Retiree Health Plan Advisory Board
Modernization Committee
Meeting Agenda

Meeting:	RHPAB Modernization Committee
Date:	July 26, 2018
Time:	1:00pm-4:00pm
Location:	Anchorage: Atwood Building, 550 W 7th, 12th Floor Conf. Room **Juneau:** State Office Building, 10th Floor Conf. Room
Teleconference:	1-855-244-8681 / Meeting Number 804 638 224 # WebEx Link: https://stateofalaska.webex.com/stateofalaska/j.php?MTID=m50f2927f78bd8e0ed89a5810a5a51a57
Committee Members:	Mark Foster, Cammy Taylor and Joelle Hall

July 26, 2018

1:00pm	**Call to Order –** Mark Foster
1:10pm	**Public Comment**
1:30pm	**Present findings on priority items-**Emily Ricci, Michele Michaud, Richard Ward
2:00pm	**Break**
2:20pm	**Discuss findings**
3:20pm	**Next steps**
3:40pm	**Public Comment**
4:00pm	**Adjourn**

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. **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.**

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.

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.

EGWP

DRAFT – Summary of Responses to Proposed Plan Design

Proposed change: Enhanced Employer Group Waiver Program (EGWP)

Plans affected: DB Retiree Plan

Reviewed by: Retiree Health Plan Advisory Board, Alaska Retirement Management Board

Proposed implementation date: January 1, 2019

Review Date: July 26, 2018

Table 1: Plan Design Changes

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

Description of proposed change:

The proposed change has a neutral actuarial impact and results in no changes to the drugs covered by the plan or member copays. [1]

An Employer Group Waiver Program (EGWP) is one method offered by the federal government to provide subsidies to the State of Alaska retiree health trusts for qualifying prescription drug costs while retaining existing retiree benefits. An EGWP, pronounced "egg whip", is a *group* Medicare Part D prescription drug plan option. An enhanced EGWP is an EGWP plan offered with a supplemental prescription drug benefit (also known as a "wrap") that provides additional coverage for drugs not covered under the Medicare Part D program.

More than 90% of states that provide drug benefits to Medicare retirees have already implemented EGWPs and have already begun to realize cost savings.[2] By implementing an enhanced EGWP it is estimated that additional federal subsidies will save the State of

[1] Attachment A: *Employer Group Waiver Program – Focus on Actuarial and Financial Impact,* Segal Consulting memo dated July 24, 2018.

[2] *State Retiree Health Plan Spending* by The Pew Charitable Trusts and MacArthur Foundation (May 2016), supplemented with research by Segal of publicly available documents.

Alaska retiree health trust $19 million to $25 million annually.[3] In addition, the future liabilities for Other Post-Employment Benefits (OPEB) will be reduced, which decreases the State assistance payment by an estimated $40 million to $60 million annually.[4]

The AlaskaCare EGWP would be available to all individuals who are: 1) eligible for Medicare; 2) enrolled in Part A or Part B; and 3) and are covered by the AlaskaCare retiree health plan. The AlaskaCare EGWP will provide prescription drug coverage in a way that preserves the benefits Medicare-eligible retirees enjoy today while also promoting cost savings for the health trusts. The additional savings will assist the State in keeping its promise to retirees to provide health benefits into the future. This will require some administrative changes that are anticipated to be minor as outlined below.

The Alaska Retirement Management Board passed a resolution on December 8, 2017 in support of the adoption and implementation of an EGWP effective January 1, 2019. [5]

If the Division of Retirement and Benefits (Division) later determines that the enhanced EGWP is not meeting the needs of our members or the State, the Division can disenroll from the program.

Member impact:

WHO IS IMPACTED-

The AlaskaCare EGWP would be available to all individuals who are: 1) eligible for Medicare; 2) enrolled in Part A or Part B; and 3) and are covered by the AlaskaCare retiree health plan.

Based on 2017 reporting, this is estimated to be approximately 48,889 individual policies for Medicare eligible retirees covered under the health plan. In general, approximately 60% of all retirees reside in Alaska, and 40% reside outside of Alaska.

Retiree members who otherwise meet the EGWP criteria but who are in the following circumstances will not be enrolled:

- Retiree members living outside of the United States (estimated to be 175 individuals)

[3] Attachment A: *Employer Group Waiver Program – Focus on Actuarial and Financial Impact,* Segal Consulting memo dated July 24, 2018.
[4] Attachment B: *State of Alaska Estimated EGWP Savings Projections* Conduent January 24, 2018
[5] Attachment C: ARMB Res 2017-20 Employer Group Waiver Program

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- Retiree members who are actively working and therefore do not qualify for Medicare Part A with no premium (estimated to be 125 individuals)

BENEFIT IMPACT-

EGWP represents an administrative change, rather than a change in plan benefits. There is no anticipated impact to the benefits that members will receive. A minor change will be necessary to comply with industry-standard fill measures which would not impact the prescription strength or type of coverage, but the timing of prescription fills (described below). An AlaskaCare EGWP would be an enhanced EGWP, which is an EGWP provided with a "wrap," or a supplemental benefit package. This "wrap" allows the plan to cover medications that would not typically be covered through a group Medicare Part D plan.

The EGWP is subject to Centers for Medicare and Medicaid Services (CMS) regulations. For example, CMS determines a formulary, or a list of prescription drugs, that qualify for a federal subsidy and are covered under the EGWP. Drugs that are not on the CMS formulary will be covered through the wrap benefit. This ensures that if a drug is covered in the AlaskaCare plan today, it will be covered under an AlaskaCare EGWP. The member will pay the same copay ($8 brand, $4 generic or $0 for all mail order) as they do today.

The determination of prescription drugs covered under the EGWP and the wrap plan will occur through the Pharmacy Benefit Manager (PBM) point-of-sale claims adjudication software.[6] The pharmacist will run the prescription as they do today, and the software program will apply appropriate coding so that the plan receives a subsidy if eligible, or covers the full cost of the medication under the wrap if not eligible for a federal subsidy.

Fill Requirements- CMS restricts filling of medication to no more than a 90-day supply of the medication being filled at one time. The current plan allows "the greater of 90-day or 100 unit supply" and would need to be changed to remove the 100 unit option.[7]

In 2017 there were approximately 2,200 members who received prescription drug fill based on a 100 unit supply, that may be impacted. These included about 100 members who received a 100 unit box of unfilled syringes.

[6] A pharmacy benefits manager (PBM) is a vendor the Division of Retirement and Benefits hires to process and adjudicate pharmacy claims and to maintain a network of contracted pharmacies.
[7] Page 2 of the May 2003 Retiree Insurance Information Booklet, as amended.
http://doa.alaska.gov/drb/pdf/ghlb/retiree/RetireeInsuranceBooklet2003with2018amendment.pdf

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Affected members can still access the same amount of medication, but the number of times they are required to fill may change. Depending on the "days' supply" the 100 unit would typically cover, this could require an increase in some member copayments, but members can still access medications via the mail order program at $0 copay.

The plan allows for vacation overrides and other exceptions as necessary; this would be preserved under an AlaskaCare EGWP.

OTHER

CMS requires that retirees enrolled in an AlaskaCare EGWP that have multiple medical conditions or high drug utilization be enrolled in a Medication Therapy Management Program (MTMP).[8] This program helps the member and their doctor make sure the medications are working to improve the health of the member, and provides a comprehensive review if medications have side effects or might have interactions with other medications the member is taking. Members may opt out of this program at any time.

Additional analysis is needed to understand how many retirees meet the criteria for enrollment into the MTMP.

FINANCIAL IMPACT-

a. Copayments - There is no anticipated impact to member's co-pay.

Table 2: Comparison of Current to Proposed AlaskaCare EGWP (no change)

	Mail Order Copay	Retail Generic Copay	Retail Brand Name Copay	Drugs Covered
Current	$0	$4	$8	Open Formulary[9]
AlaskaCare EGWP	$0	$4	$8	Open Formulary

b. Coordination of Benefits - An AlaskaCare EGWP will continue to coordinate with other AlaskaCare plans the same way it does today, so if a member with

[8] Additional information specific to the conditions and definition of high drug utilization is underway.
[9] A formulary is a list of covered prescription drugs that will be paid under a health plan. An open formulary means there are no restrictions on which drugs will be covered as long as the drug meets the definition of "prescription drug", i.e. a medical substance which must bear a label that states, "Caution: Federal law prohibits dispensing without a prescription" and is not otherwise excluded under the plan.

multiple coverages under the AlaskaCare plan does not pay copayments today for medications, they would not have to pay them under an AlaskaCare EGWP.

There are no restrictions on allowing an AlaskaCare EGWP to coordinate benefits with a plan that is not an EGWP or individual Medicare Part D plan with two exceptions:

1) CMS does not allow coordination of benefits with prescriptions filled at a Veterans Administration Pharmacy. This is not a change from how AlaskaCare benefits are coordinate with VA pharmacy claims today.
    - AlaskaCare does not currently cover pharmacy benefits related to a service connected medical condition, so this does not represent a change for military service-related prescriptions.
    - For non-service related conditions, the VA pharmacy charges a copay. The AlaskaCare does not currently cover this copay.
    - There are about 1,400 members utilizing VA pharmacies. Of these only about 100 members will not have an EGWP pharmacy option within 5 miles of the VA pharmacy currently being utilized.
2) CMS does not permit a member to have more than one EGWP or individual Medicare part D plan.
    - Additional research is required to determine how many retirees may have outside EGWP plans.

c. Premiums - CMS requires certain high-income retirees to pay an extra surcharge. This is the same requirement for members who are covered today under Medicare Part B. This surcharge is called the Income Related Monthly Adjustment Amount (IRMAA). Monthly Adjusted Gross Income (MAGI) is determined by the amount on the last line of the individual/couples IRS 1040 tax form (line 37 on form 1040, line 21 on form 1040A, or line 4 on form 1040EZ), **plus** any tax-exempt interest income (line 8b on form 1040). This information from two years prior is used to determine the IRMAA for the current premium year. For example, information from 2017 will determine the 2019 IRMAA. The below table shows the IRMAA for 2018, but this is subject to change.

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Table 3: Overview of MAGI and Surcharge Categories

Individuals MAGI	Couples MAGI	Extra Monthly Surcharge Amount
Equal to or below $85,000	Equal to or below $170,000	$0
$85,001-$107,000	$170,001-$214,000	$13.00
$107,001-$133,500	$214,001-$267,000	$33.60
$133,501-$160,000	$267,001-$320,000	$54.20
Above $160,000	Above $320,000	$74.80

No member will be required to shoulder this additional cost for their pharmacy benefits. The Division will fund a Health Reimbursement Arrangement (HRA) account to offset the full amount of IRMAA associated with the EGWP.[10]

The number of impacted members is unknown because the Division does not have access to member's household income, however based on Alaska pension information alone an estimated 650 retirees meet the minimum income threshold.[11] The Division will work to inform retirees of the income thresholds and encourage them to proactively contact the Division to: 1) understand if they will be impacted; and 2) to make arrangements for compensation.

Members paying a surcharge for Medicare Part B today can expect to be assessed a surcharge under EGWP.[12] The requirements are the same.

There are two methods the Division could use to compensate members subject to the surcharge. Both require the Division to establish and pre-fund an HRA for the impacted member.

1) If a retiree/member has the IRMAA deducted from their social security benefit, the HRA can reimburse the member on a monthly-basis.
2) If a retiree/member does not have social security and is invoiced by Medicare, the HRA can be set up to automatically pay Medicare directly each month so the member does not have to pay out-of-pocket.

[10] A Health Reimbursement Arrangement (HRA) account is an IRS-approved, employer funded, tax-advantaged account that can be used to reimburse for individual health insurance premiums.
[11] Based on 2016 pension data.
[12] Medicare premiums for high income beneficiaries. https://www.ssa.gov/pubs/EN-05-10536.pdf

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Members will need to provide the Division with documentation to ensure the HRA is being funded accurately. The Division has yet to identify exactly what that documentation will entail but has an objective of only requiring essential documentation and limiting effort by the member. Examples of potential documentation include a statement with the surcharge, a copy of tax returns, etc.

As household income can fluctuate, members may need to contact the Division annually to provide updated information to ensure the HRA funding aligns with the surcharge.

d. Other – There may be instances where a member could be fiscally impacted by the change in removing the 100 unit supply from the existing plan language which allows for fills "greater of 90-day or 100 unit, supply". If the 100 unit supply is greater than the 90-day supply and would otherwise have needed to be filled less than 4 times a year, the change requires them to seek more frequent refills resulting in them being subject to an additional copayment. However, members can mitigate the impact of this by filling their prescription through mail order or, if applicable, the specialty drug program offered through the PBM, both of which feature $0 copayments.

ADMINISTRATIVE IMPACT: There are several areas where member's may experience administrative impact. These are listed below:

a. Enrollment - The health plan will enroll Medicare eligible members into the AlaskaCare EGWP. Members do not have to apply individually, and the Division does not anticipate additional administrative impact to the member.
b. ID Cards - Members will have an ID card specifically for pharmacy benefit claims, a separate card from their Medical plan. Historically member's have had a single card for both medical and pharmacy claims, so this will be a new change and may require additional effort by the member to keep track of the cards and ensure they are submitting the correct card. The Division and the PBM will work to educate members to avoid confusion.
c. Premiums – See description of IRMAA above. Impacted members would need to undertake actions similar to what they do today in terms of paying their Medicare Part B surcharge; however, they would need to submit and complete additional paperwork to establish and maintain the plan-funded HRA to cover the IRMAA related to the pharmacy benefit.
d. Pre-authorization - CMS requires a new prior authorization on certain medications and requires prior authorizations on medication that previously did not require one. Prior authorization reviews will not only review the type of drug,

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but the diagnosis it is being used to treat as that can impact if it is covered on the EGWP formulary or under Medicare Part B or excluded from the EGWP formulary.

CMS does <u>not</u> require step therapy. Step therapy is when a member is required to try a less expensive medication before the plan will cover a more expensive drug.

CMS requires prior authorization for the following:

1) Medicare Part B or Part D determination-
   - This review focuses on identifying if a drug qualifies for subsidy under the prescription program or should be covered under Medicare Part B the medical plan.
   - It is not anticipated to impact either the plan benefits or the member copayment. For example, if its determined that the drug is covered under Medicare Part B instead of the EGWP, the member will continue to receive the same drugs they are getting today for the same copay they are paying today.
   - Additional analysis are underway, but the Division estimates approximately 4,000 prescriptions (.38% of overall prescription claims for Medicare eligible members) will be subject to this type of prior authorization.

2) EGWP formulary determination-
   - This review focuses on determining if a drug is covered or excluded under the EGWP formulary.
   - It is not anticipated to impact either the plan benefits or the member copayment. For example, if a drug is not covered through the EGWP formulary, it will be covered by the wrap. If its covered by EGWP, the plan benefits from the federal subsidy. If it is not covered under EGWP, the plan pays for the medication through the wrap benefits and the member can continue to receive the drugs they are getting today for the same copay they are paying today.
   - Additional analysis are underway, but the Division estimates approximately 1,500 prescriptions (.14% of overall prescription claims for Medicare eligible members) will be subject to this type or prior authorization.

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Prior to implementation of an AlaskaCare EGWP, members who are taking a medication that require prior authorization will be notified by the PBM and either the member, or their doctor, will have to complete and submit the required form. This will need to be completed even if the medication was already authorized under the existing plan. The Division will work with PBM to streamline this process and mitigate this administrative burden on the membership.

Following implementation, if a member is prescribed medication requiring prior authorization for the first time, they or their doctor will need to complete and submit the required form.

For most medications, once a prior authorization is established it is in effect for a year or longer; however, some medications may require more frequent reviews. These include opioids, specialty medications, etc.

e. Appeals – To appeal a medication that is denied in the EGWP, and is not otherwise covered under the wrap, the member must use a federal appeal process. This mirrors what occurs today in the medical plan for members covered under Medicare Part A and B. **The vast majority of disputed claims will be subject to the existing appeal process and members will not have any change to the administrative requirements in place today**.

The Division is still working to identify a circumstance under which a member would not be subject to the existing appeals process, so far they have been unable to identify a specific example. It is important to note that the CMS appeals process mirrors the state substantively. A comparison is outlined in below.

Table 4: Comparison of CMS appeals process and AlaskaCare appeals process

	AlaskaCare Wrap/ Current AlaskaCare Appeal Process[13]	**EGWP – Part D CMS 5-Step Appeal Process[14]**
Step 1	Redetermination by PBM	Redetermination by PBM
Step 2 (clinical)	Independent Review Organization	Independent Review Organization
Step 3	Division of Retirement and Benefits	Federal Administrative Law Judge
Step 4	State Administrative Law Judge (OAH)	Medicare Appeals Council
Step 5	State Superior Court	Federal District Court

[13] January 1, 2018 amendment to the May 2003 Retiree Insurance Information Booklet, page i-xvi. http://doa.alaska.gov/drb/pdf/ghlb/retiree/RetireeInsuranceBooklet2003with2018amendment.pdf

[14] *Medicare Appeals,* https://www.medicare.gov/Pubs/pdf/11525-Medicare-Appeals.pdf

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f. Opt-out - CMS requires the AlaskaCare plan to offer Medicare eligible retirees the option to Opt-Out of the EGWP. To disincentivize members from opting out of this program, many plans choose not to cover prescription drug benefits at all should members opt-out. The Division proposes instead enrolling members who opt-out into an alternative pharmacy benefit plan which mirrors the prescription drug benefits offered in the Defined Contribution Retirement health plan. A summary of the opt-out plan is shown below.

Table 5: Opt-out plan based on current DCR health plan

Prescription Tier	**Coinsurance**	**Minimum Covered Person Payment**	**Maximum Covered Person Payment**
Retail 30 Day at Network Pharmacy			
Generic prescription drug	80%	$10	$50
Preferred brand-name prescription drug	75%	$25	$75
Non-preferred brand-name prescription drug	65%	$80	$150
Mail Order 31-90 Day at Network Pharmacy			
Prescription Tier		**Copayment**	
Generic prescription drug		$20	
Preferred brand-name prescription drug		$50	
Non-preferred brand-name prescription drug		$100	
Out-of-Network Pharmacy			
Coinsurance for all **prescription drugs**		60%	
Out-of-Pocket Limit			
Annual individual **out-of-pocket limit**		$1,000	

This type of disincentive is already applied to the medical benefit as the plan assumes that individuals who are eligible for Medicare have enrolled and calculates the benefits assuming they are. If members have delayed or declined to enroll in Medicare, they bear the additional cost, the plan does not make up the difference.

A member who opts-out, can reenroll during the annual open enrollment for the next benefit year.

g. Other - CMS has many mandatory communications that will be mailed to members. These communications will be provided to all members covered under the AlaskaCare EGWP. The Division can include cover letters and guidance but cannot suppress these communications.

   CMS may require members with a mailing address that is a post-office box to attest that they are a resident of the United States. Additional research is ongoing to understand the number of retirees required to attest to residency.

ACCESS IMPACT: Members may experience some change in the network of pharmacies they can access, however any difference is anticipated to be minimal with the Division providing alternatives. This is not unlike what occurs under the existing plan when there is a change from one PBM to another.

CMS has established certain requirements for a pharmacy to participate in an EGWP network. In an initial analysis based on information obtained and evaluated in the PBM Request For Proposal (RFP), it appears that 19 pharmacies in Alaska are not in the EGWP network, however many of these are in areas where there are other network pharmacies members can access. As it has in past transitions or changes in networks, the incoming PBM, OptumRx, will work with non-participating pharmacies to bring them in the network prior to January 1, 2019.

At this point in time, Dillingham, Bethel, Petersburg and Wrangell have no pharmacies participating in the EGWP network.

If OptumRx is not able to bring them into the network, members can still utilize these pharmacies but will need to submit paper claims as is required for out-of-network pharmacies today. Members can also fill their prescriptions through mail order or the specialty mail services. Additional analysis will be conducted on pharmacies outside of Alaska. Additional analysis will be conducted to determine the number of members utilizing pharmacies not currently in the network. Currently this is estimated to be around 500 members.

Actuarial impact[15]

Neutral / Enhancement / Diminishment

The implementation of an enhanced EGWP will provide the same cost share structure as members receive today (see *Table 2* above). For this reason, there is no change in the

[15] "Under the ACA, a health insurance plan's actuarial value indicates the average share of medical spending that is paid by the plan, as opposed to being paid out of pocket by the consumer." https://www.actuary.org/files/Actuarial_value_basics_for_NAIC_040113.pdf

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actuarial value of the plan.[16] Based on Attachment A developed by Segal Consulting,[17] implementation of the AlaskaCare EGWP does not impact the plan's overall actuarial value based on the following:

a. The primary change associated with the transition to EGWP is the change in federal subsidies, which do not impact the actuarial value.
b. As previously noted, there will be no change to copay structure, which will remain $4 (generics), $8 (brands) and $0 (mail order).
c. There will be no change to the members that have multiple coverages in the State Plan. For these members their net drug costs will remain $0.
d. Members' access to covered drugs and pharmacies will not be impacted by the EGWP transition.
e. Implementing a 90-day supply limitation and discontinuing the 100 unit limitation will not impact actuarial value. Members can still access the same amount of medication, but the number of times they are required to fill it may change. Members can still access medications via the mail order program at $0 copay.

There is no change in the value of the benefits associated with the EGWP implementation. Therefore, there will be no impact on the actuarial value of the Retiree Plan.

Table 6: Actuarial Impact (none)

	Actuarial Impact	Notes
Current	N/A	N/A
Proposed change	None	No changes in member cost share.

DRB operational impacts:

The Division is responsible for procuring the services through a Pharmacy Third-Party Claims Administrator (PBM)). The Division will work with the vendor to auto enroll the eligible retirees and dependents through CMS into the group Medicare D plan. For those whose enrollment is denied by CMS (e.g. those living outside the United States, or currently working and not eligible for Medicare A), will be enrolled in the plan provided to non-Medicare eligible retirees and dependents.

[16]Attachment A: *Employer Group Waiver Program – Focus on Actuarial and Financial Impact,* Segal Consulting memo dated July 24, 2018

[17] Attachment A: *Employer Group Waiver Program – Focus on Actuarial and Financial Impact,* Segal Consulting memo dated July 24, 2018

The Division will be responsible for leading the transition to an AlaskaCare EGWP in conjunction with the PBM and all associated activities. This will require significant effort by staff.

The Division will need to make technical changes to its eligibility reporting system to support the transition to an AlaskaCare EGWP.

The Division will need to provide an attestation that existing retirees were covered under a pharmacy benefit that was at least as good as those offered under the EGWP (was Creditable Coverage).

The Division will need to design the pharmacy "wrap" benefit to ensure formulary and network gaps are covered by the plan in accordance with the *Retiree Insurance Information Booklet*. This will be completed with the assistance of the benefit consultants and the PBM.

The Division will need to establish processes and protocols for identifying members subject to IRMAA and necessary information to establish and maintain Health Reimbursement Arrangement (HRA) for those members.

The Division will need to establish process and protocols related to retroactive termination of coverage when untimely notified of the death of a member or a divorce as there are some CMS limitations that conflict with the existing process.

The Division will need to maintain existing support for the Retiree Drug Subsidy (RDS) program as an additional source of federal subsidies for those retirees who are not eligible for EGWP subsidies.

It was initially thought that the PBM would be the fiduciary for an EGWP, however **CMS does not require a change in fiduciary**[18]. This applies only to fully-insured plans and will have no impact on the AlaskaCare EGWP. The plan's fiduciary status will remain as it is today.

Financial impact to the plan:

An AlaskaCare EGWP is estimated to provide substantial savings to the plan, outlined below. Several consultants have provided a range of estimated savings in various reports over the last three years. The savings estimated in table 7 are based on a review of those estimates from Conduent outlined in Attachment B[19].

[18] Title 42, 423.501, 423.504 and 423.505

[19] Attachment B: *State of Alaska Estimated EGWP Savings Projections,* Conduent dated January 24, 2018.

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Table 7: EGWP estimated savings

	Current RDS program	Proposed enhanced EGWP
CMS Subsidies	$16M to $23M annually	$35M to $44M annually (net of additional expenses)
OPEB Liability Impacts	None	$300M to $350M
Reduction of State Assistance	None	$40M to $50M in annual savings[20]
Summary of Public Comments	Pending	Pending

The current federal Retiree Drug Subsidy (RDS) are about 28% of qualified drug costs, which calculates to about $19 million annually. However, RDS has limitations:

- No subsides are received for the first $405 in an individual retiree's drug spend
- No subsidies will be paid for prescription drug costs in excess of $8,350
- The amount of the subsidies cannot be used in forecasting plan experience for purposes of Other Pension Employment Benefits (OPEB).

The EGWP offers 3 substantial subsidies estimated to total between $35 million to $44 million ($16 million to $23 million over the RDS) annually:

- A direct subsidy for each member per year, even if they have $0 in drug spend
- A Coverage Gap Discount subsidy, which provides a 50% manufacturer discount on brand-name drugs when the member is in the coverage gap ($3,750-$7,508.75)
- Catastrophic coverage subsidy, where Medicare provides 80% reimbursement for highest utilizers (greater than $7,508.75)

In addition, the EGWP subsidies can be used in forecasting plan experience for purposes of OPEB, which results in an estimated reduction of between $40 million and $60 million to the State assistance payments annually.[21]

The savings analysis looked at pharmacy claims data from 2016 and 2017. Assumptions were also made that claims cost through 2019 would increase at 6.0% annual based trend, and that member copays would vary due to fluctuation in drug utilization.[22] Projected EGWP subsides were developed based on claims experience and average subsidies received by other similar groups. These savings were then reduced by the estimated increase in administrative fees, fees associated with the Patient Protection and

[20] Attachment B: *State of Alaska Estimated EGWP Savings Projections* Conduent dated January 24, 2018.
[21] Ibid.
[22] Attachment A: *Employer Group Waiver Program – Focus on Actuarial and Financial Impact,* Segal Consulting memo dated July 24, 2018.

Affordable Care Act (ACA), projected IRMAA reimbursements, changes in rebates and the estimated subsidies that would have been received under the Retiree Drug Subsidy program.

Clinical considerations:

There are no plans to implement "step therapy" or "fail first" provisions in the retiree plan, that would require additional information from clinicians. "Step therapy" is when an insurance plan requires a member to try certain lower-cost medications first before covering a more expensive type of medication.

For a very limited number of drugs, the retiree health plan already requires prior authorization, and in a few cases where a drug is extraordinarily expensive and other alternative medications are available, the plan requires members try those medications first or have a medically necessary reason why those would not work. This is not a requirement of EGWP, this is part of the current plan administration. This is limited to a very small number of drugs and should not be impacted by an AlaskaCare EGWP.

Third Party Administrator (TPA) operational impacts:

The impacts to the Medical, Dental and Long-Term Care Third Party Administrator will be minimal. The impact to the Pharmacy Benefit Manager (PBM) will be significant. There is a heavy back-end administrative burden that is performed by the PBM to minimize member impacts. This includes, but is not limited to:

- gaining approval from CMS to be an EGWP sponsor;
- creating and publishing a custom EGWP formulary that is compliant with Medicare Part D program requirements;
- administering the supplemental wrap benefits to ensure AlaskaCare benefits remain as they are today;
- enrolling Medicare eligible retirees under the EGWP;
- managing the CMS required Opt-out process;
- administering CMS required Medication Therapy Management Program;
- producing prescription drug events files, health plan management system reports, and other required CMS reporting;
- providing customer service support to retirees;
- mailing mandatory CMS communications;
- administering low income subsidies;
- administering the supplemental wrap benefits to ensure AlaskaCare benefits remain as they are today; and
- conducting CMS subsidy payment reporting.

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Provider considerations:

Impacts to providers are anticipate to be minimal. However, the PBM will run detail analysis to verify what, if any, provider impacts will occur as a result of a transition to the enhanced EGWP.

The Division's current understanding is that participating pharmacies will not be required to do any more than they do today to fill a member's prescription. Members will have a single pharmacy card, and the claims adjudication system automatically attributes the claim to the AlaskaCare EGWP or the AlaskaCare wrap benefits without intervention by the member.

Documents attached include:

Document Name	Attachment	Notes
***Employer Group Waiver Program – Focus on Actuarial and Financial Impact,* Segal Consulting dated July 24, 2018**	A	 Segal EGWP Memo
***State of Alaska Estimated EGWP Savings Projections,* Conduent dated January 24, 2018.**	B	 Conduent
ARMB Res 2017-20 Employer Group Waiver Program	C	 ARMB Resolution
Summary of public comment	D	Pending

DRAFT

Attachment A

Segal Consulting

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MEMORANDUM

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

From: Richard Ward, FSA, FCA, MAAA

Date: July 24, 2018

Re: Employer Group Waiver Program – Focus on Actuarial and Financial Impact

The AlaskaCare Retiree Plan currently participates in the Retiree Drug Subsidy (RDS), which is a federal program operated by the Centers for Medicare and Medicaid (CMS). This program provides federal subsidies to group plan sponsors to offset the cost of pharmacy benefits for Medicare retirees. To qualify, a plan must provide a minimum level of benefits, but otherwise a plan sponsor has latitude in the benefit structure and administration.

An Employer Group Waiver Program (EGWP) is an additional CMS program that provides a greater subsidy level than RDS. To qualify as an EGWP, the plan must comply with the CMS requirements and mandates for all Medicare Part D plans. An EGWP is a group plan, and the plan sponsor retains control of the design and administration provided the CMS mandates are met.

Actuarial Value

The transition to an EGWP is largely a "behind-the-scenes" change. The implementation of the AlaskaCare EGWP will not impact member benefits or cost share (copays will be identical), and there will be a negligible impact on how members' will receive their medications.

Therefore, the implementation of the AlaskaCare EGWP does not impact the Plan's overall actuarial value:

- CMS mandates that all Medicare Part D prescription drug plans limit the maximum supply per script to a 90-day fill. The current AlaskaCare benefit covers a 100-unit supply if greater than the 90-day fill.

Under either provision, members can receive a full year's supply with four (4) fills, which are $0 when the mail order benefit is utilized. Therefore, there is no impact on actuarial value.

- There will be no change to copay structure, which will remain $4 for retail generic, $8 for retail brand name and $0 for mail order prescriptions.

	Mail Order Copay	Retail Generic Copay	Retail Brand Name Copay	Drugs Covered
Current RDS	$0	$4	$8	Open Formulary[1]
AlaskaCare EGWP	$0	$4	$8	Open Formulary

- There will be no change to the members that have multiple coverages in the State Plan. For these members their net drug costs will remain $0.

- Members' access to covered drugs and pharmacies will not be impacted by the EGWP transition.

- Some high-income members will be subject to the Income Related Monthly Adjustment Amount (IRMAA), which will result in some retirees paying an additional surcharge. This is the same requirement for members who are covered today under Medicare Part B. This does not impact actuarial value. However, it is worth noting that the Division of Retirement and Benefits will reimburse any retiree that is impacted by the Part D IRMAA.

Financial Impact

The current RDS program provides approximately $16M-$23M in annual subsidies, which is used to offset the annual claims cost of about $250M-$260M (Medicare and non-Medicare retirees). Annual projected EGWP subsidies are $35M-$44M, resulting in a net gain of $19M-$21M annually. These figures are net of additional administrative costs and projected IRMAA reimbursements.

This analysis is based on 2016 and 2017 pharmacy claims data, projected to 2019 at 6.0% annual trend. Projected RDS subsidies are based on recent subsidies received by the State. Projected EGWP subsidies were developed collaboratively with the State's current Pharmacy Benefit Manager (Aetna) and are based on claims experience and average subsidies received by other similar group plans.

[1] A formulary is a list of covered prescription drugs that will be paid under a health plan. An open formulary means there are no restrictions on which drugs will be covered as long as the drug meets the definition of "prescription drug", i.e. a medical substance which must bear a label that states, "Caution: Federal law prohibits dispensing without a prescription" and is not otherwise excluded under the plan.

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

Attachment B

State of Alaska

Estimated EGWP Savings Projections

$ in millions

		Segal Estimates		Aetna Estimates		
		Low Range	**High Range**	**Existing Plan**	**Alternate Plan**	**Aetna Proposed**
(1)	Base Subsidy	$9.0	$10.0	$9.0	$9.0	$9.0
(2)	Coverage Gap Discount	22.0	25.0	25.2	24.9	23.4
(3)	Catastrophic Reinsurance	12.0	15.0	13.8	16.4	13.8
(4)	Total Subsidies (1) + (2) + (3)	$43.0	$50.0	$48.0	$50.3	$46.2
(5)	Change in Gross Claims	2.0	3.0	2.4	2.4	12.6
(6)	Change in Member Costs	(0.1)	0.1	(0.2)	0.9	0.9
(7)	Additional Admin Fees	(6.8)	(6.5)	(6.6)	(6.6)	(6.6)
(8)	ACA Fees	(0.5)	(0.4)	(0.5)	(0.5)	(0.5)
(9)	Rebate Change	(2.5)	(1.5)	3.5	3.5	9.1
(10)	Net EGWP (4) + (5) + (6) + (7) + (8) + (9)	$35.1	$44.7	$46.6	$50.0	$61.7
(11)	RDS Subsidy	19.0	21.0	21.0	21.0	21.0
(12)	Estimated Savings	$16.1	$23.7	$25.6	$29.0	$40.7
(13)	Percentage Savings Increase (10) / (11) - 1	85%	113%	122%	138%	194%

Important Notes:

- The Segal and Aetna estimates were provided to Conduent by the State of Alaska. The Segal estimates were in a presentation dated May 4, 2017 and the Aetna estimates were provided in a spreadsheet dated June 21, 2017.
- The RDS Subsidy used in the Aetna estimates was set equal to the high range from the Segal estimates. Aetna used an amount of $28.8M in their estimates, but indicated that Segal would have the best estimate. For reference, the actual RDS received for the 2016 plan year was $21.2M (as provided by State of Alaska).
- Additional details on the plan designs modeled by Aetna can be found in their analysis dated June 21, 2017.

Final FY19 Contribution Rates - State Assistance Contributions[1]					
PERS	5.58%	5.58%	5.58%	5.58%	5.58%
TRS	16.34%	16.34%	16.34%	16.34%	16.34%
JRS	32.45%	32.45%	32.45%	32.45%	32.45%
FY19 Contribution Rates Reflecting EGWP Savings - State Assistance Contributions					
PERS	4.18%	3.70%	3.57%	3.54%	3.43%
TRS	15.57%	15.53%	15.52%	15.48%	15.42%
JRS	32.45%	32.45%	32.45%	32.45%	32.45%
FY19 Projected Payroll[1]					
PERS	$2,423.3	$2,423.3	$2,423.3	$2,423.3	$2,423.3
TRS	784.4	784.4	784.4	784.4	784.4
JRS	15.1	15.1	15.1	15.1	15.1
FY19 Projected State Assistance Contributions Savings					
PERS	$33.9	$45.6	$48.7	$49.4	$52.1
TRS	6.0	6.4	6.4	6.7	7.2
JRS	0.0	0.0	0.0	0.0	0.0
Total	$39.9	$52.0	$55.1	$56.1	$59.3
Reduction in Normal Cost as of June 30, 2016[2]					
PERS DB	$3.2	$4.3	$4.6	$5.2	$7.4
PERS DCR	0.2	0.5	0.6	0.8	1.4
TRS DB	0.9	1.1	1.2	1.4	1.9
TRS DCR	0.0	0.1	0.1	0.2	0.3
JRS	0.1	0.1	0.1	0.1	0.1
Total	$4.4	$6.1	$6.6	$7.7	$11.1
Reduction in APBO as of June 30, 2016[2]					
PERS DB	$375.1	$498.8	$538.5	$609.1	$856.4
PERS DCR	2.1	4.5	5.3	6.6	11.3
TRS DB	141.4	188.0	203.0	229.6	322.8
TRS DCR	0.6	1.4	1.6	2.1	3.6
JRS	1.0	1.3	1.4	1.6	2.3
Total	$520.2	$694.0	$749.8	$849.0	$1,196.4

[1] Documented in letter dated September 15, 2017, providing Allocation of Additional State Contributions for FY19

[2] Reduction measured as of June 30, 2016, which is the basis for calculating the FY19 State Assistance Contrtibutions

Except for the EGWP savings adjustments noted above, all of the data, assumptions, methods and plan provisions used in the above calcualtions are documented in the valuation reports for the 2017 fiscal year (valuation date of June 30, 2016).

Attachment C

ALASKA RETIREMENT MANAGEMENT BOARD

Subject: Employer Group Waiver Program ACTION: x

Date: December 8, 2017 INFORMATION

Resolution 2017-20

WHEREAS, the Alaska Retirement Management Board (Board) was established by law to serve as trustee to the assets of the State's retirement systems; and

WHEREAS, under AS 37.10.210-220, the Board is to establish and determine the investment objectives and policy for each of the funds entrusted to it; and

WHEREAS, AS 37.10.071 and AS 37.10.210-220 require the Board to apply the prudent investor rule and exercise the fiduciary duty in the sole financial best interest of the funds entrusted to it and treat beneficiaries thereof with impartiality; and

WHEREAS, the retirement trust provides prescription drug coverage plans to eligible retirees and dependents, including Medicare-qualifying retirees and dependents; and

WHEREAS, the AlaskaCare retiree health plan pharmaceutical costs in the retiree health plan were $218M in plan year 2016;

WHEREAS, the pharmaceutical costs account for approximately 42% of the plan expenditures in that year; and

WHEREAS, pharmaceutical expenditures have been one of the fastest growing trends in the AlaskaCare retiree plan averaging 11% annual increase between 2014 and 2016; and

WHEREAS, the AlaskaCare retiree health plan received $21.2M in federal subsidies through the Medicare retiree drug subsidy program in plan year 2016; and

WHEREAS, the Employer Group Waiver Program is an alternative mechanism by which the AlaskaCare retiree health trust can receive an estimated $43M to $50M in federal subsidies for prescription drug benefits per plan year; and

WHEREAS, the Employer Group Waiver Program will also reduce the unfunded liability for the Other Post Employment Benefit liability; and

WHEREAS, the benefits provided to retirees and their eligible dependents can be preserved with minimal impact; and

NOW THEREFORE, BE IT RESOLVED BY THE ALASKA RETIREMENT MANAGEMENT BOARD, supports the AlaskaCare retiree health plan adoption and implemention an Employer Group Waiver Program to be effective January 1, 2019.

DATED at Anchorage, Alaska this 8th day of December 2017.

Chair

ATTEST:

Secretary

Lifetime Maximum

Proposed change: Increasing or removing the lifetime maximum

Plans affected: DB Retiree Plan

Reviewed by: Retiree Health Plan Advisory Board

Proposed implementation date: January 1, 2019

Review Date: July 26, 2018

Table 1: Plan Design Changes

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

Description of proposed change: The AlaskaCare retiree defined benefit health plan currently contains a $2 million lifetime maximum described below and found on page 14 of the 2003 booklet:

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

The proposed change would remove this language entirely and eliminate the lifetime maximum limit.[2] This will:

1) Ensure members will retain access to health insurance during a catastrophic health event;
2) Prospectively reinstate full coverage for all members who have hit the lifetime maximum;

[1] http://doa.alaska.gov/drb/pdf/ghlb/retiree/RetireeInsuranceBooklet2003with2018amendment.pdf

[2] The lifetime maximum does not apply to costs associated with claims under the pharmacy plan, but it would apply to any injections or other medications covered by the medical plan.

3) Increase the overall actuarial value of the health plan by 0.40%; and
4) Increase annual plan expenditures by an estimated $2,700,000.[3]

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

The specific consequences are described further in the member section below, but this is a priority item for Division staff who see the devastating impacts on members reaching their lifetime maximum.

Background:

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

Relatively recently, the Patient Protection and Affordable Care Act (ACA) required most health plans to remove any lifetime maximum, and as a result these provisions are becoming increasingly uncommon in health plans.[4] At the same time, the cost of health care has grown significantly over the past decade due to a variety of factors including access to new technological advancements.

Member impact:

WHO IS IMPACTED-

A lifetime maximum provision of $2 million may have seemed sufficient and typical 18 years ago, however it is now causing serious hardship for a small, but growing number of members.

It is unknown exactly how many members have reached this maximum limit as the records for individuals who have "termed," or who are no longer covered by the plan, are not retained in perpetuity. Table 1 shows the number of current members who have met or who are approaching this limit.[5]

[3] Attachment A: *Removal of the Retiree Plan Lifetime Maximum,* Segal Consulting memo dated July 25, 2018.
[4] As a retiree plan, the AlaskaCare retiree plan is exempt from this ACA provision.
[5] A member could be termed for several reasons including death, loss of coverage due to lack of premium payment if they are not eligible for premium-free health benefits, or loss of coverage through divorce or other special circumstances.

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Table 2: Overview of current member lifetime accumulators – 2018[6]

# Members	Lifetime Accumulator
5	> $2 million or more
3	> $1,700,000
11	> $1,500,000
25	> $1,000,000
181	> $500,000

There are currently 5 members who have reached the lifetime limit; and are receiving an annual $5,000 reinstatement.

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

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

1) Medicaid- for those who meet certain eligibility or income thresholds.[7]
2) Federally Facilitated Marketplace (e.g. "Individual market")- members may qualify for participating in the special enrollment period; but the regulations are unclear in this specific circumstance and the $5,000 reinstatement creates complexity for members requiring special approval and/or review.
3) Alaska Comprehensive Health Insurance Association[8] – this has been a resource for some members who have reached their lifetime maximum, but premiums range depending on age with an induvial who is 60 years of age paying $3,089 per month for a plan with $1,000 deductible to $1,153 per month for a plan with a $15,000 deductible.[9]

Other impacts: Even members who have not reached their lifetime maximum may be impacted by this provision. The Division is aware of at least one circumstance where providers have withheld care or delayed treatment until the member comes

[6] Summarized from an Aetna report from June 29, 2018.
[7] Alaska Department of Health and Social Services [DHSS], Division of Public Assistance, Medicaid Eligibility Standards: http://dpaweb.hss.state.ak.us/POLICY/PDF/Medicaid_standards.pdf
[8] Alaska Comprehensive Health Insurance Association [ACHIA]: http://www.achia.com/premiums.asp
[9] ACHIA 2018 Monthly Individual Premiums Rates: http://www.achia.com/docs/PPO%20ACHIA%202018%20Premium%20Rates%20rev11.10.2017.pdf

DRAFT

up with sufficient monetary deposit because they are concerned the recommended treatment course will exceed the remainder of their plan benefit despite having over $1 million left.

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

An unintended consequence of the $5,000 annual reinsurance provision is that even after a member reaches their lifetime maximum, they are considered by other plans to have insurance which meets minimum essential coverage provisions limiting their ability to qualify for other forms of insurance.

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

Actuarial impact

Neutral / Enhancement / Diminishment

Table 2: Actuarial Impact

	Actuarial Impact
Current	N/A
Proposed w/removal of lifetime max	0.4% increase[10]

Note: The claims data was not a credible source for the analysis, given the relatively small number of occurrences. For this reason, Segal used the Apex Actuarial Rate Modeling System[11], calibrated to account for the current membership demographics, geography and overall cost structure to determine the impact of removing the lifetime maximum.

DRB operational impacts:

Impacts to the Division will be minimal. The work associated with this will occur up front. The Division will need to notice the membership, amend the plan booklet, communicate the change, direct the Third-Party Administrator to implement the change,

[10] Attachment A: *Removal of the Retiree Plan Lifetime Maximum,* Segal Consulting memo dated July 25, 2018.
[11] The Apex Actuarial Rate Modeling System provides comprehensive plan design and rate modeling capabilities, and is widely utilized throughout the industry by consulting actuaries.

and ensure members are reinstated. Once these activities are complete the Division does not anticipate any additional work on this issue.

Financial impact to the plan:

Based on a preliminary retiree claims projection of $680,000,000 for 2019, the anticipated fiscal impact is estimated to be approximately $2,700,000 or 0. 4% in additional annual costs.[12]

Clinical considerations:

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

Third Party Administrator (TPA) operational impacts:

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

Provider considerations:

Any impacts to health plan providers are estimated to be both minimal and positive as this removes a potential barrier to care for their patients.

Documents attached include:

Document Name	Attachment	Notes
***Removal of the Retiree Plan Lifetime Maximum*, Segal Consulting memo dated July 25, 2018.**	A	 Segal Lifetime Max Memo
Summary of Public Comment	B	Pending

[12] Appendix A: *Removal of the Retiree Plan Lifetime Maximum,* Segal Consulting memo dated July 25, 2018.

Attachment A

Segal Consulting

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MEMORANDUM

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

From: Richard Ward, FSA, FCA, MAAA

Date: July 25, 2018

Re: Removal of the Retiree Plan Lifetime Maximum

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

We reviewed 2014-2017 claims data provided by Aetna for retirees over and under 65 and identified: 181 claimants from January, 2014 to December, 2018 that have exceeded claims of $500,000; 25 claimants with claims totaling over $1 million; and eleven (11) with accumulated claims over $1.5 million. Additionally, Aetna provided detailed data, as of April 2, 2018, on eight (8) claimants that have claims in excess of $1,700,000 over their lifetime, with five (5) of these members over the $2,000,000 maximum and receiving the $5,000 annual restatement.

New specialized treatments and medications continue to be developed and put into practice. As treatments and medications become more specialized, they tend to have an increase in cost associated with them. As a result, it is anticipated that the cost of care for higher cost claimants will increase as they utilize these new treatments and medications. The Alaskan marketplace also contributes to the dynamic of escalating cost, as the cost of care in Alaska is markedly higher than in the rest of the country.

Additionally, the majority of new retirees will not yet be eligible for Medicare at retirement. Retirees without Medicare generally have costs 200%-300% of those for retirees with Medicare. It is also anticipated that retirees will require these emerging treatments and medications at an ever-increasing rate.

We reviewed recent claims detail to identify the highest costs associated with the high cost claimants. Given both the escalating costs in the marketplace and the non-Medicare status of new

retirees, we have determined there may be a higher (than typical) probability that these claimants will reach the $2,000,000 maximum.

Predicting future claims activity for individuals can be challenging given the limited information on health risks and current treatment plans for each individual. The true value of this benefit enhancement will likely vary and fluctuate annually, potentially to a substantial degree. Even with over 60,000 members, the claims data are not a credible source for the analysis, given the relatively small number of occurrences.

Therefore, we utilized the Apex Actuarial Rate Modeling System[1] to determine the impact of removing the lifetime maximum. Apex indicates that removing the maximum will increase the Plan's actuarial value by 0.40%. The model was calibrated to account for the current membership's demographics, geography and overall cost structure. Our result are representative of the average anticipated increase for a typical year under typical circumstances.

Based on a preliminary retiree claims projection of $680,000,000 for 2019, this equates to approximately $2,700,000 in additional annual costs.

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

[1] The Apex Actuarial Rate Modeling System provides comprehensive plan design and rate modeling capabilities, and is widely utilized throughout the industry by insurance carriers and consulting actuaries. Segal holds an annual license to utilize this model.

Preventive Care

Proposed change: Expanded preventive services subject to network steerage.

Plans affected: DB Retiree Plan

Reviewed by: Retiree Health Plan Advisory Board

Proposed implementation date: January 1, 2019

Review Date: July 26, 2018

Table 1: Plan Design Changes

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

Description of proposed change:

Expanding preventive services will add value to the plan for most retirees and will increase the overall actuarial value of the plan. Expanding preventive will have a positive clinical and provider impact. However, expanding benefits will increase claims cost and have a negative financial impact to the plan. The Division and the Medical and Pharmacy Third Party Administrators will be minimally impacted by the changed.

The plan was first developed in 1975 and provides extensive and valuable benefits for retirees and their dependents necessary for *the diagnosis and treatment* of an injury or disease. The plan was not established as a preventive or 'wellness' plan. Preventive services that are used to screen individuals prior to symptoms being exhibited are limited to mammograms, Pap smears and Prostate Specific Antigen tests (to detect prostate cancer in males).

One of the main reoccurring complaints the Division of Retirement and Benefits (Division) receives is related to the retiree plan's lack of preventive care coverage. This is a complex topic since the plan serves two very distinct populations: those retirees and their dependents who are eligible for Medicare, and the retirees under the age of 65 (U65) who do not yet qualify for Medicare coverage. As Medicare already offers many preventive services at no cost to the beneficiary, adding preventive coverage is not as high a priority for those eligible for Medicare benefits.

Around 2010, in conjunction with certain requirements in the Patient Protection and Affordable Care Act (ACA), insurance coverage for age-specific guidelines indicating

the utilization of screening and preventive services for older adults grew increasingly common. Despite these industry changes, the omission of most preventive benefits in the plan may cause retirees to forego getting recommended age-specific vaccinations, screenings, and other preventive services. The goal of preventive services is to increase early detection and treatment of health conditions in order to improve clinical outcomes, arrest disease at an earlier stage when it is easier and more effectively treated, and to promote health-conscious behavior.

Simply adding preventive screening does not necessarily save a plan money as articulated by the Robert Woods Johnson Foundation in their 2009 study.[1] They found high-risk groups often stay away from screenings,[2] and health-conscious members may use the screenings in excess. The result is higher procedure volume and total costs without the net savings associated with early detection or treatment.

> "It is unlikely that substantial cost savings can be achieved by increasing the level of investment in clinical preventive care measures. On the other hand, research suggests that many preventive measures deliver substantial health benefits given their costs.
>
> Moreover, while the achievement of cost savings is beneficial, it is important to keep in mind that the goal of prevention, like that of other health initiatives, is to improve health. Even those interventions that cost more than they save can still be desirable. Because health care resources are finite, however, it is useful to identify those interventions that deliver the greatest health benefits relative to their incremental costs."[3]

The objective in adding preventive care to the AlaskaCare defined benefit retiree health plan is not to save money, but to save lives, and to support the members in maintaining their health. Preventive services are both mainstream and greatly desired by the membership, particularly those who are not Medicare-eligible and do not have any coverage for these services.

The Division proposes adding the full suite of evidence based preventive services to the plan that mirror those provided in most employee plans in accordance with the Affordable Care Act. These expanded services include those with an "A" or "B" rating

[1] Goodell, S., Cohen, J., & Neumann, P. (2009, Sep 1). Cost Savings and Cost-Effectiveness of Clinical Preventive Care. Retrieved from https://www.rwjf.org/en/library/research/2009/09/cost-savings-and-cost-effectiveness-of-clinical-preventive-care.html

[2] Benson WF and Aldrich N, CDC Focuses on Need for Older Adults to Receive Clinical Preventive Services, Critical Issue Brief, Centers for Disease Control and Prevention, 2012,http://www.chronicdisease.org/nacdd-initiatives/healthy-aging/meeting-records

[3] Ibid.

by the United States Preventive Task Force.[4] The specific services will change as the USPTF updates their recommendations to reflect the most current research and evidence.

The Division proposes that preventive services would be subject to normal cost-share provisions (annual deductibles, coinsurance, copay and annual maximum out-of-pocket limits, etc.), with the exception that the coinsurance paid by the plan will be reduced by 20% when the preventive care services are provided by an out-of-network provider. Further, those out-of-network expenses will not count towards the annual out-of-pocket maximum.

Table 2: Comparison of Current to Proposed Change

Benefit	Current	Proposed in-network	Proposed out-of-network
Coinsurance	• 80% after deductible. (100% after annual out-of-pocket reached.)	• 80% coinsurance after deductible. (100% after annual out-of-pocket reached.)	• 60% coinsurance after deductible. (Does not apply if no network access) Not subject to the individual out-of-pocket maximum (exception if no network access)
Mammograms	• One baseline between age 35-40. • One every two years between age 40-50. • Annually at age 50 and above and for those with a personal or family history of breast cancer.	• Biennial screening between age 50-74 • Earlier or additional screenings for those at high risk	
Pap Smear	One per year for women 18 years of age and older. Also includes limited office visit to collect the pap smear.	One every 3 years for women age 21 to 65, or every 5 years with a combination of cytology and HPV testing.	

[4] A current list of A and B services is available at: https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

Prostate specific antigen (PSA)	• One annual screening test for men between ages 35 and 50 with a personal or family history of prostate cancer, • One annual screening test for men 50 years and older.	Not covered
Vaccines	Not Covered	Coverage for those recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
Annual Routine Physical	Not Covered	Covered
Well Woman Preventive Visit	Not Covered (exception of limited exam to collect the pap smear)	Subject to any age, family history and frequency guidelines that are evidence-based items or services that have in effect a rating of A or B in the recommendation so the United States Preventive Services Task Force and Evidence informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration
Routine Cancer Screening	Not Covered (except as covered under Mammograms, PSA and Pap Smear above)	Subject to any age, family history and frequency guidelines that are evidence-based items or services that have in effect a rating of A or B in the recommendation so the United States Preventive Services Task Force and Evidence informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration

Member impact:

Studies suggest that increase in coverage for prevention may increase the use of preventive services. This will be an added benefit for all members, providing access to preventive care previously excluded under the retiree health plan.

As an example, one of the more expensive preventive services is a screening colonoscopy. The USPSTF guidelines recommend screening colonoscopies once every 10 years for non-high-risk adults starting at age 50. The AlaskaCare retiree plan has approximately 20,000 retiree adults between the ages of 50-64. Colonoscopy is a covered benefit under Medicare for whom most retirees age 65 and above are eligible.

Medicare eligible members will have access to preventive care not covered under Medicare, such as vaccination against shingles and an annual full physical examination.

The Division regularly receives complaints about the lack of preventive coverage in the plan, and the addition of these services is something the Division believes members will find both valuable and desirable.

Actuarial impact

Neutral / Enhancement / Diminishment

Table 3: Actuarial Impact

	Actuarial Impact	Notes
Current	N/A	N/A
Expanded preventive	0.75% increase[5]	80% coinsurance in network/60% out-of-network

DRB operational impacts:

The Division anticipates the expansion of preventive benefits in the retiree health plan will reduce calls, complaints and appeals to the Division related to lack of preventive coverage.

The retiree health plan is an antiquated plan design and is unusual in its lack of coverage for most preventive services. For this reason, there is a substantial communication and education need for the Division to notice members regarding the lack of preventive services. That need would no longer exist if the benefits were expanded.

[5] Attachment A: *Preventive Care Benefits – Focus on Actuarial and Financial Impact for the Retiree Plan,* Segal Consulting memo dated July 25, 2018

Financial impact to the plan:

Based on a Segal Consulting's preliminary retiree claims projection of $680,000,000 for 2019, the anticipated fiscal impact is estimated to be approximately $5,000,000 in additional annual costs.[6]

Segal's analysis looked at 2016 and 2017 medical and pharmacy claims data, and projected to 2019 at 3.0% and 6.0% annual trends respectively. For Medicare member, Medicare covers many of these services, including colonoscopies, at 100%. For these member, no change in utilization is assumed and the impact on the Plan is anticipated to be negligible. The analysis for non-Medicare members focused on the approximate 20,000 members between age 50 and 65.[7]

Clinical considerations:

It is largely agreed that the recommended preventive services can help detect disease, delay their onset, or identify them early on when the disease is most easy to manage or treat. Adding these services could have a positive clinical impact.

An example is colonoscopies. Excluding skin cancers, colorectal cancer is the third most common cancer diagnosed in both men and women. Screening can prevent colorectal cancer by finding and removing precancerous polyps before they develop into cancer. The cost of treatment is often lowest, and the survivor rates are better, when the tumor is found in the earlier stages.

Third Party Administrator (TPA) operational impacts:

Using the industry standard set by the Affordable Care Act to determine what services are covered, the impact to the TPA is minimal. This is often an "yes/no" indicator switch in a TPA's claims adjudication system. The change would simplify the administration of the AlaskaCare retiree health plan, which currently requires customization to provide the limited preventive services covered by the plan today.

Similarly, it is industry standard to have a separate network/out-of-network coinsurance for preventive services and therefore will not require any customization.

Last, offering the full suite of preventive services allows greater flexibility in disease management and broader communication options when there is not a concern about recommending a service not covered under the health plan.

[6] *Preventive Care Benefits – Focus on Actuarial and Financial Impact for the Retiree Plan,* Segal Consulting memo dated July 25, 2018.
[7] Ibid.

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Provider considerations:

The Division expects that expanding preventive coverage will have a positive impact on providers. They may gain customers in members who previously would have forgone the non-covered services, and they should see ease in administration in that they will not need to bill the member directly for the non-covered services.

The coinsurance differential may incentivize some doctors to join the network, as many members may look for a network provider to maximize their health plan benefits.

Documents attached include:

Document Name	Attachment	Notes
Preventive Care Benefits – Focus on Actuarial and Financial Impact for the Retiree Plan, Segal Consulting memo dated July 25, 2018	A	Segal Preventive Memo
Summary of Public Comment	B	Pending

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Attachment A

Segal Consulting

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MEMORANDUM

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

From: Richard Ward, FSA, FCA, MAAA

Date: July 25, 2018

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

The AlaskaCare Retiree Plan currently provides coverage for some select preventive benefits. Currently, the Plan provides coverage for the following routine lab tests:

- One pap smear per year for all women age 18 or older. Charges for a limited office visit to collect the pap smear are also covered.

- Prostate specific antigen (PSA) tests as follows:
  - One annual screening PSA test for men between ages 35 and 50 with a personal or family history of prostate cancer, and
  - One annual screening PSA test for men 50 years and older

- Mammograms as follows:
  - One baseline mammogram between age 35 and 40
  - One mammogram every two years between ages 40 and 50, and
  - One annual mammogram at age 50 years and above, and for those with a personal or family history of breast cancer.

Coverage is provided in the same manner that other medical treatments and services are covered. The Plan 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 align the scope of benefits with those required of non-Grandfathered plans under the Affordable Care Act (ACA). Note that retiree plans, such as the AlaskaCare Retiree Plan, are not subject to the same provisions under the ACA that apply to the AlaskaCare Employee Plan. Preventive benefits will continue to be subject to deductibles, coinsurance and other plan provisions that apply in 2018.

Actuarial Value

Our analysis determines the impact of expanding the scope of covered services to align the scope of benefits with those required of non-Grandfathered plans under the ACA would be an increase of 0.75% in actuarial value.

Financial Impact

Based on a preliminary retiree claims projection of $680,000,000 for 2019, this equates to approximately $5,000,000 in additional annual costs to the Plan.

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 preventive care, the data is considered credible for this analysis. For Medicare members, many of these services, including colonoscopies, are currently covered at 100% by Medicare. For these members, no change in utilization is assumed and the impact on the Plan is anticipated to be negligible. For non-Medicare members, our analysis focused those between ages 50 and 65. There are approximately 20,000 such members.

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

Travel Benefit

Proposed change: Enhancing the travel benefits to include SurgeryPlus benefits

Plans affected: DB Retiree Plan

Reviewed by: Retiree Health Plan Advisory Board

Proposed implementation date: January 1, 2019

Review Date: July 26, 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							

<u>Description of proposed change</u>:

Amend the plan booklet to 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.

The fiscal impact to the plan is estimated to be $2.8 million a year in savings associated with the SurgeryPlus travel program. There is no anticipated actuarial impact to the plan[1].

The increase in covered travel costs will be fiscally beneficial to 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]

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

The expansion of travel benefits to include 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

[1] See attachment A; Segal Consulting Memorandum, July 25, 2018.
[2] See attachment B for a list of SurgeryPlus provider metrics.

members in small communities seek care elsewhere, 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]

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 1, below, outlines the proposed changes.

Circumstance	Current	Proposed
Emergency travel[9]	Transportation to nearest hospital by professional ambulance	No change
Transplant via Aetna IOE[10]	-Member and companion -Overnight stay: -$50 per person/night -$100/night maximum -Companion expense: -$31/night	No change
Travel for minor	-Minor and companion	No change

[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.
[9] Page 42, Ibid.
[10] Page *xxxvii*, Ibid.

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	-Transportation covered[11]	
Second surgical opinion	-Transportation covered for member only	No change
Treatment 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 -1per surgical procedure -1 per allergic condition	No change
Surgery 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	No change
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.

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

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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 a high-level overview of SurgeryPlus services follow:

- 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 surgery, 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 necessarily 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 seeking care in other circumstances (e.g. treatment not available locally or surgery less expensive elsewhere).

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.

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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 in the retiree plan. This represents about 20% of eligible procedures.[12]

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 both fiscally and through anticipated positive outcomes associated with high quality care from the SurgeryPlus network of providers and the travel arrangement and coordination offered.

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

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Members will be required to pay their deductible and co-insurance to SurgeryPlus prior to receiving care; 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[13]

DRB operational impacts:

The Division anticipates minimal operational impacts as follows:

- Staff will need to manage an additional vendor and the routine work associated with that including quality control, reporting, billing, responding to member issues, 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.

Financial impact to the plan:

The overall financial impact to the plan is estimated to be savings of $2.8 million annually. This is based on members using the SurgeryPlus network for 400 procedures

[13] See Attachment A

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per year. The total savings is net of the administrative costs for SurgeryPlus and the estimated cost per member per trip of $3,000.[14]

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[15] 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).[16]

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.
- 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.

The Division is already working with the Third-Party Administrator and the external vendor to implement this benefit for the AlaskaCare employee plan effective August 1, 2018, so many of these items will have been worked through and resolved prior to any retiree health plan implementation.

Provider considerations:

The expansion of travel benefits to include the SurgeryPlus program, could create additional competition in the Alaska medical marketplace as providers compete with

[14] See Attachment A: Segal Memorandum; July 25, 2018

[15] 2016 average for SurgeryPlus's book of business.

[16] Based off of 2017 claims experience. It should be noted that while SurgeryPlus's overall book of business saw a 0.82% complication rate in 2016, the AlaskaCare retiree population is older, and so higher rates ought to be anticipated to some extent.

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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, fixed costs 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	A	Segal Travel Memo
SurgeryPlus Overview	B	State of Alaska SurgeryPlus.pdf
Public Comments	C	TBD

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Attachment A

Segal Consulting

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MEMORANDUM

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

From: Richard Ward, FSA, FCA, MAAA

Date: July 25, 2018

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	$800

• Expenses paid at a coinsurance rate other than 80% do not apply against the out-of-pocket limit		
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

Actuarial Value

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.

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.

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

Attachment B

SurgeryPlus for

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

SurgeryPlus
By EmployerDirect Healthcare

Our **Differentiators**

Surgeons of EXCELLENCE	**Employee** SATISFACTION	**Hard-Dollar ROI** SAVINGS
Rigorous Screening & Reduced Complications	Better User Experience We Handle It All	Pre-Negotiated Bundled Rates Reduced Employer & Employee Costs

SurgeryPlus By EmployerDirect Healthcare

Surgeons of Excellence Credentialing

More Comprehensive Evaluation Process

	Other Network	SurgeryPlus By EmployerDirect Healthcare
Board Certification	Optional	**Mandatory**
Specialty Training Requirements	Optional	**Mandatory**
Procedure Volume Requirements		✓
State Sanctions Check		✓
Medical Malpractice Claims Review		✓
Criminal Background Checks		✓
CMS Quality Requirements (Hospital Only)		✓
Monthly Network Management		✓
ASC Steerage		✓

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

SurgeryPlus had an overall **complication rate of ~1%** in 2017 and is under 1.50% life to date

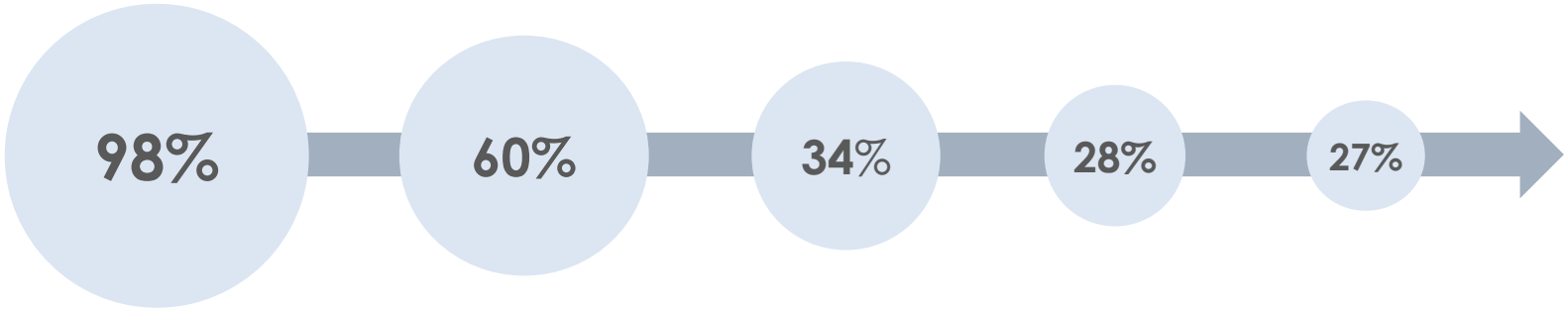
Our surgeons are committed to patient optimization; not risk selection

SurgeryPlus By EmployerDirect Healthcare

Provider Preliminary Credentialing Case Study

Examining our Rigorous Credentialing Process

- Reflects 122 Orthopedic surgeons in the Tampa, FL MSA with the following network affiliations: BlueCross BlueShield: 116 surgeons; Aetna: 99 surgeons; UnitedHealth: 82 surgeons; Cigna: 55 surgeons
- The percentages in each bubble (from left to right) represents the total percent of orthopedic surgeons who meet the SurgeryPlus credentialing requirements listed respectively below
- This does not include our interviews, site visits or reviews of standards and volumes



Credentialing Criteria	98%	60%	34%	28%	27%	25%
	Licensed [1]	Licensed	Licensed	Licensed	Licensed	Licensed
		+ Board Certified	+ Board Certified	+ Board Certified	+ Board Certified	+ Board Certified
			+ Fellowship	+ Fellowship	+ Fellowship	+ Fellowship
				+ No State Sanction	+ No State Sanction	+ No State Sanction
					+ No Criminal Charges	+ No Criminal Charges
						+ No Medical Malpractice History

SurgeryPlus By EmployerDirect Healthcare

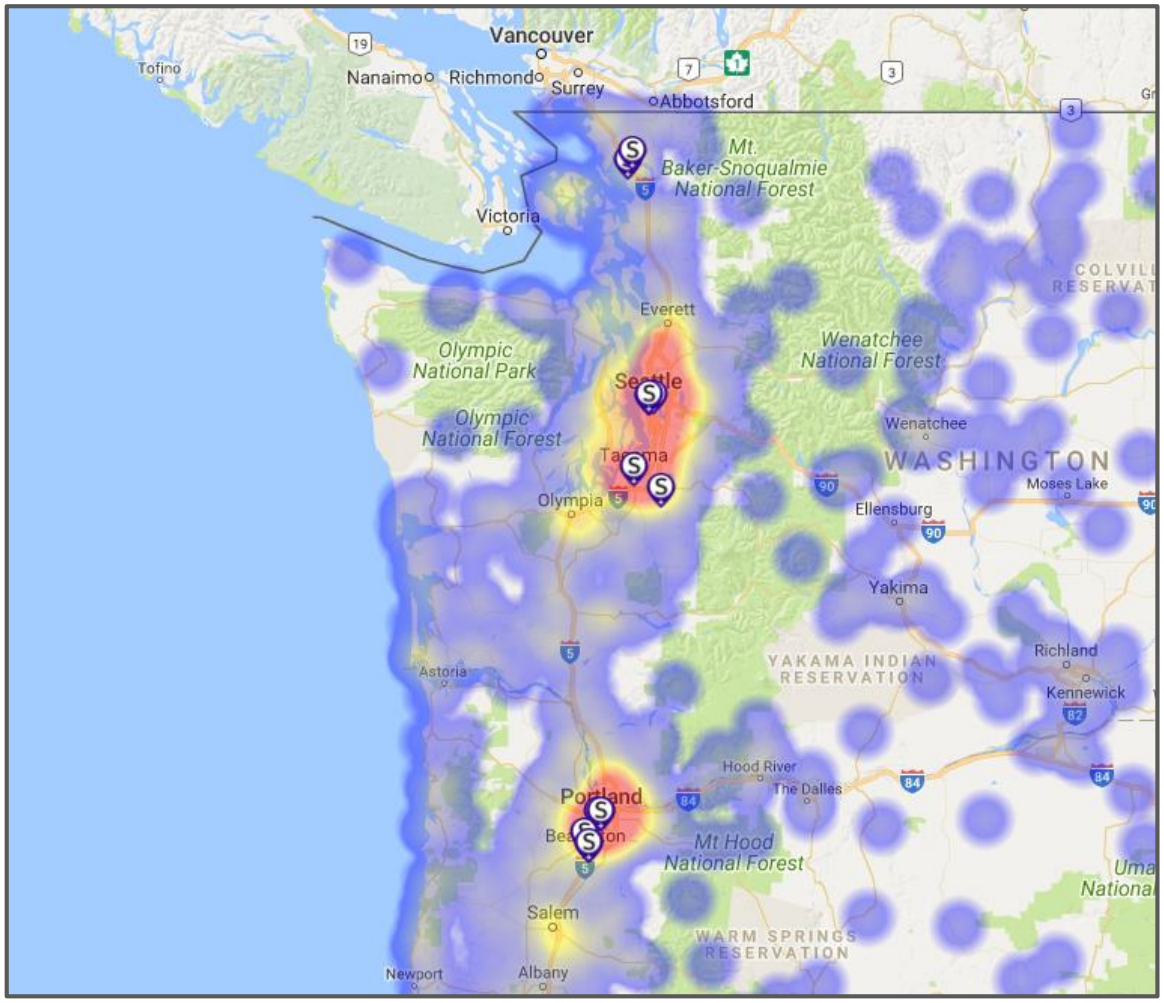
Surgeons of Excellence

(1) Two doctors remain on the carrier's portal but have retired, licensing is a standard requirement.

SurgeryPlus By EmployerDirect Healthcare

SurgeryPlus Provider Network

Seattle / Portland



Legend: SurgeryPlus Provider

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

*In Discussions

Provider Spotlight

Virginia Mason

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

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

SurgeryPlus By EmployerDirect Healthcare

Michael E. Morris, M.D.
Orthopedics

Physician Information

Facility: Virginia Mason Medical Center

1100 9th Ave.
Seattle, WA 98101
(888) 862-2737

Virginia Mason

Education

UC Irvine

USC University of Southern California

Fellowship & Residency

University of Washington — Residency

Kerlan-Jobe Orthopaedic Clinic, A Cedars-Sinai Affiliate — Fellowship

Select Professional Societies

The American Board of Orthopaedic Surgery

Notable Leadership

- Dr. Morris is the head orthopedic team physician for the Seattle Sounders (Major League Soccer)
- Voted on of Seattle's top doctors by both Seattle Metropolitan and Seattle Magazine in 2009
- Voted on of Seattle's top doctors by Seattle Met magazine in 2010

Seattle Sounders FC

SurgeryPlus By EmployerDirect Healthcare

SurgeryPlus vs. Average Carrier

State of Alaska Member Experience

	Carrier	SurgeryPlus By EmployerDirect Healthcare	
Provider Overview	**Juneau, AK**	**Seattle, WA**	
Total Hip Replacement Cost	**40 – 60% above SurgeryPlus**	**$24,000 – $26,000**	
Member Overview			
Deductible Amount	**$600**	**$600**	**Member saves $2,250**
OOPM	**$2,850**	**Waived**	
Airline/Car Travel (~$550)	✖	**S+ covers travel costs**	
Per Diem Cost ($25 per person, per day)	✖	**S+ covers travel costs**	

SurgeryPlus Can Save Members Thousands

Know What Your Procedure Costs Ahead of Time

State of Alaska WAIVES coinsurance

SurgeryPlus collects what is left on member's primary deductible

No medical bills in the mail

SurgeryPlus handles all bills following your procedure

Zero risk of out-of-network charges

Never worry any part of the procedure falls out of network

$0 coinsurance

Note: SurgeryPlus does not coordinate with current benefits in place by State of Alaska

SurgeryPlus By EmployerDirect Healthcare

SurgeryPlus Member ID Card

Unlocking Access to your SurgeryPlus Benefit

SurgeryPlus

John Doe
2100 Ross Ave, Suite 3200
Dallas, TX 75201

AlaskaCare

ACTIVATE YOUR ONLINE PORTAL EXPERIENCE

1. Visit Alaska.SurgeryPlus.com
2. Click Register Now
3. Access Code: surgeryplus
4. Complete profile and explore

The State of Alaska has partnered with SurgeryPlus to provide a supplemental surgical benefit for AlaskaCare Employee Health Plan members and their families.

SurgeryPlus offers quality surgeons that are all board certified, concierge service, and ways to lower costs for hundreds of non-emergent procedures. With this benefit, your coinsurance is waived. SurgeryPlus' concierge service can help you understand your benefits, choose a surgeon, book appointments, facilitate medical records transfer, coordinate travel and anything else you need for a great experience. Members have access to an online portal where they can search surgeons and providers for certain procedures, read success stories and learn more about the benefit.

This new travel benefit, available through Surgery Plus, is only available through our Employee Plan members' primary AlaskaCare health plan; it does not coordinate with additional AlaskaCare or other health plans. Services provided are subject to your annual plan deductible.

To learn more, call a Care Advocate at (855) 715-1680, or register online at Alaska.SurgeryPlus.com with the information provided above.

The SurgeryPlus Difference

HIGH QUALITY	GREAT EXPERIENCE	LOW COST
High-performance surgeons are 100% board-certified and rigorously screened.	A dedicated Care Advocate manages the entire procedure process for you.	SurgeryPlus waives coinsurance reducing post-procedure bills and financial burden.

Remove and keep the ID card below for you and your dependents as a reference when needing a surgery or to present at any scheduled SurgeryPlus consultation or procedure.

SurgeryPlus | AlaskaCare

MEMBER NAME: John Doe
Includes member's covered spouse and dependents
MEMBER ID: XXXXXXX
GROUP NUMBER: XXXXXX
(855) 715-1680
Alaska.SurgeryPlus.com
SURGERYPLUS BENEFIT
DEDUCTIBLE COLLECT
COINSURANCE WAIVED
Member portal registration access code: surgeryplus

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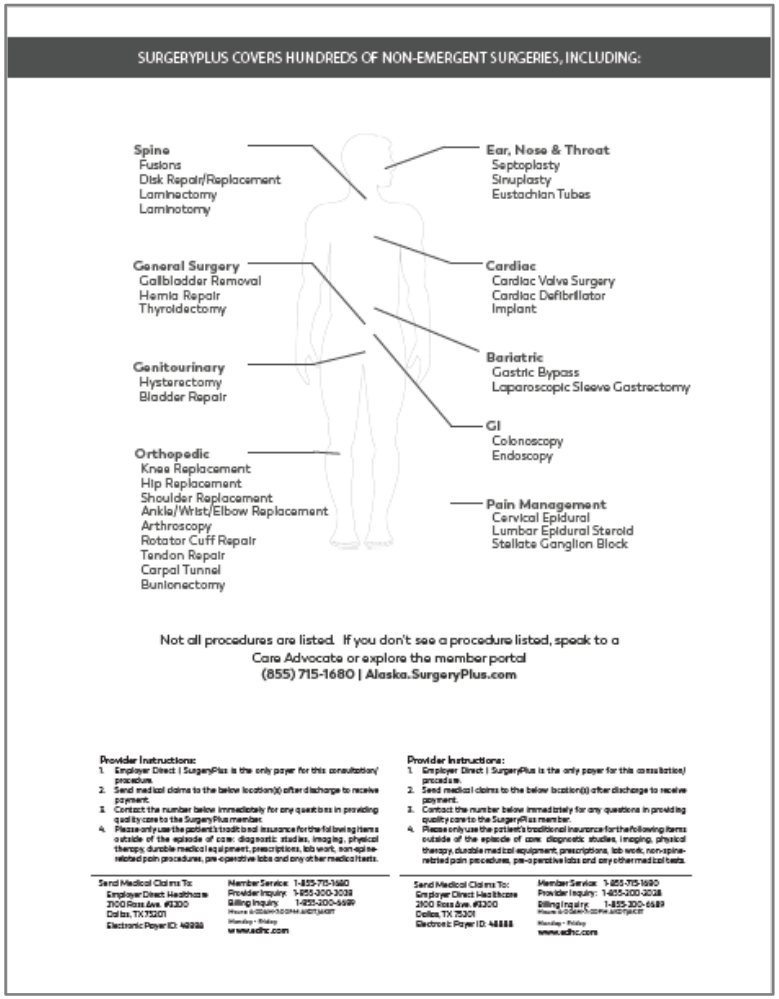
COINSURANCE WAIVED
Member portal registration access code: surgeryplus

Contact a Care Advocate if you would like additional cards for dependents on your plan



SURGERYPLUS COVERS HUNDREDS OF NON-EMERGENT SURGERIES, INCLUDING:

Spine
Fusions
Disk Repair/Replacement
Laminectomy
Laminotomy

General Surgery
Gallbladder Removal
Hernia Repair
Thyroidectomy

Genitourinary
Hysterectomy
Bladder Repair

Orthopedic
Knee Replacement
Hip Replacement
Shoulder Replacement
Ankle/Wrist/Elbow Replacement
Arthroscopy
Rotator Cuff Repair
Tendon Repair
Carpal Tunnel
Bunionectomy

Ear, Nose & Throat
Septoplasty
Sinuplasty
Eustachian Tubes

Cardiac
Cardiac Valve Surgery
Cardiac Defibrillator Implant

Bariatric
Gastric Bypass
Laparoscopic Sleeve Gastrectomy

GI
Colonoscopy
Endoscopy

Pain Management
Cervical Epidural
Lumbar Epidural Steroid
Stellate Ganglion Block

Not all procedures are listed. If you don't see a procedure listed, speak to a Care Advocate or explore the member portal
(855) 715-1680 | Alaska.SurgeryPlus.com

Provider Instructions:
1. Employer Direct | SurgeryPlus is the only payer for this consultation/procedure.
2. Send medical claims to the below location(s) after discharge to receive payment.
3. Contact the number below immediately for any questions in providing quality care to the SurgeryPlus member.
4. Please only use the patient's traditional insurance for the following items outside of the episode of care: diagnostic studies, imaging, physical therapy, durable medical equipment, prescriptions, lab work, non-spine-related pain procedures, pre-operative labs and any other medical tests.

Send Medical Claims To:
Employer Direct Healthcare
2100 Ross Ave. #3300
Dallas, TX 75201
Electronic Payer ID: 48888

Member Service: 1-855-715-1680
Provider Inquiry: 1-855-200-2038
Billing Inquiry: 1-855-200-6689
Monday - Friday
www.edhc.com

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SurgeryPlus
By EmployerDirect Healthcare

Care Advocates Handle It All

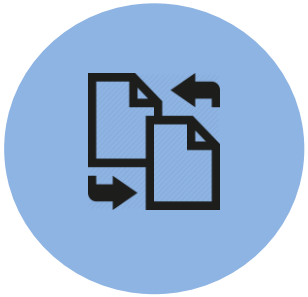
Full-Concierge Service Creates a Better Member Experience

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

SurgeryPlus
By EmployerDirect Healthcare

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:
- Diagnostic 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

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