Retiree Health Plan Advisory Board – Modernization Subcommittee
Meeting Agenda

Date:	January 15, 2020
Time:	09:00 am – 03:00 pm
Location:	ANC Atwood Conference Room
Teleconference:	855-244-8681 Access Code: 283 920 902
Committee Members:	Judy Salo (chair), Joelle Hall, Gayle Harbo, Dallas Hargrave, Mauri Long, Cammy Taylor, and G. Nanette Thompson

09:00 am **Call to Order – Judy Salo, Board Chair**

- Roll call and introductions
- Approval of agenda
- Ethics disclosure

09:15 am **Public Comment**

09:30 am **Working Session**

11:30 am **Lunch**

01:00 pm **Working Session continued**

03:00 pm **Adjourn**

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DRAFT

Retiree Health Plan Modernization Topics*

#	Draft Proposal	Estimated Actuarial Impact	Estimated Fiscal Impact
1a.	Enhance travel benefits	=0.00%	-$2,800,000/yr
1b.	Enhance travel benefits, add health concierge	=0.00%	-$2,500,000/yr
2.	Network steerage: 70% out-of-network and 90% in-network	+0.14%	+$800,000/yr
3.	Increase deductible and out-of-pocket maximum	-0.50% -1.60%	-$2,900,000/yr -$9,300,000/yr
4.	In-network enhanced clinical review of high-tech imaging and testing	=0.00%	-$250,000/yr
5.	Out-of-network reimbursement as a percentage of Medicare		
6.	Expanded telehealth services	=0.00%	-$250,000/yr
7.	Expand preventive coverage to add full suite of preventive services	+0.75%	+$5,000,000/yr
8.	Remove or increase lifetime limit (currently $2M)	+0.40%	+$2,700,000/yr
9.	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 – *public comment proposal*		
10.	Exclude coverage for drugs with over-the-counter (OTC) equivalents		
11.	Implement high-value pharmacy network with lower copays for chronic meds, medical synchronization, counseling, and packaging options for participating members.		
12.	Add wellness benefits such as gym membership or program like Silver Sneakers - *public comment proposal*		
13.	Clarify coverage of implants related to periodontal disease under the medical plan and/or under the dental plan		
14.	Implement 3-tier pharmacy benefit; change out-of-network pharmacy benefits	Dependent on final plan design	-$3,000,000/yr
15.	Limit compound coverage to high-quality, narrow network of pharmacies		
16.	Add medically necessary treatment of gender dysphoria including surgery – *public comment proposal*		
17.	Copayment for primary care		
	Plan Housekeeping Items		
18.	Clarify reimbursement policies for surgical assistants in the plan booklet		

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

Updated for: January 15, 2020

Proposal Title	Three-Tier Pharmacy Benefit
Health Plan Affected	Defined Benefit Retiree Plan
Proposed Effective Date	January 1st, 2020
Reviewed By	Retiree Health Plan Advisory Board
Proposal Drafted	April 2019
Status of Proposal	Under Consideration

Summary of Current State

The AlaskaCare defined benefit retiree pharmacy plan has an open formulary, meaning that the plan will cover drugs prescribed by a provider, acting within the scope of his or her license, for the treatment of an illness, disease, or injury. The AlaskaCare employee plan, the defined contribution retiree plan, and for those defined benefit retirees who elect to opt out of the enhanced Employer Group Waiver Program (EGWP) and instead participate in the opt-out pharmacy benefit, have a three-tier pharmacy benefit cost structure in place. With a three-tiered benefit, prescription drugs fall into one of three categories or "tiers." Each tier has a different copay or out-of-pocket cost. The first tier is for generics, the second is for preferred brand-name drugs, and the third is for nonpreferred brand-name drugs.

Objectives

a) Maintain choice for members while promoting greater use of therapeutically comparable and affordable drugs.
b) Provide savings to the members and to the health trust and balance other modernization proposals.

Summary of Proposed Change

This proposal would establish a three-tier pharmacy benefit cost structure in the AlaskaCare defined benefit retiree prescription drug plan to promote utilization of generic and preferred brand-name medications. The tiered formulary design can incentivize cost effective drugs that are therapeutically equivalent when there are multiple drugs available. The plan would be amended to establish different copayments for medications based on drug type:

Tier 1: Generic Drugs – lowest cost tier
Generic medications are therapeutically, and often chemically, identical to brand medications and are widely available at competitive prices.

Tier 2: Preferred Brand-Name Drugs – slightly higher cost tier
Preferred brand-name drugs are brand-name medications for which a generic option is not available.

Tier 3: Non-Preferred Brand-Name Drugs – highest cost tier
Non-preferred brand-name drugs are brand-name medications that are available in an equivalent generic form, or as a preferred brand-name drug. These drugs typically cost more than their generic or preferred brand-name equivalent. While many individuals can use generic, preferred brand-name, and non-preferred brand-name medications interchangeably, some individuals may have a medical need to utilize a non-preferred brand-name medication. In these instances, the member or his or her doctor may seek a medical exception. If the exception is granted, the drug will be available at the preferred brand-name drug copay.

This proposed change would only impact medications obtained at a retail pharmacy. Medications obtained via mail order would remain available for a $0 copay. Members who have coverage under multiple AlaskaCare plans, or who have other drug coverage that coordinates with AlaskaCare would continue to experience a reduction in their copays.

DRAFT-Summary of Responses to Proposed Plan Design Change

Proposed change: Implement Three-Tier Pharmacy Benefit

Plans affected: DB Retiree Plan

Reviewed by: Retiree Health Plan Advisory Board

Proposed implementation date: TBD

Review Date: June 6, 2019

Table 1. Plan Design Changes

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

Description of proposed change:

This proposal would establish a three-tier pharmacy benefit cost structure in the AlaskaCare defined benefit retiree prescription drug plan standard benefit that would promote utilization of generic and preferred brand-name medications. The plan would be amended to establish different copayments for medications based on drug type:

- **Tier 1: Generic Drugs – lowest cost tier**
  Generic medications are therapeutically, and often chemically, identical to brand medications and are widely available at competitive prices.
- **Tier 2: Preferred Brand-Name Drugs – slightly higher cost tier**
  Preferred brand-name drugs are brand-name medications for which a generic option is not available.
- **Tier 3: Non-Preferred Brand-Name Drugs – highest cost tier**
  Non-preferred brand-name drugs are brand-name medications that are available in an equivalent generic form, or as a preferred brand-name drug. These drugs typically cost more than their generic or preferred brand-name equivalent.

Table 2: Proposed Pharmacy Benefit Cost Structure vs. Current Cost Structure

		Generic	Preferred Brand-Name	Non-Preferred Brand-Name
Network Pharmacy Copayment*	Proposed	$4	$8	$16
	Current	$4	$8	N/A
Mail Order Copayment*	Proposed	$0	$0	$0
	Current	$0	$0	$0

** Up to 90 day or 100-unit supply*

While many individuals can use generic, preferred brand-name, and non-preferred brand-name medications interchangeably, some individuals may have a medical need to utilize a non-preferred brand-name medication. In these instances, the member or his or her doctor may seek a medical exception. If the exception is granted, the drug will be subject to preferred brand-name drug cost sharing.

A three-tier pharmacy benefit cost structure is currently in place in the AlaskaCare employee plan, the defined contribution retiree plan, and for those defined benefit retirees who elect to opt out of the enhanced Employer Group Waiver Program (EGWP) and instead participate in the opt-out pharmacy benefit. To administer these tiered pharmacy benefits, the AlaskaCare Pharmacy Benefit Manager, or PBM (currently OptumRx), categorizes drugs into one of the three tiers.[1] A drug list, or formulary, is posted to the AlaskaCare website and serves as a resource for members and providers to indicate what tier a medication is categorized under. If this change is implemented, a similar formulary indicating drug tiers for the AlaskaCare defined benefit retiree prescription drug plan would be made available to members and providers.

The change under consideration would not remove coverage for any drug or medication, rather it would impact the member's copayment for non-preferred brand-name medication. Depending on the cost of the drug, which can change, the formulary would be updated annually.

This proposed change would only impact medications obtained at a retail pharmacy. Medications obtained via mail order would remain available for a $0 copay. Members who have coverage under multiple AlaskaCare plans, or who have other drug coverage that coordinates with AlaskaCare would continue to experience a reduction in their copays.

Member Impact:

This change will impact members who utilize medications that would fall into the non-preferred brand-name. During the first quarter of 2019, approximately 11,000 unique members utilized drugs that would be classified as a non-preferred brand-name medication.[2] These members would experience an increase in their drug copays if they did not switch to a drug in a different tier or seek, and receive, a tier exception.

[1] A similar process is currently in place for the AlaskaCare defined benefit retiree standard pharmacy plan to categorize drugs as either brand-name or generic.
[2] Segal Memorandum, Pharmacy 3rd Tier Copayment, dated June 7, 2019.

This impact could be mitigated as affected members will be able to receive the same medication at the same or lesser cost as they do today, either through mail order for a $0 copay, or by seeking a medical necessity exception to the increased copayment for non-preferred brand-name medication.

The experience observed in the AlaskaCare Employee plans when they transitioned to a three-tier structure was mixed, largely due to the simultaneous transition from a fixed copay structure to a percentage-of-cost model, which increased out-of-pocket costs significantly for members utilizing single-source brand medications. However, migration was observed within brand drugs where therapeutic equivalents existed, with the end result being overall lower expenses on a per brand drug basis. As the AlaskaCare Retiree Plan is not considering a transition from fixed copays to percent-of-cost, the plan is unlikely to observe significant increases in out-of-pocket spend, even among members who utilize single-source brand drugs for medical reasons or patient preference.

DRB operational impacts:

Impacts to the Division of Retirement and Benefits will be minimal. The work associated with this proposal will occur up front. The Division will need to work with the PBM to notice the membership, amend the plan booklet, communicate the change to members, and direct the PBM to implement the change. Once these activities are complete, the Division does not anticipate any significant additional work on this issue.

Actuarial Impact

Neutral / Enhancement / Diminishment

The actuarial impact of this proposed change is dependent on final plan design changes and the specific drugs and products included in the non-preferred brand-name drug tier.[3]

Financial Impact to the plan:

Based on current retiree drug claims projections of $590,000,000 for 2019 and an analysis conducted by Segal Consulting and OptumRx, the anticipated financial impact of the proposed change would result in an annual savings to the plan of $3,000,000, or 0.5%. This analysis took into consideration the higher copays that would be paid for some products and drugs, as well as shifts in utilization to lower cost generic and preferred brand-name drugs and products and associated rebates.[4]

Clinical considerations:

[3] Segal Memorandum, Pharmacy 3rd Tier Copayment, dated June 7, 2019.
[4] Ibid.

The AlaskaCare defined benefit retiree pharmacy plan has an open formulary, meaning that the plan will cover drugs prescribed by a provider, acting within the scope of his or her license, for the treatment of an illness, disease, or injury. The proposed three-tier pharmacy benefit would not impose any new restrictions on coverage of any medication.

Because members will still be able to access the same medications, there is no anticipated clinical impact associated with this change.

Third Party Administrator (TPA) operational impacts:

The PBM will need to establish and maintain a formulary that classifies medications into one of three tiers, assist in identifying and informing members who may be impacted, assist in communicating the change to network pharmacies, and will need to update their programming to accommodate the change. These activities will largely occur prior to implementation. After the proposed change is established, the PBM should not anticipate significant on-going work.

Provider considerations:

The impact to providers is anticipated to be minimal. Providers may receive additional inquiries from patients about the availably of preferred brand-name and/or generic medications, may be asked to adjust prescribing habits to accommodate the maximum benefit for the member, or may be asked to assist a member in seeking a medical necessity exception for a non-preferred brand-name medication.

Documents attached include:

Document Name		Notes
Segal Memorandum, Pharmacy 3rd Tier Copayment	Segal 3 Tier Pharmacy Memo 201	

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MEMORANDUM

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

From: Richard Ward, FSA, FCA, MAAA

Date: June 7, 2019

Re: Pharmacy 3rd Tier Copayment – Focus on Actuarial and Financial Impact for the Retiree Plan

The AlaskaCare Retiree Plan currently provides coverage for medical treatments and applies the general plan provisions, such as deductible, coinsurance and out-of-pocket limitations, to determine any portion of the costs that are the member's responsibility. If the member has additional coverage, such as Medicare or other employer provided coverage, any portion of the costs covered by that plan is also considered. Below is a table outlining the current benefits offered under the Plan:

Deductibles	
Annual individual / family unit deductible	$150 / up to 3x per family
Coinsurance	
Most medical expenses	80%
Most medical expenses after out-of-pocket limit is satisfied	100%
Second surgical opinions, Preoperative testing, Outpatient testing/surgery • No deductible applies	100%
Out-of-Pocket Limit	
Annual individual out-of-pocket limit • Applies after the deductible is satisfied • Expenses paid at a coinsurance rate other than 80% do not apply against the out-of-pocket limit	$800

Benefit Maximums		
Individual lifetime maximum • Prescription drug expenses do not apply against the lifetime maximum	$2,000,000	
Individual limit per benefit year on substance abuse treatment without precertification. Subject to change every three years	$12,715	
Individual lifetime maximum on substance abuse treatment without precertification. Subject to change every three years	$25,430	
Prescription Drugs	Up to 90 Day or 100 Unit Supply	
	Generic	Brand Name
Network pharmacy copayment	$4	$8
Mail order copayment	$0	$0

A change to the benefits under consideration would add a 3rd tier to the pharmacy plan with a copay of $16:

	Network Pharmacy	Mail Order
Generic	$4	$0
Brand	$8	$0
Non-Preferred	$16	$0

Actuarial Value

The actuarial value is to be determined dependent upon final design and the specific drugs and products included in the 3rd tier.

Financial Impact

Segal coordinated with the State's current PBM, OptumRx, to determine the financial impact of this potential. Based on the current retiree claims projection of $590,000,000 for 2019 and OptumRx's analysis, the financial impact would result in an annual savings to the plan of $3,000,000, or 0.5%. This includes higher copays being paid for some products and drugs, as well as shifts in utilization to lower cost Generics and Preferred Brand drugs and products, which also generate additional rebates for the Plan.

The new tier will impact the member's copayment for drugs that would now be considered Non-preferred brand medications. Non-preferred brand drugs often do not provide any clinical advantages over other drugs in the same therapeutic class and are the least cost effective option. Based on first quarter 2019 plan utilization as reported by OptumRx, approximately 11,000 unique members between the DB and DC plans utilized a drug that would be moved from tier 2 to tier 3.

Please note that the projections in this report are estimates of future costs and are based on information available to Segal at the time the projections were made. Segal Consulting has not audited the information provided. Projections are not a guarantee of future results. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, trend rates, and claims volatility. The accuracy and reliability of projections decrease as the projection period increases. Unless otherwise noted, these projections do not include any cost or savings impact resulting from The Patient Protection and Affordable Care Act (PPACA) or other recently passed state or federal regulations.

cc: Emily Ricci, Division of Retirement and Benefits
Betsy Wood, Division of Retirement and Benefits
Noel Cruse, Segal
Daniel Haar, Segal
Quentin Gunn, Segal

Proposal Title	Deductible & Out of Pocket Maximum
Health Plan Affected	Defined Benefit Retiree Plan
Proposed Effective Date	January 1st, 2020
Reviewed By	Retiree Health Plan Advisory Board
Next Review Date	August 7th, 2019

Summary of Current State

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

A 2017 Segal study of state health plans reports that the average PPO plan deductible for state employee health plans was $483/$1,100 (single/family) in 2017. Average PPO OOP limits were $4,092/$8,409 (single/family). Retiree plan designs generally do not vary much from those for active employees, and many states provide coverage for retired employees within their active employee plan.

Lower cost share provisions have multiple effects on both the members and the health plan. First, they reduce barriers to care for members by ensuring the plan picks up the cost of medical services early on in a member's course of treatment. With the higher cost of health care in Alaska, member's may meet their individual deductible in full through a single primary care appointment.[2] Once they meet their deductible, they are responsible for up 20% of the cost (subject to recognized charge) while the plan pays 80%. When they reach their OOP limit, the plan pays 100% of the cost in full (subject to recognized charge). This substantially limits members financial exposure.

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

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

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

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

Objectives

a) Incentivize member use of network providers through benefit design.
b) Strengthen the health plan's purchasing power with providers
c) Offset additional value added to the plan through other modernization proposals.

Summary of Proposed Change

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

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

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

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

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

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

	Current	Option 1	Option 2	Option 3
Deductible Individual	$150	$200	$300	$650
Deductible Family (up to 3x individual)	$450	$800	$900	$1,950
OOP Individual	$800	$900	$1,100	$1,800
OOP Family	Unlimited	$2,700	$3,300	$5,400
Actuarial Impact[3]	None	-0.5%	-1.6%	-4.6%
Plan Savings[4]	None	$2.9 million	$9.3 million	$27.3 million

Proposal Revision History

Description	Date
Proposal Drafted	December 2018
Reviewed by Modernization Subcommittee	
Reviewed by RHPAB	

[3] Segal Memorandum dated December 10, 2018
[4] Segal Memorandum dated December 10, 2018

DRAFT-Summary of Responses to Proposed Plan Design Change

Proposed change: Increase deductible and OOP limit

Plans affected: DB Retiree Plan

Reviewed by: Retiree Health Plan Advisory Board

Proposed implementation date: TBD

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

Table 1: Plan Design Changes

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

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

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

Description of proposed change:

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

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

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

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

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

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

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

This change could:

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

Background:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Member impact:

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

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

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

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

Table 3: Comparison of estimated member impact across options

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

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

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

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

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

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

Actuarial impact:

Neutral / Enhancement / Diminishment

Table 4: Actuarial Impact

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

DRB operational impacts:

The Division anticipates minimal operational impacts as follows:

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

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

Financial impact to the plan:

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

Table 5: Financial savings to the health plan

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

Clinical considerations:

These changes not anticipated to impact any clinical considerations.

Third Party Administrator (TPA) operational impacts:

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

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

Provider considerations:

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

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

Documents attached include:

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

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MEMORANDUM

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

From: Richard Ward, FSA, FCA, MAAA

Date: December 10, 2018

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

The AlaskaCare Retiree Plan currently provides coverage for medical treatments and applies the general plan provisions, such as deductible, coinsurance and out-of-pocket limitations, to determine any portion of the costs that are the member's responsibility. If the member has additional coverage, such as Medicare or other employer provided coverage, any portion of the costs covered by that plan is also considered. Below is a table outlining the current benefits offered under the Plan:

Deductibles	
Annual individual / family unit deductible	$150 / up to 3x per family
Coinsurance	
Most medical expenses	80%
Most medical expenses after out-of-pocket limit is satisfied	100%
Second surgical opinions, Preoperative testing, Outpatient testing/surgery • No deductible applies	100%
Out-of-Pocket Limit	
Annual individual out-of-pocket limit • Applies after the deductible is satisfied • Expenses paid at a coinsurance rate other than 80% do not apply against the out-of pocket limit	$800

Benefit Maximums		
Individual lifetime maximum • Prescription drug expenses do not apply against the lifetime maximum	$2,000,000	
Individual limit per benefit year on substance abuse treatment without precertification. Subject to change every three years	$12,715	
Individual lifetime maximum on substance abuse treatment without precertification. Subject to change every three years	$25,430	
Prescription Drugs	Up to 90 Day or 100 Unit Supply	
	Generic	Brand Name
Network pharmacy copayment	$4	$8
Mail order copayment	$0	$0

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

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

Actuarial Value

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

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

Financial Impact

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

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

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

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

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

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

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

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

Please note that the projections in this report are estimates of future costs and are based on information available to Segal at the time the projections were made. Segal Consulting has not audited the information provided. Projections are not a guarantee of future results. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, trend rates, and claims volatility. The accuracy and reliability of projections decrease as the projection period increases. Unless otherwise noted, these projections do not include any cost or savings impact resulting from The Patient Protection and Affordable Care Act (PPACA) or other recently passed state or federal regulations.

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

Proposal Title	Enhanced Clinical Review
Health Plan Affected	Defined Benefit Retiree Plan
Proposed Effective Date	January 1st, 2020
Reviewed By	Retiree Health Plan Advisory Board
Proposal Drafted	December 2018
Status of Proposal	Set Aside

Summary of Current State

The plan currently covers diagnostic high-tech imaging and testing including radiology, cardiology services, musculoskeletal imaging, sleep management studies, and cardiac rhythm implant devices if a member has specific symptoms. Generally, these tests and services are not covered if performed as part of a routine physical examination. Even so, utilization and the per member per month cost associated with high-cost, high-tech imaging and testing services has risen over time, and is currently significantly higher in AlaskaCare plans than across Aetna "book of business" comparisons.

Not only does increased usage affect the plan financially, but this growth in utilization of enhanced imaging techniques can create other unintended impacts and consequences. Unnecessary imaging applications bring additional costs to the member and the plan and can result in members receiving needless exposure to radiation during the imaging process, without measurable contribution to positive health outcomes or more accurate diagnoses.

Objectives

a) Ensure that the high-tech imaging and diagnostic testing members receive from network providers is medically necessary and follows appropriate evidence-based guidelines.
b) Provide savings to the members and to the health trust and balance other modernization proposals.

Summary of Proposed Change

The proposed change would require in-network providers to seek prior authorization of certain outpatient radiology and cardiology services, sleep studies, interventional pain management programs, and musculoskeletal procedures (hip/knee replacements) for non-Medicare eligible members. This proposed change would not apply to services obtained through a non-network provider. Precertification would not apply in emergency situations.

This initiative would largely operate behind the scenes; network providers (not patients) would be responsible for obtaining preauthorization in advance of administering services and seeking reimbursement. The extra scrutiny assists in ensuring that evidence-based guidelines of appropriate care are being followed prior to the administration of high-cost imaging and/or testing.

The AlaskaCare retiree health plan could choose to adopt ECR for the full suite of services offered through the program, or ECR could be adopted for some services, and forgone for others.

DRAFT-Summary of Responses to Proposed Plan Design Change

Proposed change: Enhanced Clinical Review for High-Tech Imaging

Plans affected: DB Retiree Plan

Reviewed by: Retiree Health Plan Advisory Board Modernization Subcommittee

Proposed implementation date: TBD

Review Date: June 12, 2019

Table 1. Plan Design Changes

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

Description of proposed change:

The proposed change would require in-network providers to seek prior authorization of certain outpatient radiology and cardiology services, sleep studies, interventional pain management programs, and musculoskeletal procedures (hip/knee replacements) for non-Medicare eligible members. This proposed change would not apply to services obtained through a non-network provider.

To implement the proposed change, the AlaskaCare retiree health plan would adopt Aetna's (ECR) program. Under this program, network providers submit precertification requests to a vendor contracted by Aetna to review such requests in advance of administering services or conducting tests. After review, the precertification determination would be sent in a letter to the member and by fax to both the provider who ordered the service and the provider who would perform the service (if different from the ordering provider).

If a precertification request is denied, providers have the option to request a peer-to-peer review within 14 days from the date of denial. Another physician will review and discuss the necessity of the service with the provider at a mutually agreed-upon time. Most disputes are resolved at this level, but if a disagreement about the necessity of the service persists, the provider can appeal directly to Aetna through the standard Provider Appeal process.

Under the proposed program, precertification would not apply in emergency situations. It is not the intent of the program to intervene as providers work to stabilize patients in an

emergency. A retrospective review of emergency imaging services may be conducted between the provider and Aetna to evaluate the outcomes and impacts of clinical decisions made during an emergent episode of care.

When providers agree to join Aetna's network, they agree to conform to Aetna's published clinical policy bulletins regarding the medical necessity of services, including high-tech imaging and testing. Aetna has implemented enhanced clinical review programs with other clients, so network providers are already familiar with the process. This initiative would largely operate behind the scenes; network providers (not patients) would be responsible for obtaining preauthorization in advance of administering services and seeking reimbursement. The extra scrutiny assists in ensuring that evidence-based guidelines of appropriate care are being followed prior to the administration of high-cost imaging and/or testing.

Across Aetna's book of business, in October 2018, 170,000 total precertification requests were submitted, but only 667 were appealed (.39%). Of the 667 appealed requests, 261 were overturned for an overturn rate of 39.1%. This program has been adopted by 18,149 of Aetna's self-funded customers, covering 5.4 million members nationally.[1]

The AlaskaCare retiree health plan could choose to adopt ECR for the full suite of services offered through the program, or ECR could be adopted for some services, and forgone for others.

Table 2: Enhanced Clinical Review Service Options and Fees[2]

Service Option	PRPM[3] Fee
High-Tech Radiology (MRI/CT Scans)	$0.35
Diagnostic Cardiology	$0.10
Sleep Study	$0.05
Cardiac Implantable	$0.05
Interventional Pain Management	$0.10
Hip/Knee Replacements	$0.05
Full Suite of Services	**$0.70**

[1] *Enhanced Clinical Review Program (Follow-up Q&A for March 20, 2019 RHPAB meeting)*, Aetna Presentation dated March 20, 2019.
[2] *Enhanced Clinical Review Program (Follow-up Q&A for March 20, 2019 RHPAB meeting)*, Aetna Presentation dated March 20, 2019.
[3] Per Retiree Per Month

Table 3: Comparison of Current to Proposed Change

CURRENT:	2019 Retiree Insurance Information Booklet
Current (Page 44-45 of 2019 Retiree Insurance Information Booklet)	**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: • One pap smear per year for all women age 18 and older. • Charges for a limited office visit to collect the pap smear are also covered. • 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. • 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.
Current (Page 44-45 of 2019 Retiree Insurance Information Booklet)	**Services Requiring Pre-certification** The following list identifies those services and supplies requiring precertification under the medical plan. Language set forth in parenthesis in the precertification list is provided for descriptive purposes only and does not serve as a limitation on when precertification is required. Precertification is required for the following types of medical expenses: • Stays in a hospital • Stays in a skilled nursing facility • Stays in a rehabilitation facility • Stays in a hospice facility • Outpatient hospice care • Stays in a residential treatment facility for treatment of mental disorders and substance abuse • Partial confinement treatment for treatment of mental disorders and substance abuse

- Home health care
- Private duty nursing care
- Transportation (non-emergent) by fixed wing aircraft (plane)
- Transportation (non-emergent) by ground ambulance
- Applied Behavioral Analysis (early intensive behavioral intervention for children with pervasive developmental delays)
- Autologous chondrocyte implantation, Carticel (injection into the knee of cartilage cells grown from tissue cultures)
- Cochlear implant (surgical implant of a device into the ear to try to improve hearing)
- Cognitive skills development
- Customized braces (physical – i.e., non-orthodontic braces)
- Dental implants and oral appliances
- Dialysis visits
- Dorsal column (lumbar) neurostimulators: trial or implantation (for relief of severe pain)
- Electric or motorized wheelchairs and scooters
- Gastrointestinal tract imaging through capsule endoscopy
- Hyperbaric oxygen therapy
- Limb prosthetics
- Oncotype DX (a method for testing for genes that are in cancer cells)
- Orthognathic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint (reconstructive surgeries to attempt to correct structural abnormalities of the jaw bones)
- Organ transplants
- Osseointegrated implant
- Osteochondral allograft/knee (grafting of cartilage and bone from a cadaver to the knee joint)
- Proton beam radiotherapy
- Reconstruction or other procedures that may be considered cosmetic
- Surgical spinal procedures
- Uvulopalatopharyngoplasty, including laser-assisted procedures (surgery to reconfigure the soft palate to try to help with sleep apnea)
- Ventricular assist devices
- MRI-knee
- MRI-spine
- Intensive outpatient programs for treatment of mental disorders and substance abuse, including:
    - Psychological testing
    - Neuropsychological testing

	○ Outpatient detoxification ○ Psychiatric home care services • Travel
Proposed Change	When receiving services from a network provider, precertification must be obtained by the provider from the Third Party Administrator for the following types of medical expenses: • High-tech radiology (MRI/CT Scans) • Diagnostic cardiology • Sleep management studies • Cardiac rhythm implant devices • Interventional pain management • Hip and Knee replacements (arthroplasties)

Background

The plan currently covers diagnostic high-tech imaging and testing including radiology, cardiology services, musculoskeletal imaging, sleep management studies, and cardiac rhythm implant devices if a member has specific symptoms. Generally, these tests and services are not covered if performed as part of a routine physical examination. Even so, utilization and the per member per month cost associated with high-cost, high-tech imaging and testing services has risen over time, and is currently significantly higher in AlaskaCare plans than across Aetna "book of business" comparisons.

Not only does increased usage affect the plan financially, but this growth in utilization of enhanced imaging techniques can create other unintended impacts and consequences. Unnecessary imaging applications bring additional costs to the member and the plan, and can result in members receiving needless exposure to radiation during the imaging process, without measurable contribution to positive health outcomes or more accurate diagnoses.

Table 4 outlines utilization of high-tech imaging in the AlaskaCare under-65 retiree plan in 2017 and 2018, both in and outside of Alaska. Utilization inside and outside of Alaska was similar, however the paid amounts per service are significantly higher inside Alaska than for services obtained outside of Alaska.

Table 4: 2017-2018 AlaskaCare Under-65 Retiree Health Plan High-Tech Imaging (MRI, CT, PET) Utilization and Price[4]

	2017 Alaska	2017 Outside	2018 Alaska	2018 Outside
Total Claimants	2,615	2,746	2,306	2,551
Claimants per 1000	103.3	109.0	98.7	109.2
Total Services	5,008	5,290	4,402	4,810
Paid per Service	$817.45	$289.17	$839.58	$285.40
Total Paid	$4,093,774	$1,529,688	$3,695,835	$1,372,795

Table 4 provides further information about the costs associated with the top ten most costly imaging services obtained in 2018 in Alaska. The "paid" column reflects the total amount paid by the plan for services both in and out of Alaska. The amount paid per service inside Alaska is typically significantly higher than the amount paid per service outside of Alaska. The top ten most costly imaging services are all some form of MRI, CT, or PET scan.

Table 4: 2018 AlaskaCare Under-65 Retiree Health Plan Top-10 Paid High-Tech Imaging Services in Alaska[5]

Order by Total Paid	Procedure Code	Paid per Service in Alaska	As a % of L-48 Paid	As a % of Medicare	Total Paid in Alaska
1	70553 MRI BRAIN STEM W/O & W/DYE	$1,029.78	287%	642%	$330,559
2	71260 CT THORAX W/DYE	$316.87	170%	363%	$122,311
3	72141 MRI NECK SPINE W/O DYE	$933.79	340%	895%	$171,818
4	72148 MRI LUMBAR SPINE W/O DYE	$972.74	411%	932%	$274,314
5	73221 MRI JOINT UPR EXTREM W/O DYE	$805.48	348%	772%	$139,347
6	73721 MRI JNT OF LWR EXTRE W/O DYE	$817.68	319%	857%	$220,774
7	74176 CT ABD & PELVIS W/O CONTRAST	$503.61	305%	412%	$119,356
8	74177 CT ABD & PELV W/CONTRAST	$612.21	312%	478%	$417,528
9	77063 BREAST TOMOSYNTHESIS BI	$83.07	155%	198%	$192,816
10	77067 SCR MAMMO BI INCL CAD	$163.12	185%	306%	$608,597

[4] Information pulled from the AlaskaCare Data Warehouse, March 1, 2019.
[5] Ibid.

Member Impact:

Under the current benefits, some patients may be undergoing costly and potentially duplicative procedures that expose them unnecessarily to elevated levels of radiation. The proposed change would help ensure that the high-tech imaging and diagnostic testing member receive from network providers is medically necessary and follows appropriate evidence-based guidelines.

This proposed initiative would provide members with an additional measure of confidence that the care they are receiving is medically necessary and essential to their course of care. Furthermore, enhanced clinical review will help protect members against unnecessary medical expenses.

Because the precertification process would occur between the network provider and the Third Party Administrator, if the precertification is granted members should anticipate minimal, if any, interaction with this policy. If a service is denied, the provider may consult with a peer to discuss the need for the procedure, but the member will be informed of the denial and will need to consider next steps or other options with their provider.

The proposed initiative would primarily impact non-Medicare, or under-65 members. Medicare is typically the primary coverage for members over the age of 65, and coverage of services as well as cost of services is determined by Medicare for those members.

Actuarial Impact

Neutral / Enhancement / Diminishment

Table 3: Actuarial Impact

	Actuarial Impact	Notes
Current	N/A	N/A

Because this proposal would not change how the cost share between the plan and members is determined, this initiative is not anticipated to have an actuarial impact on the plan.[6] The plan will continue to cover high-tech imaging and diagnostic testing when medically necessary.

[6] Segal Memo *Implementation of Enhanced Clinical Review (ECR) Program for High Tech Radiology Services* dated March 15, 2019.

DRB operational impacts:

The Division will work to educate members and increase familiarity with the enhanced clinical review process. The Division will also work to educate staff members about the initiative to ensure members are provided with accurate information regarding the process and staff are prepared to assist members.

Financial Impact to the plan:

Table 4, Estimated Savings

Proposed Change	Estimated Annual Financial Impact
Enhanced clinical review for high-tech imaging and diagnostic testing	$250,000 net savings to the plan

The current per non-Medicare eligible member per month plan spend on radiology is approximately $82, compared with the per member per month average spend of $53 for the same services across Aetna's book of business.[7] It is anticipated that 2-3% of services and procedures covered by this proposal would be denied or redirected to an alternate form of care. Savings to the plan are projected to be $350,000 annually, but the total cost of the program is projected to be $100,000 annually, resulting in $250,000 annual net savings.[8]

Clinical considerations:

The proposed changes would require additional clinical review for some high-tech imaging and diagnostic testing. These services are currently available to members when medically necessary, and under the proposed initiative would continue to be available to members. This initiative would provide an extra degree of certainty that the services rendered are, in face, medically necessary.

Third Party Administrator (TPA) operational impacts:

The proposed program is already part of existing network contracts between Aetna and participating providers and has already been put into practice with other accounts. Because the administrative framework for review, determinations, and appeals already exists and has been implemented, the impact to the TPA of applying an enhanced clinical review program to the plan would be minimal.

[7] *Enhanced Clinical Review Program*, Aetna Presentation dated December 12, 2018.
[8] Segal Memo *Implementation of Enhanced Clinical Review (ECR) Program for High Tech Radiology Services* dated March 15, 2019.

The addition of this policy may result in additional appeals processing by the TPA, but as discussed above, typically the volume of appeals associated with decisions made under this program is relatively small.

Provider considerations:

As network providers are already familiar with this policy because it is part of their network agreement with Aetna, the anticipated impact to those providers is minimal. They are already familiar with the policy and with the process because they are required to conform to these procedures for other Aetna-covered patients.

Documents attached include:

Document Name		Notes
***Enhanced Clinical Review Program*, Aetna Presentation dated December 12, 2018.**	 Enhanced Clinical Review Program 12.1	
Enhanced Clinical Review Program (Follow-up Q&A for March 20, 2019 RHPAB meeting), Aetna Presentation dated March 20, 2019	 ECR Follow-up for RHPAB Modernizatior	
Financial Analysis – Segal Memo	 Segal ECR Memo 20190315.pdf	

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MEMORANDUM

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

From: Richard Ward, FSA, FCA, MAAA

Date: March 15, 2019

Re: Implementation of Enhanced Clinical Review (ECR) Program for High Tech Radiology Services

The AlaskaCare Retiree Plan currently provides coverage for medical treatments and applies the general plan provisions, such as deductible, coinsurance and out-of-pocket limitations, to determine any portion of the costs that are the member's responsibility. If the member has additional coverage, such as Medicare or other employer provided coverage, any portion of the costs covered by that plan is also considered. Below is a table outlining the current benefits offered under the Plan:

Deductibles	
Annual individual / family unit deductible	$150 / up to 3x per family
Coinsurance	
Most medical expenses	80%
Most medical expenses after out-of-pocket limit is satisfied	100%
Second surgical opinions, Preoperative testing, Outpatient testing/surgery • No deductible applies	100%
Out-of-Pocket Limit	
Annual individual out-of-pocket limit • Applies after the deductible is satisfied • Expenses paid at a coinsurance rate other than 80% do not apply against the out-of-pocket limit	$800

Benefit Maximums		
Individual lifetime maximum • Prescription drug expenses do not apply against the lifetime maximum	$2,000,000	
Individual limit per benefit year on substance abuse treatment without precertification. Subject to change every three years	$12,715	
Individual lifetime maximum on substance abuse treatment without precertification. Subject to change every three years	$25,430	
Prescription Drugs	Up to 90 Day or 100 Unit Supply	
	Generic	Brand Name
Network pharmacy copayment	$4	$8
Mail order copayment	$0	$0

Some of the benefit coverages provided by the plan require precertification to ensure proper medical protocols and guidelines are followed. These precertification requirements currently include some high tech imaging such as MRIs for the spine and knee.

The change under consideration would add an enhanced level of precertification (or preauthorization) for all high tech imagining, including, MRI/MRA, CT/CCTA, PET, and Nuclear Cardiology. This program will require network providers to follow evidenced based guidelines for these imagining services, and it will also encourage members to seek treatment from network facilities and providers. This program would only apply to services and procedures not covered by Medicare.

Actuarial Value

These changes promote efficient utilization of medical services, which helps manage program costs. However, there are no changes to how the cost share is determined and therefore, the ECR program does not affect the actuarial value of the Plan.

Financial Impact

While the Actuarial Value of the Plan would not be impacted by the implementation of this program, there would be a financial impact to plan costs. Our analysis leverages the analysis conducted by Aetna. Segal has reviewed Aetna's analysis to determine that all assumptions are appropriate and reasonable.

Radiology costs are about $80 per member per month (pmpm) for non-Medicare retirees. It is estimated that approximately 2-3% of network procedures and services covered by the ECR program would be denied or redirected to more efficient care. The cost of affected procedures is anticipated to be higher than average. Savings to the plan are estimated to be $350,000 annually.

Based on a $0.70 per retiree per month (prpm) fee for the program, and approximately 11,600 non-Medicare retirees, the total annual cost of the program is approximately $100,000, resulting in $250,000 in annual net savings.

It is worth noting that the ECR program currently coordinates exclusively with network providers. Since the Retiree Plan does not have a benefit differential for network and non-network providers and services, there is the possibility that some retirees may "shop" between network and non-network providers if the initial review results in a denial. These instances may be isolated and the overall impact minimal, but we believe it is worth noting now in order to proactively monitor the Plan for this potential behavior once the ECR program is implemented.

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

Please note that the projections in this report are estimates of future costs and are based on information available to Segal at the time the projections were made. Segal Consulting has not audited the information provided. Projections are not a guarantee of future results. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, trend rates, and claims volatility. The accuracy and reliability of projections decrease as the projection period increases. Unless otherwise noted, these projections do not include any cost or savings impact resulting from The Patient Protection and Affordable Care Act (PPACA) or other recently passed state or federal regulations.

cc: Michele Michaud, Division of Retirement and Benefits
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Betsy Wood, Division of Retirement and Benefits
Linda Johnson, Segal
Noel Cruse, Segal
Michael Macdissi, Segal
Dan Haar, Segal
Quentin Gunn, Segal

Proposal Title	Enhanced Travel & Health Concierge
Health Plan Affected	Defined Benefit Retiree Plan
Proposed Effective Date	January 1st, 2020
Reviewed By	Retiree Health Plan Advisory Board
Proposal Drafted	October 2018
Status of Proposal	Under Consideration

Summary of Current State

The current plan language regarding travel costs is confusing and covered expenses are narrow in most circumstances. The portions of covered travel costs vary depending on the qualified circumstance but are typically limited to airfare costs only; lodging, per diem expenses, and travel for a companion are rarely eligible for coverage.

Accessing the travel benefit can be confusing and many expenses are not covered. All travel, excluding emergency travel and surgery less expensive in other locations, requires pre-authorization. If travel is not-preauthorized members are not eligible for reimbursement. In addition, the plan does not pay for travel costs up front, the member is required to front those costs and submit them for reimbursement following completion of the trip which can place a financial burden on the member at a vulnerable time.

Objectives

a) Increased access to specialists that may not be available locally for members requiring care.
b) Increase covered travel costs.
c) Enhance patient outcomes through reduced complication rates based on the quality of providers in the SurgeryPlus network. Surgery Plus reports complication rates of 0.82% among members using their network compared to the 14.1% average for AlaskaCare retirees living in Alaska but seeking care outside of the state in 2017.

Summary of Proposed Change

This benefit was implemented on August 1, 2018 for the AlaskaCare Active employee plan. The addition of the SurgeryPlus network will provide members with access to surgeons who demonstrate they meet and maintain a combination of objective and subjective quality metrics. The expansion of travel benefits for diagnostic services will address an unmet need among the membership as will the expansion of lodging and per diem expenses for the member and companion. The addition of a care coordinator for members seeking care from providers outside of the SurgeryPlus network, including those available locally, will benefit members in finding a provider, transferring records, and scheduling procedures.

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

DRAFT-Summary of Responses to Proposed Plan Design Change

Proposed change: Enhancing travel benefits

Plans affected: DB Retiree Plan

Reviewed by: Retiree Health Plan Advisory Board

Proposed implementation date: TBD

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

Table 1. Plan Design Changes

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

Description of proposed change:

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

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

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

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

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

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

The expansion of travel benefits, particularly the SurgeryPlus program, could create additional competition in the Alaska medical marketplace as providers compete with those offering the same services outside of their community. This could result in reduced costs and better services as providers work to remain competitive. Alternatively, as members in small communities seek care elsewhere, any fixed cost for providing those services could be spread across a smaller number of patients increasing costs for those who receive care at home.

Background:

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

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

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

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

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

- Round-trip transportation, not exceeding the cost of coach class commercial air transportation, to the nearest professional treatment. This is limited to the member unless a companion benefit is clearly stated (e.g. travel for a minor, transplant IOE).
- Documented travel expenses for ground transportation including fares, mileage, food and lodging for the most direct route if ground transportation and the most direct one-way distance exceeds 100 miles. This applies only while the member is in transit, and ends once they arrive at the location of treatment.
- In most circumstances, travel costs do not include the following:
    - Travel for a companion
    - Lodging (with the exception of transplants at IOE, travel via ground transportation, and travel in certain circumstances where treatment is not available locally[9])
    - Food (with exceptions including transplants at IOE and travel via ground transportation)
    - Other transportation costs (e.g. taxis, etc.)

All travel, excluding emergency travel and surgery less expensive in other locations, require pre-authorization. If travel is not-preauthorized members are not eligible for reimbursement. The plan does not pay for travel costs up front, the member is required to front those costs and submit them for reimbursement following completion of the trip.

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

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

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

Circumstance	Current	Proposed
Travel for minor	-Minor and companion -Transportation covered[12]	-Add overnight lodging benefit ~~of $80/night~~ of 3-star or above hotel within 30 minutes of appointments, up to 14-day maximum; -Add per diem benefit ~~of $31 60 per patient/day; or $62~~ 120 ~~per patient & companion/day~~ to reflect State of Alaska per diem rates.[13]~~per diem rates for state employees during work travel.~~
Second surgical opinion	-Transportation covered for member only	-Add lodging and per diem benefit as described above.
Treatment and diagnostic services not available locally	-Transportation, lodging and per diem covered for member only. -Limited to treatment only -Limited to the following visit per benefit year: -1 treatment for condition -1 for follow-up -1 pre- or post-natal care -1 for maternity delivery -1 pre- or post-surgery -1 per surgical procedure -1 per allergic condition	-Restrict to services received from a network provider. -Add lodging and per diem benefit as described above to cover the member's entire length of stay subject to medical necessity. -Allow for both pre- and post-op visit coverage if post-op received within 60-days of discharge. -Add companion benefit if procedure requires general anesthesia ~~(as well as minors, or members with physical disabilities requiring a travel companion (requires medical necessity))~~or when appropriate or necessary (e.g. minors, members with physical disabilities, etc. subject to medical necessity)~~.~~

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

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

Circumstance	Current	Proposed
Surgery and diagnostic services in other locations less expensive	-Only applicable for surgery. -Transportation covered for member only. -Total cost may not exceed the recognized charge for same expenses received locally. -Total cost must include: -surgery -hospital room and board -travel to another location	-Restrict to services received from a network provider. -Restrict to services over $2,000 locally (including 2nd opinions) measured using EDH data and floor of 200% of Anchorage Medicare. -Add "if not available through the SurgeryPlus program." -Add coverage for companion ~~if procedure requires general anesthesia~~as described above. -Add lodging and per diem benefit as described~~-~~ above. ~~above to cover the member's entire length of stay subject to medical necessity.~~
SurgeryPlus Program	-Not currently available to retiree members	-All travel includes member and companion -Travel costs arranged for and covered up front by SurgeryPlus. -Hotels arranged and paid for by plan. -State of Alaska per diem rate for meals & incidentals. -Companion travel covered if medically necessary as described above. ~~$31 60 per diem for member/~~$12062 ~~with companion~~ -Members receive pre-loaded debit card in advance of trip.
Long-term stay		~~Requires additional review. Suggested per diem rate of $33.~~ -Defined as more than 30 days. -Long term lodging and meals and incidental rates apply as

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

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

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

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

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

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

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

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

Member Impact:

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

WHO IS IMPACTED:

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

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

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

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

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

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

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

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

Actuarial Impact

Neutral / Enhancement / Diminishment

Table 2: Actuarial Impact

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

DRB Operational Impacts

The Division anticipates minimal operational impacts as follows:

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

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

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

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

Financial Impact to the plan:

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

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

Clinical Considerations:

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

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

Third Party Administrator (TPA) operational impacts:

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

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

[17] See Attachment A
[18] Ibid.

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

Provider considerations:

The expansion of travel benefits, particularly the SurgeryPlus program, could create additional competition in the Alaska medical marketplace as providers compete with those offering the same services outside of their community. This could result in reduced costs and better services as providers work to remain competitive. Alternatively, as members in small communities seek care elsewhere, any fixed cost for providing those services could be spread across a smaller number of patients increasing costs for those who receive care at home.

Documents attached include:

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

DRAFT-Summary of Responses to Proposed Plan Design Change

Proposed change: Enhanc~~ed~~ing travel benefits with health concierge services

Plans affected: DB Retiree Plan

Reviewed by: Retiree Health Plan Advisory Board

Proposed implementation date: TBD

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

Table 1. Plan Design Changes

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

Description of proposed change:

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

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

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

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

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

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

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

Background:

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

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

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

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

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

- Round-trip transportation, not exceeding the cost of coach class commercial air transportation, to the nearest professional treatment. This is limited to the member unless a companion benefit is clearly stated (e.g. travel for a minor, transplant IOE).
- Documented travel expenses for ground transportation including fares, mileage, food and lodging for the most direct route if ground transportation and the most direct one-way distance exceeds 100 miles. This applies only while the member is in transit, and ends once they arrive at the location of treatment.
- In most circumstances, travel costs do not include the following:
    - Travel for a companion
    - Lodging (with the exception of transplants at IOE, travel via ground transportation, and travel in certain circumstances where treatment is not available locally[9])
    - Food (with exceptions including transplants at IOE and travel via ground transportation)
    - Other transportation costs (e.g. taxis, etc.)

All travel, excluding emergency travel and surgery less expensive in other locations, require pre-authorization. If travel is not-preauthorized members are not eligible for reimbursement. The plan does not pay for travel costs up front, the member is required to front those costs and submit them for reimbursement following completion of the trip.

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

Circumstance	Current	Proposed
Emergency travel[10]	Transportation to nearest hospital by professional ambulance	No change
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[9] Page 42-43, Ibid.
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Circumstance	Current	Proposed
Travel for minor	-Minor and companion -Transportation covered[12]	-Add overnight lodging benefit ~~of $80/night~~ of 3-star or above hotel within 30 minutes of appointments, up to 14-day maximum; -Add per diem benefit ~~of $31 60 per patient/day; or $62~~ 120 ~~per patient & companion/day~~ to reflect State of Alaska per diem rates.[13]~~per diem rates for state employees during work travel.~~
Second surgical opinion	-Transportation covered for member only	-Add lodging and per diem benefit as described above.
Treatment and diagnostic services not available locally	-Transportation, lodging and per diem covered for member only. -Limited to treatment only -Limited to the following visit per benefit year: -1 treatment for condition -1 for follow-up -1 pre- or post-natal care -1 for maternity delivery -1 pre- or post-surgery -1 per surgical procedure -1 per allergic condition	-Restrict to services received from a network provider. -Add lodging and per diem benefit as described above to cover the member's entire length of stay subject to medical necessity. -Allow for both pre- and post-op visit coverage if post-op received within 60-days of discharge. -Add companion benefit if procedure requires general anesthesia ~~(as well as minors, or members with physical disabilities requiring a travel companion (requires medical necessity))~~or when appropriate or necessary (e.g. minors, members with physical disabilities, etc. subject to medical necessity)~~.~~

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

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

Circumstance	Current	Proposed
Surgery and diagnostic services in other locations less expensive	-Only applicable for surgery. -Transportation covered for member only. -Total cost may not exceed the recognized charge for same expenses received locally. -Total cost must include: -surgery -hospital room and board -travel to another location	-Restrict to services received from a network provider. -Restrict to services over $2,000 locally (including 2nd opinions) measured using EDH data and floor of 200% of Anchorage Medicare. -Add "if not available through the SurgeryPlus program." -Add coverage for companion ~~if procedure requires general anesthesia~~as described above. -Add lodging and per diem benefit as described~~-~~ above. ~~above to cover the member's entire length of stay subject to medical necessity.~~
SurgeryPlus Program	-Not currently available to retiree members	-All travel includes member and companion -Travel costs arranged for and covered up front by SurgeryPlus. -Hotels arranged and paid for by plan. -State of Alaska per diem rate for meals & incidentals. -Companion travel covered if medically necessary as described above. ~~$31 60 per diem for member/~~$120~~62 with companion~~ -Members receive pre-loaded debit card in advance of trip.
Long-term stay		~~Requires additional review. Suggested per diem rate of $33.~~ -Defined as more than 30 days. -Long term lodging and meals and incidental rates apply as

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

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

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

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

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

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

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

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

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

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

Member Impact:

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

WHO IS IMPACTED:

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

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

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

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

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

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

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

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

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

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

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

Actuarial Impact

Neutral / Enhancement / Diminishment

Table 2: Actuarial Impact

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

DRB Operational Impacts

The Division anticipates minimal operational impacts as follows:

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

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

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

Financial Impact to the plan:

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

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

Clinical Considerations:

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

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

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

Third Party Administrator (TPA) operational impacts:

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

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

[17] See Attachment A

[18] See Attachment A

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

Provider considerations:

The expansion of travel benefits, particularly the SurgeryPlus program, could create additional competition in the Alaska medical marketplace as providers compete with those offering the same services outside of their community. This could result in reduced costs and better services as providers work to remain competitive. Alternatively, as members in small communities seek care elsewhere, any fixed cost for providing those services could be spread across a smaller number of patients increasing costs for those who receive care at home.

Documents attached include:

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

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MEMORANDUM

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

From: Richard Ward, FSA, FCA, MAAA

Date: January 31, 2019

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

The AlaskaCare Retiree Plan currently reimburses for coach airfare associated with select services and treatments. Precertification is required and travel is restricted to the treatment facility. The Plan does not reimburse members if airline miles are used to purchase tickets, nor does it reimburse for the cost of food, lodging, or local ground transportation such as airport shuttles, cabs or rental cars.

The Plan applies the general benefit provisions, such as deductible, coinsurance and out-of-pocket limits, to determine any portion of the costs that are the member's responsibility. If the member has additional coverage, such as Medicare or other employer provided coverage, any portion of the costs covered by that plan is also considered. Below is a table outlining the current benefits offered under the Plan:

Deductibles	
Annual individual / family unit deductible	$150 / up to 3x per family
Coinsurance	
Most medical expenses	80%
Most medical expenses after out-of-pocket limit is satisfied	100%
Second surgical opinions, Preoperative testing, Outpatient testing/surgery • No deductible applies	100%

Out-of-Pocket Limit		
Annual individual out-of-pocket limit • Applies after the deductible is satisfied • Expenses paid at a coinsurance rate other than 80% do not apply against the out-of-pocket limit	$800	
Benefit Maximums		
Individual lifetime maximum • Prescription drug expenses do not apply against the lifetime maximum	$2,000,000	
Individual limit per benefit year on substance abuse treatment without precertification. Subject to change every three years	$12,715	
Individual lifetime maximum on substance abuse treatment without precertification. Subject to change every three years	$25,430	
Prescription Drugs	Up to 90 Day or 100 Unit Supply	
	Generic	Brand Name
Network pharmacy copayment	$4	$8
Mail order copayment	$0	$0

The Department of Administration is contracting with SurgeryPlus to provide enhanced travel benefits, which include a per diem for lodging and meals, companion airfare, and concierge-level member services to coordinate travel arrangements with medical care. The scope of covered services and procedures eligible for travel benefits will also be expanded to include the following:

Circumstance	Current Benefit	Proposed Benefit
Emergency travel	Transportation to nearest hospital by professional ambulance	No change
Transplant via Aetna Institute of Excellence	-Member and companion -Overnight stay: -$50 per person/night -$100/night maximum -Companion expense: -$31/night	No change
Travel for minor	-Minor and companion -Transportation covered	-Add overnight lodging benefit of $80/night up to 14-day maximum. -Add per diem benefit of $31 per patient/day; or $62 per patient & companion/day.
Second surgical opinion	-Transportation covered for member only	-Add lodging and per diem benefit as described above.

Circumstance	Current Benefit	Proposed Benefit
Treatment and diagnostic services not available locally	-Transportation, lodging and per diem covered for member only. -Limited to treatment only -Limited to the following visit per benefit year: -1 treatment for condition -1 for follow-up -1 pre- or post-natal care -1 for maternity delivery -1 pre- or post-surgery -1 per surgical procedure -1 per allergic condition	-Restrict to services received from a network provider. -Add lodging and per diem benefit as described above to cover the member's entire length of stay subject to medical necessity. -Allow for both pre- and post-op visit coverage if post-op received within 60-days of discharge. -Add companion benefit if procedure requires general anesthesia.
Surgery and diagnostic services in other locations less expensive	-Only applicable for surgery. -Transportation covered for member only. -Total cost may not exceed the recognized charge for same expenses received locally. -Total cost must include: -surgery -hospital room and board -travel to another location	-Restrict to services received from a network provider. -Add "if not available through the SurgeryPlus program." -Add coverage for companion if procedure requires general anesthesia. -Add lodging and per diem benefit as described above to cover the member's entire length of stay subject to medical necessity.
SurgeryPlus Program	-Not currently available to retiree members	-All travel includes member and companion. -Travel costs arranged for and covered up front by SurgeryPlus. -Hotels arranged and paid for by plan. -$31 per diem for member/$62 with companion. -Members receive pre-loaded debit card in advance of trip.

Additionally, the Division would maintain prior-authorization requirements, and add new requirements for prior-authorization if a member is seeking less expensive treatment and intend to have travel arranged through SurgeryPlus.

Actuarial Value

While these enhancements are favorable for the member, there will be no impact on actuarial value. These changes promote efficient utilization of medical services, which helps manage program costs. However, there are no changes to how the cost share is determined and therefore, the enhanced travel benefits do not affect the actuarial value of the program.

Additional incentives that affect cost sharing (such as waiving deductibles and/or coinsurance) would likely result in an increase to actuarial value.

Financial Impact

While there is no impact on the Plan's actuarial value, there would be a financial impact.

Based on the experience with their book of business, SurgeryPlus estimates that 20% of eligible procedures will result in about 400 procedures annually, resulting in savings due to the utilization of lower cost providers and fewer associated complications. Offset by contractual administrative expenses and assuming $3,000 per procedure in travel costs, it is estimated there will be approximately $2,800,000 in annual savings to the Plan associated with the SurgeryPlus program. An expansion to the current benefits is estimated to result in additional annual costs of $300,000.

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

Please note that the projections in this report are estimates of future costs and are based on information available to Segal at the time the projections were made. Segal Consulting has not audited the information provided. Projections are not a guarantee of future results. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, trend rates, and claims volatility. The accuracy and reliability of projections decrease as the projection period increases. Unless otherwise noted, these projections do not include any cost or savings impact resulting from The Patient Protection and Affordable Care Act (PPACA) or other recently passed state or federal regulations.

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

Proposal Title	Lifetime Maximum
Health Plan Affected	Defined Benefit Retiree Plan
Proposed Effective Date	January 1st, 2020
Reviewed By	Retiree Health Plan Advisory Board
Next Review Date	August 7th, 2019

1) Summary of Current State

The AlaskaCare retiree defined benefit health plan currently contains a $2 million lifetime maximum. In 1985, the lifetime max was increased from $250,000 to $1 million, and in 1999 it was increased again to the present limit of $2 million.

The Patient Protection and Affordable Care Act (ACA) required most health plans to remove any lifetime maximum, and as a result these provisions are becoming increasingly uncommon in health plans.[1] At the same time, the cost of health care has grown significantly over the past decade due to a variety of factors including access to new technological advancements.

2) Objectives

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

3) Summary of Proposed Change

The proposed change would eliminate the lifetime maximum limit.[2]

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

4) Proposal Revision History

Description	Date
Proposal Drafted	
Reviewed by Modernization Subcommittee	08/10/2018, 09/28/2018, 10/30/2018, 04/23/2019, 06/12/2019
Reviewed by RHPAB	08/29/2018, 11/28/2018, 02/06/2019, 05/08/2019, 08/07/2019

[1] As a retiree plan, the AlaskaCare retiree plan is exempt from this ACA provision.
[2] The lifetime maximum does not apply to costs associated with claims under the pharmacy plan, but it would apply to any injections or other medications covered by the medical plan.

DRAFT-Summary of Responses to Proposed Plan Design Change

Proposed change: Increasing or removing the lifetime maximum

Plans affected: DB Retiree Plan

Reviewed by: Retiree Health Plan Advisory Board

Proposed implementation date: January 1, 2019

Review Date: July 26, 2018

Table 1: Plan Design Changes

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

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

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

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

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

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

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

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

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

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

Background:

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

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

Member impact:

WHO IS IMPACTED-

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Actuarial impact

Neutral / Enhancement / Diminishment

Table 2: Actuarial Impact

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

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

DRB operational impacts:

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

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

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

Financial impact to the plan:

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

Clinical considerations:

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

Third Party Administrator (TPA) operational impacts:

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

Provider considerations:

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

Documents attached include:

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

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

Segal Consulting

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MEMORANDUM

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

From: Richard Ward, FSA, FCA, MAAA

Date: July 25, 2018

Re: Removal of the Retiree Plan Lifetime Maximum

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

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

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

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

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

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

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

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

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

Please note that the projections in this report are estimates of future costs and are based on information available to Segal at the time the projections were made. Segal Consulting has not audited the information provided. Projections are not a guarantee of future results. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, trend rates, and claims volatility. The accuracy and reliability of projections decrease as the projection period increases. Unless otherwise noted, these projections do not include any cost or savings impact resulting from The Patient Protection and Affordable Care Act (PPACA) or other recently passed state or federal regulations.

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

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

Proposal Title	Network Incentive
Health Plan Affected	Defined Benefit Retiree Plan
Proposed Effective Date	January 1st, 2020
Reviewed By	Retiree Health Plan Advisory Board
Proposal Drafted	October 2018
Status of Proposal	Under Consideration

Summary of Current State

Most health plans include provisions in their benefit design to promote use of network providers. This incentive encourages use of the network providers which creates both cost savings for the plan and the member while further increasing the negotiating leverage of the plan. Plans with stronger incentives for network use and disincentives for non-network use can steer members towards network providers and away from non-network providers more effectively which in turn can create pressure for providers to come into network in order to increase patient volume.

Network providers have a contractual relationship with an insurance company in which both parties agree to a certain reimbursement schedules and other policies. These policies may include credentialing requirements for participating providers, an agreed upon fee schedule, and an agreement from the provider to write off the difference between the fee schedule and their billed charges rather than seeking the difference from the member; a practice commonly referred to as balance billing. When members use a non-network provider, the plan must determine what to pay for services since there is not an agreed upon fee schedule with the provider. In the AlaskaCare retiree health plan, this is called the recognized charge.

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

Uniquely, the retiree health plan does not differentiate between care received from network providers and non-network providers when paying benefits. Once a member reaches their deductible ($150/individual, limited to no more than $750/family) the plan pays a flat 80% coinsurance, regardless of provider status, until the member reaches their annual out-of-pocket limit ($800/individual).

Objectives

a) Achieve discounted provider charges in order to reduce the members cost share and reduce balance billing.
b) Increase providers willingness to participate in the network, particularly in the Anchorage area where there is competition amongst providers.

Summary of Proposed Change

The proposed change would increase the coinsurance from 80% to 90% for services received from a network provider and decrease the plan coinsurance from 80% to 70% for services received from a non-network provider.

Using a network provider brings benefits both to the member and the plan. Benefits to the member include: no balance bills, provider responsible for prior authorization not the member, and discounted charges which reduce member's cost share.

Benefits to the plan include discounted charges, providers agree to certain billing practices, and providers agree to follow pre-authorization requirements.

Benefits to the provider include , increased volume, member satisfaction preferential treatment in terms of plan design incentives.

DRAFT-Summary of Responses to Proposed Plan Design Change

Proposed change: Adding a network incentive

Plans affected: DB Retiree Plan

Reviewed by: Retiree Health Plan Advisory Board

Proposed implementation date: TBD

Review Date: October 30, 2018

Table 1: Plan Design Changes

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

Description of proposed change:

Amend the plan booklet to increase the plan coinsurance from 80% to 90% for services received from a network provider and decrease the plan coinsurance from 80% to 70% for services received from a non-network provider.

Background:

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

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

- what the provider bills or submits for that services or supply; or

- the 90th percentile of the prevailing charge rate for the geographic area where the service is furnished as determined by Aetna in accordance with Aetna reimbursement policies."[1]

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

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

Uniquely, the AlaskaCare Defined Benefit retiree health insurance plan does not differentiate between care received by a network provider and non-network providers when paying benefits. Once a member reaches their deductible ($150/individual, limited to no more than $750/family) the plan pays a flat 80% coinsurance, regardless of provider status, until the member reaches their annual out-of-pocket limit ($800/individual).

In reviewing claims incurred in calendar year 2017 in the data warehouse, there was approximately $316 million paid for medical benefits in the AlaskaCare reitree health plan (this excludes pharmacy benefits). This is outlined in Attachment B.

Approximately 60%, or $189 million was paid to network providers, and approximately 40%, or $128 million was paid to non-network providers. This includes medical claims for both Medicare-eligible and non-eligible retirees.

Table 1. AlaskaCare Retiree Medical Claims Incurred Calendar Year 2017

Network Indicator		Network		Non-Network		
Employee Status	Service Category	Paid	% of Total Paid	Paid	% of Total Paid	Total Paid

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

Retiree under 65	Inpatient Facility	$43,090,566	94%	$2,845,387	6%	$45,935,952
	Outpatient Facility	$62,367,382	83%	$12,565,761	17%	$74,933,143
	Professional	$59,270,689	63%	$34,530,858	37%	$93,801,547
	Summary	$164,728,637	77%	$49,942,006	23%	$214,670,642
Retiree 65 and over	Inpatient Facility	$5,617,693	32%	$11,752,270	68%	$17,369,963
	Outpatient Facility	$9,881,264	29%	$23,710,559	71%	$33,591,823
	Professional	$8,872,952	17%	$42,375,095	83%	$51,248,047
	Summary	$24,371,908	24%	$77,837,925	76%	$102,209,833
Summary		**$189,100,545**	**60%**	**$127,779,930**	**40%**	**$316,880,475**

While this differential is high, it may be a misleading, as members with Medicare as their primary insurance can use any provider who accepts Medicare and will not be impacted by network incentives. There is substantially higher non-network use by Medicare-eligible retirees, but additional analysis is warranted to understand this differential and rule out any data discrepancy.

Looking further at the non-Medicare eligible retirees, network usage increases to 77% of the paid among incurred at network providers and 23% at non-network providers. The highest use of non-network providers is in professional services, where 37% of claims incurred were paid to non-network provider. This aligns with consistent trends observed in the quarterly reports, and represents an opportunity to understand why non-network usage is high (e.g. lack of incentive, limited provider participation, limited access, etc.) and increase network utilization.

Use of network inpatient facilities is quite high at 94% of total paid among non-Medicare retiree claims. This is unsurprising, as both Providence Alaska Medical Center and Alaska Regional Hospital in Anchorage are both considered network providers.

Member impact:

Members using network providers: As the majority of members use network services already, members overall would benefit from this change as the coinsurance would increase from 80% to 90%, representing a reduced cost share for the period between when they meet their deductible and out-of-pocket limit. **Additional information will include an estimate for how many member this is.**

Members using non-network providers: These members would be disadvantaged by the change as the coinsurance would decrease from 80% to 70% representing an increase

cost share for the period described above. **Additional information will include an estimate for how many members this is.**

Members who cannot access a network provider: Members who do not have access to a network provider are in a difficult position, and given the remoteness of Alaska there are several communities where this may be an issue. The plan proposal does not assume an exception currently, however the proposal could be modified to include an exception or a waiver if a member cannot access a provider in their community. Alternatively, the addition of enhanced travel benefits may provide an options for members in this situation.

Members who meet their deductible but who have not yet met their out-of-pocket limit: As proposed, this would only impact members who utilize enough health care services to meet their annual deductible and continue to incur costs. This would not impact members wo meet their out-of-pocket limit, and this would not impact members who have not met their deductible. Approximately 80% of plan costs are from members who have reached their out-of-pocket limit.[2]

Members who are not Medicare-eligible: This will impact members who are not eligible for Medicare as described above.

Members who are Medicare-eligible: This will have limited impact on members who are Medicare eligible and only in circumstances where Medicare does not cover a benefit that is covered under the AlaskaCare plan in which the plan become the primary payer.

Actuarial impact:

Neutral / Enhancement / Diminishment

Table 2: Actuarial Impact

	Actuarial Impact
Current	N/A
Proposed	Increase of 0.14%[3]

DRB operational impacts:

The Division anticipates minimal operational impacts as follows:

- Staff will need to review and distribute communications to educate and increase awareness of the new plan benefit.
- A plan amendment will need to be developed, put forward for public comment, and published before the benefit takes effect.

[2] See Attachment A
[3] See Attachment A

- Staff will need to coordinate and oversee implementation of the new benefit to ensure it is accurately administered by the Third-Party Administrator.

Financial impact to the plan:

The overall financial impact to the plan is estimated to increase costs by $800,000.

From Segal Consulting Group, Attachment A:

"The impact of reducing out-of-network coinsurance is limited due to the relatively low out-of-pocket maximum. Approximately 80% of the Plan's costs are from claimants that have reached the out-of-pocket maximum. Changing the coinsurance does not impact plan, or member, costs for these claimants."

Segal notes that "Increasing the out-of-pocket maximum would result in more of these claimants' costs being affected by the change in coinsurance and, therefore, there would be a greater impact on plan, member, and costs."

Note- this analysis does not consider savings that could accrue as the result of improved pricing due to strong network negotiations.

Clinical considerations:

These changes not anticipated to impact any clinical considerations.

Third Party Administrator (TPA) operational impacts:

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

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

Provider considerations:

Implementing a network differential could increase providers willingness to participate in the network, particularly in the Anchorage area where there is competition amongst providers.

Documents attached include:

Document Name	Attachment	Notes
Segal Memorandum; October 25, 2018	A	
Network Claims Pull	B	

Public Comments	C	Under development

Segal Consulting

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MEMORANDUM

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

From: Richard Ward, FSA, FCA, MAAA

Date: October 25, 2018

Re: Coinsurance Change 90%/70% In-Network/Out-of-Network – Focus on Actuarial and Financial Impact for the Retiree Plan

The AlaskaCare Retiree Plan currently provides coverage for medical treatments and applies the general plan provisions, such as deductible, coinsurance and out-of-pocket limitations, to determine any portion of the costs that are the member's responsibility. If the member has additional coverage, such as Medicare or other employer provided coverage, any portion of the costs covered by that plan is also considered. Below is a table outlining the current benefits offered under the Plan:

Deductibles	
Annual individual / family unit deductible	$150 / up to 3x per family
Coinsurance	
Most medical expenses	80%
Most medical expenses after out-of-pocket limit is satisfied	100%
Second surgical opinions, Preoperative testing, Outpatient testing/surgery • No deductible applies	100%
Out-of-Pocket Limit	
Annual individual out-of-pocket limit • Applies after the deductible is satisfied • Expenses paid at a coinsurance rate other than 80% do not apply against the out-of pocket limit	$800

Benefit Maximums		
Individual lifetime maximum • Prescription drug expenses do not apply against the lifetime maximum	$2,000,000	
Individual limit per benefit year on substance abuse treatment without precertification. Subject to change every three years	$12,715	
Individual lifetime maximum on substance abuse treatment without precertification. Subject to change every three years	$25,430	
Prescription Drugs	Up to 90 Day or 100 Unit Supply	
	Generic	Brand Name
Network pharmacy copayment	$4	$8
Mail order copayment	$0	$0

A change to the benefits under consideration would replace the current 80% coinsurance for all medical expenses to a 90% and 70% coinsurance for medical expenses in-network and out-of-network, respectively.

Actuarial Value

Our analysis determines the impact of implementing an in-network and out-of-network coinsurance of 90% and 70% respectively, would result in an increase in actuarial value of 0.14%. This analysis is focused on the change to network benefits.

Financial Impact

Based on the current retiree claims projection of $590,000,000 for 2019, the financial impact is approximately an $800,000 increase in costs. This increase accounts for the savings associated with the reduction in coinsurance for out-of-network claims.

The impact of reducing out-of-network coinsurance is limited due to the relatively low out-of-pocket maximum. Approximately 80% of the Plan's costs are from claimants that have reached the out-of-pocket maximum. Changing the coinsurance does not impact plan, or member, costs for these claimants. Increasing the out-of-pocket maximum would result in more of these claimants' costs being affected by the change in coinsurance and, therefore, there would be a greater impact on plan, and member, costs.

Claims for services from network providers are currently paid utilizing the Aetna network discount. Therefore, increasing the coinsurance for network services increases costs. If the Plan was not currently benefiting from network discounts, then it is likely the impact of accessing the discounts would offset the cost of increasing the coinsurance, resulting in net savings.

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

Please note that the projections in this report are estimates of future costs and are based on information available to Segal at the time the projections were made. Segal Consulting has not audited the information provided. Projections are not a guarantee of future results. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, trend rates, and claims volatility. The accuracy and reliability of projections decrease as the projection period increases. Unless otherwise noted, these projections do not include any cost or savings impact resulting from The Patient Protection and Affordable Care Act (PPACA) or other recently passed state or federal regulations.

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

Proposal Title	Out-Of-Network Reimbursement
Health Plan Affected	Defined Benefit Retiree Plan
Proposed Effective Date	January 1st, 2020
Reviewed By	Retiree Health Plan Advisory Board
Proposal Drafted	March 2019
Status of Proposal	Under Consideration

Summary of Current State

The AlaskaCare retiree health plan utilizes a network of providers contracted with the plan's claims administrator to access discounted prices and to ensure certain credentialing requirements, quality metrics, and billing practices. Not only do facilities, groups, or professionals in the network agree to certain reimbursement schedules and other policies, but they also agree to write off the difference between the fee schedule and their billed charges rather than seeking the difference from the member - a practice commonly referred to as balance billing. When members use a non-network provider, the plan must determine what to pay for services, because without a network agreement, the provider and the payer have not agreed to a fee schedule or reimbursement rates. In the AlaskaCare retiree health plan, the determination of what the plan pays for out-of-network services is called the recognized charge, and "is the lesser of what the provider bills for that services or supply; or the 90th percentile of the prevailing charge rate for the geographic area where the service is furnished as determined by Aetna in accordance with Aetna reimbursement policies." Currently, the AlaskaCare retiree health plan determines the prevailing charge rates by relying on benchmarks produced by FAIR Health, a company that aggregates claims data and produces cost benchmark information based on what providers in a specific geographic area bill for services. Because the recognized charge is determined based on the amount providers bill, over time, as providers bill higher amounts, the FAIR Health benchmark can increase, resulting in a higher prevailing charge rate, and greater compensation for out-of-network providers. With very few exceptions, the recognized charge is usually higher than the negotiated charge. When out-of-network providers and facilities are reimbursed at substantially higher rates than in-network providers, it can be difficult to incentivize providers and facilities to join the network.

Objectives

a) Strengthen the health plan's purchasing power with providers.
b) Incentivize member use of network providers through benefit design.
c) Provide savings to the members and to the health trust and balance other modernization proposals.

Summary of Proposed Change

The proposed change would alter the methodology used to determine payments to out-of-network providers by changing from the 90th percentile of the prevailing charge rate for the geographic area to a percentage of the Medicare Physician Fee Schedule. This proposal offers three different reimbursement rates for out-of-network providers:

- 185% of Medicare's Fee Schedule,
- 195% of Medicare's Fee Schedule, or
- 205% of Medicare's Fee Schedule.

Members who live in areas without access to a network provider may face higher out-of-pocket costs the form of balance bills. To care for these members who do have the option to access network providers, the plan proposal includes an exception or a waiver that would reimburse out-of-network providers using the current methodology if a member cannot access a provider in their community. Alternatively, the addition of enhanced travel benefits may provide further options for members in this situation.

DRAFT-Summary of Responses to Proposed Plan Design Change

Proposed change: Determine non-network recognized charge as a percentage of Medicare's fee schedule

Plans affected: DB Retiree Plan

Reviewed by: Retiree Health Plan Advisory Board

Proposed implementation date: TBD

Review Date: May 8 ~~March 20~~, 2019

Table 1: Plan Design Changes

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

Note: we've indicated our estimate for the impacts using question marks in areas where the information is still under development.

Description of proposed change:

Amend the plan booklet to change the methodology for determining the recognized charge for non-Medicare covered professional and facility services obtained from a non-network provider from the 90th percentile of the prevailing charge rate for the geographic area to a percentage of Medicare's fee schedule.

Background:

The AlaskaCare retiree health plan utilizes a network of providers contracted with the plan's Third-Party Administrator (TPA) to access discounted prices and to ensure certain credentialing requirements, quality metrics, and billing practices. Not only do facilities, groups, or professionals in the network agree to certain reimbursement schedules and other policies, but they also agree not to seek the difference between the agreed-upon fee schedule and their billed charges from the member - a practice commonly referred to as balance billing. Balance bills can be quite substantial and are solely the responsibility of the member; the health plan does not cover balance bills. However, Medicare-accepting providers (regardless of network participation status) cannot balance bill Medicare-covered members.

When non-Medicare covered members use a non-network provider, the plan must determine what to pay for services because without a network agreement the provider and the payer have not agreed to a fee schedule or reimbursement rates. In the AlaskaCare retiree health plan, the determination of what the plan pays for non-network services is called the recognized charge, and "is the lesser of:

- what the provider bills or submits for that services or supply; or
- the 90th percentile of the prevailing charge rate for the geographic area where the service is furnished as determined by Aetna in accordance with Aetna reimbursement policies."[1]

Currently, the AlaskaCare retiree health plan determines the prevailing charge rates by relying on benchmarks produced by FAIR Health, a company that aggregates claims data and produces cost benchmark information based on what providers in a specific geographic area bill for services. This information is updated biannually.

Because the recognized charge is determined based on the amount providers bill, over time the FAIR Health benchmark increases based on billing amounts resulting in both higher prevailing charge rates and greater compensation for non-network providers. In some cases, the recognized charge may be higher than the negotiated charge, meaning both the plan and the member are paying more for the same service than they would if the service was received through a network provider. When non-network providers and facilities are reimbursed at substantially higher rates than in-network providers, it can be difficult to incentivize providers and facilities to join the network.

The AlaskaCare Defined Benefit retiree health insurance plan does not differentiate between care received by network providers and non-network providers when paying benefits. Once a member reaches their deductible ($150/individual, limited to no more than $750/family) the plan pays a flat 80% coinsurance, regardless of provider status, until the member reaches their annual out-of-pocket limit ($800/individual). Even though members' cost share does not vary based on the network status of their provider, if members receive services from a non-network provider they may be subject to balance billing and the plan may end up paying more than it would if the same services had been received from network provider.

The proposed change would alter the methodology used to determine payments to non-network providers by changing from the 90th percentile of the prevailing

[1] Page 16, AlaskaCare Retiree Health Insurance Information Booklet. http://doa.alaska.gov/drb/pdf/ghlb/retiree/DBRetireeInsuranceBooklet-01012019.pdf

charge rate for the geographic area to a percentage of the Medicare Physician Fee Schedule. The Centers for Medicare & Medicaid Services (CMS) sets the Medicare fee schedule through a formula that takes into account the time and intensity associated with providing a service, the expense of maintaining a practice, the cost of malpractice insurance, and the cost of practicing medicine in different geographic areas.[2]

Analysis is underway to represent current non-network reimbursement rates as a percentage of Medicare's fee schedule for comparison purposes, but this analysis has not yet been completed.

This proposal evaluates reimbursing non-network charges, both professional and facility, at 185% of Medicare's fee schedule.

In areas where network access is adequate, this proposal would encourage utilization of network providers, bringing savings to both the plan and to members.

However, in some areas, network access is not adequate. Members accessing non-network services in these areas would receive an exception, or a waiver, to allow for a higher reimbursement to their provider to help circumvent the possibility of balance billing.

Member impact:

The impacts of the proposed change will be most apparent in medical claims incurred by non-Medicare ~~eligible~~ covered retirees because the AlaskaCare plan is supplemental to Medicare. Members who are enrolled in Medicare can seek services from any provider that accepts Medicare; any services provided would be subject to Medicare's fee schedule. Medicare will pay first, and AlaskaCare will coordinate to pay 100% of covered expenses, less any deductible not yet met. If a Medicare-eligible member chooses not to enroll in Medicare, the AlaskaCare plan will estimate what Medicare would have paid, and deduct that amount before paying expenses.

There is substantially higher non-network use by Medicare-~~eligible~~ covered retirees, but because most of those claims are already based on Medicare's fees schedule, the impact to the plan's spend is not likely to be significant. However, analysis is warranted and underway to understand how this proposal would impact the amount the plan spends on non-network Medicare claims.

[2] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/medcrephysfeeschedfctsht.pdf

In reviewing claims incurred by non-Medicare eligible AlaskaCare retiree health plan members in calendar year 2018 in the AlaskaCare data warehouse, there was approximately $220 million paid for medical benefits (this excludes pharmacy benefits). Approximately 84%, or $185 million was paid to network providers, and approximately 16%, or $35 million was paid to non-network providers. This is outlined in Table 2.

Table 2. AlaskaCare Non-Medicare Eligible Retiree Medical Claims Incurred Calendar Year 2018[3]

		Network		Non-Network		
	Service Category	Paid	% of Total Paid	Paid	% of Total Paid	Total Paid
Retiree under 65	Inpatient Facility	$41,702,439	**96%**	$1,515,494	**4%**	$43,217,933
	Outpatient Facility	$74,715,222	**89%**	$9,338,289	**11%**	$84,053,511
	Primary Care Provider Professional	$13,828,385	**79%**	$3,745,962	**21%**	$17,574,347
	Specialty Provider Professional	$55,017,094	**73%**	$20,625,847	**27%**	$75,642,941
	Summary	$185,263,140	84%	$35,225,592	**16%**	$220,488,732

Amongst non-Medicare eligible retirees:

- 17% of non-network utilization is responsible for 27% of total specialty provider professional costs, and
- 12% of non-network utilization is responsible for 21% of total primary care provider professional costs.[4]

Use of network inpatient facilities is quite high at 96% of total paid among non-Medicare retiree claims. This is unsurprising, as both Providence Alaska Medical Center and Alaska Regional Hospital in Anchorage are both considered network providers.

Members using network providers: Members currently using network providers would not experience an impact.

[3] Information provided based on AlaskaCare data warehouse claims pull as of the week of 3/18/2019.
[4] Ibid.

Members using non-network providers: These members could be disadvantaged by the change as they may be subject to balance billing from non-network providers.

Members who cannot access a network provider: Members who live in areas without access to a network provider may face higher out-of-pocket costs the form of balance bills. To care for these members who do have the option to access network providers, the plan proposal includes an exception or a waiver that would reimburse non-network providers using the current methodology if a member cannot access a provider in their community. Alternatively, the addition of enhanced travel benefits may provide further options for members in this situation.

Members who are not Medicare-eligible: This will impact members who are not eligible for Medicare as described above.

Members who are Medicare-~~eligible~~covered: This will have limited impact on members who are Medicare~~- eligible~~ covered and only in circumstances where Medicare does not cover a benefit that is covered under the AlaskaCare plan in which the plan become the primary payer.

Actuarial impact:

Neutral / Enhancement / Diminishment

Table 2: Actuarial Impact

	Actuarial Impact
Current	N/A
Proposed	N/A

Actuarial analysis forthcoming.

DRB operational impacts:

The Division anticipates minimal operational impacts as follows:

- Staff will need to review and distribute communications to educate members about the potential impacts and increase awareness of the new reimbursement approach.
- A plan amendment will need to be developed, put forward for public comment, and published before the benefit takes effect.
- Staff will need to coordinate and oversee implementation of the new benefit to ensure it is accurately administered by the TPA.
- Staff will need to coordinate with the TPA to ensure that providers are made aware of the new reimbursement approach.

Financial impact to the plan:

The financial analysis is forthcoming.

Clinical considerations:

This proposal is not anticipated to impact members from a clinical perspective.

Third Party Administrator (TPA) operational impacts:

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

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

Provider considerations:

Implementing a new non-network reimbursement methodology would alter the level of reimbursement received by non-network provides. Many non-network providers may experience a reduction in reimbursement, while some others may experience an increase. Non-network specialty providers are most likely to be more heavily impacted than primary care providers. Specialty providers' billed charges tend to be significantly higher than Medicare's fee schedule, resulting in considerable non-network reimbursement rates.

The proposed change could increase providers' willingness to participate in the network, particularly in the Anchorage area where there is competition amongst providers.

Documents attached include:

Document Name	Attachment	Notes
Segal Memorandum	A	Forthcoming
Retiree Plan Medical Claims as a Percentage of Medicare Review (Segal)	B	 Retiree Plan Medical Claims as a Percentag

Proposal Title	Over the Counter Equivalent Drugs
Health Plan Affected	Defined Benefit Retiree Plan
Proposed Effective Date	January 1st, 2020
Reviewed By	Retiree Health Plan Advisory Board
Proposal Drafted	July 2018
Status of Proposal	Set Aside

Summary of Current State

The AlaskaCare defined benefit retiree health plan provides coverage for prescription drugs prescribed by a provider that may have an over-the-counter (OTC) equivalent.[3] Some medications in this category were initially only available with a prescription, but since their initial entry onto the market now have a generic and/or an OTC equivalent available (e.g. Prilosec).

In 2018, the retiree plans spent nearly $5.8 million on generic and brand prescription drugs known to have over-the-counter equivalents. Over 25%, or $1.5 million, was spent on brand drugs, two-thirds of which ($1.1 million) had generic therapeutic equivalents in addition to their OTC counterparts. Over the same year, beneficiaries of the retiree plan paid nearly $80,000 in copays for all drugs with an OTC equivalent: roughly $0.04/unit, or $3.60 for a 90-day supply.

$4.1 million of the total was spent on omeprazole and esomeprazole (commonly known as Prilosec and Nexium respectively). Typical prices for brand-name, generic, and OTC versions of esomeprazole are:

- Brand-Name Prescription (40mg): $500 for a 90-day supply
- Generic Prescription (40 mg): $287 for a 90-day supply
- OTC Equivalent (20mg, can be taken twice): $19.80 for 90ct[4], $39.60 for 40mg, 90-day equivalent.

The dispense-as-written notation on these drug claims reveal that the choice of brand over generic among drugs with OTC options was in most cases indicated by the member themselves, not their physician.

Objectives

a) Provide savings to the members and to the health trust and balance other modernization proposals.

Summary of Proposed Change

Discontinue coverage of prescription medication when an over the counter (OTC) equivalent of the drug is available. There are two options.

- **Option A -** Coverage for brand-name and generic prescription medication would be discontinued if an OTC equivalent of the drug is available.
- **Option B -** Coverage for brand-name prescription medication would be discontinued if both a generic AND an OTC equivalent of the drug are available.

[3] p. 70, http://doa.alaska.gov/drb/pdf/ghlb/retiree/DBRetireeInsuranceBooklet-01012019.pdf
[4] Safeway, Kroger, Carrs, Walmart) with manufacturer coupon

DRAFT-Summary of Responses to Proposed Plan Design Change

Proposed change: Removing Coverage of OTC-Equivalent Drugs

Plans affected: DB Retiree Plan

Reviewed by: Retiree Health Plan Advisory Board

Proposed implementation date: TBD

Review Date: April 23, 2019

Table 1: Plan Design Changes

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

* The financial impact varies between the two proposed options

Description of proposed change:

This proposal offers for consideration two options to discontinue coverage of prescription medication when an over-the-counter (OTC) equivalent of the drug is available. Under both scenarios, a prescribing provider could override the exclusion with a medical indication on the prescription in instances where the prescription-grade medication is medically preferable.

Option A

Coverage for brand-name and generic prescription medication would be discontinued if an OTC equivalent of the drug is available.

Option B

Coverage for brand-name prescription medication would be discontinued if both a generic AND an OTC equivalent of the drug are available.

Both Options:

An OTC drug would be considered equivalent to a prescription drug if:

- The OTC drug has the same active pharmaceutical ingredient(s) (API) as the prescription drug product, AND
- The API(s) have the same, similar or easily substitutable dosage strength, AND

- The OTC drug can be used in the same route of administration as the prescription drug. [1]

Background:

The AlaskaCare defined benefit retiree health plan provides coverage for prescription drugs prescribed by a provider that may have an OTC equivalent.[2] Some medications in this category were initially only available with a prescription, but since their initial entry onto the market now have a generic and/or an OTC equivalent available.

In 2018, the AlaskaCare Retiree Plans spent nearly $5.8 million on generic and brand prescription drugs known to have over-the-counter equivalents. Over 25%, or $1.5 million, was spent on brand drugs, two-thirds of which ($1.1 million) had generic therapeutic equivalents in addition to their OTC counterparts. Over the same year, beneficiaries of the retiree plan paid nearly $80,000 in copays for all drugs with an OTC equivalent: roughly $0.04/unit, or $3.60 for a 90-day supply.

$4.1 million of the total was spent on omeprazole and esomeprazole (commonly known as Prilosec and Nexium respectively). Typical prices for brand-name, generic, and OTC versions of esomeprazole are:

- Brand-Name Prescription (40mg): $500 for a 90-day supply
- Generic Prescription (40 mg): $287 for a 90-day supply
- OTC Equivalent (20mg, can be taken twice): $19.80 for 90ct[3], $39.60 for 40mg, 90-day equivalent.

The dispense-as-written notation on these drug claims reveal that the choice of brand over generic among drugs with OTC options was in most cases indicated by the member themselves, not their physician.

Member impact:

Option A

About 15,800 unique members received and filled a prescription for a drug that had an over-the-counter equivalent in 2018. 54% of these members, or 8,500 received two or fewer OTC-equivalent prescriptions over the benefit year.

[1] The means of drug comparison in both proposals are lifted from the FDA
[2] p. 70, http://doa.alaska.gov/drb/pdf/ghlb/retiree/DBRetireeInsuranceBooklet-01012019.pdf
[3] Safeway, Kroger, Carrs, Walmart) with manufacturer coupon

Members who are prescribed a drug with an OTC equivalent would be responsible for paying out of pocket for the entire cost of the drug, rather than paying only an $8, $4, or $0 copay.

Option B

About 1,300 claimants received and filled a prescription for a brand-name drug that had both a generic and an OTC equivalent in 2018. About 75% of these members (900) received a brand drug over generic or OTC options without an indication of physician or personal preference (the drug claims did not have a dispense-as-written code). About 250 of these claimants, or under 20% of the total, expressed a personal preference for brand over other options, without a physician's indication. This accounted for roughly 60% of the total plan's costs for brand drugs with generic and OTC options.

Due to the copay structure of brand and generic medication outside of mail-order pharmacy drugs (which have $0 in copays for both brand and generic), this change is anticipated to reduce total copayments from AlaskaCare retirees and their dependents by eliminating the $8 brand-name copay for this set of medications while also maintaining a set of therapeutically-equivalent options in the form of prescription generic drugs or over-the-counter drugs.

Actuarial impact:

Neutral / Enhancement / Diminishment - Forthcoming

Table 2: Actuarial Impact

	Actuarial Impact
Current	
Proposed	

DRB operational impacts:

Options A & B

To exclude coverage of OTC-equivalent drugs, the Division would need to amend the Defined Benefit Retiree Insurance Information Booklet to reflect the change, coordinate with the pharmacy benefit manager to ensure the change is properly implemented, and communicate the change to retirees and their dependents.

Financial impact to the plan:

Option A

The savings impact to the plan may be difficult to estimate under Proposal A. If applied to 2018, the plan may have forgone $5.8 million in expenditures at the high-end.

However, there are some factors which may impact this savings estimate:

- Physicians may override the exclusion in instances where the prescription-grade drug is medically-preferable.
- The plan receives federal subsidies and manufacturer rebates on certain drugs, and the sum of these subsidies and rebates may decrease with less upfront expenditure.
- Certain prescription drugs with over-the-counter equivalents may be protected under the Medicare formulary, which may restrict the plan's ability to exclude these drugs due to the AlaskaCare enhanced Employer Group Waiver Program – a group Medicare Part D plan.

A full financial analysis is forthcoming

Option B

This change is preliminarily estimated to save the plan $300,000-$400,000 a year.

It should be anticipated that patients who do not currently have a physician's medical indication for a brand drug, but currently receive one, will seek to obtain one from their provider.

On net, the average requested brand name with a therapeutic-equivalent in the form of a generic medication or an OTC drug is $760 per prescription, compared to the $81 per generic prescription with an OTC equivalent. Transferring 80% of members with a brand prescription and without a physician's indication onto its generic equivalent would increase generic spend by approximately $50,000 and reduce brand spend by approximately $463,000, resulting in a $413,000 overall decrease in plan spend.

If only 60% of those members convert to generic from brand, generic expenditure would increase by approximately $38,000 and brand expenditure would decrease by approximately $347,000, resulting in a $309,000 overall decrease in plan spend.

A full financial analysis is forthcoming.

Clinical considerations:

Options A & B

Prescribing providers would be more like to prescribe generic medications and/or steer members towards OTC equivalent medications. While therapeutically equivalent drugs can be expected to have the same effect as their brand-name counterparts, some individuals respond differently to different medications and may require brand-name drugs. These members will be able to seek a medical indication on their prescription from their provider to override these exclusions.

Third Party Administrator (TPA) operational impacts:

Options A & B

The TPA will need to reconfigure their system to reflect the change. The TPA will also need to communicate the change to members and to network pharmacies.

Provider considerations:

Members should ask their physician about whether their prescriptions would be impacted by this change, and if the OTC equivalent is right for their therapeutic needs. Providers will need to learn about the change and be prepared to provide a medical indication on prescriptions when necessary.

Segal Consulting

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MEMORANDUM

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

From: Richard Ward, FSA, FCA, MAAA

Date: July 25, 2018

Re: Coverage for Medications Available Over-the-Counter – Focus on Actuarial and Financial Impact for the Retiree Plan

The AlaskaCare Retiree Plan currently provides coverage for many medications that are available over-the-counter (OTC) without a prescription. The Plan applies the general pharmacy benefit provisions, such as copays, to determine any portion of the costs that are the member's responsibility. If the member has additional coverage, such as Medicare or other employer provided coverage, any portion of the costs covered by that plan is also considered. Below is a table outlining the current benefits offered under the Plan:

Deductibles	
Annual individual / family unit deductible	$150 / up to 3x per family
Coinsurance	
Most medical expenses	80%
Most medical expenses after out-of-pocket limit is satisfied	100%
Second surgical opinions, Preoperative testing, Outpatient testing/surgery • No deductible applies	100%
Out-of-Pocket Limit	
Annual individual out-of-pocket limit • Applies after the deductible is satisfied • Expenses paid at a coinsurance rate other than 80% do not apply against the out-of pocket limit	$800

Benefit Maximums		
Individual lifetime maximum • Prescription drug expenses do not apply against the lifetime maximum	$2,000,000	
Individual limit per benefit year on substance abuse treatment without precertification. Subject to change every three years	$12,715	
Individual lifetime maximum on substance abuse treatment without precertification. Subject to change every three years	$25,430	
Prescription Drugs	Up to 90 Day or 100 Unit Supply	
	Generic	Brand Name
Network pharmacy copayment	$4	$8
Mail order copayment	$0	$0

A change to the benefits under consideration would end coverage for medications that are available in the same quantity and dosage as OTC medications.

Actuarial Value

Healthcare plans typically do not cover medications as they become available OTC, except in instances where a prescription is required for a particular dosage or quantity. Typical examples are allergy medications for daily or seasonal use, such as low dosage Claritin and Allegra. If a patient requires a higher dosage than is available OTC, or the patient requires a different allergy medication, the Plan would continue to provide coverage with a prescription.

Access to necessary prescription medications is not impacted under this proposed Plan change and therefore there is no impact on actuarial value.

Financial Impact

While there is no impact on the Plan's actuarial value, there would be a financial impact. We reviewed the Plan's claims and identified approximately 100,000 prescriptions for medications that are typically OTC medications that would be impacted, with associated annual savings projected to be approximately $3,000,000.

We anticipate reviewing a list of specific medications that would be applied by the Plan's 2019 PBM. Once provided that opportunity, we will review, and potentially update, this analysis.

Based on a preliminary retiree claims projection of $680,000,000 for 2019, this equates to approximately 0.45% in savings to the Plan.

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

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

Please note that the projections in this report are estimates of future costs and are based on information available to Segal at the time the projections were made. Segal Consulting has not audited the information provided. Projections are not a guarantee of future results. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, trend rates, and claims volatility. The accuracy and reliability of projections decrease as the projection period increases. Unless otherwise noted, these projections do not include any cost or savings impact resulting from The Patient Protection and Affordable Care Act (PPACA) or other recently passed state or federal regulations.

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

Proposal Title	Preventive Services
Health Plan Affected	Retiree Defined Benefit Health Plan
Proposed Effective Date	January 1, 2020
Reviewed By	Retiree Health Plan Advisory Board
Proposal Drafted	August 29, 2018
Status of Proposal	Under Consideration

Summary of Current State

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

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

Around 2010, in conjunction with certain requirements in the Patient Protection and Affordable Care Act (ACA), insurance coverage for age-specific guidelines indicating the utilization of screening and preventive services for older adults grew increasingly common. Despite these industry changes, the omission of most preventive benefits in the plan may cause retirees to forego getting recommended age-specific vaccinations, screenings, and other preventive services. The goal of preventive services is to increase early detection and treatment of health conditions in order to improve clinical outcomes, arrest disease at an earlier stage when it is easier and more effectively treated, and to promote health-conscious behavior.

Objectives

a) Support the members in early detection of health problems, increase overall health, and in maintaining their health.

Summary of Proposed Change

The Division proposes adding the full suite of evidence based preventive services to the plan that mirror those provided in most employee plans in accordance with the Affordable Care Act. These expanded services include those with an "A" or "B" rating by the United States Preventive Task Force.[5] The specific services will change as the USPTF updates their recommendations to reflect the most current research and evidence.

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

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

DRAFT-Summary of Responses to Proposed Plan Design Change

Proposed change: Expanded preventive services subject to network steerage.

Plans affected: DB Retiree Plan

Reviewed by: Retiree Health Plan Advisory Board, Alaska Retirement

Proposed implementation date: January 1, 2019

Review Date: August 29, 2018

Table 1: Plan Design Changes

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

Description of proposed change:

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

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

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

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

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

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

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

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

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

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

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

[3] Ibid.

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

The Division proposes that preventive services would be subject to normal cost-share provisions (annual deductibles, coinsurance, copay and annual maximum out-of-pocket limits, etc.), with the exception that the coinsurance paid by the plan will be reduced by 20% when the preventive care services are provided by an out-of-network provider. [WBR(1)]Further, those out-of-network expenses will not count towards the annual out-of-pocket maximum.

Table 2: Comparison of Current to Proposed Change

Benefit	Current	Proposed in-network	Proposed out-of-network
Coinsurance / Out-of-Pocket Limits	• 80% after deductible. (100% after annual out-of-pocket reached.)	• 80% coinsurance after deductible. (100% after annual out-of-pocket reached.)	• 60% coinsurance after deductible. (Does not apply if no network access) Not subject to the individual out-of-pocket maximum (exception if no network access)

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

Benefit	Current Covered Preventive Serviced	Proposed Covered Preventive Services
Mammograms	• One baseline between age 35-40. • One every two years between age 40-50. • Annually at age 50 and above and for those with a personal or family history of breast cancer.	• Biennial screening between age 50-74 • Earlier or additional screenings for those at high risk[5]
Pap Smear	One per year for women 18 years of age and older. Also includes limited office visit to collect the pap smear.	One every 3 years for women age 21 to 65, or every 5 years with a combination of cytology and HPV testing.
Prostate specific antigen (PSA)	• One annual screening test for men between ages 35 and 50 with a personal or family history of prostate cancer, • One annual screening test for men 50 years and older.	The [DRB2]Task Force gave a "C" recommendation to men ages 55 to 69, encouraging them to make an individual decision about prostate cancer screening with their clinician. The Task Force recommends against routine screening for men age 70 and older.[6]

[5] **Risk Factors That May Influence When to Start [Breast] Screening:** Advancing age is the most important risk factor for breast cancer in most women, but epidemiologic data from the BCSC suggest that having a first-degree relative with breast cancer is associated with an approximately 2-fold increased risk for breast cancer in women aged 40 to 49 years.2, 9 Further, the CISNET models suggest that for women with about a 2-fold increased risk for breast cancer, starting annual digital screening at age 40 years results in a similar harm-to-benefit ratio (based on number of false-positive results or overdiagnosed cases per 1000 breast cancer deaths avoided) as beginning biennial digital screening at age 50 years in average-risk women.7, 8 This approach has not been formally tested in a clinical trial; therefore, there is no direct evidence that it would result in net benefit similar to that of women aged 50 to 74 years. However, given the increased burden of disease and potential likelihood of benefit, women aged 40 to 49 years who have a known first-degree relative (parent, child, or sibling) with breast cancer may consider initiating screening earlier than age 50 years. Many other risk factors have been associated with breast cancer in epidemiologic studies, but most of these relationships are weak or inconsistent and would not likely influence how women value the tradeoffs of the potential benefits and harms of screening. Risk calculators, such as the National Cancer Institute's Breast Cancer Risk Assessment Tool (available at www.cancer.gov/BCRISKTOOL), have good calibration between predicted and actual outcomes in groups of women but are not accurate at predicting an individual woman's risk for breast cancer.10

[6] https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/prostate-cancer-screening1

Benefit	Current Coverage of Preventive Service	Proposed Coverage of Preventive Services
Vaccines	Not Covered	Coverage for those recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention[7]
Annual Routine Physical	Not Covered	Covered
Well Woman Preventive Visit	Not Covered (exception of limited exam to collect the pap smear)	Subject to any age, family history and frequency guidelines that are evidence-based items or services that have in effect a rating of A or B in the recommendation so the United States Preventive Services Task Force and Evidence informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration
Routine Cancer Screening	Not Covered (except Mammograms, PSA and Pap Smear as outlined above)	Subject to any age, family history and frequency guidelines that are evidence-based items or services that have in effect a rating of A or B[8] in the recommendation so the United States Preventive Services Task Force and Evidence informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration[9]

[7] https://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf
https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf
[8]Includes breast cancer, cervical cancer, colorectal cancer, lung cancer, and skin cancer screenings: https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/
[9] https://www.hrsa.gov/womens-guidelines/index.html

Member impact:

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

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

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

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

Actuarial impact

Neutral / Enhancement / Diminishment

Table 3: Actuarial Impact

	Actuarial Impact	Notes
Current	N/A	N/A
Expanded preventive	0.75% increase[10]	80% coinsurance in network/60% out-of-network

DRB operational impacts:

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

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

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

Financial impact to the plan:

Based on a Segal Consulting's preliminary retiree claims projection of $680,000,000 for 2019, the anticipated fiscal impact is estimated to be approximately $5,000,000 in additional annual costs.[11]

Segal's analysis looked at 2016 and 2017 medical and pharmacy claims data, and projected to 2019 at 3.0% and 6.0% annual trends respectively. For Medicare member, Medicare covers many of these services, including colonoscopies, at 100%. For these member, no change in utilization is assumed and the impact on the Plan is anticipated to be negligible. The analysis for non-Medicare members focused on the approximate 20,000 members between age 50 and 65.[12]

Clinical considerations:

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

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

Third Party Administrator (TPA) operational impacts:

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

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

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

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

Provider considerations:

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

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

Documents attached include:

Document Name	Attachment	Notes
Preventive Care Benefits – Focus on Actuarial and Financial Impact for the Retiree Plan, Segal Consulting memo dated July 25, 2018	A	 Segal Preventive Memo
USPSTF A and B Recommendations	B	https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/
Recommended Adult Immunization Schedule	C	https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf
Recommended Child Immunization Schedule	D	https://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf
Summary of Public Comment	E	Pending

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MEMORANDUM

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

From: Richard Ward, FSA, FCA, MAAA

Date: July 25, 2018

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

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

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

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

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

Coverage is provided in the same manner that other medical treatments and services are covered. The Plan applies the general plan provisions, such as deductible, coinsurance and out-of-pocket limitations, to determine any portion of the costs that are the member's responsibility. If the

member has additional coverage, such as Medicare or other employer provided coverage, any portion of the costs covered by that plan is also considered.

Below is a table outlining the current benefits offered under the Plan:

Deductibles		
Annual individual / family unit deductible	$150 / up to 3x per family	
Coinsurance		
Most medical expenses	80%	
Most medical expenses after out-of-pocket limit is satisfied	100%	
Second surgical opinions, Preoperative testing, Outpatient testing/surgery • No deductible applies	100%	
Out-of-Pocket Limit		
Annual individual out-of-pocket limit • Applies after the deductible is satisfied • Expenses paid at a coinsurance rate other than 80% do not apply against the out-of-pocket limit	$800	
Benefit Maximums		
Individual lifetime maximum • Prescription drug expenses do not apply against the lifetime maximum	$2,000,000	
Individual limit per benefit year on substance abuse treatment without precertification. Subject to change every three years	$12,715	
Individual lifetime maximum on substance abuse treatment without precertification. Subject to change every three years	$25,430	
Prescription Drugs	Up to 90 Day or 100 Unit Supply	
	Generic	Brand Name
Network pharmacy copayment	$4	$8
Mail order copayment	$0	$0

A change to the benefits under consideration would align the scope of benefits with those required of non-Grandfathered plans under the Affordable Care Act (ACA). Note that retiree plans, such as the AlaskaCare Retiree Plan, are not subject to the same provisions under the ACA that apply to the AlaskaCare Employee Plan. Preventive benefits will continue to be subject to deductibles, coinsurance and other plan provisions that apply in 2018.

Actuarial Value

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

Financial Impact

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

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

With over 60,000 members and a high incidence rate of preventive care, the data is considered credible for this analysis. For Medicare members, many of these services, including colonoscopies, are currently covered at 100% by Medicare. For these members, no change in utilization is assumed and the impact on the Plan is anticipated to be negligible. For non-Medicare members, our analysis focused those between ages 50 and 65. There are approximately 20,000 such members.

Please note that the projections in this report are estimates of future costs and are based on information available to Segal at the time the projections were made. Segal Consulting has not audited the information provided. Projections are not a guarantee of future results. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, trend rates, and claims volatility. The accuracy and reliability of projections decrease as the projection period increases. Unless otherwise noted, these projections do not include any cost or savings impact resulting from The Patient Protection and Affordable Care Act (PPACA) or other recently passed state or federal regulations.

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Dan Haar, Segal

Proposal Title	Rehabilitative Care
Health Plan Affected	Defined Benefit Retiree Plan
Proposed Effective Date	January 1st, 2020
Reviewed By	Retiree Health Plan Advisory Board
Proposal Drafted	July 2018
Status of Proposal	Under Consideration

Summary of Current State

The AlaskaCare Defined Benefit retiree plan does not cover rehabilitative maintenance care, that is, care to maintain or prevent deterioration of a chronic condition. The plan currently covers outpatient rehabilitative care designed to restore and improve bodily functions lost due to injury or illness. This care is considered medically necessary only if significant improvement in body function is occurring and is expected to continue. Starting at the 26th visit all claims for the member are pended for review of chart notes. The provider must submit clinical records that document a member continues to experience significant improvement. If the records are not returned within 45 days or fail to demonstrate significant improvement in accordance with the established clinical criteria, the services are denied. The existing plan coverage of rehabilitative services is highly problematic and is the most frequently appealed plan provision. It accounts for approximately one third of all retiree appeals received by the Division in 2017, 2018 and 2019.

Objectives

a) Provide the ability for retirees to receive rehabilitative care that may include maintenance and preventive therapies of chronic conditions.
b) Decrease the volume of claims that are pended and require providers to send chart notes.
c) Decrease the volume of rehabilitative care appeals.

Summary of Proposed Change

The proposed amended change would update the plan language to allow for maintenance or preventive therapies of chronic conditions. It would increase and clearly define the plan's coverage of rehabilitative care, alleviating confusion amongst members and providers.

The proposed benefit change will cover rehabilitative care received from an in-network provider without a visit limit, and cover chiropractic care received from an in-network provider without a visit limit. Removing the limit will reduce the requirement for claim chart note review and allow for maintenance and preventive therapies of chronic conditions.

The proposed benefit will continue to have a visit limit on rehabilitative and chiropractic care received from an out-of-network provider. However, the limit amount will be increased and an option to reset the visit count at the start of each benefit year will be added. If care is received from an out-of-network provider, the member would be provided up to 45 visits per benefit year for outpatient rehabilitative care, and up to 20 visits for chiropractic care. The out-of-network provider visit limits would reset at the start of each benefit year.

The proposed change would also provide coverage for up to 10 visits per benefit year for acupuncture regardless of the provider's network status. The acupuncture visit limits would reset at the start of each benefit year.

The increase in coverage combined with the opportunity to reset the out-of-network provider visit limit with the new benefit year would eliminate the need for visit-triggered medical necessity determinations, and the corresponding appeals if the determination found that the additional services were not medically necessary. This would provide members and their providers with clear guidelines on what the plan covers.

DRAFT-Summary of Responses to Proposed Plan Design Change

Proposed change: ~~Fixed Visit Cap on~~ Coverage of Treatment of Spinal Disorders, Acupuncture and Physical/ Occupational/Speech Therapy

Plans affected: DB Retiree Plan

Reviewed by: Retiree Health Plan Advisory Board, Alaska Retirement

Proposed implementation date: January 1, ~~2019~~2020

Review Date: ~~September 28, 2018~~~~May 8~~June 12, 2019

Table 1. Plan Design Changes

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

Description of proposed change:

The plan currently covers outpatient rehabilitative care designed to restore and improve bodily functions lost due to injury or illness.[1] This care is considered medically necessary only if significant improvement in body function is occurring and is expected to continue. The plan does not cover maintenance care, that is, care to maintain or prevent deterioration of a chronic condition. The provider must submit clinical records that document a member continues to experience significant improvement. If the records fail to demonstrate significant improvement in accordance with the established clinical criteria, the services are denied as being maintenance or preventive care.

The existing plan coverage of rehabilitative services is highly problematic and is the ~~number one~~most frequently appealed plan provision ~~of the plan~~. It accounts for approximately 1/3rd of all retiree appeals received by the Division for each of the last 3 years. The member's clinical record often does not support the medical necessity of continued care because the provider fails or was unable to objectively document measurable improvement that is expected to continue.

The proposed change would increase and clearly define the plan's coverage of rehabilitative care, alleviating confusion amongst members and providers, and would

[1] See 3.3.12 Rehabilitative Care, page 43 of the AlaskaCare Retiree Insurance Information Booklet January 2019. http://doa.alaska.gov/drb/pdf/ghlb/retiree/DBRetireeInsuranceBooklet-01012019.pdf

change the plan language to allow for maintenance or preventive therapies of chronic conditions.

Currently, network use for chiropractic care is low for both under and over 65 AlaskaCare Retirees.

Table 2: AlaskaCare Total Retiree Chiropractic Network Utilization

Year	~~In-~~Network Visits	Non-Network Visits	Total Visits	Network-Use	Unique Claimants
2015	20,253	63,500	83,753	24%	9,231
2016	17,869	65,154	83,023	22%	9,339
2017	16,823	66,012	82,835	20%	10,149
2018	16,034	60,685	76,719	21%	9,449

The low utilization is partially due to differences in the Medicare and AlaskaCare networks. Medicare participants may seek services from any provider that accepts Medicare, and the associated costs are determined by Medicare's fee schedule. However, network use is also low in the non-Medicare, or under-65 population of retirees:

Table 3: AlaskaCare Under-65 Retiree Chiropractic Network Utilization

Year	~~In-~~Network Visits	~~Out-of-~~Non-Network Visits	Total Visits	Network-Use	Unique Claimants
2015	17,528	24,597	42,125	42%	4,817
2016	15,488	22,461	37,949	41%	4,606
2017	14,465	20,028	34,493	42%	4,592
2018	13,460	15,121	28,581	47%	4,070

The proposed ~~change would benefit~~change will:

1) cover rehabilitative care received from an ~~in-~~network provider without a visit limit;~~,~~ and
2) cover chiropractic care received from an ~~in-~~network provider without a visit limit.~~,~~

The proposed benefit will ~~but would~~ set visit limits on rehabilitative and chiropractic care received from an ~~out-of-~~non-network provider. If care is received from an ~~out-of-~~non-network provider, ~~T~~the ~~individual~~ member ~~would be provided~~could receive:

- up to 45~~-~~ visits per benefit year for outpatient rehabilitative care~~, and separate~~
- up to 20~~-~~ visits for ~~spinal manipulation~~chiropractic care.

Author: ~~Michele Michaud~~Division of Retirement and Benefits

~~ and 10 visists for acupuncture.~~ The ~~out of~~ non-network provider visit limits would reset at the start of each benefit year.

The proposed change would also provide coverage for:

- up to 10 visits per benefit year for acupuncture regardless of the provider's network status.

The acupuncture visit limits would reset at the start of each benefit year.

The increase in coverage combined with the opportunity to reset the out-of-network provider visit limit with the new benefit year would eliminate the need for visit-triggered medical necessity determinations, and the corresponding appeals if the determination found that the additional services were not medically necessary. This would provide members and their providers with clear guidelines on what the plan covers.

Rolfing was also ~~considered~~considered, and a literature review is attached. ~~with the division's findings~~. While the current body of clinical literature is too shallow to state definitively that Rolfing or similar therapies are sufficiently efficacious and safe, this may be due to the recency of Rolfing's resurgence in care culture, as the set of procedures were developed in the mid-20th century but fell off in popularity until 2010. For this reason, the D~~d~~ivision will continue to monitor the maturity of this field as additional research ~~comes to light.~~becomes available. ~~, but there was insufficient documentation in the medical literature at this time to support the medical efficacy of this treatment. It is considered an experimental and investigational service. This is not a mainstream benefit, and should it be covered, it would require significant manual processing making this difficult to administer. It could not be included in the visit limits above and would need to be considered a separate benefit. For these reasons, we recommend revisiting this benefit once additional clinical studies are available.~~

Table 2: Comparison of Current to Proposed Change

CURRENT:	~~**Page 36-37 2003 Booklet as amended**~~
Current (Page ~~36-37 43-44~~) Section 3.3.12 of ~~2003~~ 2019 Retiree Insurance	**Rehabilitative Care** The Medical Plan covers **outpatient** rehabilitative care designed to restore and improve bodily functions lost due to injury or illness. **This care is considered medically necessary only if significant improvement in body function is occurring and is expected to continue.** [Emphasis added.] Care (excluding speech therapy) aimed at slowing deterioration of body functions caused by neurological disease is also covered.

Author: ~~Michele Michaud~~Division of Retirement and Benefits

Information Booklet~~, as amended~~	Rehabilitative care includes: • Physical therapy and occupational therapy. • Speech therapy if existing speech function (the ability to express thoughts, speak words, and form sentences) has been lost and the speech therapy is expected to restore the level of speech the individual had attained before the onset of the disease or injury. • Rehabilitative counseling or other help needed to return the patient to activities of daily living but excluding maintenance care or educational, vocational, or social adjustment services. Rehabilitative care must be part of a formal written program of services consistent with your condition. Your physician or therapist must submit a statement to the claims administrator outlining the goals of therapy, type of program, and frequency and duration of therapy.
Current (Page 72-77) Section 5.1 of 2019 Retiree Insurance Information Booklet	The following is a list of services and supplies that are not covered and are not included when determining benefits: … • Acupuncture therapy, unless performed by a physician as a form of anesthesia in connection with surgery covered under the plan.
Proposed	**Neurological Disease (no change)** Cognitive therapy associated with physical rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function or slow deterioration of body functions caused by neurological disease. **Rehabilitative Care** ~~Outpatient benefits are limited to 45 visits per benefit year.~~ Covered expenses include charges made by a physician on an outpatient basis for physical therapy, occupational therapy and speech therapy. Inpatient services will be covered under inpatient hospital and skilled nursing facility benefits. Massage therapy is covered when it is prescribed by a licensed physician, chiropractor or naturopath and performed under the physician's, chiropractor's or naturopath's supervision, and is considered part of the overall treatment plan.

Outpatient rehabilitative care received from ~~an out-of-~~a non-network provider is limited to 45 visits per benefit year.

Chiropractic
~~Covered expenses are limited to 20 visits per benefit year.~~

Covered expenses include charges made by a licensed physician or chiropractor, on an outpatient basis. The covered services include office visit, examination, consultation, regional manipulations, or other physical treatment for conditions caused by or related to biomechanical or nerve conduction disorders of the spine, massage therapy in conjunction with and for the purpose of making the body more receptive of the spinal manipulation.

Covered chiropractic care received from a non~~n out-of-~~network provider is limited to 20 visits per benefit year.

The 20-visit maximum does not apply to expenses incurred during your hospital stay, or for surgery, including pre- and post- surgical care provided or ordered by the operating physician.

Acupuncture
Covered expenses are limited to 10 visits per benefit year.

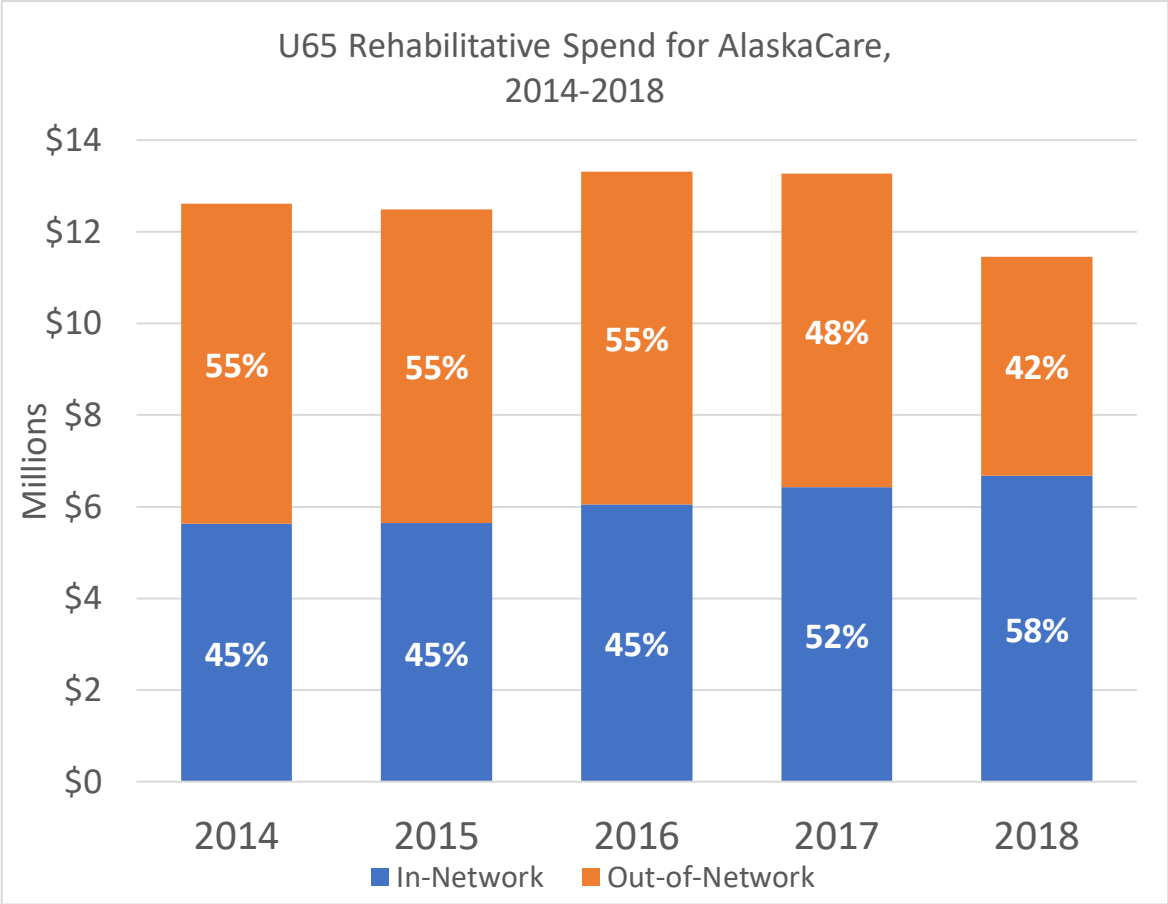
Covered expenses include charges made by a licensed physician or acupuncturist, practicing within the scope of his or her license, on an outpatient basis.

The Plan will also pay for acupuncture therapy performed by a physician as a form of anesthesia in connection with surgery covered under the Plan, and these services are not subject to the 10-visit limit.

Background

Network utilization for rehabilitative care (all types) among retiree members~~s~~ has steadily increased over the past four years, with 58% of dollars spent in 2018 going to network providers~~,~~ compared to only 45% in 2014. Table 3 below displays the trend over five plan years.

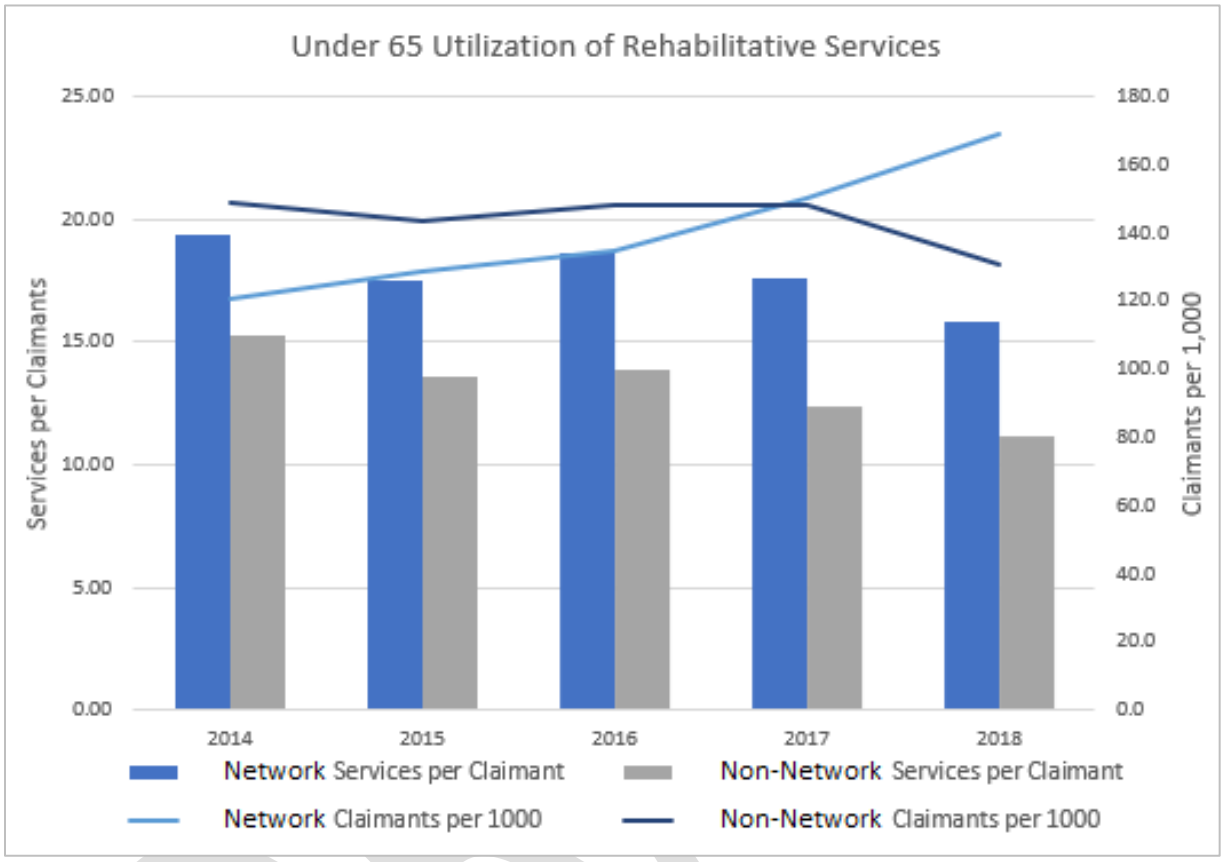
Table 3: Rehabilitative Care Spend in AlaskaCare for Non-Medicare Retirees



Over this period, the number of rehabilitative claimants per 1,000 AlaskaCare members increased by 10%, though the number of services per member dropped by nearly 20%.

Table 4 shows how the increase in network use has led to lower rehabilitative spend overall, despite a higher number of claimants per 1,000. The axis on the left represents the number of services received in or out of network per claimant, while the axis on the right represents the number of claimants per 1,000 members.

Table 4: Rehabilitative Care Spend in AlaskaCare for Non-Medicare Retirees



Member Impact:

Under the current benefit structures~~,~~ many patients ~~can~~ become frustrated because subjectively they feel better but there are no measurable gains supported in the clinical records, and the services are denied after the member has already incurred the expense. The proposed change would make the plan coverage clear for members and their providers by reducing the requirement that there be demonstrated clinical gains as a criteria for coverage and by removing the exclusion of maintenance coverage. However, to be eligible for coverage under the plan, services received must still fit the criteria outlined in *Section 3.3 Covered Medical Expenses* of the Retiree Insurance Information Booklet.

This proposed benefit will ~~result in gains for some~~expand coverage for members seeking care from a network provider, particularly those who have chronic conditions or who are

making only slight improvement, and who would receive additional services beyond what is covered today. However, while the proposed limits are sufficient to achieve a rehabilitated state in many patients, members who utilize ~~an out of~~ a non-network provider and ~~have not reached~~reach their maximum therapeutic benefit within a single benefit year must either seek additional care from an ~~in-~~network provider, or may be denied care that ~~might~~ may otherwise have been found to be medically necessary for the interim period before the visit limits are reset.

In 2018, 707 AlaskaCare retirees surpassed 20 visits from out-of-network chiropractic providers. For physical ~~PT~~therapy,~~/ OT~~occupational therapy, and speech therapy~~/ST~~ visits, 76 AlaskaCare patients surpassed the proposed 45 out-of-network visit cap.

Expanding acupuncture coverage~~,~~ would be an added benefit to members seeking this treatment.

Actuarial Impact – *Please note that the changes in this version of the proposal necessitate an update to the actuarial impact.

Neutral / Enhancement / Diminishment

Table 3: Actuarial Impact

	Actuarial Impact	Notes
~~Current~~ Proposed	N/A	N/A
10 Visit Limit on Acupuncture treatment	0.010% increase[2]	
~~10 Visit Limit on Rolf therapy treatment~~	~~0.005% increase~~	
20 Visit Limit on out-of-network Spinal Manipulation	~~0.02% reduction~~[3]	Limiting the visit cap to out-of-network care necessitates an update to the actuarial analysis.
45 Visit Limit on out-of-network other Rehabilitative Services (OT/PT/ST)	~~0.05% reduction~~[4]	Limiting the visit cap to out-of-network care necessitates an update to the actuarial analysis.

[2] *Therapy Benefits – Focus on Actuarial and Financial Impacts for the Retiree Plan,* Segal Consulting Memo updated September 26, 2018.

~~[3] *Chiropractic Benefits – Focus on Actuarial and Financial Impacts for the Retiree Plan,* Segal Consulting Memo updated September 25, 2018.~~

~~[4] *Therapy Benefits – Focus on Actuarial and Financial Impacts for the Retiree Plan,* Segal Consulting Memo updated September 26, 2018.~~

~~The net change would result in a slight reduction in the actuarial value of the benefits of 0.035%.~~

~~The plan change will be an enhancement for those retirees with a chronic condition, whose treatment is maintenance or preventive. Should the member require more than 45 visits for physical/occupational/speech therapy and/or more than 20 spinal manipulation visits in a *single* benefit year, the benefits would be exhausted during that benefit year. However, the reset of the visit limit in the next benefit year would reduce this impact.~~

DRB operational impacts:

Rehabilitative care is the most frequent reason members submit appeals to the Division ~~of Retirement and Benefits~~. Additionally, the Division spends considerable amount of time attempting to educate and explain the difference between the care that results in significant improvement, covered under the plan, and care that is maintenance or preventive care and not covered under the plan. Removing barriers to care received from ~~an in-~~a network provider and ~~S~~setting a limit on the number of visits received from ~~an out-of~~a non-network provider covered per benefit year simplifies the benefits for members and providers. Simplifying the benefits and removing the exclusion of maintenance and preventive care should help alleviate member and provider confusion over what is a covered expense and reduce the administrative burden and expense of fighting costly and complicated appeals.

Financial Impact to the plan: -*Please note that the changes in this version of the proposal necessitate an update to the actuarial impact.

Table 4, Estimated Savings

Proposed Change	Estimated Annual Financial Impact[5]
10 visit-limit for acupuncture	$ 65,000 in additional cost
~~10 visit-limit for rolf therapy~~	~~$ 30,000 in additional cost~~
20 visit-limit for chiropractic	~~$120,000 in savings~~
45 visit-limit for rehabilitative care	~~$300,000 in savings~~

[5] [5] *Therapy Benefits – Focus on Actuarial and Financial Impacts for the Retiree Plan,* Segal Consulting Memo updated September 26, 2018 and *Chiropractic Benefits – Focus on Actuarial and Financial Impacts for the Retiree Plan,* Segal Consulting Memo updated September 25, 2018.

~~The savings analysis were based on 2017 and 2018 medical and pharmacy claims data, and projected expenses through 2019 based on a 3.0% and 6.0% respective trend. Visits that result in $0 paid by the plan (due to other coverage or other reasons) were assumed to not count towards the visit limit.~~

Clinical considerations:

The proposed changes would allow for coverage of acupuncture and maintenance or preventive care, not currently covered under the plan.

Although there are always exceptions for acute cases, we believe the ~~out-of-~~non-network provider visit limits are sufficiently generous, when combined with the annual reset and the opportunity to seek additional care from a ~~n in-~~network provider, to provide little to no negative impact to clinical considerations for most patients.

Third Party Administrator (TPA) operational impacts:

The proposed changes are ones that can be easily accommodated by the third-party administrator. The proposed change would further reduce the number of medical necessity determinations and corresponding appeals when the services were found to be maintenance or preventive.

Provider considerations:

The proposed changes would reduce the administrative tasks related to clinical documentation and appeal support. It would allow the provider to clearly understand what is covered under the plan, and work with the member on the treatment plan to include educating the member if the proposed treatment exceeds plan limits if the provider is an ~~out-of~~non-network provider.

Documents attached include:

Document Name	Page numbers	Notes
Summary of public comment		
***Chiropractic Benefits – Focus on Actuarial and Financial Impacts for the Retiree Plan,* Segal Consulting Memo dated July 25, 2018.**	Chiropractic Benefits 7.25.18	

***Therapy Benefits – Focus on Actuarial and Financial Impacts for the Retiree Plan,* Segal Consulting Memo dated July 24, 2018.**	Therapy Benefits 7.25.18	
***Chiro Benefits – Focus on Actuarial and Financial Impacts for the Retiree Plan,* Segal Consulting Memo updated September 25, 2018.**	Chiropractic Benefits 9.25.18	
***Therapy Benefits – Focus on Actuarial and Financial Impacts for the Retiree Plan,* Segal Consulting Memo updated September 26, 2018.**	Therapy Benefits 9.26.18	
Rolfing Literature Review, June 3, 2019	A Review of Rolfing_6.3.19.pdf	
HealthMatters Article – May 2018	*Outpatient Rehabilitative Care Coverage in the AlaskaCare Retiree Health Plan* http://doa.alaska.gov/drb/newsletters/healthmatters/issue/30.html	
HealthMatters Article – May 2017	*Outpatient Rehabilitative Care Coverage in the AlaskaCare Retiree Health Plan* *http://doa.alaska.gov/drb/newsletters/healthmatters/issue/28.html*	
HealthMatters Article – April 2015	*Outpatient Rehabilitative Care Coverage in the AlaskaCare Retiree Health Plan* http://doa.alaska.gov/drb/newsletters/healthmatters/issue/24.html	

Proposal Title	**Rehabilitative Care**
Health Plan Affected	Defined Benefit Retiree Plan
Proposed Effective Date	January 1st, 2020
Reviewed By	Retiree Health Plan Advisory Board
Review Date	June 12, 2019

Contents

1) Summary of Current State

The existing plan coverage of rehabilitative services is highly problematic and is the most frequently appealed plan provision. It accounts for approximately one third of all retiree appeals received by the Division in 2017, 2018 and 2019.

The plan currently covers outpatient rehabilitative care designed to restore and improve bodily functions lost due to injury or illness.[1] This care is considered medically necessary only if significant improvement in body function is occurring and is expected to continue. The plan does not cover maintenance care, that is, care to maintain or prevent deterioration of a chronic condition. The provider must submit clinical records that document a member continues to experience significant improvement and starting at the 26th visit all claims for the member are pended for review of chart notes. If the records fail to demonstrate significant improvement in accordance with the established clinical criteria, the services are denied as being maintenance or preventive care.

2) Goals and Objectives

3) Summary of Proposed Change

The proposed change would increase and clearly define the plan's coverage of rehabilitative care, alleviating confusion amongst members and providers, and would change the plan language to allow for maintenance or preventive therapies of chronic conditions.

Actuarial Impact | Neutral
Member Impact | Expanded Coverage
Financial Impact | Cost Increase
Operational Impact (DRB)| Reduce Administrative Burden
Operational Impact (TPA) | Reduce Burden

The proposed benefit change will cover rehabilitative care received from an in-network provider without a visit limit, and cover chiropractic care received from an in-network provider without a visit limit. Removing the limit will reduce the requirement for claim chart note review and allow for maintenance and preventive therapies of chronic conditions.

The proposed benefit will continue to have a visit limit on rehabilitative and chiropractic care received from an out-of-network provider. However, the limit amount will change and an option to reset the visit count at the start of each benefit year will be added. If care is received from an out-of-network provider, the member would be provided up to 45 visits per benefit year for outpatient rehabilitative care, and up to 20 visits for chiropractic care. The out-of-network provider visit limits would reset at the start of each benefit year.

[1] See 3.3.12 Rehabilitative Care, page 43 of the AlaskaCare Retiree Insurance Information Booklet January 2019. http://doa.alaska.gov/drb/pdf/ghlb/retiree/DBRetireeInsuranceBooklet-01012019.pdf

The proposed change would also provide coverage for up to 10 visits per benefit year for acupuncture regardless of the provider's network status. The acupuncture visit limits would reset at the start of each benefit year.

The increase in coverage combined with the opportunity to reset the out-of-network provider visit limit with the new benefit year would eliminate the need for visit-triggered medical necessity determinations, and the corresponding appeals if the determination found that the additional services were not medically necessary. This would provide members and their providers with clear guidelines on what the plan covers.

4) Analysis

Current Definition of Rehabilitative Care

The Medical Plan covers outpatient rehabilitative care designed to restore and improve bodily functions lost due to injury or illness. This care is considered medically necessary only if significant improvement in body function is occurring and is expected to continue. Care (excluding speech therapy) aimed at slowing deterioration of body functions caused by neurological disease is also covered. Rehabilitative care includes:

- Physical therapy and occupational therapy.
- Speech therapy if existing speech function (the ability to express thoughts, speak words, and form sentences) has been lost and the speech therapy is expected to restore the level of speech the individual had attained before the onset of the disease or injury.
- Rehabilitative counseling or other help needed to return the patient to activities of daily living but excluding maintenance care or educational, vocational, or social adjustment services.

Proposed Definition of Rehabilitative Care

The proposed benefit will cover rehabilitative care received from an in-network provider without a visit limit, and cover chiropractic care received from an in-network provider without a visit limit.

The proposed benefit will set visit limits on rehabilitative and chiropractic care received from an out-of-network provider. If care is received from an out-of-network provider, the member would be provided:

- up to 45 visits per benefit year for outpatient rehabilitative care, and
- up to 20 visits for chiropractic care.

The proposed change would also provide coverage for

- up to 10 visits per benefit year for acupuncture regardless of the provider's network status.

The out-of-network provider rehabilitative and chiropractic vist and acupuncture visit limits would reset at the start of each benefit year.

The increase in coverage combined with the opportunity to reset the out-of-network provider visit limit with the new benefit year would eliminate the need for visit-triggered medical necessity.

Chiropractic Utilization

Currently, network use for chiropractic care is low for both under and over 65 AlaskaCare Retirees.

Table 1: AlaskaCare Total Retiree Chiropractic Network Utilization

Year	In-Network	Out-of-Network	Total Visits	Network-Use	Unique Claimants
2015	20,253	63,500	83,753	24%	9,231
2016	17,869	65,154	83,023	22%	9,339
2017	16,823	66,012	82,835	20%	10,149
2018	16,034	60,685	76,719	21%	9,449

The low utilization is partially due to differences in the Medicare and AlaskaCare networks. Medicare participants may seek services from any provider that accepts Medicare, and the associated costs are determined by Medicare's fee schedule. However, network use is also low in the non-Medicare, or under-65 population of retirees:

Table 2: AlaskaCare Under-65 Retiree Chiropractic Network Utilization

Year	In-Network	Out-of-Network	Total Visits	Network-Use	Unique Claimants
2015	17,528	24,597	42,125	42%	4,817
2016	15,488	22,461	37,949	41%	4,606
2017	14,465	20,028	34,493	42%	4,592
2018	13,460	15,121	28,581	47%	4,070

5) Impacts

Actuarial Impact | Neutral

**Please note that the changes in this version of the proposal necessitate an update to the actuarial impact.*

	Actuarial Impact	Notes
Current	N/A	N/A
10 Visit Limit on Acupuncture treatment	0.010% increase[2]	
20 Visit Limit on out-of-network Spinal Manipulation		Limiting the visit cap to out-of-network care necessitates an update to the actuarial analysis.
45 Visit Limit on out-of-network other Rehabilitative Services (OT/PT/ST)		Limiting the visit cap to out-of-network care necessitates an update to the actuarial analysis.

Member Impact | Expanded Coverage

Under the current benefits, many patients can become frustrated because subjectively they feel better but there are no measurable gains supported in the clinical records, and the services are denied after the member has already incurred the expense. The proposed change would make the plan coverage clear for members and their providers by reducing the requirement that there be demonstrated clinical gains as a criterion for coverage and by removing the exclusion of maintenance coverage. However, to be eligible for coverage under the plan, services received must still fit the criteria outlined in *Section 3.3 Covered Medical Expenses* of the Retiree Insurance Information Booklet.

[2] *Therapy Benefits – Focus on Actuarial and Financial Impacts for the Retiree Plan,* Segal Consulting Memo updated September 26, 2018.

This proposed benefit will expand coverage for members seeking care from a network provider, particularly those who have chronic conditions or who are making only slight improvement, who would receive additional services beyond what is covered today.

However, while the proposed limits are sufficient to achieve a rehabilitated state in many patients, members who utilize an out-of-network provider and reach their maximum therapeutic benefit within a single benefit year must either seek additional care from an in-network provider, or may be denied care that might otherwise have been found to be medically necessary for the interim period before the visit limits are reset.

Expanding acupuncture coverage would be an added benefit to members seeking this treatment.

Financial Impact | Cost Increase

Table 3: Estimated Savings

Proposed Change	Estimated Annual Financial Impact[3]
10 visit-limit for acupuncture	$ 65,000 in additional cost
20 visit-limit for chiropractic	
45 visit-limit for rehabilitative care	

Operational Impact (DRB)| Reduce Administrative Burden

Rehabilitative care is the most frequent reason members submit appeals to the Division of Retirement and Benefits. The Division spends considerable amount of time attempting to educate and explain the difference between the care that results in significant improvement, covered under the plan, and care that is maintenance or preventive care and not covered under the plan. Removing barriers to care received from an in-network provider and setting a limit on the number of visits received from an out-of-network provider covered per benefit year simplifies the benefits for members and providers. Simplifying the benefits and removing the exclusion of maintenance and preventive care should help alleviate member and provider confusion over what is a covered expense and reduce the administrative burden and expense of fighting costly and complicated appeals.

Operational Impact (TPA) | Reduce Burden

The proposed changes are ones that can be easily accommodated by the third-party administrator. The proposed change would further reduce the number of medical necessity determinations and corresponding appeals when the services were found to be maintenance or preventive.

6) Considerations

Clinical Considerations

The proposed changes would allow for coverage of acupuncture and maintenance or preventive care, not currently covered under the plan.

Although there are always exceptions for acute cases, we believe the out-of-network provider visit limits are sufficiently generous, when combined with the annual reset and the opportunity to seek additional

[3] [3] *Therapy Benefits – Focus on Actuarial and Financial Impacts for the Retiree Plan,* Segal Consulting Memo updated September 26, 2018 and *Chiropractic Benefits – Focus on Actuarial and Financial Impacts for the Retiree Plan,* Segal Consulting Memo updated September 25, 2018.

care from an in-network provider, to provide little to no negative impact to clinical considerations for most patients.

Provider Considerations

The proposed changes would reduce the administrative tasks related to clinical documentation and appeal support. It would allow the provider to clearly understand what is covered under the plan, and work with the member on the treatment plan to include educating the member if the proposed treatment exceeds plan limits if the provider is an out-of-network provider.

Consideration of Rolfing

Rolfing was also considered, and a literature review is attached with the division's findings. While the current body of clinical literature is too shallow to state definitively that Rolfing or similar therapies are sufficiently efficacious and safe, this may be due to the recency of Rolfing's resurgence in care culture, as the set of procedures were developed in the mid-20th century but fell off in popularity until 2010. For this reason, the division will continue to monitor the maturity of this field as additional research comes to light.

7) Proposal Revision History

RHPAB Board Recommendation

The RHPAB board voted on ##/##/## to approve/deny option XX

Commissioner of Administration Recommendation

The plan administrator made the determination on ##/##/## to approve the proposal…

Description	Date
Proposal Drafted	07/20/2018
Reviewed by Modernization Subcommittee	08/10/2018 09/28/2018 10/30/2018 04/23/2019 06/12/2019
Reviewed by RHPAB	08/29/2018 11/28/2018 02/06/2019 05/08/2019 08/07/2019

8) Plan Language Comparison

Current Plan Booklet Language	Proposed Plan Booklet Language
Section 3.3.12 of 2019 Retiree Insurance Information Booklet **Rehabilitative Care** The Medical Plan covers outpatient rehabilitative care designed to restore and improve bodily functions lost due to injury or illness. This care is considered medically necessary only if significant improvement in body function is occurring and is expected to continue. [Emphasis added.] Care (excluding speech therapy) aimed at slowing deterioration of body functions caused by neurological disease is also covered. Rehabilitative care includes: • Physical therapy and occupational therapy. • Speech therapy if existing speech function (the ability to express thoughts, speak words, and form sentences) has been lost and the speech therapy is expected to restore the level of speech the individual had attained before the onset of the disease or injury. • Rehabilitative counseling or other help needed to return the patient to activities of daily living but excluding maintenance care or educational, vocational, or social adjustment services. Rehabilitative care must be part of a formal written program of services consistent with your condition. Your physician or therapist must submit a statement to the claims administrator outlining the goals of therapy, type of program, and frequency and duration of therapy. Section 5.1 of 2019 Retiree Insurance Information Booklet The following is a list of services and supplies that are not covered and are not included when determining benefits: • Acupuncture therapy, unless performed by a physician as a form of anesthesia in connection with surgery covered under the plan.	**Rehabilitative Care** Covered expenses include charges made by a physician on an outpatient basis for physical therapy, occupational therapy and speech therapy. Inpatient services will be covered under inpatient hospital and skilled nursing facility benefits. Massage therapy is covered when it is prescribed by a licensed physician, chiropractor or naturopath and performed under the physician's, chiropractor's or naturopath's supervision, and is considered part of the overall treatment plan. Outpatient rehabilitative care received from an out-of-network provider is limited to 45 visits per benefit year. **Chiropractic** Covered expenses include charges made by a licensed physician or chiropractor, on an outpatient basis. The covered services include office visit, examination, consultation, regional manipulations, or other physical treatment for conditions caused by or related to biomechanical or nerve conduction disorders of the spine, massage therapy in conjunction with and for the purpose of making the body more receptive of the spinal manipulation. Covered chiropractic care received from an out-of-network provider is limited to 20 visits per benefit year. The 20-visit maximum does not apply to expenses incurred during your hospital stay, or for surgery, including pre- and post- surgical care provided or ordered by the operating physician. **Acupuncture** Covered expenses are limited to 10 visits per benefit year. Covered expenses include charges made by a licensed physician or acupuncturist, practicing within the scope of his or her license, on an outpatient basis. The Plan will also pay for acupuncture therapy performed by a physician as a form of anesthesia in connection with surgery covered under the Plan, and these services are not subject to the 10-visit limit.

Documents attached include:

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MEMORANDUM

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

From: Richard Ward, FSA, FCA, MAAA

Date: September 26, 2018

Re: Therapy Benefits – Focus on Actuarial and Financial Impact for the Retiree Plan - **UPDATED**

This is an updated version of our memo from July 25, 2018. Our results and comments are based on updated data and analysis.

The AlaskaCare Retiree Plan currently provides coverage for Physical Therapy, Occupational Therapy and Speech Therapy in the same manner that other medical treatments and services are covered. The Plan applies the general plan provisions, such as deductible, coinsurance and out-of-pocket limitations, to determine any portion of the costs that are the member's responsibility. If the member has additional coverage, such as Medicare or other employer provided coverage, any portion of the costs covered by that plan is also considered.

Additionally, the AlaskaCare Retiree Plan does not provide coverage for acupuncture unless performed by a physician as a form of anesthesia in connection with surgery covered under the plan and does not cover Rolf therapy. The updated therapy benefits would cover acupuncture and Rolf therapy procedures, which would be subject to their own individual frequency limitations of 10 annually. Currently the Plan covers acupuncture being performed by a physician as a form of anesthesia in connection with surgery covered under the Plan. The following table outlines the current benefits offered under the Plan:

Deductibles		
Annual individual / family unit deductible	$150 / up to 3x per family	
Coinsurance		
Most medical expenses	80%	
Most medical expenses after out-of-pocket limit is satisfied	100%	
Second surgical opinions, Preoperative testing, Outpatient testing/surgery • No deductible applies	100%	
Out-of-Pocket Limit		
Annual individual out-of-pocket limit • Applies after the deductible is satisfied • Expenses paid at a coinsurance rate other than 80% do not apply against the out-of-pocket limit	$800	
Benefit Maximums		
Individual lifetime maximum • Prescription drug expenses do not apply against the lifetime maximum	$2,000,000	
Individual limit per benefit year on substance abuse treatment without precertification. Subject to change every three years	$12,715	
Individual lifetime maximum on substance abuse treatment without precertification. Subject to change every three years	$25,430	
Prescription Drugs	Up to 90 Day or 100 Unit Supply	
	Generic	Brand Name
Network pharmacy copayment	$4	$8
Mail order copayment	$0	$0

A change to the benefits under consideration would apply a 45 visit annual limitation in aggregate to physical therapy, occupational therapy, and speech therapy while otherwise continuing the member to be subject to the current provisions. Additionally, plan coverage would be added to allow for acupuncture outside of solely being performed by a physician as a form of anesthesia in connection with surgery covered under the Plan and Rolf therapy separately. Acupuncture and Rolf therapy would have their own separate 10 visit annual imitation. However, it should be noted that there is a lack of Current Procedural Terminology (CPT) code and International Classification of Disease, Tenth Edition (ICD-10) structure in place to process claims specific for Rolf therapy. This may prevent the ability to properly identify Rolf therapy claims and administer an annual visit limitation.

Actuarial Value

Our updated analysis determines the impact of implementing a 45 visit annual limitation in aggregate to physical therapy, occupational therapy, and speech therapy would be a reduction of 0.050% in actuarial value. The addition of the acupuncture benefit with a 10 visit annual limitation would result in 0.010% increase in actuarial value. The addition of the Rolf therapy claims will

result in a 0.005% increase in actuarial value. The net change from these three benefits will be a 0.035% decrease in actuarial value.

Financial Impact

Based on an updated retiree claims projection of $590,000,000 for 2019, this equates to approximately $300,000 in annual savings from the change in physical therapy, occupational therapy, and speech therapy benefit, approximately $65,000 in additional cost from the change in the acupuncture therapy benefit, and approximately $30,000 in additional cost from the Rolf therapy benefit. The next decrease in costs to the Plan from these three benefit changes will be approximately $205,000.

This analysis is based on 2017 and 2018 medical and pharmacy claims data, projected to 2019 at 3.0% and 6.0% annual trends, respectively. The data was reviewed, but not audited, and found to be sufficient and credible for this analysis.

With over 60,000 members and a high incidence rate of therapeutic care, the data is considered credible for this analysis and recent utilization patterns are considered to be a sound basis for determining the impact of this prospective change. Visits that result in $0 paid by the plan (due to other coverage or other reasons) are assumed not to apply towards the annual 45-visit limitation.

Please note that the projections in this report are estimates of future costs and are based on information available to Segal at the time the projections were made. Segal Consulting has not audited the information provided. Projections are not a guarantee of future results. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, trend rates, and claims volatility. The accuracy and reliability of projections decrease as the projection period increases. Unless otherwise noted, these projections do not include any cost or savings impact resulting from The Patient Protection and Affordable Care Act (PPACA) or other recently passed state or federal regulations.

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

Proposal Title	Telehealth Services
Health Plan Affected	Defined Benefit Retiree Plan
Proposed Effective Date	January 1st, 2020
Reviewed By	Retiree Health Plan Advisory Board
Next Review Date	August 7th, 2019

1) Summary of Current State

Telehealth is the use of technology that enables remote healthcare for low-severity care. It makes it possible for physicians to treat patients whenever needed and wherever the patient is, by using a computer or smartphone.

AlaskaCare provides health and pharmacy benefits for nearly 72,000 retirees and their dependents. Within Alaska, nearly 20,000 retirees and their dependents live in communities outside of the population centers of Anchorage, Fairbanks, and Juneau and frequently in medically underserved areas. Expansion of telehealth services for AlaskaCare retirees will provide an accessible and low-cost means of reaching a medical provider in non-emergency health episodes. This would be available to Medicare and non-Medicare eligible members and could provide an additional access point to care. Telehealth services are a benefit for AlaskaCare active employees since 20##.

In 2017, low severity care[1] accounted for 31% ($237 million) of health care spend across both the AlaskaCare employee and retiree health plans. Low severity care encompasses non-emergency and minimally invasive services. Many Alaska communities do not have an after-hours or Urgent Care option, often necessitating a trip to the Emergency Room. Knowing that telemedicine is becoming an increasing need, convenience and cost-saver, this proposal would incorporate this service in order to increase patient care options for the AlaskaCare members.

2) Objective

a) Increase accessibility to patient care for non-emergency health episodes.

3) Summary of Proposed Change

This proposal would expand access to telehealth services for members covered under the AlaskaCare defined benefit retiree health plan. Access would be expanded by providing retirees and their dependents access to a vendor, or vendors that connect members with a medical provider over the phone, via mobile devices or the internet, and/or by video for non-emergency medical episodes, dermatology consultations, and caregiver consultations.

[1] Low severity care is not and should not be confused with medically unnecessary care. Low-severity care is defined as services within an episode treatment group that is either unadjusted or labeled as "level 1" by Optum Insight's severity index. More information is provided in the accompanying document titled "Episode Treatment Groups: Analyzing Health Care Data from Episodes of Care."

Telehealth services allow members to speak remotely to a licensed health care provider and receive a medical consultation for low-severity issues at a reduced cost relative to traditional options which may include an office visit, urgent care visit, or Emergency Room use.
This proposal currently contemplates two different approaches for expanding telehealth services in the AlaskaCare retiree health plan for consideration: Teladoc and CirrusMD.

4) Proposal Revision History

Description	Date
Proposal Drafted	07/20/2018
Reviewed by Modernization Subcommittee	08/10/2018, 09/28/2018, 10/30/2018, 04/23/2019, 06/12/2019
Reviewed by RHPAB	08/29/2018, 11/28/2018, 02/06/2019, 05/08/2019, 08/07/2019

DRAFT-Summary of Responses to Proposed Plan Design Change

Proposed change: Expanding Telehealth Services to AlaskaCare Retirees

Plans affected: DB Retiree Plan~~, DC Retiree Plan~~

Reviewed by: Retiree Health Plan Advisory Board

Proposed implementation date: TBD

Review Date: ~~April 23~~June 12, 2019

Table 1: Plan Design Changes

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

Description of proposed change:

This proposal would c~~E~~xpand access to ~~Teladoc, a~~ telehealth services for members covered under the AlaskaCare defined benefit retiree health plan. Access would be expanded by providing r~~eurrently used by AlaskaCare active employees to the retiree health plan. This proposal would provide r~~etirees and their dependents access to a vendor, or vendors that connect members with a medical provider over the phone, via mobile devices or the internet, and/or by video for non-emergency medical episodes, dermatology consultations, and caregiver consultations[1].

~~Teladoc is a t~~Telehealth services allow ~~where~~ members ~~can~~ to ~~call in and~~ speak remotely to a licensed health care provider and receive a medical consultation for low-severity issues at a reduced cost relative to traditional options which may include an office visit, urgent care visit, or Emergency Room use.

This proposal currently contemplates two different approaches for expanding telehealth services in the AlaskaCare retiree health plan for consideration: Teladoc, and CirrusMD.

[1] Caregiver consultations can occur when an AlaskaCare member is caring for person who is not an AlaskaCare member. The member may use telehealth services to assist in caring for the non-member, but the member must cover the full cost of the visit.

Teladoc[2]

Teladoc provides members access to a national network of U.S. board-certified, state-licensed doctors available 24/7 to diagnose, treat, and prescribe medication when necessary for non-emergency medical issues. Teladoc is currently available to employees and dependents covered under the AlaskaCare employee health plan.

The costs to the member associated with accessing Teladoc currently under consideration for the AlaskaCare retiree health plan are:

- general medical consultation: ~~for a flat~~ $5 member copay ~~per call.~~
- dermatology consultation: $75 member copay, and
- caregiver consultation: $45 member copay.

General medical consultations carry a total cost of $45, and dermatology consultations carry a total cost of $75. The member cost share for general medical consultations may be adjusted, but at this time the member cost share for dermatology consultations and caregiver consultations cannot be adjusted.

Adopting this program will increase care options available for members and may generate savings for the plan and membership if enough substitution of higher cost alternatives (i.e. emergency room visits) occurs.

- Teladoc providers have limited prescribing privileges and comply with state statutory and regulatory requirements. Some states require the first visit to be conducted via video, while other states require all visits be conducted via video.[3]
- To use Teladoc's services, members must first set up an account through the Teladoc website, mobile application, or by phone. Then, members can request a phone or video consult ~~by web, app, or phone through the website, or by phone~~. A doctor will reach out ~~by phone~~ within minutes. If a member misses the call, the doctor will try two more times to reach them. There is no time limit on consultations. The Division is exploring registration options for members that do not require members to access the service through a website.
- ~~Analysis is ongoing to evaluate how fees associated with Teladoc would be assessed to members with multiple coverages.~~ Teladoc does not coordinate with other plans or carriers, if a member who has coverage under the AlaskaCare health plan also has non-AlaskaCare health coverage, he or she will still be responsible for the Teladoc copayment or cost share.

[2] Teladoc Health Presentation dated ~~May 8~~June 12, 2019: Attachment B.
[3] ~~Teladoc Health Presentation dated May 8, 2019~~

- ~~At this time it is unclear what copay provisions would apply to a member with multiple AlaskaCare coverages~~If a member is covered under two or more AlaskaCare health plans, the plans would not coordinate. The member would be responsible for the appropriate copay associated with the received service.~~.~~
- Member payments for Teladoc services would accrue towards a member's deductible~~ and out-of-pocket maximum~~.
- Teladoc does not submit claims to Medicare, but Medicare-eligible members would be able to access Teladoc services in the same manner as non-Medicare eligible members.
- Every member who registers with Teladoc receives an account that contains his or her registration information, medical history (supplied by the member during account set-up), and Teladoc visit history. When any Teladoc physician provides a consultation for a member, the physician has access to that member's medical history and Teladoc visit history.
- Members are not required to provide their primary care provider (PCP) information to Teladoc but are given the opportunity to enter this information at time of registration, or any time afterward by accessing their Teladoc account.
- Teladoc does not automatically share visit history with a member's PCP. This is only done at the member's request. Each time a member has a Teladoc visit, he or she is asked whether they would like a copy of their Teladoc visit records sent to their PCP. If the member elects to have a record of the Teladoc visit sent to the PCP, it is faxed from Teladoc to the PCP using the contact information provided by the member.
- Members can access their Teladoc account at any time to view consult history.

CirrusMD[4]

CirrusMD is a program that integrates with health plans via 24/7 virtual care mobile and web application to provide members with continuous access to board-certified emergency medicine physicians. The program's naming convention and branding can be customized to individual health plans (i.e. ER Doc for AlaskaCare).

[4] CirrusMD Presentation: Attachment C.

CirrusMD physicians can, as appropriate, provide a diagnosis and prescription, direct the member to another site of care, and encourage patient engagement and care continuity.

Conversations between members and physicians begin on a text-first web or mobile application platform. The conversation can be converted to a phone call or video chat if the member prefers. There are no time limits on member-physician conversations.

After each visit, the platform provides a virtual visit summary that can be provided to the member's primary care or other health care provider.

Members are not assessed a copayment or other cost share for a CirrusMD visit.

Background:

In 2017, low severity care[5] accounted for 31% ($237 million) of health care spend across both the AlaskaCare employee and retiree health plans. Low severity care encompasses non-emergency and minimally-invasive services. $178 million (or 75%) of low-severity care costs were incurred by the retiree health plan, including $25.7 million in out-of-pocket expenses (this number may be conservative in that it does not include any expenditures from 'balanced billing,' or the additional sum out-of-network providers may request from members).

Table 2 provides average member and plan costs associated with dermatology professional charges in the AlaskaCare Retiree under-65 population in 2017 and 2018.

Table 2: AlaskaCare Retiree ~~Under-65~~ Dermatology Costs 2017-2018

		2017		2018	
		Out-of-Pocket per Visit	Plan Paid per Visit	Out-of-Pocket per Visit	Plan Paid per Visit
Alaska	U-65	$56.02	$233.53	$54.79	$231.99
	O-65	$48.19	$49.77	$48.88	$49.71
Outside Alaska	U-65	$49.63	$151.32	$48.52	$161.47
	O-65	$40.34	$42.03	$41.45	$43.68

[5] Low severity care is not and should not be confused with medically-unnecessary care. Low-severity care is defined as services within an episode treatment group that is either unadjusted or labeled as "level 1" by OptumInsight's severity index. More information is provided in the accompanying document titled "Episode Treatment Groups: Analyzing Health Care Data from Episodes of Care."

Table 3 provides average member and plan costs associated with primary care professional charges in the AlaskaCare Retiree health plan in 2017 and 2018.

Table 3: AlaskaCare Retiree Primary Care Costs 2017-2018

		2017		2018	
		Out-of-Pocket per Visit	Plan Paid per Visit	Out-of-Pocket per Visit	Plan Paid per Visit
Alaska	U-65	$43.98	$294.82	$42.30	$295.34
	O-65	$24.17	$35.39	$23.72	$36.96
Outside Alaska	U-65	$30.79	$114.87	$29.77	$115.63
	O-65	$18.78	$23.69	$18.74	$23.76

Member impact:

AlaskaCare provides health and pharmacy benefits for nearly 72,000 retirees and their dependents. Within Alaska, nearly 20,000 retirees and their dependents live in communities outside of the population centers of Anchorage, Fairbanks, and Juneau and frequently in medically-underserved areas. Expansion of telehealth services for AlaskaCare retirees will provide an accessible and low-cost means of reaching a medical provider in non-emergency health episodes.

This would be available to both Medicare and non-Medicare eligible members, and could provide an additional ~~source of~~ access point to care.

Actuarial impact: ~~UNDER DEVELOPMENT~~

Neutral / Enhancement / Diminishment

Table ~~4~~2: Actuarial Impact[6]

Actuarial Impact	
Current	N/A
Proposed	~~N/A – Under development~~No Impact

The changes under consideration would enhance access to telemedicine, but are not anticipated to have an actuarial impact to the plan.

DRB operational impacts:

[6] Segal Memorandum dated April 19, 2018

As AlaskaCare currently has a contract with Teladoc, the operational impact of expanding benefits is expected to be minimal. Teladoc is currently subcontracted through Aetna, the current medical Third Party Administrator (TPA). In the event of a transition, the Division may need to divert operational resources to transition telehealth services to a separate contract or a new vendor.

In order to maximize utilization of the benefit, AlaskaCare will communicate the benefit to members and participate in awareness campaigns to assist in benefit registration.

Implementation of CirrusMD's program would have a greater operational impact to the Division. However, most of the work would occur up-front, such a program development, implementation, and communication to membership. Once the program is operational, the division anticipates the impact would be minimal.

Financial impact to the plan:

The cost of implementing Teladoc in the AlaskaCare retiree plan ~~would~~ could vary~~be~~ between $653,000 and $852,900 a year, depending on member-usage. Savings would potentially arise through the avoidance of traditional high-cost services for low-severity episodes, and will therefore also vary depending on actual utilization and member experience.~~-~~ Assuming 5% of members utilize Teladoc, the projected annual savings to the plan is approximately $250,000.[7]

~~The savings estimates are under development.~~

~~If over 12% of non-emergency care was substituted through Teladoc, the plan would expect to see net savings as a result.~~

~~Table 1 below estimates plan costs given PY 2018's Retiree Plan enrollment and current Teladoc terms.[8] Cost estimates assume a low-end utilization of 7% (5040 calls/yr) and a high-end of 15% (10,800 calls/yr).~~

~~*Table 3: Cost Estimates for $5 Copay, $0.93 PEPM and 2018 Retiree Plan Populations*~~

~~Member~~	~~Subscriber~~	~~PEPM Costs~~	~~7%~~	~~15%~~	~~Annual Cost~~
~~*Retiree (Under 65)*~~	~~11,415~~	~~$127,391~~	~~$50,446~~	~~$108,098~~	~~$177,836 $235,488~~
~~*Retiree (Over 65)*~~	~~31,375~~	~~$350,145~~	~~$124,725~~	~~$267,267~~	~~$474,869 $617,412~~
~~**Total**~~	~~42,790~~	~~$477,536~~	~~$175,170~~	~~$375,365~~	~~$652,706 $852,900~~

Utilization rates are determined by number of calls per year, divided by size of membership. This means utilization is not necessarily linked to plan savings unless

[7] Segal Memorandum dated April 19, 2018

[8] ~~The per member per month (PEPM) cost is $0.93, and each call is $40. Utilization is calculated as # of calls divided by covered lives.~~

telehealth services substitute for more expensive care. Below are incurred costs of low-severity care episodes by select provider-type that may be substituted through a telehealth benefit.

Table 54: Evaluation of Avoidable, Low-Severity Care[9]

Retirees, 2017	Emergency Room	Urgent Care	Primary Care	Specialist	Total
Paid	$2,150,312	$12,926	$258,858	$1,092,239	$3,514,335
Out of Pocket	$202,515	$6,141	$160,885	$544,095	$913,636
Total	$2,352,827	$19,067	$419,743	$1,636,334	$4,427,971

More information is needed before a financial analysis of the impact of implementing CirrusMD's program can be completed.

Clinical considerations:

These changes are anticipated to impact clinical considerations minimally by providing an additional access-point of care and resource for members seeking care.

Third Party Administrator (TPA) operational impacts:

This may require manual adjudication of claims. Because the current TPA has business relationships with both Teladoc and CirrusMD, the operational impacts are anticipated to be minimal.

Provider considerations:

Members should ask their physician about telehealth services and how they may be used in tandem with more traditional care. It should be communicated to membership that telehealth services are not a substitute for having a dedicated primary care provider.

Documents attached include:

Document Name	Attachment	Notes

[9] These estimates are intentionally conservative as to not overestimate substitutable care. The following are expenditures for the least-intensive care episodes in 2017 for the Retiree Plan as determined through OptumInsights.

Segal Memorandum	A	Segal Telemedicine Memo 20190419 UPD
Teladoc Health Presentation	B	Teladoc Overview_RHPAB_0508 Teladoc Overview_RHPAB_0612
CirrusMD Presentation	C	Aetna CirrusMD Slides March 2019.pc

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MEMORANDUM

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

From: Richard Ward, FSA, FCA, MAAA

Date: April 19, 2019

Re: Telemedicine – Focus on Actuarial and Financial Impact for the Retiree Plan

Teladoc, Inc. is a telemedicine company that uses telephone and videoconferencing to provide on-demand remote medical care via mobile devices, the internet, video and phone. Teladoc provides access to board-certified, state-licensed physicians 24 hours a day for non-emergency medical issues.

Deductibles	
Annual individual / family unit deductible	$150 / up to 3x per family
Coinsurance	
Most medical expenses	80%
Most medical expenses after out-of-pocket limit is satisfied	100%
Second surgical opinions, Preoperative testing, Outpatient testing/surgery • No deductible applies	100%
Out-of-Pocket Limit	
Annual individual out-of-pocket limit • Applies after the deductible is satisfied • Expenses paid at a coinsurance rate other than 80% do not apply against the out-of pocket limit	$800

Benefit Maximums		
Individual lifetime maximum • Prescription drug expenses do not apply against the lifetime maximum	$2,000,000	
Individual limit per benefit year on substance abuse treatment without precertification. Subject to change every three years	$12,715	
Individual lifetime maximum on substance abuse treatment without precertification. Subject to change every three years	$25,430	
Prescription Drugs	Up to 90 Day or 100 Unit Supply	
	Generic	Brand Name
Network pharmacy copayment	$4	$8
Mail order copayment	$0	$0

A change to the benefits under consideration would provide access to Teledoc's services at a $5 member copay per consultation. Caregiver consultations have a $45 copay and dermatology consultations have a $75 copay, which includes one follow-up consultation. The benefit would provide an additional access point for members who are experiencing acute medical conditions.

Actuarial Value

Since the the Plan currently covers telemedicine consultations, the changes under consideration would enhance access and therefore, there would not be an impact on the Plan's actuarial value.

Financial Impact

Utilization of telemedicine services is often driven by inadequate access to physician services and a familiarity with technology services. Many of the retirees currently live in areas with acceptable levels of access to primary and specialty care, which will affect the uptake of Teladoc within the retiree population. Adding coverage for telemedicine consultations will enhance access and promote efficient utilization.

Additionally, while many in the telemedicine industry have been mindful of the ease of use issue with these services, the technology is still seen as a barrier to some. However, as younger retirees enter the plan and members become more comfortable with the process of using Teladoc, utilization can be expected to increase in future years.

For this analysis, we are assuming that the total cost of a Teladoc consultation is $40 with a $5 member copay for most services. Based on the member copay and considerations discussed previously, it is assumed that 5.0% of the members will utilize Teladoc, resulting in approximately 5,000 calls annually. Additionally, it is to be expected that a portion of those calls will not lead to a resolution, and necessitate a follow-up visit to either a primary care physician or specialist, resulting in additional cost to the plan. The plan will also be charged a per member per month administration fee of $0.93.

Savings achieved by this program are a result of members avoiding higher cost office visit services. Considering the assumptions provided above, the implementation of Teladoc is projected to result in annual savings to the plan of approximately $250,000. Based on the most recent annual claims projection of $590,000,000, this equates to an annual savings of approximately 0.04%.

This analysis is based on medical claims data from January 2017 through December 2017, which was summarized specifically to analyze the opportunity for telemedicine services. The data was reviewed, but not audited, and found to be sufficient and credible for this analysis.

Please note that the projections in this report are estimates of future costs and are based on information available to Segal at the time the projections were made. Segal Consulting has not audited the information provided. Projections are not a guarantee of future results. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, trend rates, and claims volatility. The accuracy and reliability of projections decrease as the projection period increases. Unless otherwise noted, these projections do not include any cost or savings impact resulting from The Patient Protection and Affordable Care Act (PPACA) or other recently passed state or federal regulations.

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