

Meeting: Retiree Health Plan Advisory Board Modernization Committee
Date: Wednesday, June 12th, 2019
Time: 9:00am -12:30pm
Location: **Anchorage:** Atwood Building, Room 104
Juneau: State Office Building, 10th Floor
Teleconference: (650) 479-3207
Meeting ID: 801 377 464
[join the meeting](#)
Committee Members: Cammy Taylor (chair), Joelle Hall, Judy Salo, Mauri Long

Retiree Health Plan Advisory Board (RHPAB) Modernization Committee Materials

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**Retiree Health Plan Advisory Board (RHPAB)
Modernization Committee
Meeting Agenda**

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- 9:00 am** **Call to Order**
- Introductions
 - Approve Agenda
 - Approve Previous Meeting Minutes
- 9:10 am** **Public Comment**
- 9:30 am** **Discuss Modernization Topics Analyses – DRB Presentations**
- Three-tier Pharmacy Benefits
 - Telehealth
 - Rehabilitative Care
 - Enhanced Clinical Review
- 10:45 am** **Break**
- 11:00 am** **Continue Discussion of Modernization Topics**
- 12:20 pm** **Wrap-up**
- Next Meeting: Tuesday, July 30th, 2019.

Retiree Health Plan Advisory Board

Modernization Committee Meeting Minutes

Date: Tuesday, April 23, 2019 | 9:00 a.m. to 3:00 p.m.

Location: State Office Building 333 Willoughby Avenue 10th Floor, Juneau, AK 99801 and
Robert B. Atwood Building 550 West 7th Avenue, 12th Floor, Anchorage, AK 99501

Meeting Attendance

Name of Attendee	Title of Attendee	
<i>Retiree Health Plan Advisory Board (RHPAB), Modernization Committee Members</i>		
Cammy Taylor	Committee Chair	Present
Joelle Hall	Committee Member	Present
Mauri Long	Committee Member	Present
Judy Salo	Board Chair	Present (phone)
<i>State of Alaska, Department of Administration Staff</i>		
Kelly Tshibaka	Commissioner, Alaska Department of Administration	
Paula Vrana	Deputy Commissioner, Alaska Department of Administration	
Ajay Desai	Director, Division of Retirement + Benefits	
Emily Ricci	Chief Health Policy Administrator, Retirement + Benefits	
Betsy Wood	Deputy Health Official, Retirement + Benefits	
Teri Rasmussen	Program Coordinator, Retirement + Benefits	
Shane Francis	Health Care Economist, Retirement + Benefits	
Vanessa Kitchen	Administrative Assistant, Office of the Commissioner	
<i>Others Present + Members of the Public</i>		
Daniel Dudley	Aetna	
David Broome	Aetna	
Hali Duran	Aetna	
Richard Ward	Segal Consulting	
Noel Cruse	Segal Consulting	
Bharon Hoag	Secure Care	
Anna Brawley	Agnew::Beck Consulting (contracted support)	
Pat Shier	Alaska Retiree + Pacific Health Coalition	
Brad Owens	Retired Public Employees of Alaska (RPEA)	
Wendy Woolf	Retired Public Employees of Alaska (RPEA)	

Common Acronyms

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

- ACA = Affordable Care Act (formal name: Patient Protection and Affordable Care Act)
- ARMB = Alaska Retirement Management Board
- CMS = Center for Medicare and Medicaid Services
- COB = Coordination of Benefits
- DB = Defined Benefit plan (for Tier 1, 2, 3 PERS employees and Tier 1, 2 TRS employees)
- DCR = Defined Contribution Retirement plan (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 Arrangement account, a mechanism for the employer to reimburse high-income Medicare enrollees for any premium charge for their plan (IRMAA)
- IRMAA = Income Related Monthly Adjustment Amount, a surcharge from CMS for a Medicare plan for individuals or households earning above certain thresholds
- MAGI = Modified Adjusted Gross Income, based on an individual or household's tax returns and used by CMS to determine what if any premium must be paid for a Medicare plan.
- OPEB = Other Post-Employment Benefits; an accounting term used to describe retirement benefits other than pension benefits
- OTC = Over the counter medication, does not require a prescription to purchase
- PBM = Pharmacy Benefit Manager, a third-party vendor that performs claims adjudication and network management services
- PEC = proposal evaluation committee (part of the procurement process to review vendors' bids)
- PHI = protected health information, a term in HIPAA for any identifying health or personal information that would result in disclosure of an individual's medical situation.
- RDS = Retiree Drug Subsidy program (a federal pharmacy subsidy program)
- RFP = Request for Proposals (a term for a procurement solicitation)
- RHPAB = Retiree Health Plan Advisory Board
- TPA = Third Party Administrator

Meeting Minutes

Item 1. Call to Order + Introductory Business

Chair Cammy Taylor called the meeting to order at 9:05 a.m.

Approval of Meeting Agenda

Materials: Agenda packet for 4/23/19 RHPAB Modernization Committee Meeting

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

Approval of Previous Meeting's Minutes

Materials: Draft minutes from 12/12/18 Modernization Committee Meeting

- **Motion** by Cammy Taylor to approve the 12/12/18 minutes as presented. **Second** by Joelle Hall.
 - **Discussion:** Correction: Wendy Woolf's name is spelled with two Os.
 - **Result:** No objection to approval of minutes as corrected. Minutes are approved.

Item 2. Division Updates

Emily Ricci shared that staff are still grieving for the death of Michele Michaud, former Chief Health Official and a key member of the Division team. Division staff has re-assigned responsibilities within the team to ensure the work continues moving forward, with Betsy Wood leading health policy work (such as the retiree modernization project), Andrea Mueca leading operations work, and Emily Ricci will oversee both areas. Additionally, Michele's e-mail account has been discontinued, and should no longer be used. If Board members or members of the public have questions, please send all e-mail correspondence to Emily (emily.ricci@alaska.gov) and Andrea (andrea.mueca@alaska.gov) and they will coordinate to respond to messages.

Last week, the Alaska Superior Court ruled in favor of the Retired Public Employees of Alaska (RPEA) and against the State in a case involving the Dental, Vision, and Audio (DVA) benefits. The Division is currently evaluating the ruling and its implications, as well as how best to respond to the ruling as it relates to the plan design of the DVA plan. The team will provide update at a future meeting.

Item 2. Public Comment

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

- 1) A retiree health benefit member's retirement benefit information is confidential by state law;
- 2) A person's health information is protected by HIPAA;
- 3) Testimony will be posted on the Board's website and will be publicly available, including both written comments and statements made verbally in meetings and recorded in the minutes;

- 4) By giving public testimony on those subjects, the person will be treated as having waived their right to confidentiality regarding the subject of their testimony;
- 5) An individual cannot waive this right on behalf of another individual, including spouse or family member;
- 6) The chair will stop testimony if any individual shares protected health information.

Public Comments

- **Pat Shier.** Pat thanked staff and the Board for hosting these meetings, including the opportunity to participate via phone.

Item 3. Review Modernization Topic Analyses

Materials: materials on each topic in 4/23/19 meeting agenda packet

Emily Ricci prefaced staff's presentations by noting that all of the proposals presented are discussion drafts, are still being analyzed and discussed by the Board and staff and are subject to change.

She noted that each proposal includes analysis of several impacts: to members, to providers, to the State and to Division staff in terms of administrative work, financial impacts, actuarial impacts, impacts to the third-party administrator, and other considerations.

Please send any comments on any of the proposals, or any other ideas to consider for improving the retiree health plan, to AlaskaRHPAB@alaska.gov.

Topic: Enhanced Clinical Review for High-Tech Imaging and Some Other Services

This proposed policy was first presented in a previous meeting. The review policy would be specific to certain high-tech imaging and similar tests that are costly services; studies have shown that these services are often over-utilized. For example, AlaskaCare plans (employee and retiree plans) have higher use of MRI, CT, cardiology, and some sleep or cardiology and other scans compared to Aetna's overall book of business. Additionally, there is a higher correlation with providers who have purchased one of these machines referring for those imaging tests at a higher rate. There is also a health impact to the patient for participating in a scan, as they are exposed to some radiation with each test.

The other component of the proposal is to address the issue of pre-authorization being the responsibility of the member if they seek services from a provider who is not in network. The proposal would be specific to in-network providers and is consistent with Aetna's practices with other health plans. Since this proposal was first analyzed in 2014, Aetna's network has become significantly broader and therefore is less of a burden on members to find an in-network provider in Alaska.

Table 2 (page 2) details the current language in the plan booklet and proposed changes. Any changes made after the March 20 version of this document are noted in track changes for reference. The proposed changes: new pre-certification requirements for in-network imaging services listed in the table: high-tech radiology, diagnostic cardiology, sleep management studies, cardiac rhythm implant devices, and interventional pain management. The plan has the discretion to include or exclude each service, rather than needing to adopt the same rules for all the services noted.

- Judy Salo asked whether pre-certification is required for emergency care? Is the member responsible for the cost if the claim is denied?

- Emily Ricci responded that there is an equivalent process for services in an emergency situation, but the review is retroactive to determine if the service was warranted and is not required to be approved in advance. Depending on the urgency, the service can still be provided at the discretion of the provider, or if the hospital determines it is not a time-sensitive issue, the facility may seek pre-certification if there is time. She believed it would be handled on a case by case basis, and would also depend on if the provider is in or out of network: the member would not be penalized for the additional cost in an emergency, that cost would be borne by the hospital or the provider. If the provider is in network, they would be responsible for following the terms of their contract.
- Betsy Wood noted that many providers are experienced with pre-certification for these types of services, Aetna and other insurers require this for many other plans. Questions such as how this would impact emergency care have been worked out in other plans, and the Division would look to those examples as guidelines.
- Richard Ward noted that retrospective review of emergency imaging services is often used as a learning experience after the fact, but generally providers are given broad discretion to make clinical decisions based on their professional judgment.
- Daniel Dudley added that these policies are known as “care considerations,” and are common communications between insurers and providers as an ongoing discussion about the most appropriate care decision from a cost and outcomes standpoint.
- David Broome confirmed that this is common practice, the insurer does not intervene in decisions about stabilizing patients in emergencies and conduct post-reviews instead.
- Emily Ricci proposed adding language in the plan policy that this pre-certification requirement does not apply in emergency situations, and will be handled on a retrospective basis, to clarify this further.
- Mauri Long asked about the increasingly common practice of self-referral as an overall share of the utilization increase? She understands that this did not used to be allowed, but as providers are able to self-refer for services, would this be driving increased utilization?
 - Emily Ricci deferred the question to Shane Francis and Segal Consulting, to understand what is available in the data warehouse for the plan and whether this analysis is feasible. It will require some manual work to identify these providers specifically.
 - Shane Francis believed it would be possible to do this analysis with available data.
- Mauri Long asked if these plan changes have been incorporated into the active employee plan?
 - Emily Ricci responded that this has been analyzed and considered for the employee plan, it has not been implemented yet, but they are considering this in 2020. She also noted that employees are generally more geographically concentrated in Anchorage and Juneau, versus the retiree plan with a spread of people across the state and U.S. There may be fewer cost savings associated with the employee plan for that reason. She also shared that some providers, anecdotally, have been surprised that they are not required to get pre-certification for these services, as they are common in other Aetna plans if they are in network for multiple plans.
- Cammy Taylor asked whether the estimates compared against Aetna’s overall book of business took age into account, and adjusted for age? Older people would likely have more health issues and therefore more need for imaging services when compared with the overall population.
 - Emily Ricci confirmed that the comparison with Aetna’s overall plans is age adjusted.

- David Broome added that Aetna does consider age and other demographics. He will prepare more detailed information about the analysis and the comparison population.
- Emily added that it is helpful to compare populations within the plan, including the retiree populations inside and outside Alaska, staff uses this kind of analysis as well.
- Cammy asked whether the estimates also account for the cost differential of Alaska versus the rest of the U.S., given Alaska's higher costs for care?
 - David Broome responded that the comparison is done against other Western states using public sector plans, so there are some adjustments and consideration of demographics. He noted that many people under 65 (not Medicare eligible) are living in the lower 48, but he can prepare a more detailed response of how demographics are factored in.
 - Richard Ward shared that the analysis focused on AlaskaCare specific data and looked at the impacts of the proposed policies using data (actual services and populations) within the plan. Assumptions included the type of services, number of services, cost, and whether it would be beneficial to defer or recommend an alternative service.
- Cammy understands that there is a documented increase in imaging services, and noted that in the data, there is a small number of appeals, but most are overturned. She is interested in whether there are a large number of appeals: if there is only a small number of appeals, this does not represent significant unnecessary cost to the plan overall. If there is a large number of appeals, then there may be significant savings by addressing this as a policy.
 - Richard Ward noted that redirected care must also be factored in whether the member ends up receiving a lower-cost form of imaging or test service as a result of the review.
 - Emily Ricci acknowledged these are good questions, and the group did not have the relevant data before them in the meeting to respond in full. She noted that they will look at each category of service individually, looking at a financial analysis of each category, and determine which if any are the cost drivers or have unnecessary utilization within those categories. This may help identify the most effective categories.
- Mauri Long commented that in the proposal, providers must also agree to the published clinical guidelines for each service type as part of their contractual obligation to Aetna. If this is already required, what is the additional benefit of this policy to seek pre-certification? If retrospective review of which services were ordered is already in place, to identify after the fact whether utilization that may not have been necessary, what additional benefit does this policy have?
 - Emily Ricci responded that retrospective reviews are typically only used in emergency care situations, not for non-emergency outpatient services. There is not currently an additional required review for these services, which means that these tests may be ordered without any provision for additional review, before or after. Given the complexity of the policy bulletins and providers' limited time and capacity to review these documents, providers may or may not be reviewing the most recent evidence and changing their decisions accordingly. She stated that insurers use these required reviews recognizing that providers may or may not be keeping up with the latest evidence, to ensure that they are making decisions in line with current evidence-based practices.
 - David Broome noted that the current plan does have pre-certification specifically for MRI services; this would expand the list of services across the Aetna network.

- Emily Ricci acknowledged that this is a form of managed care, and not particularly popular with providers: it does require a third-party decision (the insurer) in order to approve payment for the services. It is difficult to stay current with the evidence regarding clinical care, so this is one mechanism to do so and address unnecessary utilization. She also noted that the health care system has many administrative processes and can create barriers for providers and members accessing care. This proposal is relatively limited in scope and only applies to in network providers. Another option would be to identify specific providers in network who are ordering the most of these services and could do targeted outreach with those providers to understand why they are ordering services and education whether this is necessary in all cases. There is higher utilization of these services among the retiree population, so it is one opportunity for improving the plan, but the Division is open to discussion on whether the current proposal is the best approach. Emily also noted that the proposal would primarily impact non-Medicare eligible members, as Medicare coverage of services is already determined by set rates.

Emily continued: financial impacts are relatively small, estimated at \$250,000 annual savings to the plan.

- Cammy Taylor asked if this is an Aetna-specific program, or do other third-party administrators have similar policies?
 - Emily Ricci noted that this policy is specific to Aetna, but she is not familiar enough with other third-party administrators' policies to know how common this is. Given that this is a care management strategy, she believes it is likely other insurers use this as well.
- Joelle Hall asked the average cost of this type of service, such as a CT scan, in Alaska.
 - Daniel Dudley and Richard Ward did not have this information available in the meeting and will follow up.
 - Joelle commented that she would like to understand the scale of this impact, how many members might be affected, and considered the relative savings compared with the cost and time associated with putting this in place. She noted that if the main issue is a relatively limited number of providers who are driving the increased utilization, such as those who have their own testing machines, perhaps an alternative focused on the providers who are ordering these at the highest rates and working with those providers is a more cost-effective, easier to pursue approach.
 - Emily Ricci commented that the Division has known this is an issue for several years but has not determined an obvious solution to date.
 - Shane Francis commented that in comparing Alaska's cost of services, AlaskaCare is paying significantly more than the rest of the U.S. He sees a price inflation issue: Alaska tests may cost at least 350% to 371% of Medicare rates, much higher than the U.S. average. This is a pricing issue specifically in Alaska.
- Joelle asked whether this is a result of insufficient negotiation of rates? For example, if the negotiated rate of these prices is very high overall, then it would be an issue of price negotiation rather than putting more procedural requirements in place.
 - Emily Ricci responded that the third-party administrator is responsible for negotiating prices, and she believes that they are doing a good job in the circumstances, given the design of the retiree plan. She noted that one of the major problems with the current

plan design is lack of steerage toward utilizing in network providers with whom the insurer has a contract, which limits the State's ability to negotiate (through the TPA) competitive rates. She believes that preventive care, changing the lifetime maximum, rehabilitative care, and addressing steerage in the retiree plan are all high priorities.

- Mauri Long asked which, if any, providers who can conduct these tests in Alaska are out of network? She understands the cost and technical specifications of these machines make them a big investment and would be surprised if there are many out of network providers in state.
 - Emily Ricci did not have this information available but suggested that an analysis of the per capita distribution of testing machines may be a useful comparison, in Alaska versus other peer states.
 - Cammy expressed concern about using a per capita comparison with other states, given the state's rural distribution.
 - Emily intends to contact the Department of Health and Social Services to ask if they have documentation of which providers own and use these machines, as she believes others have already collected this information in the past.
 - David Broome further researched about the cost of a CT scan in Anchorage—he reviewed the top three local providers and found that the cost varies from \$1,600 to \$2,900 in network, among those three providers. An abdomen scan, for example, is \$2,300. He noted that pricing can be researched on Aetna's website, and includes contracted costs.

Emily asked the committee whether they prefer continuing discussion today, or that the Division conduct additional analysis and present at a future meeting? The committee agreed that this can be tabled until the next meeting, with additional information to respond to today's questions.

The Board took a break at 10:03 a.m. and resumed at 10:10 a.m.

Topic: Teladoc (Telehealth Services)

- Mauri Long stated that she believes she owns more than the threshold amount of stock in Teladoc (over \$5,000), required for stating a potential conflict. She brought this to the committee's attention and any necessary action.
 - Cammy Taylor shared that she consulted the state's ethics office on this matter, and that because this meeting is for information purposes only and no official action will be taken, Mauri does not need to recuse herself from discussion. If and when this matter comes before the full board for consideration, she may need recuse herself at that time.

Emily Ricci shared an overview of Teladoc services: Teladoc is a telehealth service that provides easy access to telehealth services, including outside of an insurance plan. It has an online platform that allows a person to create an account and schedule appointments to speak with a licensed health care provider regarding certain non-emergent health care needs. This proposal would give Teladoc access to members for three types of services: non-emergency general medical consultations, dermatology consultations, and caregiver consultations. Currently proposed co-pays for consideration for each service are: \$5 co-pay for non-emergency care (total visit charge is \$45), \$75 for a dermatology consultation (paid fully by the member), and \$45 for a caregiver consultation (also paid fully by the member). Caregiver consultations allow members who are caring for a non-member to use Teladoc services to assist in providing that care. In this scenario, because the person receiving Teladoc services is not an AlaskaCare

member, the plan would not cover any portion of the Teladoc visit, and the caregiving AlaskaCare member would be responsible for the full \$45 visit charge. She shared her recent personal experience using Teladoc while her spouse was traveling out of state and needed to fill a prescription for a minor health issue. She found the service easy to use and particularly useful in this situation, when someone is out of state and has a non-emergency medical issue.

The Division has already added this to the employee plan; there has not been significant utilization so far, but DRB plans to promote the service more actively in the next two months, including a temporary \$0 co-pay to encourage members to try it and become accustomed with using the service. However, the Division does not recommend a \$0 co-pay for this service in the retiree plan on a permanent basis, as it would be difficult to change later; the co-pay, although small, is intended to give the member a direct connection between the service and the cost. The dermatology consultation has a higher cost compared with routine call, reflected in the higher co-pay.

Shane Francis presented a summary of his analysis: he noted that “low-severity” care does not mean unnecessary care; it represents routine services and non-emergency care. This category of services represents \$25.7 million in out of pocket costs for members, exclusive of any balance billing for out of network providers. Teladoc represents potential savings not only for the plan, but also members, as they may seek services online rather than going to urgent care or an in-person visit, for at least some of the services in this category if they can be addressed through Teladoc.

Teladoc services work as follows: Teladoc requires registration online and a credit card member on file for co-pays, and the online platform allows for the member to request a call back with a description of the issue. The member reports an issue they would like to discuss with a provider and requests a call back from a provider as soon as possible. Providers on Teladoc have only limited prescribing ability, such as anti-viral and antibiotics, and cannot prescribe pain medications such as opioids and controlled substances. The most common calls are respiratory infections, urinary tract infections, and other common conditions. This service does require online access to at least initiate the provider call, as well as paying for the service via credit card, so there needs to be further discussion of accommodations for people who are not comfortable using the Internet for this service.

Shane Francis noted that approximately 40% of retirees live outside Alaska, and within Alaska there are approximately 20,000 covered lives outside the state’s population centers. This would increase access to routine health care services for all retirees, but particularly for those in state and out of state who do not live near many, or any, options for care at a convenient distance, or who may have to wait or travel significant distance to have an in-person appointment.

- Judy Salo asked why the higher cost for consultation with a dermatologist? She provided an example of checking a skin mole, would an in-person visit be less expensive than Teladoc?
 - Emily Ricci responded it will depend on whether the provider is in network and whether the individual has met their deductible. Dermatologists do have higher charges typically, and it is common to see balance billing from out of network providers. While \$75 may seem like a higher charge, it may or may not be less expensive than an in-person visit particularly in Alaska, depending on if the dermatologist is in network.
 - Judy noted that a person with dual coverage may also not see an advantage to using Teladoc for this service.

- Emily agreed, staff need to analyze the potential impacts of those who have coordinated benefits, to understand how this would impact co-pays for this group.
- Mauri Long noted that the other consideration would be whether the payment to Teladoc is considered a co-pay, deductible-eligible or an out of pocket expense.
 - Shane Francis asked whether in the employee plan, the Teladoc charges are subject to the deductible?
 - Daniel Dudley noted there was previously an error between Aetna and Teladoc systems, Aetna manually entered this information. Co-pays for these services are counted toward deductible and out of pocket maximum but will need to be manually adjusted.
 - Emily added that manual adjudication adds cost in terms of staff time, this would need to be done on retiree side as well and this will need to be considered as part of the cost.

Member impact: Emily Ricci reiterated that staff will analyze the potential impacts for members with coordination of benefits, as well as considering the relative costs of in-person dermatology visits versus those provided through Teladoc. She noted that Teladoc, while fully owned by Aetna, is not exclusive to that administrator, and could be accessed through a contract with another third-party administrator. This service would be available to Medicare and non-Medicare eligible members. Emily will research whether and how this is covered under Medicare; if it is not, AlaskaCare would presumably be the primary payer and cover this service for all retiree members and dependents.

Actuarial impact: Staff do not anticipate an actuarial impact in either direction, as this would simply increase access to services for members.

Financial impact: The employee plan is structured as a per-member per-month fee, but the retiree plan would be structured as a per-subscriber per-month fee instead, meaning the plan would pay only for those retirees who opt into this service. The three types of calls have differing charges, and the plan would cover these at different rates: the medical call would be a \$5 co-pay for the member and the remaining \$40 (of \$45) is paid by the plan. The dermatology call would cost a member \$75 the remainder would be charged to the plan. The caregiver call would be fully the responsibility of the member, also a \$45 total charge. Staff estimate there would be approximately \$0.09 difference in the per-subscriber per-call cost versus the cost to the plan of current services, based on the estimates of avoidable low-severity care that could potentially be handled through Teladoc.

- Joelle Hall asked, in addition to the per-call costs, is there an overall cost to the plan for services such as marketing to encourage members to use this service, and education to help members feel comfortable using this service in the future and therefore redirecting care?
 - Emily Ricci noted that the estimates do not include marketing and outreach at this time, but Teladoc has marketing materials available that can be customized for the plan. Staff are considering a registration drive, including an incentive for employee members who register, and potentially a reduced co-pay for the first six months. They have not seen the anticipated return on investment (ROI) to date because utilization has been lower than they assumed originally, so they intend to determine if more outreach makes a difference in utilization among employees.
 - Joelle also asked if it is feasible (and legal per HIPAA) to review the types of diagnoses and past utilization of members for non-emergency care, and whether these members that can be targeted (for marketing purposes), and encouraged to use Teladoc?

- Emily responded that staff have discussed this, and some companies have offered this service in the past, but the Division is uncomfortable with the privacy issues associated with that type of targeting, particularly as the State in this instance is a former employer. She does not believe the Division will consider this particular option.
- Mauri Long asked whether the cost includes only a per-member per-month fee, or are there other costs associated?
 - Emily Ricci explained that the cost does include a baseline administrative fee, and this impacts overall costs to the plan because there is a set cost to offering the plan, and if it is not sufficiently utilized, that set cost is spread across fewer members.
- Judy Salo asked why specifically the terminology “subscriber” versus “member”?
 - Emily Ricci clarified that in this context, “member” means anyone covered under the retiree plan, including the retiree or their dependents. “Subscriber” would be limited to the retiree, in this case who have opted into this system, and is not per member in this instance. Including dependents would make their subscriber base number fluctuate more, as people are added or removed from the plan regularly. The intent is to include a more stable number as the cost basis, in this case the employee or retiree-subscriber.
 - Judy asked if this service could be accessed by dependents directly, not just retirees?
 - Emily responded that yes, a subscriber could be any member of the plan and have access to the service, it is only cost that would be set by subscribing retirees only.
- Cammy Taylor asked for clarification whether “covered lives” counts a person with coordination of benefits once or twice, for example? She wants to ensure terms are used accurately.
 - Emily Ricci shared that covered lives include anyone covered on the plan, retirees (Medicare eligible or not) and dependents. Whether coordination of benefits factors in depends on the situation.

Shane Francis presented Table 4, an estimate of 2017 services in the retiree plan that are potentially avoidable, low-severity care that could be addressed through Teladoc services rather than in-person visits to the emergency department, urgent care, primary care and/or a specialist. The total estimate of avoided cost, based on 2017 actuals, is \$4.4 million. This does not mean that all the services, for all impacted members in all situations, would be directed to Teladoc; the estimate assumes that at least some of these services could be substituted, at lower cost to the member and the plan.

- Mauri Long asked for the employee plan, whether the Division has identified a percentage of services targeted to redirect to Teladoc, versus actual percentage?
 - Emily Ricci responded that the initial goal would be 5% for the first years of utilization, matching the employee plan.
 - Shane Francis clarified the 12% assumption: that up to 12% of the specific category of avoidable services provided could be done through Teladoc.
 - Richard Ward added that their overall estimate in the employee plan was based on a different path of assumptions, that overall 5% of services would be provided through Teladoc instead. He added that based on recent experience in the employee plan, it is likely that this should be viewed as a “slow to grow” scenario and would revise this.
 - Emily added that there may not be an initial ROI because of the slow uptake in utilization as people become more comfortable with the service. She believes this will be an industry standard going forward as more plans adopt this option, and that it will

likely be most beneficial a few years down the line and anticipates that the initial investment would pay off over time as this becomes a care standard.

- Judy Salo commented that she is personally excited about the prospect of this service and is less concerned about the ROI on its own. She asked whether, in general, the cost of this service is less than an in-person visit (office visits, urgent care and emergency care)? The key will be whether this is a less expensive option.
 - Emily Ricci noted that staff will need to research this, but she is not familiar with a situation in which an office visit cost less than \$45 (Teladoc cost). There may be more “minute clinics” that are more competitively priced, but these primarily exist in the Lower 48, not in Alaska. She would need to research dermatology costs but does not believe the cost of an in-person visit is less than \$75. She also reiterated that the primary benefit is access to care, and convenience of addressing a medical issue without having to make an appointment and attend an appointment in person.
 - Judy also asked about the comparable rate schedule of these services.
 - Richard Ward shared that a typical Alaska office visit is \$165 to 175, and an office visit in most other states is \$95 to \$100. The other urgent and emergency care options are significantly more, and may represent less substitution than routine visits, but the differential in cost would be much higher.
 - Richard added that based on Segal’s national survey of public sector health plans across the U.S., approximately one quarter offer this service.
 - Judy commented that this has great potential to have significant impact on the cost and character of medical care nationally and could reduce costs systemwide for some care.
- Mauri Long commented that if the costs for a dermatology visit are lower, she believes it may be difficult to attract more providers into the network. Having a relatively high co-pay for dermatology services may help maintain a more robust network. For example: 20% co-insurance of the Teladoc fee of \$150 would be \$30.
- Cammy Taylor asked staff to research the cost of a typical in-person dermatology visit in Alaska.
 - Richard Ward and Shane Francis commented that the cost is likely about \$300, with 20% of that amount being about \$60.
 - Joelle Hall noted that looking at the difference between a Teladoc visit and traditional visit, an additional \$15 cost may be more of a convenience charge to have more ready access, as well as for people who do not have access to a dermatologist locally and would otherwise have to travel for an appointment.
 - Judy Salo asked whether Joelle is contemplating a \$60 co-pay instead?
 - Joelle noted that the charge in Anchorage would not represent all providers’ charges in all places but could be a good initial estimate for comparison.
 - Mauri Long commented that she believes even a lower co-pay may be appropriate and gave an example of someone who is prone to skin cancer or had previous diagnoses and would be more likely to proactively reach out for a consultation if they see anything concerning. Having a remote service may be beneficial for members in this situation, while a higher co-pay may be a deterrent to seek care. A co-pay of \$25 or \$30, for example, may be more attractive as an incentive and would help people identify a potential cancer diagnosis sooner, saving considerable treatment cost and health impacts to the member.

- Judy Salo commented she is contemplating a continuum based on the types of services.
- Joelle Hall asked, for example, whether health information (such as a picture of a potentially cancerous mole) is collected through Teladoc over time, for example if someone calls for 3 different consultations over a year, is this data available as a health record? Would a primary care provider be able to access this information as well, providing a record for future reference, accessible outside the Teladoc system? Or is each episode of care considered separately, and not keep records of previous information? Is there an electronic health record built into the system that the member, the Teladoc providers, and/or other providers can access?
 - David Broome did not have this information in the meeting but will research this question. He speculated that it is likely they keep some form of electronic record, but he is not sure whether it can be shared outside the Teladoc network.
- Judy Salo asked whether this could be used for follow-up visits, for example, such as sharing information back with a primary care provider if there is something needing follow-up?
- Cammy Taylor asked, in the situation of a diagnosis of skin cancer, what if any services would Teladoc provide? They may be used, for example, as a screening mechanism, and if they live in a place that requires travel for a follow-up, can this be used as an initial screening and initiate a referral for in-person follow-up? They would not provide cancer treatment, for example. How can this be coordinated with other providers?
 - Joelle Hall added that for dermatology in particular, for cases of ongoing conditions like psoriasis that may require follow-up visits and travel, this could be a helpful supplement to in-person visits. She believes this is potentially a great benefit, especially for people who do not live in communities with specialty providers and would have much easier access short of having to travel. However, she would like to know how their data can be managed and accessed over time and ensure that the member has consistent care.
 - Emily Ricci thanked the committee for the questions and raising these important issues. She encouraged the group to think of Teladoc as a complementary service to traditional care, and useful primarily for a limited set of diagnoses and services, including an initial diagnosis that may require follow-up. She noted currently there is very limited coverage of travel for retirees and does not include coverage of travel for diagnostic services.
 - Joelle asked, for example, if a Teladoc provider diagnoses a mole needing follow-up, would this provide a basis for pre-authorizing travel for follow-up treatment?
 - Emily Ricci noted that in that situation it may be helpful to get pre-authorization for treatment services during travel, in case the diagnostic is immediately followed up by travel and therefore the travel could be covered under the plan.

Staff will revise analysis with a dermatology visit cost in Alaska and prepare a comparison of Teladoc costs for dermatology versus an in-person dermatology visit in Alaska.

Topic: Setting Recognized Charges

Emily Ricci prefaced this proposal by saying it is preliminary and will likely change during the discussion and in future work.

This proposal is to change the recognized charge (what the plan will cover) for a non-network provider as a percentage of Medicare rates for that service, rather than the current method to pay to the 90th percentile of charges for that service. An in-network provider is part of a contractual obligation with an

insurer or plan administrator, which includes the agreed rates for each service and an agreement that a provider will not bill the member additional charges (balance billing) if the provider would otherwise charge more for that service if they were not in network. In-network providers protect against balance billing for members, because this sets rates.

For out of network providers, the insurer needs to determine how they will pay (as a policy) for those services—for example, the insurer could pay 100% of charges billed, but this may mean that a provider charges significantly more than the insurer would otherwise pay in network. There is financial incentive for providers to bill more, so the insurer needs incentives to limit what they will pay for out of network services, and a policy for what they will pay. Balance billing has become an increasing problem, as out of network providers are allowed to bill members for higher charges, resulting in more costs to members.

Emily also shared challenges with the current plan design that makes it difficult to address costs: Fair Health (previously Ingenix), a national data source that collects data from providers across the U.S., including some regions of Alaska, divided by grouping of zip codes. Providers report their charges for services by CPT code, and the company generates an estimated recognized charge based on those averages in that geographic area. AlaskaCare reimburses to the 90th percentile of charges based on this data, which means that the reimbursement rate adjusts over time and therefore members are protected by a ratio rather than a dollar amount. However, the 90th percentile create incentives for providers to increase those charges over time because they can be reimbursed more collectively, out of network.

Alaska has a current regulation for fully insured plans regulated by the Alaska Division of Insurance, requiring insurance plans to reimburse up to the 80th percentile for out of network care. ISER economist Mouhcine Guettabi has conducted an analysis of the impacts of the costs of health care in Alaska and whether there is a correlation between that requirement and costs of care; his analysis to date has shown there is probably some correlation with our high health care costs and this policy. This is contentious in Alaska, particularly among providers and insurers, where there is already limited competition; it creates less incentive for providers to join a network because they can potentially be reimbursed more than if they were in network. Additionally, removing this regulation (or equivalent policy in AlaskaCare) could potentially expose members to balance billing, because the regulation does not allow that practice. (Clarification: the regulation governing fully insured plans is separate from AlaskaCare's policy, and the AlaskaCare policy does not require regulation change to implement).

The proposal is to change the out of network reimbursement policy from the 90th percentile rule to reimbursement at a certain percentage of Medicare rate. The initial proposal is 185% of Medicare rates. The Division could also consider changing the percentile reimbursement, such as 80th or 70th percentile, or could consider reimbursement at a set rate. Emily offered these as options for illustration.

- Cammy Taylor asked how the proposed 185% of Medicare rate compares with current recognized charges in Alaska?
 - Emily Ricci shared that this percentage was utilized for facility reimbursement (hospitals) based on what they are paying for Alaska Regional services currently. She noted that this becomes more challenging outside Anchorage, as the differential would change, and likely be greater, because generally prices are higher in other communities in Alaska. She shared that Division of Insurance has considered implementing 200% Medicare rate for out of network charges, instead of the 80th percentile rule. She also

shared that there was proposed legislation in 2018 to change this for the employee and retiree plan, but there are reasons why this would have been challenging to change in statute for the retiree plan, and this has been tabled to her knowledge.

Emily noted that this change to a percentage of Medicare would actually benefit primary care providers, who are reimbursed now at lower rates, but would negatively impact specialty providers such as cardiologists, who currently charge much higher rates. It would also only apply to out of network providers, so it would provide incentive for providers to join the network instead, which has historically been a challenge in Alaska but is changing partly because of other plans' design changes. Another important issue to consider with this proposal is that at least some members, particularly in Alaska, have few or no in-network care options, and would most likely continue seeing a local provider even if they are not in network. The plan would need to ensure that these members are not penalized for not having in-network options close to home.

Outside of Alaska, this would not represent a significant change for providers, and would actually be a higher reimbursement for providers compared with current rates in most other locations. This proposal also would not have a significant impact for Medicare eligible members, who must go to a Medicare provider, and Medicare providers have to agree that they will not balance bill members. This would not simply be a cost savings for the plan, but would incentivize more providers to join the network, which has benefit for members and the plan.

Emily reiterated that the plan currently has no design allowing for steerage toward in network providers, which means that members may have to pay more for an out of network provider because the coverage is different. This would increase leverage and bargaining power with providers by incentivizing network participation, without requiring changing deductibles and other member costs; however, depending on how it is structured, it could have increased cost to members, because of out-of-network balance billing.

- Judy Salo asked whether it is common for a person to receive an episode of care, for example at a hospital, where some providers are in network and others are not? Some services, like anesthesiology, are provided at a hospital but by non-network providers. Is this a problem?
 - Emily Ricci responded that the situation has improved particularly with Alaska Regional in Anchorage, they have worked to get all providers within their hospital to be in their network. It used to be more of an issue in the employee plan, and to a lesser extent the retiree plan. She also shared that in Juneau, staff met with Chuck Bill (CEO of Bartlett) to discuss the issues raised in his public testimony at an earlier meeting. In Juneau, most if not all of the anesthesiologists in Juneau are out of network. She noted that this proposal, combined with the enhanced travel benefits proposed, could provide a significant incentive for those providers to enter the network because members will seek care elsewhere. She stated that it is not an acceptable status quo for members to be significantly balance billed for local care.
- Judy Salo asked whether there would be an education plan for members to explain what the benefits are for staying in network?
 - Emily Ricci agreed, particularly with Alaska Regional, they do intend to provide education for members of why staying in network is beneficial. However, she noted that the implications for travel need to be worked out.

This policy has been implemented in the employee plan already, for the Municipality of Anchorage and providers outside Alaska. The Division will have more thorough analysis of how it is working so far next year after collecting sufficient data. They are also looking at implementing this policy on a per facility basis in Alaska, depending on the strength of the network and options for care.

There are multiple options: it could be applied to facilities only, or to professional services only, or a combination of the two—even a limited implementation of this policy for facilities alone would give the plan significant leverage compared to today.

- Mauri Long asked whether there is sufficient data from this change in the employee plan to understand impact on costs?
 - Emily Ricci shared that the employee policy was implemented January 2017; they have 2 years of data available and will be doing an analysis of this. The facilities included are the ambulatory surgery center in Anchorage, Alaska Regional, and facilities covered in the Coalition plan. The plan has already achieved significant savings ahead of schedule, including 2 plan years ahead of when they anticipated reaching a certain benchmark.
 - Mauri also asked whether there has been an impact of costs to members?
 - Emily shared that they have not had a chance to do thorough analysis of impacts on members, but have found that for ambulatory surgery centers, those facilities have been writing off the excess cost rather than balance billing members.
- Cammy Taylor shared a common complaint she has heard, that there has been a long wait time for accessing care at a network facility. Has this been resolved?
 - Emily Ricci is aware of that issue, but the complaints about that specific issues have reduced recently as well. The issues employees experienced were related to more steerage policies in the employee plan that were also put into place.
 - Cammy asked whether there is too small of a network in Alaska to make this feasible?
 - Emily pointed out this policy in itself isn't steerage, it doesn't change the plan network, it primarily impacts reimbursement for providers. Steerage isn't contemplated in the retiree plan at this time.
 - Cammy questioned whether having too low of a rate would be an issue, because not enough providers would participate, and members would be balance billed?
 - Emily reiterated that the goal is to not pay out-of-network providers more than in-network, since this creates a perverse incentive to remain out-of-network. The plan changed this just for one ambulatory surgery center in Anchorage. She stated again that the employee plan had other changes that are not being considered for the retiree plan.
 - Cammy reiterated that she is still concerned about penalizing members for not having options if the network is not adequate. She shared that in other states, the equivalent agency managing plans has put in place a standard policy for determining whether a network is robust enough to be feasible to use this policy, before considering a penalty. She recommended staff consider this option as well to protect members.
- Joelle Hall noted that reducing rates for out of network services could still incentivize providers to charge members more to make up the difference.
 - Emily Ricci agreed that this is a risk, they are still conducting analysis of this risk and possible additional costs for members if providers do balance bill. She also noted that previous data has shown that for the retiree plan, utilization in network is already high

because it includes Providence and Alaska Regional. There are still certainly many out of network providers in other communities as well, but the Division has worked to bring major providers in network.

- Betsy Wood also reminded the group that for the Medicare population, they must see Medicare providers and are protected against balance billing through that plan.
- Cammy Taylor also reminded the group that it is difficult to find Medicare providers in Alaska, so this is a challenge for those members compared with the rest of the U.S.

Emily noted that the proposed reimbursement rate, 185% of Medicare, is simply for discussion, and could be adjusted to an appropriate level.

- Joelle Hall asked whether implementing this would require, or can be accomplished by, a legislative change?
 - Emily Ricci confirmed that any change could be made by legislative action, but that would most likely still require a *Duncan* analysis per the legal considerations for the retiree plan in particular and cannot be done by legislation alone.

The Board took a break for lunch at 12:07 p.m. and resumed at 1:15 p.m.

Topic: Rehabilitative Care Benefits

The Division has met with several chiropractors recently to understand their current practices, concerns about the proposals being discussed, and other issues. An earlier version of this proposal was already discussed and considered a number of visits or other limit on rehabilitative care to clarify what the plan will or won't cover.

Since that time, the Division has been introduced to Secure Care, a company with an alternative method for appropriate utilization of these services. This may be a proposal for inclusion in the retiree health plan potentially. The plan for today's meeting is a presentation about Secure Care and a brief discussion and questions about their services.

- Cammy Taylor asked for clarification, this is for chiropractic care or other rehabilitative care?
 - Emily Ricci confirmed that this company only addresses chiropractic care at this time.

Bharon provided a brief presentation on Secure Care, an organization based in Nebraska. (Please see the attached presentation in the meeting packet for more information.) He also noted that his company is contracted with Aetna specifically for chiropractic care, but they do operate in other markets and handle care services. They are therefore currently operating in Alaska to some extent, through Aetna.

There is a great deal of focus on pain management and rehabilitative services, and a conservative approach to care in this area tends to encourage several visits to ensure that a patient is improving over time. As a result, there can be tension between providers and insurers, balancing appropriate level of care with proper utilization of these services. Secure Care's approach is conducting retrospective analysis and identifying specific issues with utilization to discuss with providers. In the company's experience, there is primarily over-utilization among 10% to 15% of providers, and it not a global issue. Their approach is to communicate regularly with the insurer and with the providers and develop benchmarks of appropriate utilization based on the data available, various conditions, and other factors. (This may be measured, for example, as a number of visits per year). Using this benchmark approach, it is easier to identify outliers (patients who are utilizing a much higher number of visits than the typical

range of normal). Secure Care provides monthly information to providers, including the benchmark utilization numbers within the plan, the range of utilization among their peers, and educates providers about these ranges. Generally speaking, providers are interested in what their peers are doing, and not wanting to order inappropriate care. He also noted that the current practice of pre-authorization or setting limits on care upfront, which has more costs for all involved.

Example: massage services are currently over-utilized in the Alaska market; the benchmark is typically approximately 2 massage visits per patient per calendar year. Secure Care would approach this by analyzing which providers are providing these services at higher frequency and reaching out to those providers to work with them and put more appropriate benchmarks in place.

- Emily Ricci asked, given their current relationship with Aetna, whether Secure Care would be able to contract with the State directly or via a different third-party administrator?
 - Bharon shared that yes, Secure Care could contract directly with a different entity, and can build their own network. He noted that they do not do claims processing, they do provide a network and utilization review; they do credentialing and other back-end services, but not have a direct relationship with plan members. He also noted that their current relationship with Aetna is such that Aetna provides some of these services, so they would look to the third-party administrator to handle those services.
- Joelle Hall asked, hypothetically, if a person is in a car crash and needs rehabilitative services, would they still be able to access medically necessary care? For a person who is seeking these services on a non-emergency basis, will their medical need be measured differently? Will members be able to access the appropriate level of care for their situation, recognizing that it may be a few visits per year or a few dozen?
 - Bharon noted that nationally, they have over 8,000 providers in their network; payers are certainly all interested in directing appropriate utilization. In the aggregate, this means that they can develop benchmarks that respond to these needs and different conditions. There is also some latitude in these benchmarks, recognizing that there are different scenarios depending on the person and situation: unlike a hard limit in the number of visits, this can accommodate a range of scenarios depending on medical need. He also noted that having a set number of visits in place may provide an incentive to seek additional care up to that limit of visits, which would not identify inappropriate or potentially inappropriate utilization until that limit is met.
- Joelle Hall commented that retirees may be more active than the average population in that age range, especially age 55-65 who are very active (Alaska).
 - Bharon agreed; this is of interest to his company to see how this population differs from the national average and is part of the reason they would like to work in Alaska.
- Cammy Taylor asked for clarification: if a member seeks care, they would still have the claim paid, is that correct? If the utilization review is done after the fact instead, would this impact a member's ability to access care and have those claims paid? Would they be billed more?
 - Bharon said the reviews are done monthly, they can work proactively to address issues by doing regular reviews and communicating with providers. If improper utilization continues, they could recommend to Aetna that the provider should be removed from the network if they do not change this behavior. If there is an egregious situation, a

provider may need to pay back the third-party administrator or be subject to an audit. This is not a common situation, and not the company's first course of action.

- Cammy asked whether, if the provider must pay back claims, would the member ultimately be responsible? She is concerned about holding the member harmless in a situation in which the provider is at fault.
- Bharon noted that this is uncommon and does occur, but if they are in network, the provider is not allowed to bill for the balance per the terms of the network contract.
- Emily added that this situation is not often known to the State or to Aetna until after the fact. For example, a member may receive a bill, even though it is not allowed under the network agreement for the provider. At this point, the member can bring the provider's breach of contract (through billing the member for the balance) to Aetna's attention. This is probably best dealt with on a case by case basis.
- Mauri Long asked whether Secure Care has operated in other care environments, or only in rehabilitative care at this point? She is interested, for example, in whether they have worked on high-tech imaging services based on the discussion earlier today.
 - Bharon responded that originally Secure Care focused on chiropractic care, but they expanded into physical therapy and other areas over time.
- Judy Salo asked whether Secure Care has worked in the area of rolfing, which has been a request of several members? She explained that rolfing is a deep tissue massage technique that is popular in Alaska.
 - Bharon is not familiar with this service; Secure Care does not cover this service.
 - Judy asked the Division if they have continued to get requests for coverage of rolfing?
 - Emily Ricci noted that because rolfers are not a licensed profession like massage therapists, they would not be able to bill because there is not a billable service (codes).
 - Bharon added that it is difficult for them to oversee and analyze data of an activity that is not regulated by the state, because there is not available data on the best practices or typical practices for this service. They limit their services to those regulated by states.
- Judy Salo asked if ART (active release techniques) is a licensed activity, and reimbursed?
 - Bharon noted that it will depend on whether the state regulates and licenses that profession, and if there is a billing code for that service, and whether there is available data and care standards to develop those benchmarks. He was not specifically familiar if this service is covered.
- Ajay Desai asked whether American Specialty Health (ASH) is similar?
 - Bharon noted that they are a competitor of Secure Care. That company's approach is to lower the fee schedule and set services limits and number of visits. He believes that this approach creates more tension with providers and caused conflicts in other markets.
 - Shane Francis asked whether this fee-setting approach is approved by their clients?
 - Bharon responded that this is a more traditional approach to managing rehabilitative care and described limitations of this model. He noted that the approach may also disincentivize providers staying in network, which is contrary to Alaska's goals. He noted that in markets other than Alaska, remaining out of network is not an issue because providers are more concerned about losing access to a network in the rest of the U.S.
- Judy Salo asked whether this primarily would impact retirees who are not eligible for Medicare, or would it impact all retirees and members?

- Emily Ricci noted that this would primarily impact non-Medicare-eligible members, but there are complications related to Medicare’s coverage (or non-coverage) of rehabilitative services such as chiropractic care, staff are working to understand the billing issues for Medicare, and whether Medicare would cover that service. It relates to the types of services and CPT codes chiropractors could bill for under Medicare.
- Judy shared that her understanding of massage therapy services is reimbursement changes significantly for those who are eligible for Medicare and gave a personal example that she could no longer use her previous chiropractor because they did not want to deal with Medicare reimbursement. Is this still the case?
- Emily responded that she is still learning the details of this policy but is not aware of any policy changes in the last two years that would have resulted in a change to this issue, so she believes this will still be an issue for Medicare eligible members.

Emily concluded by stating that staff intend to update the rehabilitative care provisions, limiting the reimbursement for out of network providers and considering a different utilization approach that is provided by Secure Care, using retroactive utilization review and benchmarks based on existing data and utilization. She also noted that the Division has been aware of Secure Care entering the Alaska market for the last 12 months, and heard about this from chiropractors, but she is not yet aware of how robust the network is in Alaska and whether it would be sufficient to make these policy changes feasible.

- Cammy Taylor commented that her understanding is that Secure Care is utilizing the Aetna network, is that correct?
 - Emily Ricci clarified that Secure Care still maintains the network, rather than Aetna negotiating directly with providers to create a network. She noted this is similar to the agreement the State adopted with the Pacific Health Coalition in the employee plan, to adopt the Coalition’s network of providers. Aetna is also providing services but using Secure Care’s network.
 - Cammy noted it is important to understand the terms of network agreements and whether those agreements are transferrable to another network, if the State selects a new third-party administrator.
 - Emily Ricci noted that this needs to be researched, including which clinical policy bulletins the payer is using. She also noted that this is a different type of utilization review, rather than setting hard limits upfront.
- Joelle Hall returned to the available utilization numbers and restated that the issue at hand is that the language of the plan is vaguely worded, and members are confused about when their services are or aren’t covered. Would the plan language also need to be changed?
 - Emily responded that yes, the plan language would need to change. She proposed changing the booklet to clarify that maintenance care is covered; this is one of the sources of conflict and confusion. She recommends not referring to Secure Care specifically, but to refer to “in network” and “out of network” and administratively the network would be determined by the third-party administrator.
- Judy Salo thanked the Division for considering this approach. She asked for more understanding in terms of timing: could any of this analysis be available for the Board’s May 8 meeting?

- Emily Ricci clarified that the proposal itself could be updated to reflect this, but the financial and actuarial analysis would not be ready by that date. Staff could provide this at the meeting for the board to reflect on and follow up with more analysis later.
- Judy Salo indicated yes, this would be valuable information for the Board, and she would like to at least have this presented in the May 8 meeting as a starting point.
- Judy Salo asked how many chiropractic providers are in network and out of network in Alaska?
 - Emily Ricci noted they would need to research this information.
 - Shane Francis offered that the split is approximately 50% in network, 50% out of network, but they will research to get more specific numbers.
 - Emily added that the Division is interested in pursuing this option and may pilot this in the employee plan to understand whether it is beneficial and clarifies the issues that have been identified in the plan to date.

Staff will update the analysis and provide this information to the Board on May 8 and will work on updating the financial and actuarial analysis.

- Joelle Hall asked whether staff has done an analysis of the impacts of changing out of network reimbursement, given that there is a pool of individuals who are not Medicare eligible, and over time more will become Medicare eligible? She interested in understanding the long-term cost-benefit analysis of these changes, for example some may yield some savings but have significant cost to implement, and as people move into the Medicare population the potential savings are diminished or are otherwise limited once people change status to Medicare. She would be interested in the “curve” for some of these proposals, over say 2005 to 2019 to a future year, and whether for example savings would be significant, or if potential savings would be limited in scope as soon as that population moves into Medicare. She would like to see an analysis of this to understand what the most impactful changes would be. This would help the Board weigh the cost-benefit of these proposals over a longer period of time.
 - Richard Ward noted that unlike the ARMB (managing the long-term pension obligations), health plan changes tend to be analyzed over the next 2-3 years, rather than analysis over future decades. He anticipates, hypothetically, the “last” Tier 3 retiree would remain in the plan for the next 50 years, including years of employment and 10 to 20 years of retirement on average. He noted also that health plan changes tend to be more dynamic, some of the policy design changes are addressing issues now and may need to be revisited from time to time. He suggests conferring with DRB staff further.
- Cammy Taylor commented that in the years she has been working on this area, she noted that the Medicare share has gone from 50 percent of the pool to 60%. What point would the population be 70%, 80%, 90% Medicare, over what period of time?
 - Richard noted that people are living longer and retiring later, so the population who is retired but not enrolled in Medicare is getting smaller.
 - Cammy agreed that these are factors, and also noted that the system is “closed”, and new people are not added to the system, other than those who would have qualified and who may return to state employment, and any dependents added. She noted that it should be possible to generally model the changes to this population over time.
 - Richard Ward noted that his firm works on the health plan and not the retirement plan, which may have longer term analysis available in terms of plan membership and

demographics over time. He tends to look at the short to medium term analysis for health plans. He recommends looking at the retirement plan data for a projection.

- Cammy reiterated that this would be helpful, and if another agency has research that could be used to understand the long-term implications of what they are considering.
- Joelle added that the group is at least interested in reviewing information to understand the degree to which it should influence decisions about which proposals to recommend in the modernization project. Some may have less long-term benefit relative to costs.
- Emily stated that staff will research this information and find existing analyses and long-term projections for the retiree population.
- Emily also noted that the reason for focusing on the non-Medicare population is because AlaskaCare is the primary payer, their medical costs are not paid by another payer, and therefore is disproportionately high to their size in terms of costs to the plan. She offered as an example; the overall retiree plan is approximately 35% pharmacy costs; this was one of the benefits of implementing the EGWP for pharmacy costs. For medical costs, the non-Medicare eligible population will always have more relatively cost to the State, because there is not a second payer like Medicare. She also noted that there are still Tier 3 employees who are not likely to retire for multiple decades, so this is certainly a long-term consideration for people not in the plan today.
- Joelle Hall described her interest in defining more clearly a threshold for cost-benefit, and factoring in other costs such as the number of years savings accrue, magnitude of savings, etc.
- Cammy Taylor shared with the group that the current breakdown is now 70% Medicare.
 - Emily Ricci asked for clarification, is this health plan or retirement plan population?
 - Cammy noted that this is from the February 2019 quarterly health plan meeting.
 - Emily noted that this is a point of time of current eligibility today; over time, this would need to be projected out to estimate how many people are not eligible how and when they would become eligible.

Staff will follow up with an estimate based on projections from the ARMB and confer with those staff.

Topic: Pharmacy Policy Changes

Emily prefaced by noting that these proposals may or may not be beneficial when staff conducts additional analysis; these are presented for initial discussion.

The proposal is to remove coverage of drugs that are available over the counter, or over the counter (OTC) equivalent. She noted that this is a common policy in other health plans, with the exception of prescriptions that are required to be covered by the Affordable Care Act. This means that the health plan would not pay for a prescription if it can be purchased without a prescription.

In 2014, when the State changed medical third-party administrators, the policy changed to discontinue coverage of over the counter drugs if there was a prescription version available. Additionally, retirees who raised issues with this policy change noted that by not covering the over the counter equivalent, this resulted in higher cost to the plan because it directed people to seek the prescription drug because it was covered and was a lower out of pocket cost than the equivalent OTC drug.

Options presented for discussion:

- Option A: Discontinue coverage of any drug that may have a prescription but is available over the counter as an equivalent. The member would be responsible for the cost of either the OTC drug or the prescription, if they chose to seek a prescription for that medication.
- Option B: Discontinue coverage of brand name drugs, if a generic and/or an over the counter equivalent is available and cover only the generic or OTC drugs.

Shane Francis presented that an “equivalent” by the FDA is considered equivalent if it has the same active ingredients, and one can take equivalent dosage or substitutable. (Example: a prescription is 40 mg Nexium, the generic is 20 mg, it is possible to substitute 2 OTCs for one prescription). Analysis of the actual expenditures of drugs with OTC equivalents was primarily Prilosec and Nexium. A brand name prescription of this drug is \$500 for a 90-day supply; the generic version is \$287 for the same supply; the OTC equivalent is approximately \$39 for the same dosage, or less than 10% of the brand name.

In situations where a member may have challenges taking a generic or OTC version (such as an allergy to an ingredient or dye), the provider could still indicate that the brand name is medically necessary.

Member impacts: approximately 15,800 members have one or more prescriptions in this category, and about 8,500 have two or more of these prescriptions. If this policy were enacted (option A, not coverage at all), members who prefer brand name drugs would need to pay out of pocket, unless there is a medical necessity determined by a physician that they need the brand name. This would significantly impact members who would still want to pay for brand name drugs, outside of the current co-pays of \$8 for brand, \$4 for generic and \$0 for coordinated benefits and mail order.

Option B: covering only generic and OTC versions of the drug, unless brand is medically necessary. This would impact approximately 1,300 prescriptions. Digging further into the actual affected prescriptions filled under the plan, about 900 did not have medical necessity indicated for the brand name, while 400 did. Looking into that 900, about 250 had personal preference for the brand, while the remaining members simply requested the brand because it was the named medication on the prescription.

Staff have not completed actuarial analysis and have started analyzing the operational and financial impacts. Current expenditures are approximately \$5.8 million for this category of prescription, but the plan would lose the rebates available for those brand drugs. Option B is estimated to save the plan approximately \$300,000 to \$400,000 per year. Given these initial findings and remaining analysis to be done, it is still unclear if this is worth pursuing. Emily asked the committee for feedback on this proposal and whether to consider pursuing it further.

- Judy Salo commented that given all the other considerations, is it feasible to bring this back to the board at the May 8 meeting, or postpone this to August?
 - Emily Ricci noted that given the magnitude of cost savings, as well as staff’s concerns about the impacts to members in terms of frustration and time changing medications, she is hesitant to say this is a priority. One alternative is to focus instead on a marketing campaign, informing consumers that there are lower cost alternatives and that they should consider switching if it is appropriate, as a way to encourage behavior change without changing the plan design. She is not necessarily convinced that this is the best use of the group’s time in terms of pursuing this policy change for the retiree plan.
 - Judy commented that her household has some personal experience with this, they have filled a brand name prescription for several years despite it having higher cost. She

speculated that many people may not have noticed this change (that a prescription now has an OTC equivalent) and would be willing to change if they knew a lower cost alternative is available, particularly if it is lower cost to them.

- Emily reiterated that many other plans do not pay for OTC drugs because insurers have determined that should be borne by the consumer, but this does not mean it is the most appropriate change for the retiree plan specifically.
- Judy Salo asked whether it is worth asking the Board to weigh in on this proposal further?
 - Cammy Taylor commented that if the August meeting is potentially the time to determine which proposals will move forward for discussion as part of the public process, then the May meeting should focus on proposals that need more discussion as a result of this committee work. She also noted that there will be several other contentious proposals in the package for discussion, so if this does not seem to have a promising cost savings attached, it may not be a priority.
 - Emily reiterated that prior to the discussions today, there have been several other positive proposals (representing potential enhanced benefits for members) discussed earlier in the year and late last year. After completing those discussions, the group is now working through the more difficult proposals that are likely going to have more pushback from members and would be offsets to these other benefits.
- Judy expressed interest in letting this proposal sit for now and focusing on the others.

Staff concurred and will table this proposal for the time being.

Item 4. Closing Thoughts + Meeting Adjournment

Emily Ricci thanked the committee and the rest of the Board for their close work on reviewing these proposals and raising important questions for discussion. Staff will work to prepare the follow-up analysis for the May 8 meeting, and for future modernization committee meetings this summer to continue the committee's work on proposals that still need discussion.

Emily Ricci shared that through this work, they have identified the major items for discussion, and what seems more or less feasible to review. They will also have several housekeeping issues in the plan booklet that they will propose clarifying changes for and would like to work through these with the Board as well as releasing the plan booklet for public comment before moving forward with any changes. Staff understand that any change to the plan is potentially contentious and needs careful review, even the housekeeping items staff anticipate proposing in the plan booklet.

Cammy Taylor proposed selecting two dates in June and July for upcoming committee meetings following the May 8 meeting. Staff will work with the committee to schedule these meetings.

The Retiree Health Plan Advisory Board will meet on Wednesday, May 8. Future Modernization Committee meetings will be scheduled for this summer.

- **Motion** by Mauri Long to adjourn the meeting. **Second** by Judy Salo.
 - **Discussion:** None.
 - **Result:** No objection to adjournment. The meeting was adjourned at 2:50.

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>

DRAFT-Summary of Responses to Proposed Plan Design Change

Proposed change: Implement Three-Tier Pharmacy Benefit

Plans affected: DB Retiree Plan

Reviewed by: Retiree Health Plan Advisory Board

Proposed implementation date: TBD

Review Date: June 6, 2019

Table 1. Plan Design Changes

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

Description of proposed change:

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

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

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

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

* Up to 90 day or 100-unit supply

DRAFT-Summary of Responses to Proposed Plan Design Change

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

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

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

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

Member Impact:

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

¹ A similar process is currently in place for the AlaskaCare defined benefit retiree standard pharmacy plan to categorize drugs as either brand-name or generic.

² Segal Memorandum, Pharmacy 3rd Tier Copayment, dated June 7, 2019.

DRAFT-Summary of Responses to Proposed Plan Design Change

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

DRB operational impacts:

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

Actuarial Impact

Neutral / Enhancement / Diminishment

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

Financial Impact to the plan:

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

Clinical considerations:

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

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

Third Party Administrator (TPA) operational impacts:

The PBM will need to establish and maintain a formulary that classifies medications into one of three tiers, assist in identifying and informing members who may be impacted,

³ Segal Memorandum, Pharmacy 3rd Tier Copayment, dated June 7, 2019.

⁴ Ibid.

DRAFT-Summary of Responses to Proposed Plan Design Change

assist in communicating the change to network pharmacies, and will need to update their programming to accommodate the change. These activities will largely occur prior to implementation. After the proposed change is established, the PBM should not anticipate significant on-going work.

Provider considerations:

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

Documents attached include:

Document Name		Notes
Segal Memorandum, Pharmacy 3rd Tier Copayment	 Segal 3 Tier Pharmacy Memo 2019	



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MEMORANDUM

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

From: Richard Ward, FSA, FCA, MAAA

Date: June 7, 2019

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

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

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

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

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

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

Actuarial Value

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

Financial Impact

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

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

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

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

DRAFT-Summary of Responses to Proposed Plan Design Change

Proposed change: Expanding Telehealth Services to AlaskaCare Retirees

Plans affected: DB Retiree Plan

Reviewed by: Retiree Health Plan Advisory Board

Proposed implementation date: TBD

Review Date: June 12, 2019

Table 1: Plan Design Changes

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

Description of proposed change:

This proposal would expand access to telehealth services for members covered under the AlaskaCare defined benefit retiree health plan. Access would be expanded by providing retirees and their dependents access to a vendor, or vendors that connect members with a medical provider over the phone, via mobile devices or the internet, and/or by video for non-emergency medical episodes, dermatology consultations, and caregiver consultations¹.

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

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

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

DRAFT-Summary of Responses to Proposed Plan Design Change

Teladoc²

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

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

- general medical consultation: \$5 member copay,
- dermatology consultation: \$75 member copay, and
- caregiver consultation: \$45 member copay.

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

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

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

² Teladoc Health Presentation dated June 12, 2019: Attachment B.

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

CirrusMD⁴

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

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

Conversations between members and physicians begin on a text-first web or mobile application platform. The conversation can be converted to a phone call or video

⁴ CirrusMD Presentation: Attachment C.

DRAFT-Summary of Responses to Proposed Plan Design Change

chat if the member prefers. There are no time limits on member-physician conversations.

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

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

Background:

In 2017, low severity care⁵ accounted for 31% (\$237 million) of health care spend across both the AlaskaCare employee and retiree health plans. Low severity care encompasses non-emergency and minimally-invasive services. \$178 million (or 75%) of low-severity care costs were incurred by the retiree health plan, including \$25.7 million in out-of-pocket expenses (this number may be conservative in that it does not include any expenditures from ‘balanced billing,’ or the additional sum out-of-network providers may request from members).

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

Table 2: AlaskaCare Retiree Dermatology Costs 2017-2018

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

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

DRAFT-Summary of Responses to Proposed Plan Design Change

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

Table 3: AlaskaCare Retiree Primary Care Costs 2017-2018

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

Member impact:

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

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

Actuarial impact:

Neutral / Enhancement / Diminishment

Table 4: Actuarial Impact⁶

Actuarial Impact	
Current	N/A
Proposed	No Impact

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

DRB operational impacts:

As AlaskaCare currently has a contract with Teladoc, the operational impact of expanding benefits is expected to be minimal. Teladoc is currently subcontracted through

⁶ Segal Memorandum dated April 19, 2018

DRAFT-Summary of Responses to Proposed Plan Design Change

Aetna, the current medical Third Party Administrator (TPA). In the event of a transition, the Division may need to divert operational resources to transition telehealth services to a separate contract or a new vendor.

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

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

Financial impact to the plan:

The cost of implementing Teladoc in the AlaskaCare retiree plan could vary between \$653,000 and \$852,900 a year, depending on member-usage. Savings would potentially arise through the avoidance of traditional high-cost services for low-severity episodes, and will therefore also vary depending on actual utilization and member experience. Assuming 5% of members utilize Teladoc, the projected annual savings to the plan is approximately \$250,000.⁷

Utilization rates are determined by number of calls per year, divided by size of membership. This means utilization is not necessarily linked to plan savings unless telehealth services substitute for more expensive care. Below are incurred costs of low-severity care episodes by select provider-type that may be substituted through a telehealth benefit.

Table 5: Evaluation of Avoidable, Low-Severity Care⁹

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

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

⁷ Segal Memorandum dated April 19, 2018

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

DRAFT-Summary of Responses to Proposed Plan Design Change

Clinical considerations:

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




Third Party Administrator (TPA) operational impacts:

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

Provider considerations:

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

Documents attached include:

<u>Document Name</u>	<u>Attachment</u>	<u>Notes</u>
Segal Memorandum	A	 Segal Telemedicine Memo 20190419 UPD
Teladoc Health Presentation	B	 Teladoc Overview_RHPAB_0612
CirrusMD Presentation	C	 Aetna CirrusMD Slides March 2019.pc

MEMORANDUM

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

From: Richard Ward, FSA, FCA, MAAA

Date: April 19, 2019

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

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

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

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

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

Actuarial Value

Since the the Plan currently covers telemedicine consultations, the changes under consideration would enhance access and therefore, there would not be an impact on the Plan’s actuarial value.

Financial Impact

Utilization of telemedicine services is often driven by inadequate access to physician services and a familiarity with technology services. Many of the retirees currently live in areas with acceptable levels of access to primary and specialty care, which will affect the uptake of Teladoc within the retiree population. Adding coverage for telemedicine consultations will enhance access and promote efficient utilization.

Additionally, while many in the telemedicine industry have been mindful of the ease of use issue with these services, the technology is still seen as a barrier to some. However, as younger retirees enter the plan and members become more comfortable with the process of using Teladoc, utilization can be expected to increase in future years.

For this analysis, we are assuming that the total cost of a Teladoc consultation is \$40 with a \$5 member copay for most services. Based on the member copay and considerations discussed previously, it is assumed that 5.0% of the members will utilize Teladoc, resulting in approximately 5,000 calls annually. Additionally, it is to be expected that a portion of those calls will not lead to a resolution, and necessitate a follow-up visit to either a primary care physician or specialist, resulting in additional cost to the plan. The plan will also be charged a per member per month administration fee of \$0.93.

Savings achieved by this program are a result of members avoiding higher cost office visit services. Considering the assumptions provided above, the implementation of Teladoc is projected to result in annual savings to the plan of approximately \$250,000. Based on the most recent annual claims projection of \$590,000,000, this equates to an annual savings of approximately 0.04%.

This analysis is based on medical claims data from January 2017 through December 2017, which was summarized specifically to analyze the opportunity for telemedicine services. The data was reviewed, but not audited, and found to be sufficient and credible for this analysis.

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

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



Teladoc[™]
HEALTH

A Doctor's Care, Anywhere

**State of Alaska
Retiree Health Plan Advisory Board**

June 12, 2019

General Medical Care

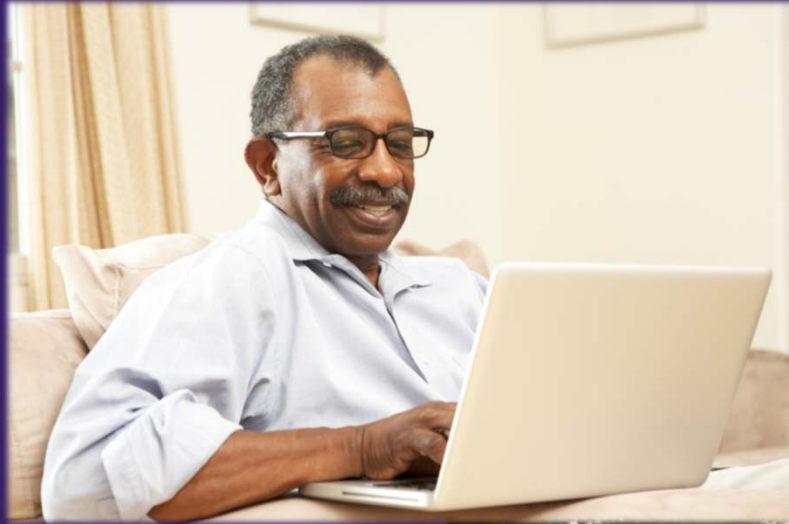


Talk to a  anytime

Teladoc[®] is a national network of U.S. board-certified doctors available on-demand 24/7 to diagnose, treat and prescribe medication, if necessary, for many non-emergency medical issues.

It's quality care when patients need it, at an affordable price.

Care delivered
conveniently
and **securely**,
however
members want
to receive it



When should Teladoc be used?



If there's no time for an office visit



When traveling or away from home



Short-term prescription refills



If a PCP is unavailable



If distance makes an office visit difficult



For pediatric care for any age

Effective resolution for a wide range of non-emergency conditions

Top Diagnoses

- Flu
- Cough
- Sinus problems
- Upper respiratory infection
- Pink eye
- Nasal congestion
- Sore throat
- Sinusitis
- Seasonal allergies
- Rash/poison ivy
- Food poisoning

Prescriptions as needed

- Best practices in prescription management
- Appropriate prescribing following CDC guidelines
- No controlled substances, psychiatric or lifestyle drugs
- 98% generic prescribing rate
- Member convenience through e-prescribing

\$40 visit fee

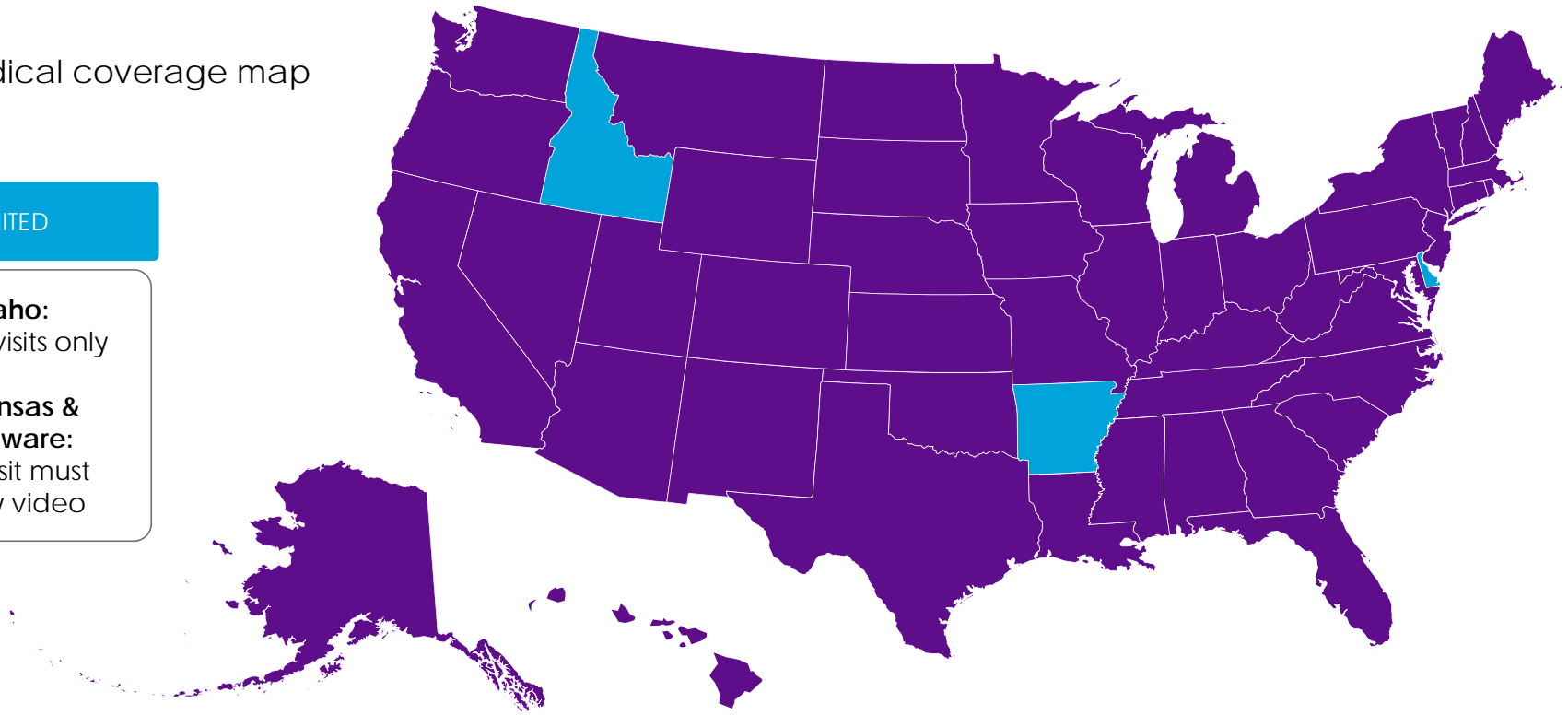
General Medical network

General Medical coverage map

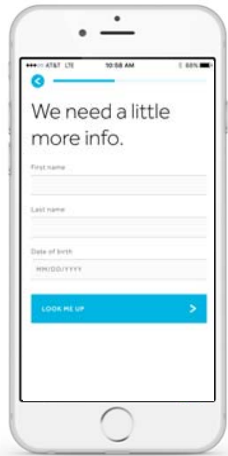
LIMITED

Idaho:
Video visits only

**Arkansas &
Delaware:**
First visit must
be by video



How General Medical works



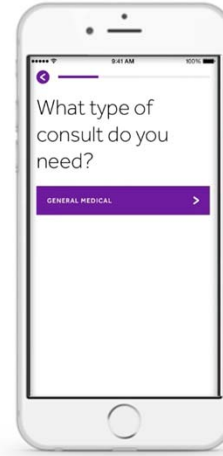
Set up an account

Set up an account by app, web or phone



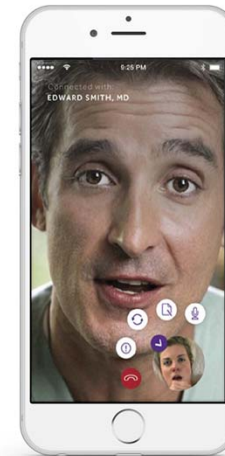
Complete medical history

The doctor will review information about past conditions, medications, allergies and the family's medical history



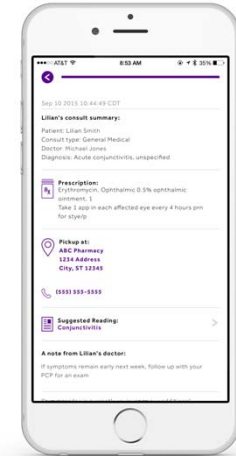
Request a visit

Request a visit with the next available doctor or schedule for a specific time



Talk to a doctor

Talk to a doctor 24/7 by phone or video



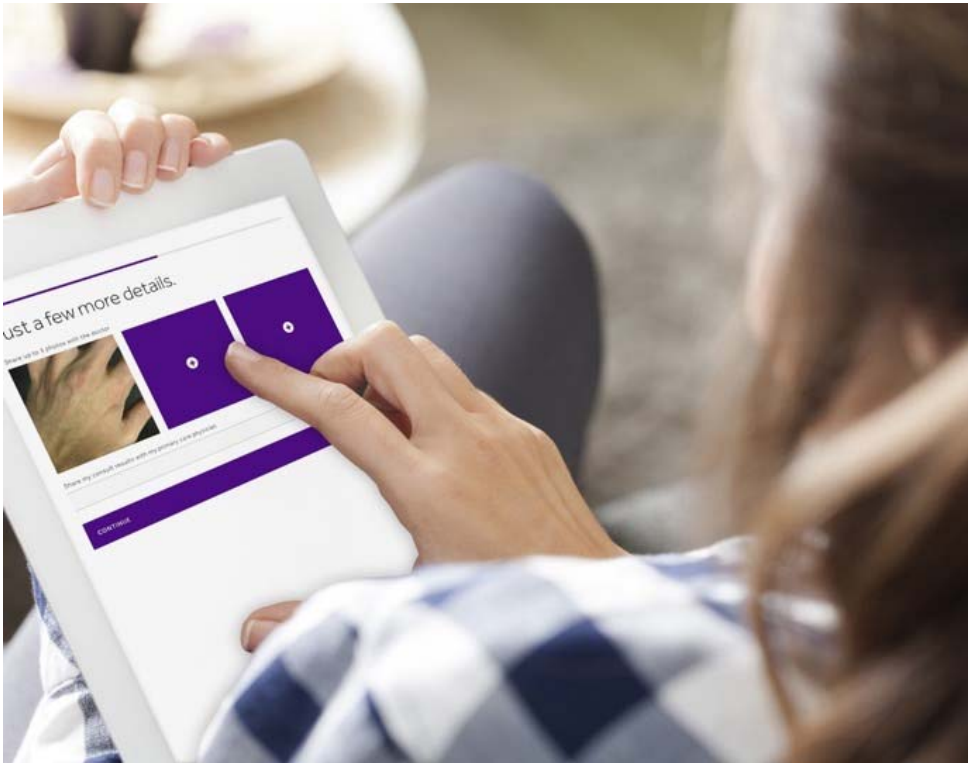
Get resolution

If medically necessary, the doctor will send a prescription to the patient's pharmacy of choice

Dermatology



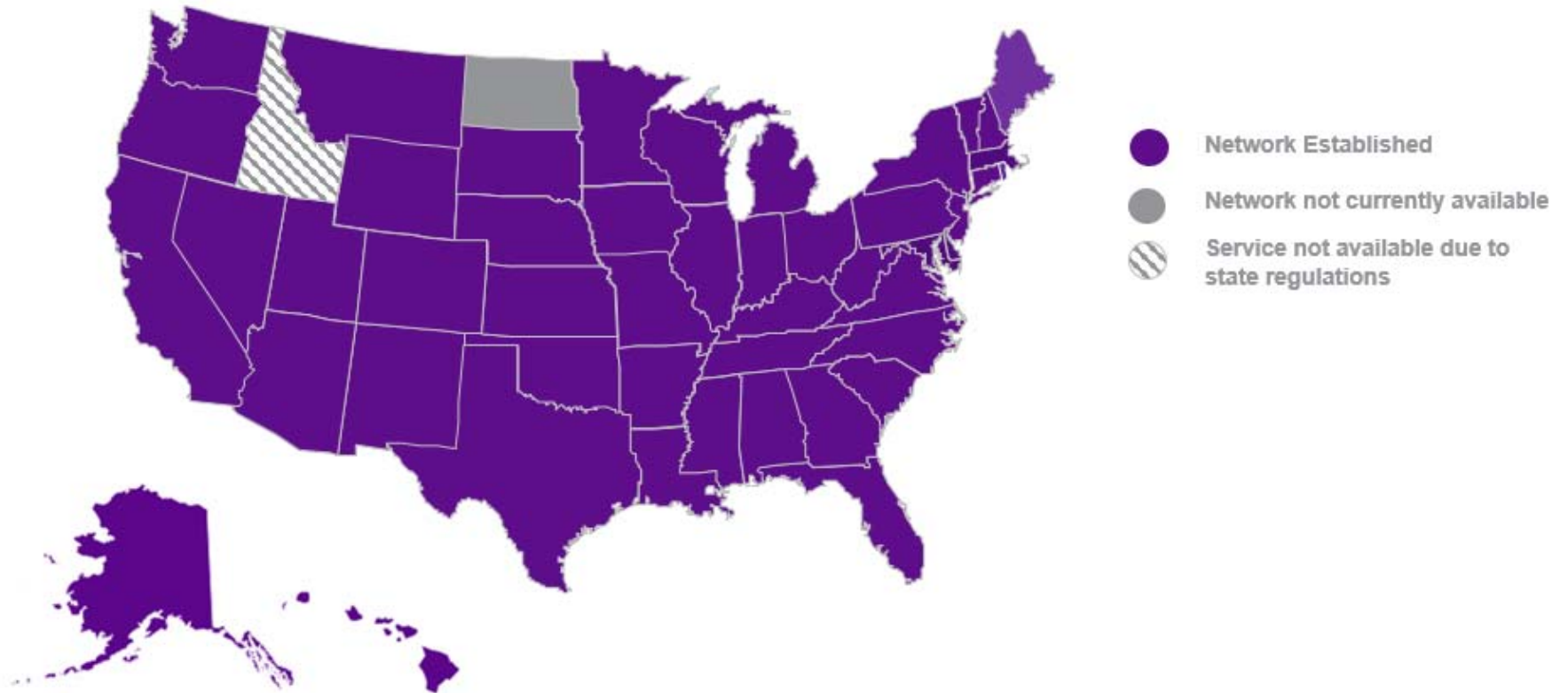
Dermatology services



- Access licensed dermatologists via web or mobile app
- Treat acute or ongoing skin conditions like psoriasis, skin infection, rosacea, and more
- Share high-quality images and receive a diagnosis within 48 hours
- \$75 visit fee

Dermatology network

Dermatology coverage map



How Dermatology works



Request initial consult

Log in to Teladoc account online or through the mobile app anytime, anywhere



Upload images

Upload a minimum of three pictures of the skin issue for the dermatologist to review



View results online

Within two business days, the licensed dermatologist will respond through the online message center

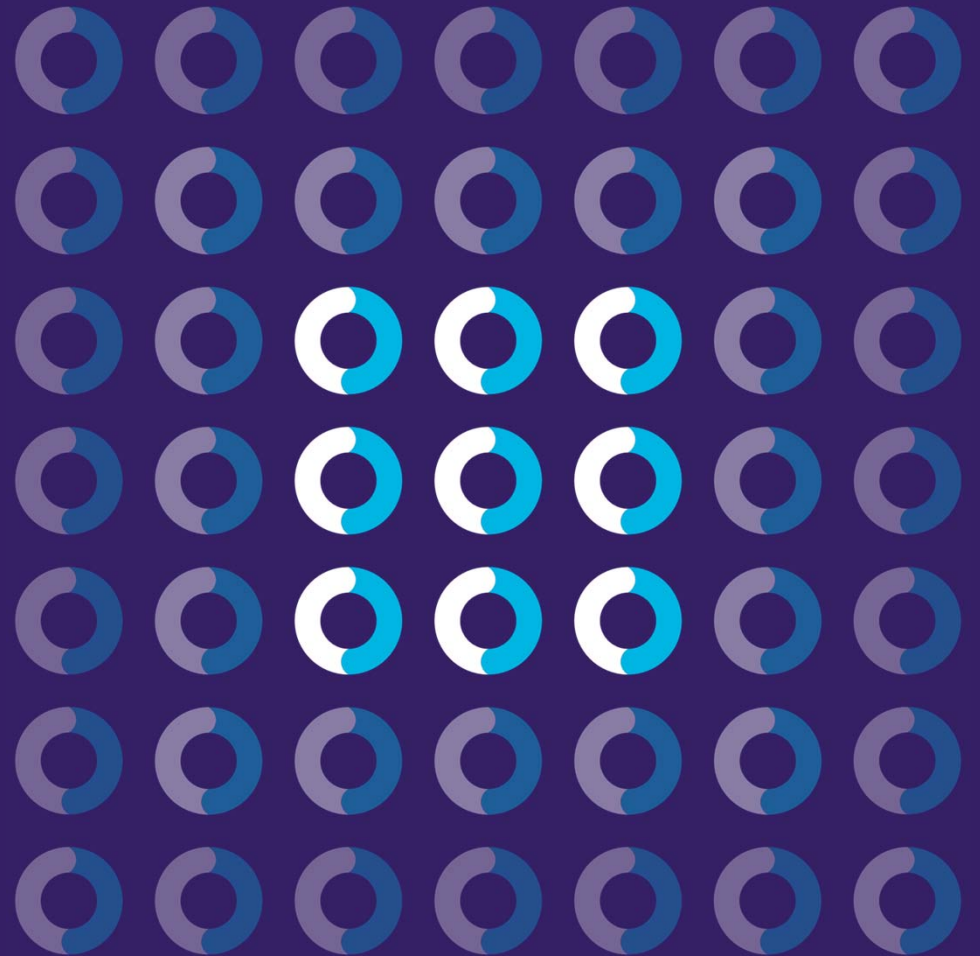


Follow up

Follow up with the doctor through the message center for free within seven days after the visit



Questions?



Extraordinary Virtual Care, Powered By CirrusMD

CIRRUS MD



Barrier-free, on-demand access to quality care via portal or mobile app



Supports a wider range of care needs, from simple to more complex conditions



Empowers members to access care at their fingertips - no copay



Powered by dedicated, board-certified ER physicians



No time limits means conversation doesn't end until members get the answers they need

Expert Care Conversation With a Dedicated Doctor

ER Avoidance, Done Right: 43 percent of virtual encounters avoided a likely ER or Urgent Care visit (based on member survey data)

Human Connection, Quality Care: 86 percent of all CirrusMD-powered encounters are resolved within the platform

Built To Build Provider Relationships: 15 percent of total virtual encounters resulted in a request for a same-day or next-day appointment with a PCP

Seamless Integration: CirrusMD's platform allows you to work in lockstep with your larger network provider team in delivering coordinated care

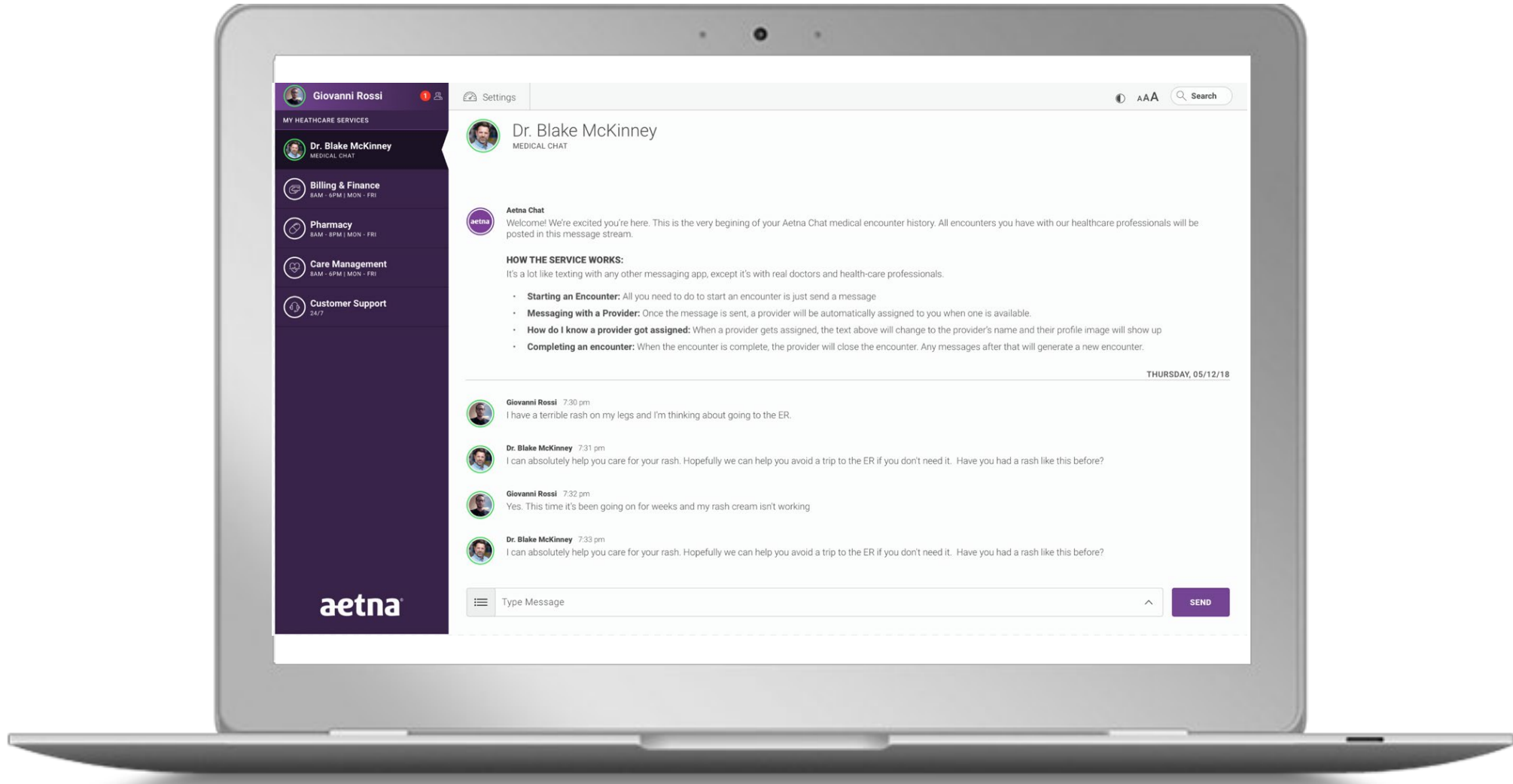
Designed to Delight: CirrusMD's experience-driven approach has earned the repeat-use trust of over **55 percent** of users, and an NPS of **76**

CIRRUS MD

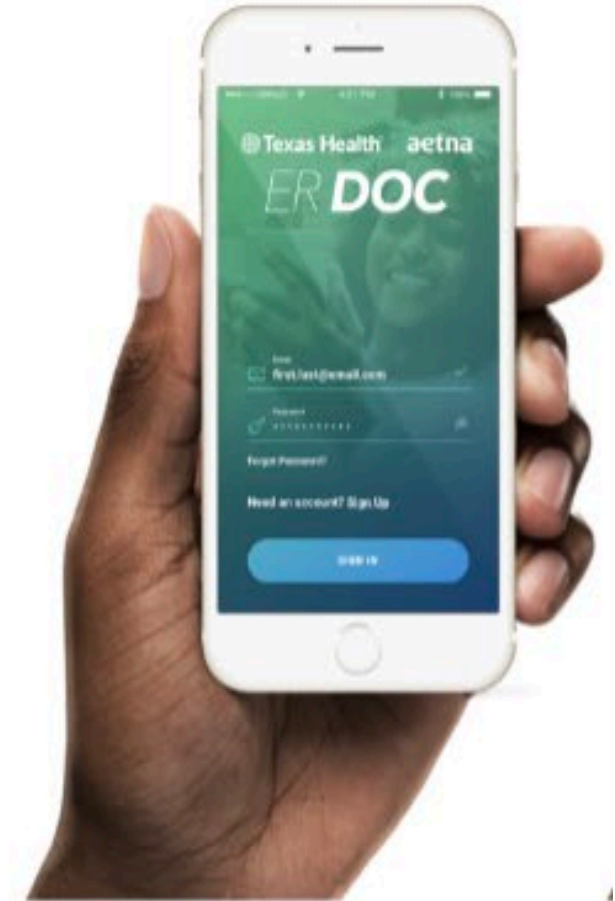
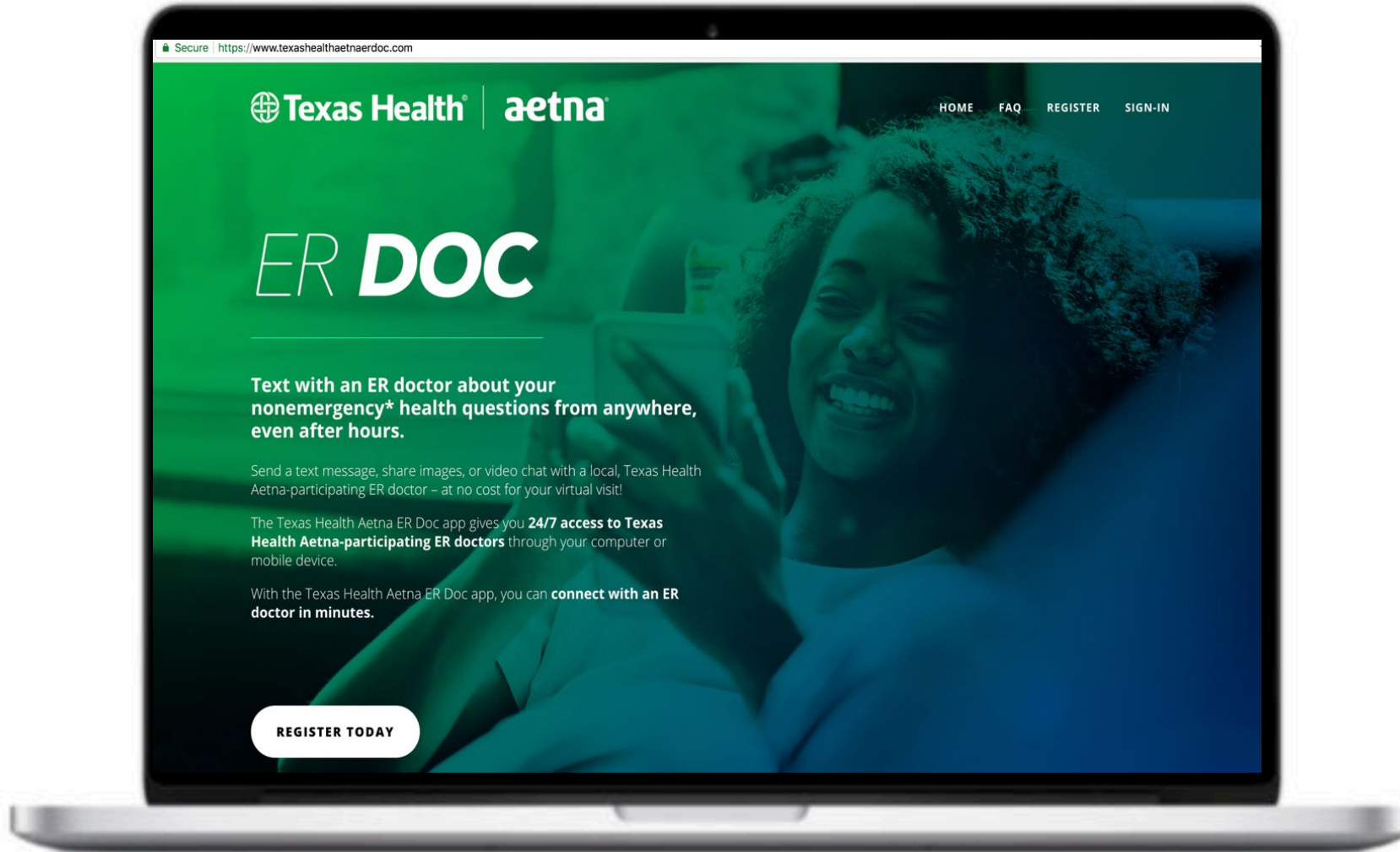
"This app was so easy to use. I briefly explained my symptoms and the doctor responded within five minutes and was engaged throughout all my questions and concerns. He made sure I was taken care of. The whole process took about ten minutes. Saved me so much time and my sanity of having to sit in the ER for hours."

Customer testimonials (samples from Sept. 2018)

The Virtual Care Platform | Simple and Intuitive Experience



Member Engagement | How to access the platform



DRAFT-Summary of Responses to Proposed Plan Design Change

Proposed change: Coverage of Treatment of Spinal Disorders, Acupuncture and Physical/ Occupational/Speech Therapy

Plans affected: DB Retiree Plan

Reviewed by: Retiree Health Plan Advisory Board, Alaska Retirement

Proposed implementation date: January 1, 2020

Review Date: June 12, 2019

Table 1. Plan Design Changes

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

Description of proposed change:

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

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

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

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

DRAFT-Summary of Responses to Proposed Plan Design Change

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

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

Table 2: AlaskaCare Total Retiree Chiropractic Network Utilization

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

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

Table 3: AlaskaCare Under-65 Retiree Chiropractic Network Utilization

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

The proposed change will:

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

The proposed benefit will set visit limits on rehabilitative and chiropractic care received from an non-network provider. If care is received from an non-network provider, the member could receive:

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

The non-network provider visit limits would reset at the start of each benefit year.

DRAFT-Summary of Responses to Proposed Plan Design Change

The proposed change would also provide coverage for:

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

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

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

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

Table 2: Comparison of Current to Proposed Change

CURRENT:	
<p>Current (Page 43-44) Section 3.3.12 of 2019 Retiree Insurance Information Booklet</p>	<p>Rehabilitative Care The Medical Plan covers outpatient rehabilitative care designed to restore and improve bodily functions lost due to injury or illness. This care is considered medically necessary only if significant improvement in body function is occurring and is expected to continue. [Emphasis added.] Care (excluding speech therapy) aimed at slowing deterioration of body functions caused by neurological disease is also covered.</p> <p>Rehabilitative care includes:</p> <ul style="list-style-type: none"> • Physical therapy and occupational therapy. • Speech therapy if existing speech function (the ability to express thoughts, speak words, and form sentences) has been lost and the speech therapy is expected to restore the level of speech the individual had attained before the onset of the disease or injury. • Rehabilitative counseling or other help needed to return the patient to activities of daily living but excluding maintenance care or educational, vocational, or social adjustment services. <p>Rehabilitative care must be part of a formal written program of services consistent with your condition. Your physician or therapist must submit a</p>

DRAFT-Summary of Responses to Proposed Plan Design Change

	statement to the claims administrator outlining the goals of therapy, type of program, and frequency and duration of therapy.
<p>Current (Page 72-77) Section 5.1 of 2019 Retiree Insurance Information Booklet</p>	<p>The following is a list of services and supplies that are not covered and are not included when determining benefits:</p> <p style="padding-left: 40px;">...</p> <ul style="list-style-type: none"> • Acupuncture therapy, unless performed by a physician as a form of anesthesia in connection with surgery covered under the plan.
Proposed	<p>Neurological Disease (no change) Cognitive therapy associated with physical rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function or slow deterioration of body functions caused by neurological disease.</p> <p>Rehabilitative Care Covered expenses include charges made by a physician on an outpatient basis for physical therapy, occupational therapy and speech therapy. Inpatient services will be covered under inpatient hospital and skilled nursing facility benefits.</p> <p>Massage therapy is covered when it is prescribed by a licensed physician, chiropractor or naturopath and performed under the physician's, chiropractor's or naturopath's supervision, and is considered part of the overall treatment plan.</p> <p>Outpatient rehabilitative care received from a non-network provider is limited to 45 visits per benefit year.</p> <p>Chiropractic Covered expenses include charges made by a licensed physician or chiropractor, on an outpatient basis. The covered services include office visit, examination, consultation, regional manipulations, or other physical treatment for conditions caused by or related to biomechanical or nerve conduction disorders of the spine, massage therapy in conjunction with and for the purpose of making the body more receptive of the spinal manipulation.</p>

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

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

Acupuncture

Covered expenses are limited to 10 visits per benefit year.

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

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

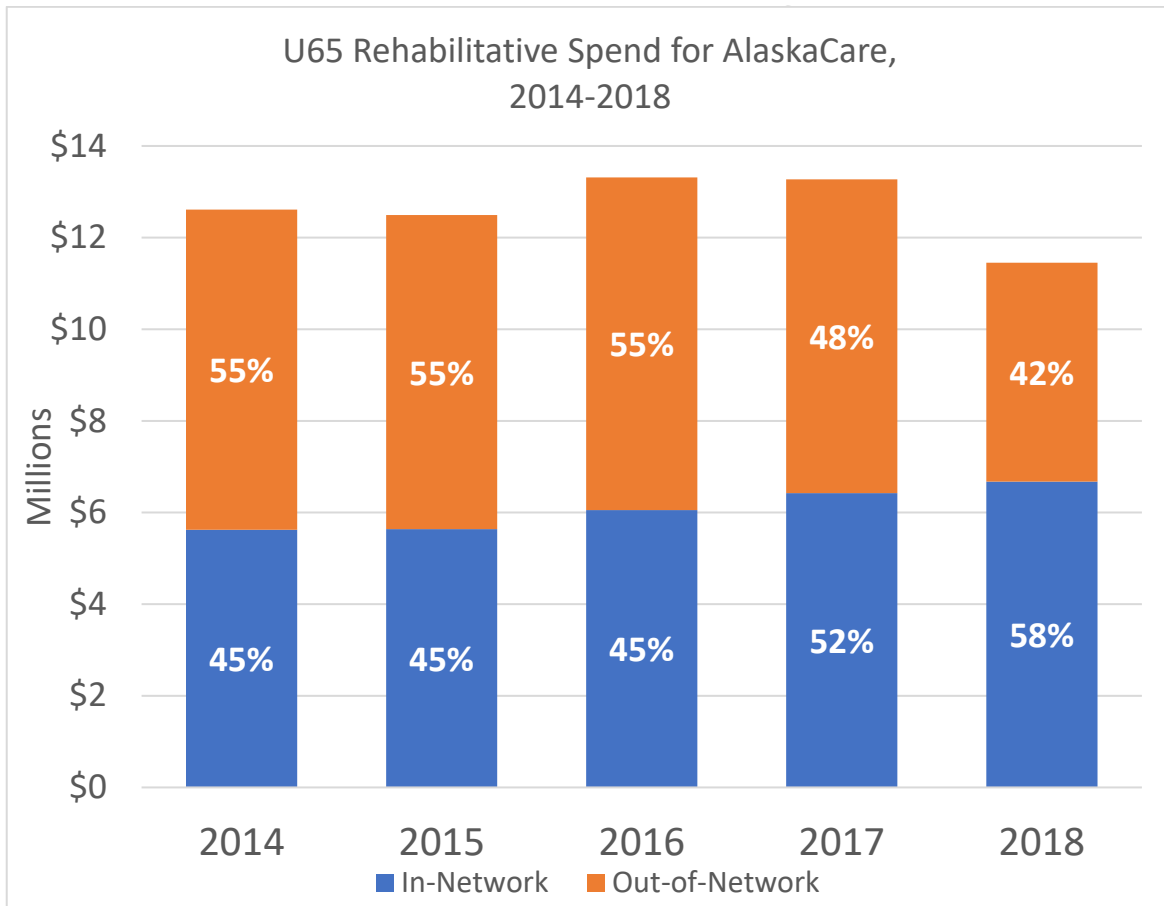
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DRAFT-Summary of Responses to Proposed Plan Design Change

Background

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

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

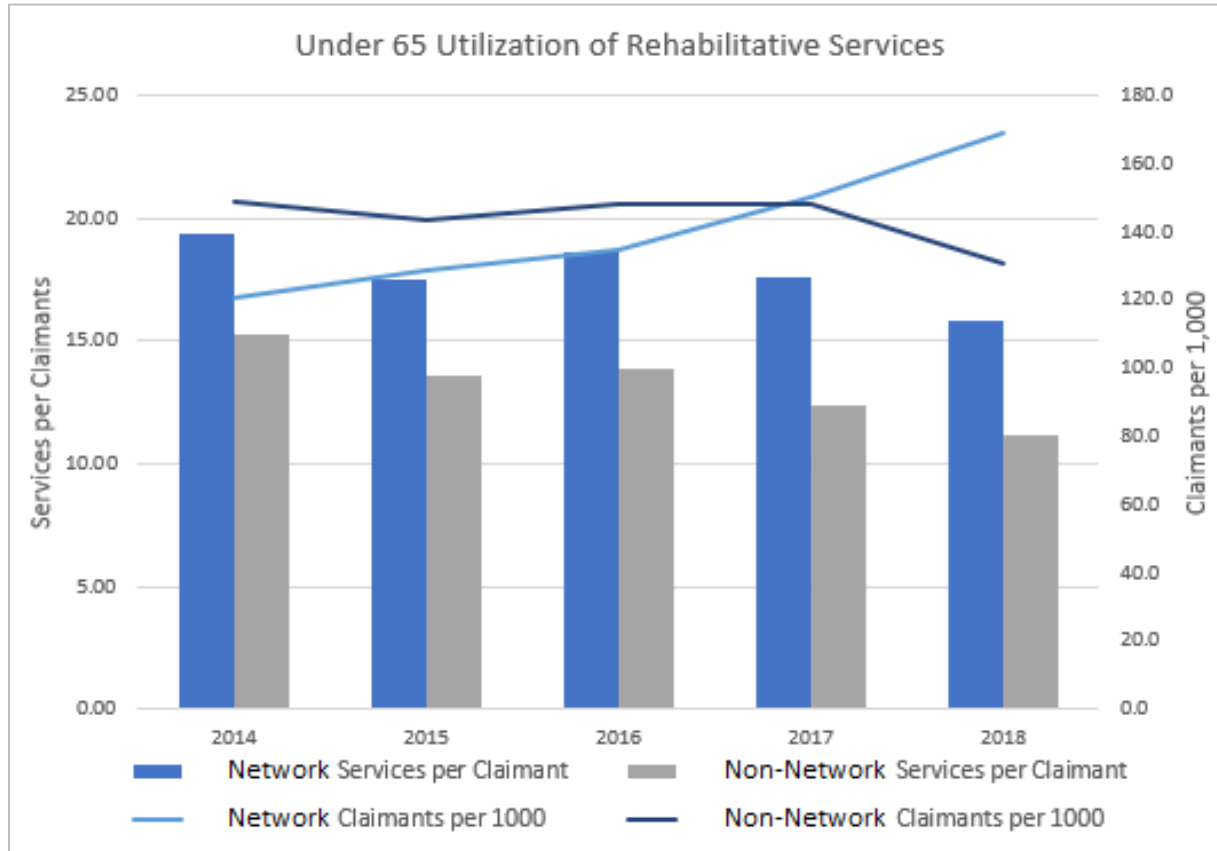


Over this period, the number of rehabilitative claimants per 1,000 AlaskaCare members increased by 10%, though the number of services per member dropped by nearly 20%.

DRAFT-Summary of Responses to Proposed Plan Design Change

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

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



Member Impact:

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

DRAFT-Summary of Responses to Proposed Plan Design Change

This proposed benefit will expand coverage for members seeking care from a network provider, particularly those who have chronic conditions or who are making only slight improvement, and who would receive additional services beyond what is covered today. However, while the proposed limits are sufficient to achieve a rehabilitated state in many patients, members who utilize a non-network provider and reach their maximum therapeutic benefit within a single benefit year must either seek additional care from an network provider, or may be denied care that may otherwise have been found to be medically necessary for the interim period before the visit limits are reset.

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

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

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

Neutral / Enhancement / Diminishment

Table 3: Actuarial Impact

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

DRB operational impacts:

Rehabilitative care is the most frequent reason members submit appeals to the Division. Additionally, the Division spends considerable amount of time attempting to educate and explain the difference between the care that results in significant improvement, covered under the plan, and care that is maintenance or preventive care and not covered under the

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

DRAFT-Summary of Responses to Proposed Plan Design Change

plan. Removing barriers to care received from a network provider and setting a limit on the number of visits received from a non-network provider covered per benefit year simplifies the benefits for members and providers. Simplifying the benefits and removing the exclusion of maintenance and preventive care should help alleviate member and provider confusion over what is a covered expense and reduce the administrative burden and expense of fighting costly and complicated appeals.

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

Table 4, Estimated Savings

Proposed Change	Estimated Annual Financial Impact⁵
10 visit-limit for acupuncture	\$ 65,000 in additional cost
20 visit-limit for chiropractic	
45 visit-limit for rehabilitative care	

Clinical considerations:

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

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

Third Party Administrator (TPA) operational impacts:

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

Provider considerations:

The proposed changes would reduce the administrative tasks related to clinical documentation and appeal support. It would allow the provider to clearly understand what is covered under the plan, and work with the member on the treatment plan to

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

DRAFT-Summary of Responses to Proposed Plan Design Change

include educating the member if the proposed treatment exceeds plan limits if the provider is an non-network provider.

Documents attached include:

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

DRAFT-Summary of Responses to Proposed Plan Design Change

HealthMatters Article – April 2015	<i>Outpatient Rehabilitative Care Coverage in the AlaskaCare Retiree Health Plan</i> http://doa.alaska.gov/drb/newsletters/healthmatters/issue/24.html	
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DRAFT



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: September 26, 2018
Re: Therapy Benefits – Focus on Actuarial and Financial Impact for the Retiree Plan - **UPDATED**

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

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

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

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

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

Actuarial Value

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

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

Financial Impact

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

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

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

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

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Rolfing Literature Review

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A brief review on the available clinical research of Myofascial Structural Integration (MSI) as it pertains to clinical application and patient preference.

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Abstract

Myofascial Structural Integration (MSI), commonly known as “Rolfing,” is a form of manual therapy that manipulates the superficial fasciae and attempts to realign the body to its natural, unstressed state. Proponents of this therapy believe MSI can treat many physical, psychological and emotional pathologies, though the efficacy of this treatment on many diagnoses remain either untested or unproven. The body of literature on MSI is shallow, partially due to its only recent resurgence in popularity in 2010. This paper reviews eight clinical studies presented on the “Rolf Institute of Structural Integration’s” official website. These studies address MSI’s efficacy for patients with long-term low back pain, children with cerebral palsy and women with fibromyalgia. Of the eight studies, seven were unable to find statistically significant evidence to support MSI as an adjunct therapy over no additional therapy at all for the primary outcome measured. However, among secondary outcomes, MSI treatment as an adjunct therapy to traditional outpatient services led to higher confidence of care and higher patient satisfaction relative to no adjunct therapy at all. The eighth study regarding fibromyalgia in women was dismissed due to study design flaws, particularly the lack of a control group, though outcomes are presented in the study’s section.

The current body of literature indicates that MSI, or “Rolfing” may hold a role of therapeutic significance as the therapy matures and additional research is presented. However, due to ethics in study design that would prevent a researcher from discouraging clinically proven treatment for a patient, MSI has not been evaluated as a standalone treatment, but as adjunct to conventional treatment. For similar ethical reasons, coverage decisions for MSI must weigh the potential risks inherent in allowing patients to eschew conventional outpatient treatment for MSI instead.

What is Rolfing?

Rolfing is a form of manual therapy broken out into a series of ten sessions referred to as “The Recipe.” Rolfing was developed by Ida Rolf, who believed these physical manipulations aligned the human body’s energy field to the Earth’s gravitational field.¹ Rolfing itself is a trademarked term, with the exclusive rights belonging to The Rolf Institute of Structural Integration (RISI) since 1979.² However, Rolfing is still known colloquially to describe ‘structural integration (SI),’ or the original physical manipulations developed by Ida Rolf. For this reason, structural integration techniques will be referred to as ‘Rolfing’ for this paper, even if practitioners belong to or adhere to other structural integration schools that splintered from the Rolf Institute following Rolf’s death in 1979.

Rolfing has been characterized by its advocates as a means of alleviating pain, and enjoyed a resurgence in practice in 2010 following its popularization by Mehmet Oz, M.D (“Dr. Oz”) on *The Oprah Winfrey Show*.³ Rolfers claim Ida discovered an association between emotions and the soft tissues of the body, and thus deep tissue manipulation can cause the release of painful repressed memories.⁴ This connection between physical structure and psychology however has not been proven.⁵

Rolfing is broadly considered a pseudoscience due to its reliance on ‘gravitational alignment’ claims and its unproven clinical efficacy for indicated diagnoses.⁶ The following paper attempts to summarize and evaluate the medical literature in its recent review of Rolfing, structural integration and myofascial (connective-tissue) release, as well as clinical claims made by both practitioners and patients.

Rolfers purport that physical techniques exerted of the fascia through deep-tissue manipulations realign the entire body and provide a holistic approach to treatment of both physiological and psychological pathologies. During later sessions of “The Recipe,” Rolfers attempt to adjust the fascia and body to “the line,” which can be characterized as a line passing through the center of one’s head down to the feet, passing through no bones except the skull. “The line” is often indicated to have spiritual significance, linking one’s body to the past and future.⁷

Fascia is a sheet of connective tissue protein that attaches and encloses separate muscles and internal organs. They are like ligaments and tendons in their composition and use, though differ in function, as ligaments join bone to bone, tendons join muscle and bone, and fasciae surround muscles and other structures.⁶

Controversy exists over what structures fall under the classification of “fascia,” with recent editions of *Terminologia Anatomica*, the international standard for human anatomic terminology, excluding superficial fascia, or the lower most level of skin, from the structure in 1997.⁸ However, Gray’s Anatomy, another respected standard for terminology, allows the inclusion of fatty layers within subcutaneous tissue to be considered fascia by contrast.⁹ This confusion, paired with limitations in the categorizations suggested by the aforementioned standards to describe large transitional areas within fascial connective tissue that share characteristics, inspired the creation of the Fascia Research Congress, which suggested a broader definition of fascia that includes nearly all connective tissues under the ‘fascial web,’ including now tendons and ligaments, with ‘proper fascia’ describing the more classical examples of fascia under the previous standards.¹⁰

Many Rolfers consider superficial fascia an integral part of the broader fascial system, and practitioners will often dedicate their foundational sessions (one through three of 10) on superficial fascia layers to “increase elasticity” in the chest and re-orient the pelvis, rib-cage, shoulder girdle, feet and legs.¹¹

However, as some Rolfers admit, there are no known randomized, controlled trials that indicate Rolfing leads to long-term structural changes to the fascia or the body. Dr. Rob Landel, head of physical therapy at the University of Southern California in 2010, indicates that Rolfing could be effective when paired with strengthening exercises and better posture, but states the holistic approach physical therapists take “[working] on other things too—joints and muscles and ligaments [...] is why Rolfing probably couldn’t stand up in a clinical trial.”¹²

To test Dr. Landel’s claim, we have selected three studies endorsed by the Rolf Institute to determine if SI is clinically effective for the indicated diagnoses of long-term pain, cerebral palsy, and fibromyalgia. Additionally, many of the studies chosen also evaluate secondary outcomes such as emotional wellbeing, vitality, general health, physical function, social function and patient satisfaction with treatment when SI is adjunct to other therapies. As many advocates of Rolfing and SI admit, the pool of available literature is shallow, though this is partly due to the recency of resurgence in 2010— many powerful statistical tools were not existent or at least common during its initial wave of popularity in the 20th century. Despite this, skepticism tends to cloud the environment of Rolfing and SI more so than other conventional physical therapies or medical massages. This review attempts to share the body of clinical literature as it exists at time of writing.

Rolfing and Indicated Effectiveness for Pain Relief

“Structural Integration as an Adjunct to Outpatient Rehabilitation for Chronic Nonspecific Low Back Pain: A Randomized Pilot Clinical Trial” (Jacobson, et al., 2015)

In 2015, a randomized, controlled study was published in *Evidence-Based Complementary and Alternative Medicine* evaluating the impact of outpatient rehabilitation (OR) and SI techniques versus OR alone for long-term pain.¹³ 46 outpatients from the Boston area who reported nonspecific low back pain were randomly divided into two treatment groups who received both received OR, with the intervention group also receiving SI treatment as adjunct.

Participants were male and female, between the ages of 18 and 65, and have experienced low back pain for over 6 months duration, not attributed to infection or chronic disease. Participants were excluded from the study if their disability prevented compliance or adherence with OR treatment, if the participant had received SI treatment in the past or were receiving other physical therapy or pharmacotherapy that could confound therapeutic outcomes from OR and SI treatment. While all five providers were graduates of “adequate training programs”¹³, only one was a graduate of RISI, while one was a graduate of the Guild of Structural Integration (GSI), and three were taught by the Kinesis Myofascial Integration (KMI) program. All five providers had over ten years of clinical experience and were members of the International Association of Structural Integrators (IASI). Graduates of the KMI program were instructed to provide the Rolf Ten Series instead of the twelve sessions taught by KMI (provided in table 1).

Table 1- Rolf Ten Series treatment goals. From “Structural Integration as an Adjunct to Outpatient Rehabilitation for Chronic Nonspecific Low Back Pain: A Randomized Pilot Clinical Trial.”

Table 1: Rolf Ten Series treatment goals.

Session	Areas increase pliability, mobility, and L/R and A/P balance
1	(i) Anterior aspect of rib cage and shoulder girdle (ii) Attachments to lateral iliac crests and greater trochanters (iii) Hamstrings, iliotibial bands
2	(i) Feet, ankles, and knees (ii) Anterior aspect of calves and thighs
3	(i) Lateral aspect of the pelvis, torso, and shoulder girdle (ii) Increased independence of thorax from pelvis (iii) Increased range of humerus relative to scapula. (iv) Increased independence of shoulder girdle from neck to rib cage
4	(i) Medial aspect of legs and floor of pelvis
5	(i) Anterior aspect of the pelvis, hips, torso, and lumbar spine
6	(i) Posterior aspect of ankle, leg, knee, hip, pelvis, and lumbar spine
7	(i) Soft tissues spanning the cervical spine and cranium, cranial structure including jaw
8	(i) Promote functional integration between upper extremities, shoulder girdle, and spine
9	(i) Promote functional integration between lower extremities, pelvic girdle, and spine
10	(i) Further optimize functional integration of extremities, shoulder, and pelvic girdles to spine
	Goals for work at end of each of the ten sessions
	(i) Promote physiologic movement of dorsal & lumbar vertebrae
	(ii) Promote physiological movement, L/R and A/P balance of sacrum and 4th and 5th lumbar vertebrae
	(iii) Promote physiologic movement, L/R and A/P balance of cervical spine

L/R: left to right.

A/P: anterior to posterior.

To “enhance fidelity of treatment to the Ten Series protocol, a senior SI practitioner [Eric E. Jacobson, the principal investigator of this study] led the therapists in a series of group discussions and reviews prior to the beginning of enrollment and also conducted monthly supervision sessions during the treatment phase of the study. However, there was no systematic collection of data on treatment fidelity.”¹³

The primary outcome evaluated was change between baseline reported pain levels (0 to 100) and a 20-week follow-up with patients after OR and SI or OR alone treatments. Secondary outcomes evaluated ranged from disability scores to patient satisfaction responses using popular survey designs.*

Additionally, four psychological variables were recorded at baseline to mitigate potential confounding factors: patients were asked before the treatment period to complete the Hospital Anxiety and Depression Scale, the Pain Catastrophizing Scale, the Tampa Scale of Kinesiophobia (fear of pain due to movement) and the Wiley-7, a scale that measures preponderance of hypochondria and somatization.

Due to the more aggressive nature of SI treatment and the lack of literature regarding SI treatment on patients experiencing chronic pain, study participants were required by an Internal Review Board (IRB) to complete biweekly Patient Questionnaires (PQs) to ensure fewer than 30% of patients experienced a significant increase above baseline-reported pain for two successive PQs, which would trigger termination of the study. Candidate selection began in April of 2011 and enrollment continued for an “unexpected total duration of 23 months”¹³ due to low OR compliance rates.

In table 2 below are the full set of primary and secondary outcomes measured in this study.

Median reductions in reported pain, the primary outcome, were not significantly different between groups that had received OR+SI versus those who received SI alone. However, in the secondary outcome measured, differences in median reductions of reported disability (RMDQ), patients of the intervention group [-4.5 to -1] had a two-point reduction in reported scores from baseline to follow-up than the control group, OR alone [-2 to 0]. However, while this reduction was statistically significant, two points is also the smallest score to determine a minimal clinically important difference (MCID) in care. An interpretation is that while the results were indicative of reducing reported disability further than the control treatment, the relatively small impact does not offer a definitive conclusion of whether SI can effectively alleviate perceived disability relative to other treatments for patients with chronic lower back pain, either as a standalone or adjunct therapy.

Other secondary outcomes measured were the SF36 composite scores for physical and mental wellbeing (no statistically significant differences were observed for composite scores), and the GSC report, where patients who received SI in addition to OR therapy reported significantly higher satisfaction with their care. While this is in line with claims reported by proponents of SI, it is difficult to interpret whether this is the result of SI as a therapy, or a manifestation of clinical action bias, where patients and providers are more likely to associate quantity of care provided with quality of overall care.¹⁴

Dr. Jacobson acknowledges the limitations of the study due to unexpected challenges in enrollment and treatment adherence, which is unfortunately very common in rehabilitative and habilitative care.¹⁵ He suggests that as the results are not definitive and the intention of this study was preliminary in nature, further research could evaluate the relationship between SI and therapeutic outcomes.

* For pain evaluation, the Visual Analog Scale for Pain (VAS Pain) was used. The disability survey was administered through the Morris Disability Questionnaire (RMDQ). Also asked of patients were responses to the Short Form 36 Health Survey (SF36), the Global Satisfaction with Care (GSC) report, and a 7-point Likert scale for responses to the following question after the treatment period: “Over the course of treatment for your low back pain in this study, how would you rate your overall medical care?”

Table 2- Outcomes for “Structural Integration as an Adjunct to Outpatient Rehabilitation for Chronic Nonspecific Low Back Pain: A Randomized Pilot Clinical Trial.”

Outcomes (range)	Change scores		p ¹
	SI + OR (n = 23)	OR alone (n = 23)	
Primary outcome			
VAS Pain (0–100 mm)	–26 [–31.5, –3.0]	0 [–24.5, 6.5]	0.075
Secondary outcome			
RMDQ (0–24 points)	–2 [–4.5, –1]	0 [–2, 0]	0.007 ⁴
Exploratory outcomes			
Days + half days disabled (0–14)	–1.0 [–3.5, 0]	0.0 [4.5, 0.5]	0.445
SF36 subscales (0–100)²			
Physical function	5 [0, 15]	5 [0, 13]	0.842
Role physical	25 [0, 50]	0 [0, 25]	0.349
Bodily Pain	16 [7, 25]	0 [0, 11]	0.009 ⁴
General health	0 [0, 8]	3 [0, 10]	0.673
Vitality	8 [0, 16]	0 [–5, 5]	0.034
Social function	0 [0, 16]	0 [–13, 0]	0.041
Role emotional	0 [0, 0]	0 [0, 0]	0.771
Mental health	0 [–4, 8]	0 [–4, 4]	0.305
SF36 composite scores²			
Physical	3 [1, 10]	3 [0, 9]	0.306
Mental	0 [–3, 3]	0 [–4, 1]	0.424
GSC (Likert –3 to +3) ³	3 [2, 3]	2 [1, 2.25]	0.0003 ⁵

Rolfing and Cerebral Palsy in Children

“Myofascial structural integration therapy on gross motor function and gait of young children with spastic cerebral palsy.” (Price, et al., 2015)

Between 2009 and 2015, Rolfer Karen Price and her team collaborated with the Department of Pediatrics, Stanford School of Medicine to compare therapies provided to children with spastic cerebral palsy (CP).¹⁶⁻²² Karen Price administered all SI treatments across the six years.

Price’s studies tended to draw small sample sizes (in one of the most recent published studies²¹, the control group had fewer than 10 participants) and either presented themselves as case studies or had lax eligibility standards²¹ for participation, allowing in participants that may have received SI treatments before, counter to standards used by Jacobson (2015)¹³. While this lax approach presents a low risk to bias clinical outcomes and can assist the collection of larger sample sizes, the design is susceptible to overrepresenting patient satisfaction because of selection bias—many participants were recruited through the publicity of free SI treatment. For this reason, while the patient preference outcomes Price determined can be considered indicative, they cannot be considered definitive when compared to conventional treatment, particularly with SI’s role as an adjunct therapy[†].

However, fundamental issues were also present in Price’s participation criteria that have high risks of interfering with the fidelity of clinical outcomes. Most noteworthy was that these criteria did not exclude nor control for patients who were receiving other forms of therapy during the length of the study:

Throughout the study, the children continued to participate in their typical treatment regimen, which included physical therapy at minimum and depending on the child, may have also included occupational therapy, medications, other complementary treatments (e.g., Feldenkrais Method), and regular recreational activities (e.g., swimming). The Institutional Review Board at Stanford University approved the protocol and parents provided informed consent prior to their child’s participation. (Price, et al. 2015).²¹

It is difficult then to ascertain the true impact of SI on children with cerebral palsy as it pertains to increasing motor function and gait due to a potentially heterogenous population across the control group (n=9) and intervention group (n=15). In other words, if the control group for instance was receiving proportionally-less occupational therapy or exercise compared to the intervention group, this could greatly confound the clinical findings of the study. Table 3 presents the extent of demographic and clinical data of the participants in this study which unfortunately does not break patients down by their level of treatment outside of SI. Additionally, while the author claims that the control and intervention group had statistically-insignificant differences between their baseline motor functions at enrollment²¹, the control group’s average motor function determined by Measure-66 scores was fairly lower compared to the intervention (37.9 to 40.6), and the inability to determine a statistically significant

[†] Often new therapies will test their impact on therapeutic outcomes by being performed alongside more established treatments. This is done for two reasons primarily: to better establish baseline efficacy, and to not deprive participants of treatments with known efficacy for the length of the study. However, an inherent flaw to this approach is the role of action bias, where patients interpret treatment on a “more is better” approach.

difference between these two populations is likely the result of the small sample sizes, not similar baselines.

Table 3- Participants for “Gross motor function improves in young children with spastic cerebral palsy after myofascial structural integration therapy.”

Demographic and clinical information on participants.

	Randomized Cohort		Non-Randomized Cohort
	Waitlist-Control (n = 9)	Treatment ^a (n = 15)	Treatment ^b (n = 5)
Mean age, years (SD)	2.2 (0.8)	2.4 (1.0)	2.1 (0.7)
Male, % (n)	55.6 (5)	40.0 (6)	20.0 (1)
Non-White, % (n)	44.4 (4)	26.7 (4)	60.0 (3)
Type of spastic cerebral palsy, % (n)	Hemiparesis: 44.4 (4) Diplegia: 0.0 (0) Quadriparesis: 55.6 (5)	Hemiparesis: 33.3 (5) Diplegia: 20.0 (3) Quadriparesis: 46.7 (7)	Hemiparesis: 60.0 (3) Diplegia: 0.0 (0) Quadriparesis: 40.0 (2)
Gross Motor Function Classification System level, % (n)	Level 1: 11.1 (1)	Level 1: 20.0 (3)	Level 1: 40.0 (2)
	Manual ability Classification System	Manual ability Classification System	Manual ability Classification System
	Level 2: n = 0	Level 2: n = 1	Level 2: n = 0
	Level 3: n = 1	Level 3: n = 2	Level 3: n = 1
	Level 4: n = 0	Level 4: n = 0	Level 4: n = 1
	Level 2: 33.3 (3)	Level 2: 26.7 (4)	Level 2: 20.0 (1)
	Level 3: 0.0 (0)	Level 3: 20.0 (3)	Level 3: 0.0 (0)
	Level 4: 55.6 (5)	Level 4: 33.3 (5)	Level 4: 40.0 (2)
Mean Gross Motor Function Measure-66 score at Enrollment (SD)	37.9 (19.8)	40.6 (14.7)	40.3 (17.7)

^aDifferences between Waitlist-Control and Treatment groups within the Randomized Cohort were not statistically different.

^bDifferences between the Randomized and Non-Randomized cohorts were not statistically different.

Outcomes of Price's research were not clearly presented. Analysis of children's gait did not find a statistically significant difference in stride-length, velocity, or foot width between the two groups. Foot length potentially altered between these two groups ($p=0.04$), however failed to achieve statistical significance at the 1% level.[‡]

Parents were non-randomly asked to complete two patient preference surveys and the results were positive, with 'Parent Rating of Satisfaction' averaging at 8.4/10 and Parent Rating of Child Satisfaction at 8.6.

One parent wrote that her child experienced "improved walking, climbing stairs, sitting on floor cross-legged, decreased limp." Another parent noticed that her child held his "left hand less fisted." A common comment was that the children enjoyed the massage. One parent said, "It felt so good to him like massage." Another exclaimed, "Rolfing – she loved it! And we saw many gains during therapy." Changes were also noted in subjective well-being and quality of life, such as "improved mood." One parent reported that her child had a "more relaxed demeanor [,] improved sleep [, and was] calmer for longer periods of time." Another parent concluded her survey by writing, "We will do it again in the future." (Price, et al. 2015).²¹

Price describes SI as safe, replicable and potentially a source of continued maintenance treatment for children with non-progressive movement disorders. She states a purpose of research into SI efficacy is to eventually alleviate the financial burdens parents face when considering this treatment option, as many health insurances do not reimburse for this form of care, creating a financial burden for the standard 10 sessions recommended by SI practitioners and proponents.

Rolfing and Fibromyalgia

"Fibromyalgia syndrome treated with the structural integration Rolfing® method" (Stal & Teixeira, 2014)

Fibromyalgia syndrome (FMS) is a broad disorder characterized by widespread musculoskeletal pain than can influence sleep, memory loss, mood and fatigue.²³ Many patients with FMS also have tension headaches, joint disorders, irritable bowel syndrome (IBS), anxiety and depression. The cause of FMS is not known, though FMS is thought to be genetic, as well as potentially arising from infections and physical/emotional trauma. There are no accepted tests to check for FMS, patients are diagnosed based on the severity and location of body pain, fatigue levels not otherwise attributable, and cognitive difficulties commonly referred to as 'fibro fog,' which may impact ability to focus.²³

While there are no known cures for FMS, patients are often prescribed treatments to mitigate symptoms, including analgesics and antidepressants, physical and occupational therapies as well as counseling. Some proponents of SI believe symptoms of FMS can be mitigated with the realignment of fascia through SI therapy²³, and in 2014, the Department of Neurology at the University of Sao Paulo,

[‡] In statistics, a p-value can be interpreted as the probability that the outcome achieved was due to an association between variables and not chance. Different fields have different p-value thresholds (commonly at 0.05, 0.01 and 0.001). Clinical fields tend to require p-values below 0.01 and 0.001 for additional outcome certainty, though the ability to attain these thresholds may require high sample sizes.

School of Medicine in Brazil recruited a 30 participant cohort to test the impacts of SI therapy on the most common symptoms of fibromyalgia: pain, depression and anxiety.

Participants were all female, between the ages of 28 and 62, and were diagnosed with FMS according to the medical criteria proposed by the American College of Rheumatology.²⁶ Participants were recruited from outpatient facilities in Sao Paulo and had been receiving conventional treatment for at least one year. Patients who had received SI treatment in the past were excluded from the study. All SI therapy was performed by Dr. Paula Stal, a coauthor of the study.

Inclusion criteria were fibromyalgia patients able to understand and answer with autonomy to proposed tests and who had never received Rolwing treatment. Exclusion criteria were severe psychic changes or illiteracy. All patients were under conventional outpatient treatment for at least one year and had not shown expected improvement. Because pain is a subjective symptom and patients were already been treated, the group itself was considered control. We decided to compare the group to it, where patients were the evaluators of their pain before and after application. (Stal & Teixeira, 2014)

Stal and Teixeira's use of a "pre-post" study design is atypical for the United States and much of western clinical research due to its tendency to produce erroneous results.²⁷ The fundamental difference between a pre-post analysis and a randomized controlled trial (RCT) is the former's lack of a control group. While Stal and Teixeira refer to the pre-intervention population as its own control group, the two are not synonymous, as the pre-intervention population would not capture trend changes, as it's a singular point-in-time. The authors attempt to establish that participants had been receiving traditional treatment for over 12 months with no improvement, thus any improvement observed could be the result of SI treatment. However, without a control group to properly capture externalities that could impact the post-intervention population (for instance, better standard practices adopted at the outpatient facilities the patients routinely attend), outcomes are likely overstated. In both Jacobson (2015) and Price's (2015) studies, patients in the control group saw significant improvement from the beginning of the intervention period toward the end, even though the control group was not subject to the experiment. If Price or Jacobson designed their study similar to Stal and Teixeira, SI's impacts would have likely been far more visually pronounced, even if erroneously.

For this reason, it is difficult to evaluate the credibility of outcomes presented in this study, especially as they seem to contradict the findings of the previous RCT studies: Table 4 contains the composite results of Stal and Teixeira's study. Despite Jacobson and Price finding no statistically significant difference in pain relief compared to their controls, Stal and Teixeira's study seemingly reduced its 87% of patients reporting "unbearable pain intensity" to 3% after three months of treatment. While the outcomes will be presented for posterity's sake, this study should not be considered part of the greater SI literature due to its unaddressed design flaws.

Table 4- Outcomes for “Fibromyalgia syndrome treated with the structural integration Rolfing® method”

Table 2 Pain intensity according to verbal numeric analog scale

Pain intensity	Before treatment		At treatment completion		Three months after treatment completion	
	n	%	n	%	n	%
No pain	0	0	5	16.7	4	13.3
Mild	0	0	6	20	8	26.7
Moderate	0	0	13	43.3	13	43.3
Severe	4	13.3	6	20	4	13.3
Unbearable	26	86.7	0	0	1	3.3

Table 3 Anxiety level according to Beck Anxiety Inventory

Anxiety level	Before treatment		At treatment completion		Three months after treatment completion	
	n	%	n	%	n	%
Minimum	0	0	12	40	21	70
Mild	2	6.7	12	40	5	16.7
Moderate	8	26.7	5	16.7	3	10
Severe	20	66.7	1	3.3	1	3.3

Table 4 Depression level according to Beck Depression Inventory

Depression level	Before treatment		At treatment completion		Three months after treatment completion	
	n	%	n	%	n	%
Minimum	3	10	17	56.7	23	76.7
Mild	4	13.3	6	20	5	16.7
Moderate	14	46.7	7	23.3	2	6.7
Severe	9	30	0	0	0	0

Table 5 Changes in pain intensity, depression and anxiety

Variables	Moments	Mean	SD	Median	Minimum	Maximum	n	p
Pain	Beginning	9.07	1.14	10.0	7	10	30	<0.001
	Treatment completion	2.80	1.79	3.0	0	5	30	
	Three months later	3.07	2.02	3.0	0	9	30	
Depression	Beginning	29.80	11.41	30.5	10	53	30	<0.001
	Treatment completion	11.43	9.27	8.5	0	31	30	
	Three months later	8.13	6.43	8.0	0	27	30	
Anxiety	Beginning	37.30	12.75	36.5	13	58	30	<0.001
	Treatment completion	13.87	10.01	11.5	1	53	30	
	Three months later	10.53	9.58	7.0	0	44	30	

Conclusion

Many holistic therapies are maligned due to limited clinical evidence or the exaggerated nature of claims presented by their supporters. However, many of these criticisms are unsympathetic to both the difficulty of conducting replicable research in health care, as well as the role of patient preference toward treatment and their personal continuum of care. The author would note that the initial rise of popularity in “Rolfing” occurred during a period of American medical science where the Food and Drug Administration (FDA) did not test the efficacy of drugs, only their safety.²⁸ It can be argued that the lack of evidence to support MSI’s efficacy for indicated diagnoses is partially due to its only recent resurgence in popularity, and the slow adaptation of an older treatment to today’s research culture. However, coverage decisions for therapies without clinical evidence come at significant risk to both the patient and payer, particularly in the case of MSI, which has not been evaluated as a standalone procedure, as all clinical trials have been performed with the assumption that participants were

routinely receiving conventional care elsewhere. All study participants were also screened beforehand for pathologies that may be exacerbated by MSI, and these pathologies have not been properly documented or researched.

For instance, the American Cancer Society in 2009 listed Roling as a potential concern to cancer patients if deep tissue massage was exercised near tumor sites.²⁹ This presents a current problem, as many practitioners of Roling or MSI bill their services as basic manual therapies³⁰ to bypass insurance exclusions for the practice, introducing these risks to patients. This creates unintended friction due to differing benefit structures for rehabilitative and habilitative care, as MSI typically is performed over 10 or 12 sessions, which may surpass benefit limits for this form of care. This creates another risk for patients, as it ‘crowds out’ covered services with experimental treatments, potentially leaving the patient on the hook when they seek out conventional care after the fact.

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DRAFT-Summary of Responses to Proposed Plan Design Change

Proposed change: Enhanced Clinical Review for High-Tech Imaging

Plans affected: DB Retiree Plan

Reviewed by: Retiree Health Plan Advisory Board Modernization Subcommittee

Proposed implementation date: TBD

Review Date: June 12, 2019

Table 1. Plan Design Changes

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

Description of proposed change:

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

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

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

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

DRAFT-Summary of Responses to Proposed Plan Design Change

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

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

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

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

Table 2: Enhanced Clinical Review Service Options and Fees²

Service Option	PRPM³ Fee
High-Tech Radiology (MRI/CT Scans)	\$0.35
Diagnostic Cardiology	\$0.10
Sleep Study	\$0.05
Cardiac Implantable	\$0.05
Interventional Pain Management	\$0.10
Hip/Knee Replacements	\$0.05
Full Suite of Services	\$0.70

¹ *Enhanced Clinical Review Program (Follow-up Q&A for March 20, 2019 RHPAB meeting)*, Aetna Presentation dated March 20, 2019.

² *Enhanced Clinical Review Program (Follow-up Q&A for March 20, 2019 RHPAB meeting)*, Aetna Presentation dated March 20, 2019.

³ Per Retiree Per Month

DRAFT-Summary of Responses to Proposed Plan Design Change

Table 3: Comparison of Current to Proposed Change

CURRENT: 2019 Retiree Insurance Information Booklet	
<p>Current (Page 44-45 of 2019 Retiree Insurance Information Booklet)</p>	<p>Radiation, X-rays, and Laboratory Tests</p> <p>The Medical Plan pays normal benefits for X-rays, radium treatments, and radioactive isotope treatments if you have specific symptoms. This includes diagnostic X-rays, lab tests, TENS therapy, and analyses performed while you are an inpatient. Charges for these services are not paid if related to a routine physical examination except as noted below.</p> <p>The plan provides coverage for the following routine lab tests:</p> <ul style="list-style-type: none"> • One pap smear per year for all women age 18 and older. • Charges for a limited office visit to collect the pap smear are also covered. • Prostate specific antigen (PSA) tests as follows: <ul style="list-style-type: none"> ○ One annual screening PSA test for men between ages 35 and 50 with a personal or family history of prostate cancer, and ○ One annual screening PSA test for men 50 years and older. • Mammograms as follows: <ul style="list-style-type: none"> ○ One baseline mammogram between age 35 and 40, ○ One mammogram every two years between age 40 and 50, and ○ An annual mammogram at age 50 and above and for those with a personal or family history of breast cancer. <p>These tests will be paid at normal plan benefits following the deductible. Other incidental lab procedures in connection with pap smears, PSA tests, and mammograms are not covered.</p>
<p>Current (Page 44-45 of 2019 Retiree Insurance Information Booklet)</p>	<p>Services Requiring Pre-certification</p> <p>The following list identifies those services and supplies requiring precertification under the medical plan. Language set forth in parenthesis in the precertification list is provided for descriptive purposes only and does not serve as a limitation on when precertification is required.</p> <p>Precertification is required for the following types of medical expenses:</p> <ul style="list-style-type: none"> • Stays in a hospital • Stays in a skilled nursing facility • Stays in a rehabilitation facility • Stays in a hospice facility • Outpatient hospice care • Stays in a residential treatment facility for treatment of mental disorders and substance abuse • Partial confinement treatment for treatment of mental disorders and substance abuse

DRAFT-Summary of Responses to Proposed Plan Design Change

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

DRAFT-Summary of Responses to Proposed Plan Design Change

	<ul style="list-style-type: none">○ Outpatient detoxification○ Psychiatric home care services● Travel
Proposed Change	<p>When receiving services from a network provider, precertification must be obtained by the provider from the Third Party Administrator for the following types of medical expenses:</p> <ul style="list-style-type: none">● High-tech radiology (MRI/CT Scans)● Diagnostic cardiology● Sleep management studies● Cardiac rhythm implant devices● Interventional pain management● Hip and Knee replacements (arthroplasties)

Background

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

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

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

DRAFT-Summary of Responses to Proposed Plan Design Change

Table 4: 2017-2018 AlaskaCare Under-65 Retiree Health Plan High-Tech Imaging (MRI, CT, PET) Utilization and Price⁴

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

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

Table 4: 2018 AlaskaCare Under-65 Retiree Health Plan Top-10 Paid High-Tech Imaging Services in Alaska⁵

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

⁴ Information pulled from the AlaskaCare Data Warehouse, March 1, 2019.

⁵ Ibid.

DRAFT-Summary of Responses to Proposed Plan Design Change

Member Impact:

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

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

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

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

Actuarial Impact

Neutral / Enhancement / Diminishment

Table 3: Actuarial Impact

	Actuarial Impact	Notes
Current	N/A	N/A

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

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

DRAFT-Summary of Responses to Proposed Plan Design Change

DRB operational impacts:

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

Financial Impact to the plan:

Table 4, Estimated Savings

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

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

Clinical considerations:

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

Third Party Administrator (TPA) operational impacts:

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

⁷ *Enhanced Clinical Review Program*, Aetna Presentation dated December 12, 2018.

⁸ *Segal Memo Implementation of Enhanced Clinical Review (ECR) Program for High Tech Radiology Services* dated March 15, 2019.




DRAFT-Summary of Responses to Proposed Plan Design Change

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

Provider considerations:

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

Documents attached include:

<u>Document Name</u>		<u>Notes</u>
<i>Enhanced Clinical Review Program, Aetna Presentation dated December 12, 2018.</i>	 Enhanced Clinical Review Program 12.12	
<i>Enhanced Clinical Review Program (Follow-up Q&A for March 20, 2019 RHPAB meeting), Aetna Presentation dated March 20, 2019</i>	 ECR Follow-up for RHPAB Modernization	
Financial Analysis – Segal Memo	 Segal ECR Memo 20190315.pdf	



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MEMORANDUM

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

From: Richard Ward, FSA, FCA, MAAA

Date: March 15, 2019

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

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

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

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

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

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

Actuarial Value

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

Financial Impact

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

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

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

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

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

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

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

Quality health plans & benefits
Healthier living
Financial well-being
Intelligent solutions



Enhanced Clinical Review program

(Follow-up Q&A for
Feb. 6, 2019 RHPAB meeting)



Program Details

- **Program Summary:**
 - Add preauthorization for participating providers for high tech radiology services –
 - MRI/MRA, CT/CCTA, PET, Nuclear Cardiology
 - Providers need to follow evidence-based guidelines of appropriate care
 - Steerage for members to in-network facilities/physician

- **Provider Approval Process:**
 - Requesting provider completes precertification
 - Determination is sent in a letter to the member, and by fax to both rendering and ordering provider.
 - **Alaska Heart Institute feedback (Jan. 2019):** Our network team surveyed this provider about their experience with Aetna ECR and they did not report any incidences of member disruption.

- **Denial Process:**
 - Providers may request a peer-to-peer review within 14 days from the date of the denial.
 - Providers may choose a convenient time for the peer-to-peer review. It may take 1-2 days to complete the peer-to-peer where a discussion and determination is made.
 - If Precertification denial is upheld after a peer-to-peer review, the provider can appeal directly to Aetna through the standard Provider Appeal process.

- **Precertification Statistics** (October 2018 -- Aetna BOB):
 - 170,000 total requests
 - 667 appealed (.39%)
 - 261 were overturned, an overturn rate of 39.1%
 - 2% of appeals from denials

Savings and Fees

- **Savings Opportunity: \$9.02 PRPM**
- **Program Fee: \$0.70 PRPM**
 - High tech radiology (MRI/CT Scans) \$0.35
 - Diagnostic Cardio \$0.10
 - Sleep Study \$0.05
 - Cardiac Implantable \$0.05
 - Interventional Pain Management \$0.10
 - Hip/Knee Replacements \$0.05
 - Choose a custom bundle or all programs
 - Variable cost via Claim Wire, no fixed cost
- **Implementation:** Required 60-day notice
- **Aetna Vendor:** MedSolutions DBA eviCore Healthcare

Savings Projection

- **Mitigate inappropriate utilization due to a multitude of factors including:**
 - New technologies intensify the application of imaging studies for new diagnostic means
 - Greater consumer demand
 - Aging population
 - Increased capacity through self-referrals by physicians
 - New standards of care
 - Defensive medicine
- **Aetna Savings Model:**
 - Based on Aetna BOB percentage of services redirected/not authorized due to Medical Necessity Review
 - Aetna BOB Average Cost Per Denied Service
 - Customer-specific data (Census/Network)
 - Savings reflect the avoided cost of services not authorized

Program Reporting

Current Period Results

Modality	Services Redirected / Not Authorized	Denial Rate
Hi-Tech Radiology	241	9.5%
Diagnostic Cardiology	29	7.9%
Cardiac Implantable Device	0	0.0%
Sleep Studies	91	45.7%
Hip & Knee Replacement	1	5.0%
Pain Management	17	6.9%
TOTAL	379	11.3%
<i>Avg Cost per Test</i>		<i>\$1,122</i>
<i>Gross Program Savings</i>		<i>\$312,643</i>
<i>Net Program Savings</i>		<i>-\$50,197</i>
<i>Gross Savings PMPM</i>		<i>\$0.52</i>
<i>Net Savings PMPM</i>		<i>-\$0.08</i>

Precertification Decisions

Modality	Prior Period			Current Period		
	Requested	Approved	Denied	Requested	Approved	Denied
Hi-Tech Radiology	2,168	1,931	237	2,530	2,289	241
Diagnostic Cardiology	288	253	35	367	338	29
Cardiac Implantable Device	1	1	0	2	2	0
Sleep Studies	138	81	57	199	108	91
Hip & Knee Replacement	19	16	3	20	19	1
Pain Management	97	94	3	245	228	17
Grand Total All Procedures	2,711	2,376	335	3,363	2,984	379

Performance Guarantees

- Contractual performance guarantees are based upon a two day turnaround time response
- Performance Guarantee Results:
 - 2nd Quarter of 2018 – BOB PG was 95% met
 - 98% within 5 business days
 - 99% of urgent request completed within 8 hours
 - Real-time peer-to-peer review goal to reach a conclusion

Thank you

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