Retiree Health Plan Advisory Board
Meeting Agenda

Date:	Thursday, February 12, 2026
Time:	1:30 pm – 3:30 pm
Location:	**Join the meeting now** | ANC Atwood 19th Floor
Telephone Only:	+1 907-202-7104, 120 105 850#
Board Members:	Lorne Bretz, Dallas Hargrave, Paula Harrison, Michael Humphrey, Donna White

1:30 pm Call to Order

- Roll Call and Introductions
- Approval of Agenda and Minutes
- Ethics Disclosure and Public Comment

1:35 pm Public Comment

1:40 pm RHPAB Business

- Selection of Chair and Vice Chair
- Selection of Modernization Subcommittee Member

2:00 pm Division Updates/ Modernization Topics

- RFPs – Upcoming or in progress
  - Pharmacy Benefit Manager
  - Oncology Support Program
  - Voluntary Supplemental Benefits
  - Political Subdivision Group Health Insurance
- Delta Dental Out-of-Network Methodology
- Quarterly Reporting Meeting Structure
- Modernization Topics
  - RPEA Letter
- Subcommittee Meeting
- RHPAB Meeting Dates for 2026
  - May 7, 2026
  - August 6, 2026
  - October 29, 2026

3:20 pm Public Comment

3:30 pm Wrap up/Adjourn

AlaskaCare Retiree Health Plan Advisory Board
Meeting Minutes

Tuesday, October 28, 2025

Board Members		DRB		Guests	
Lorne Bretz	P	Chris Murray	P	Randall Burns	P
Dallas Hargrave	P	Ronan Tagsip	P	Wendy Woolf	P
Paula Harrison	P	Liz Hawkins	P	Richard Ward (Segal)	P
Michael Humphrey	P	Marie Speegle	P	Quentin Gunn (Segal)	P
Cammy Taylor	P	Clara Roomsburg	P	Amy McClendon (Segal)	P
Donna White	P	Erin Russell	P	Noel Cruse (Segal)	P
		Erika Burkhouse	P	Bruce Campbell	P
		Jesse Peterson	P	Kathleen King	P
		Meghan Jones	P		
		Steven Alvarado	P		

Call to Order

Chair Cammy Taylor noted that Steve Ramos had retired and welcomed Chris Murray.

Chris Murray was acting as Chief Health Administrator in Steve Ramos' absence and had been working on the plan for about 4½ years.

Ronan Tagsip, Erika Burkhouse, Jesse Peterson, Clara Roomsburg, Erin Russell, Meghan Jones, Liz Hawkins, Marie Speegle and Steven Alvarado introduced themselves.

Chair Cammy Taylor noted there were guests in Anchorage from RPEA – Randall Burns and Wendy Woolf.

Approval of Meeting Agenda and Minutes

Chair Cammy Taylor announced there were no changes, corrections or additions to the agenda and it was approved. There were no changes, corrections or additions to the 2 sets of minutes in the Board packet and they were approved.

Ethics Disclosure

There were no ethics disclosures.

Public Comment

Randall Burns, President of the Retired Public Employees of Alaska, announced that 3 names had been submitted to the Office of the Governor to fill the seat on the Advisory Board and 3 names to the to fill the Modernization Subcommittee seat.

Department & Division Update

Chris Murray requested that Segal present first because the PBM RFP had been released and he hoped Segal could attend the kickoff call scheduled for 10 a.m., on October 28.

Chair Cammy Taylor approved Segal presenting first.

Richard Ward discussed the premium rate development for the main retiree plans. When developing recommended premium rates or funding rates for a period, Segal was aiming to cover claims, administrative and operational costs; balance stability and competitiveness of rates from year to year; and manage risk and selection. Rates reflected equity between different plan and coverage options. The timing difference between premium revenue and expenses was also considered. The focus was more near-term for medical and drug. As for changes, pharmacy rebates would be projected to offset expected claims costs. Concerning EGWIP, there would be changes to the expected subsidies and changes for the Inflation Reduction Act (IRA). There was no distinction for Medicare and non-Medicare members in the Defined Benefit Plan and the same rates would apply. Mr. Ward explained how rates were developed. The plan was well funded. There were changes to Medicare Part D drug plans related to the IRA, which drove changes in the EGWIP subsidies. The max out of pocket for Part D plans would increase to $2,100.

Mr. Ward discussed the change to the Manufacturer Fair Price and it was estimated that claims costs would reduce. Mr. Ward displayed a slide showing projected costs for calendar year 2026 and recommended that rates increase by 5 percent. Concerning the DVA plan, Segal intended to develop and make recommendations for rates for the next calendar year. The DVA plan was 100 percent funded by retirees and was well-funded. Segal was in the process of a multi-year managed spend-down as they were trying to manage the expected gap between revenue and expenses. Segal intended to cover claims and administrative and operational expenses and taking a near- to mid-term view. Mr. Ward provided a background on the Legacy and the Standard Plans. It was expected that the increases to dental services and preventive care would be funded by making adjustments to the vision benefit and implementing a network structure. Mr. Ward provided information related to current assets, the IBNR liability and the funding policy.

Mr. Ward furnished a slide summarizing the plan changes, which had been well-received and were being utilized. Due to high utilization, there may not be savings in the short term but it was expected that there would be over the long term and Segal would report back after having a full year of experience. There would be changes to the dental plan in 2026. Segal recommended a 6-percent rate increase for the Legacy Plan and an 8.5-percent increase for the Standard Plan. The increases were more than trend due to wanting to manage the gap between the premium revenue and expenses. Applying the recommended premiums would result in a spend-down rate of about 4.6 percent. Without the plan changes, the spend-down rate would be 11 percent. Mr. Ward shared a graph showing past, current and near-term plan projections. It appeared that there had been a moderate annual spend-down and the 2026 changes should result in being in the target funding range. Mr. Ward explained how long-term care (LTC) premiums were set and noted that premiums would not change next year.

Mr. Bretz asked what the percentage lapse was.

Mr. Ward would obtain information on the percentage lapse but thought it was fairly low. Mr. Ward continued the presentation and furnished a slide showing the last 2 full valuations on a present value basis and noted that assets exceeded the net liability. It may be possible to reduce premiums in coming years but investment caution needed to be exercised before doing that.

Chair Cammy Taylor inquired who managed the investments for LTC.

Mr. Ward believed the ARM Board made investment decisions for the pension funds and that the LTC investment portfolio and policy mirrored that, so it happened by extension.

Mr. Humphrey was happy with Mr. Ward's presentation on LTC. According to the 2023 table, it appeared that rates should not be reduced for several years.

Ms. Taylor and Mr. Bretz agreed.

Mr. Ward would follow up with the lapse rate information through Division staff.

Mr. Murray reminded the Board that some folks would be exiting the Board meeting to attend the PBM RFP kickoff call. The 2026 plan changes had been approved and would allow for foreign ambulance services; Teladoc for acute services, dermatology and behavioral health care; and 3D imaging and increased prophylaxes visits in the standard DVA Plan. The OHTH program would be eliminated. The allowance for the topical application of fluoride, the timespan between crowns and the allowable amount for a metal crown would be increased.

Chair Cammy Taylor voiced that as of September 30 telehealth was not covered by Medicare and queried if telehealth availability needed to be confirmed.

Mr. Murray responded that AlaskaCare would cover the telemedicine benefit basically at the level it was prior to September 30, 2025. For all intents and purposes, there would be no difference in coverage with the telemedicine benefit with the exception that AlaskaCare would pay primary in cases where Medicare reduced coverage. Mr. Murray stated open enrollment for retiree DVA plans would begin on November 5 and end at 5 p.m. on November 26. Annual open enrollment guides were being sent by mail. The PBM RFP was released about 2½ weeks ago and there had been good responses and a new contract was expected by January 1, 2027. The Division was in the process of drafting the oncology RFP, so it would probably not be stood up by January 1, 2026. Mr. Murray was hopeful it would be out by the end of the year and start in the middle of calendar year 2026.

Mr. Murray stated that nothing had changed in terms of the plan's vaccine coverage but there had to be reliance on recommendations of several federal advisory agencies. The FDA's recommendations had not changed. The CDC Advisory Committee on Immunization Practices recommended that COVID-19 boosters happen in consultation with a physician. Mr. Murray emphasized that it was a recommendation. The Division would keep everyone informed of any changes. There was not much price movement in terms of drug prices related to tariffs but it was being monitored. It was expected that there would be savings with the Manufacturer Fair Price Program and significant savings when going out for RFP. It was too early to know how the market would react to tariffs and drug prices. There was no plan to change prescription drug benefits. As there had been an uptick in fraudulent calls, the Division was trying to educate members by putting information on the website and in newsletters and working with vendors to ensure they knew how best to educate members. If anyone received a questionable call, they should hang up and call the vendor directly. Regarding the LTC plan, a licensed

home-health care professional had to provide services in order to retain tax qualified status. It did not allow a family member to perform such services.

Chair Cammy Taylor asked if a family member who was a licensed home-health care worker would qualify.

Mr. Murray answered that that question had been posed to Attorney Allison Baldock and the Division was waiting for the answer and would share it with the Board. There had also been a question about the statutory requirement for Medicare as primary and the Legal Department stated that Medicare would pay primary to AlaskaCare when it was a Medicare eligible expense.

Chair Cammy Taylor asked if any change would require a statutory change.

Mr. Murray answered that a statuary change would be needed to make changes.

Chair Cammy Taylor commented on the landscape changing over the years as it related to the age one would sign up for Medicare and AlaskaCare continuing to be primary and then moving into a secondary or tertiary position in 1975. Between 1975 and sometime in the 90s medicare reimbursed at the usual and customary rate. The other provision of that statute the Department of Law had paid attention to historically was that the coverage for persons age 65 or older should be the same as for those under 65. It appeared that Medicare changed the way they reimbursed doctors sometime in the mid-90s. The Medicare Modernization Act in 2003 imposed 2 things for 2006 and 2007, which was IRMAA and a penalty if one did not sign up for Medicare. At the same time, it excluded those still employed and covered by a group health plan, so those folks had been excused from the penalty.

Mr. Murray appreciated that information.

[The Board took a 10-minute break]

Modernization Topics/Priorities

Mr. Murray addressed diagnostic colonoscopy coverage. Preventive colonoscopies were covered 100 percent with no cost share. Mr. Murray proposed removing the coinsurance for diagnostic colonoscopies but still applying the deductible. If the Board wanted to move forward with this at this meeting, it could start on January 1, 2026.

Chair Cammy Taylor found it to be a good solution.

Motion by Mike Humphrey to adopt/approve the resolution for diagnostic colonoscopy coverage.
Second by Dallas Hargrave.
Result: Motion passed unanimously and without objections.

Mr. Murray would send the recommendation to the Commissioner and did not foresee any issues as the Division had spoken with the Commissioner and received verbal support.

Chair Cammy Taylor thought it had been decided that massage therapy and dependent coverage to age 26 at the Modernization Committee level. Chair Cammy Taylor asked if the dates for the 2026 quarterly meetings and the Board's meetings had been determined.

Mr. Murray replied that the quarterly meetings were typically done at a specific cadence and had probably been determined and RHPAB meetings would commonly occur on Thursdays. The only reason to change a quarterly meeting date would be in the event of a holiday.

Liz Hawkins added that the Division would put the regular RHPAB meetings after the Board meetings. The next Modernization meeting had not yet been scheduled. Ms. Hawkins could send the Board some dates.

Chair Cammy Taylor mentioned that the Board could be polled and Ms. Hawkins contacted to discuss January dates.

Dallas Hargrave questioned if the Board needed to choose the Modernization Committee member and if it should be on a future agenda.

Chair Cammy Taylor recalled that the last time there was a recommendation by RPEA the Division selected the member. There had been a discussion about the Board doing it. It was informal and the Committee had no authority to make any decisions or recommendations except to recommend that Board members consider certain things.

Mr. Murray mentioned there had been discussion between the Division and the Boards and Commissions entity within the state. Mr. Murray believed guidance and feedback had been provided but he could not confidently speak on it at this meeting. Mr. Murray could revisit what had been sent over and communicate the findings.

Chair Cammy Taylor requested that Mr. Murray send the names and information submitted by RPEA to all Board members so the information would be available in case the Board needed to take action.

Mr. Murray would send that information and attempt to seek out what was exchanged between Steve Ramos and Boards and Committees.

Public Comment

Randall Burns, President of the RPEA, stated it would be helpful to determine how investments were accounted for in the ARM Board or the DRB's system as it related to the DVA and LTC.

Wrap Up / Adjourn

Chair Cammy Taylor entertained a motion to adjourn.

Motion by Mike Humphrey to adjourn.
Second by Lorne Bretz.

Chair Cammy Taylor adjourned the meeting.

Segal

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Memorandum

To: Chris Murray, Acting Deputy Director/AlaskaCare Chief Health Official, Division of Retirement and Benefits

From: Richard Ward, FSA, FCA, MAAA

Date: February 5, 2026

Re: Adjustments to Standard Dental Plan Out-of-Network Methodology (Retiree Plan)

The State of Alaska is exploring the possibility of modifying the methodology used for reimbursing out-of-network dental providers for the Standard Dental plan. Currently, reimbursements are generally based on the lesser of submitted charges or 75% of the 80th percentile of the prevailing charge rate for the geographic area in which the dental service is furnished, as determined by Delta Dental in accordance with its reimbursement policies.[1] The proposed change would transition to using the lesser of submitted charges or Delta Dental's proprietary out-of-network fee schedule as the basis for determining reimbursements. Approximately 13%-15% of claims are paid out-of-network on an annual basis for retirees residing in and out of Alaska.

No changes would be made to the out-of-network methodology for the Standard Vision or Audio benefits and no changes would be made to the Legacy Plan's Dental, Vision or Audio benefits.

Under this new methodology, out-of-network providers would generally receive lower reimbursement amounts than they do currently. This adjustment is intended to align the plan's payments more closely with Delta Dental's established fee structures, which are designed to reflect reasonable and customary charges within the industry. Most of Delta Dental's customers, including other state clients, utilize their propriety out-of-network fee structure rather than a percent of prevailing charges approach. The majority of other group plan sponsors in Alaska that contract with Delta Dental utilize this approach as well.

One of the primary benefits of this change is the potential for cost savings for the Standard Dental plan. As retirees enrolled in the DVA program are responsible for paying the entirety of their premiums, any reduction in plan expenses will directly benefit members in the form of lower premiums over time. By controlling costs, the plan seeks to maintain affordability and sustainability for all participants.

Lower payment levels for non-network providers creates an additional incentive to contract with Delta Dental and enhance network access for all members.

[1] Out-of-network services rendered by an endodontist in the State are reimbursed on the lesser of submitted charge or 100% of the 80th percentile of the prevailing charge rate for the geographic area where the service is furnished as determined by Delta Dental in accordance with its reimbursement policies.

This change may expose members to increased balance billing risk. If an out-of-network provider's charges exceed the amount reimbursed by the plan under the new methodology, the provider may require the member to pay the difference. As a result, members who utilize out-of-network dental services could experience higher out-of-pocket costs due to a reduction in the average reimbursement out-of-network providers would be receiving. Members will continue to have the option of choosing a lower cost network provider within the Standard Plan or changing to the Legacy Plan, which will continue to provide higher payments to non-network providers.

Below is a table outlining the current benefits offered under the Dental plan benefits:

Dental Benefits	Standard Plan	Legacy Plan
Deductible		
Annual individual deductible (applies to Class II and III)	$50	$50
Coinsurance		
Class I (preventive) services	100%	100%
Class II (restorative) services	80%	80%
Class III (prosthetic) services	50%	50%
Benefit Maximums		
Annual individual maximum (applies to all classes)	$3,000	$2,000

The Standard Plan dental benefits include a Preventive First provision, which excludes preventive services from the annual deductible and benefit limit.

For vision benefits. the Legacy Plan does not utilize a network and has a member cost share requirement of 20% for most services. The Standard DVA Plan allows access to a network of providers and members pay fixed copays for exams and have allowances for frames and contact lenses.

Below is a table outlining the current benefits offered under the Vision plan benefits:

Vision Benefits	Standard Plan	Legacy Plan
Network Provisions		
Access to a broad network of visions providers	Yes	No
Coinsurance		
All services	Member pays various copays and allowances	80%
Benefit Maximums		
Examinations	One per benefit year	One per benefit year
Lenses	Two per benefit year	Two per benefit year
Frames	Every other benefit year	One set every two consecutive years
Aphakic and contact lens lifetime maximum	N/A	$400

The Audio benefits under the Plans pays up to $2,000 for each person in a covered rolling 36-month period. There is no deductible and the plan pays 80% of the recognized charge for auditory services.

Actuarial Value

Because actuarial values reflect differences in cost-sharing provisions (i.e., deductibles, coinsurance, copayments, and out-of-pocket limits) and not a reflection on how broad or narrow the provider network is, there will not be any impact to actuarial value due to a change in OON methodology.

Financial Impact

The estimated financial impact to the plan is approximately $700,000 - $800,000 in claims savings for the Standard plan based on an analysis provided by Delta Dental. Because the underlying OON pricing analysis is based on Delta Dental's proprietary fee schedule specific to each State a retiree is receiving services from, Segal does not have direct access to all of the pricing schedules necessary to validate the savings. However, Delta Dental did provide Segal with some State of Alaska pricing information on an individual code basis that aligns with approximately a 25% decrease in out-of-network claims.

Using the most recent retiree DVA claims projection of $59,900,000 for 2026 (dated September 18, 2025), this equates to be an approximate 1.1% - 1.3% decrease in annual net costs to the Plan. Specific to the Standard plan, this savings represents about 2.2% - 2.5% of the projected $31,900,000 in plan cost for 2026. This will equate to approximately a $1 - $4 offset, dependent on tier, to future Standard Plan enrolled retiree per month contribution cost increase.

Additional Notes

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

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

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encouraged to discuss any issues raised with your legal, tax and other advisors before taking, or refraining from taking, any action.

cc: Ronan Tagsip, Division of Retirement and Benefits
Noel Cruse, Segal
Tanya Sun, Segal
Quentin Gunn, Segal

DRAFT

AlaskaCare Retiree Health Plan Modernization Topics*

1. Active Topics

Proposal Number	Plan	Title	RHPAB Priority	Division Priority	Level Of Effort	Proposal/ Actuarial
R***	Medical	Behavioral/Mental Health Program Offerings			M	-
R* **	**Medical**	**Oncology Support Services**		H	**M**	**-**
R***	Medical	Rehabilitative Care/Licensed Massage Therapists			M-H	-
R***	Multiple	Chronic Disease Management Program(s)			H	-
R***	DVA	Standard DVA Plan audio benefits			M	-
R***	Medical	Members Not Eligible for Medicare Part A			H	-
R***	Pharmacy	Weight Loss and Diabetes prescription cost				-
R***	Medical	Dependent coverage to age 26				

**P=draft proposal available, A=actuarial analysis available*

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

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AlaskaCare Retiree Health Plan Modernization Topics*

2. Pended Topics

Proposal #	Plan	Description
R002	Medical	Network Incentive: 70% out-of-network and 90% in-network
R003	Medical	Increase deductible, out-of-pocket maximum
R004	Medical	In-network enhanced clinical review of high-tech imaging and testing
R005	Medical	OON reimbursement as % of Medicare
R006	Medical	Expanded Telehealth Services
R010	Rx	Drugs with over the counter (OTC) equivalents
R011	Rx	Implement high-value pharmacy network with lower copays for chronic meds, medical synchronization, counseling, and packaging options for participating members.
R013	DVA & Medical	Consider expanding coverage for implants related to periodontal disease under the medical plan and/or under the dental plan
R014	Rx	3 tier pharmacy benefit; review oon benefits
R015	Rx	Limit compound coverage to high-quality, narrow network of pharmacies
R017	Medical	Copayment for primary care
R018		Plan Housekeeping/Review (ex., clarify reimbursement policies for surgical assistants, DVA standalone booklet)
R028	Medical	Pacific Health Coalition Membership
R012	Medical	Lifestyle/Wellness Programs
R025	Medical	Medicare Advantage

3. Completed Topics

Proposal #	Plan	Description	Effective Date
R001	Medical	Add supplemental non-emergent surgery and travel benefits	01/01/2025
R007	Medical	Expand preventive coverage to add full suite of preventive services	01/01/2022
R008	Medical	Raise or eliminate lifetime maximum benefit	01/01/2024
R009c	Medical	Add acupuncture and licensed acupuncturists	01/01/2025
R016	Medical	Add medically necessary treatment of gender dysphoria including surgery – *public comment proposal*	01/01/2021
R020	Rx	Add prior authorizations for certain specialty medications	01/01/2022
R022	Medical/ Rx	GCIT designated network benefits	01/01/2023
R023	Medical	Remove penalty for failure to precertify certain services	01/01/2023
R024	DVA	Standard DVA Plan dental preventive first and annual max	01/01/2025
R026	DVA	Standard DVA Plan Vision benefit and network addition	01/01/2025
R027	Medical	Add virtual physical therapy and musculoskeletal care program	01/01/2025
		Lantern deferred deductible	01/01/2025
R029	Medical	Breast imaging in-network cost share adjustment	01/01/2025
R032	Medical	Colonoscopy in-network cost share adjustment	01/01/2026
R030	Dental	Standard Dental Plan benefit enhancements	01/01/2026
R031	Medical	Foreign ambulance services	01/01/2026
R034	Medical	Teladoc	01/01/2026

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

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January 23, 2026

Chris Murray, Acting Deputy Director and Chief Health Administrator
Division of Retirement and Benefits
P. O. Box 110203
Juneau, AK 99811—0203

Current Members
Retiree Health Plan Advisory Board (RHPAB)
P. O. Box 110203
Juneau, AK 99811—0203

Dear Mr. Murray and RHPAB Members:

The Executive Board of the Retired Public Employees of Alaska (RPEA) understands that the Retiree Health Plan Advisory Board (RHPAB) will meet soon, in part to discuss the prioritization of the many retiree health plan (Plan) modernization topics that the Alaska Division of Retirement and Benefits (Division or DRB), in coordination with the RHPAB Modernization Subcommittee and the RHPAB itself, has introduced since 2020.

As the Division and the RHPAB, together with its Modernization Subcommittee, undertake in 2026 the continuing work of establishing Plan priorities, the RPEA respectfully submits the requests presented below on topics that it believes should be addressed as a part of any discussion around updating Plan benefits, to be prioritized along with those topics already identified by the DRB and the RHPAB.

1. Plan Booklet Section 3.1.4. Recognized Charge

   RPEA asks that DRB review what AlaskaCare / Aetna presently uses / recognizes as the current posted charge for each medical service (the "recognized charge"). We are concerned that deficient contributions to the Fair Health database for Alaska have resulted in the ongoing use of stale and derived recognized charge data from Fair Health. Please confirm that AlaskaCare third-party administrators (TPAs) regularly provide data to Fair Health, and that Aetna uses the most current information from Fair Health when determining the recognized charge for services.

2. Remedy Plan Booklet Section 3.1.7 Effect of Medicare on the Retiree 'Special Population' and Address Fair Coverage

As you know, there exists a "special population" of 65 and older AlaskaCare retiree members who worked decades for the State of Alaska – or any of the other many public entities in Alaska – but who are not eligible for premium-free Medicare Part A.

Recent information informally shared by the DRB indicates that there are more than 400 members in this population. While this is not a substantial number of Plan members, for that very reason we believe the low numbers together with the criticality of their situation, mandates immediate attention.

Historically, with little guidance from the Plan Booklet, those who are a part of this "special population" looked to DRB interpretations to understand their coverage. The DRB Publication "Medicare Parts A & B and the AlaskaCare," dated **June 2007**, stated:

> If you are not eligible for Part A, Social Security will send you a letter confirming that. You must send a copy of that letter to the claims administrator. AlaskaCare will then continue to pay for Part A services *just as it did* before you turned aged 65 (emphasis added).

DRB's latest Medicare Overview (on the current DRB Website) continues to say AlaskaCare will pay *as primary* for Part A services, just as it did before age 65:

> https://drb.alaska.gov/retiree/healthplans.html#medicareOverview states, in part:
>
> If you are a Defined Benefit member and you are not provided with premium-free Medicare Part A, **you will not be required to enroll in Part A,** but you must submit a copy of your decision letter from Social Security to the AlaskaCare medical claims administrator and to the Division of Retirement and Benefits, and **AlaskaCare will continue to pay as your primary plan for Part A services received under your Defined Benefit Retiree Health Plan.** (Emphasis added.)

Given the similarity of these instructions, we must ask: why are retirees in this unfortunate group being treated differently? As the Division is aware, AlaskaCare is *not* paying these AlaskaCare members "just as it did" before a person turned 65: it is treating them differently and putting them in a "special population."

This population deserves what has been represented. Manual collection of the precise number involved in this special population should not be difficult and explicit clarification in the Plan Booklet of their coverage is required. It is our understanding that Aetna processes claims for this "special population" under a plan or network called "CMED." What is this CMED and why is Aetna using a different plan or network other than the AlaskaCare Retiree Plan? RPEA requests a copy of the CMED plan/network booklet apparently being used to handle the Part A claims of this AlaskaCare population.

As you know, the DRB has recognized for some time the harsh consequences to this group of retirees and in 2014 sought to rectify them. Mike Barnhill, then Commissioner of Department of Administration, drafted this language at that time:

> Effective [_____], if you submit a copy of a letter to you from Medicare certifying that neither you nor your spouse are eligible for premium-free Medicare Part A, the Division will reimburse you for 100% of the premium charged by Medicare and paid by you for Part A coverage.

Another remedy could be to direct administration of their inpatient claims as though they were under-65 AlaskaCare insureds. Other possible remedies may well be found as a result of the DRB and the RHPAB working in consultation.

Clearly the unfairness to this "special population" has been on the radar of the Division since at least 2014. It is unfair to make the needs of this "special population" wait years for a functioning BEARS system to measure and address the coverage needs of this group. Indeed, another consequence of treating these Plan members differently is that there currently is no limit on their out-of-pocket expenses, as mandated in Section 3.1.3 of the AlaskaCare Retiree Plan Booklet for other AlaskaCare participants.

RPEA requests that the DRB take steps to develop a plan to address this 'special population' and present it to the RHPAB for consideration during this current year.

3. Add Licensed Massage Therapists as Qualified Providers in Plan Booklet Section 3.3.3

The original Retiree Health Plan adopted Section 3.3.3 defining the 'qualified providers' who can provide and bill for services. At the time, these were providers licensed by the State and who could bill for services.

Since that date, the State of Alaska instituted professional licensing of Acupuncturists and Massage Therapists. Acupuncture and Massage Services were always covered in the Plan. Prior to being licensed, Acupuncturists or Massage Therapists typically billed their services through a Section 3.3.3 'qualified provider'. Since becoming licensed, many of these professionals no longer utilize Section 3.3.3 providers to bill for their services; they bill the retiree directly.

In 2025, licensed acupuncturists were added as qualified providers in Section 3.3.3. As a result, Plan members now have access to acupuncture services not previously available because the Plan did not recognize licensed acupuncturists, and the original list of Section 3.3.3 providers were not generally providers of acupuncture services.

This is also true today of massage therapists. Prior to their being licensed by the State of Alaska, these providers were often co-located with a Section 3.3.3 provider and billed through / under the license of that provider. After massage therapists became licensed, many of them halted using Section 3.3.3 providers to gain access to billing for their services and they now bill the Plan directly.

However, unlike the now-recognized acupuncturists, under the current Plan, retirees are presently denied access to massage therapy services from massage therapists who do not work for or under the license of another recognized Section 3.3.3 provider. From our perspective, this essentially means that because massage therapists are not recognized as 'qualified providers' under the Plan, AlaskaCare members are being denied medically necessary services.

Section 3.3.3 should be immediately amended to add massage therapists as qualified providers for the same reason acupuncturists were added. It is nonsensical and a de facto denial of medically necessary massage services when the current Plan covers massage therapy services when billed under the license of a recognized provider who is NOT a professional licensed massage therapist but deny that same service if it is billed directly to the Plan by a State-licensed massage therapist professional.

Two different scenarios illustrate this point:

> One member was referred to Orthopedic Physicians of Alaska (OPA) by a physician for massage therapy. The licensed massage therapist at OPA billed Aetna directly under his license. The service was not covered because that licensed provider is not listed in Section 3.3.3, though the member was referred to a reputable entity for treatment and the treatment itself is covered by the Plan.
>
> Second scenario: One member was referred to a chiropractor who contracts with a massage therapist co-located in his office. The chiropractor bills for those services and the identical services are covered because the chiropractor happens to be is listed as a qualified provider in section 3.3.3.

Massage is a service always covered by the Plan. Members should not be placed in this rather existential situation, made vulnerable by the fact that the Plan now has a disconnect between which providers were first listed as qualified to be licensed in the State of Alaska at the Plan's inception and which providers have subsequently been recognized and licensed by the State in the face of – and for the sake of – responsible, quality, and safe practices.

In fairness to members, that disconnect must be remedied. It is entirely out of synch with other major market plans – most notably, the AlaskaCare Active employee plan, which counts licensed massage therapists as qualified providers. It is critical that Massage Therapists be added as qualified providers in Section 3.3.3 to conform the plan to current medical practice standards and billing procedures.

4. Globally Address Plan Booklet Section 3.3.18 Travel

RPEA asks that the admittedly rather complex issue of travel be globally addressed by the DRB and the RHPAB. We recognize that it is complex because travel both in-state and out-of-state contributes to the constraint on people seeking to live and work here in Alaska, especially as they age. Travel is both expensive and time consuming for Alaskans who live, work, and retire in Alaska.

Many retirees living in outlying areas of the state are required to use the AlaskaCare travel benefit to access medical and surgical care in more urban Alaska locations, or outside the state. As the DRB knows, necessary medical care even for more urban-based retirees is often referred to medical providers and facilities outside Alaska.

The RPEA firmly believes the present travel benefit is insufficient. For example, it does not cover the travel associated with diagnostic services, services which are often as critical as treatment. Further, we do not believe that travel should require precertification, as it is not a medical service or supply. Finally, there is no benefit for the travel or lodging of an accompanying adult to assist the Plan beneficiary with the logistics associated with sometimes major medical and surgical treatments away from home.

In addition, we must mention again that for those rural Alaskans dependent on the Alaska Ferry System to access medical care, the travel benefit covers the cost of ferry travel for the retiree only and does not also cover the cost of the member's vehicle. A good example of the need to reconcile Plan travel policies: when the Alaska State ferry drops members in Whittier or Valdez, travel from the ferry dock to the nearest medical care facility or doctor's office requires a motor vehicle.

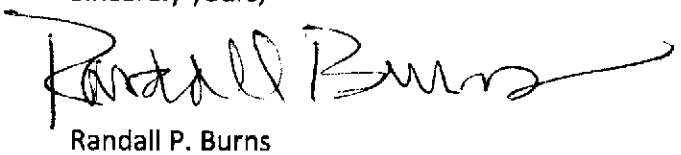
5. Full Plan Booklet Review

   The RPEA believes that a wholistic review and redraft of the Plan booklet is necessary to coordinate the many amendments since 2003 and to integrate all terms consistently within and across the entire document.

Finally, the RPEA is concerned that changes to the 2026 preauthorization requirement for GLP-1 drugs was not discussed with the RHPAB before it was put into effect. We believe these types of changes should go through the public process as outlined in 2 AAC 39.390 and discussed with the RHPAB prior to being implemented.

In closing, the RPEA thanks the Division and the RHPAB and its members for considering these suggestions. We look forward to working collaboratively to assure Plan changes keep step with the ever-changing nature of the health / medical care field while also mindful of the limits of our health trust, which – at least for the moment – appears not to be a significant issue.

Sincerely yours,



Randall P. Burns
President
Retired Public Employees of Alaska

cc: RPEA Executive Board
Members, RPEA Health Benefit Committee
RPEA Membership