual and the OOP limit by $100

Option 2 – Increase deductible by $150 per individual and the OOP limit by $300

~~Option 3 – Increase deductible by $500 per individual and the OOP by $1,000~~

For all of these options, this proposal includes limiting the OOP limit to no more than 3 per family, reflecting the limit currently in place for the deductible.

Table 2: Comparison of current and proposed options for deductible and OOP limits

	Current	Option 1	Option 2	~~Option 3~~
Deductible Individual	$150	$200	$300	~~$650~~
Deductible Family (up to 3x individual)	$450	$~~800~~600	$900	~~$1,950~~
OOP Individual	$800	$900	$1,100	~~$1,800~~
OOP Family	Unlimited	$2,700	$3,300	~~$5,400~~
Actuarial Impact[1]	None	-0.5%	-1.6%	~~-4.6%~~
Plan Savings[2]	None	$2.9 million	$9.3 million	~~$27.3 million~~

This change could:

- increase the amount members pay for medical services
- increase member's incentive to use network-providers
- strengthen the health plan's purchasing power with providers
- offset additional value added to the plan through other proposals (e.g. preventive care, removal of lifetime maximum, etc.)

Background:

In 2017, approximately 57,000 (78%) members had $150 in expenses in 2017 that applied to their deductible and 22,000 (30%) met their OOP limits.

Compared to other commercial health plans in the United States, the Alaska Care defined benefit health plan features deductible and out-of-pocket limits that are significantly lower than the average health plan. While it is difficult to find an exact comparison for the health plan because it is a retiree-only plan and has unique features, according to the Kaiser Family Foundation the average deductible in 2018 for employer-sponsored health plans was $1,005 for Preferred Provider Organization (PPO) plans with a family coverage deductible with a separate per-person structure.[3]

A 2017 Segal study of state health plans reports that the average PPO plan deductible for state employee health plans was $483/$1,100 (single/family) in 2017. Average PPO OOP limits were $4,092/$8,409 (single/family). Retiree plan

[1] Attachment A: Segal Memorandum dated December 10, 2018
[2] Ibid.
[3] Kaiser Family Foundation, 2018 Employer Health Benefits Survey – Section 7: Employee Cost Sharing. Retrieved from https://www.kff.org/report-section/2018-employer-health-benefits-survey-section-7-employee-cost-sharing/attachment/table-7-9/

designs generally do not vary much from those for active employees, and many states provide coverage for retired employees within their active employee plan.

Lower cost share provisions have multiple effects on both the members and the health plan. First, they reduce barriers to care for members by ensuring the plan picks up the cost of medical services early on in a member's course of treatment. With the higher cost of health care in Alaska, member's may meet their individual deductible in full through a single primary care appointment.[4] Once they meet their deductible, they are responsible for up 20% of the cost (subject to recognized charge) while the plan pays 80%. When they reach their OOP limit, the plan pays 100% of the cost in full (subject to recognized charge). This substantially limits members financial exposure.

Lower cost share provisions as expressed by higher actuarial plan values are associated with higher utilization of medical services. Higher utilization of services in and of itself should not be viewed negatively; the purpose of health insurance is to assist members in affording necessary medical services in the most appropriate setting at the appropriate time. However, utilization of low value services, those which provide little benefit, are not proven to be efficacious, or which could be avoided without any impact to a member's overall health outcome, add cost to the member and the plan without providing substantial benefit.

The concern with lower cost share provisions, such as those in the retiree plan is that it reduces member's sensitivity to price, making them less likely to distinguish between high value and low value services, and less likely to distinguish between provider type, e.g. network or non-network providers.

Most health plans include provisions in their benefit design to promote use of network providers. Network providers are facilities, provider groups, or which both parties agree to a certain reimbursement schedules and other policies. These policies may include credentialing requirements for participating providers, an agreed upon fee schedule, and/or an agreement from the provider to write off the difference between the fee schedule and their billed charges rather than seeking the difference from the member- a practice commonly referred to as balance billing.

When members use a non-network provider, the plan has to determine what to pay for services since there is not an agreed upon fee schedule with the provider. In the AlaskaCare retiree health plan, this is called the recognized charge, and "is the lesser of:

[4] In 2018, the two most common (established) office visit codes for general practice were 99213 (allowed amount in AK= $155) and 99214 (allowed amount in AK= $232).

- what the provider bills or submits for that services or supply; or
- the 90th percentile of the prevailing charge rate for the geographic area where the service is furnished as determined by Aetna in accordance with Aetna reimbursement policies."[5]

The recognized charge is, with very few exceptions, higher than the negotiated charge, meaning both the plan and the member are paying more for the same service than they would if the service was received through a network provider.

Most health plans try to incentivize member use of network providers through benefit design, e.g. provide a higher level of plan coverage for use of network providers, and require higher cost share by the member when using non-network providers. This incentive encourages use of the network providers which creates both cost savings for the plan and the member while further increasing the negotiating leverage of the plan. Plans with stronger incentives for network use and disincentives for non-network use are able to steer members towards network providers and away from non-network providers more effectively which in turn can create pressure for providers to come into network in order to increase patient volume.

Uniquely, the AlaskaCare Defined Benefit retiree health insurance plan does not differentiate between care received by a network provider and non-network providers when paying benefits. Once a member reaches their deductible or OOP limit, they may not be as sensitive to provider type and may have limited incentives to use network providers.

Member impact:

Members impacted be these changes: Approximately 61,000 members, (78%) would experience a change in their OOP costs by any of these options.

This change would increase the financial cost of using health plan services to the majority of members for each of the options under consideration. Regardless of the option selected, a deductible increase would affect all members who would meet the current deductible, whether by having $150 in expenses in that plan year, or having some expenses from a prior year carried forward to apply towards the next year's deductible (61,000 members in 2017). However, the option selected would have different impacts. The larger the change in deducible and OOP limits, the smaller number of people that would experience the full impact of the changes. For those who do reach their deductible

[5] Page 15, AlaskaCare Retiree Health Insurance Information Booklet. http://doa.alaska.gov/drb/pdf/ghlb/retiree/RetireeInsuranceBooklet2018final.pdf

and OOP limit, the impact per member affected would be more significant under option~~s~~ 2~~ and 3~~.

Table 3: Comparison of estimated member impact across options

	Option 1	Option 2	~~Option 3~~
Potential Impact on Annual Member OOP	$150	$450	~~$1,500~~
Members Experiencing Full Impact*	10,500	8,700	~~5,100~~

* Full impact is defined as the full change in deductible and full change in OOP limit.

<u>Members who are not Medicare-eligible:</u> While this change will apply to all members, it is anticipated to impact members who are not Medicare eligible more immediately as:

1) Plan costs for services are higher than Medicare's fee schedule in most cases; and
2) Members are responsible for those first dollar costs through the deductible and OOP limit.

<u>Members who are Medicare-eligible:</u> This plan change is anticipated to impact Medicare-eligible members as well, however the impact may be reduced as:

1) The AlaskaCare plan is secondary to Medicare for most medical services;
2) Depending on the Medicare deductible, Medicare may pay a portion of the services applied to the AlaskaCare deductible; and
3) Medicare's fee schedule is lower meaning members cost share requirement may be lower in between their deductible and OOP limit than those in the commercial plan.

<u>Actuarial impact:</u>

Neutral / Enhancement / Diminishment

Table 4: Actuarial Impact

	Actuarial Impact[6]
Current	N/A
Option 1	Decrease of 0.5%
Option 2	Decrease of 1.6%
~~**Option 3**~~	~~Decrease of 4.6%~~

<u>DRB operational impacts:</u>

The Division anticipates minimal operational impacts as follows:

[6] See Attachment A: Segal Memorandum dated December 10, 2018

- Staff will need to review and distribute communications to educate and increase awareness of the new plan benefit.
- A plan amendment will need to be developed, put forward for public comment, and published before the benefit takes effect.
- Staff will need to coordinate and oversee implementation of the new benefit to ensure it is accurately administered by the Third-Party Administrator.

Financial impact to the plan:

The overall financial impact to the plan will vary depending on the option being considered. All of the options produce additional savings for the plan.

Table 5: Financial savings to the health plan

	Financial Impact[7] ($)
Current	No impact
Option 1	$2,900,000
Option 2	$9,300,000
~~Option 3~~	~~$27,300,000~~

Clinical considerations:

These changes not anticipated to impact any clinical considerations.

Third Party Administrator (TPA) operational impacts:

The impact to the TPA is anticipated to be moderate as:

- The TPA will need to program these changes and ensure all member communications, claims systems, and call center staff are aware of the change.
- This could provide the TPA with additional leverage to negotiate with providers; either to bring them into network or to negotiate improved contractual provisions with existing network providers.

Provider considerations:

Increasing members cost share could increase providers willingness to participate in the network, particularly in the Anchorage area where there is competition amongst providers.

[7] See Attachment A: Segal Memorandum dated December 10, 2018

<u>Documents attached include:</u>

Document Name	Attachment	Notes
Segal Memorandum; December 10, 2018	A	

330 North Brand Boulevard Suite 1100 Glendale, CA 91203-2308
T 818.956.6700 www.segalco.com

MEMORANDUM

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

From: Richard Ward, FSA, FCA, MAAA

Date: December 10, 2018

Re: Deductible and Out-of-Pocket Maximum Change – Focus on Actuarial and Financial Impact for the Retiree Plan - **UPDATED**

The AlaskaCare Retiree Plan currently provides coverage for medical treatments and applies the general plan provisions, such as deductible, coinsurance and out-of-pocket limitations, 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	
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

A change to the benefits under consideration would replace the current annual individual/family deductible and individual out-of-pocket maximum limit with one of the following options:

	Annual Individual/Family Deductible	Annual Individual Out-of-Pocket Limit
Option 1	$200 / up to 3x per family	$900
Option 2	$300 / up to 3x per family	$1,100
Option 3	$650 / up to 3x per family	$1,800

Actuarial Value

Our analysis determines the impact of increasing the annual individual/family deductible and annual individual out-of-pocket limit would result in the following decreases in actuarial value:

	Change in Actuarial Value
Option 1	-0.5%
Option 2	-1.6%
Option 3	-4.6%

Financial Impact

Based on the current retiree claims projection of $590,000,000 for 2019, the financial impact would result in the following annual savings to the plan:

	Annual Savings
Option 1	$2,900,000
Option 2	$9,300,000
Option 3	$27,300,000

A change in deductible and out-of-pocket limit would impact most plan members, due to these provisions being rather low. We estimate that about 61,000 members would experience a change in their out-of-pocket costs due to any change in the deductible or out-of-pocket limit. The magnitude of the change, of course, is determined by the dollar amount of the deductible change and out-of-pocket limit.

The larger the change in deducible and OOP limits, the smaller number of people that would experience the full impact of the changes, but for those that do experience the full impact, the changes would be more significant.

	Option 1	**Option 2**	**Option 3**
Potential Impact on Annual Member OOP*	$150	$450	$1,500
Members Experiencing Full Impact	10,500	8,700	5,100

* The full impact is the full change in deductible and full change in OOP limit.

This analysis is based on 2016 and 2017 medical and pharmacy claims data, projected to 2019 at 3.0% and 6.0% annual trends, respectively. The data was reviewed, but not audited, and found to be sufficient and credible for this analysis.

With over 60,000 members and a high incidence rate of medical services, the data is considered credible for this analysis and recent utilization patterns are considered to be a sound basis for determining the impact of this prospective change.

Please note that the projections in this report are estimates of future costs and are based on information available to Segal at the time the projections were made. Segal Consulting has not audited the information provided. Projections are 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, trend rates, and claims volatility. The accuracy and reliability of projections decrease as the projection period increases. Unless otherwise noted, these projections do not include any cost or savings impact resulting from The Patient Protection and Affordable Care Act (PPACA) or other recently passed state or federal regulations.

cc: Michele Michaud, Division of Retirement and Benefits
Emily Ricci, Division of Retirement and Benefits
Linda Johnson, Segal
Michael Macdissi, Segal
Noel Cruse, Segal
Daniel Haar, Segal

2018 Member Satisfaction Survey

Prepared for:

State of Alaska

Division of Retirement and Benefits

November 2018

Prepared by:

DSS Research

Looking Beyond the Expected

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Background. The State of Alaska engaged DSS Research to conduct a survey among State of Alaska retirees and active employees to assess satisfaction with the administration of services by Aetna and Moda.

Questionnaire. The State of Alaska provided the questionnaire. DSS was responsible for programming the survey for telephone administration.

Data collection. Data were collected from October 10 – 31, 2018.

Sample design.

- **Qualified respondents.** State of Alaska retirees and active employees with an Aetna and/or Moda plan.
- **Sample source.** The State of Alaska provided a list of qualified members.
- **Sample type.** Stratified random sample. Quotas were set by status (active or retired). Among retired members, quotas were set by age (under 65 or 65 and older) and location (in Alaska or not in Alaska) to roughly reflect population proportions.
- **Sample size.** 714 qualified respondents completed the survey, distributed as follows.

Completes	
Respondent groups	**Total**
Retirees	**564**
In Alaska <65	108
In Alaska 65+	235
Not in Alaska <65	60
Not in Alaska 65+	161
Active employees	**150**
Total	**714**

Data processing and tabulation. DSS performed all coding, data cleaning and verification, and produced detailed tables that summarize the results.

Most are satisfied with the AlaskaCare benefits and plans in 2018.

- 93.8% of members are completely, very or somewhat satisfied overall with AlaskaCare benefits.
- 95.4% are satisfied with Aetna's administration of the pharmacy plan and 92.8% are satisfied with Aetna's administration of the medical plan.
- 90.1% are satisfied with the dental services from Moda.

The vast majority are also satisfied overall with claims processing, the network and the Aetna Concierges.

- 93.6% are satisfied with the speed of claims processing.
- 90.7% are satisfied overall with the Aetna provider network.
- Satisfaction with the number of dental providers in the Moda/Delta Dental network is as follows:
  - General practitioners: 93.6%.
  - Dental specialists: 88.2%.
  - 37.1% are at least *somewhat* willing to pay a higher monthly premium in exchange for the ability to use any dentist.
- 88.6% rated the Concierges as *excellent*, *very good* or *good* for their knowledge of the AlaskaCare plan. Concierges also received the following scores for their ability to resolve questions or issues related to:
  - AlaskaCare travel benefit assistance: 86.7%.
  - Vision benefits: 84.1%.
  - Medical claims: 83.5%.
  - Pharmacy claims: 82.0%.
- 85.3% indicated that Aetna's customer service has improved at least *somewhat* since 2014.

The most common benefits retirees would like to see added to the health plan include better coverage for services related to dental, vision, preventative care and wellness. Vaccinations and flu shots are also a common suggestion.

Scores on many measures are highest among retirees not in Alaska and lowest among actives employees.

Results on only two measures changed significantly from last year. Higher percentages than in 2017:

- Are satisfied with the number of general practitioner dental providers in the Moda/Delta Dental network (93.6% vs. 89.4%).
- Indicated that they called the Aetna Concierge about a pharmacy claim (45.3% vs. 32.3%).

Statistical references and footnotes

All statistical testing is performed at the 90% confidence level.

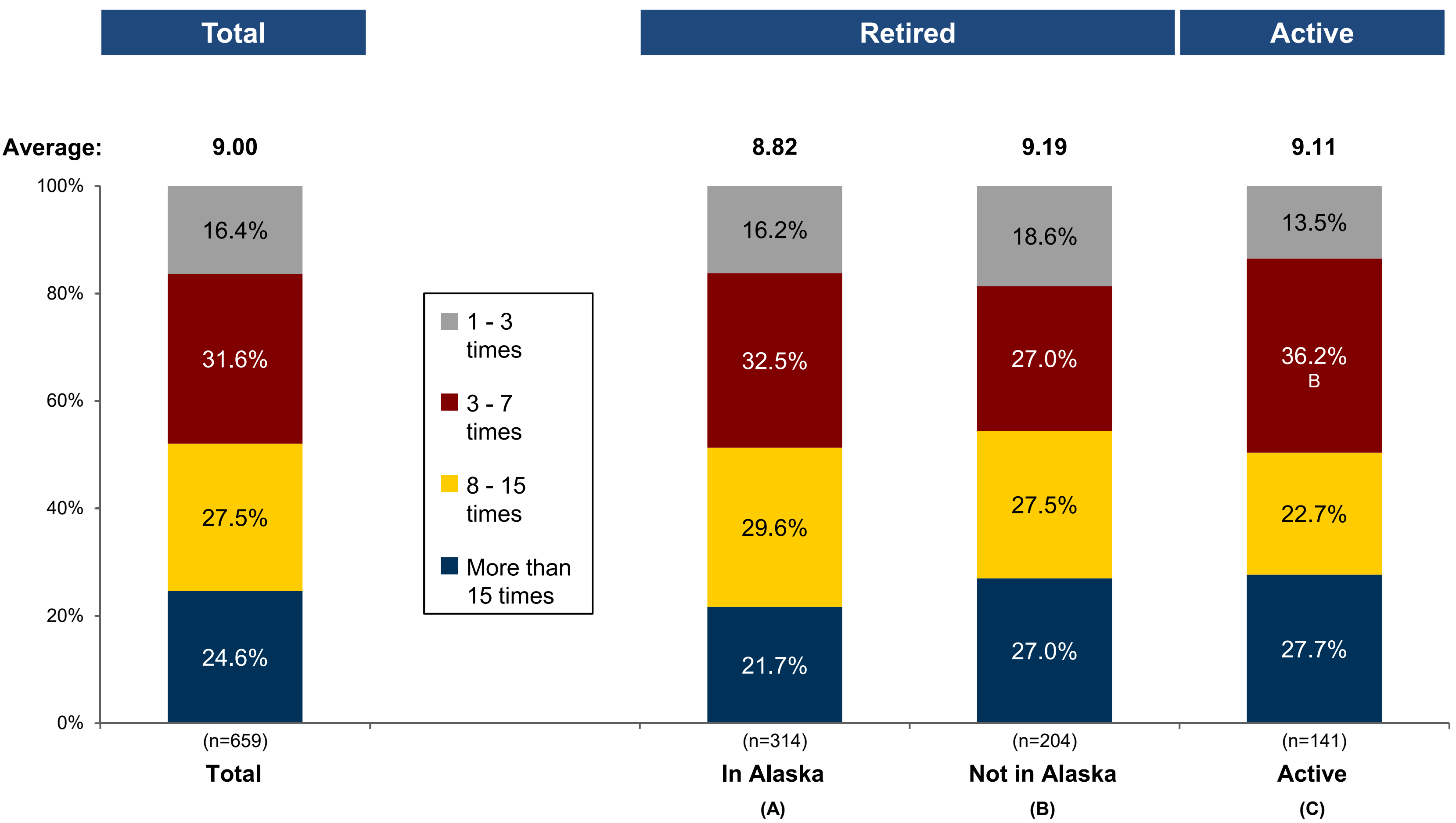
ABC	Indicates that the result is significantly higher than the result in the corresponding column.
~	Indicates a new question in 2018.
*	Indicates a change in question text in 2018; trending is not appropriate.
^	Indicates a base size less than 20; interpret results with caution

Percentages lower than five percent are not labeled in charts or graphs where space does not permit.

Totals reported in graphs may not be equal to the sum of the individual components due to the rounding of all figures to whole numbers.

Usage

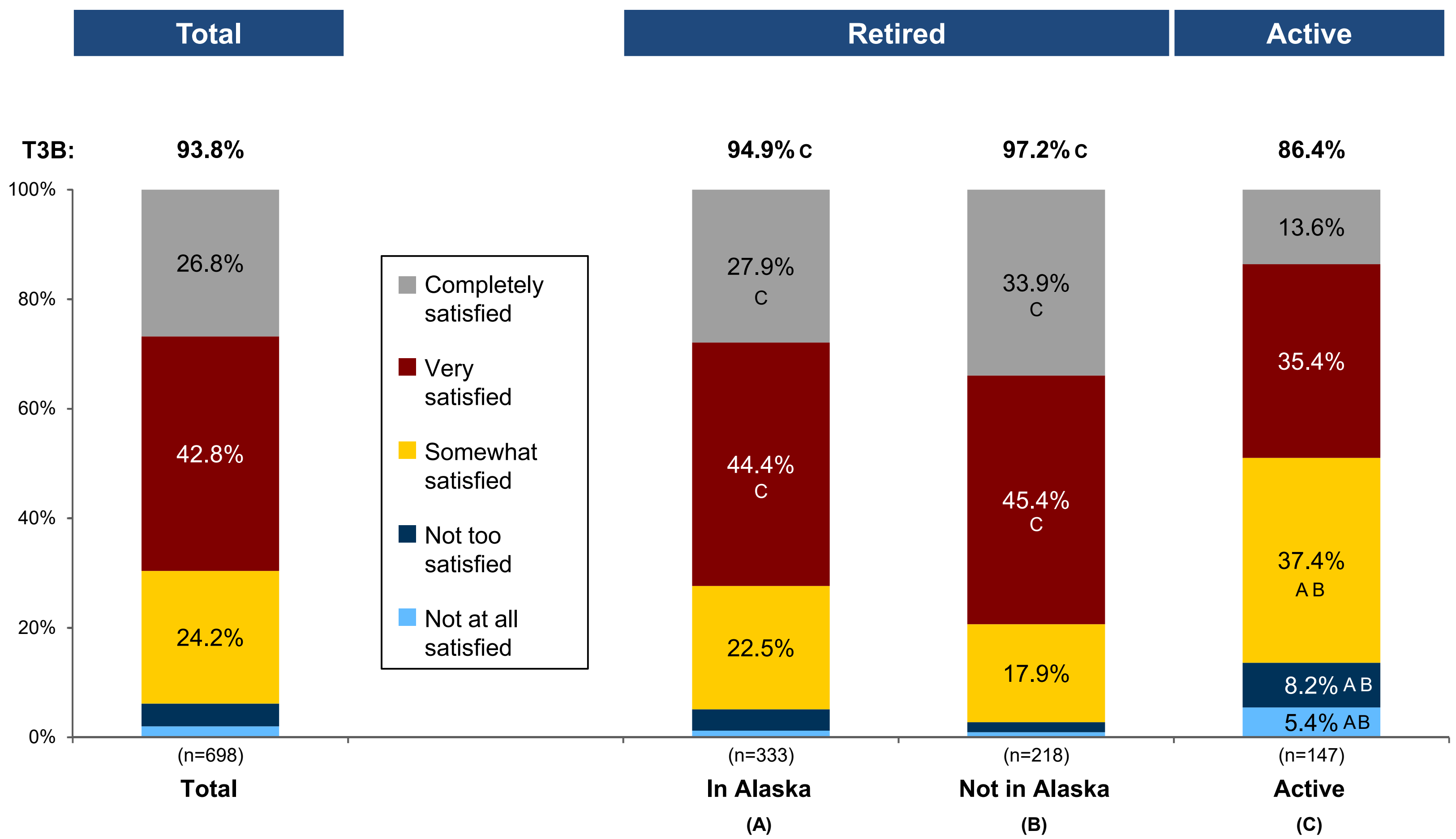
Q1. Since January 1, 2018, how often have you or anyone else covered by your policy used services covered by the AlaskaCare Plan?



Members have used services covered by AlaskaCare nine times, on average, since the beginning of the year.

Please refer to page 4 for statistical references and footnotes.

Q2. What is your overall level of satisfaction with the benefits you received through the AlaskaCare plan since January 1, 2018?



More than 90% are completely, very or somewhat satisfied overall with their AlaskaCare benefits. Satisfaction is significantly higher among retirees than active employees.

Please refer to page 4 for statistical references and footnotes.

Q2a. Why are you not more satisfied with the benefits the AlaskaCare plan has provided?

(Asked among those who indicated that they are *somewhat*, *not too* or *not at all satisfied* with the benefits received through the AlaskaCare plan)

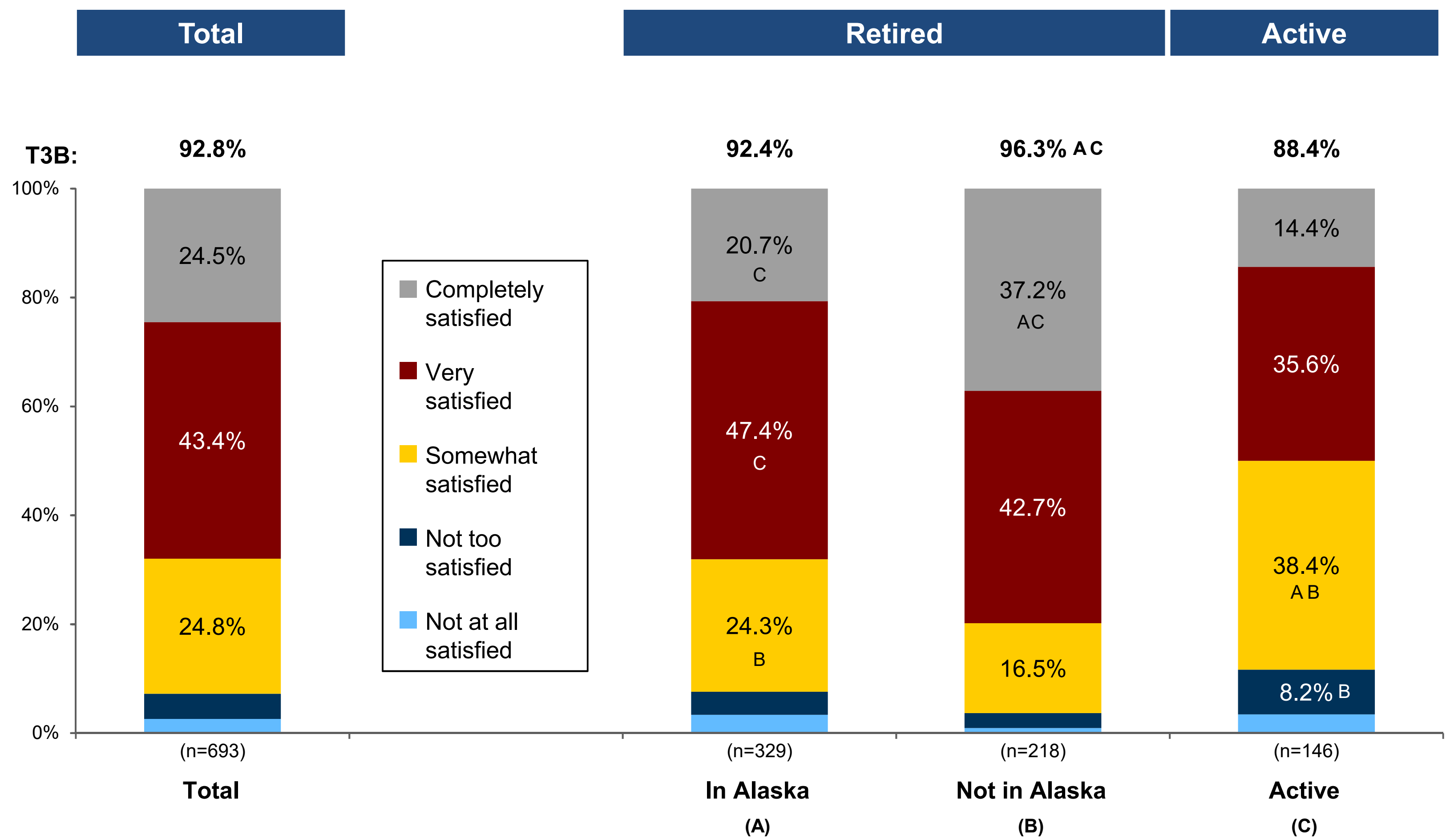
Mentions of 5.0% or more in Total	Status			Total	Total as Percent of Responses
	Retired		Active		
	In Alaska	Not in Alaska			
	Number of coded respones				(n=209)
Dissatisfied with benefits/coverage/product/plans/care	29	14	28	71	34.0%
Dissatisfied with claims/billing/slow payment/many lost/denied/inaccurate claims	25	9	16	50	23.9%
Dissatisfied with/high costs/premiums/out-of-pocket expenses/value	14	4	27	45	21.5%
No preventative services offered	14	15	2	31	14.8%
Difficult to work with/use/poor administrative policies/support	16	5	8	29	13.9%
Dissatisfied with changes/reduced benefits/coverage	11	5	4	20	9.6%
Dissatisfied with prescription benefits/coverage/plan/formulary	8	4	7	19	9.1%
Poor/dissatisfied with/no network/providers/choice of providers	5	2	10	17	8.1%
Dissatisfied with dental/vision benefits/coverage/plan	10	2	4	16	7.7%
Not helpful/unprofessional/untimely/inaccurate customer service	7	3	5	15	7.2%
Inadequate/inaccurate info/EOB confusing	6	0	5	11	5.3%

Coverage limitations, issues with claims and high costs are the most commonly mentioned reasons for dissatisfaction with the AlaskaCare plan benefits.

Please refer to page 4 for statistical references and footnotes.

Administration of medical plan

Q3. Overall, how satisfied are you with Aetna's administration of your 2018 AlaskaCare medical plan?



More than nine in 10 are satisfied with Aetna's administration of their medical plan. Satisfaction is significantly higher among retirees not in Alaska than among those in Alaska or active employees.

Please refer to page 4 for statistical references and footnotes.

Q3a. Why are you not more satisfied with Aetna's administration of your 2018 AlaskaCare medical plan?

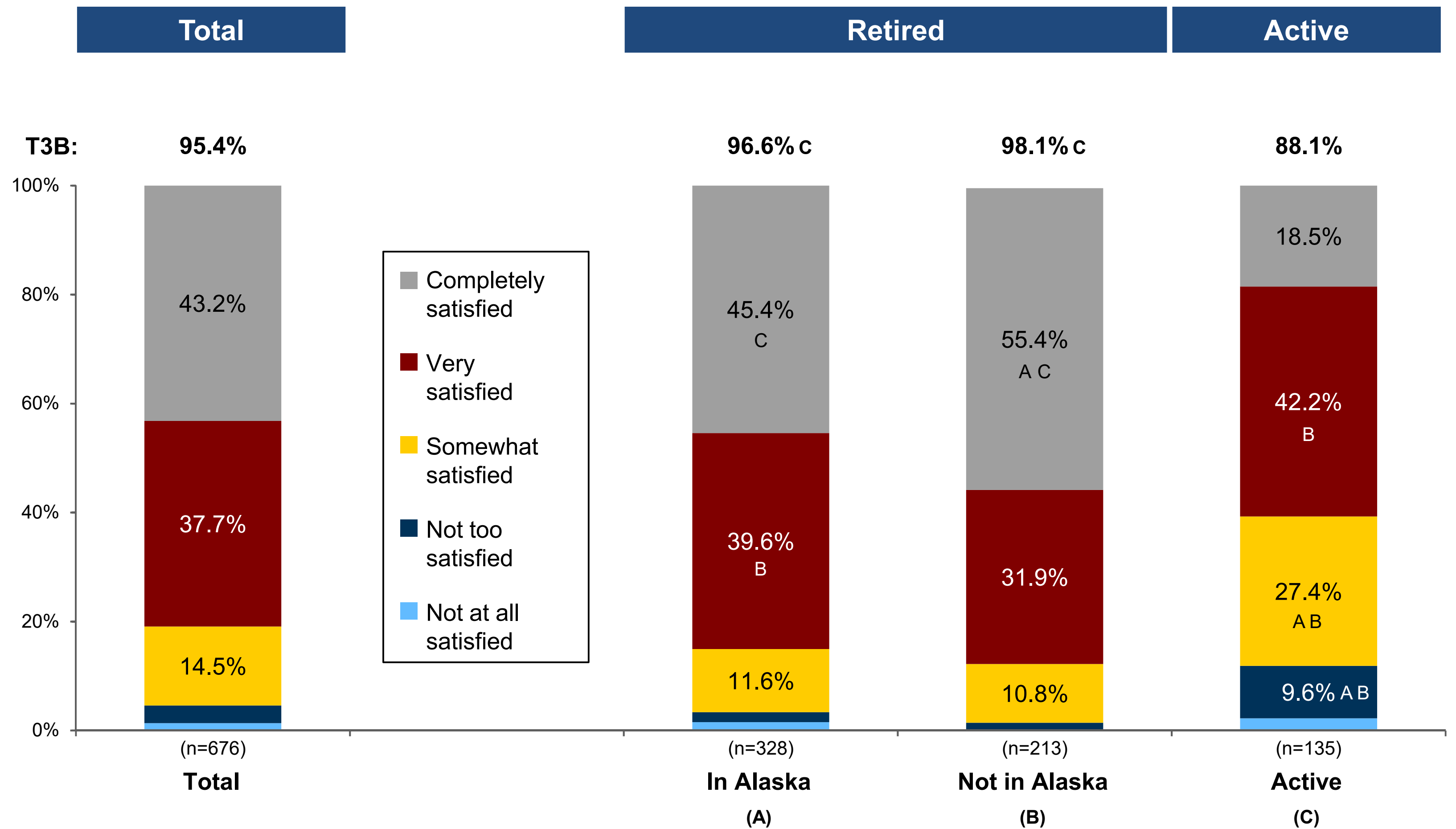
(Asked among those who indicated that they are *somewhat*, *not too* or *not at all satisfied* with Aetna's administration of their 2018 AlaskaCare medical plan)

Mentions of 5.0% or more in Total	Status			Total	Total as Percent of Responses
	Retired		Active		
	In Alaska	Not in Alaska			
	Number of coded respones				(n=213)
Dissatisfied with claims/billing/slow payment/many lost/denied/inaccurate claims	30	10	26	66	31.0%
Difficult to work with/use/poor administrative policies/support	18	7	15	40	18.8%
Dissatisfied with benefits/coverage/product/plans/care	25	6	9	40	18.8%
Inadequate/inaccurate info/EOB confusing	15	3	7	25	11.7%
Inadequate/incorrect communications from plan	7	6	6	19	8.9%
Not helpful/unprofessional/untimely/inaccurate customer service	9	5	4	18	8.5%
Dissatisfied with/high costs/premiums/out-of-pocket expenses/value	6	3	7	16	7.5%
Dissatisfied with online/electronic/automated capabilities	5	3	5	13	6.1%
Dissatisfied with changes/reduced benefits/coverage	7	5	0	12	5.6%
Medicare mentions	6	5	0	11	5.2%

Members most often mentioned issues with the timeliness and accuracy of claims processing as their reason for dissatisfaction with the administration of the medical plan.

Please refer to page 4 for statistical references and footnotes.

Q4. Overall, how satisfied are you with Aetna's administration of your 2018 AlaskaCare pharmacy plan?



The vast majority are satisfied with Aetna's administration of the pharmacy plan. Satisfaction is significantly higher among retirees than active employees.

Please refer to page 4 for statistical references and footnotes.

Q4a. Why are you not more satisfied with Aetna's administration of your 2018 AlaskaCare pharmacy plan?

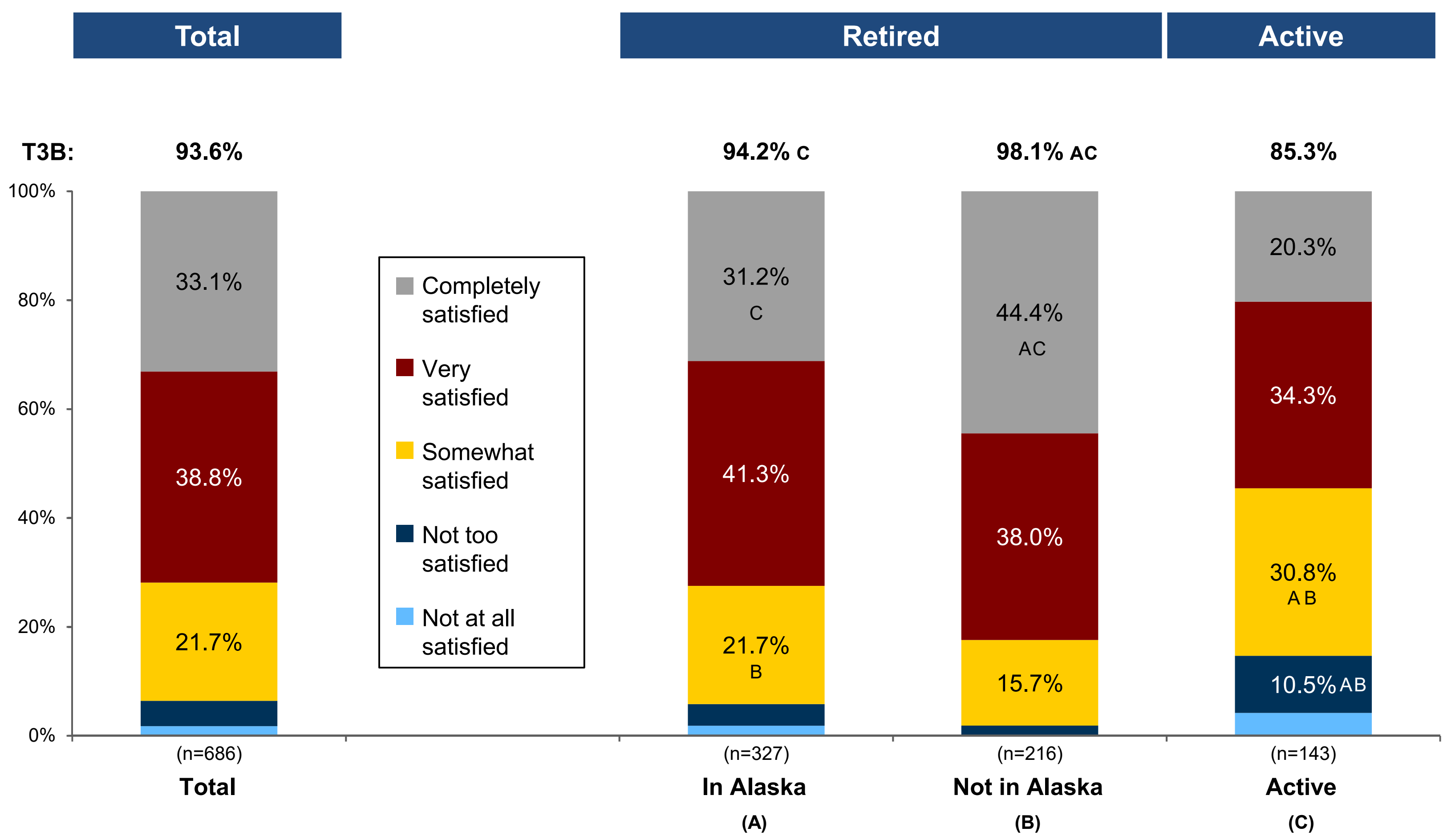
(Asked among those who indicated that they are *somewhat*, *not too* or *not at all satisfied* with Aetna's administration of their 2018 AlaskaCare pharmacy plan)

Mentions of 5.0% or more in Total	Status			Total	Total as Percent of Responses
	Retired		Active		
	In Alaska	Not in Alaska			
	Number of coded respones				(n=125)
Dissatisfied with prescription benefits/coverage/plan/formulary	10	8	18	36	28.8%
Difficult to work with/use/poor administrative policies/support	9	4	6	19	15.2%
Difficult to order/slow to receive/lost prescription/inaccuracies	7	5	6	18	14.4%
Dissatisfied with benefits/coverage/product/plans/care	6	5	5	16	12.8%
Dissatisfied with/high costs/premiums/out-of-pocket expenses/value	3	0	12	15	12.0%
Dissatisfied with claims/billing/slow payment/many lost/denied/inaccurate claims	4	2	6	12	9.6%
Difficult/untimely referrals/authorizations/pre-certifications	3	3	2	8	6.4%
No preventative services offered	3	5	0	8	6.4%
Inadequate/incorrect communications from plan	2	2	3	7	5.6%

The most common issues with the administration of the pharmacy plan are related to coverage limitations or the formulary.

Please refer to page 4 for statistical references and footnotes.

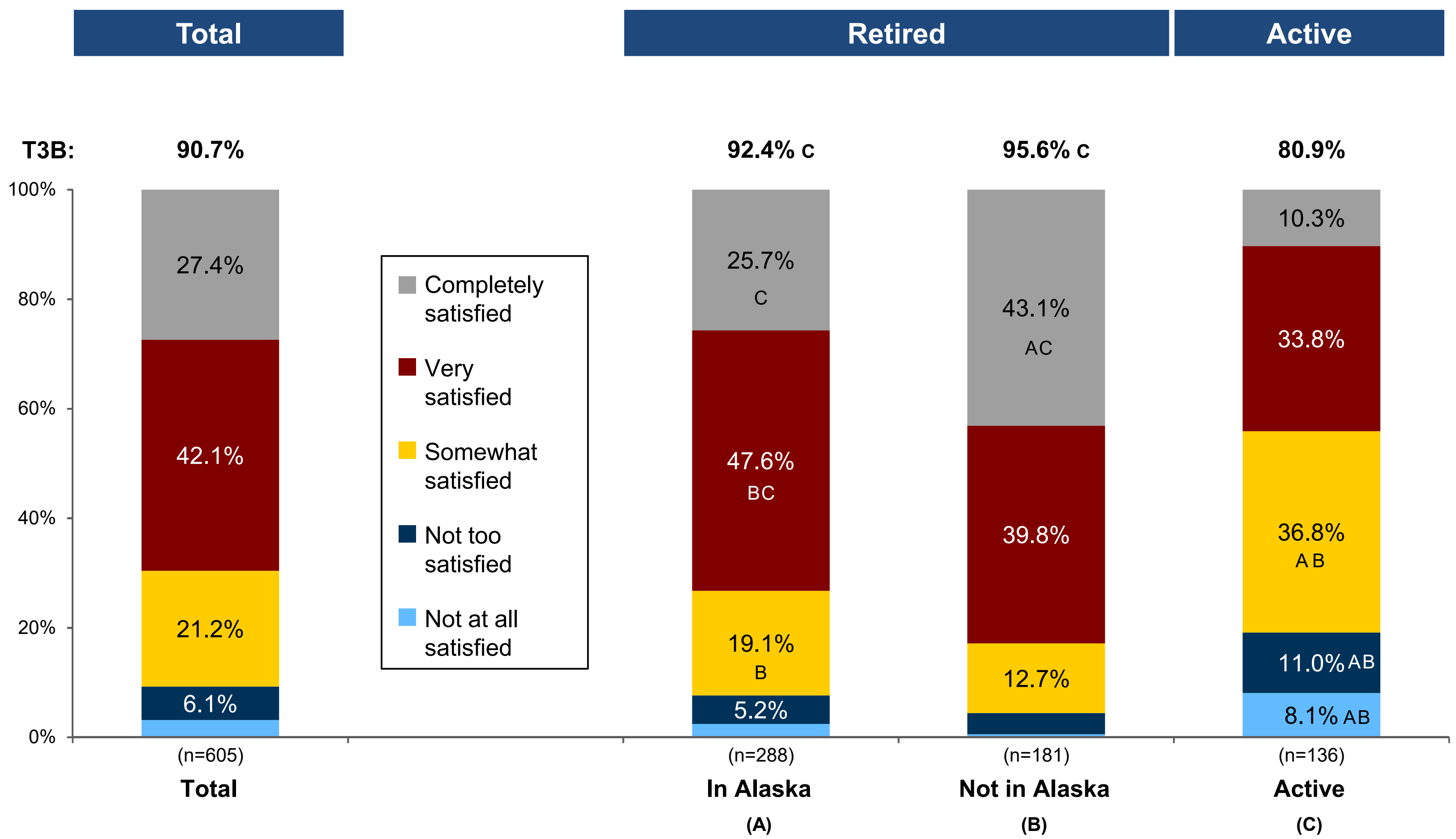
Q5. What is your overall level of satisfaction with the speed at which your claims were processed in calendar year 2018?



More than nine in 10 are satisfied with the speed of claims processing. Satisfaction varies significantly by employee group and is highest among retirees not in Alaska and lowest among active employees.

Please refer to page 4 for statistical references and footnotes.

Q6. What is your overall level of satisfaction with the Aetna provider network in your area?



Nine in 10 are satisfied with the provider network, but satisfaction is significantly lower among active employees than retirees.

Please refer to page 4 for statistical references and footnotes.

Q6a. Why are you not more satisfied with the provider network?

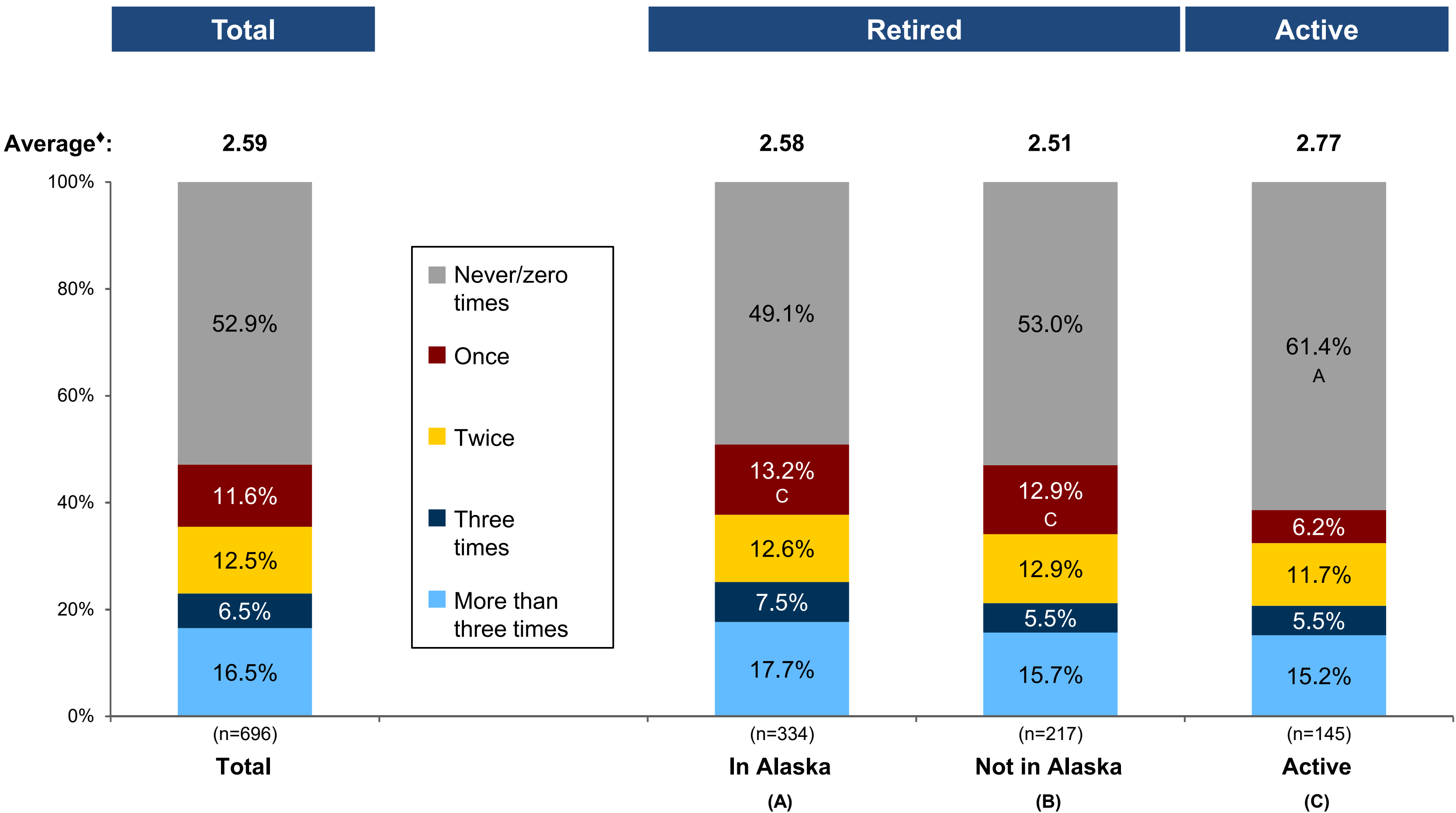
(Asked among those who indicated that they are *somewhat*, *not too* or *not at all satisfied* with the provider network)

Mentions of 5.0% or more in Total	Status			Total	Total as Percent of Responses
	Retired		Active		
	In Alaska	Not in Alaska			
	Number of coded respones				(n=171)
Not enough providers/specialists	33	8	41	82	48.0%
Coverage issues/mentions	12	3	9	24	14.0%
No providers near me	7	5	12	24	14.0%
Information mentions	5	7	7	19	11.1%
Issues with billing/claims	10	4	4	18	10.5%
Cost mentions	7	1	5	13	7.6%
Satisfied/okay mentions	3	3	3	9	5.3%

The most common issue with the network is that it does not include enough providers.

Please refer to page 4 for statistical references and footnotes.

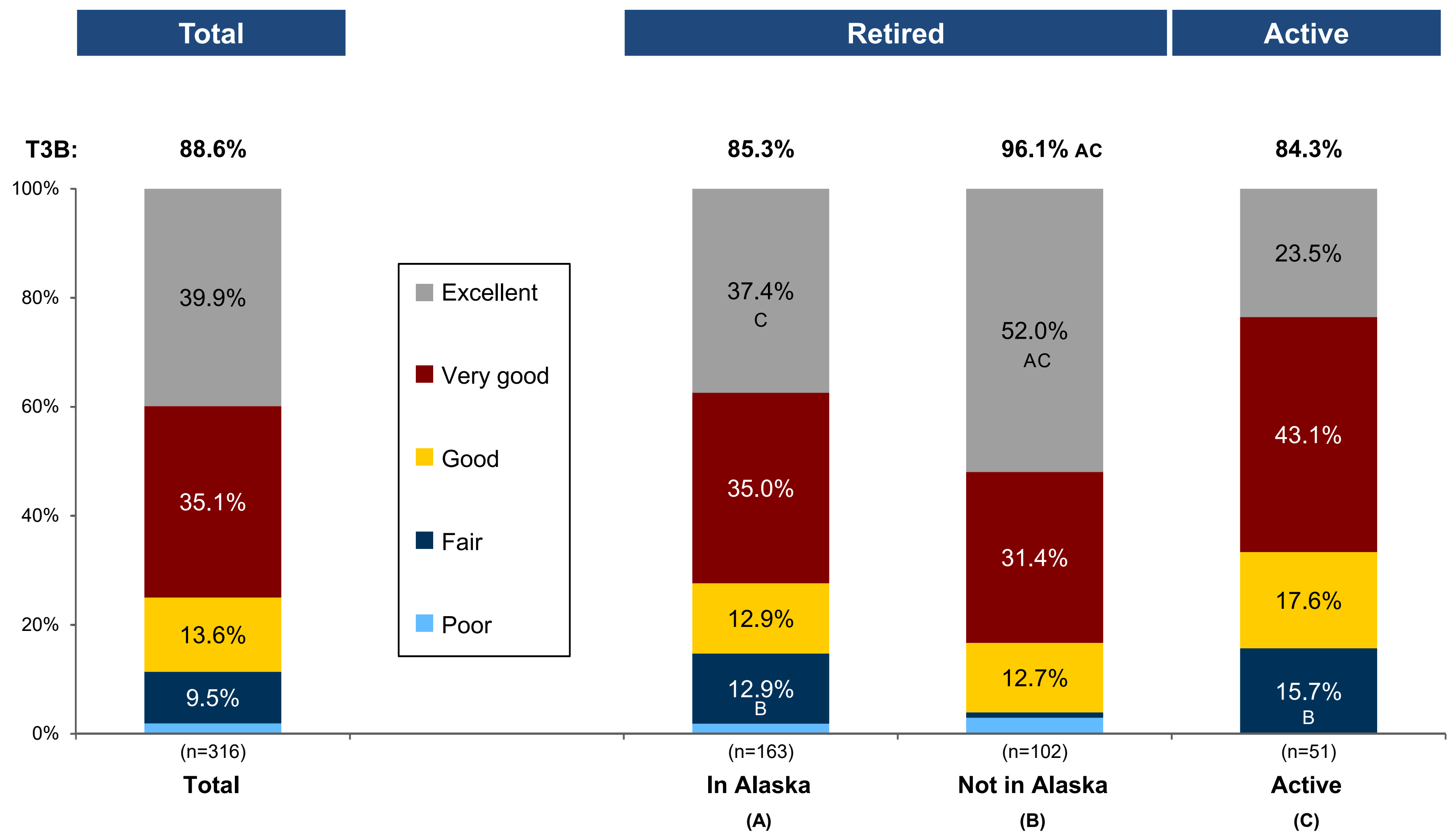
Q7. During calendar year 2018, how often have you called the Aetna Concierge?



More than half did not call the Aetna Concierge. However, those who have called did so more than twice, on average.

♦ Note: Average among those who have called at least once. Please refer to page 4 for statistical references and footnotes.

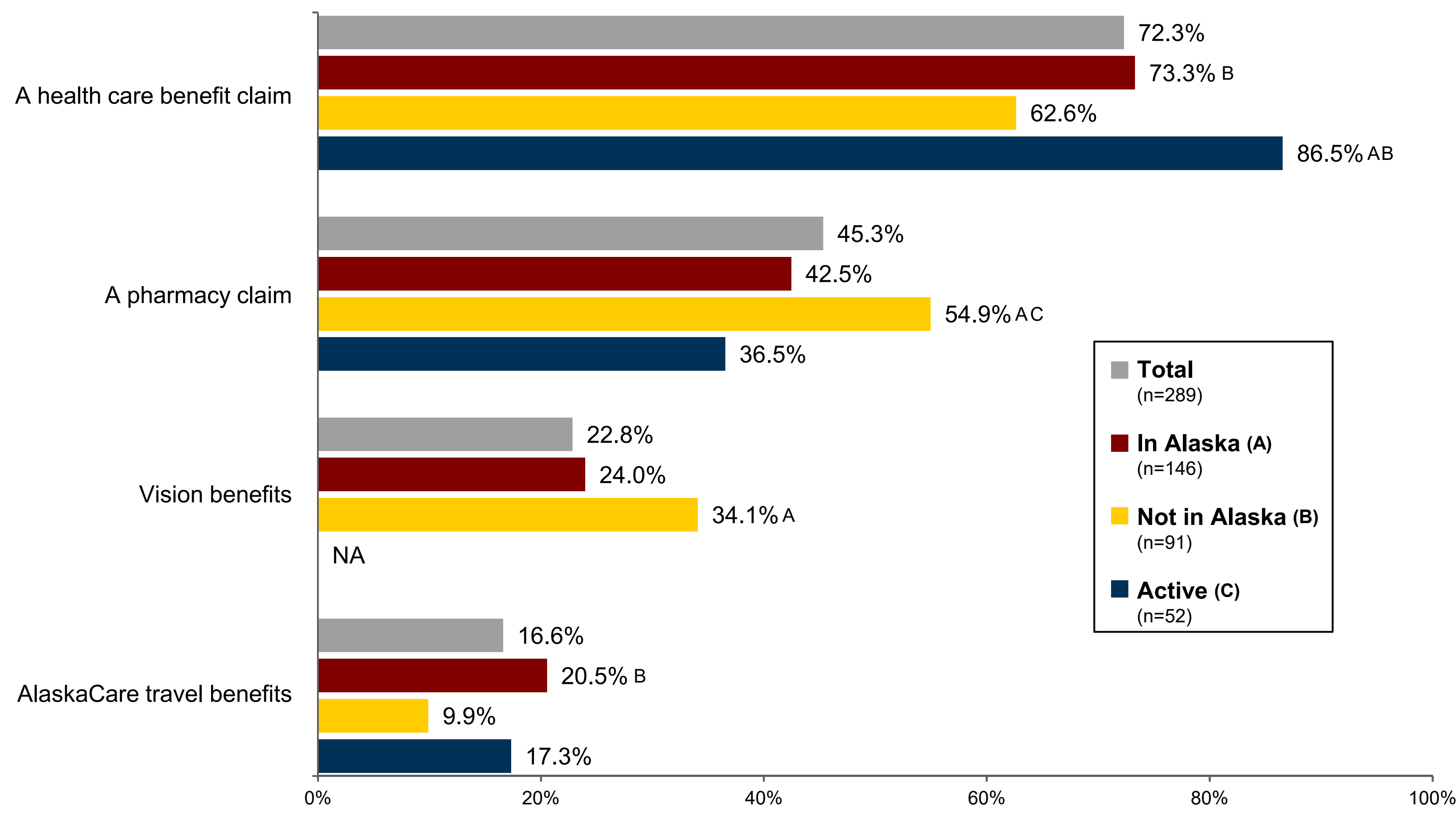
Q8. During your most recent call, how would you rate the level of AlaskaCare plan knowledge demonstrated by the Aetna Concierge?



Nearly nine in 10 rated the Concierges' knowledge of the AlaskaCare plan as *excellent*, *very good* or *good*. The rating among retirees not in Alaska is significantly higher than among other members.

Please refer to page 4 for statistical references and footnotes.

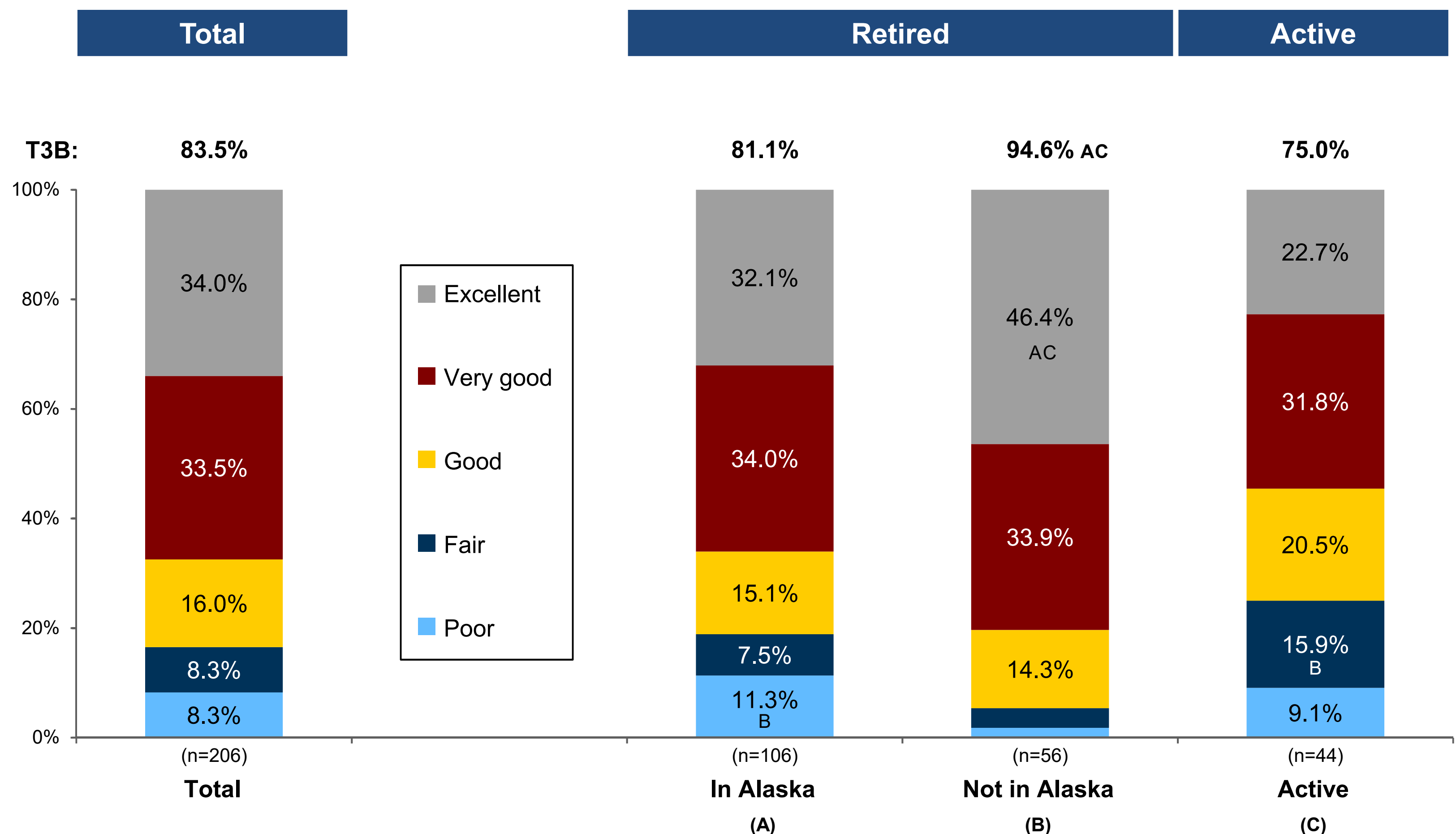
Q9. Did your call to the Aetna Concierge involve any of the following topics?



A health care benefit claim remains the most common reason for calling an Aetna Concierge and is significantly more common among active employees than retirees.

NA: Vision benefits not applicable for active employees. Please refer to page 4 for statistical references and footnotes.

Q10. How would you rate the Aetna Concierge's ability to resolve your question or issue related to your health care benefit claim?



More than eight in 10 rated the Concierges' ability to resolve medical claim issues as *excellent*, *very good* or *good*. Retirees not in Alaska gave a significantly higher rating than retirees in Alaska and active employees.

Please refer to page 4 for statistical references and footnotes.

Q10a. Why were you not satisfied?

(Asked among those who rated the Aetna Concierge's ability to resolve questions or issues related to their health care benefit claim as *fair* or *poor*)

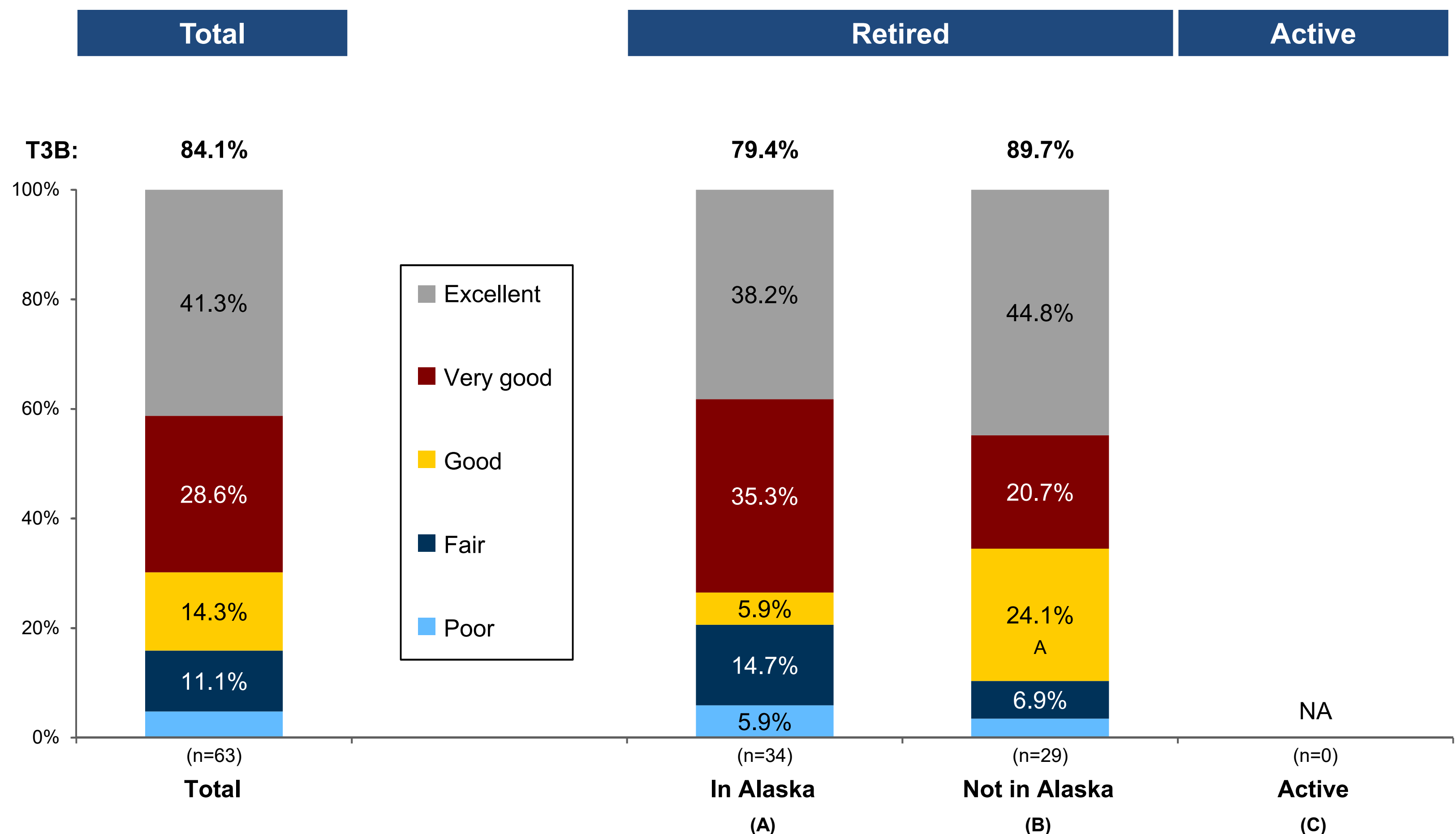
Mentions of 5.0% or more in Total	Status				
	Retired				
	In Alaska	Not in Alaska	Active	Total	Total as Percent of Responses
	Number of coded respones				(n=32)
Not helpful/unprofessional/untimely/inaccurate customer service	7	0	6	13	40.6%
Difficult to work with/use/poor administrative policies/support	4	0	3	7	21.9%
Inadequate/incorrect communications from plan	6	0	1	7	21.9%
Dissatisfied with claims/billing/slow payment/many lost/denied/inaccurate claims	4	1	2	7	21.9%
Dissatisfied with benefits/coverage/product/plans/care	2	0	0	2	6.3%
Difficulty with appeals (long wait, no answer, too much paperwork)	0	1	1	2	6.3%
Good/satisfied with network/provider/choice of providers	2	0	0	2	6.3%
Medicare mentions	2	0	0	2	6.3%

The most common issue with the Concierges' ability to resolve claims questions or issues involves unhelpful customer service.

Please refer to page 4 for statistical references and footnotes.

Concierge

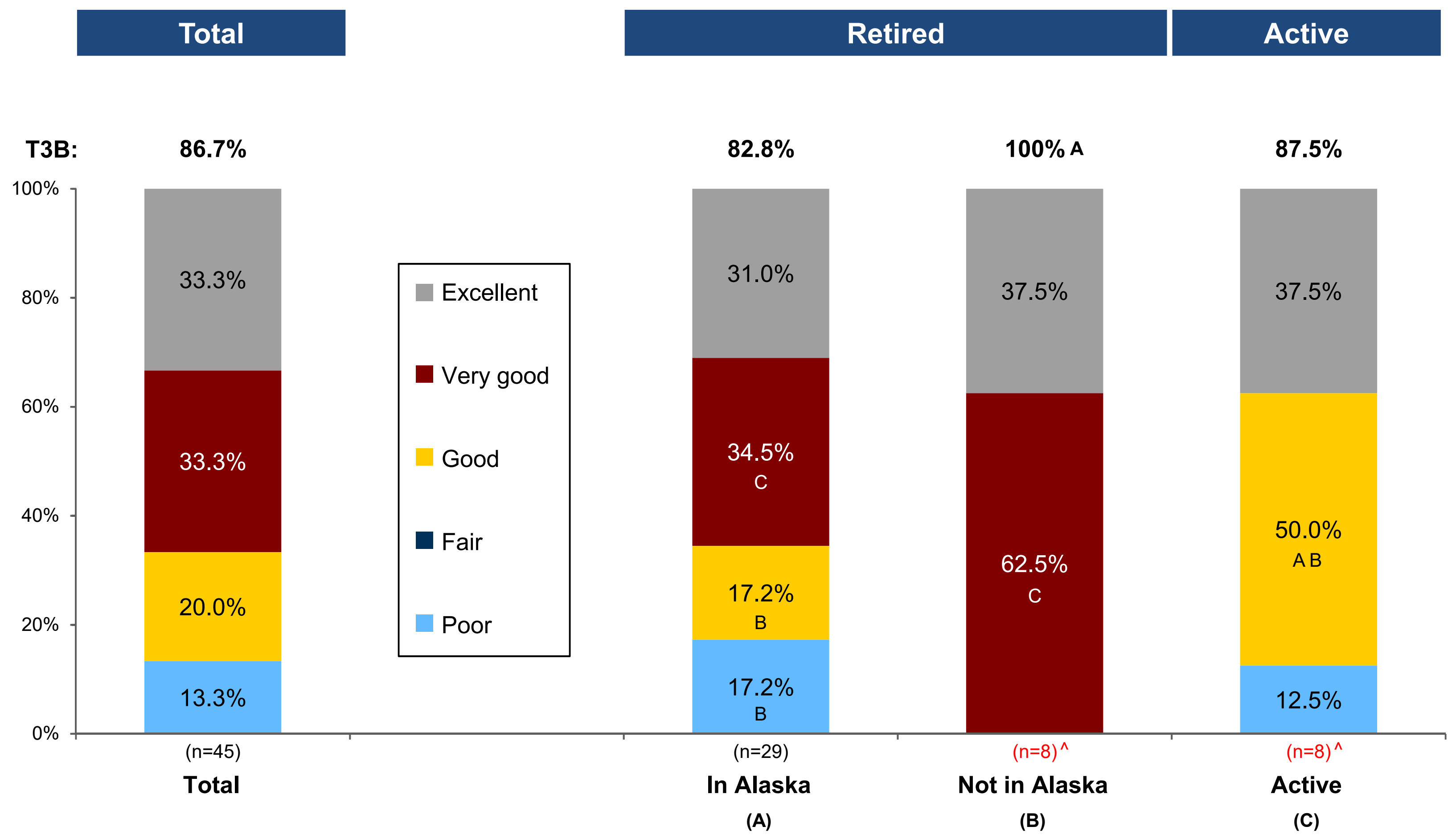
Q11. How would you rate the Aetna Concierge's ability to resolve your question or issue related to your vision benefits?



The majority of retirees rated the Concierges highly for their ability to resolve vision benefits issues.

NA: Vision benefits not applicable for active employees. Please refer to page 4 for statistical references and footnotes.

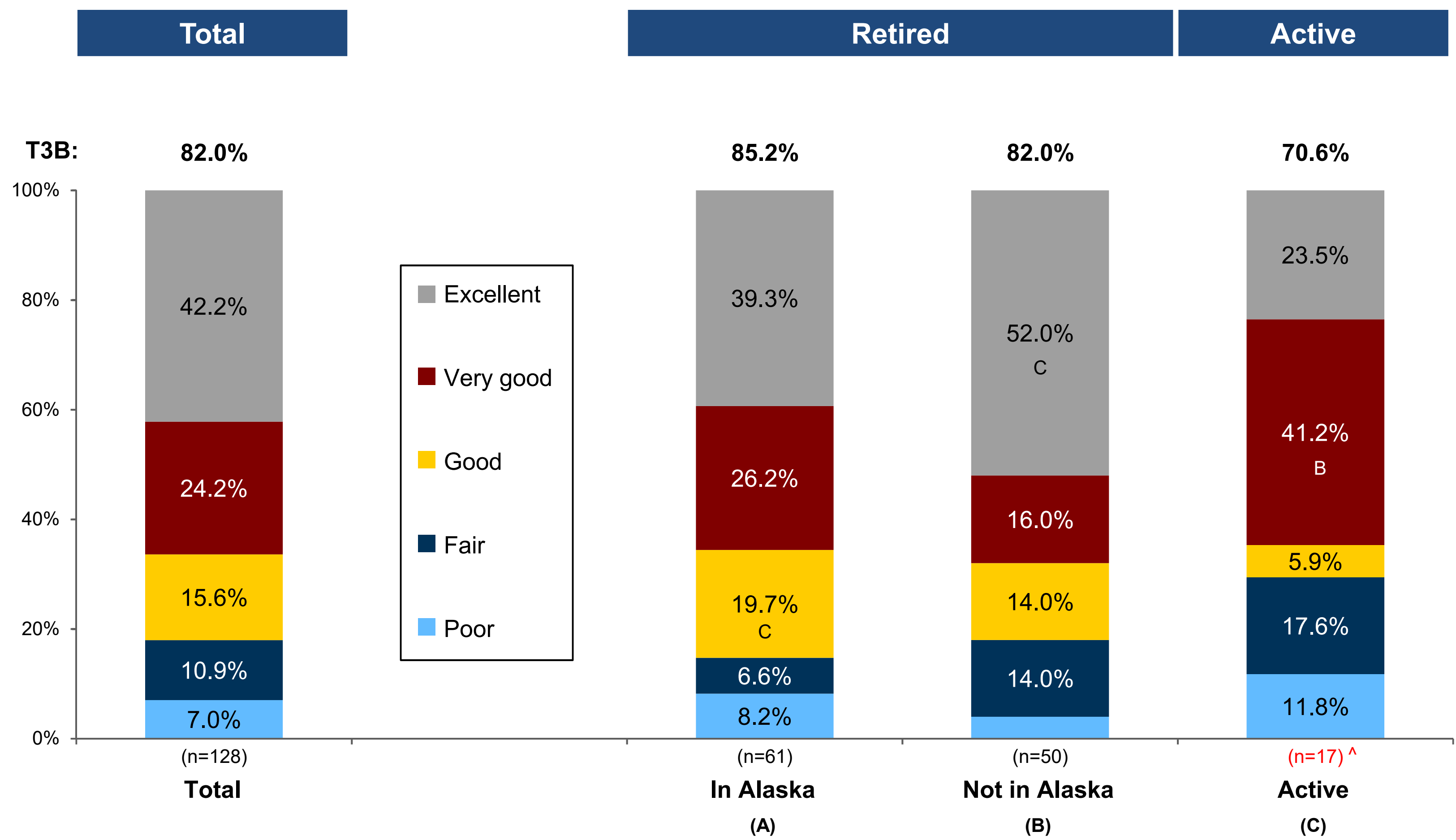
Q12. How would you rate the Aetna Concierge's ability to resolve your question or issue related to your AlaskaCare travel benefit assistance?



The majority of those who called about AlaskaCare rated the Concierges highly for their ability to resolve issues with this program.

Please refer to page 4 for statistical references and footnotes.

Q13. How would you rate the Aetna Concierge's ability to resolve your question or issue related to your pharmacy claim?



In total, more than eight in 10 rated the Concierges highly for their ability to resolve pharmacy claim issues.

Please refer to page 4 for statistical references and footnotes.

Q13a. Why were you not satisfied?

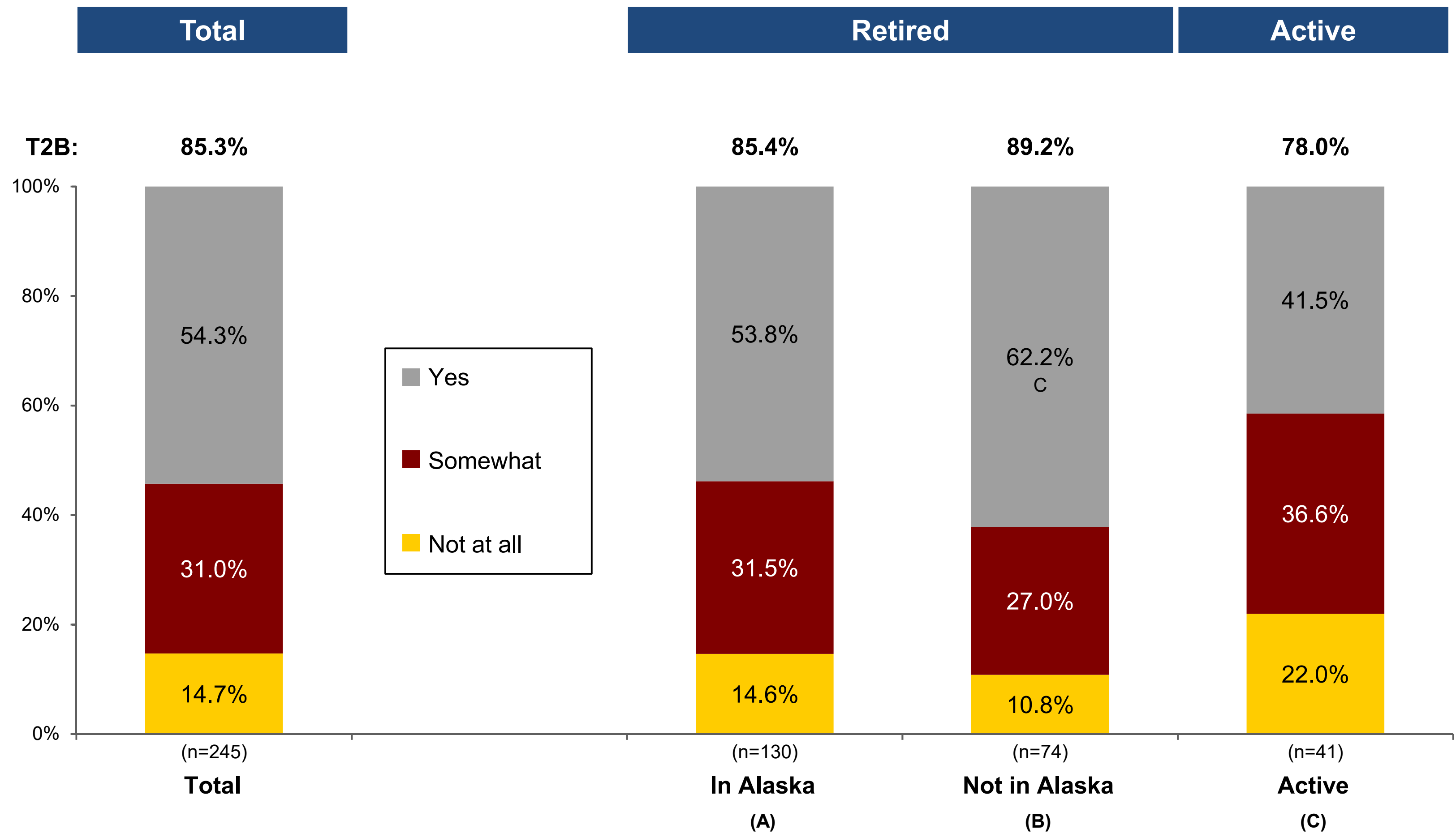
(Asked among those who rated the Aetna Concierge's ability to resolve questions or issues related to their pharmacy claim as *fair* or *poor*)

Mentions of 5.0% or more in Total	Status			Total	Total as Percent of Responses
	Retired		Active		
	In Alaska	Not in Alaska			
	Number of coded respones				(n=23)
Not helpful/unprofessional/untimely/inaccurate customer service	1	3	3	7	30.4%
Dissatisfied with prescription benefits/coverage/plan/formulary	2	2	1	5	21.7%
Difficult to work with/use/poor administrative policies/support	1	2	0	3	13.0%
Inadequate/incorrect communications from plan	1	1	1	3	13.0%
Dissatisfied with claims/billing/slow payment/many lost/denied/inaccurate claims	1	2	0	3	13.0%
Difficult to order/slow to receive/lost prescription/inaccuracies	0	1	1	2	8.7%
Difficult/untimely referrals/authorizations/pre-certifications	1	1	0	2	8.7%

Among the few who are not satisfied with the resolution of their pharmacy claim questions or issues, unhelpful customer service and coverage limitations are the most common reasons.

Please refer to page 4 for statistical references and footnotes.

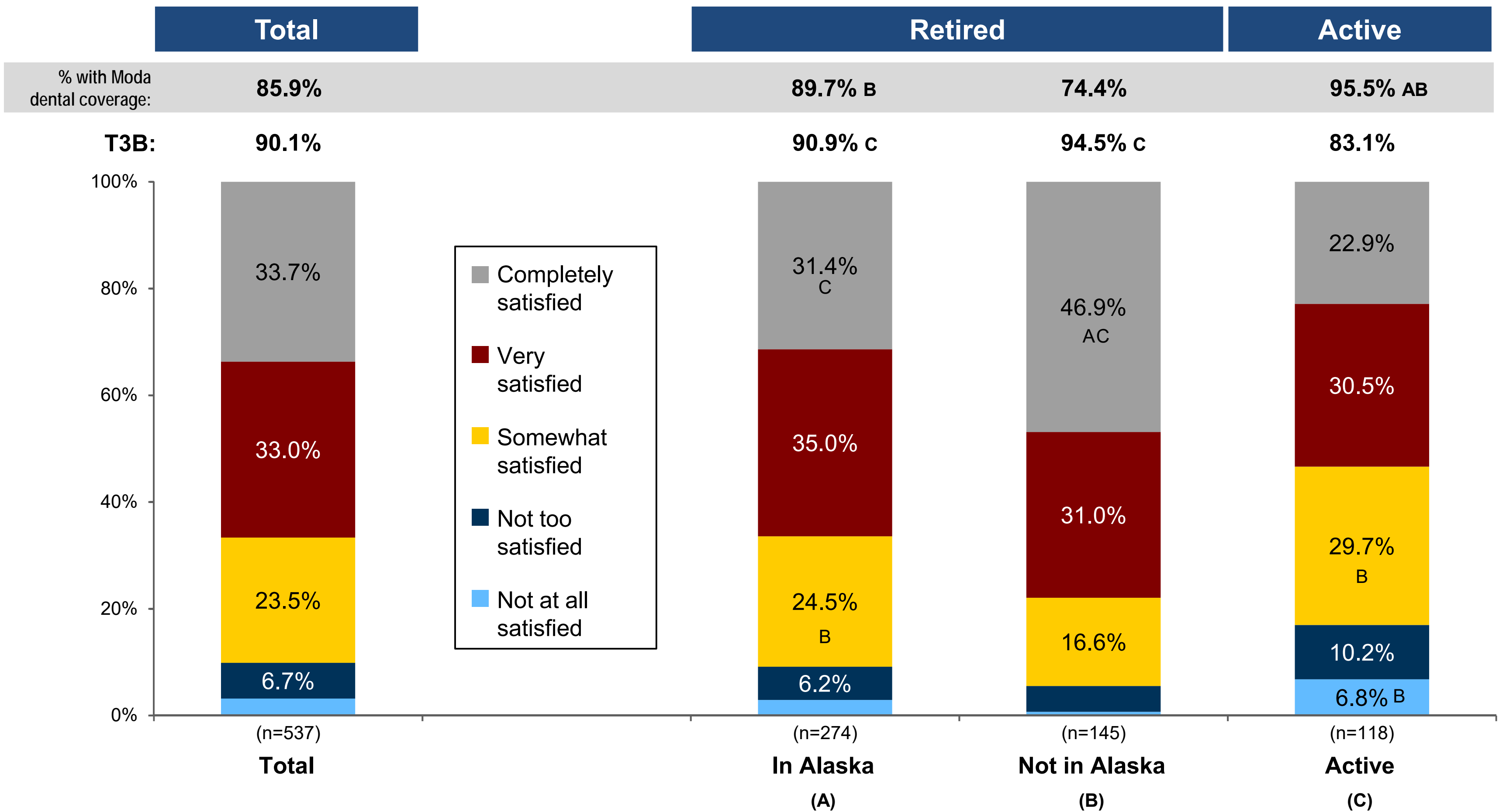
Q14. Based on your personal experience, has Aetna's customer service improved since 2014?



The majority of those who have called a Concierge indicated that customer service has improved.

Please refer to page 4 for statistical references and footnotes.

Q15a. Do you have dental coverage with Moda through AlaskaCare? Q15. What is your overall level of satisfaction with the services Moda has provided you since January 1, 2018?

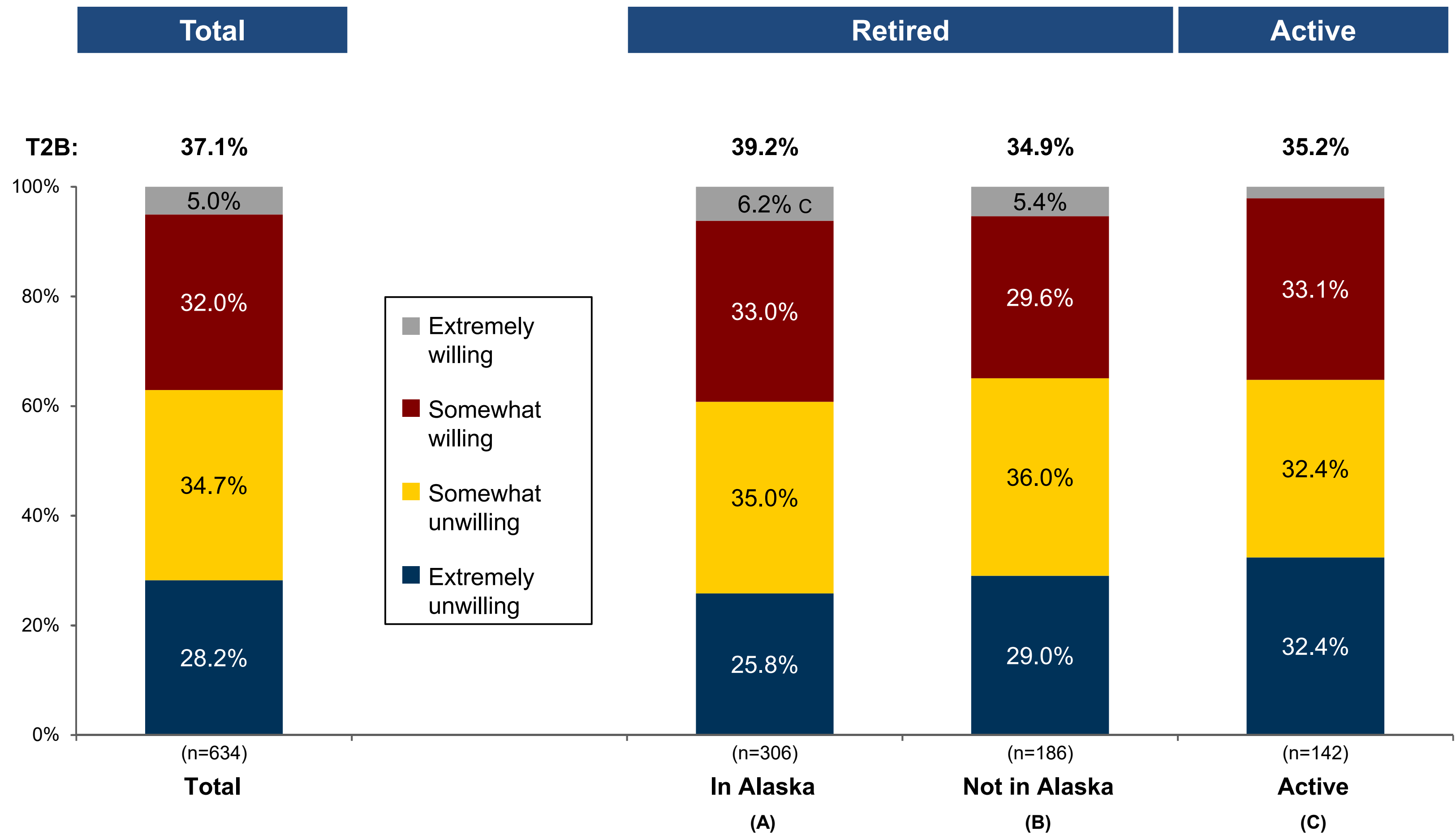


Moda dental coverage is significantly more common among active employees than retirees. However, satisfaction with this type of coverage is significantly lower among active employees than retirees.

Please refer to page 4 for statistical references and footnotes.

Dental coverage

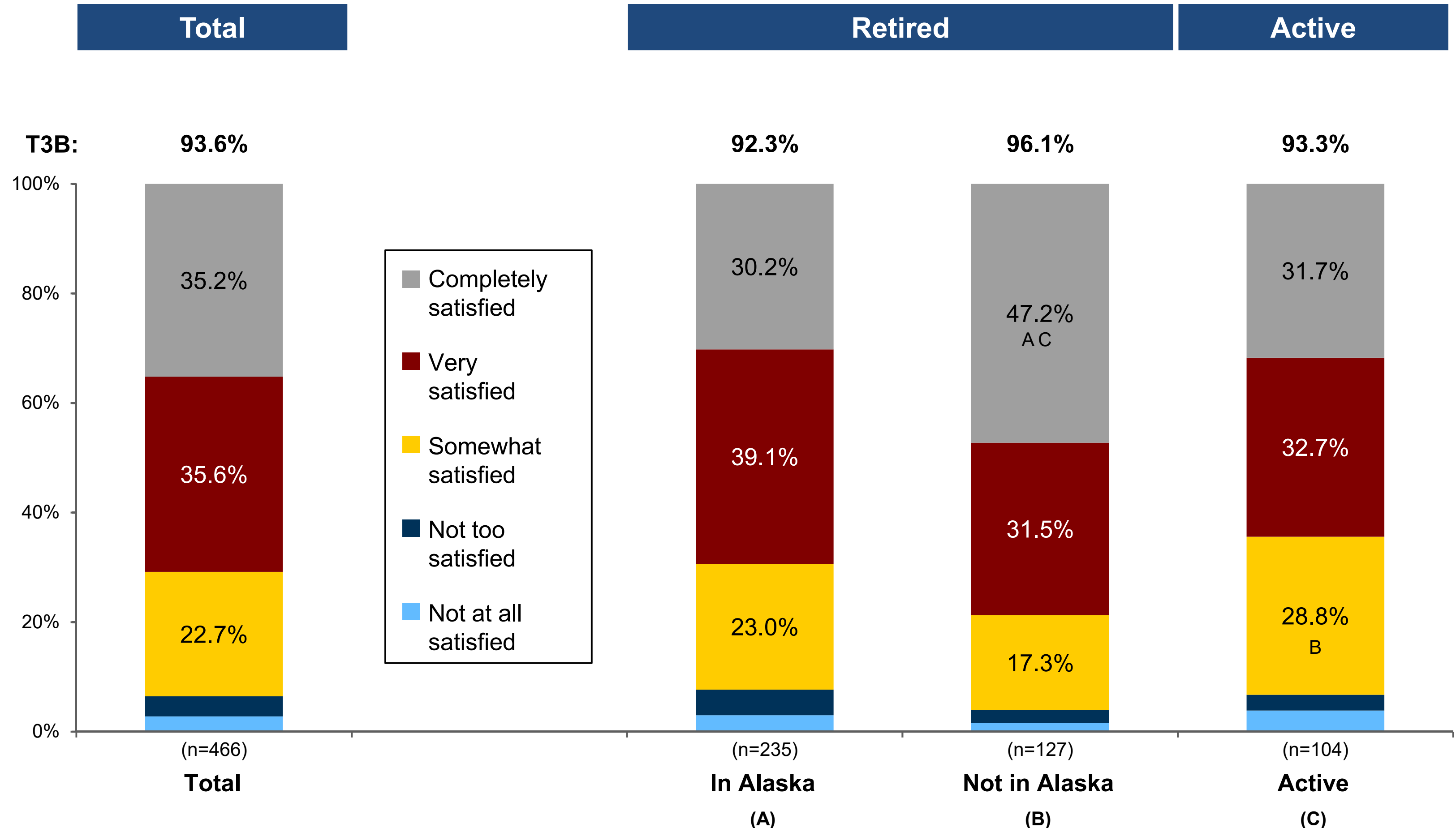
Q16. The AlaskaCare plan employs a dental network to help curb dental cost and keep member premiums affordable. Please rate your willingness to pay a higher monthly premium in exchange for the ability to use any dentist. *



Few are *extremely willing* to pay a higher premium in exchange for the ability to use any dentist. However, more than one-third are at least *somewhat willing* to do so.

Please refer to page 4 for statistical references and footnotes.

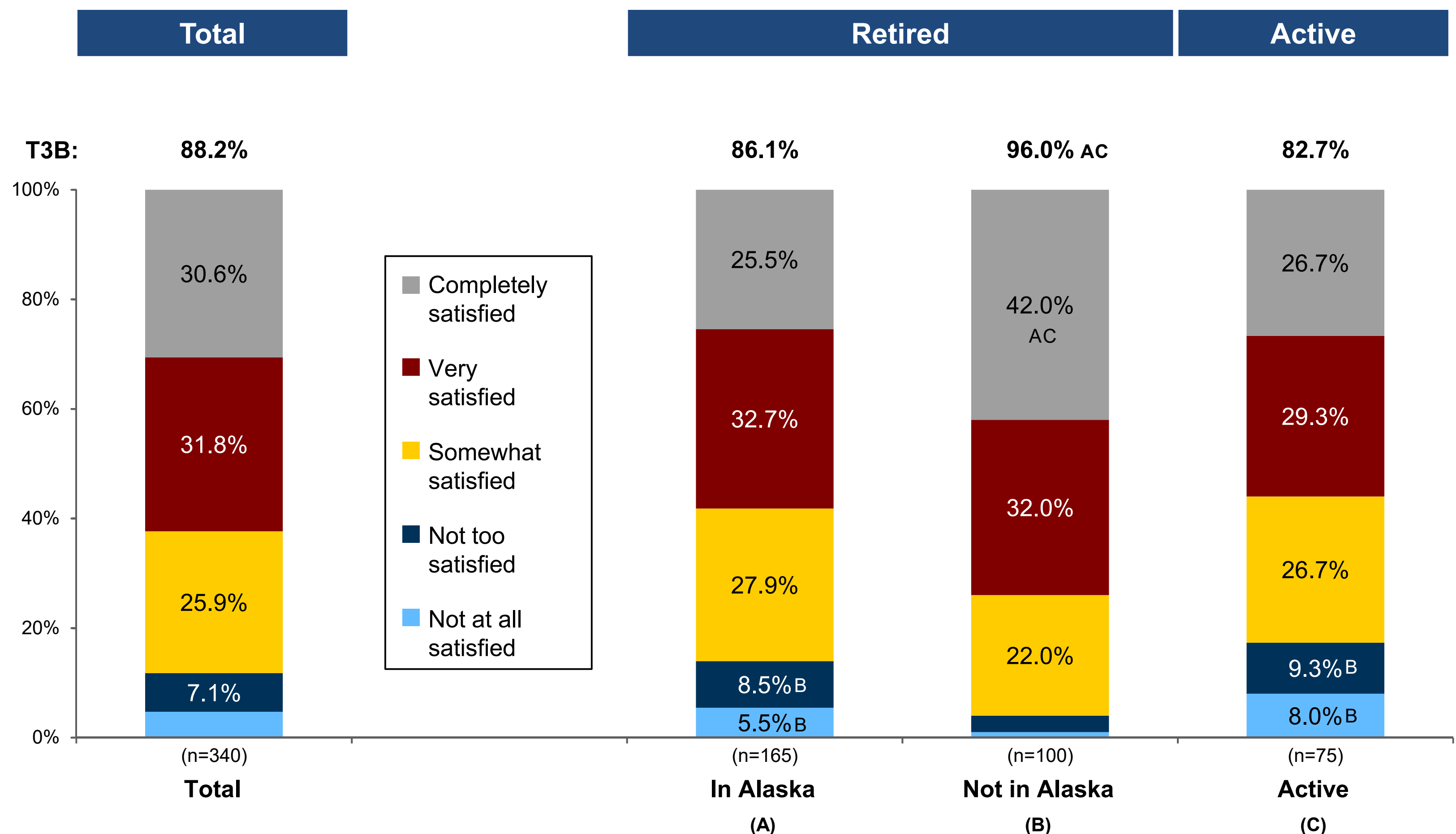
Q17. What is your overall level of satisfaction with the number of general practitioner dental providers in the Moda/Delta Dental network in your area?



More than nine in 10 are satisfied with the number of general practitioner dental providers in the network.

Please refer to page 4 for statistical references and footnotes.

Q18. What is your overall level of satisfaction with the number of dental specialists in the Moda/Delta Dental network in your area?



The vast majority are satisfied with the number of dental specialists in the network. Satisfaction is significantly higher among retirees not in Alaska than among members in the other two groups.

Please refer to page 4 for statistical references and footnotes.

Q21a. If the Division of Retirement and Benefits were able to add benefits to the health plan that are not currently covered, what benefits would you like to see added? ~

(Asked among Retirees only)

Mentions of 3.0% or more in Total	Status			Total	Total as Percent of Responses
	Retired		Active		
	In Alaska	Not in Alaska			
	Number of coded respones				(n=429)
Better dental/vision	64	34	-	98	22.8%
Better preventative/wellness coverage	39	24	-	63	14.7%
Vaccinations/flu shots	29	27	-	56	13.1%
Overall satisfied/no problems	25	22	-	47	11.0%
Better medical coverage	27	12	-	39	9.1%
Acupuncture/chiropractor	14	3	-	17	4.0%
Hearing/hearing aids	12	4	-	16	3.7%
Long term care	7	7	-	14	3.3%
Health club/gym/exercise benefits	2	11	-	13	3.0%
Travel coverage	13	0	-	13	3.0%
Massage therapy	11	2	-	13	3.0%
No/none/nothing/N/A	29	22	-	51	11.9%
Don't know/not sure	15	10	-	25	5.8%

The most common benefits members would like to see added to the health plan include better coverage for care related to dental, vision, preventative care and wellness. Vaccinations and flu shots are also common suggestion.

Please refer to page 4 for statistical references and footnotes.

Respondent profile

	Total	In Alaska (A)	Not in Alaska (B)	Active (C)
		Status		
		Retired		
Total respondents:	(n=714)	(n=343)	(n=221)	(n=150)
Residence				
Retirees in Alaska (NET)	**48.0%**	**100%**	**-**	**-**
Retirees in Alaska <65	15.1%	31.5%	-	-
Retirees in Alaska 65+	32.9%	68.5%	-	-
Retirees not in Alaska (NET)	**31.0%**	**-**	**100%**	**-**
Retirees not in Alaska <65	8.4%	-	27.1%	-
Retirees not in Alaska 65+	22.5%	-	72.9%	-
Active employees	**21.0%**	**-**	**-**	**100%**
Q19. Are you Medicare eligible?				
% Yes	57.0%	68.6% C	75.0% AC	2.1%
Q20. Other than Medicare and AlaskaCare, are you covered by another health plan?				
% Yes	23.3%	22.8%	19.5%	29.9% B
Q21. In general, how would you rate your overall health?				
% Excellent or Very good	57.2%	54.7%	56.2%	64.7% AB
% Excellent, Very good or Good	89.0%	90.9% B	84.5%	91.3% B
Q22. Which of the following describes your coverage level? (Asked among Retirees only)				
Retiree only	**33.6%**	**32.2%**	**35.9%**	**-**
Retiree and dependents (NET)	**66.4%**	**67.8%**	**64.1%**	**-**
Retiree and one or more children	0.4%	0.6%	0.0%	-
Retiree and spouse	62.3%	63.4%	60.5%	-
Retiree, spouse, and child(ren)	3.8%	3.8%	3.6%	-

Please refer to page 4 for statistical references and footnotes.

Appendix: Retirees under 65 vs. Retirees 65 or older

	Retirees	
	Under 65 (A)	65 or older (B)
Total respondents:	(n=168)	(n=396)
Q1. Since January 1, 2018, how often have you or anyone else covered by your policy used services covered by the AlaskaCare Plan?		
1 - 3 times	20.4%	15.7%
3 - 7 times	32.1%	29.5%
8 - 15 times	26.5%	29.8%
More than 15 times	21.0%	25.0%
Q2. What is your overall level of satisfaction with the benefits you received through the AlaskaCare plan since January 1, 2018?		
% Completely, Very or Somewhat satisfied	94.5%	96.4%
Q3. Overall, how satisfied are you with Aetna's administration of your 2018 AlaskaCare medical plan?		
% Completely, Very or Somewhat satisfied	94.4%	93.8%
Q4. Overall, how satisfied are you with Aetna's administration of your 2018 AlaskaCare pharmacy plan?		
% Completely, Very or Somewhat satisfied	97.5%	97.1%
Q5. What is your overall level of satisfaction with the speed at which your claims were processed in calendar year 2018?		
% Completely, Very or Somewhat satisfied	95.1%	96.1%
Q6. What is your overall level of satisfaction with the Aetna provider network in your area?		
% Completely, Very or Somewhat satisfied	94.7%	93.1%

Please refer to page 4 for statistical references and footnotes.

Appendix: Retirees under 65 vs. Retirees 65 or older

	Retirees	
	Under 65 (A)	**65 or older (B)**
Total respondents:	(n=168)	(n=396)
Q7. During calendar year 2018, how often have you called the Aetna Concierge?		
Never/zero times	38.6%	55.8% A
Once	15.1%	12.2%
Twice	12.7%	12.7%
Three times	8.4%	6.0%
More than three times	25.3% B	13.2%
Q8. During your most recent call, how would you rate the level of AlaskaCare plan knowledge demonstrated by the Aetna Concierge?		
% Excellent, Very good or Good	89.0%	89.7%
Q9. Did your call to the Aetna Concierge involve any of the following topics?		
A health care benefit claim	81.1% B	61.9%
A pharmacy claim	34.4%	55.1% A
Vision benefits	22.2%	31.3%
AlaskaCare travel benefits	14.4%	17.7%
Q10. How would you rate the Aetna Concierge's ability to resolve your question or issue related to your health care benefit claim?		
% Excellent, Very good or Good	86.3%	85.4%
Q11. How would you rate the Aetna Concierge's ability to resolve your question or issue related to your vision benefits?		
% Excellent, Very good or Good	77.8% ^	86.7%
Q12. How would you rate the Aetna Concierge's ability to resolve your question or issue related to your AlaskaCare travel benefit assistance?		
% Excellent, Very good or Good	100% ^ B	80.8% ^
Q13. How would you rate the Aetna Concierge's ability to resolve your question or issue related to your pharmacy claim?		
% Excellent, Very good or Good	74.2%	87.5%
Q14. Based on your personal experience, has Aetna's customer service improved since 2014?		
% Yes or Somewhat	**89.7%**	**85.3%**
% Yes	57.4%	56.6%
% Somewhat	32.4%	28.7%
% Not at all	**10.3%**	**14.7%**

Please refer to page 4 for statistical references and footnotes.

Appendix: Retirees under 65 vs. Retirees 65 or older

	Retirees	
	Under 65 (A)	65 or older (B)
Total respondents:	(n=168)	(n=396)
Q15a. Do you have dental coverage with Moda through AlaskaCare?		
% Yes	88.2% B	81.7%
Q15. What is your overall level of satisfaction with the services Moda has provided you since January 1, 2018?		
% Completely, Very or Somewhat satisfied	92.5%	92.0%
Q16. Please rate your willingness to pay a higher monthly premium in exchange for the ability to use any dentist. *		
% Extremely or Somewhat willing	36.4%	38.2%
Q17. What is your overall level of satisfaction with the number of general practitioner dental providers in the Moda/Delta Dental network in your area?		
% Completely, Very or Somewhat satisfied	95.5%	92.9%
Q18. What is your overall level of satisfaction with the number of dental specialists in the Moda/Delta Dental network in your area?		
% Completely, Very or Somewhat satisfied	90.4%	89.6%

Please refer to page 4 for statistical references and footnotes.

Appendix: Retirees under 65 vs. Retirees 65 or older

	Retirees	
	Under 65 (A)	65 or older (B)
Total respondents:	(n=168)	(n=396)
Residence		
Retirees in Alaska (NET)	**64.3%**	**59.3%**
Retirees in Alaska <65	64.3%	-
Retirees in Alaska 65+	-	59.3%
Retirees not in Alaska (NET)	**35.7%**	**40.7%**
Retirees not in Alaska <65	35.7%	-
Retirees not in Alaska 65+	-	40.7%
Active employees	**-**	**-**
Q19. Are you Medicare eligible?		
% Yes	5.5%	98.7% A
Q20. Other than Medicare and AlaskaCare, are you covered by another health plan?		
% Yes	23.5%	20.6%
Q21. In general, how would you rate your overall health?		
% Excellent or Very good	61.9% B	52.4%
% Excellent, Very good or Good	92.9% B	86.5%
Q22. Which of the following describes your coverage level?		
Retiree only	**25.1%**	**37.2% A**
Retiree and dependents (NET)	**74.9% B**	**62.8%**
Retiree and one or more children	0.6%	0.3%
Retiree and spouse	65.9%	60.7%
Retiree, spouse, and child(ren)	8.4% B	1.8%

Please refer to page 4 for statistical references and footnotes.

Appendix: 2018 vs. 2017

	Total	
	2018 (A)	2017 (B)
Total respondents:	(n=714)	(n=703)
Q1. Since January 1, 2018, how often have you or anyone else covered by your policy used services covered by the AlaskaCare Plan?		
1 - 3 times	16.4%	16.4%
3 - 7 times	31.6%	30.5%
8 - 15 times	27.5%	30.7%
More than 15 times	24.6%	22.4%
Q2. What is your overall level of satisfaction with the benefits you received through the AlaskaCare plan since January 1, 2018?		
% Completely, Very or Somewhat satisfied	93.8%	92.1%
Q3. Overall, how satisfied are you with Aetna's administration of your 2018 AlaskaCare medical plan?		
% Completely, Very or Somewhat satisfied	92.8%	91.1%
Q4. Overall, how satisfied are you with Aetna's administration of your 2018 AlaskaCare pharmacy plan?		
% Completely, Very or Somewhat satisfied	95.4%	95.1%
Q5. What is your overall level of satisfaction with the speed at which your claims were processed in calendar year 2018?		
% Completely, Very or Somewhat satisfied	93.6%	92.8%
Q6. What is your overall level of satisfaction with the Aetna provider network in your area?		
% Completely, Very or Somewhat satisfied	90.7%	90.4%

Please refer to page 4 for statistical references and footnotes.

	Total	
	2018 (A)	2017 (B)
Total respondents:	(n=714)	(n=703)
Q7. During calendar year 2018, how often have you called the Aetna Concierge?		
Never/zero times	52.9%	56.4%
Once	11.6%	10.9%
Twice	12.5%	9.9%
Three times	6.5%	6.3%
More than three times	16.5%	16.5%
Q8. During your most recent call, how would you rate the level of AlaskaCare plan knowledge demonstrated by the Aetna Concierge?		
% Excellent, Very good or Good	88.6%	88.8%
Q9. Did your call to the Aetna Concierge involve any of the following topics?		
A health care benefit claim	72.3%	75.3%
A pharmacy claim	45.3% B	32.3%
Vision benefits	22.8%	21.3%
AlaskaCare travel benefits	16.6%	12.9%
Q10. How would you rate the Aetna Concierge's ability to resolve your question or issue related to your health care benefit claim?		
% Excellent, Very good or Good	83.5%	81.3%
Q11. How would you rate the Aetna Concierge's ability to resolve your question or issue related to your vision benefits?		
% Excellent, Very good or Good	84.1%	89.1%
Q12. How would you rate the Aetna Concierge's ability to resolve your question or issue related to your AlaskaCare travel benefit assistance?		
% Excellent, Very good or Good	86.7%	84.4%
Q13. How would you rate the Aetna Concierge's ability to resolve your question or issue related to your pharmacy claim?		
% Excellent, Very good or Good	82.0%	81.7%
Q14. Based on your personal experience, has Aetna's customer service improved since 2014?		
% Yes or Somewhat	**85.3%**	**79.8%**
% Yes	54.3%	54.1%
% Somewhat	31.0%	25.8%
% Not at all	**14.7%**	**20.2%**

Please refer to page 4 for statistical references and footnotes.

	Total	
	2018 (A)	2017 (B)
Total respondents:	(n=714)	(n=703)
Q15a. Do you have dental coverage with Moda through AlaskaCare?		
% Yes	85.9%	87.4%
Q15. What is your overall level of satisfaction with the services Moda has provided you since January 1, 2018?		
% Completely, Very or Somewhat satisfied	90.1%	90.9%
Q16. Please rate your willingness to pay a higher monthly premium in exchange for the ability to use any dentist. *		
% Extremely or Somewhat willing	37.1%	-
Q17. What is your overall level of satisfaction with the number of general practitioner dental providers in the Moda/Delta Dental network in your area?		
% Completely, Very or Somewhat satisfied	93.6% B	89.4%
Q18. What is your overall level of satisfaction with the number of dental specialists in the Moda/Delta Dental network in your area?		
% Completely, Very or Somewhat satisfied	88.2%	85.2%

Please refer to page 4 for statistical references and footnotes.

	Total	
	2018 (A)	2017 (B)
Total respondents:	(n=714)	(n=703)
Residence		
Retirees in Alaska (NET)	**48.0%**	**47.2%**
Retirees in Alaska <65	15.1%	14.4%
Retirees in Alaska 65+	32.9%	32.9%
Retirees not in Alaska (NET)	**31.0%**	**31.3%**
Retirees not in Alaska <65	8.4%	11.4% A
Retirees not in Alaska 65+	22.5%	19.9%
Active employees	**21.0%**	**21.5%**
Q19. Are you Medicare eligible?		
% Yes	57.0%	56.0%
Q20. Other than Medicare and AlaskaCare, are you covered by another health plan?		
% Yes	23.3%	24.1%
Q21. In general, how would you rate your overall health?		
% Excellent or Very good	57.2%	62.0% A
% Excellent, Very good or Good	89.0%	90.6%
Q22. Which of the following describes your coverage level?		
Retiree only	**33.6%**	**29.1%**
Retiree and dependents (NET)	**66.4%**	**70.9%**
Retiree and one or more children	0.4%	1.1%
Retiree and spouse	62.3%	64.4%
Retiree, spouse, and child(ren)	3.8%	5.5%

Please refer to page 4 for statistical references and footnotes.