Retiree Health Plan Advisory Board
Meeting Agenda

Date:	Tuesday, October 28, 2025
Time:	9:00 am – 12:00 pm
Location:	Join the meeting now | ANC Atwood 19th Floor
Telephone Only:	+1 907-202-7104, 991 415 859#
Board Members:	Cammy Taylor, Lorne Bretz, Dallas Hargrave, Paula Harrison, Michael Humphrey, Donna White

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9:00 am **Call to Order**

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

9:05 am **Public Comment**

9:10 am **Updates**

- 2026 Plan Benefit Changes – Status Update
- Open Enrollment
- Pharmacy Benefit Manager Request for Proposal
- Oncology Support Program Request for Proposal
- Telemedicine Update
- Vaccine Coverage
- Drug Prices and the Effect of Tariffs
- Potential Phone Scams
- LTC Family Caretaker Exclusion
- Statutory Requirement for Medicare as Primary
- Med/Rx, DVA, and LTC Premiums

10:30 am **Break**

10:40 am **Modernization Topics/Priorities**

- Cost Share for In-Network Diagnostic Colonoscopies

11:50 am **Public Comment**

12:00 pm **Wrap up/Adjourn**

AlaskaCare Retiree Health Plan Advisory Board
Modernization Committee
Meeting Minutes

Wednesday, July 16, 2025

Board/Committee Members		DRB		Guests	
Cammy Taylor	P	Erika Burkhouse	P	Randall Burns (RPEA)	P
Michael Humphrey	P	Liz Hawkins	P	Quentin Gunn (Segal)	P
Lorne Bretz	P	Megan Jones	P	Joel Krzan (Aetna)	P
Paula Harrison	P	Chris Murray	P	Richard Ward (Segal)	P
Mauri Long	P	Jesse Peterson	P	Wendy Woolf (RPEA)	P
Judy Salo	P	Steve Ramos	P		
		Clara Roomsburg	P		
		Erin Russell	P		
		Marie Speegle	P		
		Ronan Tagsip	P		

Call to Order

The meeting was called to order by Cammy Taylor. Roll call and introductions were done.

Approval of Meeting Agenda

The agenda was approved.

Ethics Disclosure

Cammy Taylor requested that Board members state any ethics disclosures.

- No disclosures were stated by Board members.

Public Comment

There were no public comments.

Modernization Topics/Priorities

Telemedicine

Steve Ramos recommended that the Board pause until the federal government comes out with a new Medicare standard for telemedicine. If the federal government does not change Medicare coverage for telemedicine, our current Plan coding can stay the same. If the federal government made a change, then the Plan would not align with Medicare and we would likely want to have alignment to a standard that allowed the adoption of new technology enhancements over the course of time for our telemedicine coverage to stay current. Generally, we do not code our Plan the same as Medicare. We would likely have custom coding to get close to Medicare or move to our claim administrator standard that is better than Medicare.

- Michael Humphrey wondered how fast the recoding could be done after Medicare made changes.
    - Mr. Ramos replied it was common for Aetna to do coding updates within a 30-day period. Rolling out something new required more background work and might take 60 or 90 days for

Aetna to code our Plan. Adopting the Aetna standard would result in a slightly lower level of covered services but significantly better than what Medicare indicated they would cover. We want to be thoughtful about determining who is getting care and giving them time to move those telemedicine visits to face-to-face visits so they do not end up with denied claims that were getting paid previously. We may decide to give everybody a 3-month notice and will likely consider whether we will send disruption letters.

- Cammy Taylor asked if our telehealth codes currently matched Medicare, do those codes automatically stop if Congress does not reauthorize them at the end of September, or do the codes stay until we make a decision about what to do next.
    - Mr. Ramos answered the codes will stay in place until we make a decision about what to do next but the problem was not having a standard at that point. Having a standard would allow enhancements over time based on what is considered acceptable by subject matter experts in the field.
- Mauri Long wanted to understand the difference in cost between a telemedicine appointment and an in-person appointment, why we had a specific policy for telemedicine, why we were analyzing this now, and what was the issue with people seeing their doctor via telemedicine if it was acceptable and more convenient.
    - Mr. Ramos explained that before 2020 there were a relatively small number of telemedicine visits mostly for people at a far distance from specialists, for forwarding things like dermatology pictures or x-rays, or behavioral health. When telemedicine was rolled out for the military treatment system, it was found that patients were much more comfortable in a telemedicine setting than a face-to-face setting and it contributed to better outcomes. Medicare had much more restrictive rules on telemedicine at the time, such as having to see the provider within a certain amount of time of the telemedicine visit and you had to live in a rural area. In 2020, we started with the Aetna standard because you could not go anywhere face to face, and Medicare expanded their previous coverage. Similar codes were used and sometimes the same codes were used with a modifier to indicate a telemedicine visit. Codes were allowable if they were of an appropriate intensity level for telemedicine. To enable people living in remote places in Alaska to have access to care, our partners at Aetna advised us to pay telemedicine on parity as if it was coded for a face to face, which was not the norm for everyone everywhere. When we expanded the benefits, we had to balance what was good for our retirees and what it will cost the Plan because 80% of our retirees are Medicare primary and the Plan moves to the primary payer position when a service is not covered by Medicare.
    - Joel Krzan clarified to Mr. Ramos that Aetna had parity in all 50 states and parity between provider types.
- Ms. Long inquired if the $1.5 to $2.5 million financial impact on Page 2 specifically addressed the primary versus secondary payer position, was it based on actual claims for virtual versus in-person since 2020; and what percentage of people are distant versus in Anchorage, Juneau, or another city who could be face to face but choose telemedicine. If this change goes into effect, Ms. Long thought it would affect our rural population a lot more substantially than others, so she wanted to know what percentage of telemedicine in the last couple years was for people in a rural environment.
    - Mr. Ramos confirmed the $1.5 to $2.5 million impact included the Plan in the primary payer position. Mr. Ramos personally thought the Plan would not revert to only allowing telemedicine if you were rural. Mr. Ramos will provide newer projections when available.

Adopting the Aetna standard would result in a reduction of about $300,000 from what we were paying now. We would not need to tell very many people that they needed to change what they were doing if we adjusted to the carrier standard that was more robust than the Plan's coverage before 2020 but a little less coverage than currently.

- Richard Ward from Segal explained that the expectation for moving the coordination of benefits (COB) was based off a cost shift of the Plan covering what Medicare had been paying primary and the Plan had been paying secondary in the past couple years. The analysis did not consider the percentage of people who were distant versus in town and could be face to face but chose telemedicine, which was difficult to assess because it might be situational depending on need and ability to be mobile.
- We have zip codes for members but location was not looked at in this instance because the consideration was for a program-wide policy.
- Mr. Krzan said the $300,000 reduction from adopting the Aetna standard may have included about $80,000 for employees, so the reduction for retirees was closer to the low to mid $200,000 range. Aetna's standard changed in December of 2023 for most of their clients in the state.

Teladoc

The Plan does not have Teladoc but Steve Ramos thought Teladoc could help address the challenge in obtaining primary care for people in Alaska who are Medicare primary. Five years ago, we paid approximately $1 per member per month when Aetna turned on Teladoc coverage during COVID. At that time, some of the retirees had difficulty using the technology. Since then, people maybe have matured more into technology. We could reach a breakeven point with Aetna's current proposal of $0.45 per member per month. Mr. Ramos introduced Joel Krzan, our Account Director from Aetna, to deliver a presentation on the Teladoc analysis.

Mr. Krzan explained that Aetna and Teladoc have a business-to-business arrangement allowing Aetna to resell Teladoc services in Aetna's contracts as done today for the active employees and was previously included briefly for retirees. Teladoc does not bill Medicare and does not do COB, so Teladoc would be covered in a primary position for all retirees. Teladoc is a large, recognized vendor that had provided 60 million virtual care visits according to the slide from 2 years ago. The proposed virtual services were acute primary care (general medicine), dermatology, and behavioral health. Aetna has Teladoc implementation teams and an integrated experience with the mobile app. To obtain Teladoc services, you register once through either the Aetna Health app or the Teladoc app. The registration process takes about 10 or 15 minutes to complete your medical history. Once you are registered, you can request a visit through the app and are put in a queue for a licensed provider or you can schedule an appointment for a later time. You receive a text when the visit is about to start. You upload your pharmacy information and view prescriptions in the app.

Teladoc was not designed to be your PCP home but could be a bridge to address acute primary care needs while waiting for an initial appointment to establish with a primary care provider (PCP) who accepts Medicare. Teladoc provided 24/7 access to a board-certified doctor who can treat acute primary care needs, such as an emergency prescription refill, if time or distance make an office visit difficult, if you are traveling in the U.S., or if your doctor is unavailable. Mr. Krzan has a PCP and his children have

pediatricians but had found Teladoc incredibly convenient for himself and his children, for example, when traveling in the U.S. or when having pink eye symptoms at 4 a.m. In Mr. Krzan's personal experience, the turnaround time for a Teladoc visit was often within 30-60 minutes.

For dermatology, you upload images and provide details about your symptoms, and you receive a response within 1 day and can message that doctor for 7 days at no additional charge. It can be challenging to find a therapist who has not opted out of Medicare. For behavioral health, Teladoc guarantees 72-hour availability from when you first seek an appointment. You have the option to meet with a therapist, psychologist, or psychiatrist 7 days a week from 7 a.m. to 9 p.m. local time. You will have a consistent provider for behavioral health. The average length of engagement for active employees was between 4 and 5 visits. Teladoc behavioral health services are available for adolescents via video only. For active employees, 4% or 5% of virtual visits come from Teladoc. The under-65 group has access to other virtual providers including Alma and Headlight. Many virtual providers do not bill Medicare but the Plan will pay in the primary position for Teladoc.

- Cammy Taylor asked who decides how long the ongoing treatment sessions are available for behavioral health.
    - Mr. Krzan replied that mental health parity applied. In the network, there was no review process from Aetna and no limit to the amount of therapy visits you can receive. You and your provider make the decision on the frequency to meet and how long to continue therapy. Close to 30% of therapy visits with community providers are on virtual platforms.

Mr. Krzan continued the presentation. The proposed administrative fee was $0.45 per retiree per month, which was approximately $255,000 per year based on an average of 47,000 retiree subscribers. For 2026 through 2028, the proposed total cost per service was $58 for acute primary care, $85 for dermatology, and $100 for behavioral health follow-up visits with a psychiatrist or psychologist and a higher fee for the initial visit. Mr. Krzan believed the behavioral health sessions were 45-50 minutes. The DRB proposed $25 copays for all Teladoc services.

- Michael Humphrey inquired if the administrative fee per retiree was for the family unit or for each retiree plus dependents.
    - Mr. Krzan answered per family unit, meaning $0.45 would be charged per subscriber but not an additional $0.45 for the spouse or child.
- Ms. Taylor wanted to confirm if it was $0.45 per each retiree if the household had 2 retirees that were double covered.
    - Mr. Krzan responded that there were two subscribers in the case of double coverage, so $0.45 would be charged per subscriber.

Mr. Krzan explained the financial analysis on general medical services. Assuming 6% utilization, the annual cost was about $141,000. Utilization by active employees was about 6.5%. Utilization was 5.9% in the Teladoc book of business for 7.5 million people. Teladoc asked people where they would have gone had they not used Teladoc that day, and the survey data suggested about 6.5% would have sought care at an emergency room and about 93.5% would have gone to a PCP or urgent care. Folks in Alaska are more rural and possibly have a higher propensity to go to the ER. Using the book of business assumption to be conservative, the savings was a little over $3000 for non-Medicare and about a $700 savings for

Medicare primary based on AlaskaCare paying primary versus the 20% COB. Deflecting 6.5% of ER visits would save about $346,000. On the under-65 plan, a PCP or urgent care visit cost a lot more than the Plan paying $33 for a Teladoc visit. Based on data of PCP and urgent care visits for those with Medicare primary, the Plan paid low $30s per visit in COB, resulting in no savings or added cost. Calculating the cost of service and avoided care, the overall net savings was about $112,000. If actual utilization was half the projected usage and therefore less deflected care, it would cost $70,000 annually because the $255,000 administrative fee was the same. There were ways to get the word out about using the Teladoc service. Mr. Krzan thought it was safe to assume closer to 6% utilization rather than 3% or 3.5%.

- Mauri Long asked if the assumption was that people who were utilizing behavioral health care now through telemedicine would transfer to the Teladoc platform, and what was the difference in copay for a telemedicine visit with a behavioral health provider versus a community therapist.
    - Mr. Krzan did not think Teladoc would shift care or take business away from existing network community providers. In looking at other clients, most folks who were established with a therapist will continue seeing that therapist. Teladoc would open up additional access and create a different avenue for someone who is looking for a new therapist. The proposed copay for a Teladoc service was $25.
    - Mr. Ramos stated there were no copays for office visits; it was a 20% coinsurance. The $25 Teladoc copay was close to the amount of the 20% coinsurance and factoring in the percent of people who met or did not meet their deductible when they used this service. Mr. Ramos thought the average office visit was $180 for under-65. If all the projections come true, there will be a savings of $100,000. Providing the projected 4260 Teladoc visits meant those people got care they might not have otherwise received.
        - Mr. Krzan said the average office visit was $180 for under-65 and about $150 or $160 allowed for Medicare primary.
- Judy Salo thought that access to Teladoc 7 days a week was very attractive. Ms. Salo inquired if double coverage applied to the $25 copay in the same way as the 20% coinsurance; if not, people who were double covered might choose to access a local provider to avoid the $25 copay.
    - Mr. Ramos replied that dual coverage did not apply to the $25 Teladoc copay. Approximately 10,000 retirees were dual covered, so about 50,000 or 60,000 retirees were not dual covered.
    - Mr. Krzan clarified that Aetna did not administer COB for Teladoc, regardless if it was Medicare or a commercial plan.
- The following questions were raised. If someone who was double covered wanted to obtain care, did Teladoc take away any of the provider choices that people had access to now? Was participation in either program mutually exclusive? Could a person use both services, depending on the situation?
    - Mr. Ramos assured that current coverage and coding of telemedicine benefits would be maintained in the Plan. Teladoc was an addition to and separate from telemedicine. A person could use both services.
    - Mr. Krzan gave the analogy of Teladoc being another tool in the tool belt. Aetna provides access to a 24-hour health information line to self-triage symptoms. Aetna has a free nurse 24/7/365 who can guide patients in deciding whether they can wait until they see their PCP or obtaining care more quickly so symptoms do not persist or get worse. The Aetna nurse could suggest the option of Teladoc if there is not an open urgent care near you or if your PCP is not on call afterhours. Teladoc is a complementary service for acute care.

Mr. Krzan explained that the financial analysis considered weighted averages based on utilization rates and cost of visits for the Medicare primary and non-Medicare populations. For example, a Teladoc counselor was much less expensive than one in the network but the Plan would pay more for Teladoc if Medicare was primary. At current consumption rates, it was at about a breakeven point. If more Medicare primary folks use the service than assumed, maybe because they were unable to access care previously, it could result in an uptick in unanticipated cost for behavioral health. Unmet anxiety and depression needs can be a precursor to more serious physical and mental health exacerbations, so creating access for the Medicare population could have good downstream effects for people's health and costs down the line.

Mr. Ramos said if Teladoc was underutilized, he may come back a year from then and say this is not working out. The perspective when putting this proposal together was viewing it is a tool we can provide to retirees that will get us 4200 visits they might not have otherwise had, and we are doing something good if we can provide this additional service and break even.

- Ms. Taylor asked if this proposal will be put on the agenda for the Board meeting.
    - Mr. Ramos answered it will be put on the next agenda if the Committee agreed to move forward.
- Mr. Humphrey thought this proposal addressed some of the trouble areas for the Medicare population and covered some gaps in obtaining primary care, mental health, and dermatology. Mr. Humphrey noted it can take 6 months to see a dermatologist.
- The Committee was in favor of this proposal going to the Board.

Mr. Ramos credited Mr. Krzan and Brandi Garcia for bringing resources to our account that we did not have the benefit of before. Segal weighed in on this proposal and the DRB faces in attendance had discussed this thoroughly, so it was a team effort.

Travel

Steve Ramos was not sure if there was a consensus for him to create a plan for travel. The health team at the DRB internally talked about travel. Lantern was recently turned on, which comes with a travel benefit that covered lodging, people receive a credit card with a local travel allowance, and plane tickets were purchased for people instead of having to purchase the tickets and seeking reimbursement later, so it was a big enhancement for the surgeries and services covered by Lantern. The oncology RFP was being worked on but the intention was to pair the treatment of cancer to the same kind of concierge travel that comes with Lantern. We may not understand our needs until we see the dust settle from these new programs that will enhance travel significantly. Mr. Ramos asked the Board to provide a clearer idea of what the Board was interested in.

Cammy Taylor heard that oncology was not covered by Lantern so you only get your airfare covered and the other issue was that companion travel was not covered by Lantern. Ms. Taylor noted one of the comments heard the most from retirees was about providing travel for cases requiring diagnosis in another location, particularly when you live in a remote location or it is a rare condition, but you need to put guardrails because it can feel like you are opening the door to any travel.

Mr. Ramos thought almost all travel qualified as a diagnostic trip, whether it was a diagnostic test or a consultation with a specialist, with the exception of having a procedure done. The DRB had conversations with the Director and the Commissioner's Office. Mr. Ramos summarized the recent added benefits and enhancements, such as no longer requiring precertification for travel, coverage for preventive services, and increasing the lifetime maximum from $2 million to $8 million. Mr. Ramos thought it was important to discuss how to construct an offset to an enhancement. Mr. Ramos was not sure it was palatable to increase the $150 deductible or $800 max out of pocket. A travel enhancement was never a benefit, so there was no expectation that enhanced travel should be covered.

- It was questioned whether the oncology RFP was envisioned to include travel for a second opinion when there is no local expertise. Before deciding on your treatment plan, you may want to go to MD Anderson or another cancer facility.
    - Mr. Ramos explained that the oncology RFP will be different than the Lantern services. It will more likely be a concierge for your cancer journey to get you to the right person at the right place at the right time for the diagnosis and treatment of the cancer, which was anticipated to gain efficiencies that will result in maybe a half million dollars in net savings but, more importantly, may help more people live or live longer. We do not know what will be in the package until we get RFP responses but Mr. Ramos thought it will include second opinions and other things that are essential to diagnosing and treating cancer.
- During the years Judy Salo lived in Kenai, she recalled one of the big concerns for people who were diagnosed with cancer was how to get radiation. For a lot of people in rural Alaska, it was a very expensive process to travel to a metropolitan area to get 6 weeks of radiation. Ms. Salo wondered what was covered currently for radiation treatment and if obtaining radiation was still an issue.
    - Mr. Ramos did not have the answer or any anecdotal information on Ms. Salo's question.
    - A prudent approach was to wait and see the RFP responses on what each of the bidders can provide and the value of those options.
- When Mr. Humphrey consulted for the State of Alaska's Medicaid program, he had many conversations about how travel was being used. Mr. Humphrey did not know how it turned out but thought the Medicaid program might be a resource for the DRB to have a conversation about travel.
    - Mr. Ramos said they knew some people and will make a few calls to see what they can learn.

Ms. Taylor asked the Committee's thoughts about putting this topic on pause until we found out what services will be covered by the oncology RFP.

- When building healthcare plans, Mr. Humphrey made the mistake several times of including everything he possibly could, and the interactions with programs was not working well and there were communication conflicts, so he agreed with Mr. Ramos about letting the dust settle.
- The Committee agreed to pause on travel until further analysis was done on the RFP.

Mr. Ramos mentioned they were contacted by Providence to have a meeting to talk about what they could do for us. Mr. Ramos relayed to Providence that we were very interested in them having primary care clinics for folks with Medicare primary and we were interested in services like their portable mammogram van. Providence was told that we would like a heads up anytime they offered a new service or were bringing out a mobile unit so we could notify our members.

Licensed Massage Therapists

Steve Ramos stated there were no easy controls for determining medical necessity for licensed massage therapy other than reviewing clinical records. Mr. Krzan at Aetna and Haley Duran, our senior account manager, have helped with researching our ideas. Guardrails were needed to avoid paying for 25 or 35 massages per year for every retiree, and there was no viable solution yet. Rehabilitative care was set up for medical necessity review at 20 visits, and claims start to pend if it has not occurred by Visit 25. All rehabilitative care was in the same bucket. For example, if we wanted to have medical necessity review for massage therapy at Visit 10, medical necessity review for all rehabilitative care would move to Visit 10. There was an anecdotal assertion that there was an unmet need for massage therapy but we have no data to support that assertion. There was a very nominal amount of denied claims but it is possible that people were not submitting massage therapy claims because they knew it was not covered under the Retiree Plan. Aetna was asked to look at how we use rehabilitative care and the amount of massage therapy we might expect to have based on Aetna's book of business or our Employee Plan.

Joel Krzan noted the Employee Plan consumed more massages per capita than the various retiree populations. There were not a lot of denied services. There was prudent behavior on the Employee Plan where they adhered to Aetna's standard on modalities. According to the data, if concurrent review was at a threshold earlier than the 25th visit, it would impact a few hundred people. It could create a lot more potential for appeal and provider friction by moving concurrent review up for several hundred people when maybe it is a much smaller number who were struggling to find a massage by a recognized provider type. Aetna was trying to come up with ideas that do not impact the current musculoskeletal rehab benefit but would maybe have more equitable cost sharing for massage.

Mr. Ramos thought there was 30% more usage in the Employee Plan than the Retiree Plan, which did not bode well for the cost impact from the increased number of services billed to the Plan. The question to consider was how to add an enhancement at a net-zero change to the Plan benefits or the actuarial value when it had never been a benefit, and how do you apply it in a thoughtful and appropriate way. Aetna is researching whether we can charge copays for all massages. Segal will make projections on the increase in massages resulting from adding licensed massage therapists (LMTs) as recognized providers, and the copay amount to neutralize the impact.

Cammy Taylor commented that medically necessary massage therapy services had always been covered by our Plan as long as the billing came through another provider that was qualified under the Plan. Ms. Taylor felt it may not be fair to treat this as a new service when it had been covered in the past. Previously, massage therapists were not licensed in the state of Alaska. Now that massage therapists are licensed, they get a referral from a medical provider for a particular set of services and a plan of care is made. LMTs have no problems with billing the Employee Plan, ASEA, and maybe also Blue Cross/Blue Shield.

Mr. Ramos explained that the Plan says it will be part of the written record when a provider writes a referral or prescription for a person to get massages by an LMT but the Plan had no means of getting or assessing the prescription. Therefore, the Plan cannot differentiate between somebody getting a luxury massage on the beach and somebody getting a massage at the direction of a provider. Mr. Ramos thought the Employee Plan had a limit of 10 massages but he was not sure. Physical therapy Clinical

Policy Bulletins state that medical massages were generally considered medical necessary for the first 2 weeks after an injury or illness, which we are unable to assess. The premise we are operating on is that if you had the service in a doctor's office under a current recognized provider, then we assume he has an LMT in his practice for the sole purpose of the benefit of his patients who he referred to the LMT.

- Mauri Long asked if LMTs were considered recognized providers under the Employee Plan, why the Employee Plan standards do not apply to the Retiree Plan, does the Employee Plan have a medical necessity requirement, and why was there a difference between LMTs and other recognized providers who are required to submit their plan of care and records. Ms. Long recalled raising this issue to the Committee many years ago when she was on the RHPAB Board. Massage therapists had expressed their frustration to Ms. Long about the expense of paying a recognized provider to do their billing for the Medicare population when there was an order for medically necessary massage. This resulted in increased cost of medical massage therapy to our plan. Ms. Long's goal was to have LMTs be medically recognized providers so they can bill the Retiree Plan directly. LMTs can bill the Employee Plan and other plans directly. Ms. Long wondered if it would help if independent LMTs provided documentation identifying the cost to our plan, or was there anything else that would help.
    - LMTs were considered recognized providers under the Employee Plan.
    - Mr. Ramos stated the Employee Plan allowed a certain number of massage therapy visits per year. All the AlaskaCare plans are evidence-based, so only services and supplies that are considered medically necessary are benefits in the plans. Employee Plan members do not have the same deductible and $800 max out of pocket as Retiree Plan members, so the plans are not comparable. Employee Plan members are not constitutionally protected from diminishment, so there is no issue if benefits change. Mr. Ramos reiterated we do not have the tools to make the assessment of medical necessity as per the Clinical Policy Bulletins. LMTs were not recognized provider types before. Our responsibility is not to make sure LMTs get additional market share. Our responsibility is to provide benefits to retirees. It is not the LMT's fault that we have a systematic inability to differentiate between a spa day and a medical treatment. We do not have any data showing a performance gap that we need to close. Mr. Ramos said they were working hard with Aetna and Segal to figure out a way to do this. Mr. Ramos did not want to see 60,000 people get 25 massages per year and then get access to maintenance visits. If a doctor wrote a prescription and transmitted it to Aetna, the problem was that Aetna could not assimilate it and apply it. Medical necessity review for rehabilitative care was 20 visits but Mr. Ramos did not understand why we would wait until 20 massages were given to assess medical necessity when the Clinical Policy Bulletin said massage therapy was medically necessary for the first 2 weeks following an injury or illness.
- Since active employees would not paying for massage therapy, one suggestion was to ask LMTs who are network providers to provide data on how many people were paying on their own. Although the structural problem still remained, this information could help address the need for more data.

Long-Term Care

The Town Hall tomorrow was dedicated to long-term care. Steve Ramos apologized for not sending the slide deck but it will be sent to all Board Members and anybody else who wanted it. The slide deck clearly explained most of the things that people had questions about. Mr. Ramos had provided training

to various retiree groups but it had been a while since anybody requested it. If the Board wanted training after looking at the slide deck, Mr. Ramos was glad to do it.

COVID Vaccine

Chris Murray explained that the Plan defined vaccines and preventive care based on the recommendations from organizations including the Advisory Committee on Immunization Practices and United States Preventive Services Task Force (USPSTF). The COVID vaccine recommendations have not changed. The Plan did not make independent clinical coverage decisions about preventive care. The Plan aligned with expert recommendations to ensure consistent evidence-based coverage for retirees, consistent with federal guidance. Mr. Murray thought the organizations' current COVID vaccine recommendation was for all adults 18 and older; if so, then it will be covered as preventive. If the federal guidance changes and those organizations no longer recommend the COVID vaccine, then the Plan would not be able to treat it as preventive, so the Plan would follow normal coverage rules like any other medical service that is not classified as preventive.

- Mr. Ramos recalled reading that the COVID vaccine was recommended for 65 and older as well as immunocompromised adults 18 and older.
    - Mr. Murray performed a Google search and found on the CDC's front page that the CDC recommended the 2024-2025 COVID-19 vaccine for most adults 18 and older and it was especially important to get the COVID vaccine if you are 65 and older. Mr. Murray will get the specific recommendations and share them with the Board.

Mr. Ramos corrected a statement he made earlier. The Employee Plan did not have a limit on massages but there was a medical necessity requirement.

Public Comment

- Randall Burns, President of the RPEA, reported that the board met yesterday. One of the issues the board discussed was the long-term impacts of the legislation enacted by Congress, the Big Beautiful Bill. Mr. Burns encouraged the RHPAB, this Committee, and the Division to pay attention to the portions of the Bill related to healthcare as they get further investigated, and be aware of possible impacts this legislation could have on the AlaskaCare Health Plan. Given the current national policies around healthcare, the RPEA remained concerned and hopeful that this Committee, the Board, and the Division were paying close attention to related issues of importance to the Retiree Health Plan such as possible investigations of EGWP and whether it continues in its current form. The RPEA wanted to go on record as saying they wanted to confirm this was part of your ongoing action and activity to keep everyone abreast of potential impacts on the AlaskaCare Plan going forward.
- Wendy Woolf spoke on her own behalf, not on behalf of the RPEA. Based on today's discussion, Teladoc sounded like a good idea. If the decision is made to add Teladoc to the Retiree Plan, Ms. Woolf cautioned that we are clear on the rollout that this is an additional service being provided but it may be removed if it was found not to be cost effective to our plan, and it will not be considered a diminution.

Wrap Up / Adjourn

Motion by Mauri Long to adjourn the meeting. Second by Michael Humphrey.

The next RHPAB board meeting will be held next week.

AlaskaCare Retiree Health Plan Advisory Board
Meeting Minutes

Monday, July 21, 2025

Board Members		DRB		Guests	
Lorne Bretz	P	Steve Ramos	P	Randall Burns	P
Dallas Hargrave	A	Chris Murray	A	Stephanie Rhoades	P
Paula Harrison	P	Ronan Tagsip	P	Wendy Woolf	P
Michael Humphrey	P	Liz Hawkins	P	Alex (Delta)	P
Cammy Taylor	P	Marie Speegle	P	Scott D. (Delta)	P
Donna White	P	Clara Roomsburg	P	Tammy (Delta)	P
		Erin Russell	P	Richard Ward (Segal)	P
		Erika Burkhouse	P	Quentin Gunn (Segal)	P
		Jesse Peterson	P	Amy McClendon (Segal)	P
		Meghan Jones	P		
		Steven Alvarado	A		

Call to Order

Chair Cammy Taylor called the meeting to order. She noted that she and Michael Humphrey are in the Anchorage conference room. Lorne Bretz, Paula Harrison, and Donna White are online. Dallas Hargrave was not observed. Randall Burns and Wendy Woolf are in the Anchorage conference room.

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

Richard Ward with Segal introduced himself. He was joined by Amy McClendon and Quentin Gunn.

Scott Dally, Alex Van Dyke, and Tammy Skeels with Delta Dental introduced themselves.

Approval of Meeting Agenda and Minutes

Chair Cammy Taylor requested that the end of the agenda contain a quick discussion to address the next Board meeting. The agenda was approved with that change.

Ethics Disclosure

There were no disclosures.

Public Comment

Wendy Woolf asked how orthodontia specifically affects premiums and if the Division has a recommendation related to diagnostic colonoscopy.

Stephanie Rhoades commented that the materials for this meeting are not on the website. She had been disconnected after she called in and waited 26 minutes for the meeting to start.

Modernization Topics/Priorities

Chair Cammy Taylor stated that the Board had looked at potential changes to the dental plan as a result of a request related to 3D imaging used by endodontists and oral surgeons. It is covered in the legacy plan, not the standard plan. The Division and Delta had provided information related the differences in the 2 plans, the feedback they had received, and usage. The Committee will move forward to the Board a select group of procedures to be considered for addition to the standard plan. Packet page 15 shows the actuarial summary for each proposed change. Page 4 reflects a chart showing the premium impact based on the actuarial summaries. The Committee recommended 3 changes to the Board, which includes increasing preventive and periodontal cleanings to 4, putting forward only 3D imaging under the x-ray section, and changing the crown frequency limit for replacement from 7 to 5 years and adopting a coverage allowance for porcelain crowns. She entertained a motion to approve amending the standard dental plan to increase preventive and periodontal cleanings from 2 to 4.

Motion by Michael Humphrey to approve amending the standard dental plan to increase preventive and periodontal cleanings from 2 to 4.
Second by Lorne Bretz

Chair Cammy Taylor noted the result would be 4 preventive cleanings or 4 periodontal cleanings per year and would include scaling. The actuarial impact would be 0.86 percent.

Lorne Bretz inquired what percentage of the population might utilize the feature.

Steve Ramos was not sure that there would be much of an increase. Although, it would remove a piece of the deciding factor in choosing the legacy or the standard plan.

Richard Ward agreed that a small portion of the membership will access more than 2 cleanings a year. He thinks it is in the 10 to 15 percent range.

Result: Motion passed unanimously.

Chair Cammy Taylor addressed the change in x-rays. The Committee is recommending that the standard plan adopt the 3D imaging, not the other changes to x-rays that are different than what the legacy plan offers. It would result in a 1 percent actuarial change.

Result: 3D imaging passed unanimously.

Chair Cammy Taylor moved to the other Class 1 fluoride and sealants. Those changes would be de minimus with respect to the actuarial change.

Result: Passed unanimously.

Chair Cammy Taylor noted that the next item recommended by the Committee is a change to the crowns provision. The legacy plan does not cap when a crown is replaced, but the standard plan has a 7-year cap. The recommendation is to move from 7 to 5 years and to add coverage for porcelain.

Lorne Bretz mentioned that he supports this.

Result: Passed unanimously.

Chair Cammy Taylor voiced that the final item for consideration was brought to the Board's attention through the Commissioner's office, not by retirees. It relates to orthodontia. She outlined the 3 orthodontia options on packet page 3. The actuarial value ranges from 1 to 4.3 percent. She questioned what information the Division gets from retirees or from Delta about requests for orthodontia.

Mr. Ramos answered that in 11 years, he recalls it coming up relating only to cleft palate treatment. It was not looking at dental coverage as much as health coverage, which was not achievable.

Scott Dally added that the majority of retirees are not going to take full advantage or orthodontists for themselves, but a number of retiree plans may cover children who might need that service. He has been asked if ortho is offered. It is not a big demand, but there is inquiry.

Mr. Ramos asked if Alex Van Dyke manages other retiree plans that cover orthodontics.

Alex Van Dyke replied that she does not manage retiree plans with orthodontia benefits. She will check to see if her colleagues do and let Mr. Ramos know.

Mr. Ward added that their other state-level plans with retiree-specific dental plans do not cover ortho.

Michael Humphrey stated he understands it is not a common benefit for retiree plans but queried if realignment of teeth would be covered in the event of an accident, etc.

Mr. Ramos responded that he does not think realignment of teeth would be covered. He added that it cannot be covered under the health plan.

Ms. Van Dyke remarked that typically anything related to the jaw will not be covered by orthodontia. The orthodontia benefit will be seen with teeth realignment.

Chair Cammy Taylor remarked there is a provision for coverage in Section 3.3.20 – medical treatment of mouth, jaws, and teeth. The medical plan covers medical conditions of the teeth, jaw, jaw joints, and supporting tissues, including bones, muscles, and nerves. There is a reference to the dental plan for information on what the dental plan covers. She outlined the medical services included. She assumes that an accident involving fractures or injury to natural teeth would be allowed under the medical plan and include wiring.

Mr. Ramos stated regarding wiring that G answered it – appliance therapy, which excludes braces.

Mr. Dally commented that orthodontia is not used for recovery from an accident. All mentioned by Chair Cammy Taylor would probably fall under medical.

Tammy mentioned that braces would not be covered under G.

Mr. Ramos voiced that the section of the book being referred to is the health plan, not dental. There had been a conversation with Aetna, and there is no way to spin orthodontia to a medical-in-nature coverage.

Ms. Van Dyke noted that the original question was how would it be covered in the case of an accident, and the answer is it would not be covered under medical or dental today.

Chair Cammy Taylor stated, regarding orthodontia, that the Committee was not recommending it to the Board but thought it should be brought to the Board's attention because it came through the Commissioner's officer.

Michael Humphrey remarked that he thinks utilization of orthodontics would be low and that he thinks about it in terms of how many retirees it will benefit. The cost will impact every retiree that takes dental. He is not sure the cost impact would be worth the benefit.

Chair Cammy Taylor asked if the Board wants to take this up in a formal motion or table it until there is additional information.

Michael Humphrey expressed that the conversation can be continued. He questioned if there is a way to do it for an accident.

Motion by Michael Humphrey to not add orthodontia to the dental plan.
Second by Donna White.
Result: Motion passed unanimously.

Chair Cammy Taylor declared that the next item for discussion is the cost share for in-network diagnostic colonoscopies. The proposal came from the Division and is somewhat consistent with what was done with the breast cancer imaging. She understands that colon cancer is more prevalent in younger people. They would not fall under the category for preventive coverage, but if they had symptoms, their doctor would send them for a diagnostic colonoscopy. The Committee sensed that screening is important, but there were questions how it would apply to different retiree categories by age. If one is under 65 and AlaskaCare is their primary coverage, the benefit would defer the annual deductible and out-of-pocket payments, so one would be 100-percent covered for a diagnostic colonoscopy. She explained what would happen for folks who have another primary insurance or Medicare and AlaskaCare as their secondary insurance.

Mr. Ramos remarked, in the case of AlaskaCare as a secondary insurance, that he does not know if the $150 deductible and the 20 percent would result in a benefit to the member.

Chair Cammy Taylor stated it needed to be investigated more, but it seems that Medicare would apply its deductible and pay 80 percent for the remainder and AlaskaCare would pay the difference, so those on Medicare would get full coverage and the concurrent deductible applied at the same time, so once the $150 AlaskaCare deductible is met, it would pay what Medicare does not pay, so if the $150

deductible is deferred, one would lose the benefit of having a concurrent application of the deductible and would have to pay $150 after paying the Medicare deductible.

Mr. Ramos voiced that he agrees. He provided an example of a member experiencing a savings but it not being known what would happen with the $150 deductible.

Richard Ward added that from a process or administration perspective, the example characterizes the impact and the considerations. He explained it from an analysis standpoint and stated it is impactful for those who have cost share for diagnostic colonoscopies.

Chair Cammy Taylor commented that the biggest impact might be to those under 65. Once you're on Medicare, AlaskaCare picks up the difference. She asked if diagnostic colonoscopies received from a Medicare provider, which is not in a network, are excluded from this.

Mr. Ramos answered that members over 65 are generally in what is termed a CMED plan and they do not have a network, so the piece saying one would get it at first-dollar coverage if going to a network provider would only apply to those under 65 in the Aetna PPO plan. It will never be an issue for those over 65 because Medicare is primary.

Chair Cammy Taylor inquired if the cost to the Plan would be the $150 deductible for those over 65 and if the retiree over 65 would risk paying more over time for the deductible in the year if they use other medical services after the diagnostic colonoscopy because the $150 deductible would have to be paid at a later date.

Mr. Ramos replied that it would be in exchange for the $200 coinsurance at the time.

Chair Cammy Taylor expressed that after paying the $150 deductible AlaskaCare will pay whatever is left, so the retiree would be deferring the $150 savings against their deductible for a later date, so if they do not use anything else the rest of the year, it would be a great savings, but if they have to pay for any medical services after that, a deductible would apply.

Mr. Ward confirmed that is correct. He added that a deductible could be applied but it would depend on the circumstances.

Michael Humphrey noted that Segal's cost estimate is between $100K to $155K or 0.01 10 0.02. There is not much impact on the plan.

Mr. Ward affirmed that is correct. There is not much member cost share associated with diagnostic colonoscopies currently. He indicated that there will not be a voluntary uptick in utilization.

Chair Cammy Taylor expressed that those who need it and are on Medicare will get 100 percent coverage between the 2 plans, absent the deductibles. Only the deductible will be impacted. She asked if most retirees pay their entire $150 deductible because they use so many services or if a small percentage meet their deductible so, therefore, having it waived here will not impact them with respect to paying the separate $150 at a later date.

Michael Humphrey replied that he thinks they will pay it at a later date. The $150 deductible will be paid if one attends 2 or 3 office visits.

Chair Cammy Taylor remarked that she is concerned about the potential negative impact and what it would be if this was one's first service of the year and the possibility of retirees paying more out of pocket for deductible during the year as a result of this benefit. She queried how that could be evaluated.

Mr. Ward responded that he believes there will be a small savings for a small number of people and no impact for the majority of folks over the course of a year. There had been less than $1 in member cost share per person in the plan.

Michael Humphrey voiced that he hopes such a plan change will encourage folks to get colonoscopies but he is not optimistic.

Mr. Ward agreed. No utilization effect had been assumed for this.

Mr. Ramos added that they are not dug in on the position. It was brought forward because it looked like a promising concept, but Chair Cammy Taylor made a great point. His guess is that less than half of the retirees pay their full $150 because of coordination with Medicare. He suggested seeing what Aetna can do to help determine how the claims price out.

Mr. Ward commented that the same considerations were present when making a similar change for diagnostic mammograms, which has been approved. They can provide some general utilization data on who and how many meet the deductible. Making this change will result in a very low financial impact.

Chair Cammy Taylor mentioned that she wants to think about the impact and how a claim will flow. She declared that the item will be tabled to think through the issues and how it will affect retirees. She addressed the topic of foreign ambulance services on packet page 22. The memo stating "for patients with life-threatening conditions needing immediate medical attention" prompted her to review the health plan language. The language in the health plan is different and refers to an emergency condition and then defines it. She queried if the medical plan language will be tracked for foreign ambulance services. She read language in the plan booklet travel language and asked if it will be distinguished that travel will continue to be solely within U.S. borders and then ambulance would include foreign.

Mr. Ramos answered that the difference in the language in the memo and the health plan was unintentional. They will not change any language other than to pluck out the exclusion for foreign ambulances. Liz Hawkins can update the way the proposal reads so it will follow the same language and so it will be communicated that this is the same ambulance coverage that would otherwise be allowed in the United States. As for the plan booklet travel language, they will wordsmith it, but it was not intended that the ambulance benefit outside the U.S. be something different or that the bar be raised to a higher level of acute care.

Chair Cammy Taylor entertained a motion to adopt foreign ambulance service coverage to the retiree health plans.

Motion by Mr. Humphrey to adopt foreign ambulance service coverage to the retiree health plans.
Second by Ms. White.
Result: Motion passed unanimously.

Chair Cammy Taylor moved to the Teladoc item.

Steve Ramos stated the Commissioner's office is concerned about retirees' inability to get primary care if they have Medicare primary. This could be a Band-Aid for that in certain cases. They had asked Aetna to investigate this for the retiree population. This was not cost effective with the prior per employee per month (PEPM) fee, so the PEPM fee will be reduced. There will be a $25 member copay.

Chair Cammy Taylor expressed that being able to see the same providers for behavioral health may appeal to retirees.

Michael Humphrey added that behavioral health providers are available 24/7 through Teladoc.

Chair Cammy Taylor inquired if the copay will be a flat $25 for any available service and if more information is needed from Teladoc before adopting the proposal.

Mr. Ward confirmed that the copay will be a flat $25 for any available service.

Mr. Ramos mentioned that a patient may not necessarily be connected to the same provider for acute care appointments. However, patients will be connected with the same provider for behavioral health appointments.

Chair Cammy Taylor inquired whether additional information was needed from Teladoc to move forward.

He does not think more information is needed from Teladoc before adopting the proposal. If the Board recommends it, it will be included in the proposal letter for the Commissioner to authorize the change.

Michael Humphrey remarked that it covers all the areas in Alaska where there are problems with acute care, dermatology, and particularly behavioral health.

Chair Cammy Taylor entertained a motion to adopt Teladoc as a service to the retiree health plan.

Motion by Michael Humphrey to adopt Teladoc as a service to the retiree health plan.
Second by Paula Harrison.
Result: Motion passed unanimously.

Chair Cammy Taylor asked if Board members would consider the next meeting date being in late October rather than November. There were no objections by the Board. She requested that Steve Ramos poll the Board to determine the best date to meet in late October.

Liz Hawkins stated that she will provide a variety of dates.

Public Comment

Wendy Woolf emphasized that it will be helpful for retirees if the packet information is posted online at least 5 days before a meeting or ASAP if it is not possible to do it 5 days before. She noted that the Modernization Packet still is not posted.

Stephanie Rhoades thanked the Board for adding the 3D cone beam x-rays to the plan.

Paula Harrison spoke of retirees who continue to work and have primary insurance but not Medicare and Aetna paying for only dental, vision, and audio, and she requested that be addressed on a future agenda and that steps be taken to make a change.

Chair Cammy Taylor commented it is worth looking into. She will look forward to Liz Hawkins' email to choose a date for the next meeting.

Wrap Up / Adjourn

The meeting adjourned.

State of Alaska
RETIREE HEALTH PLAN ADVISORY BOARD
Related to Coverage for Professional Ambulance Services Received Outside of the United States under the AlaskaCare Defined Benefit Retiree Health Plan

Resolution 2025-01

WHEREAS, the Retiree Health Plan Advisory Board (Board) is authorized by Administrative Order No. 336 to facilitate engagement and coordination between the State of Alaska's retirement systems' members, the Alaska Retirement Management Board, and the Commissioner of Administration regarding the administration of the retiree health plan; and

WHEREAS, the Alaska retiree health care trusts provide health coverage through the AlaskaCare Defined Benefit Retiree Health Plan (Plan) to retirees and their dependents; and

WHEREAS, the Plan currently provides members with coverage for transportation to the nearest hospital by professional ambulance, specifically when received within the contiguous limits of the United States, Alaska, and Hawaii; and

WHEREAS, the Division has contracted with a third-party vendor to administer benefits for eligible medical claims incurred and submitted by members outside of the United States; and

WHEREAS, the Division may contract with a different third-party vendor in the future to provide similar services; and

WHEREAS, the Division has proposed to consider adding to the Plan the option to extend coverage to medically necessary professional ambulance services received outside of the United States, including ambulance transportation by ground or air, via fixed wing aircraft and/or helicopter, for patients with an emergent condition needing immediate medical attention, as defined in the AlaskaCare Retiree Insurance Information Booklet and outlined in detail in the Program Proposal presented to the Retiree Health Plan Advisory Board on July 21, 2025 (Program Proposal); and

WHEREAS, the Division has solicited public comments on the Program Proposal to consider adding medically necessary professional ambulance services received outside of the United States, which resulted in 100% of public comments in favor of implementation of the Program Proposal; and

WHEREAS, the Program Proposal has been evaluated by an independent certified Fellow of the Society of Actuaries, who found that the proposed change would result in an enhancement to the Plan which would have a de minimis on the Plan's actuarial value; and

WHEREAS, the Program Proposal has been evaluated by an independent certified Fellow of the Society of Actuaries, who found that the proposed change is anticipated to result in approximately $150,000 to $300,000 in additional annual costs to the Plan; and

WHEREAS, the Division's analysis has included: evaluation of the need and rationale for the proposed change, data analysis based on actual experience, evaluation of the impact of the change to the current benefits; evaluation of any gaps, restrictions, reductions, eliminations, expansions, or additions to the current benefits; the number of members potentially impacted by changes and the seriousness of any impacts;

NOW THEREFORE, BE IT RESOLVED THAT THE RETIREE HEALTH PLAN ADVISORY BOARD recommends the AlaskaCare Defined Benefit Retiree Health Plan adopt and implement coverage for medically necessary professional ambulance services received outside of the United States to the Plan's benefits as outlined in the Program Proposal submitted to the Board on July 21, 2025, to be effective January 1, 2026.

DATED this 6th day of October 2025.

State of Alaska
RETIREE HEALTH PLAN ADVISORY BOARD
Related to Reintroducing Teladoc as a Virtual Provider Option
under the AlaskaCare Defined Benefit Retiree Health Plan

Resolution 2025-02

WHEREAS, the Retiree Health Plan Advisory Board (Board) is authorized by Administrative Order No. 336 to facilitate engagement and coordination between the State of Alaska's retirement systems' members, the Alaska Retirement Management Board, and the Commissioner of Administration regarding the administration of the retiree health plan; and

WHEREAS, the Alaska retiree health care trusts provide health coverage through the AlaskaCare Defined Benefit Retiree Health Plan (Plan) to retirees and their dependents; and

WHEREAS, the Plan currently provides members with coverage for eligible telemedicine services; and

WHEREAS, the availability of telemedicine service provider options increases access to timely and affordable care, particularly for members who experience difficulty in accessing a provider who accepts Medicare, those in rural locations, or those who have limited mobility; and

WHEREAS, the Division has contracted with a third-party vendor to administer benefits services received through Teladoc for active employee plan members, with the option to expand coverage to the Retiree Plan; and

WHEREAS, the Division may contract with a different third-party vendor in the future to provide similar services; and

WHEREAS, the Division has proposed to consider adding to the Plan the option to obtain acute care, dermatology, and behavioral health services through the virtual provider service platform, Teladoc, with a $25 member copay, as outlined in detail in the Program Proposal presented to the Retiree Health Plan Advisory Board on July 21, 2025 (Program Proposal); and

WHEREAS, for non-Medicare members medical services provided as part of an ongoing written plan of care, when administered by an eligible health care provider practicing within the scope of their license, are included benefits, and

WHEREAS, for Medicare-eligible members, services received through Teladoc are not currently billable through Medicare, and therefore would be covered by AlaskaCare Plan as primary; and

WHEREAS, the Division has solicited public comments on the Program Proposal to consider reintroducing Teladoc services for acute care, dermatology, and behavioral health, which resulted in 100% of public comments in favor of implementation of the Program Proposal; and

WHEREAS, the Program Proposal has been evaluated by an independent certified Fellow of the Society of Actuaries, who found that the proposed change would be considered an expansion of provider options which does not impact the actuarial value of the Plan; and

WHEREAS, the Program Proposal has been evaluated by an independent certified Fellow of the Society of Actuaries, who found that the proposed change is anticipated to result in approximately $100,000 to $200,000 in additional annual costs to the Plan; and

WHEREAS, the Division's analysis has included: evaluation of the need and rationale for the proposed change, data analysis based on actual experience, evaluation of the impact of the changes to the current benefits; evaluation of any gaps, restrictions, reductions, eliminations, expansions, or additions to the current benefits; the number of members potentially impacted by changes and the seriousness of any impacts;

NOW THEREFORE, BE IT RESOLVED THAT THE RETIREE HEALTH PLAN ADVISORY BOARD recommends the AlaskaCare Defined Benefit Retiree Health Plan adopt and implement the reintroduction of Teladoc services for acute care, dermatology, and behavioral health, as outlined in the Program Proposal submitted to the Board on July 21, 2025, to be effective January 1, 2026.

DATED this 6th day of October 2025.

State of Alaska
RETIREE HEALTH PLAN ADVISORY BOARD
Related to Enhancing the Dental Benefits Available Under the
AlaskaCare Retiree Standard Dental-Vision-Audio Plan

Resolution 2025-03

WHEREAS, the Retiree Health Plan Advisory Board (Board) is authorized by Administrative Order No. 336 to facilitate engagement and coordination between the State of Alaska's retirement systems' members, the Alaska Retirement Management Board, and the Commissioner of Administration regarding the administration of the AlaskaCare Retiree Health Plan; and

WHEREAS, the AlaskaCare Retiree Dental-Vision-Audio (DVA) Plans are funded by members' monthly premium payments; and

WHEREAS, the Division of Retirement and Benefits (Division) currently administers two DVA Plan options, the Legacy Plan and the Standard Plan; and

WHEREAS, the Legacy Plan maintains fidelity to the DVA Plan benefits established prior to 2014 and reimburses out-of-network providers at a higher rate; and

WHEREAS, the Standard Plan was established in 2020 to help retirees offset the cost of their dental care; and

WHEREAS, the Standard Plan allows coverage for prophylaxis (cleaning) or periodontal maintenance up to two times per benefit year, or up to four times per benefit year for those with periodontal disease; and

WHEREAS, Standard Plan members can only access additional cleanings through the Oral Health Total Health (OHTH) program offered by the contracted third-party vendor, Delta Dental, which provides two additional yearly cleanings for those with diabetes, and one additional cleaning for members in their third trimester of pregnancy; and

WHEREAS, 3D dental imaging is becoming more common practice for diagnostic purposes in dentistry, and is not a covered benefit under the Standard Plan; and

WHEREAS, under the Standard Plan, the topical application of fluoride is limited to twice in a calendar year up to age 19, and for those age 19 and older, up to twice in a calendar year only if there is a history of periodontal surgery, high risk of decay due to medical disease, chemotherapy, or a similar type of treatment; and

WHEREAS, under the Standard Plan, sealant application or repair, per tooth, and preventive resin restoration for a permanent tooth of a moderate to high caries risk patient is also currently covered;

however, coverage is limited to the unrestored occlusal surfaces of permanent molars once per tooth in any five-year period; and

WHEREAS, the coverage for crowns is provided under the Standard Plan as a Class III Prosthetic Service, when necessary to restore decayed or broken teeth to a state of functional acceptability, limited to once in a seven-year period per tooth, up to the allowable amount for a metallic crown, and the difference between the metallic crown and porcelain crown is currently paid by the member; and

WHEREAS, the Division of Retirement and Benefits (Division) has proposed to consider 1) removing Delta Dental's OHTH program, and increasing Plan coverage from two, to four prophylaxis, scaling, and periodontal maintenance visits per calendar year for all Standard Plan members; 2) allowing coverage for 3D imaging, once per calendar year; 3) increasing the allowance for the topical application of fluoride from two times per calendar year based on age criteria, to four times per calendar year with no age limit, and removing current eligibility criteria for sealant application, sealant repair, preventive resin restoration in a moderate to high carries risk patient for a permanent tooth and allow once per tooth per year for each service; and 4) reducing the frequency limit from once per tooth every seven years, to once per tooth every five years and updating the reimbursement allowance from the allowable amount for a metal crown, up to the allowable amount for a porcelain crowns, as outlined in detail in the Program Proposal presented to the Retiree Health Plan Advisory Board on July 21, 2025 (Program Proposal); and

WHEREAS, the Program Proposal has been evaluated by an independent certified Fellow of the Society of Actuaries, who found that implementing all proposed changes would result in enhancements to the Plan that are favorable for members and would have an actuarial value increase of 2.86 percent; and

WHEREAS, the Program Proposal has been evaluated by an independent certified Fellow of the Society of Actuaries, who found that the proposed change is anticipated to result in approximately $870,000, or 1.46 percent in additional annual claim costs to the Plan; and

WHEREAS, the Division has solicited public comments on the Program Proposal to enhance the dental benefits under the Standard Plan, which resulted in 100% of public comments in favor of the implementation; and

WHEREAS, the Division's analysis has included: evaluation of the need and rationale for the proposed change, data analysis based on actual experience, evaluation of the impact of the changes to the current benefits; evaluation of any gaps, restrictions, reductions, eliminations, expansions, or additions to the current benefits; the number of members potentially impacted by changes and the seriousness of any impacts;

NOW THEREFORE, BE IT RESOLVED THAT THE RETIREE HEALTH PLAN ADVISORY BOARD recommends the AlaskaCare Standard DVA Plan implement the proposed enhancements to the dental benefits, as outlined in the Program Proposal submitted to the Board on July 21, 2025, to be effective January 1, 2026.

DATED this 6th day of October 2025.

Open Enrollment

Dental-Vision-Audio (DVA) open enrollment for the 2026 Plan year begin Wednesday November 5th and end at 5:00 pm on Wednesday November 26th. The annual DVA open enrollment guide will arrive by mail and will review the differences between the Legacy and Standard DVA plans. It will include all changes that took effect in 2025 and the enhancements to the Standard Dental Plan for 2026.

Vaccine Coverage

We understand there's growing concern about potential changes to COVID vaccine coverage, especially considering recent editorials. Currently, the Division is not aware of any final decisions that alter current vaccine recommendations. Rest assured, recommended vaccines remain covered benefits under your AlaskaCare Retiree Health Plan.

Here's what retirees can count on:

- AlaskaCare Health Plans are evidence-based.
- Medically necessary services and supplies are covered.
- If a vaccine or immunization is recommended by recognized U.S. health authorities, it will be covered for the population it's intended for.
    - For more details, see Section 3.3.1 on page 31 of your AlaskaCare Retiree Insurance Information Booklet.

Looking ahead:

- If national guidelines change, coverage may adjust accordingly.
- Potential plan changes will go through the accepted process.
- New vaccine recommendations could be added to coverage.
- Vaccines that lose recommendation status or FDA Emergency Use Authorization may be removed from coverage.

We'll continue monitoring developments and will share updates as soon as more information becomes available.

From section 3.3.11 in the AlaskaCare Retiree Insurance Information Booklet, Immunizations covered by the Plan include those, "recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention: Immunizations for infectious disease; and materials for administration of immunizations."

Excerpted from page 44.

3.3.11 Preventive Care and Screening Services

The purpose of providing preventive care benefits is to promote wellness, disease prevention and early detection by encouraging **covered persons** to have regular preventive examinations to identify potential health risks and provide the opportunity for early intervention. This section describes **covered expenses** for preventive care and supplies when you are well.

The recommendations and guidelines referenced in this section will be updated periodically. This plan is subject to updated recommendations or guidelines that are issued by the following organizations beginning on the first day of the **benefit year**, one year after the recommendation or guideline is issued:

a) Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
b) United States Preventive Services Task Force;
c) Health Resources and Services Administration; and
d) American Academy of Pediatric/Bright Futures Guidelines for Children and Adolescents.

Excerpted from page 47.

Preventive Care Immunizations

Covered expenses include charges made by your **physician** or a provider for immunizations for infectious diseases that have been recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention: Immunizations for infectious disease; and materials for administration of immunizations.

Excerpted from page 46.

Routine Physical Exams

Covered expenses include charges made by your **physician** or other **health professional** for routine physical exams. This includes routine vision and hearing screenings given as part of the routine physical exam. A routine exam is a medical exam given by a **physician** or other **health professional** for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**, and also includes:

a) Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.

b) Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration Guidelines for Children and Adolescents.

c) Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include, but are not limited to:

- Screening and counseling services, such as:
    - Interpersonal and domestic violence;
    - Sexually transmitted diseases; and
    - Human Immune Deficiency Virus (HIV) infections.
- Screening for gestational diabetes for women.
- High risk Human Papillomavirus (HPV) DNA testing for women aged 30 and older.

d) X-rays, lab and other tests and radiological services given in connection with the exam.

e) For covered children, from birth to age 2:

- an initial **hospital** checkup
- periodic well child exams
- consultation between the health professional and a parent

Drug prices in the United States and the Effect of Tariffs

The Division continuously monitors the costs of drugs and all related pharmacy plan expenses. Despite the current concerns regarding the possible impacts of tariffs on drug prices, it's too early to speculate how the market will react. The Division will have sufficient forewarning (years) to act should the trust fund start to deplete prematurely. The Division will monitor any emerging cost trends and share information transparently through the quarterly reporting and ARMB meetings. Currently, there is no plan to change prescription drug benefits.

Potential Phone Scams

Our members are reporting an uptick in spam or fraudulent calls from all vendors. Being under continuous attack may even be the new normal. Our team is working to respond to this by drafting articles for our newsletters and our website. We'll also be working with our vendors to make sure their agents know how to best help our members calling to verify if a contact was real. The Division is working with all vendors and our own agents to provide training and member-facing information.

LTC Family Caretaker Exclusion

LAW recently advised the Division that the AlaskaCare Long-Term Care Plans cannot provide benefits for services provided by family members or persons living in the Plan holder's residence because IRS rules exclude this for tax qualified plans.

Statutory Requirement for Medicare as Primary

LAW recently advised that in review of AS 39.35.535(b) (which AS 39.30.090 cites), the statute is clear that the benefits payable to persons age 65 or older supplement any benefits provided under the federal old age, survivors, and disability insurance program. 3.1.7 in the AlaskaCare Retiree Insurance Information Booklet reinforces this by explaining that AlaskaCare is supplemental to Medicare. This has been the case since 1975 when the statute was created. Thus, to change the Booklet in the way RHPAB is seeking to do would likely require a legislative change to amend AS 39.35.535.

State of Alaska

AlaskaCare 2026 Premium Rate Development

Medical and Pharmacy
Dental, Vision, and Audio
Long-Term Care

October 2025

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Segal

Premium Rate Development

- At its most basic level, premium rates are developed to cover claims costs as well as administrative and operational expenses
- In many plans, this is considered over a multi-year period and balances other considerations, such as:
  - Annual premium rate stability/volatility
  - Premium rate competitiveness
  - Managing risk and selection
  - Equity between plan and coverage options
  - Timing difference between premium revenue and expenses

Primary objective is the overall financial health and viability of the entire plan over the long term

Premium Rate Development – Med/Rx

1. For the Medical/Rx plan, recent claims experience is trended forward to the next plan year to get projected claims
   - There are generally little/no changes to consider
   - Rates are by coverage tier, but do not differ by Medicare status
   - Net of Rx rebates, EGWP and RDS subsidies
2. Add administrative and operational costs to projected claims to get initial full premium
3. Rates are used to determine contributions for a small number of retirees
   - There are less than 150 Retirees on the Defined Benefit plan that pay contributions
4. Long-term (employer and State) funding is determined by the Retiree Health/OPEB valuation as part of the overall pension/retirement actuarial valuation

Retiree Health liability is well funded, supported by $14.2B in assets

2026 Inflation Reduction Act (IRA) Impact

- Part D Base Subsidy
  - Base subsidy increasing from $142.67 PMPM to $200.28 in 2026, before risk and other adjustments
  - Additional $10.00 provided for participating in CMS Premium Stabilization Demonstration Program
    - Decrease from $15 in 2025. Future is uncertain for 2027+
- Part D Max OOP increases to $2,100 from $2,000 for 2026
- First year of Manufacturer Fair Price
  - CMS identified 10 high-cost drugs and negotiated fixed net prices for entire Part D program

Januvia	Fiasp/Novolog	Farxiga	Enbrel	Jardiance
Stelara	Xarelto	Eliquis	Entresto	Imbruvica

  - Results are lower claims costs and elimination of rebates, resulting in savings for these drugs, which is estimated to be about $9M in net savings in 2026
  - 15 additional drugs for 2027 and more in 2028+

Increase in EGWP subsidies and lower net costs for 10 MFP drugs should offset rising Rx costs

Medical/Pharmacy Projection

- Segal projects the following financial results for Calendar Year (CY) 2026:

	CY2026
Total Projected Claims	$912,503,000
Administration and Operational Expenses	$23,680,000
Pharmacy Contract Renegotiation/RFP	$0
Rx Rebates	($89,000,000)
EGWP/RDS Subsidy	($172,348,000)
Total Projected Cost	$674,835,000
Premium Based Revenue*	$625,820,000
$$ Funding Overage/Gap	($49,015,000)
% Funding Overage/Gap	(7.8%)

* Medical/Rx revenue is based on all participants at the Retiree composite rate x 12. A small number of retirees that pay premiums pay these rates and the revenue figure provided is illustrative of the annual revenue that would result from all retirees paying the current rates. State and Employer contributions are payroll based and not reflected in this projection.

- Claims experience continues to increase due to overall market conditions combined with a slowing in the overall shift of members from non-Medicare to Medicare status
- Rates were increased by 5% in CY2025 but unchanged CY2024
- Ongoing growth in Medicare membership continues to help offset increases in aggregate per capita costs due to trend. A Medicare primary participant costs approximately 55-65% less than a non-Medicare primary participant
- Continued shifts in the projected EGWP subsidies due to the Inflation Reduction Act
- Recommendation is to increase rates for 2026 by 5.0%

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Medical and Pharmacy

- Medical/Rx per member per month (PMPM) plan experience for FY23 – FY25:

	Period 1	Period 2	Period 3	P1=> P2	P2=> P3
	Jul '22-Jun '23	Jul '23-Jun '24	Jul '24-Jun '25		
Members <65 PMPM	**$1,436.16**	**$1,563.95**	**$1,621.90**	**9%**	**4%**
Members 65+ PMPM	**$551.20**	**$601.68**	**$729.57**	**9%**	**21%**
Composite PMPM	**$729.91**	**$783.02**	**$886.55**	**7%**	**13%**

Note: Subscriber's plan is used to determine dependent's age for over/under age 65 status.

- The projected claims reflect an increase in medical trend year over year
- Trend increases are consistent for Medicare and non-Medicare groups
- Increase in Medicare membership (as a %) has slowed and is now about 83%
- A Medicare primary participant costs approximately 55-65% less than a non-Medicare primary participant. Slowing shift towards Medicare has tempered the associated trend offset
- The transition to the Employer Group Waiver Plan (EGWP) from the Retiree Drug Subsidy (RDS) is providing additional drug subsidies and rebates from the federal government and will continue to mitigate trend
- IRA provided an initial improvement in EGWP subsidies, but annual changes continue to be monitored.

CY2026 Medical and Pharmacy Funding Rates

- Segal is recommending a 5.0% increase in the contribution rates for CY2026.

Baseline	CY2025	CY2026	$$ Change	% Change
Medical - Composite	$1,098.00	$1,153.00	$55.00	5.0%
Medical - Tier II/III Retiree Only	$739.00	$776.00	$37.00	5.0%
Medical - Tier II/III Retiree & Spouse	$1,478.00	$1,552.00	$74.00	5.0%
Medical - Tier II/III Retiree & Child	$1,045.00	$1,097.00	$52.00	5.0%
Medical - Tier II/III Retiree & Family	$1,784.00	$1,873.00	$89.00	5.0%
Baseline Annual	$625,820,472	$657,168,492	$31,348,020	5.0%

Premium Rate Development - DVA

1. For the DVA plan, recent claims experience is trended forward to the next plan year to get projected claims
   - Claims are adjusted for prior, and upcoming changes
2. Add administrative and operational costs to projected claims to get initial full premium
3. Factor in long-term considerations to determine final rates

DVA Plan is well reserved, resulting in final rates determined so that premiums in the near-term manage long-term solvency issues and future premium increases when "excess" reserves are spent

Background

- The Legacy Plan was re-introduced effective January 1, 2020 and replicates the plan that was in effect prior to January 1, 2014. The 2020 Standard Plan reflects the benefits that were in effect beginning in 2015 with minor/typical annual modifications.
- After a review of 2021-22 experience indicated that the two plans' experience was comparable, the Legacy Plan's 2023 contribution rates were lowered to be the same as the Standard Plan's contribution rates.
- Effective January 1, 2025, the Standard plan introduced the Prevention First program, increased the dental plan maximum by $1,000, adjusted the vision plan copay and network structure.
  - No changes were made to the Legacy Plan.
- Based on preliminary financial statements, the total assets ($12.4M) to IBNR ($4.2M) ratio is 297% as of June 30, 2025.
  - This is a decrease from $17.0M in assets and a 388% ratio at FYE2024.
  - Total assets may be adjusted as of the final audited financial statements.
- The current target ratio is a range from 150% to 250%, which equates to $6.3M to $10.5M in assets.
- The June 30, 2025 assets utilized in this analysis are based on the initial and unaudited statements provided by DRB. Final audited statements are not anticipated to vary significantly from those already provided.
  - The assets to IBNR ratio may change as part of the updates to the audited financial statements.

2025 Plan Changes Summary

- The following changes were made to the Standard Plan effective January 1, 2025:
  - Increasing the plan maximum from $2,000 to $3,000
  - Adding Prevention First
  - Introducing a vision network and adjusting plan coverages
  - The projected impact on the Standard Plan premiums for these changes is -1.3% (-$1 pmpm)
- There currently is not enough claims experience to determine the actual impact of the plan changes.
  - Twelve months of data is the minimum amount required.
- However, the plan continues to be impacted by migration from the Legacy to the Standard plan. This is continuing to affect the overall spend on the plans as the overall mix of utilizers versus non-utilizers adjusts between the two plans.

2026 Plan Changes

- The following plan changes have been approved (by the RHPAB) for consideration for the Standard Dental plan effective January 1, 2026:
  - Preventive Cleanings: Remove Delta Dental's OHTH program, and increase Plan coverage from two, to four prophylaxis, scaling, and periodontal maintenance visits per calendar year for all members.
  - X-Rays and Imaging: Allow Plan coverage for 3D imaging, which is currently a Plan exclusion, once per calendar year.
  - Crowns: Reduce the frequency limit from once per tooth every seven years, to once per tooth every five years. Update the reimbursement allowance from the allowable amount for a metal crown, up to the allowable amount for a porcelain crown.
  - Other Class I Changes: Increase the allowance for the topical application of fluoride from two times per calendar year based on age criteria, to four times per calendar year with no age limit. Remove current eligibility criteria for sealant application, sealant repair, preventive resin restoration in a moderate to high carries risk patient for a permanent tooth and allow once per tooth per year for each service.

2026 Plan Changes Cost

- Below is a summary of the potential cost for each of the plan changes on the Standard Dental plan:

Plan Change	Annual Cost (CY26)	Premium Impact (Retiree Only)
Preventive Cleanings	$200,000	$1.00
X-Rays and Imaging	$240,000	$1.00
Crowns	$240,000	$1.00
Other Class I Changes	De Minimis	N/A

Dental, Vision, and Audio Funding Rates
Proposed Premiums with Plan Changes

- Segal is recommending a rate increase of 6.0% increase to the Legacy Plan and 8.5% increase to the Standard to account for the 2026 plan design changes. This increase is slightly higher than trend, which is necessary to continue the managed spend-down and achieve a “soft landing”.

Standard Plan Rates	2025	2026	$ Change
Retiree	$71.00	$77.00	$6.00
Retiree & Spouse	$142.00	$154.00	$12.00
Retiree & Child	$129.00	$140.00	$11.00
Retiree & Family	$202.00	$219.00	$17.00
Legacy Plan Rates	**2025**	**2026**	**$ Change**
Retiree	$75.00	$80.00	$5.00
Retiree & Spouse	$149.00	$158.00	$9.00
Retiree & Child	$135.00	$143.00	$8.00
Retiree & Family	$212.00	$225.00	$13.00

2026 DVA Projections
Proposed Premiums with Plan Changes

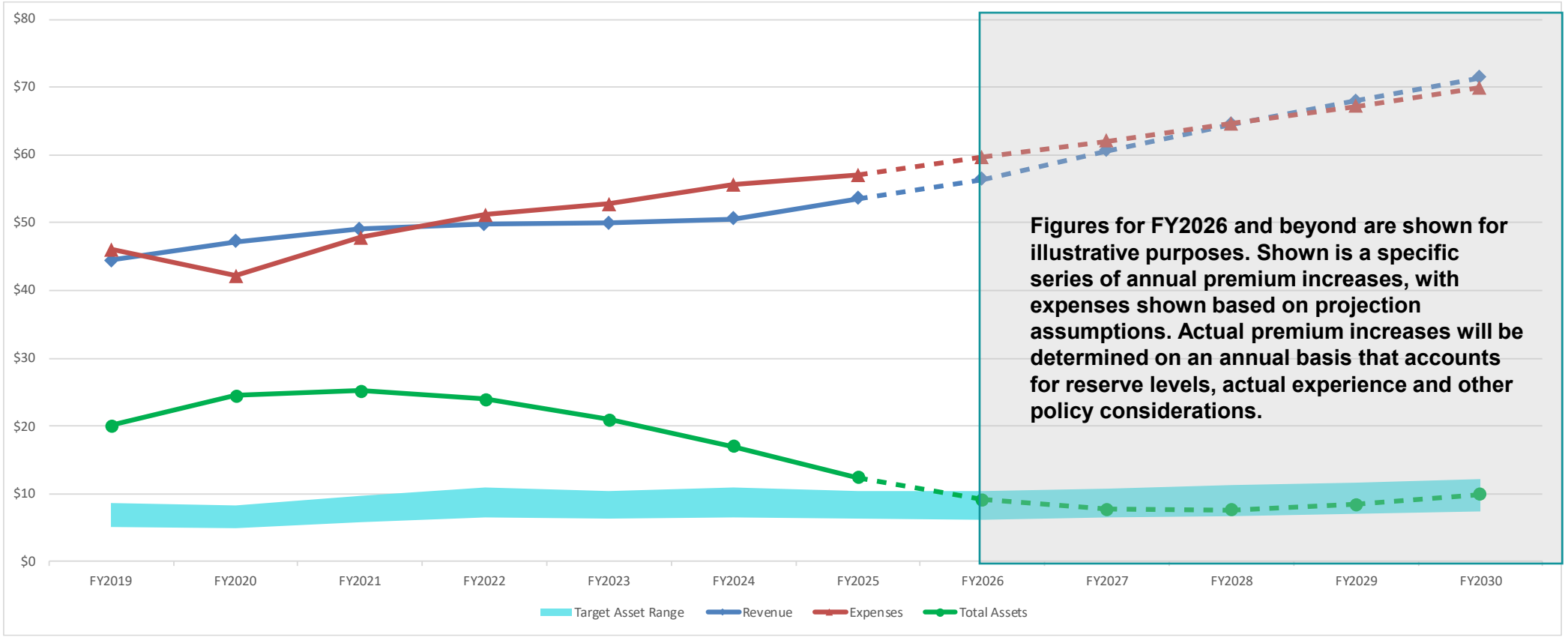
- Segal projects the following financial results for CY2026.
  - This is assuming the recommend contribution rate increases (6.0% Legacy, 8.5% Standard) effective January 1, 2026:

	Legacy	Standard	**Total**
Total Projected Claims	$27,018,012	$31,353,342	$58,371,354
Administration and Operational Expenses	$1,042,951	$1,201,472	$2,244,424
Total Projected Cost	$28,060,963	$32,554,814	$60,615,777
Premium Based Revenue	$27,420,639	$30,552,108	$57,972,748
$$ Funding Overage/Gap	($640,324)	($2,002,706)	($2,643,030)
% Funding Overage/Gap	(2.3%)	(6.6%)	(4.6%)

- These rate increases will further temper the spend-down rate and it is expected that assets will be within the target funding range by FYE2026.
- Included is an **illustrative** series of future increases to manage the spend down of assets and minimize future shock increases.

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 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.

Projected DVA Revenues, Expenses, Net Assets ($millions)
Increases for CY26 and Subsequent Years – Including Plan Changes



	Eff 1/1/2025	Eff 1/1/2026	Eff 1/1/2027	Eff 1/1/2028	Eff 1/1/2029
Legacy Plan		**Illustrative Rates Only**			
Rate Increases	8.0%	6.0%	6.0%	5.0%	4.0%
EE	$75.00	$80.00	$85.00	$89.00	$93.00
EE+SP	$149.00	$158.00	$167.00	$175.00	$182.00
EE+CH	$135.00	$143.00	$152.00	$160.00	$166.00
EE+Fam	$212.00	$225.00	$239.00	$251.00	$261.00

	Eff 1/1/2025	Eff 1/1/2026	Eff 1/1/2027	Eff 1/1/2028	Eff 1/1/2029
Standard Plan		**Illustrative Rates Only**			
Rate Increases	3.0%	8.5%	6.0%	5.0%	4.0%
EE	$71.00	$77.00	$82.00	$86.00	$89.00
EE+SP	$142.00	$154.00	$163.00	$171.00	$178.00
EE+CH	$129.00	$140.00	$148.00	$155.00	$161.00
EE+Fam	$202.00	$219.00	$232.00	$244.00	$254.00

Premium Rate Development - LTC

For the LTC plan, the benefits are paid well after the premiums are paid. Therefore, a long-term view is necessary

1. Project forward all anticipated benefits (and expenses), accounting for assumed mortality, morbidity, lapses, etc
2. Project forward all anticipated premium revenue (at current rates), accounting for assumed mortality, morbidity, lapses, etc
3. Add net difference between projected benefits and premiums and factor in assumed investment returns
4. If present value of net assets is greater than $0, then current premiums are anticipated to be sufficient.

Segal recommends maintaining current premium rates through the next actuarial valuation. The 2023 valuation continues to show a funded status over 100%, and assets have increased substantially during FY2025.

However, care should be exercised before modifying premiums rates based on short term gains (or losses).

LTC Valuation Results (June 30, 2023)

Component	6/30/2021 ($000)	6/30/2023 ($000)
1. PV of Future Benefits	$779,931	$803,949
2. PV of Future Expenses	$8,503	$8,636
3. PV of Future Premiums (PVFP)	$336,381	$331,774
4. Valuation Liabilities (=3 – 1- 2)	($452,053)	($480,538)
5. Valuation Assets	$696,258	$681,985
6. Valuation Margin (= 5 + 4)	$244,205	$201,447
7. Margin as a % of PVFP (= 6/3)	72.6%	60.7%
8. Funded Status (= 5/4)	154.0%	141.9%

Total Long-term care assets as of June 30, 2025 are $958,615,564 based on draft financial statements.

Historical LTC Funded Status

Valuation Date	Margin ($000)
May 31, 2012	$30,289
June 30, 2015	$27,244
June 30, 2017	$7,372
June 30, 2019	$94,564
June 30, 2021	$244,205
June 30, 2023	$201,447

Questions?

Executive Summary	Diagnostic Colonoscopy Coverage (R032)
Health Plan Affected	Defined Benefit Retiree Plan
Proposed Effective Date	January 1, 2026
Reviewed By	RHPAB Modernization Committee; RHPAB
Review Date	June 13, 2025; July 21, 2025

1) Background

A colonoscopy is a procedure to check for any abnormal tissue, polyps, or other signs of cancer in the colon or rectum. There are two types of colonoscopies: screening and diagnostic.

- A diagnostic colonoscopy is a procedure furnished to a person with signs and symptoms of colorectal cancer, a prior positive colorectal cancer screening (such as Cologuard at home testing), or a personal history of polyps, abnormal tissue, or gastrointestinal conditions or symptoms.
- A screening colonoscopy is a procedure furnished to a person without signs or symptoms of gastrointestinal conditions, no family or personal history of colorectal cancer, and no previous polyps or other irregularities in the large intestine, for the purpose of early detection of colon cancer.

Currently, diagnostic colonoscopies are subject to the medical Plan's general benefit provisions, and covered at 80% of the recognized charge, with a retiree coinsurance of 20%. Under the preventive care provisions, screening colonoscopies are covered at 100% of the recognized charge when received in-network, or when precertification is obtained when a network provider is not available. The Division is considering the removal of the members' coinsurance for non-preventive colonoscopy services when received in-network.

2) Objective

Provide access to colonoscopies for diagnostic purposes at a minimal cost for our members.

3) Summary of Proposed Change

The AlaskaCare Retiree Health Plan would remove the member coinsurance for colonoscopies when received in-network. The deductible would still apply.

4) Impacts

Actuarial Impact to AlaskaCare | Increase

The Division's contracted benefit consultant (Segal) has estimated an actuarial value increase for the Plan to be between 0.01% and 0.02%.

Financial Impact to AlaskaCare | Minimal

The financial impact to the Plan, based on the retiree medical and pharmacy claims projection of $856,400,000 for 2025 (dated September 27, 2024) and trended forward at 7% to $916,400,000 for 2026, equates to approximately $100,000 to $155,000 in additional annual costs to the Plan, which equates to 0.01% to 0.02%.

Member Impact | Enhancement

Members of the Retiree Plan would benefit from the ability to access diagnostic colonoscopies without

coinsurance.

Operational Impact (DRB)| Minimal

The Division anticipates minimal operational impacts. The Division will follow the standard process for making plan changes per 2 AAC 39.390 and provide directions to the Third-Party Administrator to implement the benefit change. Once the implementation activities are complete, the Division does not anticipate any additional operational impact.

Operational Impact (TPA) | Minimal

The impact to the Third-Party Administrator (TPA) is anticipated to be low.

Provider Impact |Minimal

The provider impact is estimated to be minimal.

5) Implementation and Communication Overview

Division staff will follow the standard process for making changes to the Defined Benefit Retiree Plan, which includes completion of the following:

- Proposal analysis and stakeholder input
- Public comment period(s)
- Any needed language updates to the Retiree Insurance Information Booklet

6) RHPAB Recommendations

The Retiree Health Plan Advisory Board voted on Month/Day 2025 to recommend/not to recommend implementation of this proposal.

Description	Date
Proposal Drafted	May 2025
Reviewed by Modernization Subcommittee	June 13, 2025
Reviewed by RHPAB	July 21, 2025

Segal

Richard Ward, FSA, FCA, MAAA
West Region Market Director, Public Sector
T 956.818.6714
M 619.710.9952
RWard@Segalco.com

500 North Brand Boulevard
Suite 1400
Glendale, CA 91203-3338
segalco.com

Memorandum

To: Steve Ramos, Chief Health Administrator, Division of Retirement and Benefits

From: Richard Ward, FSA, FCA, MAAA

Date: April 21, 2025

Re: Removal of Cost Share for Non-Preventive Colonoscopies (Retiree Plan)

The State is considering removal of cost-sharing for non-preventive colonoscopy procedures, including sigmoidoscopy, as a benefit under the Retiree Plan.

Currently, the plan covers routine cancer screening colonoscopies based on age, family history, and frequency guidelines, which are:

a. Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force; and

b. Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration.

c. Found in the American Cancer Society guidelines for colorectal cancer screening.

However, when there is a diagnostic need for a colonoscopy or related screening, 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	$8,000,000	
Prescription Drugs	Up to 90 Day or 100 Unit Supply	
Up to 90 Day or 100 Unit Supply	Generic	Brand Name
Network pharmacy copayment	$4	$8
Mail order copayment	$0	$0

Actuarial Value

Most colonoscopy procedures are preventive in nature and are currently covered with no cost share requirement from the member. As a result, the inclusion of this benefit for the Plan can be viewed as an enhancement favorable that will have a slight impact on actuarial value. The anticipated increase in actuarial value for the plan is anticipated to be between 0.01% and 0.02%.

Financial Impact

Segal's analysis included a comprehensive review of colonoscopy claims with member cost share greater than $0 without restriction based on a diagnostic categorization. We then projected forward based on future expectations of costs.

Based on the most recent retiree medical and pharmacy claims projection of $856,400,000 for 2025 (dated September 27, 2024), and trended forward at 7% to $916,400,000 for 2026, this equates to approximately $100,000 - $155,000 in additional annual costs to the Plan, which equates to 0.01% to 0.02%. Depending on the effective date of the plan change, there could be a partial fiscal year impact during the first year.

Additional Notes

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

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benefits for active, disabled, or terminated employees during a period other than that which is referred to in the projection, nor does it reflect any anticipated increase in the number of those eligible for retiree benefits, or any changes that may occur in the nature of benefits over time.

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cc: Chris Murray, Division of Retirement and Benefits
Ronan Tagsip, Division of Retirement and Benefits
Noel Cruse, Segal
Amy McClendon, Segal
Quentin Gunn, Segal