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**Retiree Health Plan Advisory Board
Modernization Committee
Meeting Agenda**

Meeting: Modernization Committee
Date: October 30, 2018
Time: 9:30am -12:30pm
Location: **Anchorage:** Atwood Building, 550 W 7th, 19th Floor Conf. Room
Juneau: State Office Building, 6th floor Conf Room
Teleconference: **1-855-244-8681 / Event number: 286 717 599**
WebEx Link:
<https://stateofalaska.webex.com/stateofalaska/onstage/g.php?MTID=e253a21583a25b0d48aacb14f40401f7c>

Committee Members: Cammy Taylor (chair) and Joelle Hall

October 30, 2018

9:30am **Call to Order Cammy Taylor**

- **Approve Agenda**
- **Approve previous Meeting Minutes**
- **Introductions**

9:40am **Public Comment**

- **Read the Oral Public Comment Script**

10:00am **Discuss Analysis – DRB Presentations**

- **Enhanced Travel Benefits with Wrap**

11:00am **Break**

11:20am **Continue to Discuss Analysis – DRB Presentations**

- **Network Incentives**

12:25pm **Final Thoughts**
Announce date of next meeting

12:30pm **Adjourn**

Meeting Minutes

9/28/18

Retiree Health Plan Advisory Board

Modernization Committee Meeting Minutes

Date: Friday, September 28, 2018 9:30 a.m. to 12:30 p.m.

Location: State Office Building 333 Willoughby Avenue 10th Floor Juneau, AK 99801 and
Robert B. Atwood Building 550 West 7th Avenue, Suite 1970, Anchorage, AK 99501

Meeting Attendance

Name of Attendee	Title of Attendee	Attendance
<i>Retiree Health Plan Advisory Board (RHPAB), Modernization Committee Members</i>		
Mark Foster	Committee Chair	Present
Joelle Hall	Committee Member	Present
Cammy Taylor	Committee Member	Present
Judy Salo	Board Chair	Present
<i>State of Alaska, Department of Administration Staff</i>		
Ajay Desai	Director, Division of Retirement + Benefits (DRB)	
Michele Michaud	Deputy Director + Chief Health Official, DRB	
Emily Ricci	Chief Health Policy Official, DRB	
Andrea Mueca	Health Operations Manager, DRB	
Betsy Wood	Health Policy Manager, DRB	
Vanessa Kitchen	Administrative Assistant, Office of the Commissioner	
<i>Others Present + Members of the Public</i>		
Richard Ward	Segal Consulting (actuary for AlaskaCare plans)	
John Zutter	CEO, Surgery Plus	
Wendy Wolf	Retired Public Employees Association (RPEA)	
Anna Brawley	Agnew::Beck Consulting (contracted meeting support)	

Common Acronyms

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

- ACA = Affordable Care Act (formal name: Patient Protection and Affordable Care Act)
- CMS = Center for Medicare and Medicaid Services
- DB = Defined Benefit plan (for Tier 1, 2, 3 PERS employees and Tier 1, 2 TRS employees)
- DCR = Defined Contribution Retirement plan (for Tier 4 PERS employees and Tier 3 TRS employees)
- DOA = State of Alaska Department of Administration
- DRB = Division of Retirement and Benefits, within State of Alaska Department of Administration
- DVA = Dental, Vision, Audio plan available to retirees
- EGWP = Employer Group Waiver Program, a federal program through Medicare Part D that provides reimbursement for retiree pharmacy benefits
- EOB = Explanation of Benefits, provided by the plan administrator detailing claims coverage
- HIPAA = Health Insurance Portability and Accountability Act (1996)
- HRA = Health Reimbursement Account, a mechanism for the employer to reimburse high-income Medicare enrollees for any premium charge for their Medicare plan (IRMAA)
- IRMAA = Income Related Monthly Adjustment Amount, a surcharge from CMS for a Medicare plan for individuals or households earning above certain thresholds
- MAGI = Modified Adjusted Gross Income, based on an individual or household's tax returns and used by CMS to determine what if any premium must be paid for a Medicare plan.
- OPEB = Other Post Employment Benefits; an accounting term used to describe retirement benefits other than pension benefits
- OTC = Over the counter medication, does not require a prescription to purchase
- PBM = Pharmacy Benefit Manager, a third-party vendor that performs claims adjudication and network management services
- PHI = protected health information, a term in HIPAA for any identifying health or personal information that would result in disclosure of an individual's medical situation.
- RDS = Retiree Drug Subsidy program (the pharmacy subsidy program AlaskaCare currently has)
- RHPAB = Retiree Health Plan Advisory Board

Meeting Minutes

Item 1. Call to Order + Introductions

Committee Chair Mark Foster called the meeting to order at 9:35 a.m. The committee conducted roll call for members present.

- **Motion** by Cammy Taylor to approve the meeting agenda. **Second** by Joelle Hall.
- **Result:** No objection. Meeting agenda approved.

The committee briefly reviewed the minutes from the August 10 committee meeting.

- **Motion** by Joelle Hall to approve the previous meeting minutes. **Second** by Cammy Taylor.
 - Cammy Taylor noted that there is a typo on page 3 of the minutes, the second motion should state that the minutes were approved, not the agenda. This typo will be corrected.
- **Result:** No objection. Minutes from the previous meeting approved.

Item 2. Public Comment (Part 1)

No one present in the meeting provided public comments.

Item 3. Continue Discussion + DRB Analysis of Modernization Proposals

Materials: Modernization Topics Table in 9/28/18 meeting agenda packet

Mark Foster invited staff to present an update and frame the discussion about modernization.

Modernization Table: Identify Next Items for Analysis

Emily Ricci noted that the table of modernization topics (page 27 in packet) is the same information shared in the August 29 meeting; the table has been formatted to fit a portrait page, but the content did not change. This table was originally developed in May 2018 and shared with the Board. Items 13, 14 and 15 were added in response to public comments requesting these services: 13. *Rehabilitative Services*, 14. *Wellness Benefits*, and 15. *Medically Necessary Treatment for Gender Dysphoria*, including gender reassignment surgery.

The four items already discussed are: 1. *Expand Preventive Coverage*, 2. *Remove or Increase Lifetime Limit of Benefits*, 7. *Enhance Travel Benefits*, and (both) 8. *Implement Clear Service Limits for Rehabilitative Care* and 13. *Expand Rehabilitative Care*, such as acupuncture. Staff conducted analysis of these four proposals, which will be continued to be discussed today. Staff is seeking guidance from the Board, through this committee, on additional proposals to consider. Emily noted that the four proposals discussed would add benefits to the members, and may therefore increase the overall value of the plan and cost to the State. It is a balancing act, and the State must consider other proposals that, when the package is considered as a whole, will not add to the State's unfunded liability or increase the value of the plan in an unsustainable way.

Staff propose considering offsets that specifically can leverage the State's purchasing power and can therefore bring value to members as well. For example, contracts with providers and networks are a means of managing costs by having a preference or incentive for seeking services within the network instead of from an out of network provider, who has not negotiated the prices within the network.

These types of incentives are known as “steerage,” designed to incentivize members to seek care from in-network providers by having less out of pocket cost to the member. This is proposed as #11 on the modernization topics table.

The retiree health plan does not have any of these mechanisms currently, due in part to the fact that there has not been a wide network in Alaska and there were limited options for many people who don’t live in urban areas. Emily noted that this has been changing over the past 3 to 5 years; it is appropriate to re-evaluate the merits of this mechanism and discuss including it in the plan. Currently, state regulations require that fully-insured health plans cover health services at the 80th percentile for out of network providers; however, the retiree plan is not subject to those regulations and actually pays at the 90th percentile for out of network providers. It is challenging because some providers in Alaska are incentivized to stay out of a network because they will get paid more than they would within the network, and the plans do not disincentivize this choice. Staff propose exploring a change to this policy, resulting in out of network providers being reimbursed at a lower rate than in-network providers. This could be added to the list of topics as #16.

Additionally, higher prices in this health plan also result in members paying more: if a provider charges \$200 for a service to this plan and \$150 for the same service under other plans, the State is paying more on this claim, the members are paying more in the form of deductibles and out of pocket costs, but the level of service remains the same.

Another proposal to consider: instead of requiring members to pay a deductible and then coinsurance, establishing a co-pay for primary care services. Further analysis is required to identify appropriate copay rates. The copayment could potentially accrue to a member’s deductible and out of pocket maximum. This would be beneficial to the member and incentivize use of primary care services. This could be added to the list of topics as #17.

- Joelle Hall asked whether the health plan is subject to the 80th percentile rule?
 - Emily Ricci explained that the State plan is not subject to the rules of the Division of Insurance, and therefore the 80th percentile rule does not apply. However, the State is subject to its own 90th percentile rule, even more favorable to out of network providers.
- Joelle Hall asked for clarification about the proposal regarding out of network providers? Can #11 and the new #16 be considered together, or can they be considered separately?
 - Emily responded the proposals are connected, but could be considered separately. There is a risk of implementing a lower reimbursement rate for out of network providers, because the provider could still balance bill (pass the cost of what the insurance company does not cover on to the patient). Considering them together would create more leverage in price negotiations, but, they are different proposals and will be analyzed separately.
- July Salo asked staff to highlight, where applicable, how these proposals might impact members who are Medicare eligible versus those who are not?
 - Emily responded that patients are protected from balance billing under Medicare, per the requirement that they agree to the Medicare rates and do not bill patients above that rate. Participation in a network is also a contractual agreement to not balance bill.
 - This is particularly an issue for specialty care, where there is the highest risk of balance billing because there is lower participation of Alaska specialty providers in network . There is less of a disparity between in network and out of network care for primary care services.

- Michele Michaud added that the 80th / 90th percentile rules are designed to protect members against the insurance company not covering enough of the bill, but the consequence is also providers' disincentive for participating in networks in Alaska.
- Emily also noted that there is a shift toward participating in the network in the last few years, and large group plans in particular are implementing stronger steerage rules in order to get better value for their plan.
- Cammy Taylor asked how this would be different for members enrolled in Medicare?
 - Emily Ricci responded that there will not likely be significant impacts because providers agree to certain terms when accepting Medicare patients.
 - A service that is not covered by Medicare would still be covered by AlaskaCare the same way it is for those who are not Medicare eligible.
- Judy Salo commented that she noticed how many people on the last Town Hall event lived outside Alaska. Is it difficult to find out of network providers out of state?
 - Emily Ricci answered that in general, the national network of major providers is more robust than in Alaska. One notable out of network provider that members prefer to use is the Mayo Clinic in Arizona, who has refused to join the network. The State asks the plan's third party administrator to include the broadest network possible. However, some rural areas face similar challenges to Alaska. One of the bigger differences is that out of network providers in other states typically are reimbursed at lower levels than what the retiree plan reimburses at now, so balance billing is not as much of an issue outside Alaska.
- Judy Salo asked about the implications of changing the reimbursement methodology within Alaska?
 - Emily Ricci shared an example from the employee plan. With regards to facility charges, the employee plan has moved away from the 80th percentile to 185 percent of Medicare in the Anchorage area and outside of Alaska. The new reimbursement rate is potentially higher than what out of network providers receive from other plans in the Lower 48, but is still lower than what the plan was paying previously in Alaska.
 - For example: the retiree plan pays \$146 per member per month for ambulatory surgical centers in Alaska compared to \$92 per member per month for ambulatory surgical center services outside of Alaska.
- Mark Foster shared that when the University of Alaska changed their health plan design to reimburse at a percentage of Medicare prices, an orthopedic group began to balance bill patients with this plan. University employees were upset, as were providers, and there was pressure on this provider to reduce their rates. This provider did reduce their rates during the next negotiation with insurers. He shares this as an example that there can be significant change if these market pressures are applied, even in Alaska. He also noted that the provider market is evolving, and providers (especially specialty providers) are consolidating in response to pricing negotiations.
- Joelle Hall commented that, for example, adding the travel benefit service to the plan will provide a concrete leverage point for negotiating in-state prices for the same services. The travel benefit has a cost, but will give members options to decide whether to go out of state for this service, especially if it has the same or lower cost for high quality care. She suggests the group consider implementing the travel benefit earlier in order to provide a leverage point, and either implement the steerage proposals at the same time or shortly after if it is beneficial for other negotiations.
 - Emily Ricci responded that the group can also discuss expanding the list of travel benefits available, beyond SurgeryPlus, as a way to broaden choices for members. However, there

are situations where a member cannot travel and does not have access to an in-network provider for the service they need. The plan can discuss with the third party administrator what circumstances exceptions should be made, to not further burden members with few options. However, adding more travel benefits could also include adding in-state providers within the travel network, such as traveling to another in-state hospital for the procedure.

- Cammy Taylor commented that she would like to track the positive, negative or neutral actuarial and financial impact of each proposal, as a means of comparing how the various proposals will impact the overall value of the plan. She would like to know which proposals will add or subtract overall, to be able to better compare offsets.
She also asked what will be done with the significant savings that will be gained from implementing the EGWP pharmacy subsidies, approximately \$60 million, will those savings be factored into adding new benefits or value to the plan as part of the modernization discussion?
 - Emily Ricci noted that the EGWP administrative change did not have an actuarial impact: the change will generate more savings to the plan, but did not change the benefits directly. Similarly, the proposed travel benefit change does not impact actuarial value because it is the same level of benefit, although it does have a financial impact.
 - Cammy reiterated that communications about the modernization project should be clear about whether or not the savings from EGWP will be factored in as an opportunity to add benefits to the plan. Some have read the documents this way, and it is confusing. If the EGWP related savings should not be factored in, this should be stated more clearly. Additionally, she urged the State to look at the financial impact of these proposals and not just actuarial impact, she noted that the framework of *Duncan v. RPEA* and any subsequent judgment about this project would want to look at financial impacts, especially to retiree members. Legislators and other leaders will want to know the impacts to members.
- Joelle Hall requested that staff update the table to include the current status of each proposal and note which are being actively considered at this time.
- Cammy Taylor also requested that the table indicate which proposals will add benefit to members, versus which are cost-saving or revenue-enhancing proposals, so it is clear which ones could be used as offsets for adding new benefits. For example, some proposals will allow more leverage for the State to negotiate prices, versus a change that produces a fixed savings.
- Emily Ricci requested the committee consider what proposals the State should conduct analysis on, that have not already been analyzed. She pointed out, for example, that many members have asked for more wellness benefits (#14) or more support and lower co-pays for chronic medications and other services (#12).
 - Ajay Desai commented that staff should consider the time necessary to complete several new analyses, and proposed not defining a timeline to complete all the analyses now.
- Judy Salo asked whether the proposals for rehabilitative benefits (#11 and 16) should be combined?
 - Emily Ricci suggested that this is possible, but that the group should hear the discussion first because there are reasons not to combine these two topics.

The committee took a 15-minute break from 10:26 to 10:41 a.m.

Mark Foster invited staff to present information on the rehabilitative care benefit proposal.

Rehabilitative Care Analysis (Proposal #8)

Materials: Rehabilitative Care Analysis Memos + HealthMatters in 9/28/18 meeting agenda packet

Michele Michaud explained that the plan covers rehabilitative care as it relates to treatment of an injury or illness, and as long as there is significant improvement in function associated with the care. However, the plan does not cover preventive or maintenance visits, which includes services to maintain the patient's current level of functionality or prevent future injury or illness. This benefit has been the subject of significant confusion, because members do not understand this nuance in the benefit: approximately 1/3 of all appeals for claims denied are due to the clinical records not demonstrating that the service was associated with significant improvement for an injury or illness. The goal is to help members understand the benefit and reduce the number of claims associated with members seeking services that the plan does not cover.

To address this issue, staff is proposing a limited number of visits per year for the services, using the number of visits each year rather than the standard of "significant improvement." The initial proposal is 45 visits for outpatient rehabilitative care, a separate number of 20 visits for spinal manipulation (chiropractor services) and 10 visits for acupuncture. There is flexibility in this proposal, including the maximum number of visits, so these limits should be discussed further. Additionally, by setting a limit of number of visits, it may increase benefits to a member with a chronic condition because it may cover a larger number of visits than would be allowed now under the current standard of significant improvement.

Staff also explored the possibility of including rolfing services, but there are some challenges: rolfing professionals are not typically embedded in a physician's office and would require a separate prescription for this service. It is also not a mainstream benefit and is not a standard benefit in many other plans.

- Cammy Taylor commented that she has heard from multiple retirees and providers that while the plan benefit has not changed, in 2014 with the change to Aetna as TPA, Aetna interpreted this benefit more narrowly and imposed the standard of significant improvement. The wording in the plan booklet refers to reduction of pain as well. She noted that she is not taking a position on whether adopting a set number of visits per year is the solution, but posed questions:
 - What is the correct interpretation of the plan benefit as stated in the booklet, regarding medically necessary care?
 - What is the appropriate number of visits per year for these services?
 - If a member sees a provider who could be classified under multiple categories presented (such as sports medicine), how will it be determined which service is under which limit? She recommends speaking with providers about this issue.
 - Michele Michaud responded that there are valid concerns about how service should be covered, and staff can solicit comment from providers to better understand that perspective. However, providers also have a direct interest in the outcome of the State's decision to cover this service, so their input should be considered with this in mind. Additionally, the plan benefit has always required that the care be medically necessary, and a lot of the claims have been denied because the provider has not sufficiently documented significant improvement as required for coverage of the service.

- Judy Salo asked for clarification about the outpatient services: this includes physical, occupational and speech therapy. She also asked if there is data on the average number of visits per year for chiropractic and other services available?
 - Michele Michaud shared that she applied the number-of-visit limits as proposed, using previous years' appeals related to rehabilitative services, to estimate the impact. In 2016, this would address about half of appeals; in 2017, about 95% of appeals; and in 2018 so far, about 40% of appeals. Applying different number limits generated different resolution levels of appeals, so it is not consistent, but would address a significant number of them.
 - Judy also noted that it is difficult to define the "average" number of chiropractor visits, given that not everyone needs or wants this service. There will likely be significant resistance from a subset of members who regularly use these services for maintenance, and believe that they are effective. She also asked if Medicare covers chiropractic care, what is their criteria for medical necessity for that care, is there a visit limit? She has heard from multiple people that they are concerned about the limits on this service.
 - Michele responded that Medicare covers chiropractic care, but not massage therapy. She is unfamiliar with the current Medicare standard for the service.
- Cammy Taylor also commented that she is concerned that setting a number-of-visits limit will actually increase the costs in the plan. However, there needs to be a balance between maintaining mobility for retirees, since remaining mobile helps people stay healthy and active, and need those services. The goal with this proposal should be continued access for medically necessary care, while managing the cost potentially if this greatly increases access and utilization of the service, even where it is not medically necessary.
- Judy Salo also noted that while members have expressed concerns about this issue, the provider is often the source of the confusion or members' concern because the provider tells their patient that their plan does not cover the service. Educating providers about the benefit may be helpful.
- Cammy Taylor commented that a previous issue related to providers and coverage in the plan had been resolved by having providers and the administrator talk directly and clear up the confusion.
 - A staff member noted that the total number of appeals has gone down in 2018, but did not have the information to provide the number during the meeting.
- Joelle Hall described two different steps in the rehabilitation process: first, rehabilitation to improve a condition, such as a vehicle accident injury and needing to function better. Once they reach a more functional static point, the service becomes maintenance to stay at that level of functionality. Between those two phases, the patient could quickly use up 20 visits in a year and not have other services available, particularly when getting to a maintenance level of service.
- Cammy Taylor agreed, and also noted that there are differences between restoration after an injury, and being at risk or developing a neuromuscular condition, in which not having the services may result in the patient becoming worse. She suggested that "maintenance" should include this scenario as well. This is a separate situation from one in which people find benefit in going to the chiropractor, but the service is not medically necessary as related to a particular diagnosis.
- Mark Foster commented that in terms of process, he would like to hear from a practitioner (current or former) who is familiar with this from a medical perspective, and who can advise about appropriate limits for medical necessity and other considerations; this information could be used to determine a limit and estimated number of appeals it would likely resolve. He also requested the State research a project in Oregon, who recently went through a process to address rehabilitative

care. He would like to see a summary analysis of what other states have considered and their conclusions. He sees this as not just an administrative and financial exercise, but has medical implications and would like input from subject matter experts or learn from other states' work.

- Emily Ricci responded that one possibility is to consider a fixed limit on the front end, such as the number of visits, and then include a mechanism to consider exceptions as situations arise where more visits are medically necessary. She offered that staff can research what other states have covered, and speak with other states about their experience and what they cover. She also suggested that staff could form another working group on this topic, similar to what they are already doing with independent pharmacists to talk through the issue and gather their input and perspective. She noted that staff intend to ask members of that working group to present to the committee in the future, and this model could be used with other providers.
- Mark agreed this would be very beneficial. He suggested the State set clear boundaries with providers regarding what plan benefits will be considered, so the discussion stays focused.
- Emily noted that the conversation should not include discussion of price and network negotiations, which often come up quickly but are not the purpose of a working group.
- Michele noted that it will also be important to include different types of providers, as they have different perspectives and priorities.

Michele Michaud continued the presentation, noting that the packet includes information about the current plan and proposed changes. She also noted that neurological diseases are treated separately in the plan currently, and would not be included in this proposed change.

Member impacts: This clarification would benefit members who do not currently understand the current benefit or whose claims are denied because they do not have a significant medical improvement, even if they self-report improvement. However, it may negatively impact members who utilize a large number of visits now, or who would otherwise exceed the annual limit of visits. Including acupuncture would increase the benefit since that service is not covered now; currently, it is only covered as an alternative for anesthesia for surgery.

Actuarial impact: Overall, the actuarial impact is a slight diminishment of benefits, even factoring in the inclusion of acupuncture as an increased benefit. However, it would be an enhancement of benefits for retirees with a chronic condition, whose claims may be denied now.

Financial impact: Despite the reduced actuarial impact, the financial impact would be positive because it would represent a net savings overall. Adding acupuncture and rolfing therapy would have an increased cost, but would be offset by other savings.

Richard Ward presented a summary of Segal's analysis, he noted that it is a straightforward analysis and looked at actual claims to determine what impacts an annual visit limit would have. He also noted that rolfing therapy does not have a CPT code and is more difficult to analyze, but noted that it would be an additional value to the plan since it is not covered now. Overall, there are relatively small impacts to the plan financially and actuarially.

- Judy Salo asked about how other states have treated acupuncture, such as its use in lieu of pain medication, and as treatment for opioid addiction. There appears to be a national trend of

increasing use of acupuncture, and is concerned that with this increased use, there may be a larger than anticipated impact to the plan.

- Richard Ward noted that the actual cost of acupuncture treatment is low compared with many other services, and the limited number of visits would limit the overall benefit per member each year. An increased use or more common use of services is difficult to predict, as there are always new or newly-identified best practices and people's preferences change. He also noted that there are a growing number of patients who are seeking alternatives to traditional treatments, so it is not necessarily standard as of now, but is more common for plans to cover these other types of treatments such as acupuncture. Since these treatments tend to be less expensive, it is an opportunity for higher value, lower cost services. He speculated that there will tend to be more coverage of this service in the future.
- Judy Salo speculated that perhaps as more treatments are covered by insurance, the cost per service may go up, as providers respond to the market when it is covered.
- Richard Ward agreed that this is a risk, providers do tend to seek reimbursement for services based on the highest reimbursement they can receive. He speculated that there may be less risk of this with these types of services, but generally it is an opportunity that providers take advantage of where possible.
- Cammy Taylor asked whether there are any studies regarding the efficacy of acupuncture and other services for treatment of pain, and the relative cost or benefit of those treatments compared with opioids and other pain medication?
 - Mark Foster noted that Boulder and Denver, Colorado is a useful example and should have some data that can inform this conversation. He noted that they have shifted to covering more alternative options. He also noted that the Roling Institute is located in Boulder. He suggested that staff research this example.
 - Richard Ward agreed that this is definitely an opportunity to address the negative impacts of opioids and pain medications, so there is value in considering other options given the consequences of people taking these medications over time.
 - Ajay Desai shared a personal example which has based his opinion that other alternative therapy options should be available and recognized, and chiropractic services should not be used simply for comfort.
 - Emily Ricci commented that the group should continue conversation about these services. She noted that most of the services on this list are considered mainstream services, but other services such as rolfing are still alternatives. She noted that in some other plans, they separate rehabilitative care from alternative treatments, with separate limits for the two types of care. This could include a fixed dollar amount for alternative treatments, and a general list of treatments to be covered, but not specific limits on each treatment.
 - Judy Salo commented that she likes this idea, and that the group could consider also including preventive treatments in that category of alternative treatments. She believes this would allow people to have more choice about the types of services they want to use, and more wellness benefits. She noted that, for example, some physicians prescribe exercise for patients, although it is not a medication per se, as a way to improve overall health.
 - Emily Ricci proposed that #14 regarding wellness benefits could also include alternative treatments, such as gym memberships, rolfing, and other services. She also noted that there should be boundaries on what can be paid for, so that the plan is not in the position of

- covering any service for any reason. This could be a list of covered services and an annual dollar amount that members can access in the way that works for them.
- Judy Salo noted that she believes having a dollar amount stated in the plan would also mitigate the risk of having providers increase prices in response to these services being covered by insurance. She likes the idea of having a dollar amount that members can access.
 - Emily concluded that staff will explore this option and will look into ways that the plan could provide these benefits through, for example, a health reimbursement account or similar account. The member would pay for services directly, such as a gym membership, within the bounds of what can be covered. This would minimize claims or appeals related to the plan because the plan would not be directly paying for those benefits.

Travel Benefit Analysis

Materials: Travel Benefit Analysis Memos in 9/28/18 meeting agenda packet

Emily Ricci shared a summary of the proposal, which was also presented in the August 10 meeting. She gave a personal example.

She suggested that the group also consider coverage of travel benefits for services not available in state, but also longer-term treatments (example: cancer treatments such as radiation) that may be cheaper out of state, but become costly when factoring in the cost of staying out of state for a longer time.

The proposed travel benefit for the SurgeryPlus program would be limited to specific elective surgeries for which there is a set price, negotiated within their network. Not all providers are eligible to provide in the network, as they need to meet stringent quality requirements. For example, within the Virginia Mason network, not all surgeons would qualify, even if they are in network. SurgeryPlus maintains contracts with providers for some elective surgeries.

How it works: SurgeryPlus provides 3 options for a patient based on their surgery procedure, and work with the patient to determine that they are a candidate for the surgery, medical necessity, any risks or co-morbidities, which would mean surgery has to be performed in a hospital. Patients determine which provider and/or location they prefer. Once the provider, SurgeryPlus and the patient agree that the service is appropriate, SurgeryPlus books a round trip flight from the patient's home community, books the patient's hotel, provides per diem via a pre-loaded debit card for expenses, and handles follow-up tasks including making sure the patient gets home safely. The service may also cover travel for a companion, such as a spouse or a parent for a minor patient. For patients who are enrolled in Medicare, some of the benefits would not apply because Medicare is the primary payer, but SurgeryPlus can still coordinate travel benefits and pay for the flight upfront, rather than the member paying out of pocket.

She noted that AlaskaCare has implemented this service for the active employee plan two months ago, and are working out the administrative issues but can report on how it is working in the near future.

- Cammy Taylor asked whether a service that is not available locally, but is not one of the surgeries covered in this service, can they still access this benefit? And does this include allowing a companion to travel with them and pay per diem?
 - Emily Ricci answered that members could not use this service for a surgery that is not part of the SurgeryPlus network, but the benefit would still include coverage of the flight upfront and travel coordination. The travel coordination is a benefit as well.

- Cammy commented that it seems unfair for members who cannot get a service in-state and need to travel, but will have to pay more out of pocket for other expenses. She suggested that there should be more parity between those surgeries and members who need other surgeries that cannot be gotten locally, or would be cheaper if not done locally.
- Emily agreed that this is not ideal, but this proposal does offer some benefit now; other issues related to travel still need to be addressed. For example, if travel is paid upfront and the member does not show up; determination of whether a travel companion necessary for the patient; and what is the appropriate length of stay. If the plan offers a similar benefit that is not the pre-packaged version offered by SurgeryPlus, more of these decisions would need to be made by the State.
- Cammy responded that this seems like it needs a different plan design for that situation.
- Emily noted that it is helpful that the vendor can still provide travel coordination, and they have reserved that right in their contract.
- Joelle Hall asked if this benefit is implemented as stated, could it be implemented without having figured out the parity issue for people needing surgeries not covered by this service?
 - Emily noted that they are in the process of addressing this in the active employee plan, and can report back in the future.
- Joelle Hall also asked, would this represent a diminishment in the plan if this travel benefit is provided for out of state care, but similar travel benefits are not provided within the state?
 - Emily offered her personal opinion that it would not be a diminishment of the current plan, as it would not be taking away existing benefits in the plan, but adding a new travel benefit for some services.
- Judy Salo commented that this seems like the travel benefits discussed, and the decisions of what to cover, are like designing a “wrap” of benefits for these services, similar to that discussed for EGWP.
 - Emily Ricci agreed. She noted that in the employee plan, they have waived co-insurance for this service. Other plans have also waived deductibles for this service, meaning that there is even more incentive, but there would be actuarial impact if this policy is used in the plan.
- Mark Foster asked of SurgeryPlus: which of their clients (other plans) have driven the most patients to this service, whether they are public or private? And who has been least successful or slowest at driving utilization toward this service? What common factors are there within these two groups?
 - John Zutter, CEO of SurgeryPlus, commented that their two most successful clients, both with members who are remote and need to travel generally for care, have had high degree of awareness of the availability of the service, through member communications (e-mail, mailers, health fairs, etc.) and integration with other vendors, such as onsite clinics and other services that can partner with SurgeryPlus. Utilization goes up when people know they have this option. The second factor in success is incentives to use this service and change their behavior—typically this is achieved in plan design, using both incentives and disincentives to use this service instead of seeking the service locally. This may include waived deductibles and co-insurance, or a health savings account incentive. The lower rates compared with local care also give an incentive.

He also noted that their least successful client does not have any incentives or promotion of this option, and typically only engages with members during open enrollment and therefore limited communications about what is available. For example, SurgeryPlus cannot offer payment plans, and therefore members may have to pay more out of pocket or upfront and are less likely to use it. This client is also in a large metropolitan area where there are a lot of other service options, so there is less incentive to travel for care elsewhere.

Mark Foster asked staff to provide any final information or questions to the committee before adjourning today's meeting.

- Emily Ricci noted that the “wrap” of travel benefits is a proposal that staff will need to research further, it will have additional cost to the plan if implemented as discussed, but needs further study. She suggested that staff should do more analysis and will revisit this in future.
- Joelle Hall commented that the travel benefit as described seems to be an issue of managing expectations, providing this for some services will seem unfair, even though it is legally allowed and does not diminish current benefits. This will need to be considered carefully.
- Cammy Taylor asked staff to consider whether adding some benefits, such as allowing a companion and other services, for surgeries not covered by SurgeryPlus, and the associated costs of providing those services.
- Judy Salo requested that staff bring the information back to the committee at the October 23 meeting, and asked if this is a reasonable timeframe?
 - Emily Ricci responded that staff have completed some work on the topic and will prepare something for the next meeting. They are working through other issues, such as addressing which surgeries should be covered, establishing whether it is cheaper than what is available in state, and which would be most advantageous to include in the plan.
 - Richard Ward commented that he can also prepare analysis, but would need to coordinate with SurgeryPlus staff to estimate impacts on utilization if more people use the travel benefits for surgeries outside their network.
- Judy reiterated it will be helpful to have at least some information about these topics before the November 28 full board meeting, even if it is incomplete.
- Joelle Hall asked for information about where and how people travel now, for what services, and whether the travel is from another place in the state to Anchorage, or from Alaska to another state. She would like to see more information about usage patterns now. Will this information factor into what is covered, or will it be the same policy for all scenarios?
 - Emily Ricci responded that staff have discussed this, and are considering multiple scenarios depending on whether the service is available locally. For example, if the desired service (such as a specific surgery) is not available, it is logical to include in the plan. If a service is available locally, there needs to be a significant cost differential to justify the travel, and this could be treated differently than necessary out of state travel, or the surgeries specifically covered under SurgeryPlus.
 - Michele added that there should be consideration of in network versus out of network travel, and to include incentives to use in network providers if traveling.
- Staff will bring an updated version of this proposal to the October 23 committee meeting.

Item 5. Final Thoughts + Meeting Adjournment

- Cammy Taylor thanked staff and the consulting team for the great work on these proposals!
- Emily Ricci on behalf of staff thanked Mark Foster for his service on the Board, and his hard work on this and other projects.
- Judy Salo commented that Mark is welcome to join discussions at any time going forward, as a member of the public, if he is interested.
- Joelle Hall asked staff whether materials are available online, so the public can track the discussion and the process of considering these modernization proposals?
 - Staff confirmed that materials are available online on the RHPAB web page.
- Emily Ricci commented that staff are preparing for the next Tele Town Hall meeting on October 25. They will continue to answer questions about EGWP and other topics, but are also considering presenting and then getting input on modernization project overall.
- Judy Salo commented that the modernization project is broad and complex, she recommends developing a couple questions to focus the public's input on the process and what is helpful.
- Joelle Hall suggested that there needs to be clear statement of what the process is, and is not, and set clear expectations about the role of the advisory group, and clarify that this committee is a committee of the board for the purpose of serving that advisory role. Staff should make clear that there is a process, and outline a clear decision-making process for the public to understand. There should be a timeline of the process overall, when and how decisions will be made, and information as much as possible about public comment periods. The board and the staff need to discuss the process and establish a transparent timeline and process. It is better to be very transparent and share more information, not less.
- Judy Salo also suggested use of a survey to members to ask their input on the proposals.
- Joelle Hall suggested, like the Anchorage Assembly or the Legislature, to host work sessions with the RHPAB board, to allow for dialogue with retiree groups and others to discuss the proposal in a more informal manner, well before formal public testimony and comment in advance of a formal decision. She believes this would be very helpful the process and mitigate the risk of future misunderstandings.
 - Emily commented that staff agree with this idea. She also noted that the State already fields an annual customer service survey of members, conducted by an independent third party. They are preparing to launch this survey soon and will review the questions to determine if other information would be helpful to ask.
- **Motion** by Mark Foster to elect Cammy Taylor as the new committee chair. **Second** by Judy Salo.
- **Result:** Cammy Taylor is the new committee chair, and will chair the October 23 meeting.
- **Motion** by Mark Foster to adjourn the meeting. **Second** by Judy Salo.
- **Result:** The meeting was adjourned at 12:30 p.m.

The next meeting will be Tuesday, October 23, 2018, 9:30 a.m. to 12:30 p.m.

Public Comment Guidelines

Retiree Health Plan Advisory Board Public Comment Guideline

Public Comment	
Purpose	The public comment period allows individuals to inform and advise the Retiree Health Plan Advisory Board about policy-related issues, problems or concerns. It is not a hearing and cannot be used to address health benefit claim appeals. The protected health information of an identified individual will not be addressed during public comment.
Protocol	<p>Individuals are invited to speak for up to three minutes.</p> <ul style="list-style-type: none"> • A speaker may be granted the latitude to speak longer than the 3-minute time limit only by the Chair or by a motion adopted by the Full Advisory Board. • Anyone providing comment should do so in a manner that is respectful of the Advisory Board and all meeting attendees. <p>The Chair maintains the right to stop public comments that contains Private Health Information, inappropriate and/or inflammatory language or behavior.</p> <p><u>Members providing testimony will be reminded they are waiving their statutory right to keep confidential the contents of the retirement records about which they are testifying. See AS 40.25.151.</u></p>
Protected Health Information	
<p>Protected Health Information (PHI) submitted to the Board in writing will be redacted to remove all identifying information, for example, name, address, date of birth, Social Security number, phone numbers, health insurance member numbers.</p> <p>If the Board requests records containing protected health information, the Division will redact all identifying information from the records before providing them to the Board.</p>	

Retiree Health Plan Advisory Board Public Comment Guideline

Frequently Asked Questions	
How can someone provide comments?	<p>IN PERSON - please sign up for public comment using the clipboard provided during the meeting.</p> <p>VIA TELECONFERENCE – please call the meeting teleconference number on a telephone hard line. To prevent audio feedback, do not call on a speaker phone or cell phone. You may use the mute feature on your phone until you are called to speak, but do not put the call on hold because hold music disrupts the meeting. If this occurs, we will mute or disconnect your line.</p> <p>IN WRITING – send comments to the address or fax number below or email AlaskaRHPAB@alaska.gov. For written comments to be distributed to the Advisory Board prior to a board meeting they must be received thirty days prior to the meeting to allow time for distribution and identifying information will be redacted (see “Protected Health Information”).</p> <p>PRIVATE HEALTH INFORMATION: The state must comply with federal laws regarding Private Health Information. Written information submitted for public comment which contains identifying information will be redacted to ensure compliance with privacy laws.</p> <p>Address: Department of Administration, Attn: RHPAB, 550 W 7th Avenue, Ste 1970, Anchorage, AK 99501 Fax: (907) 465-2135</p>
Can I bring my questions or concerns about a claim or medical issue to the Board?	<p>The Board does not have authority to decide health benefit claim appeals. Members should call Aetna at 1-855-784-8646 to address their question and/or concern. After contacting Aetna, members can also contact the Division of Retirement and Benefits at 1- 800-821-2251 or 907-465-8600 if in Juneau.</p>
For additional information:	<p>For additional information please call 907-269-6293 or email AlaskaRHPAB@alaska.gov if you have additional question.</p>

Enhanced Travel Benefits with Wrap

DRAFT-Summary of Responses to Proposed Plan Design Change

Proposed change: Enhancing ~~the~~ travel benefits ~~to include SurgeryPlus benefits~~

Plans affected: DB Retiree Plan

Reviewed by: Retiree Health Plan Advisory Board

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

Review Date: ~~July 26~~ October 30, 2018

Table 1- Plan Design Changes

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

Description of proposed change:

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

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

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

The increase in covered travel costs will benefit the membership and will increase their options for treatment. The addition of the SurgeryPlus network will provide members

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

DRAFT-Summary of Responses to Proposed Plan Design Change

with access to surgeons who demonstrate they meet and maintain a combination of objective and subjective quality metrics.² The expansion of travel benefits for diagnostic services will address an unmet need among the membership as well the expansion of lodging and per diem expenses for the member and companion as applicable.

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

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

Background:

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

- 1) In emergency situations³
- 2) For a minor (under 18 years of age) with a parent/legal guardian⁴
- 3) For certain transplant services at an Aetna Institute of Excellence (IOE) with a companion and lodging⁵
- 4) Second surgical opinions⁶
- 5) Treatment not available locally⁷
- 6) Surgery in other location if provided less expensively⁸

The current plan language regarding travel costs is confusing and covered expenses are narrow in most circumstances. The portions of covered travel costs vary depending on the qualified circumstance above. Generally, unless otherwise specified, travel costs include the following:

² See attachment B for a list of SurgeryPlus provider metrics.

³ Page 42, AlaskaCare Retiree Health Insurance Information Booklet, 2003:

<http://doa.alaska.gov/drb/pdf/ghlb/retiree/RetireeInsuranceBooklet2003with2018amendment.pdf>

⁴ Page 41, Ibid.

⁵ Page xxxvii-xl. Ibid.

⁶ Page 43, Ibid.

⁷ Page 42, Ibid.

⁸ Page 44, Ibid.

DRAFT-Summary of Responses to Proposed Plan Design Change

- Round-trip transportation, not exceeding the cost of coach class commercial air transportation, to the nearest professional treatment. This is limited to the member unless a companion benefit is clearly stated (e.g. travel for a minor, transplant IOE).
- Documented travel expenses for ground transportation including fares, mileage, food and lodging for the most direct route if ground transportation and the most direct one-way distance exceeds 100 miles. This applies only while the member is in transit, and ends once they arrive at the location of treatment.
- In most circumstances, travel costs do not include the following:
 - Travel for a companion
 - Lodging (with the exception of transplants at IOE, travel via ground transportation, and travel in certain circumstances where treatment is not available locally⁹)
 - Food (with exceptions including transplants at IOE and travel via ground transportation)
 - Other transportation costs (e.g. taxis, etc.)

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

Table 1, below, outlines the proposed changes.

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

⁹ Page 42-43, Ibid.

¹⁰ Page 42, Ibid.

¹¹ Page xxxvii, Ibid.

DRAFT-Summary of Responses to Proposed Plan Design Change

Travel for minor	<ul style="list-style-type: none"> -Minor and companion -Transportation covered¹² 	<p><u>No change</u>-Add overnight lodging benefit of \$80/night up to 14-day maximum;</p> <p><u>-Add per diem benefit of \$31 per patient/day; or \$62 per patient & companion/day</u></p>
Second surgical opinion	<ul style="list-style-type: none"> -Transportation covered for member only 	<p><u>No change</u>-Add lodging and per diem benefit as described above.</p>
Treatment <u>and diagnostic services</u> not available locally	<ul style="list-style-type: none"> -Transportation, lodging and per diem covered for member only. -Limited to treatment only -Limited to the following visit per benefit year: <ul style="list-style-type: none"> -1 treatment for condition -1 for follow-up -1 pre- or post-natal care -1 for maternity delivery -1 pre- or post-surgery -1 per surgical procedure -1 per allergic condition 	<p><u>No change</u></p> <p><u>-Restrict to services received from a network provider.</u></p> <p><u>-Add lodging and per diem benefit as described above to cover the member's entire length of stay subject to medical necessity.</u></p> <p><u>-Allow for both pre- and post-op visit coverage if post-op received within 60-days of discharge.</u></p> <p><u>-Add companion benefit if procedure requires general anesthesia.</u></p>
Surgery <u>and diagnostic services</u> in other locations less expensive	<ul style="list-style-type: none"> -Only applicable for surgery. -Transportation covered for member only. -Total cost may not exceed the recognized charge for same expenses received locally. -Total cost must include: <ul style="list-style-type: none"> -surgery -hospital room and board -travel to another location 	<p><u>No change</u></p> <p><u>-Restrict to services received from a network provider.</u></p> <p><u>-Add "if not available through the SurgeryPlus program."</u></p> <p><u>-Add coverage for companion if procedure requires general anesthesia.</u></p> <p><u>-Add lodging and per diem benefit as described above to cover the member's entire length of stay subject to medical necessity.</u></p>

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

DRAFT-Summary of Responses to Proposed Plan Design Change

SurgeryPlus Program	-Not currently available to retiree members	-All travel includes member and companion -Travel costs arranged for and covered up front by SurgeryPlus. -Hotels arranged and paid for by plan. -\$31 per diem for member/\$62 with companion -Members receive pre-loaded debit card in advance of trip.
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SURGERYPLUS BACKGROUND: The Division competitively bid travel coordination and administrative services in the first half of 2018. The selected bidder was SurgeryPlus. Extensive details are available in Attachment B, but a high-level overview of SurgeryPlus services follows:

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

DRAFT-Summary of Responses to Proposed Plan Design Change

- If necessary, the member can travel back to the surgeon for necessary follow up care.

SurgeryPlus will also provide travel administration services for members who are Medicare-eligible and are not using the SurgeryPlus network along with members seeking care in other circumstances (e.g. treatment not available locally or [surgery and/or diagnostic services](#) less expensive elsewhere [and not otherwise covered by the SurgeryPlus network](#)).

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

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

Member Impact:

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

WHO IS IMPACTED:

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

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

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

DRAFT-Summary of Responses to Proposed Plan Design Change

In reviewing claims data, SurgeryPlus estimates utilization at around 400 procedures per year.¹³

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

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

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

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

Actuarial Impact

Neutral / Enhancement / Diminishment

Table 2: Actuarial Impact

Actuarial Impact	
Current	N/A
Proposed	No actuarial impact ¹⁴

DRB Operational Impacts

The Division anticipates minimal operational impacts as follows:

- Staff will need to manage [another](#) vendor and the routine work associated with that including quality control, reporting, billing, responding to eligibility questions, and communications.
- Staff will need to review and distribute communications to educate and increase awareness of the new plan benefit.

¹³ See attachment A; Segal Consulting Memorandum, July 25, 2018

¹⁴ See Attachment A ****This will be updated to include the wrap services****

DRAFT-Summary of Responses to Proposed Plan Design Change

- A plan amendment will need to be developed, put forward for public comment, and published before the benefit takes effect.
- Staff will need to coordinate and oversee implementation including plan education and cultural training for the SurgeryPlus team, ensuring coordination between SurgeryPlus and the Third-Party Administrator are working smoothly, coordinating eligibility, and responding to member questions and/or concerns.

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

Financial Impact to the plan:

The financial impact to the plan [for the addition of the SurgeryPlus travel network and services](#) is estimated to be savings of \$2.8 million annually. This is based on members using the SurgeryPlus network for 400 procedures per year. The total savings is net of the administrative costs for SurgeryPlus and the estimated cost per member per trip of \$3,000.¹⁵

[The fiscal impact of the expanded travel wrap is under analysis.](#)

Clinical Considerations:

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

Access to SurgeryPlus program- Provider quality is a distinguishing feature of the SurgeryPlus network which reports complication rates of 0.82% among members using their network¹⁶ compared to the 14.1% average for AlaskaCare retirees living in Alaska but seeking care outside of the state in 2017 (13.8% for professional services, 17.1% for outpatient care and 27.6% for inpatient care).

Third Party Administrator (TPA) operational impacts:

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

¹⁵ See Attachment A

DRAFT-Summary of Responses to Proposed Plan Design Change



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

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

Provider considerations:

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

Documents attached include:

Document Name	Attachment	Notes
Segal Memorandum; July 25, 2018	A	 Segal Travel Memo
SurgeryPlus Overview	B	 State of Alaska SurgeryPlus.pdf
Public Comments	C	TBD

Segal Consulting Travel Memo



330 North Brand Boulevard Suite 1100 Glendale, CA 91203-2308
 T 818.956.6700 www.segalco.com

MEMORANDUM

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

From: Richard Ward, FSA, FCA, MAAA

Date: July 25, 2018

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

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

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

Deductibles	
Annual individual / family unit deductible	\$150 / up to 3x per family
Coinsurance	
Most medical expenses	80%
Most medical expenses after out-of-pocket limit is satisfied	100%
Second surgical opinions, Preoperative testing, Outpatient testing/surgery • No deductible applies	100%
Out-of-Pocket Limit	
Annual individual out-of-pocket limit • Applies after the deductible is satisfied	\$800

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

Actuarial Value

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

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

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

Financial Impact

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

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

This analysis is based on medical claims data from December 2016 through November 2017, which was summarized specifically to analyze the opportunity for an enhanced travel benefit. The data was reviewed, but not audited, and found to be sufficient and credible for this analysis.

Segal reviewed the assumptions used by SurgeryPlus and consider them to reasonable. For budgeting purposes, in order to be conservative in projecting the impact of a new program, Segal's analysis utilizes a 20% margin.

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

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

State of Alaska SurgeryPlus

SurgeryPlus for



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

Our Differentiators

Surgeons of EXCELLENCE

Rigorous Screening &
Reduced Complications

Employee SATISFACTION



Better User Experience
We Handle It All

Hard-Dollar ROI SAVINGS

Pre-Negotiated Bundled Rates
Reduced Employer & Employee Costs

Surgeons of Excellence Credentialing

More Comprehensive Evaluation Process

	Other Network	 By  EmployerDirect Healthcare	
Board Certification	Optional	Mandatory	Unlike some of our peers, our quality starts with the physician; a poor doctor will lead to a poor result even in the best facility
Specialty Training Requirements	Optional	Mandatory	
Procedure Volume Requirements		✓	
State Sanctions Check		✓	
Medical Malpractice Claims Review		✓	SurgeyPlus had an overall complication rate of ~1% in 2017 and is under 1.50% life to date
Criminal Background Checks		✓	
CMS Quality Requirements (Hospital Only)		✓	
Monthly Network Management		✓	Our surgeons are committed to patient optimization; not risk selection
ASC Steerage		✓	

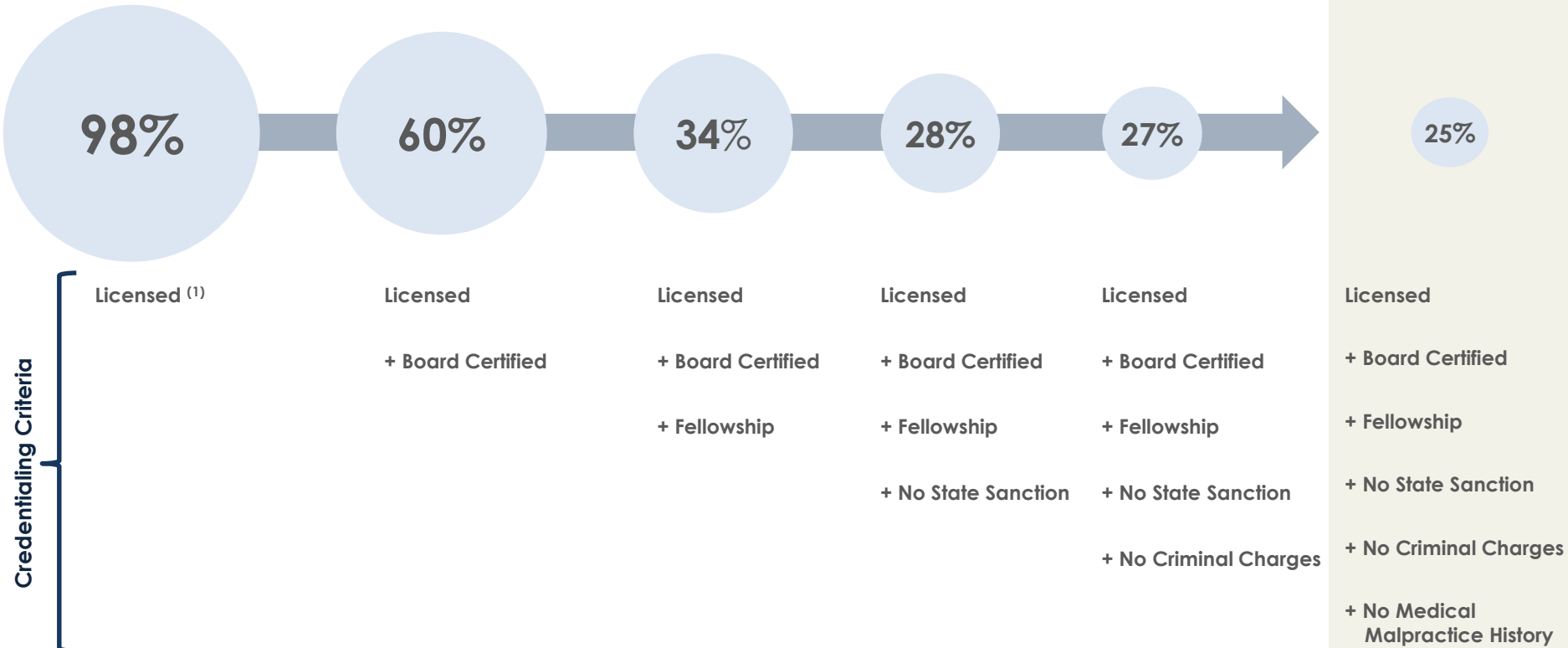
Provider Preliminary Credentialing Case Study

Examining our Rigorous Credentialing Process

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



Surgeons of Excellence



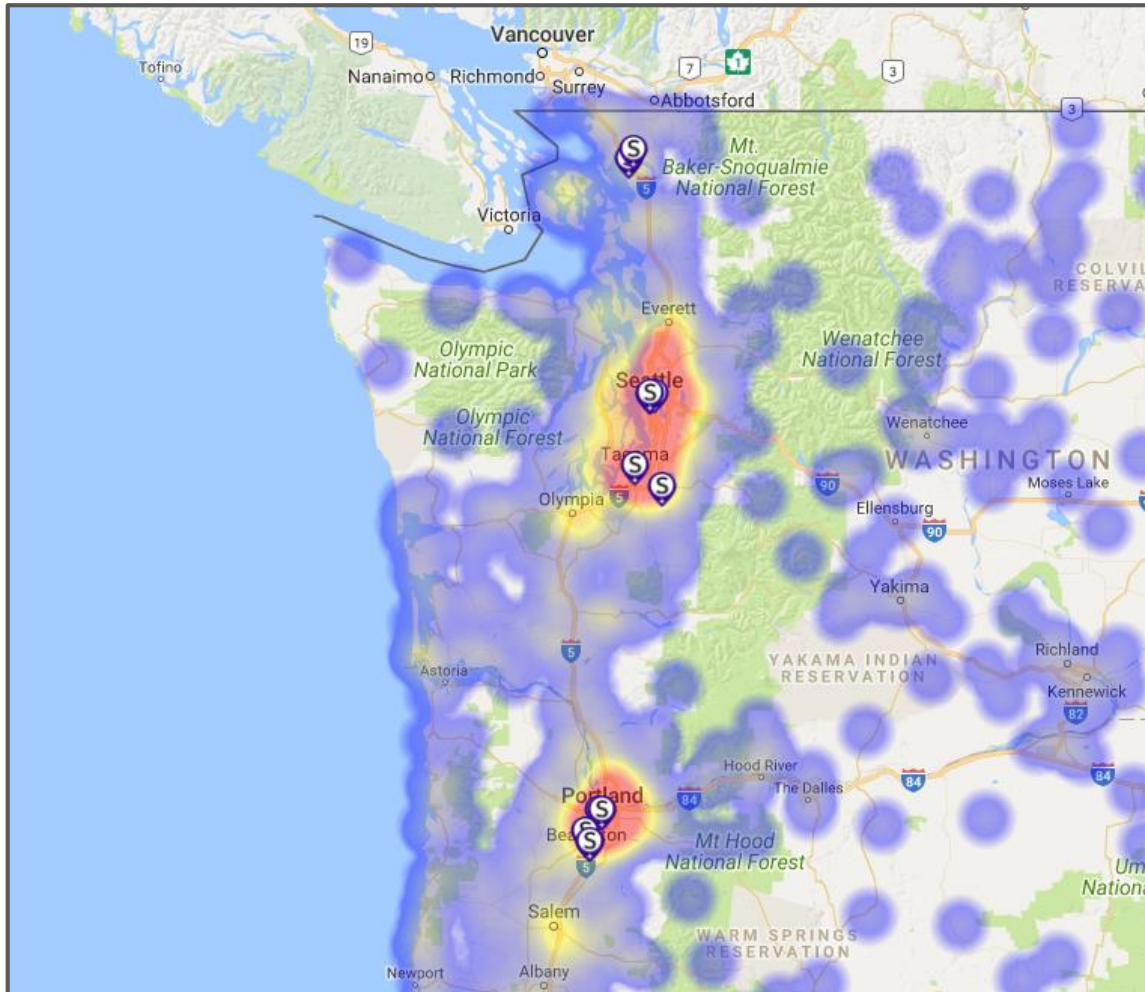
Credentialing Criteria

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





SurgeryPlus Provider Network

Seattle / Portland



Legend:  SurgeryPlus Provider

Seattle, WA		
Category	Covered?	S+ Facilities

Orthopedics	✓	 Virginia Mason  THE POLYCLINIC <small>Where you come first.</small>
Spine	✓	
Bariatrics	✓	
General	✓	
GYN	✓	
Thyroid	✓	
GI	✓	
ENT	✗*	
Cardiac	✓	

*In Discussions

Provider Spotlight


Virginia Mason

Virginia Mason

- Performed over 15,000 surgical procedures in 2016
- COE for Walmart, Boeing, FedEx
- Recognized 5 consecutive years by US News & World as a national high performer in Orthopedics

Michael E. Morris, M.D.

Orthopedics

Physician Information

Facility: Virginia Mason Medical Center

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



Education



Fellowship & Residency

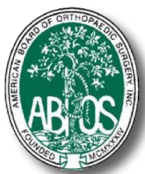


Residency



Fellowship

Select Professional Societies



The American Board of
Orthopaedic Surgery

Notable Leadership

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



SurgeryPlus vs. Average Carrier

State of Alaska Member Experience

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

SurgeryPlus Can Save Members Thousands

Know What Your Procedure Costs Ahead of Time

State of Alaska WAIVES coinsurance

SurgeryPlus collects what is left on member's primary deductible

No medical bills in the mail

SurgeryPlus handles all bills following your procedure

Zero risk of out-of-network charges

Never worry any part of the procedure falls out of network

\$0 coinsurance

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

SurgeryPlus Member ID Card

Unlocking Access to your SurgeryPlus Benefit



ACTIVATE YOUR ONLINE PORTAL EXPERIENCE

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

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



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

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

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

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

The SurgeryPlus Difference

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

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




MEMBER NAME:
John Doe
Includes member's covered spouse and dependants
(855) 715-1680
Alaska.SurgeryPlus.com
Member portal registration access code: surgeryplus

MEMBER ID: XXXXXXXX
GROUP NUMBER: XXXXXXXX

SURGERYPLUS BENEFIT	
DEDUCTIBLE	COLLECT
CONSUANCE	WAIVED




MEMBER NAME:
John Doe
Includes member's covered spouse and dependants
(855) 715-1680
Alaska.SurgeryPlus.com
Member portal registration access code: surgeryplus

MEMBER ID: XXXXXXXX
GROUP NUMBER: XXXXXXXX

SURGERYPLUS BENEFIT	
DEDUCTIBLE	COLLECT
CONSUANCE	WAIVED

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

SURGERYPLUS COVERS HUNDREDS OF NON-EMERGENT SURGERIES, INCLUDING:

Spine

- Fusions
- Disk Repair/Replacement
- Laminectomy
- Laminotomy

General Surgery

- Gallbladder Removal
- Hernia Repair
- Thyroidectomy

Genitourinary

- Hysterectomy
- Bladder Repair

Orthopedic

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

Ear, Nose & Throat

- Septoplasty
- Stapedioplasty
- Eustachian Tubes

Cardiac

- Cardiac Valve Surgery
- Cardiac Defibrillator Implant

Bariatric

- Gastric Bypass
- Laparoscopic Sleeve Gastrectomy

GI

- Colonoscopy
- Endoscopy

Pain Management

- Cervical Epidural
- Lumbar Epidural Steroid
- Stellate Ganglion Block

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

Provider Instructions:

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

Send Medical Claims To:
Employer Direct Healthcare
2100 Ross Ave. #3200
Dallas, TX 75201
Electronic Payer ID: 48888

Member Service: 1-855-715-1680
Provider Inquiry: 1-855-300-3038
Billing Inquiry: 1-855-300-6689
Hours: 8:00am-5:00pm AEST/EST
Monday - Friday
www.edhc.com

Provider Instructions:

1. Employer Direct | SurgeryPlus is the only payer for this consultation/procedure.
2. Send medical claims to the below location(s) after discharge to receive payment.
3. Contact the number below immediately for any questions in providing quality care to the SurgeryPlus member.
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Send Medical Claims To:
Employer Direct Healthcare
2100 Ross Ave. #3200
Dallas, TX 75201
Electronic Payer ID: 48888

Member Service: 1-855-715-1680
Provider Inquiry: 1-855-300-3038
Billing Inquiry: 1-855-300-6689
Hours: 8:00am-5:00pm AEST/EST
Monday - Friday
www.edhc.com

Care Advocates Handle It All

Full-Concierge Service Creates a Better Member Experience



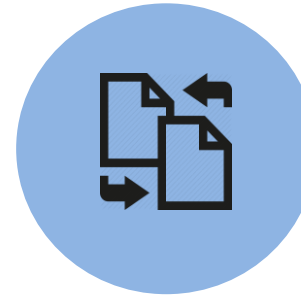
Locate

Find best fitting Surgeon of Excellence



Schedule

Book timely appointments & manage logistics



Coordinate

Bundle service providers & transfer records



Follow Up

Ensure complete member satisfaction

Managed by the Metrics for Scalability

Wait Time

~5 seconds

First-Time Call Length

~4 minutes

Time to Consult

~21 days

% of Calls to Cases

~52.4%

% of Cases to Procedures

~50.7%

Time to Procedure

~35 days

Most Common Covered Procedures

Commonly Covered Procedures by Category

Knee:

- Knee Replacement
- Knee Replacement Revision
- Knee Arthroscopy
- ACL/MCL/PCL Repair

Hip:

- Hip Replacement
- Hip Replacement Revision
- Hip Arthroscopy

Shoulder:

- Shoulder Replacement
- Shoulder Arthroscopy
- Rotator Cuff Repair
- Bicep Tendon Repair

Foot & Ankle:

- Ankle Replacement
- Bunionectomy
- Hammer Toe Repair
- Ankle Fusion
- Ankle Arthroscopy

Spine:

- Laminectomy / Laminotomy
- Anterior Lumbar Interbody Fusion (ALIF)
- Posterior Lumbar Interbody Fusion (PLIF)
- Anterior Cervical Disk Fusion (ACDF)
- 360 Spinal Fusion
- Artificial Disk

Wrist & Elbow:

- Elbow Replacement
- Elbow Fusion
- Wrist Fusion
- Wrist Replacement
- Carpal Tunnel Release

General Surgery:

- Gallbladder Removal
- Hernia Repair (inguinal, ventral, umbilical, and hiatal)
- Thyroidectomy

GI:

- Diagnostic Colonoscopy
- Endoscopy

GYN:

- Hysterectomy
- Bladder Repair (Anterior or Posterior)
- Hysteroscopy

Bariatric:

- Gastric Bypass
- Laparoscopic Gastric Bypass
- Laparoscopic Sleeve Gastrectomy

Cardiac:

- Defibrillator Implant
- Permanent Pacemaker Implant
- Pacemaker Device Replacement
- Valve Surgery
- Cardiac Ablation

ENT:

- Ear Tube Insertion (Ear Infection)
- Septoplasty
- Sinuplasty

Network Incentives

DRAFT-Summary of Responses to Proposed Plan Design Change

Proposed change: Adding a network incentive

Plans affected: DB Retiree Plan

Reviewed by: Retiree Health Plan Advisory Board

Proposed implementation date: TBD

Review Date: October 30, 2018

Table 1: Plan Design Changes

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

Description of proposed change:

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

Background:

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

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

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

DRAFT-Summary of Responses to Proposed Plan Design Change

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

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

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

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

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

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

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

DRAFT-Summary of Responses to Proposed Plan Design Change

Table 1. AlaskaCare Retiree Medical Claims Incurred Calendar Year 2017

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

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

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

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

Member impact:

Members using network providers: As the majority of members use network services already, members overall would benefit from this change as the coinsurance would

DRAFT-Summary of Responses to Proposed Plan Design Change

increase from 80% to 90%, representing a reduced cost share for the period between when they meet their deductible and out-of-pocket limit. **Additional information will include an estimate for how many member this is.**

Members using non-network providers: These members would be disadvantaged by the change as the coinsurance would decrease from 80% to 70% representing an increase cost share for the period described above. **Additional information will include an estimate for how many members this is.**

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

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

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

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

Actuarial impact:

Neutral / **Enhancement** / Diminishment

Table 2: Actuarial Impact

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

² See Attachment A

³ See Attachment A

DRAFT-Summary of Responses to Proposed Plan Design Change

DRB operational impacts:

The Division anticipates minimal operational impacts as follows:

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

Financial impact to the plan:

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

From Segal Consulting Group, Attachment A:

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

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

Note- this analysis does not consider savings that could accrue as the result of improved pricing due to strong network negotiations. The AlaskaCare employee plan has achieved substantial savings from providers by implementing stronger network incentives and disincentives.

Clinical considerations:

These changes not anticipated to impact any clinical considerations.

Third Party Administrator (TPA) operational impacts:

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

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

DRAFT-Summary of Responses to Proposed Plan Design Change

- Exceptions for members who cannot access a network provider will have to be managed manually.

Provider considerations:

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

Documents attached include:

<u>Document Name</u>	<u>Attachment</u>	<u>Notes</u>
Segal Memorandum; October 25, 2018	A	
Network Claims Pull	B	
Public Comments	C	Under development

Segal Consulting Coinsurance Memo

MEMORANDUM

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

From: Richard Ward, FSA, FCA, MAAA

Date: October 25, 2018

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

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

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

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

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

Actuarial Value

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

Financial Impact

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

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

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

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

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

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

Network Claims Pull

Calendar/Fiscal Incurred - Original Claims: New Dashboard

AlaskaCare

Employee Status = Retiree under 65,Retiree 65 and over

Incurred Calendar Year = 2017

Network Indicator		In-Network					Non-Network					Summary			
Employee Status	Service Category	Paid	% of Total Paid	Paid PMPM	Claims	Claimants /1000	Paid	% of Total Paid	Paid PMPM	Claims	Claimants/ 1000	Total Paid	Paid PMPM	Claims	Claimants /1000
Retiree under 65	Inpatient Facility	\$43,090,566	94%	\$155.30	3,130	50.0	\$2,845,387	6%	\$10.26	406	5.9	\$45,935,952	\$165.56	3,536	53.6
	Outpatient Facility	\$62,367,382	83%	\$224.78	48,121	544.7	\$12,565,761	17%	\$45.29	6,347	62.2	\$74,933,143	\$270.07	54,468	568.5
	Professional	\$59,270,689	63%	\$213.62	257,970	904.7	\$34,530,858	37%	\$124.45	112,449	728.1	\$93,801,547	\$338.07	370,419	1,001.4
	Summary	\$164,728,637	77%	\$807.93	627,578	994.6	\$49,942,006	23%	\$180.00	119,192	732.8	\$214,670,642	\$987.92	746,770	1,040.2
Retiree 65 and over	Inpatient Facility	\$5,617,693	32%	\$9.51	1,345	10.8	\$11,752,270	68%	\$19.90	13,702	109.8	\$17,369,963	\$29.41	15,047	119.9
	Outpatient Facility	\$9,881,264	29%	\$16.73	21,976	105.7	\$23,710,559	71%	\$40.14	183,697	614.2	\$33,591,823	\$56.87	205,673	703.1
	Professional	\$8,872,952	17%	\$15.02	96,669	165.7	\$42,375,095	83%	\$71.74	832,381	928.1	\$51,248,047	\$86.76	929,050	976.4
	Summary	\$24,371,908	24%	\$334.99	1,177,392	892.6	\$77,837,925	76%	\$131.77	1,029,722	939.0	\$102,209,833	\$466.76	2,207,114	1,008.6
Summary		\$189,100,545	60%	\$486.14	1,804,968	889.9	\$127,779,930	40%	\$147.18	1,148,908	854.8	\$316,880,475	\$633.32	2,953,876	978.9

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