Retiree Health Plan Advisory Board
Meeting Agenda

Date:	Wednesday May 27, 2020
Time:	8:30am - 12:30pm
Location:	**Video Teleconference Only**
	Join meeting
Teleconference:	Conf #: 650-479-3207 ID#: 805 987 251 Password: 5368 9774
Committee Members:	Judy Salo (chair), Joelle Hall, Gayle Harbo, Dallas Hargrave, Mauri Long, Cammy Taylor, and G. Nanette Thompson

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8:30 am **Call to Order – Judy Salo, Board Chair**

- Roll Call and Introductions
- Approval of Agenda
- Approve Previous Meeting Minutes
- Ethics Disclosure

8:40 am **Public Comment**

9:00 am **Department & Division Update**

- COVID-19 Response
  - Division Actions
  - Temporary Plan Changes

COVID-19 Testing

10:15 am **Break**

10:30 am **Education Session**

- Medicare Advantage

11:30 am **Modernization Next Steps**

12:15pm **Final Thoughts**

- Next meeting: August 2020

12:30 pm **Adjourn**

https://aws.state.ak.us/OnlinePublicNotices/Notices/View.aspx?id=197013

Retiree Health Plan Advisory Board

Board Meeting Minutes

Date: Thursday, February 6, 2020 9:00 a.m. to 3:30 p.m.

Location: State Office Building 333 Willoughby Avenue 10th Floor, Juneau, AK 99801 and Robert B. Atwood Building 550 West 7th Avenue, 19th Floor, Anchorage, AK 99501

Meeting Attendance

Name of Attendee	Title of Attendee	
Retiree Health Plan Advisory Board (RHPAB) Members		
Judy Salo	Chair	Present
Cammy Taylor	Vice Chair	Present
Joelle Hall	Member	Present
Gayle Harbo	Member	Present
Dallas Hargrave	Member	Present
Mauri Long	Member	Present
Nan Thompson	Member	Present
State of Alaska, Department of Administration Staff		
Ajay Desai	Director, Division of Retirement + Benefits	
Emily Ricci	Chief Health Administrator, Retirement + Benefits	
Betsy Wood	Deputy Health Official, Retirement + Benefits	
Teri Rasmussen	Program Coordinator, Retirement + Benefits	
Steve Ramos	Vendor Manager, Retirement + Benefits	
Mike Gamble	Member Liaison, Retirement + Benefits	
Vanessa Kitchen	Administrative Assistant, Office of the Commissioner	
Others Present + Members of the Public		
Daniel Dudley	Aetna	
Hali Duran	Aetna	
Richard Ward	Segal Consulting (contracted actuarial)	
Noel Cruse	Segal Consulting (contracted actuarial)	
Anna Brawley	Agnew::Beck Consulting (contracted support)	
Sharon Hoffbeck	Retired Public Employees of Alaska (RPEA)	
Brad Owens	Retired Public Employees of Alaska (RPEA)	
Barbara Steck	Retiree / public member	

Disclaimer: The following minutes are not a verbatim transcript. Please refer to the meeting recording for a definitive account of the discussion and information presented.

Common Acronyms

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

- ACA = Affordable Care Act (formal name: Patient Protection and Affordable Care Act)
- ARMB = Alaska Retirement Management Board
- CMS = Center for Medicare and Medicaid Services
- COB = Coordination of Benefits
- DB = Defined Benefit plan (for Tier 1, 2, 3 PERS employees and Tier 1, 2 TRS employees)
- DCR = Defined Contribution Retirement plan (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
- MAGI = Modified Adjusted Gross Income, based on an individual or household's tax returns and used by CMS to determine what if any premium must be paid for a Medicare plan.
- OPEB = Other Post-Employment Benefits; an accounting term used to describe retirement benefits other than pension benefits
- OTC = Over the counter medication, does not require a prescription to purchase
- PBM = Pharmacy Benefit Manager, a third-party vendor that performs claims adjudication and network management services
- PEC = proposal evaluation committee (part of the procurement process to review vendors' bids)
- PHI = protected health information, a term in HIPAA for any identifying health or personal information that would result in disclosure of an individual's medical situation.
- 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

Vice Chair Cammy Taylor called the meeting to order at 9:05 a.m. A quorum was present. Chair Judy Salo was still in transit.

Approval of Meeting Agenda

Materials: Agenda packet for 2/6/20 RHPAB Meeting

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

Approval of Previous Meetings' Minutes

Materials: Draft minutes from previous RHPAB Meetings.

- **Motion** by Joelle Hall to approve August 22, 2019 special meeting minutes. **Second** by Gayle Harbo.
  - **Discussion**: None.
  - **Result**: No objection to approval of minutes. Minutes are approved.
- **Motion** by Joelle Hall to approve October 8, 2019 special meeting minutes. **Second** by Gayle Harbo.
  - **Discussion**: None.
  - **Result**: No objection to approval of minutes. Minutes are approved.
- **Motion** by Joelle Hall to approve November 14, 2019 meeting minutes. **Second** by Gayle Harbo.
  - **Discussion**: None.
  - **Correction**:
    - Page 5: "… if you are in two different systems, you cannot select two…"
  - **Result**: No objection to approval of minutes. Minutes are approved.
- The January 15, 2020 modernization committee minutes were provided for information.
  - **Correction**:
    - Page 17: "result of injury or disease, including periodontal disease, since it is a surgery; but in other cases…."

Ethics Disclosure

Judy Salo requested that Board members state any ethics disclosures in the meeting.

- Mauri Long reiterated her disclosure that she owns a small number of shares in Teladoc.

Item 2. Public Comment

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

1) A retiree health benefit member's retirement benefit information is confidential by state law;
2) A person's health information is protected by HIPAA;

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

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

- **Brad Owens, Executive Vice President, RPEA**. Brad stated he would like to reserve the right to make comments during the afternoon portion of the meeting. He requested of the Board that members of the public be allowed to ask questions or offer comments during the course of the meeting, rather than just during the public comment period.
    - Cammy Taylor asked what format he recommends?
    - Brad gave the example of a presentation, where the speaker pauses and solicits questions. If it is possible for members of the public to ask questions at those times, in addition to board member questions, this would be appreciated.
    - Judy commented that we can take the idea under consideration. We would want to think about it in terms of efficiency of our time. Let us give it some thought. It would be hard to plan for the amount of time an issue would take.
    - Gayle noted that it would depend on the number of people who wish to ask questions, and the number of questions on an issue.
    - Nan recommended allowing questions from the public once at the end of each presentation, with time limits as needed.
    - Brad suggested limiting the participatory questions to retirees that attend in person. Anyone on-line would need to comment during the public comment period only.
    - Judy said they can consider that, but the open meetings act and the public comment in the Administrative Order are something we need to take a look at before we make any commitment.

Item 3. Department of Administration + Division of Retirement & Benefits Updates

Emily Ricci thanked board members for traveling to attend the meeting in person in Anchorage. She provided several updates.

Staff Updates

The Division has a new staff member Mike Gamble, who previously worked with the Division, and is joining the health team. His position is currently with Vendor Management, and we anticipate his position being dedicated to supporting members who are dealing with complex issues. At one time we had a member liaisons position, we found this model worked well. We are being thoughtful in how we roll this out to our members because we want to make sure we are directing members to the right channels. We are not rolling this out as a member liaison yet but will introduce it in a few months.

- Judy Salo asked if this position is new, or existing?
    - Emily responded that the position was a Wellness/Communications Coordinator (Sharon Lewis' position) and has been reclassified and redefined to serve as a member liaison.
- Judy noted that in the vendor meeting, they review records of calls from the TPAs, how many and how long the calls lasted. Does the Division collect information on their internal call center operations?
    - Emily clarified that the DRB call center serves both the health plan and the retirement (pension) plan. They meet regularly to review what topics people are calling about and what issues are occurring, particularly if many people reach out about the same topic. The team is also working to send a brief survey after each call to collect feedback, similar to the ones already used by the pension team.

Dental, Vision and Audio (DVA) Plan Update

Emily shared updates on this plan, through the end of January 2020: there are 37,331 members who were eligible to enroll in this plan (either currently enrolled or offered the opt-in). Following the court order to change the "default" plan to the Legacy plan, more members called to make an election. The rough final numbers as of January 1 are as follows: Standard plan 14,047 ; Legacy plan 23,284, meaning about 16,000 people were defaulted into the Legacy plan. To date over 500 members have contacted the Division to request a change, because they previously understood that taking no action would mean that they stay in the Standard plan. Staff are addressing these requests, including some manual work to change elections or address members' concerns.

EGWP (IRMAA) Update

2019 was the first full year of the Employer Group Waiver Plan (EGWP), the Medicare Part D plan. There are approximately 2,500 to 3,000 IRMAA reimbursement requests, all manually processed by staff. Staff are working to simplify this process, ideally making it a 1-step process rather than 2-step that happens today. They anticipate more requests coming in, and are working through the paperwork, including hiring a short-term employee and potentially a procurement to process these in the future. The goal is to change the process in a way to reduce staff time and make the process more automatic. Staff have worked hard to catch up on processing these reimbursement requests and are currently ready to address new submittals going forward. Retirees likely experienced delays over the last several weeks but going forward should have fewer delays.

Betsy Wood reminded the group that this is an annual process, and that because it only applies to people eligible for Medicare, IRMAA reimbursements will continue to grow over time as more members are Medicare eligible.

- Gayle Harbo commented that the information provided was helpful, including the fact that you do not have to change your bank information if it was submitted last year. She also noted that while there may be a delay in processing, retirees will still receive the same reimbursement level they have paid in surcharges, so it will even out in the end.
- Nan Thompson asked the income threshold for the IRMAA surcharge?
    - Betsy responded that for an individual, the income threshold is $87,000. For a couple filing jointly, it is $174,000. It is calculated on the retiree's income two years prior, and moves forward on a rolling basis, so a person's eligibility or IRMAA amount will change over time, as the retiree's income changes from year to year.

Third Party Administrator (TPA) Procurement Update

Emily shared that all procurements have been awarded for 2020, the protest period has closed, and the Division is finalizing negotiations with the vendors to sign the contracts. The remaining issues are primarily related to legal language, and in the meantime the Division is operating under an extended letter of authorization. This will be completed soon.

EGWP Operational Issues

Several members use a P.O. Box for their mailing address, and Medicare requires that a person provides a physical residential address to verify that the enrollee is living in the U.S. and therefore eligible for care. Division staff have been contacting retirees directly who have only listed a P.O. Box, to ask them to submit a physical address per CMS requirement. CMS may determine that a person is not eligible for Medicare if they do not confirm that they physically live in the U.S. This impacts approximately 543 people currently; previously the number was over 2,000 people, and they have been able to make contact with many people and resolve most of the cases.

It has been difficult to reach many people, so the Division is considering how to address this issue. One option is that they may be required to move people into the opt-out pharmacy plan, because Medicare needs to confirm that the person is in the Medicare service area and therefore not be eligible for EGWP. Another option is to retain them in the standard plan. So far, many of these members live in rural areas and may not have a standard physical address, so the Division would also like to work with people individually to determine how to represent their address. This does not require changing a person's mailing address, just confirming address for CMS.

The Division also contacted CMS to understand what the impact on overall subsidies would be, if fewer members are enrolled: it would be approximately $330,000 per year. Keeping members in the standard plan (same as the plan for the non-Medicare eligible) would have less disruption for members but has higher cost. The opt-out plan would represent higher costs for members.

Emily added that it is possible to retroactively enroll these members back into EGWP when they are able to provide an address compliant with the plan, which would also provide the members' benefits and associated subsidies retroactively.

- Gayle asked whether the members are part of PERS, TERS or other units? And are they in Alaska, or elsewhere?
    - Betsy indicated this information is available and can be shared with the board as a follow up item.
    - Gayle recommended including this in the PERS and other newsletters which are sent regularly, those reach members and may be another way to communicate.
    - Emily thanked her for that suggestion and noted that they are hoping the board members can help spread the word as well.
- Cammy asked whether the pension system requires a physical address, particularly for the cost of living allowance for Alaska?
    - Ajay Desai noted that many people opt for direct deposit rather than physical checks. Delivering 1099 forms require a physical address as well, so this poses a challenge from that perspective. He noted that when working for a different pension plan, the plan took a drastic step of stopping one month's payment to get the recipient's attention and

incentivize them to respond. This is not necessarily the approach to take, and it is difficult because of the legal requirements from CMS.

- Nan suggested checking with the Permanent Fund Division, which also requires physical residency in Alaska and could provide an alternative verification of residency that CMS may accept? Could Department of Revenue provide this information?
    - Ajay confirmed that this method was used in the past with the pension system, and have access to that system, so this is an option. The Division could also review past claims to see where people received services, to confirm where they live if possible.
    - Emily added that Andrea Mueca is leading this effort and is currently out of the office.
- Judy commented that she has had difficulty sending address verification to the correct place, so she hopes that these issues are not exacerbated.
    - Emily noted that they have had issues with the subcontractor handling the paperwork DRB is working to improve the vendor performance and is also sending direct communications.
- Gayle asked whether members were enrolled last year?
    - Emily responded that this is the first year that the EGWP system has been in place. There is a one-time response required and this is the first time the request to members is occurring.
    - Betsy added that members have had 13 months to respond because of the initial grace period, so this needs to be resolved now that the grace period is up.
- Judy asked for clarification how to provide this information to the proper channel?
    - Emily confirmed that members can contact the Division, as well as call OptumRx

Retiree Member Survey

Betsy shared that the Division is working on a survey to retiree members, in addition to the annual phone survey conducted at the end of each calendar year to a sample of retirees and employees. This would be a survey to collect feedback from members about how the Division is doing in terms of service, as well as asking members what they want to get from their benefits, what is most important, and what changes they would most value in their plan. She asked Board members to think about what questions they would want to ask, what information to gather, and what would inform future decisions in the modernization project.

The current concept is to have an online survey, conducted with as many retirees as possible, with communication efforts to let people know about the survey and encourage them to apply. They considered a paper survey, this would be much more time intensive, but they want to hear from retirees who are not on the e-mail list already. For example, they could mail a postcard with the survey link to encourage retirees to participate.

- Judy asked staff to share a rough draft of the survey questions with the board members, to serve as a test group and make other recommendations.
    - Staff agreed this is a good idea.
- Gayle suggested continuing to use the poll questions in the tele town hall events, this is a limited audience but is also a good way to gather feedback.

- Cammy commented that the membership numbers indicate a large number of people over age 75, and many will likely not have access to a computer. Could there be a phone-based option as well, in which a member can call and answer the questions verbally?
    - Betsy agreed this is a good idea, the main consideration will be keeping the number of phone respondents manageable.
- Gayle also recommended limiting the number of questions to 5-10 at the most; more and more businesses ask for feedback in surveys, and people are more likely to respond if it is short.
    - Betsy agreed this is a consideration. There may be opportunity to do multiple surveys over time, to get more feedback and not overload people with a long survey.
- Mauri requested staff provide the breakdown of retiree members by age group in the health plan, for the discussion this afternoon.
    - Staff will collect this information over the lunch break and bring to the afternoon session for discussion.
    - Emily noted that this is an important consideration, as well as the projection of retiree population over time (10 years or more). They will collect data from existing sources.

OptumRx Digital Processing

Division staff are working with OptumRx to develop a process for members to opt out of some EGWP paper communications.

The Board took a 15-minute break at 10:03 a.m., and returned to the meeting at 10:18 a.m.

Item 4. Education Session: Changes to Actuarial Value vs. Cost Impact Comparison

Materials: Documents beginning page 71 in 2/6/20 meeting packet

Richard Ward provided an overview of actuarial value: the purpose of using this measure to evaluate the plan, and potential changes to the plan, is to model the projected overall cost (present and future) to the health plan depending on what benefits are provided and at what cost-sharing between the plan and the member.

Emily Ricci added that this is an education session to refresh the board on what actuarial value is, how it is used for health plans, and how it should be utilized to evaluate proposals in the modernization project.

Richard directed the group to the presentation starting page 71:

Actuarial value (AV) is calculated differently for pension plans and health plans: they will focus on information for the health plan. It is a measure of the overall value of the plan across all members and services, and generally expressed as a percent. For example: a 90% actuarial value plan is one in which overall, the plan will pay about 90% of the costs of the plan, and the member will be responsible for the remaining 10%. If the service costs $1,000, the plan pays $900 and the member $100. It is calculated from the cost-saving measures of the plan: deductibles, co-pays, and other cost sharing. This is an industry standard as a concept: for example, the Affordable Care Act defines thresholds for health plans on the commercial market, and assigns a general value based on actuarial value: a platinum plan is 90% AV, a gold plan is 80% AV, silver plan 70% AV, and bronze plan 60% AV. The ACA also requires provision

of essential benefits, and actuarial value is calculated on in-network benefits only. However, there is no industry standard for what actuarial value is appropriate or required, it is set in each health plan.

- Mauri asked for clarification about use of the word "discounting" in this context: does this calculation include present value, or is "discount" mean something else?
    - Richard confirmed it is not a present-value calculation, it is "discount" in the sense of reducing cost of the plan, applied before cost-sharing split between plan and member.

Richard continued: actuarial value does not apply to all aspects of the plan design, such as what benefits are covered or in what situations. It is specific to cost-sharing provisions. Actuarial value is prospective, meaning that it applies to future assumptions about plan cost-sharing and trends in utilization and costs, not retroactively on actual claims.

- Mauri asked for clarification, does this include discounting for present value?
    - Richard noted these assumptions are based on future trends, and what is likely to happen in the next year, but not discounted back to today's dollars because it is a proportion of what cost is taken on by the plan versus the member. The analysis only looks at the upcoming year, not 5-10 years out, and done on a yearly basis.

Richard continued: the analysis uses group specific data and can look at specific sets of claims from the previous year to develop trends, such as considering all chiropractic claims to determine how this will impact in the future. There are also existing data sets aggregated from health plans overall that provide a model for considering potential changes. To the extent possible, the consultant uses actual AlaskaCare claims data for the analysis, with a few small exceptions, to make the best assumptions possible.

There are several situations in which actuarial value is used: the small remaining Retiree Drug Subsidy, which requires demonstrating that the plan meets or exceeds the minimum provisions for the Medicare Part D plan. Some other states require an annual test to demonstrate that a plan meets a minimum threshold for actuarial value (Kentucky and Tennessee have examples of this). It is a measure that allows for overall comparison across different health plans, without having to compare every single provision of the plan, because each health plan will have many different provisions that are difficult to compare.

There are other provisions that impact actuarial value, particularly defining a dollar amount that does not change over time: deductibles increase actuarial value, because a fixed dollar deductible means that over time the plan will pay more, due to inflation and the increasing cost of care for the same service. Similarly, a benefit maximum will decrease actuarial value over time, because it sets a hard cap on spending and therefore results in the plan paying less (relatively) over time as the member is responsible for more of the plan costs over time, if and when they meet the maximum benefit.

Emily noted that, more people are impacted by the deductible amount than the lifetime maximum, in the plan as currently configured. Members are getting increased value over time as the deductible remains the same and overall costs of care increase.

Richard continued: Financial value is the actual dollar value of the plan, the costs of providing the covered services and utilization of those services by the population. Financial value can be impacted in more ways: it still includes deductibles, co-pays and benefit limits, but also payment levels to providers (network and non-network), wellness and health management programs to potentially avoid more costly care, incentives toward certain services (e.g. telehealth), federal subsidies such as EGWP, which

drugs are covered, and eligibility requirements. The graphic on page 76 illustrates the overlap in these two measures of value, and what is included or not included in each.

- Judy asked what "a change in benefit lacking utilization" is, under actuarial value?
    - Richard responded that this means a rare or not utilized benefit, such as coverage for an expensive but very rare drug, for a condition that none of the members have and therefore is not an actual cost to the plan. Coverage of this could change the actuarial value, but not financial value until it is utilized.
- Nan commented that this is helpful information. She asked for clarification: is it reasonable to assume that costs for care will go up over time, and therefore the actuarial value would change over time?
    - Richard responded yes, this is true particularly for fixed dollar amounts in the plan, and this plan has many of these, from deductibles to drug co-pays to the lifetime maximum. In general, most of the fixed-dollar provisions increase the actuarial value of the plan.
- Joelle asked what the actuarial value of the plan was back in 1986 when originally conceived?
    - Richard responded the plan was never assigned a specific actuarial value at that time, but there were analyses done on the changes done in 1999-2000 that illustrates the impact of those changes. The analysis at the time, or rather multiple analyses, shared that there were some enhancements and some diminishments, with the net effect of a small enhancement to the plan compared to the original. There was no baseline value determined at that time.
- Cammy asked, for example, if a plan is currently at 90% value and additional services are covered, does this change actuarial value, or just financial value? How would adding preventive benefits change actuarial value?
    - If the share of coverage stays the same, if those services were covered at 90% as well, it does not cover actuarial value.
      Richard also clarified because those services are covered at 0% currently, adding coverage for those specifically would change the coverage amount to a higher percent, which would impact the plan overall.
    - Betsy added that since preventive services are an essential benefit, in that situation it was already factored in as 0% coverage. If the service is not already contemplated in the plan and not factored into the calculation, then it would not be factored into the valuation.
    - Cammy asked for clarification: why are some services included and not others?
        - Richard noted this is driven by the requirements of the ACA, specifically for the essential benefits. If a benefit is not considered one of those essential benefits, it would be factored into the analysis.
- Mauri asked whether adding or changing services such as chiropractic care and rolfing would impact value?
    - Richard responded that adding benefits, such as rolfing, may not impact actuarial value if the proportion of cost sharing by the plan is the same. However, if you put additional limits or change coverage of the service for members (by limiting the number of services per year or otherwise), then it could decrease actuarial value.
    - Emily added that it would be helpful to consider what benefits and coverage overall is included in the "pie" of cost sharing among member and plan to calculate the value, and

this would help inform discussions about changes in benefits. For example, which essential benefits are included in the analysis now, versus what is not included.

- Steve Ramos asked a question: if the out of pocket maximum is $800, and co-insurance is 80%, then it would complicate the calculation of value because it would not necessarily mean the service is covered at 80% for each member. How do you calculate this?
    - Richard responded that this is true, and deductibles also impact this. However, it is calculated on a group basis not an individual basis, so the nuances of individual cases and claims is aggregated up.

Judy thanked the team for the presentation, no further questions.

Item 5. Modernization Project: 2020 Next Steps

Materials: Documents beginning page 78 in 2/6/20 meeting packet

Emily shared an overview of this presentation: it was prepared by staff to help guide the discussion and provide ideas for the Board to organize their discussion and advisory decision-making. She encouraged the Board to consider identifying the proposals to continue working on now (currently there are 20), and which to set aside for future work.

She summarized the first slides, stating the purpose of RHPAB as established in Administrative Order 288. Specifically, the Board may make recommendations to the Commissioner about the retiree health plans (including optional plans and the medical and pharmacy plans). The Board must consider both long-term and short-term fiscal viability of the plan and impact of potential changes; affordability of the plan, for both the plan sponsor and members, including premiums; and the clarity of the plan, for beneficiaries and for the Division to implement.

- Mauri asked for clarification: is the plan sponsor the Division, or another party?
    - Emily clarified that the plan sponsor is the State of Alaska, administered by the Department of Administration, Division of Retirement and Benefits.
- Mauri commented that to date, the Board has not focused so much on the impact of other participating employers in the plan, they have primarily discussed the impact to the State itself. Should this be incorporated into the discussions, and what would this look like?
    - Emily agreed that this is a good idea, staff have also been focused on the primary impacts to the State and health trust.
    - Dallas Hargrave commented that when considering the retirement system, they can consider the impact of (for example) PERS members, and impact to health costs.
    - Ajay Desai noted that each year, they determine the overall liability for the plan (retirement plan, health plan), including <u>all</u> costs for covering the benefits assigned to current retirees and future retirees for their entire lifetime, with a calculated present value. This provides a determination of whether the fund's current balance and projected earnings for that year, and whether it is sufficient to meet that need; any gap is the unfunded liability. Because the agreement between the State and other employers is that they must pay in 22% (PERS) or 12% (TERS) of the plan costs over time,

they are already paying into this overall cost for the plan. The additional liability is the responsibility of the State, out of the General Fund.
    - Dallas commented that it is a recruitment and retention tool to have a solvent retirement plan and good health benefits, he brings this perspective to the Board.
    - Emily summarized: there is some consideration of other employers, but they have a fixed percentage of cost they must pay. So, there are implications for cost-sharing for all employers, to close the gap of unfunded liability.
- Mauri Long asked whether the unfunded liability is shared among employers?
    - Ajay confirmed that with the statute change in 2008, each employer has a set formula for cost sharing, noted above, to close the unfunded liability by the target year of 2039. This applies to both the retirement fund and the retirement health trust.
    - Emily asked what is being contributed to date?
        - Ajay confirmed that they have been contributing at the 22% and 12% levels, and the State has contributed an additional 8%. To date, the State has paid about $7.5 billion into these funds. With EGWP now in place, the State was able to substantially reduce the required payments to close the unfunded liability gap by a great deal, without reducing benefits to members. Over time this will continue to help the State reduce the amount to pay in over time to meet this gap; unlike the Retiree Drug Subsidy, this is prospective and on a per member basis, not on actual costs alone. This will have a significant positive impact equal to about $1 billion dollars (total, present value) toward the unfunded liability. He again thanked the Board for supporting that change and helping achieve these great savings. He encouraged the Board to think about how to further increase benefits, without increasing costs to employers (or members) to the degree possible.

Emily continued: page 83 includes the goals of the modernization project: to improve member benefits as well as preserving the overall benefit to the employers and implementing standard cost saving measures common in other health plans. There are two key questions: 1) What changes should we evaluate? 2) How should they be implemented? Today's discussion will focus on question 1. The next meeting in May would focus on the question 2, how to do this: previously staff shared multiple options, including changing the Defined Benefit plan itself or allowing retirees opt into a separate plan. Another option to consider is a Medicare Advantage plan for members to opt into. And the Board should consider as an option, to not change the plan and leave it as is. Emily offered that the group should not lose sight of the fact that status quo is an option. She noted that if this is discussed in the spring, staff can utilize time between the May and August meetings to develop recommendations for this consideration.

Emily pointed to key questions on page 86, for the Board's consideration:

- What is the purpose of medical insurance? What did "lifetime major medical coverage" mean, how has that changed, and what proposals meet the threshold of essential insurance?
- What is the plan's short term and long-term goals? Do the changes support these goals?
- What challenges do members face today, and how would the change impact members today and in the future?

- Mauri commented on the choice of words of "medical insurance" versus "health care coverage." She understands that this has changed over time and points out it is an important distinction and relevant to considerations for the *Duncan* decision. It is difficult to identify the cost avoidance or savings associated with prevention and wellness, but she noted that routine wellness and self-care are critical for controlling costs.
    - Emily agrees with this sentiment and noted that the terms they put forward are used interchangeably but are different. She agrees that health care is a larger set of benefits, and because this relates to the insurance component of medical care specifically, and in situations where people are faced with a catastrophic event and the plan does not cover it. From the Division's perspective, it is most concerning if the plan is intended to provide that coverage in catastrophic events and it is not. Emily shared her personal feeling that benefits are also important and relevant, but her concern about the insurance aspect of this is significant.
- Nan commented that she understands the distinction between these, but noted that if there are incentives to remain healthy and cost-sharing to support that, it can avoid those catastrophic events in at least some cases, and reduce the financial burden to the plan in the long run. She supports an emphasis on health overall and not just medical insurance.
    - Emily agreed that wellness on a population level is certainly a good strategy, to avoid higher-cost care incidents. She noted that it sounds like everyone is aligned in terms of values. She suggested that there are different purposes to these proposals, and the implications for whether they are covered, in light of the essential purpose of medical insurance.

She noted that staff will be updating each proposal to include the following:

- Member impact
- Financial analysis
- Actuarial analysis
- Implementation options
- Communications plan
- Timeline
- Division recommendation: this section is new and will be based on the discussions to date.

The process will include the Board's evaluation on each proposal, and when ready, an advisory vote and recommendation by the Board. This will be an iterative process until the final votes are taken.

Emily noted that the list of proposals on page 89 have been numbered in a way that the numbers will remain in place to avoid future confusion about which is being discussed.

- Dallas Hargrave suggested that the Board consider how to prioritize these proposals and suggested a "dot voting" exercise could be useful, and possibly multiple rounds of voting, to develop a priority list and see what members agree on or diverge on.
    - Emily agreed, and noted these tools are available in the meeting today. Staff also considered a quadrant diagram, or a spectrum or continuum to place each proposal on. Staff are open to the Board's preference for this process.

- Judy asked the group whether there are any that members agree on to remove from the list for current consideration?
    - Joelle commented that one process is to list all proposals on the whiteboard, to put initials or another mark next to each, and designate a number of votes per person. The number of votes needs to be discussed, as it has implications for the amount of proposals the group may come up with.
- Mauri noted that there are additional benefits, and there are offsets to care for additional costs. She noted that everyone would just vote for benefits if they could, so there needs to be consideration of how to include those offsets in the voting as well.
- Dallas commented that the group could develop criteria for evaluating these, such as member impact. However, not all information is available now, more analysis is needed, so it may be difficult to do this until the analysis is complete.
    - Emily agreed; staff need time to complete analysis, so there is not complete information about all proposals.
- Cammy commented that many retirees have asked for additional benefits, but do not necessarily understand that offsets can and must be considered in order to implement new benefits. It would be helpful to consider how to communicate this or quantify how much offset is needed in order to provide that new benefit.
    - Emily agreed this is important, and offsets need to be considered. Some proposals need further analysis to be complete and therefore could end up being a benefit or an offset depending on how the calculations turn out. She recommends not categorizing these until the analysis is done, on this basis.
    - Betsy added that in part, staff need direction on which proposals to move forward, and ask for more information: for many, there is not enough information to make a recommendation whether it is a good idea or not. This will help staff prioritize which proposals to focus on and complete the work.
- Judy proposed that the group identify a preliminary list of most important benefits, and most strategic offsets to create the ability to add benefits. She proposed using the information available, and at least identifying a set of proposals to focus on.
    - Emily reiterated staff's request for direction: the division wants to focus the limited resources of staff time and consulting time to complete this analysis. They asked the Board to narrow down the list down of proposals to worked on for the next 6 months.

Judy proposed that Board members individually review the list over the lunch hour, identify their top priorities, and combine the list. The group agreed this is a good process, and discussed specifics:

- **Rename R001b = Add Health Decision Support**
- R004 = the group discussed whether to leave this item as pending, given what they learned about how this happens now and that it only applies to in-network providers. This remains pending.
    - Emily noted that another option to address utilization and cost is to create a tiered network approach and put coverage of some services into a different tier. This has been discussed for several years, but there are logistical concerns with this.
    - **Add this as R019**, Tiered Network Benefits for Some Services.
- **Split R009 into three proposals**:

    - 9a = clear service limits for existing covered services (chiropractic, etc.)
        - Would this also include non-network limits? Not necessarily. This will remain general, as the specifics may change depending on the analysis.
    - 9b = adding coverage of rolfing to covered services
    - 9c = adding coverage of acupuncture and acupressure to covered services
- **R012 =** wellness benefits may be difficult for tax reasons, but the group was reluctant to remove this from the list. Could this be redefined to be broader? Could it be covered under another method, such as Medicare Advantage? **Change to "wellness benefits."**
- **R015 =** compound pharmacy coverage, the Division has been addressing this in other ways. This will remain pending per the document.
- Emily added that coverage up to age 26 has been requested frequently, but they have not included this on the list because it is a statutory change and would require legislative change. Does the group wish to include this on the list?
    - The group would like to add this as **R020 = change dependent coverage up to age 26**.
- Dallas recommended that staff prepare a document with these updates and distribute for use after lunch. It should include a distinction between enhancements and offsets.
- Cammy asked for clarification: is the retiree plan required to conform with ACA requirements?
    - Emily confirmed that the plan is exempt from many of the provisions of the ACA, but not all aspects of the plan. She did not have information about all aspects of these requirements.
    - Cammy asked if there are things to consider re: ACA requirements?
        - Emily confirmed to her knowledge, no this is not a factor.

The group discussed logistics of how to proceed in the afternoon. The group will have 5 votes for additional benefits, and 2 votes for potential offsets. Judy asked the group to return at 1:15 instead.

The Board took a lunch break at 12:05 p.m., and returned to the meeting at 1:15 p.m.

Item 5 (continued). Modernization Project: 2020 Next Steps

Chair Judy Salo re-convened the meeting after the lunch break.

Staff and the board discussed and clarified the process for votes:

- Each member has 5 votes for what they consider enhancements, and 2 for offsets. The group discussed how to distinguish between these: rather than identifying as one or the other, the group will use 7 votes total. As noted, there are different definitions of "benefit" or "offset" and the group is primarily interested in narrowing down the list of possible items for discussion.
- The group will not individually identify which vote is which but tally them for each proposal.
- Once each person has marked their votes, the group will consider which ones have the most votes.

Board members each reviewed the list and marked their votes on the whiteboard in Anchorage; staff in Juneau made the same markings to keep track.

- Mauri asked about R017 Primary Care: is this part of the employee plan currently?

- Emily responded yes, this is covered with a co-pay for the employee plan, for in-network providers only. This does not require you to meet your deductible, and the co-pay does not apply to the deductible, but it does apply to the out of pocket maximum. She shared that some retiree members have said that they prefer the current system, because they are fine with paying the full cost upfront and meeting the deductible first, versus a co-pay outside the deductible. There are pros and cons to this. Emily shared that her personal experience as an employee was to appreciate this, as it is less out of pocket cost than the old system of including in the deductible.

The group tallied their votes: 6 proposals have 4 or more votes (R001b, R006, R007, R008, R009a, R009c). 3 proposals have 3 votes (R003, R012, R014). The remaining proposals got 2, 1 or zero votes.

- Emily noted that proposals R005 (out of network as % Medicare) and R019 (tiered network benefit) are very important to the Division but will require a great deal of analysis.
    - Dallas commented that this is the Board's initial thoughts; the Division could continue working on other priorities it feels are important.

The group discussed how to proceed: they noted that this may not reflect a mix of enhancements and offsets that might be necessary, and also may not reflect Division recommendations of priorities. The group proceeded with items that got at least 4 votes, for discussion.

1b: Enhanced Travel Benefits and Decision Support Service

Questions, comments or more information requested by the Board:

- Judy: The board had a presentation from SurgeryPlus, but the Division indicated they want to write a vendor-neutral proposal and not for a specific business model. Is this generic?
    - Yes, will not be specific to SurgeryPlus.
- Joelle: Is the $2.5 million in savings net of the costs to implement and provide services?
    - Yes, the assumption is that it will be net savings.
- Nan: How many people will be impacted over time, and how will this impact Medicare beneficiaries? She is concerned how this would be implemented over time.
- Mauri: Is it possible to estimate cost and/or actuarial impacts over time, and not just on a one-year basis? For example, would the net benefit/cost change in a few years?
- Dallas: The Bartlett Hospital CEO had commented that he did not vote for the travel benefits, because he is concerned about the impacts to the Alaska health care system—for example, a profitable line of business for the hospital subsidizes other lines of business, such as mental health care. He noted this as a perspective to consider.
    - Mauri commented that this is a good point and she agrees. However, she is interested in how this could benefit members and the cost for members, particularly for expensive procedures, so she is still interested in this idea if it has a net benefit.
    - Judy appreciates the access to high-quality specialty care, particularly when not available locally, and navigating the system to find a good specialist.
    - Mauri agreed. A friend recently diagnosed with Parkinson's disease has had difficulty finding care locally in Alaska, and frustrating to find quality care.
- Judy requested data on utilization of the travel benefits in the active employee plan, for reference when considering this proposal.

8: Remove Lifetime Benefit Maximum

Questions, comments or more information requested by the Board:

- Judy commented that the discussion in January focused on whether to remove or simply increase the maximum, and the implications of these options. And if there is an increase, to benchmark the number to increase over time to account for inflation. She also recalled that the proposal to remove the maximum seemed like a better option and requested that actuarial analysis reflect the relative impacts of either option.
    - Emily responded that the Division is also leaning toward removing the maximum and will review the actuarial impacts. She suspects it will be small, because it is a small number of people in this situation.
    - Staff will also review (to the extent possible) how many people have reached that maximum in recent years. Emily noted that in many of these cases, people also died shortly after because of their health complications, and/or they may not be easy to track in the system.
    - Emily noted that there are hospitalization limits in Medicare Part A, so this would be relevant for Medicare eligible members. So, it is possible that Medicare members can reach this maximum as well. Staff will research this and provide more information for the Board.
- Dallas asked for clarification, pharmacy benefits are not part of the lifetime maximum.
    - Emily confirmed pharmacy benefits are not, but if drugs are administered in a medical setting, which then get covered under the medical plan and often these are expensive drugs, so there are still implications for pharmacy benefits in those circumstances.
    - Betsy noted that some information from the quarterly TPA meetings will be useful information for this discussion.
- Judy requested staff to provide a hypothetical example, or multiple examples, to help the Board better understand how this could impact members.

6: Telehealth Services

Questions, comments or more information requested by the Board:

- Judy noted that there was discussion on this item but requested more information about the costs of this service, balanced against any cost avoidance.
- Nan asked for any information about where this service is available now, particularly in the retiree plan but also other plans, such as currently available services in rural Alaska health facilities? How many people could utilize this service, and in what circumstances?
- Judy noted that there are currently provider-to-provider consultations happening and would not want to duplicate services that already exist.
- Joelle noted that she did not vote for this item, because she feels it would be a significant burden on the Division to implement. There is no coordination of benefits, and it would be a standalone service potentially—it would be useful for some, but may be more confusing for others and may result in worse communications with existing providers if the retiree does not proactively communicate. She is concerned that it would be difficult to use, difficult to communicate, and challenging to implement. She urges caution in proceeding with this.

- Nan commented that she sees this proposal as an alternative to in-person care, including a way to get an initial consult without having to travel. She sees this proposal primarily as reimbursement, and how to pay for care other than in person care. She sees this as a positive, to increase access to care.
- Mauri reminded the group that this specific service (in this case, Teladoc services) were rolled out in the employee plan: she understood that the original proposal was focused on this specific service, that only applies to some services. However, she noted that coordination of benefits is significant, and would like to understand how this works in the employee plan. She would like to see a specific proposal for what this would entail, including administrative costs, to move forward with this plan.
    - Emily confirmed that on the employee side, this service has been positive: members needed to create an account and utilize the service at least once, and there was a slow ramp-up in participation. It required a great deal of communication and encouraging people to enroll, but this is not necessarily a bad idea. She noted that it was difficult to get the attention of employees and organized a registration drive and incentives (within tax rules). The Commissioner regularly promoted the service, and this did significantly increase enrollment. They went from 7% to 10% utilization over that period. Members can register online and over the phone, so this is feasible for retirees across the country. It is likely not feasible to streamline coordination of benefits, because it requires manual adjustment of each claim, so this means that likely coordination would not be an option. They could add services such as dermatology and behavioral health, but these have higher co-pays and would also make it difficult to coordinate benefits.
- Dallas believes this has great potential benefit for members as well as the plan, especially avoiding afterhours urgent or emergency care.
- Judy commented that she is interested in the potential for behavioral health services: more telehealth options are available across the country, and this is certainly an important service. Does AlaskaCare plan cover this already, or could cover as a service?
    - Emily noted that the plan has had issues with fraudulent billing from some providers, so there would need to be more clear guidance and rules for billing, specifically for telemedicine services and counseling. The services are covered in person and subject to deductible, co-insurance and out of pocket, provided that they are billing the appropriate codes (in-person code for an in-person meeting, or telemedicine if remote). They would not cover, for example, services such as a massage that requires being physically present.
    - Betsy added that the Division is concerned about avoiding fraud, but also ensuring that the service provided is appropriate and billed accordingly, and that it is medically necessary. Staff would work with Aetna to come up with more clear guidelines.
- Judy requested staff to consider what options would be available to members, whether it is a service like Teladoc or reimbursement for other services. She would like more specific proposals to consider and to design this proposal accordingly.
    - Emily agreed, and noted that it will be important to be specific enough to define benefits to be clear for members and the plan, but also not be so specific to a vendor or business model. For example, perhaps a new vendor or service will have a great service

but does not exist now and will come up in a few years. It will be helpful to have some flexibility for members.

7: Expand Preventive Services for All Retirees

Questions, comments or more information requested by the Board:

- Nan commented that while most people will end up in Medicare over time, this is still relevant until that point as people are not Medicare eligible yet, and
- Joelle commented that the packet is thorough, she does not have additional requests for information at this time.
- Mauri noted that there does seem to be need for financial and actuarial analysis to be completed, which will be helpful. She likes the idea of covering the USPSTF-graded preventive services.
- Judy asked if this proposal is related to wellness benefits?
    - Yes, it certainly is—it includes preventive benefits generally.
- Betsy noted two questions from the previous meeting and a note:
    - People were interested in whether Cologuard is covered (a home colorectal cancer screening test), as it is more cost effective.
    - The Board requested considering the relative cost/benefit of covering preventive coverage at 100% rather than 80% (i.e., no co-insurance for the member), and what impact this has. For example, is it relatively little difference, in which case it may make sense to cover preventive care at that level.
    - The proposal will be updated that Medicare part D vaccines are already covered in the pharmacy plan, so this will be reflected in the update.
- Cammy noted that there is a discrepancy of the overall cost, please confirm the numbers are accurate, since this is an older proposal.
    - Betsy noted this: she also noted that for all proposals, they will include how many people it impacts and over what time period, as well as how that impacts cost over time.
- Joelle noted the current breakdown of the retiree members by age group now, and over time what projected numbers are, for Medicare eligible and not eligible. She suggested the curve of, for example, when the last DB retiree enters the system, and what year the last DB retiree would "exit" the system. She also commented that understanding long term trends would be helpful—at some point, some changes to the plan may no longer have a benefit or cost avoidance, and end up costing more for a few expensive people, for example.
    - Emily commented the peak retiree population is likely to be in 2030 or 2031: it is projected to peak around 57,000 members at that time and reduce after that point. There are currently 37,000 people in the system, so this is an increase of about 20,000 people. The retiree pension plan anticipates a peak in benefit payments in 2036, and significantly taper out by 2084.
    - Richard added that as the population ages, the proportion of Medicare enrollees will grow, which means the cost increase will be less as more costs are the responsibility of Medicare. Currently there is a 2-3% growth in Medicare eligible each year. There are approximately 27,000 (73%) Medicare eligible retirees, and 10,000 (27%) are not. This has changed over the last few years.

    - Betsy commented that staff will prepare a demographic slide, showing historical growth and current breakdown by age and projected future growth/demographics in this group.
- Cammy commented that while she expected costs to go down as people aged into Medicare, she noted that pharmacy spending did not decrease—this was impacted by EGWP in 2019 in terms of controlling cost growth in this area, but this was otherwise surprising.

9a: Define Clear Service Limits for Rehabilitative Care

9c: Expand Preventive Services for All Retirees [combined]

Questions, comments or more information requested by the Board:

- Judy commented that this and R009c had 4 votes each, related to rehabilitative care.
- Nan noted that one key question was whether "rehabilitative" should be restoration of function after an injury or maintaining health or function. She understands this is a point of contention legally. How can this be defined, and whether to include maintenance, is useful.
- Judy commented that she appreciated the work the Division did on other options: for example, working with individual providers or monitoring outliers in usage. Could this be applied to this proposal in place of other changes, or in addition?
    - Emily noted that this is an exciting option, but it requires participation in a network. If the provider is in the network, they can be held to that agreement; if they are not, there is no incentive. She reiterated the Division's interest in items R005 and R019. Right now, because of current reimbursement policies, there is no incentive for out of network chiropractors to get in network because they will not be reimbursed more.
- Judy asked how services not covered by Medicare are covered by AlaskaCare?
    - Emily confirmed that for any service not covered by Medicare, AlaskaCare is primary. However, it is sometimes difficult to determine whether it is covered, depending on the situation. Then the provider will first bill Medicare to see if and how it is covered, to request an explanation of benefits. For example, in some circumstances, Medicare will pay dental implants. However, many oral surgeons in Alaska have opted out of Medicare, and therefore will not get a Medicare EOB. The Division is still working through these circumstances and how to address this issue.
    - Judy asked if you could receive pre-authorization from Medicare, would they send in advance whether the service will be covered or not?
        - Richard confirmed that no, Medicare will not prospectively say whether they cover a service or not, even hypothetically.
    - Cammy asked if there is a billing code method to determine if a service is covered?
        - Emily confirmed no, this is not dependent on codes.
    - Mauri added that rolfing, acupuncture and other services all use the same CPT code for manual therapy. There is no way to distinguish unless codes change.
    - Cammy noted that it seems that the circumstances in which the service is provided determines how the billing is handled, is that correct?
        - Emily confirmed it is complicated and they are still figuring out the rules: they are determining how to comply with statute, regulations, plan provisions and other components.

Next Steps

- Joelle commented that there are still significant offsets: R003 and R014 have 3 votes each, and the group does still need to consider offsets. She posed to the group, what else to include? How do we account for the offsets that would be needed, potentially, to allow these? She also noted that the Division has put forward R005 and R019 as priorities. If the Board does not put forward other offsets to think about, these would be the default.
- Dallas proposed that the group consider tiers of recommendations: he likes keeping anything with 4 or more votes, as this is a majority vote of the Board, and could consider adding in the items with 3 votes as lesser priorities.
- Cammy pointed out that R003, increasing deductible and out of pocket maximums, is also an offset: is this proposal mostly complete, could it be brought forward?
    - Betsy confirmed that she believes this proposal is complete and could be discussed.
- Cammy commented that both R003 and R014 are similar in terms of financial impact, and that the pharmacy plan changes would be mitigated in part if people utilized the $0 co-pay mail order pharmacy. But she understands that the proposal could still save money to the plan through price negotiation. Is more analysis needed?
- Joelle offered that the increase in deductible would likely impact everyone, by $50 or whatever the recommendation is, but the pharmacy changes could potentially impact fewer people a great deal, and would depend on how many prescriptions they have and at what tier. What impacts the least number of people, or has the overall least impact? Is that having the same change for all members, or an increase in cost for relatively fewer members? Is there a cap on pharmacy benefit, like an out of pocket maximum?
    - Cammy clarified that the plan does have a waiver option, if a person can only take one drug that is non-preferred and cannot take any alternative. Or a person could utilize a generic instead, or mail order in any case, if it is a maintenance drug and not one-time.
    - Emily stated that the Board should consider which proposals they would like to consider, and not necessarily only follow the Division recommendations. If additional analysis is needed, it can be included.
- Judy commented that more analysis would be useful, to have more concrete numbers for the discussion, on both of those proposals (R003 and R014).
- Mauri commented that she voted for R003 because she understands the courts have seen this as an acceptable offset that can be calculated into actuarial value; and she noted that the buying power of $150 has gone down over time, significantly since that number was put in place. She questions whether it is a significant hardship to increase by $50, recognizing that the current plan is very generous. She understands that this will still impact people but sees this as a very feasible offset to consider.
    - The group agreed to keep R003 on the list as a potential offset.
- Judy suggested considering R020 (age of dependent care up to age 26) on the list, it did not rise to prominence on this list, but it was a very popular addition to the plan, had a great deal of support when discussed as part of the Affordable Care Act, and she speculates that given the young adult population being relatively healthy, that it would have relatively limited cost.

- Dallas commented that he has heard from multiple employees that having coverage under the employee plan for dependents up to age 26 influences their working decisions. They may delay

retirement in order to maintain coverage for their dependents. So, this is also a consideration, he is unsure if this is a positive or negative effect but is happening now.
    - Emily added that if this were changed in the Legislature, it would have a fiscal note attached to a bill. She noted that this could be logistically difficult to weigh against the other proposals, that are policy changes and not law changes.
    - Judy agreed, and suggested that the Board monitor any bills introduced to change that legislation.
- Judy asked whether any bills have been pre-filed or filed related to the retirement plan?
    - Emily shared that HB 229, filed by Rep. Spohnholz, would establish a Health Care Transformation Corporation and Council, and create an all-payer claims database, which would require reporting data from all plans statewide and provide data on which to base health plan decisions and pricing. This is part of an ongoing project from the Health Care Transformation Project.
    - HB 29: Insurance Coverage for Telehealth has a hearing next week, regarding benefits under Division of Insurance. Staff does not have a position on this bill and have generally educated legislators about why it is important to manage the health plan through regulation and policy, not statute. They have also educated why it would be challenging to include their division under Division of Insurance, and why to keep these separate.

12: Wellness Benefits

Questions, comments or more information requested by the Board:

- Dallas commented that he favors this proposal, because it would enhance benefits but also potentially offset other costs to the plan over time. It would support wellness broadly, which would include mental health, financial health, etc. He believes this is worth considering.
    - Emily commented that in the employee plan, they have created a wellness program with built-in incentives for participating, e.g. a reduction in other costs if they do certain activities. She noted that it may be more difficult to create a similar program for retirees, but staff met with Elizabeth Ripley at Mat Su Health Foundation to discuss best practices for senior wellness. MSHF has been active in initiatives such as reducing senior falls, for example. There are higher rates of depression, substance misuse (particularly alcohol), and other health concerns among seniors.
- Nan commented that perhaps a wellness program to advise on healthy living and healthy lifestyles, for example specific counseling for people to improve their health.

Item 6. Public Comment

See Item 2 in the minutes for public comment guidelines.

Judy Salo reminded meeting attendees of the guidelines for public comments provided in the meeting and invited anyone who wishes to provide public comment at this time to speak.

Public Comments

- **Barbara Steck**. Barbara also prepared a list of her preferred proposals for discussion: R001b (also selected by the Board), R003 (as an offset, also Board), R007 (also Board), R008 (also Board), and R009a (also Board). And she also is open to R014 (as an offset). She also commented

that several years ago, BP provided Fitbit to all employees as an incentive for being physically active, with a reward for utilizing that program. She is interested in a program like this as well, as an example.

Item 7. Closing Thoughts + Meeting Adjournment

Closing Thoughts

- Mauri shared that she is not available for May 7 meeting. Cammy is also not available; she is back in town on May 9.
    - Teri commented that the quarterly meeting is scheduled for May 5-6 and could be rescheduled as well. However, this is difficult so they will likely keep those dates. The Retiree meeting will be Wednesday, May 6.
    - The group proposed meeting the last week of May, after the Memorial Day weekend? May 27 or 28 would be possible. The group will tentatively confirm May 27, and check calendars.
- Dallas asked the Board and staff to clarify what proposals remain on the list.
- Emily restated the priorities from the Board: there are 9 proposals total; 11 with Division priorities.
    - Priority 1 proposals: R001b, R006, R007 and R008
    - Priority 2 proposals: R003, R009a, R009c, R012, and R014
    - Division priorities, to include as well: R005 and R019.
- Betsy commented that regarding R020 (coverage up to 26), staff would like to create a fact sheet explaining this specific proposal and why it is different than the others, because it requires statute change. This can provide the Board more information to help communicate with other retirees.

- **Motion** by Mauri Long to adjourn the meeting. **Second** by Gayle Harbo.
    - **Result**: No objection to adjournment. The meeting was adjourned at 3:13 p.m.

The next Retiree Health Plan Advisory Board meeting is planned for May 27, 2020. 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.

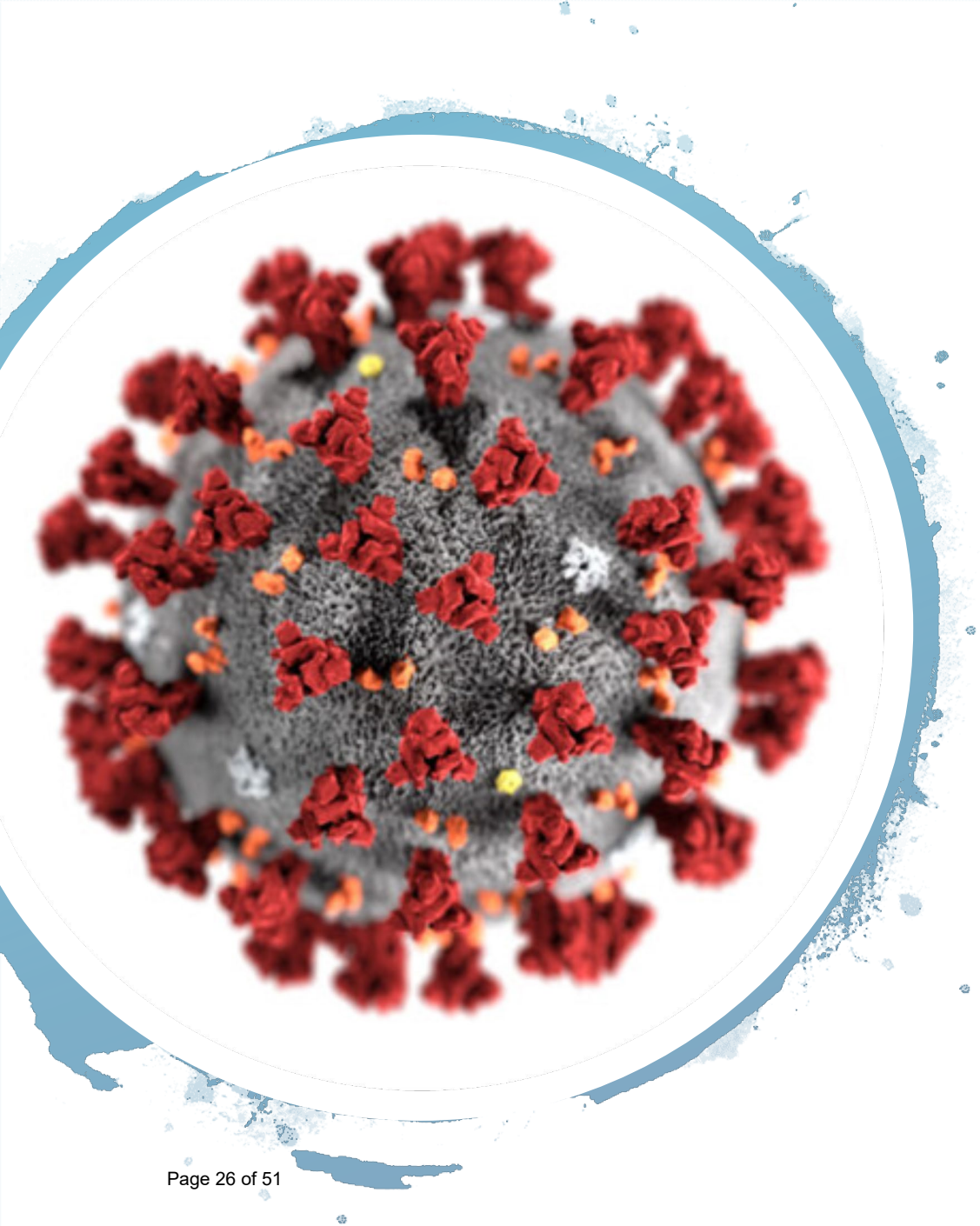
COVID-19 Response

Emily Ricci, MPH
Chief Health Administrator

Betsy Wood, MPA
Deputy Health Official

AlaskaCare Retiree Health Plan

Retiree Health Plan Advisory Board
May 27, 2020



In response to the COVID-19 national public health emergency declared on January 31, 2020 and the State of Alaska public health disaster emergency declared on March 11, 2020, the Division of Retirement and Benefits (Division) implemented temporary administrative changes and suspensions in the AlaskaCare health plans

Disclosure

The temporary administrative changes are prospective in nature and shall remain in effect until earlier of the date of:

1) the termination of the suspensions contained in the applicable COVID-19 Disaster Order of Suspension;

2) the termination of the Declaration of Public Health Disaster Emergency issued by Governor Mike Dunleavy; or

3) the national public health emergency is terminated by the Secretary of Health and Human Services, including any extensions or amendments thereof.

The temporary administrative changes are in response to a State of Alaska and federally recognized health emergency and do not provide a vested right to coverage for any individual. The Division of Retirement and Benefits retains the sole discretion to rescind or modify these temporary administrative changes depending on the circumstances.

COVID-19 Global Pandemic - 2020

January

World
- World Health Organization (WHO) announced a new coronavirus
- Outbreak centered in Wuhan, China
- 9826 cases - 213 deaths

U.S.
- First U.S. case confirmed in Washington state (1/21)

February

World
- Disease is named COVID-19
- Increase in countries outside China confirming cases
- 85,403 cases - 2,924 deaths

U.S.
- Travel restrictions announced
- U.S. declares public health emergency (1/31)
- FDA expands testing in U.S.
- 68 cases and first death

March

World
- WHO declares COVID-19 a pandemic
- 750K cases - 36,405 deaths

U.S.
- States implement stay at home directives
- U.S. declares national emergency (3/13)
- CARES Act (3/27)
- 189K cases - 3,900 deaths

Alaska
- Governor declares public health disaster (3/11)
- First Alaska case announced (3/12)
- Health Mandates: Travel; Elective Medical Procedures; Elective Oral Health Procedures; Intrastate Travel
- 232 cases and 4 deaths

AlaskaCare
- First temporary changes enacted (3/4)
- Additional town hall events

April

World
- 3.1m cases and 220K deaths

U.S.
- Families First Coronavirus Response Act (4/1)
- 1.1m cases and 55K deaths

Alaska
- Updates to Health Mandates
- Governor's Order of Suspension of certain state statues and regulations
- 363 cases and 9 deaths

AlaskaCare
- Additional temporary changes enacted
- Additional town hall events

May

World
- 5m cases and 328K death

U.S.
- 1.6m cases and 95k deaths

Alaska
- Reopen Alaska Responsibly Plan implemented
- 402 cases, 10 deaths

AlaskaCare
- Ongoing evaluation of temporary changes
- Additional town hall events

Challenges of a Global Pandemic

Prevention

Not enough Personal Protective Equipment (PPE)

Preparation for the Stay at Home orders

Access to medication, food, supplies

Testing

Insufficient test quantity

Inaccurate tests

Limited type of tests

Vague symptoms

Prioritized case testing

Treatment

Insufficient supplies

Drug shortages

Staffing challenges

Potential surge in patients

New treatment protocols

Increased demand on overall health care system capacity

Access to Care

Fear of exposure at hospitals/health care facilities

ER Avoidance

Concern about costs

Hunker down directives

Cancellation/postponement of non-urgent procedures

Our Priorities:

Support	Support the public health COVID-19 response.
Assist	Assist members in accessing the care and services they need to remain healthy and safe.
Reduce	Reduce strain on the health care delivery system.
Protect	Protect members from losing health coverage.
Ensure	Ensure continued quality service to and safety of our members.

Support Support public health COVID-19 response.

- Collaborate with Department of Health and Social Services and Division of Insurance
- Early planning and action by the Division:
  - **Waive member cost share for COVID-19 testing and associated office visits**
    Effective March 9, 2020
  - **Waive applicable cost sharing provisions for COVID-19 inpatient care**
    Effective March 26, 2020
  - **Increase email communications**
    Effective March 4, 2020
  - **Expand townhall to include state epidemiologist/medical directors**
    Effective March 13, 2020

Assist

Assist members in accessing the care and services they need to remain healthy and safe.

- Focus on assisting members wherever they may be located
  - **Allow early refills for up to 90-days supply (excluding opioids)**
    Effective March 3, 2020
  - **Expand Teladoc services to AlaskaCare retirees**
    Effective March 9, 2020
  - **Expand set of telemedicine billing codes eligible for coverage to align with Medicare**
    Effective March 4, 2020

    Waive member cost-share for telemedicine visits
    Effective March 4, 2020
  - **Expand Aetna crisis support line to retirees**
    Effective March 6, 2020
  - **Provide temporary coverage for influenza and pneumococcal vaccines**
    Effective March 6, 2020 (flu) and March 13, 2020 (pneumonia)

Reduce

Reduce strain on the health care delivery system.

- Reduce financial barriers for providers and patients
  - **Waive applicable cost sharing provisions for COVID-19 inpatient care**
    Effective March 26, 2020
    Waive member cost-share for telemedicine visits
    Effective March 4, 2020
- Streamline administrative requirements
  - **Suspend precertification and utilization management requirements**
    Effective March 29, 2020
  - **Extend precertification periods for prescriptions and medical services**
    Effective March 29, 2020
- Support changes in the delivery system
  - **Expand set of telemedicine billing codes eligible for coverage to align with Medicare**
    Effective March 4, 2020

Protect

Protect members from losing health coverage.

- Suspend disenrollment
  - **Maintain benefits for Direct Bill participants who miss payments**

    Effective April 1, 2020
  - **Maintain benefits for COBRA participants and extend enrollment period**

    Effective March 4, 2020
- Suspend verification
  - **Suspend incapacitated dependent verification review**

    Effective April 14, 2020
  - **Suspend full-time student review**

    Effective April 6 , 2020

Ensure

Ensure continued quality service to and safety of our members.

- Keeping members and staff safe
  - **DRB offices closed to the public**
    Effective March 16, 2020
  - **12 out of 13 health team members working remotely**
    Effective March 20, 2020
  - **CHCS Long-Term Care assessments transitioned to remote evaluations**
    Effective March 17, 2020
- Ensure continuity of operations
  - **Aetna, Delta Dental and OptumRx member teams transitioned to working remotely**
    Effective end of March 2020
  - **DRB is actively monitoring COVID related claims and member calls to identify trends and any needed adjustments**
- Extend administrative deadlines
  - **Extend IRMAA deadline for 2019 claim forms from March 30 to May 31, 2020**

What comes next?

While the state re-opens, vigilance is required

Health plan continues to monitor developments and is prepared to make changes as necessary

Evaluating the temporary administrative changes and considering appropriate time for termination, suspensions, or extensions

Anticipate some major changes in the health care delivery system and working to stay ahead of those

Resources

Centers for Disease Control and Prevention

- https://www.cdc.gov/coronavirus/2019-ncov/index.html

Alaska Department of Health and Social Services

- covid19.alaska.gov

COVID-19 Health Alerts and Mandates for Alaska

- https://covid19.alaska.gov/health-mandates/

CDC Coronavirus Self Checker

- https://www.cdc.gov/coronavirus/2019-nCoV/index.html

COVID-19 Testing

- http://dhss.alaska.gov/dph/Epi/id/Pages/COVID-19/testing.aspx

Questions?

Retiree Health Care Advisory Board

Medicare Advantage Overview

May 27, 2020

Segal

Medicare ABCs

Medicare has four parts:

1	**Part A**	Hospital Services
2	**Part B**	Physician Services
3	**Part C**	Medicare Advantage
4	**Part D**	Outpatient Prescription Drugs

- Each has different entitlement, enrollment, benefits and payment rules
- Medicare is administered by the Centers for Medicare & Medicaid Services (CMS), which in turn contracts with administrators, health plans, and prescription drug plans to provide various benefits

Medicare Modernization Act of 2003

- Authorized government financial support to employers that provide prescription drug benefits
- Increased the types of employer-sponsored plans that could contract and coordinate with Medicare by providing for “employer group waiver plans” or “EGWPs”
- Changed Medicare Plus Choice to Medicare Advantage
- Created the Retiree Drug Subsidy (RDS)

Medicare Advantage Overview

- Private plan options that offer Medicare services—Parts A & B—and often additional benefits
- Fully insured premiums typically cover cost of benefits and enhancements above CMS payment
- MA carriers receive capitated payments from Federal CMS that subsidize the cost of coverage
- Federal CMS provides payment based on capitation Rates (monthly payment) & Risk-adjustment. These payments can vary:
  - By county
  - By risk level of group
  - By ability of carrier to capture and report
  - Star Rating System (quality, member satisfaction for health plan)
- MA plans are flied with CMS on a county by county basis
  - Each county comprises a “service area”

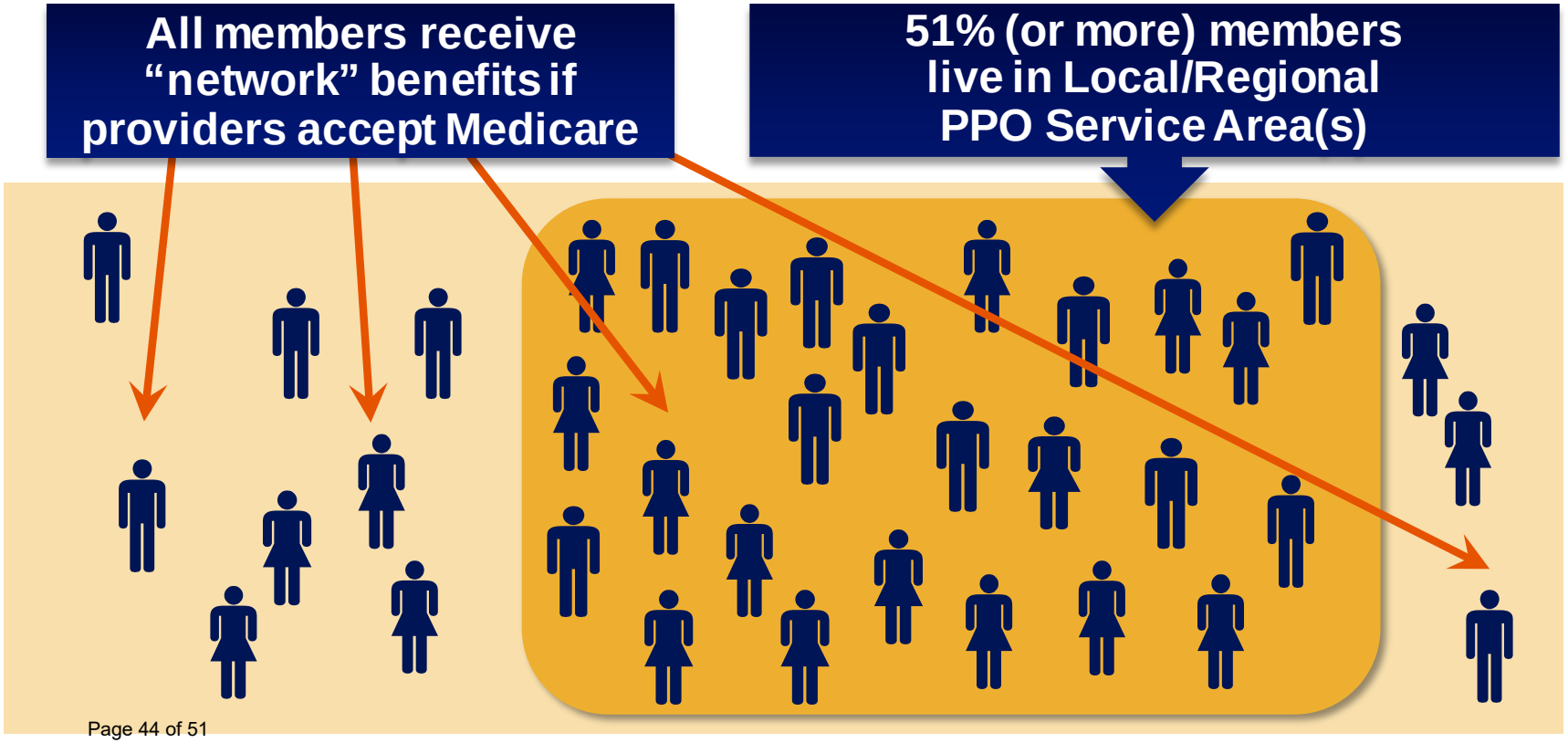
Medicare Advantage vs. Traditional Medicare

Traditional Medicare	Medicare Advantage
Fee-for-Service	Capitation-like subsidies
Federal Government is payer	Private Insurance
Basic Medicare Part A and Part B Benefits, can purchase supplemental coverage	Medicare + Supplemental benefits integrated
"Network" = providers accepting Medicare	Local and Regional Provider Networks
Same benefits nationally	Benefits vary by location
No Medical Management	Medical Management and (often) Wellness
Premiums/Deductible set annually by Fed	Premiums and benefits result of competitive bidding and market forces
FFS/Indemnity style	HMO/PPO

Medicare Advantage Plans

National Passive PPO for Groups

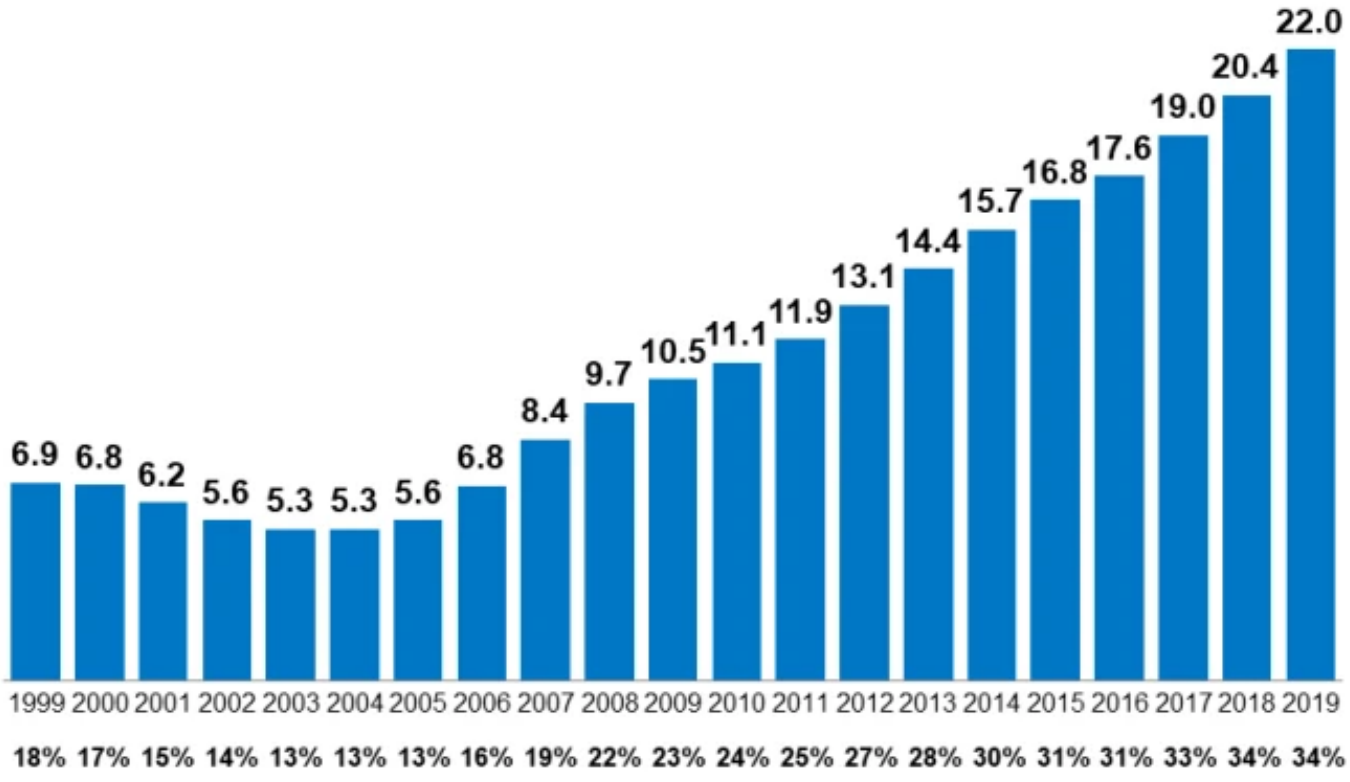
- If a regional PPO provides coverage to at least 51% of the members in a "service area," it can provide coverage on a national passive PPO basis
- Offers same member cost sharing and benefits whether using in-network or out-of-network providers



Medicare Advantage Enrollment Growth

Figure 1

Total Medicare Advantage Enrollment, 1999-2019
(in millions)



NOTE: Includes cost plans as well as Medicare Advantage plans. About 64 million people are enrolled in Medicare in 2019.
SOURCE: Kaiser Family Foundation analysis of CMS Medicare Advantage Enrollment Files, 2008-2019, and MPR, 1999-2007; enrollment numbers from March of the respective year, with the exception of 2006, which is from April.

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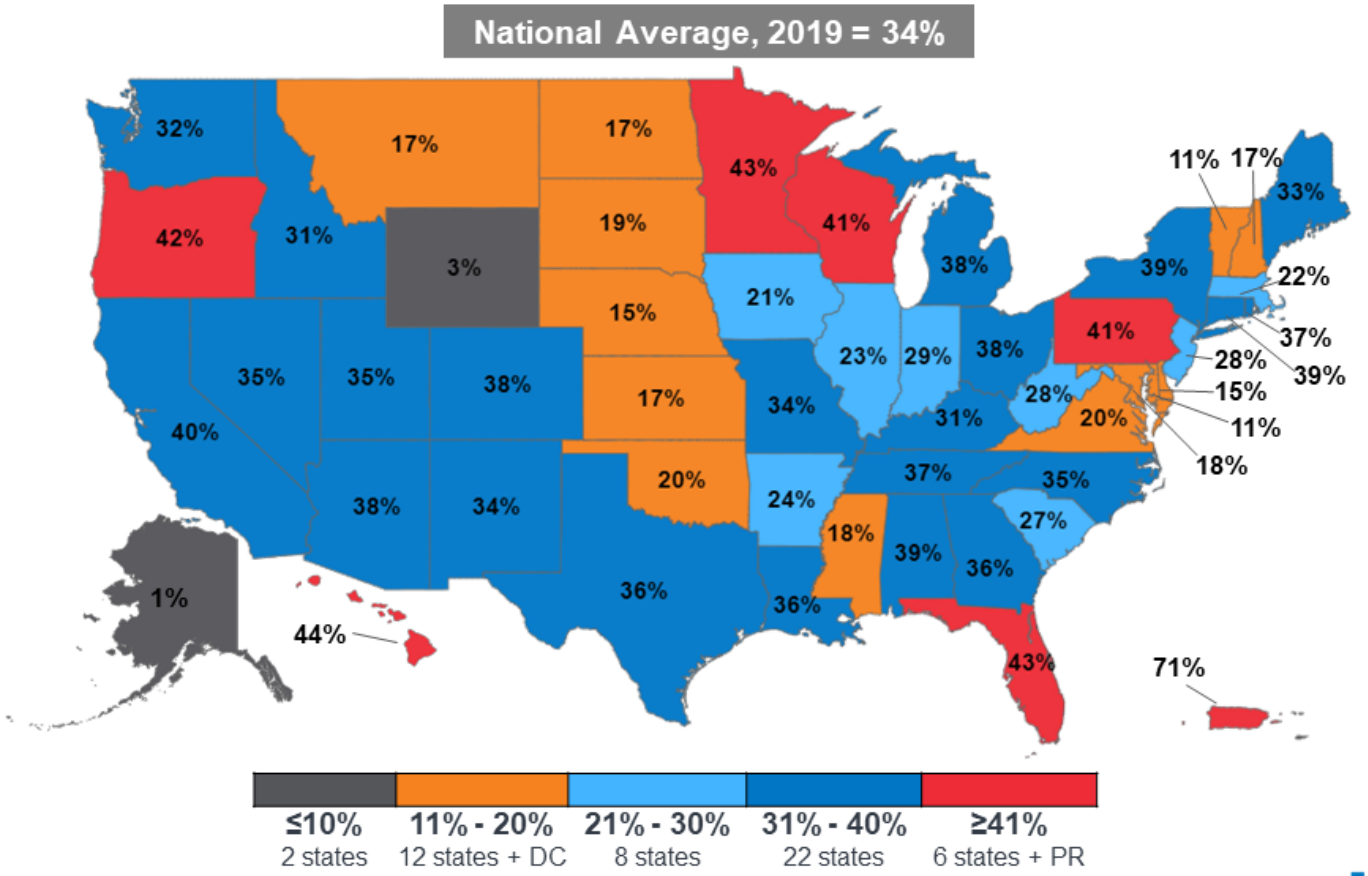
Medicare Advantage Enrollment by State

Figure 2

Medicare Advantage Penetration, by State, 2019



NOTE: Includes cost plans, as well as other Medicare Advantage plans. Excludes beneficiaries with unknown county addresses.
SOURCE: Kaiser Family Foundation analysis of CMS State/County Market Penetration Files, 2019.

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Segal

Medicare Advantage Market

- **Group MA PPOs**
  - Aetna
  - Blues
  - Humana
  - UHC
- **Group MA HMOs, above plus**
  - CIGNA
  - Kaiser
  - Host of local/regional carriers

Advantages of MA

- Enhanced care management coordination
- Enhanced EGWP risk scores
- Access to federal funds
- Economies of scale

Medicare Advantage Considerations

- Currently no Medicare Advantage options in Alaska
- Generally covers more comprehensive services than Medicare, such as preventive
- Through MA PPO members maintain access to all providers that accept Medicare
- Access Silver Sneakers and other current programs
- Health Management and other wellness services
- Federal funding beyond Medicare FFS payments results in savings opportunity when compared to traditional Medicare
- Lower 48 retirees may help in meeting the 51% requirement for Group PPOs

Thank You

Retiree Health Plan Modernization Topics

Priority	#	Draft Proposal
1	R001b	Enhance travel benefits + Decision Support Services
1	R006	Expanded telehealth services
1	R007	Expand preventive coverage to add full suite of preventive services
1	R008	Remove or increase lifetime maximum (currently $2M)
2	R003	Increase deductible and out-of-pocket maximum
2	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 - add coverage for Acupuncture / Pressure
2	R012	Add wellness benefits such as gym membership or program like Silver Sneakers
2	R014	Implement 3-tier pharmacy benefit; change out-of-network pharmacy benefits
D*	R005	Out-of-network reimbursement as a percentage of Medicare
D*	R019	Tiered Network Benefits for Some Services

*Division priority.

Updated: 5/20/20

AlaskaCare DB/DCR Retiree Plan Members by Age Band Reporting Period Feb 2019-Jan 2020			
Enrollment by Age Band	Subscribers	Dependents	Total
<1 - 20	0	1,710	1,710
21 - 30	2	645	647
31 - 40	7	148	155
41 - 50	99	435	533
51 - 60	2,951	3,506	6,458
61 - 70	20,189	12,341	32,530
71 - 80	15,614	8,886	24,500
81 - 90	4,774	1,851	6,625
91 - 100	659	117	776
100 +	7	0	7
Total	44,302	29,639	73,941