Retiree Health Plan Advisory Board
Meeting Agenda

Date:	Thursday, November 4, 2021	
Time:	9:00am – 12:00pm	OnlinePublicNotices
Location:	Join meeting	
Teleconference:	(650) 479-3207 Access Code: 177 349 1951 Password: RHPAB (74722 from phones)	
Committee Members:	Judy Salo (chair), Lorne Bretz, Joelle Hall, Dallas Hargrave, Paula Harrison, Cammy Taylor, and G. Nanette Thompson	

9:00 am **Call to Order – Judy Salo, Board Chair**

- Roll Call and Introductions
- Approval of Agenda
- Approve Previous Meeting Minutes (August)
- Ethics Disclosure and Public Comment Script

9:15 am **Public Comment**

9:30 am **Department & Division Update**

- Legal/Regulatory Update
- EGWP Out of Area
- DVA Open Enrollment
- Coming in 2022
    - Aetna ID Card Updates
    - New DRB Website
    - Preventive Care and Prior Authorization for Specialty Medications 2022 Implementation Update
- Plan Booklet Draft Changes
- COVID Update

Long Term Care Valuation

Gene Therapy Network

2022 Planning Session

12:00 pm **Adjourn**

2022 Proposed Meeting Dates

Retiree Health Plan Advisory Board

Special Board Meeting Minutes

Date: Thursday, September, 2021 9:00 a.m. to 12:00 p.m.

Location: WebEx (virtual) meeting

Meeting Attendance

Name of Attendee	Title of Attendee	
Retiree Health Plan Advisory Board (RHPAB) Members		
Judy Salo	Chair	Present
Cammy Taylor	Vice Chair	Present
Lorne Bretz	Member	Present
Dallas Hargrave	Member	Present
Paula Harrison	Member	~~Absent~~
Nan Thompson	Member	Present
State of Alaska, Department of Administration Staff		
Ajay Desai	Division Director, Retirement + Benefits	
Emily Ricci	Chief Health Policy Administrator, Retirement + Benefits	
Betsy Wood	Deputy Health Official, Retirement + Benefits	
Teri Rasmussen	Program Coordinator, Retirement + Benefits	
Andrea Mueca	Health Operations Manager, Retirement + Benefits	
Steve Ramos	Vendor Manager, Retirement + Benefits	
Erika Burkhouse	Assistant Vendor Manager, Retirement + Benefits	
Chris Murray	Member Liaison, Retirement + Benefits	
Elizabeth Hawkins	Appeals Specialist, Retirement + Benefits	
Others Present + Members of the Public		
Daniel Dudley	Aetna (medical third party administrator)	
David Broome	Aetna (medical third party administrator)	
Kimberly Krebs	Aetna (medical third party administrator)	
Andrew Robison	Aetna (medical third party administrator)	
Nicole Brown	OptumRx (pharmacy third party administrator)	
Sara Guidry	OptumRx (pharmacy third party administrator)	
Richard Ward	Segal Consulting (contracted actuarial)	
Noel Cruse	Segal Consulting (contracted actuarial)	
Amy Jimenez	Segal Consulting (contracted actuarial)	
Scott Young	Buck Consulting (contracted actuarial)	
Anna Brawley	Agnew::Beck Consulting (contracted support)	
Wendy Woolf	Retired Public Employees of Alaska (RPEA)	
Gary Newman	Public member	

Common Acronyms

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

- ACA = Affordable Care Act (formal name: Patient Protection and Affordable Care Act)

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

Meeting Minutes

Item 1. Call to Order + Introductory Business

Chair Judy Salo called the meeting to order at 9:00 a.m. A quorum was present.

Approval of Meeting Agenda

Materials: Agenda packet for 9/9/21 RHPAB Special Meeting

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

Approval of Previous Meeting Minutes

Materials: Agenda packet beginning page 3 for 9/9/21 RHPAB Special Meeting

- **Motion** by Cammy Taylor to approve the May 13 regular meeting minutes as presented. **Second** by Nan Thompson.
    - **Discussion**: None.
    - **Result**: No objection to approval of May minutes as presented. Minutes approved.
- **Motion** by Cammy Taylor to approve the August 5 regular meeting minutes as presented. **Second** by Nan Thompson.
    - **Discussion**: None.
    - **Result**: No objection to approval of August minutes as presented. Minutes approved.

The August 19 modernization subcommittee meeting minutes were also provided for reference.

Ethics Disclosure

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

- No disclosures were stated by members.

Item 2. Public Comment

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

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

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

Public Comments

- Gary Newman, Fairbanks. Mr. Newman was employed by the University of Alaska, and served on its health care advisory board for several years. During his time, the board reviewed

preventive health care coverage, and supported including these benefits with their health plan. He personally supports adding preventive benefits, appreciates the Division and RHPAB working on this, and believes it will support members' health: it is easier to prevent something than to have to treat it later, and he believes this proposal has the potential to help reduce health plan costs over time.

He also shared a comment about Teladoc: he understands that Teladoc was previously offered through the retiree plan. Telehealth has been a great resource for people to access care without having to travel, and he noted that currently hospitals are stressed with COVID patients and that having other options for healthcare is important. He understands there is a cost to providing this service, but believes it would be worth the cost.

Item 3. Review of Public Comments Received

Materials: Summary of public comments, shared as separate item for the 9/9/21 agenda packet

Judy Salo asked Emily Ricci to share a summary of public comments:

The Division held a public comment period on these two proposals from August 11 to August 27, then extended the deadline one week to September 3.

Rather than attempting to summarize the comments and risk misrepresenting or leaving out people's perspectives, staff decided to simply provide the Board all comments and let them review as is (with appropriate redactions of personal health information, contact information, etc.), to ensure people's views are accurately represented.

She noted some highlights:

- Most comments were about the preventive benefits proposal, generally in support of this idea.
- Many people requested inclusion of a Silver Sneakers or similar fitness benefit. As discussed previously, the Division considered whether and how this could be provided, including through a Medicare Advantage plan, but it determined not to be feasible to include in the retiree plan itself, because of the structure of this particular plan. Staff are aware that this is an often-requested program, and that many people appreciate having it.
- There were a number of comments about the prior authorization proposal; members were concerned about barriers of access to care, especially if their prescription was denied. There is concern about an insurance company making a decision, versus a person's physician.
- A few comments about the prior authorization proposal were supportive, describing their own experience with specialty medications and the value of clinical review. However, most were concerned about or had questions about the proposal, and expressed worries about whether it would be a barrier to accessing care, or result in a denial of a necessary medication. Several comments indicated a lack of understanding about the specific details of the proposal, so this gives staff a better understanding about what misunderstandings are happening, and what needs to be addressed more carefully in member communications.
- There were also several comments about removing the lifetime maximum, and when the Division may act on that proposal. This has been discussed in the past, but is not included in this set of proposals. Staff will continue working on this item.

Judy invited Board members to share any comments and questions they received about these proposals.

- Dallas Hargrave shared that he noted several questions related to the process, and that some people were concerned about whether this met a required public comment period, which is typically 30 days; they were concerned that it was less than 30 days. He noted that, given the number of comments, he believed it was sufficient time to comment, but also values process and the importance of providing adequate time for comment. He asked whether staff were required to use a 30-day comment period, and why this timeframe was chosen.
    - Emily responded staff also greatly value process: they also see the Board, in quarterly meetings, committee meetings and their communications with members, as an important part of the process overall. The period was not 30 days, due to a short implementation timeline and the need to work with the third party administrator (OptumRx) to prepare for this change, from updating coding to member outreach. In order to give 60 days' notice for prior authorization, for example, OptumRx will need to reach out to members with current prescriptions at the beginning of November
      The timeline is also compressed because of ongoing litigation, and staff time needed to prepare for trial: they were expecting to go to trial next week (week of September 13), but this has been postponed at short notice, so they were unable to pause in preparation for this until shortly beforehand.
      Emily noted that the comment period was approximately 3.5 weeks, from August 11 to September 3, including the extension of a week (originally August 27). The Division also mailed a postcard to all members notifying them of the proposed changes and inviting comment, and hosted a special Tele Town Hall on September 1 to share information about the proposals and answer questions.
      Additionally, the Division is always accepting public comments, and shares these with the Board. It takes time to redact contact information, review and redact any potential personal health information that cannot be shared, and prepare the comments for publication. This takes time to ensure they are protecting members' privacy.
- Judy shared that she felt the postcard notification was very helpful for members.
- Cammy Taylor received several comments with concerns about prioritizing cost savings, and what standards will be used to make care decisions. She noted the materials were helpful, and outlined the details of the proposal that helped the Board and members understand what's being proposed.
  She also received comments that people are concerned about and want to ensure continuity of care, meaning no interruption in accessing critical medications, and that OptumRx needs to be mindful of this. She also heard concerns about potential access issues, from timely approval and access to medications people rely on for complex conditions, to access in rural areas where it is difficult to quickly access a pharmacy. She also noted people were concerned about an insurance company approving prescriptions without clinical review or context for what the condition is and whether that medication is needed, so the safety aspects of the prior authorization. She is aware the Division can implement prior authorization, as a policy, and appreciated the opportunity to discuss the implementation concerns, review the proposal in detail, and discuss members' concerns and any potential issues in advance.
- Lorne Bretz observed there were many comments, he appreciated that people shared their views and concerns. He also saw many questions shared, and asked whether the Division responds to questions in public comments?

    - Emily explained staff do not directly respond to public comments as a policy, but they are developing an FAQ to address those questions that come up often. Staff also encourage members to call the Division directly, or in this case OptumRx, with questions about their own situations. This will be especially important during implementation, when people are notified and want to understand how a change impacts them.
- Lorne also noted several people wanted an opt-in policy, rather than this change applying across the board. Was an opt-in policy considered? And/or, did the Division consider adopting one of the proposals and not the other—are they necessarily tied together?
    - Emily responded she understands the interest in an opt-in policy. She noted the plan is constrained by the need to balance any additional costs or benefits to the plan, in terms of actuarial value and benefit level, and not increase this without either an offset or a cost-neutral proposal, because of their responsibility for the long-term fiscal health of the plan. She noted in this case, the prior authorization proposal isn't actually an offset: the preventive care benefits are an additional benefit, which they believe will not significantly increase the cost, but will have significant health impacts for members. Prior authorization is not a change in benefits, but an additional check in the process that will help protect members against potential risks of specialty medications by adding clinical review.
- Lorne also asked whether what the provision are in the Defined Contribution (DCR) plan, does the DCR plan have these benefits?
    - Emily noted that the DCR plan (versus the Defined Benefit plan) has preventive benefits as well as prior authorization, and matches more closely the employee plan, which has more prior authorization and other controls built in. These policies are already in place.
- Lorne also asked whether it's possible to model the changes on the dental plan, which he understands is an optional benefit?
    - Emily responded yes, the dental plan is considered optional, the medical plan is not. There is still outstanding legal questions about whether changes to the dental plan are considered diminishments, such as changes to premiums.
- Lorne clarified he was referring to the opt-in or choice of plans, and whether that was possible to include in the medical plan like it is in the dental plan.
    - Emily responded having two medical plans with these policies would be difficult and costly to manage, and not something the Division is prepared to set up. They have discussed optional plans for some benefits, such as Medicare Advantage, but this is different than adding benefits or opt-in choices to the core plan. The additional cost of implementing and maintaining two plans would not be feasible.
- Dallas noted that he did not have additional concerns to share, but reviewed all the comments, and found the given summary accurate.
- Nan commented there were the most comments and interest in the preventive benefits plan, she appreciated the process and that people responded to the request for comments. She noted that several of the questions she got she could answer, but that there were several that should be responded, she will ask those today. She also saw some questions and comments that reflect lack of understanding of what's proposed and could be clarified, to help alleviate members' concerns. She also advocated for a Silver Sneakers plan to be included, but understands the reasons why this isn't feasible in the plan currently.

- Nan saw two shared two major concerns: transparency and timing. People were concerned about having benefits and access to those benefits limited, including by delays in the process. To address this, she believes that transparency and responding quickly to members' requests—including any incomplete requests, denials, etc.—will help. No one wants to create more barriers or burden for people already in challenging health situations. She is interested in having a good implementation, and hopes it will be smooth and well-planned, like staff have done with prior implementations such as for EGWP. She is confident it will be handled well, but will also be watching closely and hoping the Division ensures members' concerns are addressed.
- Nan saw several comments concerned that this driven by the insurance company's push to save money: she clarified that the State, not the insurance company, has brought this proposal, and it does not impact how services to the TPA are paid for, or that savings would accrue back to them. If there are any savings, as projected there will be, they would accrue back to the State and the fund that resources the health plan. She sees these policies not as cost savings, but stewardship of public resources. She also noted the prior authorization change is a process change, not a change in benefits. She appreciated that rather than the Division just imposing this with no discussion, they used a thorough process to review impacts, discuss the proposal, seek member comments and work to address questions and concerns . She did not believe this was an offset, but noted that is a legal issue to be addressed by the courts if needed.
- Nan noted that several people who have serious conditions were concerned and shared specific questions and worries about how this would impact their ability to get prescriptions. She urged the Division to follow up and help people in this situation, to minimize any impacts on them.
- Nan also noted that people have long memories, and bring up issues or problems with implementation of prior changes from several years ago. She understands that people don't forget those frustrations or challenges, and that trust takes time to rebuild; there has been a lot of distrust of the State because of prior actions. She believes that hasn't been the case lately, given the care taken in discussing and implementing any changes, but also noted these concerns are valid.
- Nan asked for reference, in the employee plan, how many pharmacy related claims or prior authorizations have been denied? How many appeals? Do staff anticipate a lot of denials?
    - Emily responded it is difficult to compare, the employee plan has more controls in place beyond this prior authorization component. But she believes the number per year is less than 50. Staff can research this.
    - Sara Guidry researched the number and shared later in discussion: in one year, the employee plan had 47 level-1 appeals for pharmacy claims, and, 8 level-2 appeals.
- Nan asked how the Division tracks implementation problems or issues, and how they plan to address these?
    - Emily responded, staff will work through the process in detail, identify anything that could possibly go wrong, brainstorm potential problems in advance and outline mitigation or prevention steps. During implementation, which would begin this fall, they will use a similar process to EGWP's implementation. For example, at that time they needed to review whether people had medications covered by Medicare Part B versus Part D. That was a larger number of people than this group with specialty medication prescriptions. They are currently identifying people impacted, and who need to be

contacted via letter. This will be information from September's claims, but letters will be sent in November by Optum.

- During this same period (before the Jan 1 implementation date) staff would receive biweekly updates on who had completed the process. This moved to weekly updates closer to the date. They identified how to outreach to members who hadn't taken action yet. Depending on the number who they would need a response from, they would do a large communication or (if a small number) individual phone calls. They would also review the process with individual cases as a quality control measure: identifying which and how many prior authorization processes were approved, abandoned, denied or have a negative outcome.
- On a regular basis, staff also conduct regular reviews of appeals, quarterly typically, but they will also plan to do monthly appeals review of the pharmacy plan during this initial period. The team also does quality control of appeals, looking at a sample of cases for whether they were completed and done correctly.
- The team also regularly reviews complaints on a monthly basis, which may not have had an appeal associated, but which represent issues people experience with using benefits. This may have to od with customer service, timeliness of processing, etc.
- Lastly, staff are available to work with members directly, the member liaison position is tasked with this, as well as their call center. The liaison can help individual members work through the process or address their specific questions.
- Nan thanked staff for the overview, and looks forward to implementation.

- Nan also asked, how will a person who has tried existing drugs (FDA approved, commercially available) and found these are not effective, and instead would like to participate in a clinical trial for a new drug that hasn't been approved yet. How would the prior authorization process impact a clinical trial participation, would it create a barrier?
  - Sara Guidry shared this would not be a barrier, as clinical trials for drugs that aren't approved are handled through the clinical trial itself, and not covered or paid for by the plan. There would not be a claim submitted to the plan, so no need for authorization.
- Judy shared what she heard from others, a lot of interest and gratitude for adding preventive care benefits, and several questions, many of which she was able to respond to or were addressed today. She reiterated that the postcard was very helpful to inform people.

Item 4. Board Discussion

Judy transitioned to board discussion, and encouraged robust discussion among the members. She noted that the Board takes few votes, which are advisory, and wants to make sure the topic is amply covered before the vote.

- Lorne asked whether there was a summary analysis or tally of the public comments' positions on the proposals? He wondered how many supported, opposed or had questions.
  - Emily: Staff did not quantify the numbers in the comments, but could do this during the meeting today. She noted that the vast majority of comments on the preventive care proposal were supportive. She also noted this is the primary complaint from members on a regular basis, that the plan does not currently cover these benefits.

- She noted that several comments opposing the prior authorization proposal were describing it as a diminishment, which reflects a misunderstanding of the proposal that staff will work to address. Staff are working on an FAQ with many of the questions raised in the comments.

Preventive Care Proposal Discussion

Materials: Summary proposal beginning page 50 in 9/9/21 meeting packet

- Judy asked whether Medicare eligible people will have less coverage than those who aren't Medicare eligible, if their preventive benefits do not cover certain things that this plan will cover. Or, will this operate like EGWP and other provisions, where AlaskaCare will be secondary coverage and pick up what isn't covered by Medicare?
  - Emily responded the plan is secondary to Medicare, but like other benefits, this is correct, it would be covered by AlaskaCare provided the service is eligible under that plan and for that member (meaning, they meet age or risk factor requirements). She asked Richard Ward to also respond.
  - Richard shared for the most part, the preventive benefits as proposed (following Aetna's policy) match Medicare coverage. There are some things that Medicare doesn't cover, but these would be covered by the AlaskaCare plan in that case.
  - Emily noted that in the proposal (starting page 51 in the packet) there is a list of comparison with the proposed benefit coverage and Medicare, detailing the differences for a few policies. Examples: mammograms (page 55) and Pap smears (page 56). She noted that often coverage depends on gender, age, risk factors and other prior history, so it's difficult to indicate one overall coverage for a procedure, whether it is covered and the frequency of coverage.
- Judy: This will be important to address, and inform members about. For example, she is aware of several issues with Medicare coverage of chiropractic care, with many members having issues with coverage for those services. She suggested identifying coverage issues like this upfront, and educating members about how this will impact Medicare eligible people.
  - Andrew Robison responded generally speaking, Aetna reviews and coordinates with Medicare benefits, and is used to reviewing and processing secondary benefits through a different plan. He believes many of these claims will need to be manually processed to ensure they are handled correctly.
- Dallas shared after reflecting on the comments and hearing others' summary, he felt what's been said matches his understanding and thoughts. He appreciates the process the Division has had to work through these proposals with the Board and with members. He believes it makes sense, and plans to support both proposals.
- Cammy noted that preventive benefits have been a big topic of discussion and great interest to members since the Board was formed, back to its first meeting in 2018. She is pleased to see this moving forward.

  She asked, for out of network providers who people without in-network options will want to see, how does the waiver or exemption process work, so they can access preventive care without paying an additional amount since they have no network option? Is this something the member needs to proactively take care of now, or will Aetna have a way to determine this automatically, such as based on their geography? What if anything should members do now?

    - Emily responded for the most part, it is a geographic determination, Aetna will be able to make this determination. The challenge would be addressing an issue where a provider isn't accepting new patients, so it may look like an in-network option is available that isn't. Aetna and the Division can't know this in advance, so this is something the member would need to notify about and request an exemption.
    - Andrew Robison added the main concern he anticipates is Medicare eligible people who have no available primary care option in their area who accepts Medicare—this will be an issue for Alaska retirees in particular, and will need proactive attention.
    - Emily noted that Andrea Mueca and the operations team will be reviewing this situation, among others, and will determine how to address it upfront as much as possible for members who may be impacted by this issue. Staff can do outreach to members in these areas and encourage them to seek an exemption or waiver upfront, so that this is on file when they actually need to utilize care.
    - Cammy noted for retirees on this plan, the network provisions are new, so it will be important to do that outreach for members who aren't used to needing to find in-network providers for medical care under this plan.
- Judy asked whether and how travel costs will be covered for preventive services, is this now covered as well?
    - Emily agreed this is something staff need to review, particularly for people with limited care options in their area and who travel for care. Since preventive benefits have not been covered before, it is unclear how much people will also utilize travel to use these benefits. This is something to monitor.
- Nan shared her strong support for the preventive care, she noted she was surprised about the lack of coverage when she retired, before she was Medicare eligible. She encouraged the Division to educate members about how to find available providers, how to identify who is in network, and how to request an exemption, especially for retirees in rural areas. She noted that many members are in rural areas and have limited or no choices, so helping them find options will be important.

Specialty Pharmacy Prior Authorization Proposal Discussion

Materials: Summary proposal beginning page 113 in 9/9/21 meeting packet

Judy invited Board member comments on the second proposal.

- Nan: She reiterated her prior comments and recommendations, especially minimizing impacts and any barriers for people with serious conditions who need these medications. She is hopeful that most people will not notice, given the implementation process planned, but will be monitoring this. She thanked the Division for their process and attention to implementation, and hopes it is a similarly smooth process to the EGWP implementation. She sees RHPAB's role as supporting good stewardship of the health plan and public funds, and this is consistent with that. She plans to vote in support.
- Lorne: No additional comments.
- Cammy recommended that the letter notice needs to go to the prescriber, not just to the member. She noted that currently it is challenging to contact provider offices, with short staffing across the board, especially for specialty providers. Proactive outreach will be very important to ensure that providers have notice and time to file the paperwork, especially if they have less

capacity to do administrative work right now. She also encouraged the Division to ensure that OptumRx has a strong concierge service and support for members with questions.

- Dallas echoed Nan's comments about stewardship, and appreciated the process and time that staff took to prepare this effort. He plans to support these proposals.
- Judy again encouraged as much notice and outreach as possible to members, particularly those with specialty medications who may be impacted, so the Division and OptumRx have ample time to troubleshoot issues and help members with the necessary steps if they do need a prior authorization.

Item 5. Board Advisory Vote: Resolution 2021-01

Materials: DRAFT Resolution 2021-01, shared as separate item for the 9/9/21 agenda packet

Judy requested a motion to approve Resolution 2021-01. The resolution expresses the Retiree Health Plan Advisory Board's support for both proposed health plan policies: adding preventive benefits and implementing the specialty pharmacy prior authorization process.

Board Advisory Vote: Preventive Care Benefits

- **Motion** by Nan Thompson to adopt Resolution 2021-01. **Second** by Dallas Hargrave.
- **Discussion:** Judy invited a review of each clause in the resolution, and any proposed amendments:
    - Clause 1 (Board purpose): no comments
    - Clause 2 (AlaskaCare plan and health trusts): no comments
    - Clause 3 (purpose of expanding preventive care benefits):

      Cammy Taylor moved amendment 1 (below), second by Nan Thompson.
        - Cammy proposed an amendment also noting that the clinical care standards are aligned with the Affordable Care Act (ACA), not just the TPA's own standards. "… **<u>designed to align with national standards and</u>** third party…"
        - Emily cautioned that because the retiree health plan is not subject to the provisions of the ACA, so this should not be referenced as a requirement.
        - Ajay suggested that reference to the requirements of the ACA could be confusing, because it is not subject to that plan. He expressed concern about whether this would set up an expectation or obligation to change coverage as a result of changes to ACA requirements. He suggested there could be reference to the employee plan instead, since it aligns with this.
        - Judy shared concern about whether referring to the employee plan, which is a separate plan negotiated via a collective bargaining agreement, would also not be useful.
        - Emily suggested "align with national standards" instead: the group agreed this is acceptable.

      Vote: Amendment 1 passes.

Bretz	Hargrave	Harrison	Salo	Taylor	Thompson
No Objection	No Objection	Absent	No Objection	No Objection	No Objection

    - Clause 4 (expansion of preventive care): no comments

- Clause 5 (pharmacy benefits):
  Nan Thompson moved amendment #2 (two changes below; see also Clause 7 notes), second by Cammy Taylor.
  - Emily: recommended moving the clause from Clause 7 to Clause 5, and adding to the fourth clause as follows: "**… however, the plan does not currently have a prior authorization process in place for specialty medications filled through a pharmacy**." This reflects the fact that the medical plan, which does already cover some medications, already has prior authorization in place.
- Clause 6 (purpose of prior authorization policies): no comments
- Clause 7 (current cost of specialty medications to the plan):
  - Nan: What does the term "utilizers" mean here?
    Betsy: This language is from the proposal. She noted that the term reflects that while all members have pharmacy coverage, not all members utilize the plan year to year. "Utilizers" refers to people who filled one or more prescriptions in a year, not the total membership. She also noted that because people may fill more than one, the total number of prescriptions is related to utilizers but not the same count.
    Nan: Recommend changing language to describe the term more clearly:
    "(associated with 3.7% of ~~utilizers~~ members filling prescriptions in 2020"
  - Judy: Concern about the wording in the first part of the clause, it is confusing.
    Betsy: Recommend striking "~~the plan does not currently have a prior authorization process in place for specialty medications, though~~"

  Vote: Amendment 2 passes.

Bretz	Hargrave	Harrison	Salo	Taylor	Thompson
No Objection	No Objection	Absent	No Objection	No Objection	No Objection

- Clause 8 (purpose of prior authorization): no comments
- **Cammy Taylor moved amendment 3, adding a new Clause 9 after current Clause 8 (below). Nan Thompson second.**
  "**Whereas the prior authorization criteria will be based on evidence-based medicine and guidelines from national specialty societies, and not on cost or the use of step therapy.**" She noted that it has been clear throughout that step therapy and cost controls are not what is being implemented, this reaffirms that.
  Vote: Amendment 3 passes.

Bretz	Hargrave	Harrison	Salo	Taylor	Thompson
No Objection	No Objection	Absent	No Objection	No Objection	No Objection

- Clause 10:
  Judy asked for clarification about what is meant by "no change to the amount that retirees pay," and if this should be reworded to be more clear.
  Cammy Taylor moved amendment 4 (below). Nan Thompson second.

"~~there will be no change to the amount retirees pay for their medications~~ member copayments will remain $4 for generic medications, $8 for brand medications, and $0 medications filled via mail order"

- Clause 11 (Division proposed prior authorization policy): no comments
- Clause 12 (anticipated actuarial value increase, preventive): no comments
- Clause 13 (anticipated actuarial value increase, prior auth): no comments
- Clause 14 (anticipated long term liability reduction): no comments
- Clause 15 (Division analysis of proposal): no comments
- Clause 16 (public comment process): no comments
- Clause 17 ("therefore be it resolved, support both of these proposals"): no comments

- **Discussion**: None.
- **Result**: The board voted on Resolution 2021-01. Judy Salo asked for a roll call vote. Item passes with 4 yes, 1 abstention**.**

Bretz	Hargrave	Harrison	Salo	Taylor	Thompson
Abstain	Yes	Absent	Yes	Yes	Yes

Item 7. Closing Thoughts + Meeting Adjournment

2021 Board Meetings

The board's meetings are scheduled as follows for the remainder of 2021. For regular meetings, quarterly vendor meetings will be held the day before (Wednesday).

- Thursday, November 4, 2021 (regular quarterly meeting)

Judy Salo noted that the Division and Board will determine closer to the meeting date whether the meeting is held virtually or in person, depending on current conditions.

Closing Thoughts

- Judy thanked staff for their excellent work on this process, and the Board for their work over the years in vetting and working with staff to refine the proposals.
- Lorne Bretz commented that he appreciated receiving all public comments directly, rather than just a summary from staff.
- Nan Thompson thanked Judy Salo for doing a great job chairing the meeting.

Motion by Lorne Bretz to adjourn the meeting. **Second** by Nan Thompson.
Result: No objection to adjournment. The meeting was adjourned at 10:58.

The next Retiree Health Plan Advisory Board meeting will be Thursday, November 4, 2021.

Check RHPAB's web page closer to the meeting to confirm the schedule, location and to download materials for upcoming meetings. http://doa.alaska.gov/drb/alaskacare/retiree/advisory.html.

AlaskaCare Retiree Health Plan
Addition of Coverage for Preventive Care and Prior Authorization for Specialty Medications
Implementation Activities

September

- RHPAB Advisory Vote
- Commissioner Approval
- Implementation Begins

October - December

- Plan booklet updates
- Plan coding updates
- Claim processing setup
- Log early prior authorization requests
- Targeted member outreach
- Training for Aetna, OptumRx, and DRB call centers
- Member communication (web updates, newsletters, townhalls)

January

Go Live!

- Monitor member experience
- Respond to member escalations
- Monitor reporting
- Continue member communication

Proposed Changes to the 2022 AlaskaCare Retiree Health Plan Booklet

The Department of Administration, Division of Retirement and Benefits, proposes to adopt changes to the AlaskaCare Defined Benefit and Defined Contribution Retiree Health Plan Booklets, effective for the 2022 plan year.

The proposed plan booklet updates have been posted at www.AlaskaCare.gov.

All comments must be received no later than 4:30 p.m. on November 19, 2021.

Members of the public may comment on the proposed plan booklet changes by submitting written comments:

By Mail: State of Alaska Department of Administration

Division of Retirement and Benefits

PO Box 110203, Juneau AK 99811-0203

By Email: doa.drb.alaskacare.retiree.plan@alaska.gov.

AlaskaCare Retiree DB Insurance Information Booklet

Summary of Updates for Plan Year 2022

The table below outlines updates made to the AlaskaCare Retiree DB Insurance Information booklet effective January 1, 2022. The updates were primarily in response to *RHPAB Resolution 2021-01* related to the addition of prior authorizations for certain specialty medications and coverage for preventive care services for the AlaskaCare Defined Benefit Retiree Health Plan.

Legend:	Items highlighted in green were added.
	Items highlighted in yellow were updated
	Items highlighted in orange were removed.

<table>
<tr><th>2022 Plan Booklet Language</th><th>2021 Plan Booklet Language</th></tr>
<tr><td>
Section 1.1 Medical Benefits
New language added to support RHPAB Resolution 2021-01.
Coinsurance
<table>
<tr><td>Preventive care with a network provider or when use of an out-of-network provider has been precertified.
No deductible applies</td><td>100%</td></tr>
<tr><td>Preventive care with an out-of-network provider</td><td>80%</td></tr>
</table>
Out of Pocket Limit

Applies after the deductible is satisfied
Expenses paid at a coinsurance rate different than 80% do not apply against the out-of-pocket limit
Preventive care expenses from an out-of-network provider do not apply against the out-of-pocket-limit (unless use of an out-of-network provider has been precertified)

</td><td></td></tr>
<tr><td>
Section 3.2 Precertification
New language added to support RHPAB Resolution 2021-01.
You may request precertification of use of an out-of-network provider for preventive services if there are no network provider options in your area.
</td><td></td></tr>
</table>

2022 Plan Booklet Language	2021 Plan Booklet Language
Section 3.2.1 Services Requiring Precertification • New language added to support *RHPAB Resolution 2021-01*. • Use of an out-of-network provider for preventive care services.	
Section 3.3.11 Preventive Care and Screening Services • New Section added to support *RHPAB Resolution 2021-01*. **Preventive Care and Screening Services** The purpose of providing preventive care benefits is to promote wellness, disease prevention and early detection by encouraging **covered persons** to have regular preventive examinations to identify potential health risks and provide the opportunity for early intervention. This section describes **covered expenses** for preventive care and supplies when you are well. The recommendations and guidelines referenced in this section will be updated periodically. This plan is subject to updated recommendations or guidelines that are issued by the following organizations beginning on the first day of the **benefit year**, one year after the recommendation or guideline is issued: a) Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; b) United States Preventive Services Task Force; c) Health Resources and Services Administration; and d) American Academy of Pediatric/Bright Futures Guidelines for Children and Adolescents. *Scope of Preventive Care Services* Services are considered preventive care when a **covered person**: a) does not have symptoms or any abnormal studies indicating an abnormality at the time the service is performed; b) has had a screening done within the age and gender guidelines recommended by the U.S. Preventive Services Task Force with the results being considered normal; c) has a diagnostic service with normal results, after which the **physician** recommends future	**Section 3.3.11 Radiation, X-rays and Laboratory Tests** The Medical Plan pays normal benefits for X-rays, radium treatments, and radioactive isotope treatments if you have specific symptoms. This includes diagnostic X-rays, lab tests, TENS therapy, and analyses performed while you are an inpatient. Charges for these services are not paid if related to a routine physical examination except as noted below. The plan provides coverage for the following routine lab tests: a) One pap smear per year for all women age 18 and older. b) Charges for a limited office visit to collect the pap smear are also covered. c) Prostate specific antigen (PSA) tests as follows: o One annual screening PSA test for men between ages 35 and 50 with a personal or family history of prostate cancer, and o One annual screening PSA test for men 50 years and older. d) Mammograms as follows: o One baseline mammogram between age 35 and 40, o One mammogram every two years between age 40 and 50, and o An annual mammogram at age 50 and above and for those with a personal or family history of breast cancer. These tests will be paid at normal plan benefits following the deductible. Other incidental lab procedures in connection with pap smears, PSA tests, and mammograms are not covered.

2022 Plan Booklet Language	2021 Plan Booklet Language
preventive care screenings using the appropriate age and gender guidelines recommended by the U.S. Preventive Services Task Force; or d) has a preventive service done that results in a diagnostic service being done at the same time because it is an integral part of the preventive service (*e.g.,* polyp removal during a preventive colonoscopy). If a health condition is diagnosed during a preventive care exam or screening, the preventive exam or screening still qualifies for preventive care coverage. Services are considered diagnostic care, and not preventive care, when: a) abnormal results on a previous preventive or diagnostic screening test requires further diagnostic testing or services; b) abnormal test results found on a previous preventive or diagnostic service requires the same test be repeated sooner than the normal age and gender guideline as recommended by the U.S. Preventive Services Task Force would require; or c) services are ordered due to current symptom(s) that require further diagnosis. *Coverage* Unless otherwise specified, preventive care services are not subject to a **copayment** or **deductible** and will be paid at 100% of the provider's rate, if the **provider** is a **network provider**. Preventive care services provided by an out-of-**network provider** are subject to payment under **medical plan** provisions governing non-preventive care services. If there are no **network providers** in the area where you live, you may contact **Aetna** and request to use an out-of-**network provider** for preventive care services under this section. If your request to use an out-of-**network provider** is authorized, the preventive care services you receive will not be subject to a **copayment** or **deductible** and will be paid at 100% of the **recognized charge**. If your request to use an out-of-**network provider** is denied, or if you fail to request **pre-certification**, all charges incurred for preventive care services will be subject to payment under the	

2022 Plan Booklet Language	2021 Plan Booklet Language
medical plan provisions governing non-preventive care services. Unless otherwise specified, preventive care services under this section are limited to once per **benefit year**. *Routine Physical Exams* **Covered expenses** include charges made by your **physician** or other **health professional** for routine physical exams. This includes routine vision and hearing screenings given as part of the routine physical exam. A routine exam is a medical exam given by a **physician** or other **health professional** for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**, and also includes: a) Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force. b) Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration Guidelines for Children and Adolescents. c) Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include, but are not limited to: • Screening and counseling services, such as: o Interpersonal and domestic violence; o Sexually transmitted diseases; and o Human Immune Deficiency Virus (HIV) infections. • Screening for gestational diabetes for women. • High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older. d) X-rays, lab, and other tests and radiological services given in connection with the exam. e) For covered children, from birth to age 2: • an initial **hospital** checkup • periodic well child exams • consultation between the health	

2022 Plan Booklet Language	2021 Plan Booklet Language
professional and a parent *Newborn hearing screening exam* Covered expenses include screening test for hearing loss prior to the date the child is 30 days old and diagnostic hearing evaluation if the initial screening test shows the child may have a hearing impairment. *Preventive Care Immunizations* **Covered expenses** include charges made by your **physician** or a provider for immunizations for infectious diseases that have been recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention: Immunizations for infectious disease; and materials for administration of immunizations. *Well Woman Preventive Visits* **Covered expenses** include charges made by your **physician,** obstetrician, or gynecologist for: a) A routine well woman preventive exam office visit, including pap smears. A routine well woman preventive exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**. b) Routine preventive care breast cancer genetic counseling and breast cancer (BRCA) gene blood testing. c) **Covered expenses** include charges made by a **physician** and lab for the BRCA gene blood test and charges made by a genetic counselor to interpret the test results and evaluate treatment. These benefits will be subject to any age; family history; and frequency guidelines that are: a) Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force; and b) Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration.	

Routine Cancer Screenings **Covered expenses** include, but are not limited to, charges incurred for routine cancer screening as follows: a) Colonoscopies (removal of polyps performed during a screening procedure is a **covered expense**); b) Digital rectal exams; c) Double contrast barium enemas (DCBE) d) Fecal occult blood tests; e) Lung cancer screening f) Mammograms; g) Prostate specific antigen (PSA) tests; and h) Sigmoidoscopies These benefits will be subject to guidelines on the basis of age, family history, and frequency that are: a) Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force; and b) Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration c) Found in the American Cancer Society guidelines for colorectal cancer screening *Preventive Screening and Counseling Services* **Covered expenses** include screening and counseling by your **health professional** for some conditions. a) Obesity and/or Healthy Diet Screening and counseling services to aid in weight reduction due to obesity. **Covered expenses** include: o Preventive counseling visits and /or risk factor reduction intervention; o Nutrition counseling; and o Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related disease. For persons age 22 and older, the **medical plan** will cover up to 26 visits per 12 consecutive months. However, of these only 10 visits will be allowed under the **medical plan** for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol)	

2022 Plan Booklet Language	2021 Plan Booklet Language
and other known risk factors for cardiovascular and diet related chronic disease. In determining the maximum visits, each session of up to one hour is equal to one visit. b) Misuse of Alcohol and/or Drugs Screening and counseling services to aid in prevention or reduction of the use of an alcohol agent or controlled substance. **Covered expenses** include preventive counseling visits, risk factor reduction intervention and a structured assessment. The **medical plan** will cover a maximum of five screening and preventive counseling visits of up to one hour in a 12 consecutive month period. These visits are separate from outpatient treatment visits. c) Use of Tobacco Products Screening and counseling services to aid in the cessation of the use of tobacco products. A tobacco product means a substance containing tobacco or nicotine including cigarettes, cigars, smoking tobacco, snuff, smokeless tobacco, and candy-like products that contain tobacco. Coverage includes the following to aid in the cessation of the use of tobacco products: o Preventive counseling visits; o Treatment visits; and o Class visits. o Tobacco cessation prescription and over-the-counter drugs o **Eligible health services** include FDA- approved **prescription drugs** and over-the-counter (OTC)drugs to help stop the use of tobacco products, when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing. The **medical plan** will cover a maximum of eight visits of up to one hour in a 12 consecutive month period. d) Sexually Transmitted Infections **Covered expenses** include the counseling services to help you prevent or reduce sexually transmitted infections.	

2022 Plan Booklet Language	2021 Plan Booklet Language
e) Genetic Risk counseling for Breast and Ovarian Cancer **Covered expenses** include counseling and evaluation services to help you assess whether or not you are at increased risk for breast and ovarian cancer. f) Prenatal Care Prenatal care will be covered as preventive care for pregnancy-related **physician** office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure, fetal heart rate check, and fundal height) received in a **physician**'s, obstetrician's, or gynecologist's office. g) Comprehensive Lactation Support and Counseling Services 1. Lactation Support **Covered expenses** include comprehensive lactation support (assistance and training in breast feeding) and counseling services provided to females during pregnancy, or at any time following delivery, for breast-feeding by a certified lactation support provider. **Covered expenses** also include the rental or purchase of breast-feeding equipment as described below. Lactation support and lactation counseling services are **covered expenses** when provided in either a group or individual setting. Benefits for lactation counseling services are subject to the visit a maximum of 6 visits in a 12 consecutive month period. Visits in excess of the lactation counseling maximum as shown above, are subject to the cost sharing provisions outlined in *Section 3.1 How Medical Benefits are Paid.* Coverage includes the rental or purchase of breast feeding **durable medical equipment** for the purpose of lactation support (pumping and storage of breast milk) as follows. 2. Breast Pump **Covered expenses** include the following: • The rental of a **hospital**-grade electric pump for a newborn **child** when the newborn **child** is confined in a **hospital**. • The purchase of:	

2022 Plan Booklet Language	2021 Plan Booklet Language
o An electric breast pump (non-hospital grade). A purchase will be covered once every three years; or o A manual breast pump. A purchase will be covered once per pregnancy. If an electric breast pump was purchased within the previous three-year period, the purchase of another breast pump will not be covered until a three-year period has elapsed from the last purchase. 3. Breast Pump Supplies Coverage is limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump. Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility. The plan reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided, as determined by the **claims administrator**. h) Family Planning Services – Female Contraceptives For females with reproductive capacity, **covered expenses** include those charges incurred for services and supplies that are provided to prevent pregnancy. All contraceptive methods, services and supplies covered under this preventive care benefit must be approved by the U.S. Food and Drug Administration (FDA). Coverage includes counseling services on contraceptive methods provided by a **physician**, obstetrician or gynecologist. Such counseling services are **covered expenses** when provided in either a group or individual setting. Contraceptive counseling services are subject to a two-visit maximum in a 12 consecutive month period. Visits in excess of this	

2022 Plan Booklet Language	2021 Plan Booklet Language
maximum are subject to the cost sharing provisions outlined in *Section 3.1 How Medical Benefits are Paid*. The following contraceptive methods are **covered expenses**: 1. Voluntary Sterilization **Covered expenses** include charges billed separately by the provider for female and male voluntary sterilization procedures and related services and supplies including, but not limited to, tubal ligation and sterilization implants for women. **Covered expenses** do not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement. 2. Contraceptives Contraceptives can be paid either as a medical benefit or **pharmacy** benefit depending on the type of expense and how and where the expense is incurred. Benefits are paid as a medical benefit for female contraceptive **prescription drug**s and devices (including any related services and supplies) when they are provided, administered, or removed, by a **physician** during an office visit. *Limitations* Not covered under the Preventive Care and Screening Services benefit are charges incurred for: 1. Diagnostic lab, diagnostic tests, diagnostic procedures, or other labs, tests or procedures ordered, or given, in connection with any of the preventive care benefits described above; 2. Exams given during your inpatient stay for medical care; 3. Services not given by a **physician** or under his or her direction; 4. Immunizations that are not considered preventive care such as those required due to your employment or travel; 5. Pregnancy expenses (other than prenatal care as described above); 6. Services and supplies incurred for an abortion; 7. Services as a result of complications resulting from voluntary sterilization procedure and related follow-up care;	

2022 Plan Booklet Language	2021 Plan Booklet Language
8. Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA; 9. Male contraceptive methods, sterilization procedures or devices; 10. The reversal of voluntary sterilization procedures, including any related follow-up care; or 11. Charges incurred for family planning services while confined as an inpatient in a **hospital** or other **facility** for medical care.	
Section 3.3.18 Travel • Updated to clarify return transportation. a) Transportation to the nearest hospital by professional ambulance. A professional ambulance is a land or air vehicle specially equipped to transport injured or sick people to a destination capable of caring for them upon arrival. Specially equipped means the vehicle contains the appropriate stretcher, oxygen, and other medical equipment necessary for patient care enroute. A medical technician trained in lifesaving services accompanies the transported patient. Following an emergent event, returning transportation costs to the site of illness or injury may be covered subject to the provisions as outlined in section b.	a) Transportation to the nearest hospital by professional ambulance. A professional ambulance is a land or air vehicle specially equipped to transport injured or sick people to a destination capable of caring for them upon arrival. Specially equipped means the vehicle contains the appropriate stretcher, oxygen, and other medical equipment necessary for patient care enroute. A medical technician trained in lifesaving services accompanies the transported patient
Section 3.3.20 Medical Treatment of Mouth, Jaws and Teeth • Updated bullet d) to reflect new standard of care. d) Dental implants if necessary due to disease, including periodontal disease, or accident. False teeth for use with the implants are covered only under the *dental plan* as a Class III service.	d) Dental implants if necessary due to disease, including periodontal disease, or accident but only if dentures or bridges are inappropriate or ineffective. False teeth for use with the implants are covered only under the *dental plan* as a Class III service.
Section 3.3.25 COVID-19 Vaccinations • Update to clarify COVID vaccine coverage. COVID-19 Vaccinations The medical plan will cover FDA approved COVID-19 vaccinations at 100%, subject to recognized charge	COVID-19 Vaccinations The medical plan will cover FDA approved COVID-19 vaccinations at 100%, subject to recognized charge.

2022 Plan Booklet Language	2021 Plan Booklet Language
through the end of the COVID-19 national public health emergency. The medical plan will cover medically necessary, FDA approved COVID-19 vaccinations per *section 4.4 Covered Vaccines* once the COVID-19 national public health emergency ends. (See *section 4.4, Covered Vaccines)*.	
Section 4.4 Covered Vaccines • Section 4.3.5 was replaced with 4.4 to align with *RHPAB Resolution 2021-01*. In addition to the immunizations covered under *section 3.3.11, Preventive Care and Screening Services*, **covered expenses** include other immunizations for communicable diseases, including serums administered by a nurse or **physician**. Charges for office visits in connection with the immunizations are not covered.	**Section 4.3.5 Covered Vaccines** **Medicare Part D-Eligible Vaccines** The pharmacy benefits under the Plan cover some vaccines regardless of whether you are eligible for Medicare. Covered vaccines are listed in the formulary available at AlaskaCare.gov under the therapeutic drug class "viral vaccine". Vaccines covered under the pharmacy plan are those that fall on the Medicare Part D covered vaccine list that are: a) Vaccines administered at the pharmacy. b) Vaccines administered in a doctor's office **only if** they coordinate with a pharmacy to bill the Plan for the entire cost of the vaccination, including the injection of the vaccine. c) If you receive a vaccination in a doctor's office that does not coordinate with a pharmacy, your provider will bill you for the entire cost of the vaccination. You will have to pay the entire bill up front and request reimbursement from the pharmacy benefits manager. It is important to know that your provider may charge you more than the recognized charge amount for the vaccination, but your plan will only reimburse up to the approved amount. You will be responsible for any amount you pay the provider above the recognized charge. Vaccines that are not covered by the Plan include: a) Influenza vaccines (flu shots), including seasonal flu vaccine and the H1N1 (swine flu) vaccine. b) Pneumococcal vaccine (pneumonia shot). For a complete list of vaccines and participating pharmacies contact the pharmacy benefit manager 24 hours a day, 7 days a week or visit the Division's

2022 Plan Booklet Language	2021 Plan Booklet Language
	website at *AlaskaCare.gov*. **COVID-19 Vaccines** The pharmacy benefits under the Plan will cover FDA approved COVID-19 vaccinations at 100%, subject to recognized charge.
Section 5.1 Limitations and Exclusions • Updated to align with *RHPAB Resolution 2021-01*. Marital examinations except as provided in *section 3.3.11, Preventive Care and Screening Services*	Routine physical and marital examinations except as provided in *Section 3.3.11 Radiation, X-rays, and Laboratory Tests*
Section 7.6 Changing your DVA Coverage • Updated to clarify that you can increase coverage or change from or to the Standard or Legacy plans. You may increase coverage or change DVA plans only:	You may increase coverage only:

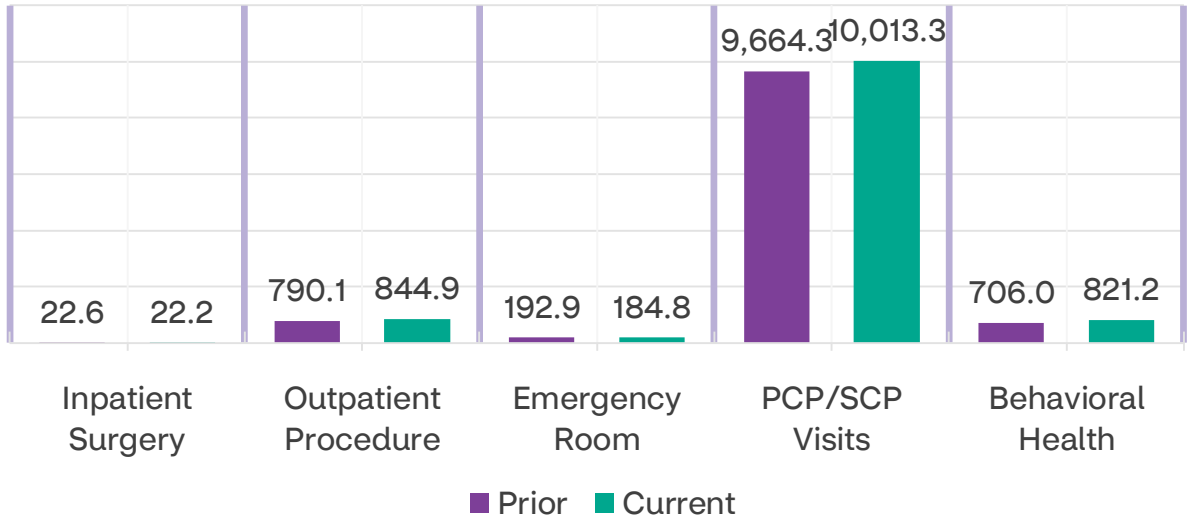
Overall Results

Why is this important? Important insight into overall healthcare changes in 2020 due to the COVID pandemic may have impacted healthcare utilization.

	Prior	Current	Change	Aetna BoB
% members using benefits	82.5%	84.2%	1.7%	85.0%
Telemedicine visits[1]/1,000	460.2	1,272.8	176.6%	978.5

[1]Represents all types of telemedicine visits including Teladoc® and Minute Clinic® virtual visits if applicable.

Utilization Per 1,000 Trends – Key Categories

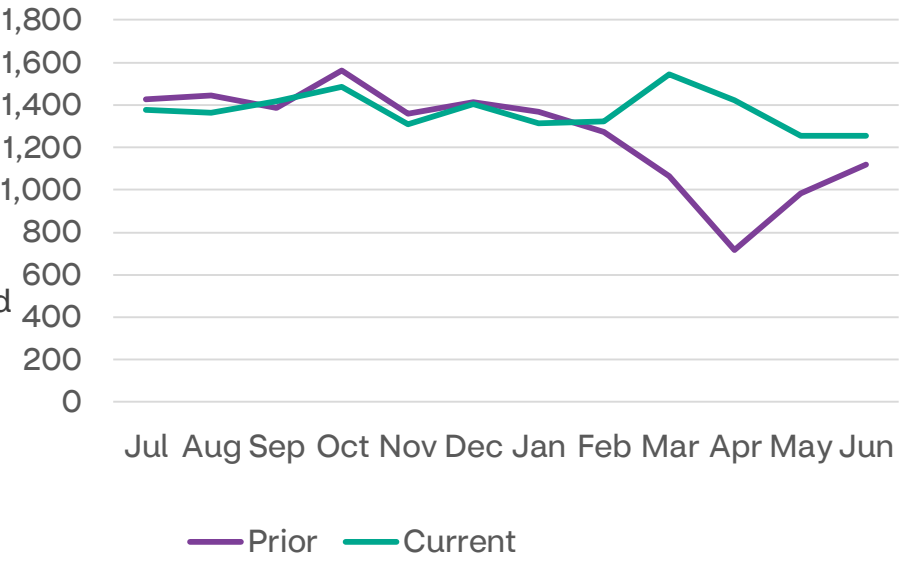


Total HealthCare Services

5.3%
PMPM Trend

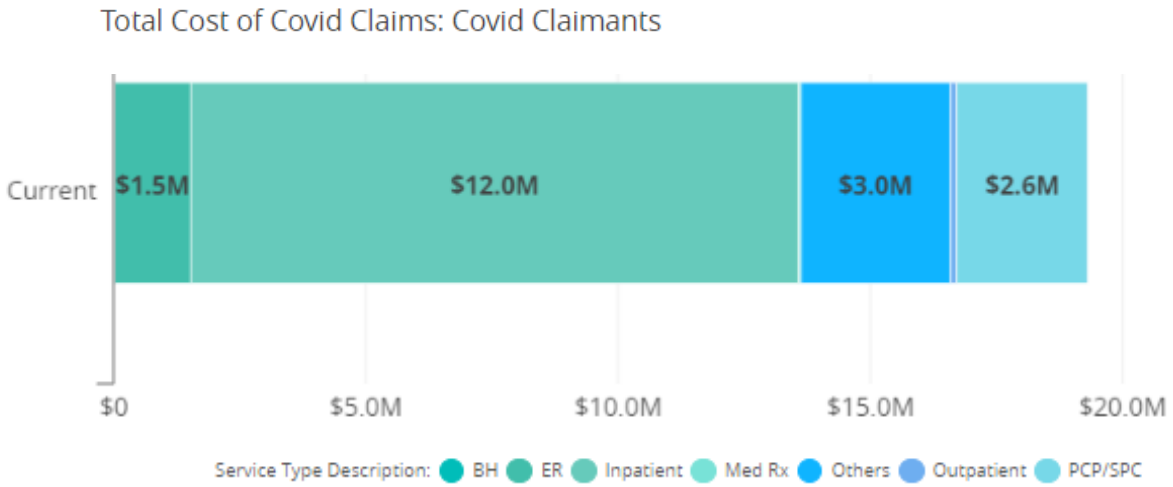
8.9%
Utilization Trend

Overall Utilization Per 1,000 Members



Impact of COVID-19 on Overall Results

Why is this important? Important insight into overall healthcare changes in 2020 due to the COVID pandemic may have impacted healthcare utilization.



Claimant Distribution	Claimants
Confirmed	1,967
Probable	11
Exposure	7,809
Lab Test Only	5,931

2.5% of Total Allowed attributed to COVID Claimants

15,718 Total Claimants

21,905 Total Virus Tests

1,713 Total Antibody Tests

Observations:

- *The current 12 months of data includes a period of returning utilization vs the prior period included significant drops in utilization.*
- *Telemedicine increased significantly as expected and is still well above the Aetna benchmark. Telemedicine begins to trail off in '21 but will remain higher than pre-pandemic levels.*
- *Outpatient utilization and cost is increasing due to deferred utilization in the Inpatient setting (members avoiding hospital Covid exposure)*

Long Term Care Valuation (June 30, 2021)

Retiree Health Plan Advisory Board

November 4, 2021

Segal

Background

- Established in 1987
- Available to all employees/retirees eligible for the DB and DC Plans
- 100% Voluntary (fully funded by participant premiums)
- Self-insured
- Approximately 29,000 policy holders
- Approximately 12,000 annual claims
  - About 500 open claimants at any given time
- Expenses total about $20,000,000 annually
- Well-funded and premiums have not changed since inception
- Bi-annual actuarial valuation

Four Plan Options

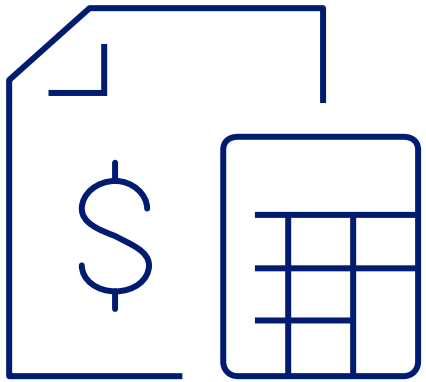
Benefit Summary by Plan Option

	Bronze*	Silver	Gold	Platinum
Enrollment (June 30, 2021)	**4,400**	**8,300**	**5,700**	**2,800**
Lifetime Max	$200,000*	$400,000	$300,000	$300,000
Inflation Protection	None	None	5% Simple to age 85	5% Compound to Age 85
Elimination Period	90 Day	90 Day	90 Day	90 Day
Benefit Trigger	2 of 5 ADLs	2 of 6 ADLs or CI	2 of 6 ADLs or CI	2 of 6 ADLs or CI
Nursing Home Daily Benefit	$125 in-state, $75 out-of-state	$200	$200	$200
Assisted Living Facility Daily Benefit	If approved	$150	$150	$150
Home Health Care Daily Benefit	$75 in-state, $40 out-of-state	$125	$125	$125
Hospice Daily Benefit	Not covered	$125	$125	$125
Respite Benefit	Not covered	Up to $200 daily, 14 days annually	Up to $200 daily, 14 days annually	Up to $200 daily, 14 days annually

* Eligibility limited to those retired prior to Feb 1, 2000

Valuation Methodology

- Similar to a pension valuation
- Project expected future expenses: claims and administration
- Project expected future income: premiums and investment returns
- Convert to present values at June 30, 2021 using 5% discount rate
- Assumptions include:
  - Mortality
  - Lapses (retiree discontinues paying premiums)
  - Morbidity (claim incidence, length, amount)



Valuation Results

Component	June 30, 2019	June 30, 2021	Change
1. PV of Future Benefits	$740,263	$779,931	$39,668
2. PV of Future Expenses	$7,108	$8,503	$1,395
3. PV of Future Premiums (PVFP)	$315,648	$336,381	$20,733
4. Valuation Liabilities (=3 – 1- 2)	($431,723)	($452,053)	($20,330)
5. Valuation Assets	$526,287	$696,258	$169,971
6. Valuation Margin (= 5 + 4)	$94,564	$244,205	$149,641
7. Margin as a % of PVFP (= 6/3)	30.0%	72.6%	42.6%
8. Funded Status (= 5/4)	121.9%	154.0%	32.1%

Margin increase driven by strong FY2021 investment returns

Historical Margin

Valuation Date	Margin (Assets – Liabilities)
June 30, 2009	$3,298
May 31, 2012	$30,280
June 30, 2015	$27,244
June 30, 2017	$7,372
June 30, 2019	$94,564
June 30, 2021	$244,205

Margin has fluctuated over time

Investment Performance

Investment Results ($000)			
Fiscal Year	Net Investment Income	Average Fund Balance	Fund Return
2013	$16,961	$274,218	6.2%
2014	$36,114	$305,279	11.8%
2015	$10,182	$341,080	3.0%
2016	$14,478	$376,669	3.8%
2017	$28,892	$415,207	7.0%
2018	$20,001	$456,686	4.4%
2019	$39,328	$502,959	7.8%
2020	$43,259	$562,536	7.7%
2021	$106,624	$649,736	16.4%
Average	$35,103	$482,184	7.3%

Returns have consistently exceeded 5% discount rate

Appendix

Premiums

Bronze Option - Monthly Rates	
May 1, 2000 Age	**Premium**
< 50	$16.10
50-54	$21.45
55-59	$26.80
60-64	$48.25
65-69	$80.45
70-74	$128.70
75-79	$193.05
80-84	$294.95
≥ 85	$412.90

Premiums

Age at enrollment	Silver Option $400,000 maximum No inflation protection	Gold Option $300,000 maximum Simple inflation protection	Platinum Option $300,000 maximum Compound inflation protection
≤ 40	$26	$76	$148
41	$27	$77	$150
42	$28	$78	$153
43	$30	$79	$155
44	$31	$81	$158
45	$33	$82	$161
46	$35	$84	$164
47	$37	$85	$167
48	$39	$89	$170
49	$41	$92	$172
50	$44	$96	$175
51	$46	$100	$177
52	$49	$103	$180
53	$52	$109	$184
54	$56	$114	$188
55	$60	$120	$192
56	$63	$126	$195
57	$67	$131	$199
58	$75	$143	$212
59	$84	$156	$225
60	$92	$168	$237

Premiums

Age at enrollment	Silver Option $400,000 maximum No inflation protection	Gold Option $300,000 maximum Simple inflation protection	Platinum Option $300,000 maximum Compound inflation protection
61	$100	$181	$250
62	$108	$193	$263
63	$123	$212	$281
64	$137	$231	$300
65	$151	$250	$319
66	$166	$269	$338
67	$180	$288	$357
68	$201	$313	$381
69	$222	$339	$404
70	$244	$364	$428
71	$265	$389	$451
72	$286	$414	$475
73	$314	$444	$502
74	$343	$474	$529
75	$371	$503	$556
76	$399	$533	$584
77	$427	$563	$611
78	$471	$609	$654
79	$515	$654	$698
80	$559	$700	$741
81	$603	$746	$784
82	$646	$791	$828
83	$731	$887	$923
84	$815	$982	$1,018
≥ 85	$900	$1,078	$1,113

ACTUARIAL VALUATION OF THE

STATE OF ALASKA LONG TERM CARE PROGRAM AS OF 6/30/2021

SEGAL

JULY 30, 2021

LEWIS & ELLIS
MR. BRIAN D. RANKIN, FSA, MAAA

CONTENTS

PURPOSE & SCOPE

BACKGROUND AND SCOPE

The Segal Company ("Segal") retained Lewis & Ellis, Inc. ("L&E") to perform an actuarial analysis of Alaska's Long-Term Care ("LTC") Program as of June 30, 2021. Specifically, our assignment was to develop a projection of future cash flows and to evaluate the adequacy of current assets and premium levels based on those cash flows.

This report summarizes the results of our actuarial valuation of Alaska's LTC Program as of June 30, 2021. Please note that this report is not meant to serve as complete actuarial documentation for this valuation. Additional data/information can be provided upon request.

We developed projected values using a seriatim projection model and we used those projected values along with current program financial information to determine the financial standing of the program. Consistent with the purpose of the valuation, no membership growth was assumed. The projection period is 60 years for the LTC in force. Gains and losses are accumulated at the effective earned rate over the projection period. The value at the end of the projection period could then be discounted at the earned rate to determine the magnitude of the deficiency reserve if the ending value was negative.

The projections of earnings are further dependent on numerous other assumptions that are outlined in detail in the following sections of this report. They are based on program experience where available and otherwise on our knowledge of industry experience. We have not generated liabilities and reserves consistent with statutory reporting requirements as this self-funded plan is not subject to such requirements.

Most of the data utilized by L&E in determining the values was obtained from State of Alaska representatives. We did not attempt to audit or verify the accuracy of this data; however, we did review the information for reasonableness and consistency. Any inaccuracies in this information could affect the results of this report, perhaps materially. The type of information provided includes, but is not limited to:

- Electronic listing of State of Alaska members;
- Claim payments from 2009 to May 31, 2021;
- Plan descriptions and gross premium rates for the model plan/age cells;
- Financial Statements for 2013-2021;

LIMITS ON DISTRIBUTION AND UTILIZATION

This report has been prepared for Segal and the State of Alaska. L&E has developed this report for the purpose and with the limitations stated above. When distributed, this report must be distributed in its entirety.

Although the valuation projects earnings, this report should not in any way be presented or construed as an actuarial appraisal in accordance with Actuarial Standards of Practice Number 19.

Any reader of this report must possess a substantial level of expertise in areas relevant to this analysis to appreciate the significance of the assumptions and the impact of these assumptions on the illustrated results. This report must be read in its entirety to be understood. The reader should be advised by, among other experts, an actuary competent in the area of actuarial projections of LTC blocks of business so as not to misinterpret any of the projected results.

In addition, any third party with access to this report acknowledges, as a condition of receipt, that L&E does not make any representations or warranty as to the accuracy or completeness of this report. This report is not intended as a representation of the future solvency of the Program and should not be viewed as such.

CONFIDENTIALITY OF REVIEW & RELIANCES

This actuarial valuation was performed based on the best estimate assumptions that are appropriate at the date of valuation. We do not reflect the potential for adverse deviations in actual future experiences in our best estimate assumptions. Assumptions could change as more information becomes known, which would impact the funded status reported in this valuation.

All source records and detail information are maintained at the Allen, Texas office of L&E, and members of L&E staff are available to explain any matter presented herein. Please direct any inquiries to Brian Rankin.

SUMMARY

The purpose of the remainder of this report is to provide analysis of the reserve adequacy for all plans. Premiums, benefits and expenses were projected for 60 years for the State of Alaska's LTC program and then discounted back to June 30, 2021 at an appropriate discount rate. This present value was then compared to the total assets at June 30, 2021[i] to determine if the current assets are sufficient to fund future claims and expenses for the next 60 years.

VALUATION RESULTS

The following table summarizes the present value of cash flows discounted at the net earned rates.

Component	6/30/2019 ($000)	6/30/2021 ($000)
1. PV of Future Benefits	$740,263	$779,931
2. PV of Future Expenses	$7,108	$8,503
3. PV of Future Premiums (PVFP)	$315,648	$336,381
4. Cash Flows (3-1-2)	($431,723)	($452,053)
5. Valuation Assets	$526,287	$696,258
6. Valuation Margin (5+4)	$94,564	$244,205
Margin as a % of PFVP (6/3)	30.0%	72.6%
Funded Status (5/4)	121.9%	154.0%

VALUATION MARGIN

The Valuation Margin has fluctuated over the last six years as a result of plan experience, investment returns, actuarial assumptions and the growth of the Program. The table below shows the margin/deficit for the Long-Term Care Program for the valuation reports beginning in 2009 ($000).

Valuation Date	Margin (Deficit) ($000)
June 30, 2009	$3,298
May 31, 2012	($70,875)
May 31, 2012 (Revised)	$30,289
June 30, 2015	$27,244
June 30, 2017	$7,372
June 30, 2019	$94,564
June 30, 2021	$244,205

[i] The census data for the projections were based on data as of 5/31/2021

METHODOLOGY

The present value calculations needed to compute Program liabilities consider expected future benefits, expenses and premium revenue discounted to the current valuation date. The present value calculations consider all future variables that affect the members' continued participation in the LTC Program, as well as the benefits or expenses they will generate.

Information was provided to Lewis & Ellis regarding program specifications and supporting data. Claims detail was provided through May 31, 2021. The remaining information was as of June 30, 2021. Seriatim records were used to project future premiums and claims using proprietary software and then summarized by various plans in spreadsheets. All items of income and expenses were projected, as well as all items affecting cash flows. The models recognize the timing of benefit payments, premium income, expenses and other significant cash flow items.

Appropriate considerations in plan modeling to major plans include the following:

- Type of coverage (nursing home, home health care, or both);
- Benefit period;
- Presence (or absence) of automatic inflation benefit;
- Level of premiums;
- Issue age range; and,
- Gender.

All of the above considerations were taken into account in determining the modeling for each individual.

ASSUMPTIONS

L&E relied on Alaska personnel to provide a variety of information and data on the LTC coverage in force. Although we did not independently verify nor audit this information supplied, we did review the information for reasonableness and consistency.

Alaska personnel supplied us with information regarding the gross premium rates, benefits, and coverage outlines for all of the LTC plans currently in force. The information was transmitted to us electronically.

Prior valuation assumptions were validated against recent program experience. Future experience is based on projected future claim costs. Actual results will almost certainly differ from projected results. Each assumption utilized for completing the calculations is shown in detail in the remainder of this section.

Loss ratios on Long Term Care business are typically quite low in the early durations, but increase significantly by policy duration and as the insured ages. Alaska's experience has been consistent

with this pattern. The State of Alaska has established the Retiree LTC Insurance Fund to support future LTC liabilities. As of June 30, 2021, the total assets of the LTC Fund were approximately $757 million.

Except where the plan provides for an automatic increase in the claim costs, neither the claim costs nor gross premiums have been adjusted for possible future claims inflation.

MODEL PLANS

The following model plans are listed with a brief description of each plan.

Benefit	Benefit Summary by Plan Option			
	Bronze	Silver	Gold	Platinum
Lifetime Max	$200,000*	$400,000	$300,000	$300,000
Inflation Protection	None	None	5% Simple to age 85	5% Compound to Age 85
Elimination Period	90 Day	90 Day	90 Day	90 Day
Benefit Trigger	2 of 5 ADLs	2 of 6 ADLs or CI	2 of 6 ADLs or CI	2 of 6 ADLs or CI
NH Daily Benefit	$125 in-state, $75 out-of-state	$200	$200	$200
ALF Daily Benefit	If approved	$150	$150	$150
HHC Daily Benefit	$75 in-state, $40 out-of-state	$125	$125	$125
Hospice Daily Benefit	Not covered	$125	$125	$125
Respite Benefit	Not covered	Up to $200 daily, 14 days per calendar year	Up to $200 daily, 14 days per calendar year	Up to $200 daily, 14 days per calendar year

DISTRIBUTION

The following tables outline the distribution of current policyholders. :

Benefit Option	Lives	Distribution
Bronze	4,422	20.8%
Silver	8,313	39.1%
Gold	5,703	26.8%
Platinum	2,829	13.3%
Total	21,267	100.0%

Gender	Lives	Distribution
Female	12,098	56.9%
Male	9,169	43.1%
Total	21,267	100.0%

Lapses

The lapse assumption reflects the expected portion of participants who terminate their policies each year by not paying the renewal premiums. Lapse assumptions can vary based on a wide variety of factors, including the participants' age at enrollment and the number of years participants have their policies. In general, it is assumed that the longer that participants keep their policies, the less likely they are to lapse. Lapse rate assumptions greatly affect long-term care insurance premiums because when individuals lapse, future liabilities are immediately reduced although current assets are not affected.

Prior valuations have utilized ultimate lapse rate of 0.5%. We believe this is an appropriate ultimate lapse rate and therefore the lapse assumptions are consistent with the prior actuarial valuation.

Policy Year	Voluntary Lapse Rate
1	2.3%
2	1.2%
3	1.0%
4	0.9%
5	0.8%
6	0.7%
7	0.6%
8+	0.5%

Mortality

Sex distinct 1994 GAM Table

Morbidity

For Long-Term Care insurance products, the substantial financial risks lie in morbidity assumptions. The morbidity assumptions reflect the amount of claim costs expected for participants. The key components driving claim costs are:

- Claim Incidence, which is the probability of going on claim
- Claim continuance, which is the length of time staying on claim, and
- Utilization, which is the level of claim payment.

It would be preferable to use the experience from the Alaska LTC Program. However, there have been less than 1,500 claims since the inception of the Program in 1987. Since this data is not fully credible the expected claim costs were developed from L&E's expected incidence rates and continuance tables and adjusted for State of Alaska's experience relative to L&E's expected costs.

EXPENSES

We reviewed the actual expenses provided in the financial statements. The administrative expenses have averaged 1.4% for fiscal years 2013 through 2019. Typical LTC insurance industry expense assumptions are significantly higher than this. This projection assumes administration expenses of 2.0% of premium increasing by 1.5% per year.

DISCOUNT RATE

We assumed a level 5,0% earned interest rate. The discount rate is a major component of the valuation process and is used to determine present values of the future premiums, expenses and benefits. We reviewed the Program investment returns over the last five fiscal years. We calculated investment returns based on investment income and the average balance of the fund at the beginning and end of each fiscal year:

	Investment Results ($000)		
Fiscal Year	Net Investment Income	Average Fund Balance	Fund Return
2013	16,961	274,218	6.2%
2014	36,114	305,279	11.8%
2015	10,182	341,080	3.0%
2016	14,478	376,669	3.8%
2017	28,892	415,207	7.0%
2018	20,001	456,686	4.4%
2019	39,328	502,959	7.8%
2020	43,259	562,536	7.7%
2021	106,624	649,736	16.4%
Average	35,103	482,184	7.3%

Based on recent investment experience, the prior valuation rate and input from the State of Alaska we selected a 5.0% earned rate for the LTC valuation. This rate was assumed for all future years of the projection.

The assumed discount rate is 25 basis points less than the expected return of the Retiree LTC Insurance Investment Guidelines. The discount rate is also 370 basis points less than the average return over the last five years. The Sensitivity Analysis section includes results based on changing the discount rate.

RATE INCREASES

If the State of Alaska LTC Program has a deficit[ii] (liabilities in excess of assets) it can be recovered only through actuarial gains or increases in future premiums. The actuarial valuation does not dictate a premium adjustment at this time. It is important that the financial progress of the Program be monitored closely so that the State of Alaska can act quickly to adjust future premiums to maintain the Program's solvency.

Regarding all assumptions previously discussed, actual experience may differ from that assumed in the projections. To the extent actual experience is different from the assumptions underlying this report, so will actual results differ from the projected results shown here. Sensitivity of results to changes in assumptions is provided in the Sensitivity Analysis section.

CLAIM RESERVE (CLAIMS PAYABLE)

The financial statements included a liability of claims payable. We calculated the claim liability by using the seriatim listing that was provided that contained Pending Claims as of the valuation date. We used this L&E continuance tables in order to calculate the present value of amounts not yet due (PVANYD). There were only 329 open claims which limits the credibility of the experience. We also reviewed the overall experience of the Alaska LTC Program Experience by calendar year.

Fiscal Year	Claims Payable ($000)	Source
2013	16,822	Alaska
2014	21,612	Alaska
2015	26,630	L&E
2016	28,574	L&E
2017	31,352	L&E

[ii] Commercial LTC insurance programs are required to maintain statutory reserves and additional surplus. These two items could be another resource to mitigate rate increases.

Fiscal Year	Claims Payable ($000)	Source
2018	34,802	L&E
2019	36,015	L&E
2020	51,614	L&E
2021	60,000[iii]	L&E

ACTUAL EXPERIENCE TO PROJECTED VALUES

The Alaska LTC Program covers less than 25,000 lives. In addition, LTC experience fluctuates on several factors including demographics, the economy and access to facilities. We compared the prior valuation to recent experience:

	Paid Claims ($000)			
Fiscal Year	Actual	Projected	Actual - Projected	Actual/ Projected
2020	14,905	17,999	(-3,094)	83%
2021	16,191	20,602	(-4,411)	70%

Claim costs were developed based on a combination of Alaska experience, industry experience, client data and actuarial judgment. To project future claim experience, the claim cost models were calibrated to produce loss ratios that are similar to recent experience.

The future projected claims were generated by applying the claim costs to the 5/31/2021 census. The projected claims (which are used in the actuarial valuation) are somewhat greater than recent experience. The incurred loss ratios are consistent with recent experience.

[iii] Estimate based on 5/30/2021 data.

SENSITIVITY ANALYSIS

We ran sensitivity tests to determine if the reported assets are sufficient with respect to morbidity, voluntary lapses, mortality, and investment earning. Results are highly sensitive to the assumptions underlying the calculations. Sensitivity Results ($000):

Scenario	Sufficiency (Deficiency)	
	5.00%	5.25%
Base	244,205	269,320
Increase morbidity by 3.5%	216,908	243,128
Increase morbidity by 5.0%	205,209	231,903
Voluntary lapse @ 150%	268,368	292,410
Voluntary lapse @ 50%	217,909	244,676
Mortality @ 90%	178,168	207,447

We also ran sensitivity tests to determine what investment rate would be required if the assumptions were all equally adverse. The 4% adverse projections assumed that claims and expenses are 4% greater and that the termination[iv] (lapse and mortality) rates are 96% of projected. We also tested the projected experience as 5% adverse. We then determined what investment rate would be required so that there is no future deficiency:

Adverse Experience	Required Investment Return
4.00%	3.65%
5.00%	3.72%

[iv] Lower lapse and mortality rates increase future claims since more future policyholders will go on claim.

PROJECTED CASH FLOWS

Fiscal Year	Lives	Earned Premium	Expenses	Paid Claims	Incurred Claims	Loss Ratio
2022	20,609	35,093,735	789,609	18,421,506	20,051,300	57%
2023	19,888	33,865,925	773,413	21,918,012	22,235,506	66%
2024	19,180	32,661,414	757,094	25,414,518	24,613,031	75%
2025	18,469	31,449,481	739,936	26,397,240	27,171,316	86%
2026	17,750	30,226,323	721,825	28,449,071	29,927,690	99%
2027	17,025	28,991,363	702,718	28,297,014	32,858,801	113%
2028	16,293	27,744,347	682,580	31,107,295	35,935,849	130%
2029	15,553	26,485,270	661,377	34,081,234	39,159,324	148%
2030	14,807	25,214,701	639,094	37,202,558	42,492,189	169%
2031	14,055	23,933,170	615,711	40,449,040	45,901,987	192%
2032	13,298	22,644,077	591,286	43,793,567	49,371,823	218%
2033	12,538	21,351,203	565,889	47,203,199	52,824,346	247%
2034	11,779	20,058,688	539,607	50,634,073	56,219,862	280%
2035	11,023	18,771,032	512,542	54,029,855	59,467,613	317%
2036	10,273	17,493,052	484,811	57,333,510	62,542,428	358%
2037	9,531	16,229,884	456,550	60,485,075	65,357,250	403%
2038	8,801	14,986,944	427,910	63,426,708	67,872,140	453%
2039	8,086	13,769,836	399,056	66,101,174	70,037,920	509%
2040	7,390	12,584,268	370,168	68,448,771	71,746,568	570%
2041	6,716	11,435,935	341,436	70,404,312	72,978,170	638%
2042	6,066	10,330,380	313,054	71,908,438	73,668,839	713%
2043	5,445	9,272,894	285,223	72,918,847	73,826,448	796%
2044	4,856	8,268,384	258,140	73,403,577	73,419,820	888%
2045	4,299	7,321,240	231,999	73,340,476	72,428,654	989%
2046	3,779	6,435,154	206,979	72,711,158	70,862,057	1101%
2047	3,296	5,612,978	183,243	71,520,411	68,791,461	1226%
2048	2,852	4,856,663	160,930	69,780,022	66,152,136	1362%
2049	2,447	4,167,239	140,157	67,507,420	63,057,766	1513%
2050	2,082	3,544,798	121,011	64,743,053	59,586,817	1681%
2051	1,755	2,988,493	103,550	61,550,312	55,771,537	1866%
2052	1,466	2,496,521	87,801	57,992,966	51,730,551	2072%
2053	1,213	2,066,173	73,756	54,149,039	47,543,292	2301%
2054	995	1,693,942	61,375	50,099,764	43,258,229	2554%
2055	808	1,375,656	50,591	45,918,695	38,975,004	2833%
2056	650	1,106,656	41,309	41,685,131	34,776,252	3142%
2057	518	881,980	33,416	37,479,903	30,723,501	3483%
2058	409	696,531	26,786	33,375,676	26,885,094	3860%
2059	320	545,244	21,282	29,442,011	23,328,975	4279%
2060	249	423,231	16,768	25,739,522	20,073,234	4743%
2061	191	325,908	13,105	22,309,846	17,129,710	5256%
2062	146	249,089	10,167	19,177,122	14,506,763	5824%
2063	111	189,053	7,832	16,352,528	12,186,034	6446%
2064	84	142,567	5,995	13,834,578	10,157,760	7125%
2065	63	106,878	4,562	11,616,115	8,419,019	7877%
2066	47	79,690	3,452	9,684,533	6,925,185	8690%
2067	35	59,123	2,600	8,021,022	5,671,941	9594%
2068	26	43,656	1,948	6,601,293	4,610,036	10560%
2069	19	32,086	1,453	5,399,352	3,723,192	11604%
2070	14	23,468	1,079	4,389,605	2,999,831	12782%
2071	10	17,076	797	3,551,093	2,406,713	14094%
2072	7	12,352	585	2,860,932	1,925,784	15590%
2073	5	8,878	427	2,296,558	1,537,582	17320%
2074	4	6,333	309	1,838,097	1,223,361	19317%
2075	3	4,480	222	1,465,559	962,711	21491%
2076	2	3,138	158	1,162,034	753,122	24002%
2077	1	2,174	111	914,804	582,290	26787%
2078	1	1,487	77	714,191	445,047	29921%
2079	1	1,004	53	551,936	336,348	33504%
2080	-	667	36	421,982	250,921	37596%
Total PV Future:		336,381,001	8,502,584	779,931,104	802,319,723	239%

Lead the way

Delivering on the promise of gene therapy

Gene therapy is on the brink of something big. With the promise of treating or curing conditions that were once thought incurable, gene therapy is expected to transform the health care industry over the next few years.

There's a number of gene therapy Food and Drug Administration (FDA) approvals already on the market and even more to come. But these high-cost therapies can carry big price tags. So we're leading the fight to take a complex and costly process and make it simple and as affordable as possible. We're making gene therapy accessible so your employees can get the treatment they need without the worry, while optimizing costs for you.

The science is a breakthrough. Our network is the game changer.

Our network boasts over 130 centers vetted for quality in care made easy with care coordination. The best part? Costs are already included in the framework of a standard medical plan.

A designated network

An arrangement of facilities vetted for quality and value.

Plan design with care coordination

A plan that delivers access to quality care with cost savings.

Specialty pharmacy service

A direct pipeline from manufacturer to provider that limits costs by eliminating markups.

A dedicated clinic team

A quality team to guide members through the process, from precertification to aftercare.

Financial protection program

For customers who choose not to purchase traditional stop loss, a focused product that offers financial protection for gene therapies is available.

Big impact

How does it work?

Gene therapy works by replacing or repairing defective genetic material within a cell.

Gene therapy services:

- Cellular immunotherapy
- Genetically modified viral therapy
- Cell and tissue therapy, and more

What can it treat?

Over a thousand gene therapies are in development to treat conditions like hemophilia, spinal muscular atrophy and retinal disease. And that's only the beginning.

Less cost

Only a small number of employees may ever need gene therapy, but for those who do, our plan makes a big impact. Your employees' medical costs will always be well managed, through network design and built-in stop loss for added protection. And for plans that already have built-in stop loss, there is additional financial protection and security.

Get ready for an influx

With over a thousand more therapies in the FDA approval pipeline and clinical trials, you'll soon see an uptick in demand for these therapies. That's why we're laying the groundwork today, with a comprehensive set of capabilities to optimize access, quality and cost.

What's next?

16
current FDA-approved gene and cell therapies*

1,000+
therapies in phases 1–3 of clinical trials*

10 to 20
gene and cell therapies expected to be approved each year through 2025[1]

$45B
potential impact in the industry in the next 5 years[2]

Up to $2M
per employee in gene therapy costs[2] without our financial protection

Deliver the promise of gene therapy.
Contact your Aetna® rep today.

*Based on internal research.

[1]Stanton D. In the pipeline: Surge of cell and gene therapies likely in 2020. BioProcess International. September 30, 2019. Available at: BioProcessIntl.com/bioprocess-insider/therapeutic-class/in-the-pipeline-surge-of-cell-and-gene-therapies-likely-in-2020/. Accessed August 31, 2021.

[2]Brennan T, Chaguturu S, Knecht D. CVS Health white paper. Gene therapy: Keeping costs from negating its unprecedented potential. January 13, 2020. Available at: PayorSolutions.CVSHealth.com/insights/gene-therapy-keeping-costs-from-negating-its-unprecedented-potential/. Accessed August 31, 2021.

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DRAFT

Retiree Health Plan Modernization Topics*

1. Active Topics

Proposal Number	Description	Priority
R001b	Enhance travel benefits, add health concierge	1
R006	Expanded telehealth services	1
R008	Remove or increase lifetime maximum (currently $2M)	1
R009A	Rehabilitative Care - Clear Service Limits: Implement clear service limits for rehabilitative care such as chiropractic, physical therapy, occupational therapy, etc. and expand rehabilitative services to include rolfing, acupuncture, and/or acupressure	2
R009C	Rehabilitative Care – New Coverage: Add coverage for acupuncture/acupressure	2
R012	Add wellness benefits such as gym memberships or program like Silver Sneakers	2
R014	Implement 3 tier pharmacy benefit; change out-of-network pharmacy benefits	2
R005	Out-of-network reimbursement as a percentage of Medicare	Division Priority
R019	Tiered network benefits for certain services	Division Priority
R018	Plan Housekeeping - Examples: • Update plan exclusions • Clarify reimbursement policies for surgical assistants	Division Priority
R021	Medicare Advantage Plan	Division Priority
R***	Add coverage for orthodontic braces to treat cleft palate – *member request*	

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

Updated for November 2021

DRAFT

Retiree Health Plan Modernization Topics*

2. Pended Topics

Proposal Number	Description
R001a	Enhance travel benefits
R002	Network Incentive: 70% out-of-network and 90% in-network
R003	Increase deductible, out-of-pocket maximum
R004	In-network enhanced clinical review of high-tech imaging and testing
R010	Exclude coverage for drugs with over the counter (OTC) equivalents
R011	Implement high-value pharmacy network with lower copays for chronic meds, medical synchronization, counseling, and packaging options for participating members.
R013	Consider expanding coverage for implants related to periodontal disease under the medical plan and/or under the dental plan
R015	Limit compound coverage to high-quality, narrow network of pharmacies
R017	Copayment for primary care

3. Completed Topics

Proposal Number	Description	Effective Date
R007	Expand preventive coverage to add full suite of preventive services	1/1/2022
R016	Add medically necessary treatment of gender dysphoria including surgery – *public comment proposal*	1/1/2021
R020	Add prior authorizations for certain specialty medications	1/1/2022

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

AlaskaCare Quarterly Meeting Dates for 2022

AlaskaCare Quarterly Meeting Employee Plan
- ☑ Tuesday, February 8, 2022
- ☑ Tuesday, May 3, 2022
- ☑ Tuesday, August 2, 2022
- ☑ Tuesday, November 1, 2022

AlaskaCare Quarterly Meeting Retiree Plan
- ☑ Wednesday February 9, 2022
- ☑ Wednesday, May 4, 2022
- ☑ Wednesday, August 3, 2022
- ☑ Wednesday, November 2, 2022

Retiree Health Plan Advisory Board Meeting
- ☑ Thursday February 10, 2022
- ☑ Thursday, May 5, 2022
- ☑ Thursday, August 4, 2022
- ☑ Thursday, November 3, 2022

Health Benefit Evaluation Committee Meeting
- ☑ Friday, February 11, 2022
- ☑ Friday, May 6, 2022
- ☑ Friday, August 5, 2022
- ☑ Friday, November 4, 2022

AlaskaCare Quarterly Meeting – Q3 of 2021
- ☑ Employee Plan -Tuesday, February 8, 2022
- ☑ Retiree Plan - Wednesday February 9, 2022
- ☑ RHPAB - Thursday February 10, 2022
- ☑ HBEC - Friday, February 11, 2022

AlaskaCare Quarterly Meeting – Q4 of 2021
- ☑ Employee Plan - Tuesday, May 3, 2022
- ☑ Retiree Plan - Wednesday, May 4, 2022
- ☑ RHPAB - Thursday, May 5, 2022
- ☑ HBEC - Friday, May 6, 2022

AlaskaCare Quarterly Meeting – Q1 of 2022
- ☑ Employee Plan - Tuesday, August 2, 2022
- ☑ Retiree Plan - Wednesday, August 3, 2022
- ☑ RHPAB - Thursday, August 4, 2022
- ☑ HBEC - Friday, August 5, 2022

AlaskaCare Quarterly Meeting – Q2 of 2022
- ☑ Employee Plan - Tuesday, November 1, 2022
- ☑ Retiree Plan-Wednesday, November 2, 2022
- ☑ RHPAB - Thursday, November 3, 2022
- ☑ HBEC - Friday, November 4, 2022