

Retiree Health Plan Advisory Board Meeting Agenda

Date: February 06, 2020
Time: 9:00am - 3:30pm AlaskaTime
Location: **Anchorage:** Atwood Building, 19th Floor Conference Room
Juneau: State Office Building, 10th Floor Conference Room
Teleconference: 650-479-3207 ID#809 155 127
Committee Members: Judy Salo (chair), Joelle Hall, Gayle Harbo, Dallas Hargrave, Mauri Long, Cammy Taylor, and G. Nanette Thompson

- 09:00 am Call to Order – Judy Salo, Board Chair**
- Roll Call and Introductions
 - Approval of Agenda
 - Approve Previous Meeting Minutes
 - Ethics Disclosure
- 09:10 am Public Comment**
- 09:30 am Department & Division Update**
- 10:00 am break**
- 10:15 am Education Session - Changes to Actuarial Value vs. Cost Impact Comparison**
- 11:00 am Modernization: 2020 Next Steps**
- 12:00 pm Lunch on Your Own**
- 01:30 pm Modernization: 2020 Next Steps – Continued**
- 02:30 pm break**
- 03:00 pm Public Comment**
- 03:30 pm Final Thoughts/Adjournment**
- Next meeting: May 2020

Retiree Health Plan Advisory Board

Board Meeting Minutes

Date: Thursday, August 22, 2019 9:00 to 11:00 a.m.

Location: Teleconference Only

Meeting Attendance

Name of Attendee	Title of Attendee	
<i>Retiree Health Plan Advisory Board (RHPAB) Members</i>		
Judy Salo	Chair	Present
Cammy Taylor	Vice Chair	Present
Joelle Hall	Member	Present
Gayle Harbo	Member	Absent
Dallas Hargrave	Member	Present
Mauri Long	Member	Present
Nan Thompson	Member	Absent
<i>State of Alaska, Department of Administration Staff</i>		
Ajay Desai	Director, Division of Retirement + Benefits	
Emily Ricci	Chief Health Policy Administrator, Retirement + Benefits	
Andrea Mueca	Health Operations Manager, Retirement + Benefits	
Betsy Wood	Deputy Health Official, Retirement + Benefits	
Steve Ramos	Vendor Manager, Retirement + Benefits	
Teri Rasmussen	Program Coordinator, Retirement + Benefits	
<i>Others Present + Members of the Public</i>		
Rebecca Polizzotto	Alaska Department of Law	
Lindsey Ferrin	AlaskaCare Account Manager, Moda / Delta Dental	
Stacy Carmichael	Moda / Delta Dental	
Margaret Thornburg	Moda / Delta Dental	
Richard Ward	Segal Consulting	
Anna Brawley	Agnew::Beck Consulting (contracted support)	
Sharon Hoffbeck	Retired Public Employees of Alaska (RPEA)	
Brad Owens	Retired Public Employees of Alaska (RPEA)	
Dale Durrwachter	Retiree, Fairbanks	
Approx. 15 RPEA members	Present via teleconference, not individually identified	

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

Common Acronyms

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

- ACA = Affordable Care Act (formal name: Patient Protection and Affordable Care Act)
- ARMB = Alaska Retirement Management Board
- CMS = Center for Medicare and Medicaid Services
- COB = Coordination of Benefits
- DB = Defined Benefit plan (for Tier 1, 2, 3 PERS employees and Tier 1, 2 TRS employees)
- DCR = Defined Contribution Retirement plan (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

Item 1. Call to Order + Introductory Business

Chair Judy Salo called the meeting to order at 9:03 a.m. A quorum was present (on the phone).

Ethics Disclosure

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

- No members stated any ethics disclosure.

Item 2. Retiree Dental, Vision and Audio (DVA) Plan Overview and Update

Materials: Presentation for 8/22/19 RHPAB Special Meeting

Update from Division (DRB)

Emily Ricci provided an overview and purpose of today's meeting: this is a special meeting called to provide an update on current litigation regarding the Retiree Dental, Vision and Audio (DVA) plan and next steps from the Division. Slide 2 summarizes the current status: AlaskaCare retirees can access a supplemental benefits plan, the DVA plan, for dental, vision and audio benefits. Unlike the medical plan, the DVA plan is fully funded by member premiums for participating members.

In 2014, in an effort to protect members from rising premiums and preserve the value of their dental benefits, the Division implemented changes designed to adopt nationally recognized dental standards of care and promote the use of network providers. These include standards for frequency of care, covered services and other provisions.

These changes were the subject of a 2016 lawsuit brought by the Retired Public Employees of Alaska (RPEA). This case is ongoing, but in April 2019, the Alaska Superior Court found in favor of RPEA, and directed the State to offer one of three options:

1. Return to the coverage provisions of the 2013 retiree dental plan;
2. Provide individual retirees the option to return to the original (2013) plan or continue with the current (2014) plan; or
3. Negotiate a new alternative plan that the plaintiff RPEA accepts as comparable, not diminishing retirees' benefits.

The State has decided to appeal the court's decision, but in the meantime will pursue Option 2 provided by the court: to allow retirees to choose between their current plan (the Standard Dental Plan) and the original plan (the Legacy Dental Plan), beginning January 1, 2020. Retirees will have the option later this fall, during an open enrollment period, to choose which plan to select, including an option for those who opted out of coverage after January 1, 2014 to re-enroll into one of these plans. As long as the State offers two plans, retirees will have an opportunity each year during the open enrollment to remain in their plan or change to another plan.

Emily invited questions from board members; none at that point.

She continued: At the same time this process is happening, the Division has undergone the procurement process for the third-party administrator (TPA) for both medical and dental benefits. They have spent

several months in contract negotiation, and on August 7, 2019 announced a notice of intent to award for the dental plan for Delta Dental of Alaska, formerly referred to as Moda. Now that this award has been announced and the contract finalized, the Division can work with the vendor to develop the two dental plans to be offered to members beginning in 2020.

The two plans will have different coverage provisions and monthly premium rates, based on the overall costs of these plan benefits; the Division is finalizing this information and will provide it to members and the board. Delta Dental has not administered the plan that was in place in 2013 and six years have passed since this plan was last administered, so while the plan was previously offered, it is effectively a new plan for Delta Dental.

- Judy Salo thanked the Division for this information, and appreciates the reasons for the Division not sharing this information until it was no longer confidential. She noted, however, that there is a short period of time for the Division to stand up these plans, as well as time for members to make an informed decision about which plan is best for them. How will the Division communicate this with members, and on what timeframe?
 - Emily Ricci responded that this is covered in subsequent slides.

Emily shared that there are many considerations and aspects of the plan that need to be created for the Legacy dental plan, as it is not currently offered. This is comparable to standing up a completely new plan in terms of effort. Key tasks include:

- 1) Coding and testing the claims adjudication system;
- 2) Building an eligibility file and account structure to address the second dental plan option, including coordinating between the Division's system and Delta Dental's system;
- 3) Designing and implementing an open enrollment system, which is used for the active employee plan but not currently with the retiree plans; and
- 4) Training staff who communicate with members, at the Division as well as Delta Dental, about the provisions of the plan and all the information that these staff would need to assist members.

Emily again paused for questions; no one had questions at that point.

She continued by providing an overview of planned communications with members to let them know about these options and the open enrollment period, as well as an education campaign to reach all retirees. Member communications will begin in late August, with the following methods:

- 1) A paper letter mailed to retirees in late August explaining the plan and that more information will be coming in the fall;
- 2) A special edition retiree e-newsletter (sent via e-mail);
- 3) Updates to the website, including an FAQ list which the Division will add to periodically;
- 4) Ongoing information and reminders in the monthly e-newsletters;
- 5) Social media posts throughout the period, especially during open enrollment;
- 6) Tele town hall events: the Division has contracted with the town hall vendor to host at least two events per month through the fall; and
- 7) A mailed postcard during the open enrollment period reminding retirees to enroll.

Teri Rasmussen added that the communications plan overall begins with an awareness campaign that this change is coming and retirees will need to take action in the future; then education and

understanding about their options and what action they need to take; and finally, a campaign to remind retirees to review their options and make a choice during the open enrollment period. At the same time, the Division will be training staff and working to prepare for open enrollment, manage retirees' questions and issues during the open enrollment period, and generally ensure that retirees have had an opportunity to make an informed choice by the end of the open enrollment period.

Betsy Wood added that the tele town halls have been particularly useful, not only to answer members' questions but to collect additional frequently asked questions directly from members and utilize those in the FAQs page and other communications. This gives the Division a better idea what people want to know, what people are confused about or aren't aware of, and generally improving the feedback loop.

Teri shared that the Division has planned, in addition to the monthly town halls, to host one additional event each in September and October specifically to answer questions about the DVA plan. Staff will send a save the date invitation soon so members can plan to participate.

- Judy Salo asked for clarification: the dental plans will change and become two options, but will vision and audio benefits stay the same in the two options?
 - Emily responded that while the original concept was not to change these plans, staff realized that there may be opportunity for changing some of the vision benefits at the same time, resolving ongoing issues that retirees experience. However, one lesson of 2013 was not to make many changes at once, so they are weighing the options and may or may not make additional changes at this time saving those changes for a future discussion. For example, addressing benefits related to progressive lenses and contacts are things that retirees have asked for, and changes to the vision plan could provide additional clarity and benefits, but there are risks with making too many changes at once, particularly in terms of valuation of the plan.

Emily continued: Slide 9 outlines the proposed open enrollment period for this plan, which is a common practice in health plans but not applicable (for the most part) to retirees currently. Open enrollment periods are typically a few months before a new benefit year, in this case before calendar year 2020. The open enrollment period for the active employees is November 6-27, 2019; during this time, retirees would also have an opportunity to choose their preferred dental plan. Retirees who are currently enrolled in the dental plan, or who changed their coverage after January 1, 2014 would be eligible to participate in this open enrollment plan.

The time period ending November 27 is very challenging to extend. There needs to be sufficient time for the Division and the vendor to process members' eligibility and enrollment, provide that information to Delta Dental, and prepare for the new plan to take effect in January 1, 2020. They have considered making this a longer period for employees in the past, but it is not feasible given the amount of preparation after enrollment closes and before January 1. For members who could not access the portal during the open enrollment period (for example, traveling out of country), they could contact the Division and work directly with staff to make an election, but this can only be done on a limited basis.

During open enrollment, retirees would be able to make a dental plan selection through an online portal designed for this purpose; members could also request paper forms to make their election. A retiree is not required to take action during this time. If they do not take any action or elect a different plan for 2020, they will remain enrolled in their current plan, the Standard dental plan (or, if they are already not

enrolled in the plan, they will remain not enrolled). This ensures that retirees will not lose the coverage they have today if they do not change their selection, but they have the opportunity to do so.

If a retiree does make a new selection (for example, opts for the Legacy plan rather than the Standard plan), they will receive a new ID card in the mail either the last week of December or early January, depending on how quickly and easily the eligibility process is completed. Members who remain in the current plan will also receive a new card. Regardless of which plan members choose, they will still be able to use their existing ID card until the new one arrives even if the new one does not arrive until after January 1, 2020. Additionally, any member can contact Delta Dental or go online to their account to download an electronic copy of their ID card. Emily emphasized that this is an extremely short timeframe, but this is unfortunately unavoidable given the complexity of this undertaking.

Andrea Mueca added that Division staff is actively working on communications, materials and addressing all of the logistical and operational aspects of this process and can communicate with the Board to share updates and communications pieces as they are available.

- Mauri Long asked, during the open enrollment period, will members receive sufficient detail about the provisions of the two options, and implications for retirees? For example, will they receive information about the differences between premiums, coverage amounts, etc.?
 - Emily responded that all that information will be available in the portal during the open enrollment period, beginning November 6. However, they are also preparing materials including a side-by-side comparison of the two plans and key differences to inform the member's choice. These communications will be available much earlier than the November open enrollment period, including comparisons of the two plans in communications in September and October.
- Mauri recommends that members should have this information directly in the portal, so that they can make that decision when they are enrolling. She also recommends having a concierge service, step by step instructions, and other resources for retirees—she noted she is a relatively recent retiree, but still struggles with some online functions. She imagines that many other retirees, particularly those who don't use computers often, will want more support.
 - Andrea responded that this is certainly being addressed: for members who choose to enroll online, they will be able to verify their member information, review the two options side by side in the enrollment portal, and then make their choice in the portal and send this information to the Division through that website.
 - There will also be a paper enrollment option for retirees who choose to use this method, and members using paper enrollment forms can receive assistance from the Division as well. Paper forms will take more time to process than the online version, but the Division will offer multiple options for members to enroll and be available to answer questions.
- Cammy Taylor asked about how Recognized Charge will be included in the plan?
 - Emily responded that in the current plan, the Division sets the recognized charge for out of network providers at 75% of the 80th percentile of Fair Health (a health price database using actual claims data) which allows the Division to set reimbursement rates based on aggregated data on what these services cost in each location. The Legacy plan would return to reimbursing out-of-network providers at 100% of the 90th percentile. In

both plans, the recognized charge for network providers will be determined by the network contracts in place between the provider and Delta Dental.

- Cammy also expressed concern about members who live in areas with no or few in-network dental providers, and whether they would be penalized in terms of cost for going to an out-of-network providers. She encouraged the Division to look at the implications for these members, and whether the Standard or Legacy plan will be a better fit for those with limited choices.
 - Emily agreed that this is a consideration, they are working to outline and address the implications for networks in the Legacy plan.
- Cammy also asked whether the provisions of the Standard plan would change for retirees?
 - Emily responded that at this time the Division does not anticipate making concurrent changes to the current plan, but this is still in development as well.

Emily directed the group to slide 8. One complication of this process is that currently, the DVA plan provisions are included in the plan booklet of the AlaskaCare medical plans, for Defined Benefit (DB) Retirees as well as the Defined Contribution Retirees (DCR). Because the plan booklet is already a large, complex document, they could either include information about both plans in the booklet as separate options, or they could remove those provisions from the medical booklet and create standalone booklets for both DVA plan options. She also noted that retirees currently have a single booklet for these plans and are accustomed to one reference point. Any changes to the booklets would be posted as drafts with a 30-day comment period.

Emily asked the Board for input: is it better to include all this information in one booklet, as they do currently, or should it be carved out as a separate booklet for reference?

- Judy Salo commented that she supports carving these out, since this plan is paid for by members rather than being directly part of the medical plan. She believes this will be simpler going forward, for the reasons Emily presented, and avoid confusion about the plans.
- Joelle Hall noted that she is not a plan member, so she has no direct experience using this booklet; she defers to the retiree members of the board.
- Dallas Hargrave agreed, his is also not a plan member and supports what retirees would prefer.
- Mauri Long shared that she has not browsed the plan booklet recently and has not formed her opinion yet. She would like to review the existing booklet; she noted that it is helpful to have a single book for reference, which currently includes all the DVA plan provisions. Relatively speaking, it seems that the DVA provisions comprise a small portion of the booklet. However, she is open to the idea of having a separate booklet.
- Cammy Taylor also reviewed her booklet. Is there a new printed version of the booklet with all the relevant amendments? She has a compiled copy but would like an updated version, she requested a print version from the Division with all updated information.
 - Emily noted that the newest version is online, including all recent amendments, and is available in print on request to the Division.
She also responded that there are certainly many cross-references and other provisions that integrate information about the medical and DVA plans. It may be more feasible in the short term to keep everything in one booklet, and longer-term to separate the DVA plan provisions out, addressing all the issues such as cross-references in the booklet.
- Mauri asked: what is the Division's rationale for separating the booklet in the future?

- Emily responded that the same DVA plan is offered to DB and DCR plans, so essentially the same information is repeated in two places—in the DB booklet and the DCR booklet. Going forward, this may compound possibilities for error as both plans change over time, so there may be oversights where it is changed in one plan booklet and not the other. This would allow for a streamlined, single document for the DVA plan. It is a separate plan and applies to multiple groups. Additionally, she noted that going forward with the plan modernization project, there will continue to be complications managing the booklets for multiple plans.
In the short term, it will likely be simpler to maintain the single booklet and add the provisions of the Legacy plan booklet into both DB and DCR booklets. Beginning next year (2021), the Division could consider that separate plan booklet, with more time to develop the document and ensure it works with the medical plan booklet.
- Cammy Taylor also asked: regarding coordination of benefits, how will this change impact retirees with coordinated benefits?
 - Emily shared that currently, retired couples who are both eligible to enroll in the DVA plan can coordinate benefits—they would be paying double premiums if they both elect to enroll in a DVA plan, but this is how the system works today. The intent is to continue allowing coordination of benefits across plans, including between the Legacy plan and Standard plan. However, a person with a single DVA plan enrollment and their dependents would need to be in the same plan: they cannot enroll themselves in one plan and their dependents in a different plan.
- Mauri Long asked for clarification: two spouses are both eligible for the DVA plan because they are both vested retirees, they could each elect different plans, is that correct?
 - Emily confirmed that yes, this is the case. However, if one spouse is fully vested and the other is not, and the second spouse is considered a dependent on the DVA plan, they would have to be enrolled in the same plan as the first spouse who is vested.
- Cammy Taylor asked for clarification: the DVA plan requires that the premiums are priced separately for a single individual, versus an individual with a spouse or other dependent(s)? Unlike the medical plan, where there is no additional cost for dependents or spouse?
 - Emily confirmed that this is correct, the premiums are different depending on the number of people covered.
- Judy Salo asked whether it is possible to identify how many people are cross-covered, and whether communications could be tailored to that population to provide information about coordination of benefits and how they can make that decision?
 - Emily responded that it may or may not be feasible to access this information in the timeframe. If they are able to do so, they will certainly look at how to identify this population and possibly send targeted communications to them, explaining their specific situation and options re: coordinated benefits. Additionally, they plan to encourage retirees in this situation to contact the Division to talk through the options.
 - Judy added that this may streamline communications and reduce errors or confusion, if they can provide that information as relevant.

Emily Ricci invited Richard Ward to address the anticipated differences in cost and value for the two plans. He noted two primary differences: one is the value of the plan based on the coverage provisions, premium amounts, and the anticipated value of the plan compared to. The second is the methodology

used to set recognized charge to determine reimbursement for out-of-network services: the current (Standard) plan sets the recognized charge at 75% of the 80th percentile; the 2013 (Legacy) plan sets the recognized charge at 100% of the 90th percentile, and typically reimburses at higher rates. This will have an impact on premiums for the plan.

- Mauri Long asked for a general update on the status of the DVA plan trust, and how it is performing financially as a result of the 2014 dental plan changes? How does this factor into decision making?
 - Emily responded that staff can provide this. She suggested that, given that the next quarterly meeting is not until November, that the Board consider another special teleconference meeting in the next two months (a shorter teleconference like this one) to provide this update. In the meantime, they will share the latest publicly available information about the DVA trust, also available [online](#).

Emily Ricci invited Lindsey Ferrin, account manager for the AlaskaCare dental plans, to add any additional comments for the benefit of the Board. Lindsey shared that Delta Dental will work closely with the Division to set up the functionally new Legacy Plan and address the logistical considerations discussed previously, as well as communications with members. Delta Dental staff will be engaged with training and communications with members as well, including participation in upcoming health coalition events.

- Judy Salo thanked Division staff for providing this information and anticipates more in the future as they continue through the process to get the plan ready. She noted it will be very important to have early awareness communications and provide accurate information as much as possible, as early as possible. She also noted that Board members and other retirees should plan to stay abreast of the current information, encourage their peers to read the information and stay involved, and ensure that retirees are receiving communications and reaching out if they have questions—this will be a shared effort with staff, RHPAB and retiree groups. She also noted Board members will need more advance notice than this meeting allowed for scheduling the next teleconference, and asked Board members to keep the general timeframe of mid-September in mind and watch their e-mail for scheduling messages.
- Cammy Taylor asked for clarification—the first communication will go out in late August?
 - Emily responded yes, the first letter provides an overview of the plan availability and that they will be asked to make a choice in the near future. Concurrently staff will train call center staff and post FAQs online to answer questions from retirees as soon as they receive that first letter. Division staff will share the estimated arrival date(s) for retirees to get that letter in the mail; typically, they have a 4-6 day advance notice from the mailing vendor, and will let the Board know when people will start receiving letters.

Item 3. Public Comment

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

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

Members of the public who provide comments are also encouraged to submit their comments in writing to the Retiree Health Plan Advisory Board: rhpab@alaska.gov.

Public Comments

- **Brad Owens, RPEA.** Brad commented that there is a large amount of information being presented today, without much detail for members to make an informed decision. He asked for clarification for the State's decision to select the judge's Option 2 (offering two plans), versus choosing Option 1 (returning to the original 2013 plan). He believes that Option 1 is less complicated and is closer to the original plan and would have been a better choice. However, he noted that the Division is entitled to make that choice and is working hard to do comply with the ruling. He believes the new Moda plan being the default plan is not legally sound, as it was found to be an unconstitutional diminishment of benefits in the current case. Additionally, he believes an open enrollment of less than 30 days is problematic and done for administrative convenience, since it coincides with the employee open enrollment. He requested that the Division provide the estimated premiums for the Legacy plan as soon as possible, as well as having access to the information that Segal Consulting will utilize to set premiums. In the court hearing on August 8, 2019, Judge Aarseth retained jurisdiction over the case even during appeal, to monitor the implementation of this option. He recommended the Division submit all materials and proposed premiums to the court for review. He commented that the State has created this difficulty by making those changes to the DVA plan in 2014, and assuming that it was outside the constitutionally-protected benefits associated with the plan. He noted that retirees were not involved in that decision, and the communication process in 2014 was insufficient; the Division simply made the changes and informed people of those changes after the fact. He encouraged Judy Salo and the rest of the Board to closely monitor all communications going out to retirees, and to involve retirees more in the decision process and communications. He requested that the Board ask for a record of all funds spent on this effort, and whether it is being paid for with DVA Trust funds (premiums paid by members) or general funds.
- **Dale Durrwachter** supports the proposal to make the 2013 the default plan, rather than the current plan. He currently carries four ID cards for all the various plans he is enrolled in. He also supports the idea of a separate booklet for the DVA plan. He notes that "retirees generally pay what we are told to pay," and gave an example of a procedure that he has had to have corrected multiple times. He encourages attention to detail, and to provide this detailed information to retirees as soon as possible.

Item 4. Closing Thoughts + Meeting Adjournment

Closing Thoughts

- Emily Ricci shared additional information:
 - At the August 8 court hearing, the judge noted that he believes the Division is acting in good faith to comply with the court ruling and appreciates the level of logistical effort needed to address the findings of the court. The Department of Law has filed an update with the court and will continue to do so.
 - The Division did consider each option given by the court; one challenge of returning to a single plan, or making the Legacy plan the default plan, is that the Legacy plan will cost more in member premiums, because of the provisions such as network. While this may be a better choice for some members, the Division did not want to require people to pay a larger amount with no input or decision on their part, it may be a financial hardship for some.
 - Additionally, many retirees including those who retired in 2014 and later have only had access to the current (Standard) plan. For these retirees, returning by default to the Legacy plan would be different than what they have now, and would also potentially be a diminishment of benefits from their perspective. The Division understands that retirees will need time and sufficient information and education to make an informed choice.
- Judy Salo asked when the frequently asked questions document and initial letter will be ready to share with retirees?
 - Teri Rasmussen shared that staff have drafted and currently in final review of these products, and there will be additional details available by early October as they finalize the plan provisions, enrollment process and other information.
 - Emily Ricci added that the goal is to be open and transparent with retirees, but balanced with the goal of sharing only accurate and complete information—rather than providing inaccurate information or something that is overly vague. It is difficult, and they understand that they will be criticized either way, for either not communicating soon enough, or sending out vague or incomplete information.
- Judy Salo recommended posting the meeting minutes as soon as possible, she understands this takes time, but recommends posting highlights soon so retirees can anticipate communications.
 - Teri responded that the audio recording is typically posted within 24 hours, the minutes take more time but they will expedite the minutes for this meeting for posting online.
- Emily shared that staff will communicate with the Board early next week to schedule a follow-up teleconference meeting in September.

Motion by Mauri Long to adjourn the meeting. **Second** by Cammy Taylor.

- **Discussion:** None.
- **Result:** No objection to adjournment. The meeting was adjourned at 10:50 a.m.

The next Retiree Health Plan Advisory Board meeting is planned for Thursday, November 14, 2019.

Check RHPAB's web page closer to the meeting to confirm the schedule, location and to download materials for upcoming meetings. <http://doa.alaska.gov/drj/alaskacare/retiree/advisory.html>

Retiree Health Plan Advisory Board

Board Meeting Minutes

Date: Tuesday, October 8, 2019 10:00 a.m. to 12:00 p.m.

Location: Teleconference Only

Meeting Attendance

Name of Attendee	Title of Attendee	
<i>Retiree Health Plan Advisory Board (RHPAB) Members</i>		
Judy Salo	Chair	Present
Cammy Taylor	Vice Chair	Present
Joelle Hall	Member	Present
Gayle Harbo	Member	Present
Dallas Hargrave	Member	Present
Mauri Long	Member	Present
Nan Thompson	Member	Present
<i>State of Alaska, Department of Administration Staff</i>		
Emily Ricci	Chief Health Policy Administrator, Retirement + Benefits	
Andrea Mueca	Health Operations Manager, Retirement + Benefits	
Betsy Wood	Deputy Health Official, Retirement + Benefits	
Steve Ramos	Vendor Manager, Retirement + Benefits	
Teri Rasmussen	Program Coordinator, Retirement + Benefits	
<i>Others Present + Members of the Public</i>		
Rebecca Polizzotto	Alaska Department of Law	
Kevin Dilg	Alaska Department of Law	
Lindsay Ferrin	AlaskaCare Account Manager, Moda / Delta Dental	
Dr. Teri Barichello	Moda / Delta Dental	
Tricia McDonald	Moda / Delta Dental	
Richard Ward	Segal Consulting (contracted actuarial)	
Scott Young	Buck Consulting (contracted actuarial)	
Anna Brawley	Agnew::Beck Consulting (contracted support)	

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

Meeting Minutes

Item 1. Call to Order + Introductory Business

Chair Judy Salo called the meeting to order at 10:00 a.m. A quorum was present (on the phone).

Approval of Meeting Agenda

Materials: Agenda for 10/8/19 RHPAB Special Meeting

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

Judy stated that public comment will begin at 11:30 as scheduled: given the tight agenda for today's meeting and the two hours allotted, she will be limiting public testimony to 3 minutes and enforcing this limit as needed, to ensure everyone who wishes to has a chance to speak.

Ethics Disclosure

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

- No members stated any ethics disclosure.

Item 2. Retiree Dental, Vision and Audio (DVA) Plan Overview and Update

Materials: Materials shared in packet for 10/8/19 RHPAB Special Meeting

Emily shared an overview of today's meeting: DRB staff will provide an overview of materials for the upcoming open enrollment period for the Retiree DVA plan, specifically dental benefit options. At the same time, the Division is updating the website with more information, new materials and other updates that will be shared during this meeting.

DRB Updates and Announcements

Emily shared announcements:

1. The Division has extended the open enrollment period for retirees to elect a DVA plan, starting three weeks earlier than originally planned (starting October 16 instead of November 6, when employee open enrollment starts). This required fast turnaround in terms of decision making, materials creation and other preparation for starting the open enrollment period.
2. The Division has also posted an updated retiree plan booklet, including new information about the two dental plan options and other minor changes to other parts of the booklet. Here, "minor changes" from the Division's perspective includes: 1) formatting change, 2) typos and 3) updating differences between the plan booklet and how the plan booklet is carried out in practice. Emily noted that "minor" may be defined differently. The plan draft includes a track-changes version noting all changes, and a "clean" version for easier reading. The comment period is open through Friday, October 25. Comments can be submitted via e-mail, by calling the Division or participating in an upcoming Town Hall. All information about the plan booklet and public comments is available on the DRB website.

Review of Materials

Emily shared an overview of the materials shared in the meeting, beginning with the benefit comparison table. She noted that the print materials were finalized last week and are currently with the printer, to be mailed to retirees by Friday, October 11th so they arrive in time for the beginning of the open enrollment period next week. Materials are also being posted online today.

Benefit Comparison Table

This table provides a comprehensive, detailed overview of both dental plan options, including what is or is not covered under the plans and at what level. It also notes provisions for which the two plans are the same, and reiterates that the two options are specifically for dental benefits; both options include the same vision and audio benefits, which were not changed.

Please refer directly to the benefit comparison table for detailed information about each provision and how the two plans compare.

Starting 2020, members who select the Standard plan (the plan currently in place) will have access to an exclusive provider network (PPO, Preferred Provider Organization) with even lower negotiated rates than in the existing network. This will allow access to the existing network of providers (Premier Network), as well as the new PPO network beginning January 1, 2020. The Legacy plan does not have access to the PPO network, but to the existing Premier network.

- Judy Salo asked how a member can determine whether their provider is in the PPO network, or find a provider in this network?
 - Lindsay Ferrin (Delta Dental) responded that a member can search on Delta Dental / Moda's website to either look for a specific provider name, or select the PPO or Premier networks and find all providers noted as in-network.
 - Members can also call Delta Dental with any questions, and for assistance in finding providers within the network in their area.

Emily continued: as a reminder, a network is a contracting agreement between providers and insurance companies to 1) accept a specific rate for services, negotiated between the two parties and 2) to not bill the member / patient additional charges beyond what the insurer pays for in-network care. This practice is known as "balance billing" and puts the member at risk for additional costs beyond what the insurance company has agreed to pay. The two plans both have billing policies to pay charges up to a certain percentile of charges for out of network care. For the Standard plan, they will pay 75% of the 80th percentile of charges for out of network care; for the Legacy plan, they will pay up to 90th percentile for out of network care. For both plans, members may be billed additional charges by the provider if the provider is out of network. If a member sees an in-network dentist, the provider cannot bill additional charges, and must charge the negotiated rate. Starting in 2020, both in-Alaska and out-of-Alaska provider charges' reimbursement rates will be determined by FairHealth, a national database of claims that provides data on charges by specific geographic area, as charges can differ by state or location.

Emily continued reviewing the covered services in each plan: the Standard plan has adopted ADA (American Dental Association) recommended and evidence-based standards and best practices for dental care, such as frequency limitations for routine cleanings, x-rays, fluoride and other services. The Legacy plan covers the same services, without differing limitations.

Emily provided a summary of key differences between the two plans: services are covered in three classes: Class I Preventive, Class II Restorative, and Class III Prosthetics. The primary difference is the extent to which the plan covers these services, after a deductible for Class II and Class III: Class I is covered 100% (no deductible), Class II at 80% (\$50 deductible), and Class III at 50% (also \$50 deductible). Most services remain covered in the same class between both plans, with some exceptions. For example, inlays and crown buildups are covered as Class II (80%) service in the Standard Plan, but as a Class III service (50%) in the Legacy plan. However, periodontal maintenance is covered as a Class I service in the Standard plan but Class II service in the Legacy plan. Emily also noted that dentures and some related services are covered in the Standard plan as Class III services, but in the Legacy plan they are covered as Class II services. As noted previously, services (Class I, Class II and Class III) and any associated frequency limitations are evidence-based standards in the Standard plan, and in the Legacy plan are the same as what was offered prior to the 2014 changes to the dental plan.

- Joelle Hall asked for clarification about crowns and other Class III services, whether the limitation of 7 years is for each tooth or for the entire set of teeth?
 - Lindsay Ferrin clarified that the coverage is per tooth: that is, a person could get two or more crowns in a 7-year period, provided those are not for the same tooth. It does not mean one single crown per person / set of teeth in a 7-year period.
 - Emily Ricci added that recent innovations have extended the useful life of crowns and similar procedures, and that if a crown fails earlier than expected (for example, within the first year or two years), this would be the dentist's responsibility to replace and absorb the cost of that replacement.
 - Dr. Teri Barichello responded that new techniques and materials have resulted in crowns lasting longer, about 10-15 years, and that if a crown fails earlier than expected, that should be considered the dentist's responsibility as a warranty for their work.

The benefit comparison document provides a detailed overview, but cannot provide a full estimate of anticipated cost of care, or the level of detail needed to provide detailed coverage information about individual procedures. The plan booklet, now posted online and including provisions for both Standard and Legacy dental plans, also provides more detail but will not tell a member the estimated cost or itemized coverage for a procedure. Emily encouraged members who have or are anticipating services such as inlays, crown buildups and porcelain restorations to call Delta Dental to understand what services are covered and the differences between the two plans. This may be relevant when considering the total cost of care under each plan, according to retirees' anticipated needs in the next year.

Similarly, there are differences between the plans as it relates to dentures; Delta Dental could explain in detail the implications for a member's individual situation and anticipated needs. She also noted that implants are complicated and can sometimes be covered under the medical plan rather than the dental plan; generally speaking, the Standard plan has higher level of coverage for implants and related services than the Legacy plan. And for all services, the plan still has an annual benefit limit, so less coverage of some services may limit the degree to which the plan will cover other services.

Emily also reminded the group that orthodontics not covered in either plan, consistent with the plan today, and that vision and audio benefits remain the same in both plans.

- Judy Salo commented that it seems that each member will need to evaluate which plan is the better choice for their situation. She also noted that the complexity of the plan benefits, and the fact that most people will not have gone to the same dentist for years or decades, it may be difficult to determine what the member needs and what the coverage limitations mean for them. Is there a way for retirees to effectively track what services they have gotten over time, and what is covered?
 - Lindsay Ferrin responded that there are ways to review records through Delta Dental’s website, and a member can contact their dentist for more information. The information would be available on the website, but would be limited to any claims within Delta Dental’s history for that member, they do not have records from individuals’ previous care.
 - Dr. Teri Barichello added that frequency limitations are determined by Delta Dental’s claims data, and they do not have access to any records or claims not processed through their system. So any determination of coverage necessary has to be limited to previous claims in the system; if someone received dental care several years ago but not under this plan and not through Delta Dental, this past care would not be factored into the member’s current benefits.
- Judy Salo also asked how members can best get this information, given that often providers and insurance companies or plan administrators communicate directly with each other, and can address technical details more than the member will be equipped to do?
 - Dr. Teri Barichello agreed that often this is preferable, as they can quickly address technical issues more than the member is able to. It may be easier for members to ask their providers to communicate with Delta Dental about how services would be covered, and be able to generate an estimated cost of services under the two scenarios.

Open Enrollment Guide

Emily proceeded to provide an overview of the enrollment guide, a companion document to the benefit comparison table, designed to help members through the enrollment process. Both documents will arrive in the mail for retirees and will be posted on the website. She further noted that the enrollment decision is not a one-time choice, that can never be changed: while the Division offers two dental plans, there will be an open enrollment period each fall in advance of the next plan year, in which retirees can change from one plan choice to the other. This would allow a retiree, for example, to select the Legacy plan for 2020, in the following year (2021) to opt into the Standard plan, and to opt back into the Legacy plan for 2022.

She also explained that the monthly premiums differ between the two plans: the way the premiums were calculated for this first year are not based on the number of members who select one plan or the other, but plan premiums for the DVA plan are based on the estimated total cost of the plan, as members fully fund this plan through premiums, unlike the medical plan which is primarily funded by the Retiree Health Trust. While typically monthly plan premiums are determined also from the level of coverage for various services and estimated costs of providing services over time, in this case for this year, estimated future utilization was not taken into account to set rates for this coming year (2020). That will change in future years.

- Cammy Taylor asked for clarification: the Standard plan now has a provider network and a new PPO network—why is this not available for the Legacy plan?
 - Emily Ricci responded that the PPO plan includes competitive pricing negotiated by Delta Dental, and they will not be able to secure this PPO in perpetuity. She added that given

current litigation and the implications of making changes to the Legacy plan, the plan that existed prior to 2014, the Division has been extremely cautious in making any changes or adding benefits to the Legacy plan, as they would need to be very confident that the provisions included in the Legacy plan can be offered indefinitely. They are therefore limiting changes to the Legacy plan that were not already in place prior to 2014.

Rate Setting for Retiree Medical and Dental Plans

Emily Ricci directed the group to the letters beginning on page 10, and noted that at the November quarterly RHPAB meeting (or at a future meeting, depending on timing of other issues to cover on the next meeting agenda) the Division intends to present on how rates are set, and involve the Board in those discussions earlier in the process before rates are set for the following year. She noted that the letters in the packet address the medical plan as well, but the purpose of this meeting is to discuss the DVA plan, so the discussion in today's meeting will be limited to the dental plan premiums. The Division approached premium setting with the following goals:

- Spread risk and purchasing power across the entire DVA plan as a whole, and not maintain two entirely separate plans with separate funding sources.
- Delineate differences between covered services in the two plans.
- Delineate differences between payments for services in the two plans.

Emily reiterated that while estimated utilization of services over time is typically used to set premium rates, in this instance the Division did not include that for the DVA plan, as they recognized that the Legacy plan would likely have significantly higher premiums, given its coverage provisions. If this method had been used, the Legacy plan would have had higher premiums and the Standard plan slightly lower premiums. As the rates have been set beginning in 2020, the premiums for the Standard plan will to some degree cover some estimated costs associated with the Legacy plan.

She also noted that currently the DVA plan is well-funded, and has significant assets: this is a long-term discussion for the Board in a future meeting, to consider how best to manage that plan over the long term, with the goals of keeping it solvent but preserving value for members.

Presentation: 2020 AlaskaCare Budget Projection, Retiree DVA Plan | Richard Ward, Segal Consulting

Richard introduced himself, and directed the group to the slides beginning on page 26 of the presentation. He noted that currently, the DVA plan is well funded and has over 150% total assets above projected costs. The plan premiums were therefore set slightly lower than the estimated cost of the plan going forward, for coverage of services under the Standard plan, given that the plan is currently well funded. Rates will be adjusted in future as assets are spent down; further adjustments may be needed.

Methodology: the team reviewed the last 12 months of claims paid (July 2018 to June 2019) and used enrollment data through June 2019 as a basis. He noted that the costs and utilization have been relatively stable over the last few years, so using additional years of data would not impact the overall findings. Currently they estimate the following cost increases over time: Dental 3.5% annual cost increase, Vision 3.5% annual cost increase, and Audio 4% annual cost increase. This includes actual cost changes as well as a survey of providers to understand relevant cost trends nationally. He also explained that even factoring in costs that have been incurred (services rendered by a certain date, not yet submitted or reimbursed by the plan), approximately \$3.1 million as of June 30, 2019, the plan has approximately \$20.6 million in assets, a ratio of 674% to estimated liabilities. Best practice is to have the

plan assets between 150% to 250% (for this plan, \$4.6 to \$7.6 million) to cover any anticipated costs and not threaten the solvency of the plan. This means the plan is very well funded, even with excess assets given projected needs. This also means that, because the goal is not to significantly change premiums from year to year for members, premiums have been set for relatively lower in 2020 to be able to spend down some of the assets built up over time. Longer term, it will be an ongoing process to set rates each year to manage sufficient assets for the plan to cover projected costs, without having to put in place significant rate changes from year to year. Page 30 is a projection of what rate increases would be to achieve optimum use of the plan assets while not overly increasing premiums for members over time.

Emily clarified that the information provided about the assets of the DVA trust relate to longer-term policy discussions with the board; the goal today is to share information and help members understand the differences between the premiums for the two plans, and how they were determined.

Richard presented the information on page 32: Standard plan rates have been kept the same in 2020 as they are in 2019, and Legacy plan rates have been set at approximately 10 to 11% higher than Standard plan rates. He reiterated that expected utilization was not factored in for 2020 premiums, but will need to be a policy decision in future years as the plan collects utilization data and can identify any significant differences in costs and/or utilization for the two plans. Currently, they generally expect more utilization for certain services depending on the level of coverage under each plan, and the extent to which people select one plan or the other according to their projected needs and which option is more advantageous in terms of cost to the member for those services.

Please see page 32 of the packet for a comparison of the two plans' monthly premiums.

Page 33 reiterates some key differences between the coverage and network provisions of the two plans, and an analysis of the overall difference in cost of the plan: overall, there is a 14.3% difference between the Standard plan and Legacy plan, with the largest differences in network provisions and the coverage of recognized charges, meaning the Legacy plan has overall higher costs for network providers and a higher reimbursement out of network using the recognized charge formula. This does not take into account projected enrollment, utilization of services, or whether people will selectively choose a plan that will result in higher cost to the plan. This also means that if premiums were set only with this policy, the Standard plan would be slightly less per month in premiums than is presented for 2020. Current (2019) rates are also still below projected expenses, in order to spend down some of the total plan assets over time to get closer to the ideal range at which the plan should be funded.

Additionally, because of plan design provisions in the Standard plan and which services are offered or covered at what level, the Standard plan is considered to have an overall greater level of benefits. The Legacy plan has a greater level of benefits for some specific services and the fact that it does not have coverage limitations on many services, but overall is slightly lower value by comparison.

- Mauri Long asked for a summary of the DVA plan rates for the past five years, 2014 to now?
 - Richard Ward responded that DVA plan premiums have remained constant since 2017, and that there was an approximately 5% increase in 2016.
 - Mauri clarified that she is most interested in the premium rates before and after the 2014 plan changes, and how the previous increases in premium rates compared. What was the trend prior to the plan changes in 2014? Were they increasing, decreasing, same as now?

- Emily shared historical premiums. In 2013: \$70 premium for retiree only. In 2014: \$63 premium for retiree only. (Similar changes made across all coverage households, scaling up depending on the number of household members covered). Emily also noted that prior to the 2014 plan changes, premiums were increasing steadily in most years prior to that point: in 2005, rates were \$48. By 2013 they had increased to \$70. Part of the intent of the previous plan changes was to reduce the rate of premium increase over time.
- Cammy Taylor asked what the policy decisions were prior to now, why premiums were not decreased from year to year, given the build-up of assets?
 - Emily directed the group back to the projections, and explained that while the net assets are above the ideal target, meaning there are extra assets to fund the plan over time, the expenses have been above revenue collected via premiums. It is reasonable to assume that costs will continue to increase, and reducing premiums while costs increase could result in a more sudden drop in net assets, which would later result in having to suddenly increase premiums sharply. This is painful for members, and had to be done for the employee plan a few years ago, which was an understandably unpopular decision. The Division wants to avoid making significant premium increases, and instead spread this impact over time by closely monitoring the comparison between revenue and expenses in a way that the net assets are within ideal range, and avoiding sharp increases in the future if the net assets drop too low. The Division can also try to control costs through plan design and other mechanisms, which has been taken into account in the Standard plan since 2014.
- Cammy asked whether projected expense increases are based on provider rates or other costs?
 - Emily responded that the costs and projected costs are a combination of factors, including estimated rates, reimbursement rates by plans, utilization of services, and projected number of members utilizing the plan over time. For example, A large increase in membership could increase total costs to the plan, even if all other costs remain the same.
 - Richard Ward confirmed this is accurate.
 - Emily added that depending on the plan's experience (utilization, who chooses which plan, etc.) in 2020, the projections may change significantly for the following year.
- Judy Salo commented that in general, dental procedures are becoming more sophisticated but are also more expensive. However, the \$2,000 benefit limit has not changed over time. Judy requested that this be part of the discussion for the November meeting: how many people are meeting, exceeding or are close to meeting that limit. She would like to understand how much this is impacting members and whether it is possible to change that limit in a future year, given the information shared.
 - Emily Ricci responded this can certainly be discussed. She noted that plan design can also impact this: they have made several changes in the employee plan, including preventive services not counting toward the out of pocket maximum. The Division could consider similar changes in the Standard plan, carving out some services from the annual benefit limit; as stated previously, there are difficulties with making changes, especially adding benefits, to the Legacy plan. This will be discussed further in future meetings.
 - Emily also noted that while there are no changes proposed in the plan to Vision or Audio benefits, there have been requests to change the maximum annual spending on Audio benefits as well. However, because all of these services in the DVA plan are paid for by

members, the Division has to be careful in making changes because it could significantly increase cost and reduce value for members paying into the plan.

Emily Ricci offered Scott Young (Buck Consulting) an opportunity to share his perspective: Scott shared that Buck Consulting did a peer review of Segal Consulting's work, including reviewing assumptions and cost factors, as well as replicating their analysis. Buck found that Segal's analysis was sound and were able to reproduce equivalent findings, including the same general rates. They also concurred with the premiums set and the policy decisions being informed by available data. Buck also made recommendations to Segal, which were incorporated into the analysis. Buck's commentary on the process is included in the agenda packet.

Demonstration: Retiree DVA Plan Open Enrollment Portal

Andrea Mueca provided a walk-through demonstration of the new website to help retirees complete enrollment online: she noted that this demonstration is not a live website yet, but will be launched on midnight, Wednesday, October 16, 2019.

This demonstration was provided live in the meeting via screen sharing. The finished website will be launched on October 16 for members to begin making open enrollment elections.

- There will be step-by-step instructions posted on the Division's website when the website is launched, as well as instructions included in the enrollment guide mailed to retirees this week.
- The website will include the benefit comparison table, premium amounts and other information directly in the enrollment process, which will also be available elsewhere online.
- There is also an option to opt into the AlaskaCare retiree e-newsletter, sent monthly by the Division with important and helpful information.
- The website asks the user to 1) verify their eligibility to participate in open enrollment, 2) select whether they would like to opt into the Standard plan or Legacy plan, 3) select which member(s) of their household they will cover, including premium costs for each, and 4) a button to Enroll. Once enrollment has been completed, the website will generate a confirmation page with a timestamp to verify it has been completed.
- A person can complete the enrollment process as many times as they would like before the end of the enrollment period, if they want to change their selections; the system will use the most recent completed enrollment as the final decision.
- If a person enters their information and is not determined eligible by the website, there is a prompt to contact the Division to verify
- There are also paper forms available, if a person would like to complete enrollment via hardcopy. Forms must be postmarked by the last date of open enrollment: Wednesday, November 27, 2019.

Board questions or comments:

- Cammy Taylor noted that, according to Moda's annual report, approximately 5,000 retirees are over age 75, and a significant number are over 80. Additionally, people may be traveling or not receive the mailed packet in time to take action, or otherwise do not take action to make a selection, what options do they have? She noted this is a lot of information to absorb, a complex decision to make. She is concerned about retirees' ability to complete this process.
 - Emily Ricci responded that the Division has worked to address any potential issues members might have enrolling, and offering multiple ways to do so, including offering paper forms to

make a selection. If a person has extenuating circumstances or cannot act in time for the end of open enrollment, the Division will work with that member to complete the process as soon as possible. She noted that processing paper forms is time consuming and opens additional room for user error, but members can contact the Division to request a paper form to complete the process, and they will mail the form as soon as possible.

- Cammy also asked, can people in Anchorage or Juneau come to the Division's office directly for support or to complete the process?
 - Emily confirmed that yes, this is an option. The enrollment process can also be completed over the phone, the call center is being trained to answer any questions about the process and assist with open enrollment.

Item 3. Public Comment

Before beginning public comment, the Board established who intended to provide public comments. Individuals were asked to state their full name for the record. Because there are several people wishing to provide comment, comments will be limited to 3 minutes per person, at the discretion of the chair. Judy Salo also reminded Board members and members of the public of the following:

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

Members of the public who provide comments are also encouraged to submit their comments in writing to the Retiree Health Plan Advisory Board: rhpab@alaska.gov.

Public Comments

Members posing questions were not able to have questions answered given the time constraint, but questions were collected with the intent of addressing them in writing on the Division's FAQ page online, and also addressing them in the upcoming Tele Town Hall about the DVA plan on Thursday, October 17.

1. A member commented that he anticipates more details being available to make a decision about which plan to choose, but he would like more information about implants, particularly what is covered in the Legacy plan. He noted there has been previous discussion about implants and what is covered in the medical versus dental plan, and asked if that issue has been resolved in the dental or medical plan.
 - Judy Salo responded that the current meeting will not allow for answering questions, but questions will be collected and addressed at the upcoming Town Hall event.
 - will plan to attend the Town Hall. He noted that he is interested in any follow-up about the determination of whether and when implants are covered under the medical plan, per

- medical/surgical necessity, and how to figure out which plan will cover that procedure if he gets implants.
- Emily Ricci noted the time constraint, but shared that the next Town Hall is scheduled for Thursday, October 17, beginning at 10 a.m. AKDT. She encouraged members to contact Delta Dental for this question, but will collect more detailed information about when implants are covered, and post this to the FAQs.
2. A member commented several of the coverage provisions were confusing in the table. She also asked for confirmation that if a retiree does not take action, they remain in the Standard plan?
 - Yes, this is correct.
 - The member requested that the open enrollment information clearly state what the current dental benefits are, and current monthly premiums.
 3. A member asked, would future changes to dental benefits be applied to both plans, or just one of the plans?
 4. A member asked how you can research whether their provider is in the PPO network, and what the relative costs would be?
 5. A member asked where can you find details about which services are covered in more detail?
 - Judy Salo responded that detailed information about the plans and any provisions for specific services are in the plan booklet.
 - Emily Ricci added that there are general provisions in the plan booklet, but she encouraged members to contact Delta Dental: there are thousands of dental services' billing codes, so it is generally best to speak to the plan administrator directly to understand exactly what would be covered and at what level. Delta Dental's contact information is on your ID card.
 6. A member asked how are you able to track the 7 years frequency in the standard plan when you can switch each year between plans? That is, if you leave the Standard plan and later come back into it, would the frequency track from the previous limitations you were under in the Standard Plan, or does it restart?

Item 4. Closing Thoughts + Meeting Adjournment

Closing Thoughts

- Emily Ricci shared that all information shared today is posted on the Division's website as of today. Staff are collecting questions and posting answers as soon as possible, typically within 24 hours.
- Upcoming Tele Town Halls: (All times are Alaska time zone)
 - Thursday, October 17, 10:00 to 11:00 a.m.
 - Tuesday, October 22, 10:00 to 11:00 a.m.
 - Thursday, November 7, 10:00 to 11:00 a.m.
 - Thursday, November 21, 10:00 to 11:00 a.m.
- Staff understand that this is a lot of information for retirees to understand and a complex decision to make, so they are available to answer questions and are working to communicate as much as possible with retirees before and during open enrollment. The Division is also open to any suggestions how best to communicate this information and educate retirees, so please send suggestions! For example, staff could stage a live demonstration of the website at a future event.

Motion by Gayle Harbo to adjourn the meeting. **Second** by Cammy Taylor.

- **Discussion:** None.
- **Result:** No objection to adjournment. The meeting was adjourned at 12:13 p.m.

The next Retiree Health Plan Advisory Board meeting is planned for Thursday, November 14, 2019.

Check RHPAB's web page closer to the meeting to confirm the schedule, location and to download materials for upcoming meetings. <http://doa.alaska.gov/dr/alaskacare/retiree/advisory.html>

Common Acronyms

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

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

Retiree Health Plan Advisory Board

Board Meeting Minutes

Date: Thursday, November 14, 2019 9:00 a.m. to 4:15 p.m.

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

Meeting Attendance

Name of Attendee	Title of Attendee	
<i>Retiree Health Plan Advisory Board (RHPAB) Members</i>		
Judy Salo	Chair	Present
Cammy Taylor	Vice Chair	Present
Joelle Hall	Member	Present
Gayle Harbo	Member	Present
Dallas Hargrave	Member	Present
Mauri Long	Member	Present
Nan Thompson	Member	Excused Absent
<i>State of Alaska, Department of Administration Staff</i>		
Paula Vrana	Deputy Commissioner, Department of Administration	
Ajay Desai	Director, Division of Retirement + Benefits	
Emily Ricci	Chief Health Policy Administrator, Retirement + Benefits	
Andrea Mueca	Health Operations Manager, Retirement + Benefits	
Steve Ramos	Vendor Manager, 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>		
Kevin Dilg	Alaska Department of Law	
Daniel Dudley	Aetna	
Hali Duran	Aetna	
Nicole Utley	OptumRx	
Julian Nadolny	OptumRx	
Stephanie Gaffney	OptumRx	
Richard Ward	Segal Consulting (contracted actuarial)	
Noel Cruse	Segal Consulting (contracted actuarial)	
Quentin Gunn	Segal Consulting (contracted actuarial)	
Brian Rankin	Lewis & Ellis (contracted actuarial)	
Anna Brawley	Agnew::Beck Consulting (contracted support)	
Dr. Phil Hofstetter	CEO, Petersburg Medical Center	
Wendy Woolf	Retired Public Employees of Alaska (RPEA)	
Barbara Stack	NEA-Retired	

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

Common Acronyms

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

- ACA = Affordable Care Act (formal name: Patient Protection and Affordable Care Act)
- ARMB = Alaska Retirement Management Board
- CMS = Center for Medicare and Medicaid Services
- COB = Coordination of Benefits
- DB = Defined Benefit plan (for Tier 1, 2, 3 PERS employees and Tier 1, 2 TRS employees)
- DCR = Defined Contribution Retirement plan (Tier 4 PERS employees, Tier 3 TRS employees)
- DOA = State of Alaska Department of Administration
- DRB = Division of Retirement and Benefits, within State of Alaska Department of Administration
- DVA = Dental, Vision, Audio plan available to retirees
- EGWP = Employer Group Waiver Program, a federal program through Medicare Part D that provides reimbursement for retiree pharmacy benefits
- EOB = Explanation of Benefits, provided by the plan administrator detailing claims coverage
- HIPAA = Health Insurance Portability and Accountability Act (1996)
- HRA = Health Reimbursement Arrangement account, a mechanism for the employer to reimburse high-income Medicare enrollees for any premium charge for their plan (IRMAA)
- IRMAA = Income Related Monthly Adjustment Amount, a surcharge from CMS for a Medicare plan for individuals or households earning above certain thresholds
- MAGI = Modified Adjusted Gross Income, based on an individual or household's tax returns and used by CMS to determine what if any premium must be paid for a Medicare plan.
- OPEB = Other Post Employment Benefits; an accounting term used to describe retirement benefits other than pension benefits
- OTC = Over the counter medication, does not require a prescription to purchase
- PBM = Pharmacy Benefit Manager, a third-party vendor that performs claims adjudication and network management services
- PEC = proposal evaluation committee (part of the procurement process to review vendors' bids)
- PHI = protected health information, a term in HIPAA for any identifying health or personal information that would result in disclosure of an individual's medical situation.
- PPO = Preferred Provider Organization, a type of provider network
- RDS = Retiree Drug Subsidy program (a federal pharmacy subsidy program)
- 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 Judy Salo called the meeting to order at 9:02 a.m. A quorum was present.

Approval of Meeting Agenda

Materials: Agenda packet for 11/14/19 RHPAB Meeting

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

Approval of Previous Meeting's Minutes

Minutes were not available at the start of the meeting due to a printing issue and were approved later in the afternoon portion of the meeting.

Ethics Disclosure

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

- No members stated an ethics disclosure.

Item 2. Public Comment

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

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

Members of the public who provide comments are also encouraged to submit their comments in writing to the Retiree Health Plan Advisory Board: rhpab@alaska.gov.

Public Comments

- No one wished to provide comment during this time.

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

Emily Ricci thanked the Board for being available for two additional special teleconference meetings in August and October, in addition to the quarterly meetings.

Dental, Vision and Audio (DVA) Plan Update

Emily shared that open enrollment for the DVA plan is ongoing, and open enrollment will close November 27, 2019 [*Update following the meeting: the DVA plan open enrollment period was extended through Friday, December 13, 2019*]. Members have received several communications about this event, including additional scheduled tele town halls, two reminder postcards (the second was mailed this week) and e-mail communications. The reminders encourage members to initiate the process, review their options, and complete the process via the website or requesting a paper form to complete their elections. Division staff as well as Moda / Delta Dental staff have also been present at all health fairs, to answer questions of members.

The next tele town hall will be Friday, November 22. Additional e-mail communications are planned as well, between now and the deadline. Staff will provide the Board a summary update after the process completes, including a review of how the process went and the number of plan elections by members. Staff anticipates additional work, including mailing new ID cards and verifying members' information, in the weeks after open enrollment closes.

Concurrently, employee open enrollment (medical and dental plan, as well as voluntary supplemental benefits) is happening, also closing on November 27.

- Gayle Harbo asked an estimate of how many members are eligible, and out of those how many people have participated?
 - Andrea Mueca confirmed there are about 41,000 members in the current DVA plan or eligible to participate. Staff will provide an update of the number of people who participated, after open enrollment closes.
 - Teri Rasmussen clarified that not all members may choose to take action, if they decide to remain in the Standard plan. Staff have encouraged all members to actively choose a plan, even if they are choosing the plan they are already in, so they have made an informed choice.
- Gayle commented that she recently completed the process, and that it was easy and straightforward, she complimented staff on the process.
- Cammy Taylor asked for clarification: the enrollment numbers provided yesterday in the vendors' meeting included a higher number than quoted today. What is the discrepancy?
 - Andrea responded that the 41,000 quoted is the number of retirees; the number of members is larger, including dependents of retirees. The retiree must make the plan election, so this is why the previous number was cited.
- Judy Salo commented that Board members are being contacted and asked for advice about how to participate. She asked for confirmation: should we advise individuals to choose to make an election, online or via paper form?
 - Emily confirmed that yes, the Division wants people to make an educated choice, and to take action, even if they choose to stay in the Standard plan as they are today.

- Judy noted that she has advised people that they do not need to take action if they do not want to change, but she will change her messaging to encourage people to review the choices and make a choice.
- Judy asked where to direct members if they have questions?
 - Emily responded that there is a regularly-updated list of FAQs on the website, staff have been updating this as new questions arise.
- Judy also asked for confirmation for contact person. Can they contact staff?
 - Yes, please provide the Division's contact information to anyone who has questions.
- Judy also asked for information to provide to members who have asked whether their dentist is in network? This has been a common question.
 - Emily confirmed that the Delta Dental website has a tool to search for a provider—she noted that the website requires you to specify which state and which network you are in, the plan is the Alaska Premier PPO Network. Members can also call Delta Dental to request a verbal list of providers in their area, as well as a printed list of providers they can provide by e-mail.
- Cammy asked for clarification: if you are a dual-eligible household, and both spouses are retiree members, both individuals can opt into different plans. However, if you are in two different systems, spouses must elect the same plan.
 - Emily responded yes, this is correct. Spouses can elect each other to be dependent members, but the system does not allow for this across different plans. Staff have been encouraging members to review their estimated costs, by person, to more accurately estimate what each plan would cost them over the coming year.

Third Party Administrator (TPA) Procurement Update

Emily Ricci shared that the medical third party administrator procurement process for all AlaskaCare plans (including retiree and employee plans) has been completed, the State has chosen to issue a Notice of Intent to Award to Aetna, the current vendor. There were no protests, so this process has been finalized and the contract will be executed soon after finishing legal review. Previously the State announced that the dental TPA contract beginning 2020 would be awarded to Moda / Delta Dental, the current vendor for that plan. The contract is a 5-year term, with up to 5 years of additional renewals. This is to provide stability for members, while retaining the ability to re-negotiate or initiate a new procurement after that period, if it is in the interest of the State. This initial 5-year period will allow the Division to focus on other policy priorities in the meantime. The contracts take effect January 1, 2020.

The pharmacy benefit manager (PBM) contract has a shorter timeframe, with a 3-year period and multiple year renewals. This was awarded in 2019 to OptumRx and will provide the Division a shorter time period to evaluate the performance of this contract and be able to re-bid the contract in the near future if needed.

- Mauri Long asked whether the vision and audio plans are in a separate contract?
 - Emily responded that both will be included in the medical contract, as they are today. However, the contract was written in a way to include core medical services, but additional services could be carved out in the future if the State deems it advantageous to put these out for separate bid. These include COBRA, wellness and disease management, and others. The State could bid these competitively as separate contracts

in the future if needed. This provides some flexibility if the need arises. Any proposals to carve out these services and consider a separate competitive bid would be discussed with the Board in future.

- Mauri commented that the process has raised questions for her, such as how each contract service is managed. She asked how each service (medical, vision, audio, etc.) is managed in terms of the health trusts: for example, there is a separate DVA trust.
 - Emily clarified that the payments for DVA, even though they are part of the same contract now, are accounted for separately and paid for out of the DVA funds rather than the primary health trust. Richard Ward with Segal Consulting will provide an overview of how rates are set, and spending is tracked.

Division Retirement System Replacement RFP

Ajay Desai shared an overview: this project originated in 2016, with the goal of modernizing the Division in terms of services, but also software. The current system they use is pre-2000 and needs to be replaced; it is an old but critical system. The help center system, however, is new. The goal is to be able to fully coordinate these systems and make them work together and replace the old mainframe system. Rather than incremental fixes to continue to make the old system work, they want to invest in a new enterprise system that can manage multiple functions: health care, pension management, financial management, employer contributions, and 24/7 customer service that members can do online.

After an assessment to estimate the cost and effort needed to implement this change, Ajay outlined a two-step process: first, to bring a team of experts to assist in the transition. The firm is a project management consultant with previous experience assisting large employers in large change processes like this one. The firm Linea was retained in February, after a competitive bid: the firm has a strong reputation in this area. The firm outlined a full process, system requirements for the new platform, and communicated with potential vendors to refine the requirements and project management plan.

The second phase is now underway: the State has solicited bids from several vendors and there are three potential vendors being considered. They will be selecting the final vendor for the new system soon and will create a detailed roadmap for how the new system will be designed and implemented. They anticipated a 3.5 to 4-year process. He noted that this is the first time this project has been presented to the Board, but he has previously provided several updates to the Alaska Retirement Management Board (ARMB).

- Judy Salo asked about the anticipated role of this board (RHPAB)? She shared, for example, regular communications with members will be important, that is a function the Board can assist.
 - Ajay responded that currently, there are about 14 databases being used, and much (about 80-85%) of the work being done now must be done manually or created from scratch. This means that significant systems changes, like EGWP, requires a great deal of manual work that in a newer system could have been done automatically. Functions such as rate setting, estimating member contributions, etc. could be done much more efficiently, and give the Division much more sophisticated tools to track finances, analyze and manage performance of the system overall. It would also integrate several functions into one system.
 - He anticipates involvement across all stakeholders and entities involved in the pension, AlaskaCare, etc. Members (employees and retirees) are important stakeholders. The

Division will provide regular updates about how the project is progressing, and engage with RHPAB, AlaskaCare members and other stakeholders along the way.

- Judy asked for an overview of the systems issues and inefficiencies that this would fix and looks forward to future updates at the quarterly meetings.
- Judy asked Gayle Harbo for any comments from the perspective of ARMB, as she is a board member. Gayle asked Ajay for the information he provided in September regarding the cost, and any other updates from that meeting.
 - Ajay responded that the estimated cost will be \$30 million, inclusive of project management cost, enterprise system cost and all other anticipated costs. This was a 2018 capital-budget appropriation by the Legislature, already approved. He added that the estimated cost of continuing to use and update the existing systems, and conduct processes manually, would have been \$60 million over the same period. He also noted that the current costs are covered by the health trust, not the General Fund, so it is imperative to make the systems efficient, make best use of staff time, and ensure that the trust funds are being used as best as possible.
- Dallas asked that, if the purpose is to invest upfront and reduce costs down the line, what is the estimated savings back to members for investing in this new system?
 - Ajay clarified that the purpose is not to reduce staff, so this would not be a cost savings in terms of staff positions. However, being able to repurpose staff time, and utilize their skills in better ways than completing current functions manually, will allow staff to assist members more directly and promptly, and be responsive to AlaskaCare members who are having difficulty with the online system. He looks forward to staff being able to focus on other functions, such as systems improvements and customer service.
 - Emily added that the system is at the end of its useful life cycle, and likely reached that end years ago. She reiterated the challenges and time-consuming processes that take up so much staff time. This would free up significant staff capacity to work on policy projects, such as those being discussed with the Board. She is excited about having a new system in place and being able to reallocate staff capacity.
 - Ajay also noted that the project management consultant they have been working with is highly skilled and has provided valuable services to map out a change process. Additionally, the two vendors they are currently considering both have very high-quality platforms and either would be an excellent choice to implement this new system. However, the Division will not have additional staff through this process, so they will rely on contracted resources as well as in-house staff to complete it.

Judy requested that staff provide an update on the project at the next quarterly meeting.

AlaskaCare EGWP (Pharmacy Plan: Medicare Part D Employer Group Waiver Plan) Update
Materials: Documents beginning page 4 in 11/14/19 meeting packet

Emily Ricci invited Julian Nadolny (OptumRx) to present a summary of the EGWP performance update.

Julian provided an overview of the five subsidies comprising EGWP, and updated numbers for the first three quarters of 2019: the total subsidy to date for 2019, Q1-3 is \$39,003,157. Julian noted that they anticipate the subsidies to continue to grow in Q4, as more members enroll in Medicare Part D.

Updates by Subsidy Category

1. CMS Direct Subsidy: a per member per month payment, prospective to subsidize drug costs. Payment to date (Q1-3): \$1,016,057.
2. Coverage Gap Discounts: quarterly payments from manufacturers for brand name drugs in the coverage gap (up to 70%). Alaska's plan does not have a coverage gap for members, but manufacturers provide these payments and the plan receives these. Payment to date (Q1-3): \$23,594,078.
3. Catastrophic Reinsurance: a monthly subsidy for drug costs 80% above the true out of pocket (TROOP) threshold. Payment to date (Q1-3): \$13,511,110.
4. Low Income Premium Subsidy: paid for premium assistance for qualifying members. Only one AlaskaCare member qualifies for this subsidy directly; the rest goes to the health trust. Payment to date (Q1-3): \$165,940.
5. Low Income Cost Sharing Subsidy: paid for cost sharing assistance for qualifying members. Payment to date (Q1-3): \$715,972.

Judy commented that this is an impressive level of subsidy, and thanked Julian for the presentation. No additional board comments.

The Board took a 15-minute break at 10:02 a.m., and returned to the meeting at 10:15 a.m.

Item 4. DVA Plan + Long Term Care (LTC) Plans Premium Rate Development

Materials: Documents beginning page 5 in 11/14/19 meeting packet

Richard Ward presented information about how rates are developed for the DVA and LTC plans: he noted that Brian Rankin with Lewis & Ellis was also on the phone, a firm Segal partnered with to complete rate setting for the LTC plan.

Emily added that this is an educational presentation, there is no action item for the Board at this point; however, when the Division undertakes rate setting next year, they will include the Board in that discussion at that point. This is background information to prepare for future discussions.

Richard continued: premium rates are generally developed to cover the projected costs (claims costs, administration and operational expenses) of administering the plan, so that the premiums collected cover the cost of the plan. It is best practice to have smooth premium amounts from year to year, and not drastically change the premium cost from year to year. Premiums should also be competitive, to maximize value of the benefit versus cost of premiums, particularly for voluntary plans where members can choose to participate. Having competitive, solid premiums helps manage risk by encouraging a diverse population to participate (meaning, not all high-needs, high-cost individuals participate, and no one else, which means more risk to the plan stability). Additionally, there should be enough revenue collected over time to match with estimated utilization and expenses of the plan. For the DVA plan, it is likely that payments will be made out the same year premiums are taken in; however, the LTC plan typically includes people paying in for several years, and not utilizing benefits until later in life, when the need arises. Overall, the goal is to maintain the long-term health of the plan.

DVA plan: To project estimated costs over time and therefore revenue needed to cover the cost, there is a relatively short time frame (typically, the same plan year for premiums paid vs benefits received). The

analysis included the last 2 years of premiums and claims. In the recent past there were no significant changes to consider in the plan design, so the estimates did not significantly vary from year to year. However, because there are plan changes starting 2020, this will impact the rate estimates going forward. In setting 2020 rates, the team did not attempt to model the changes, but utilized the existing estimates. The rates for the Standard plan are likely somewhat higher than they would have been without this change, but this provides a conservative estimate if there is relatively higher enrollment in the Legacy plan. In future years, the team will be able to use the new information about the two plans to make updated estimates for rates. In addition to claims data, the rate includes administrative and operational costs and long-term projections or considerations of cost. The DVA plan currently has a robust reserve, so there is not a short-term concern about potential costs; however, it is important to not collect excess revenue over time, but to aim for a healthy ongoing reserve to cover costs over time.

For 2020, Segal has estimated that there will be a 4.3% gap (\$1.9 million) between premiums collected and expenses—this gap is intentional, because there is excess reserve compared to projected costs. This is intended to smooth out the difference between revenue and expenses. If costs go up additionally, e.g. another 4.3% than what is projected, this could require a sharper premium increase than originally planned. The goal is to minimize the rate of change of the premium over time, i.e. not having to sharply raise premiums. Even in a spend-down mode as the plan is in now, with excess reserve compared with best practices, premium rates may need to increase periodically to ensure that the fund continues to be adequately resourced, even as the reserve is spent down to the ideal range.

- Mauri Long asked what IBNR stands for?
 - Richard responded, “Incurred But Not Reported.” This is estimated claims liability for the plan at any given time—claims that are associated with services provided, but not paid yet at that point. (For example, a claim incurred in December 2019 but paid in 2020). This must be factored into projections, along with actual payments. The funding target is estimated using 1.5 to 2.5 times IBNR.
 - Emily added that the target was developed using a threshold established in the employee plan; the Board may discuss whether this is an appropriate target level for the retiree DVA plan.
- Mauri asked about the relationship between IBNR and the other estimates?
 - Richard responded IBNR expenses are related, it is not accounted for in the other data such as actual claims, but it is a percentage based on historical actual claims. It is also a disclosure that the State must make per accounting rules, as it is an outstanding liability; this is a common practice for managing funds of this type. For example: the team used claims data and the previous IBNR for June 2018, to estimate the IBNR for December 2018.
- Mauri asked whether the team uses historical data to adjust these estimates over time?
 - Richard responded yes, previous estimates help refine subsequent assumptions in these projections—the more historical data available on the plan, the better the estimate can be over time as it can be refined with actual data. The same method is used for projected claims from year to year, to refine the trend; they also use industry standards, but adjust for each individual plan, to the extent each plan deviates from the average. He noted, for example, the employee plan has a lower trend (rate of increase in claims) than the retiree plan—so they use a higher rate estimate for retiree projections.

- Mauri noted that the DVA plan (specifically dental plan) has been the focus of discussions recently, because of the lawsuit against the State and subsequent activity around the plan. She noted that there is a \$2,000 annual benefit for dental claims in the plan currently, which sets a cap on what the plan pays per member per year. She asked how the dental versus audio and vision claims interact in the estimate, and why there is such a difference in costs from year to year, given that dental benefits have a maximum. Is this administration expenses primarily? Or what other factors are contributing to increasing costs?
 - Richard responded:
 - To the question about maximum benefit, not all members utilize the maximum number of benefits each year. So, only some members are reaching that limit. For those members not using the benefit, their premiums will increase just the same, such as the cost of two cleanings. For members who do hit the maximum benefit, the cost to the plan doesn't increase over time; their out of pocket expenses would increase, if overall costs for services increase.
 - To the question about vision and audio benefits: the benefits have not changed over the same time period, and the expenses associated with those costs are also incorporated in the estimate. This has not been discussed as much dental claims, but it is the same approach across all 3 benefit types. Because there has not been a change to the actual benefits or claims trends, there have not been any adjustments to these benefits, only dental. If there were changes, it is likely they would change the percent trend for those benefits, to account for it.
 - A participant commented that approximately 6% of members in the DVA plan utilized the maximum \$2,000 benefit.
- Cammy Taylor asked about an additional memo the Board received, outlining the operation and administrative expenses separated out from interest: she noted that the interest amounts had varied significantly, with some years having a much lower amount of interest returned. She requested that interest be included in reporting, broken out in the estimate.
 - Richard will include this in future reports. He also noted that because this is a shorter-term plan (payments are made sooner than a long-term plan like LTC or pension plan), the interest rate is much lower and will not have as much of a significant impact.
- Gayle Harbo commented that she would like to see a historical report on interest, especially back to 2003 for reference, to see the impact of the national recession.
 - Richard will follow up; he will need to coordinate with the CFO to receive this information, as they typically do not utilize historical estimates on a long timeframe.
 - Emily added that this information is available online, there are reports for the DVA trust back to 1997. She will provide the link to the Board for reference.
- Joelle Hall noted that revenue and expenses are shown net of interest; she reiterated the variation of interest collected over time. How is interest factored into the estimate of over- or under-funding the plan over time?
 - Richard responded that the interest is incorporated into long-term estimates, but because the plan is so well-reserved, there is not a need currently to significantly change rates. Because the current policy is to spend down the plan's reserve to a more appropriate level for projected need, a negative bottom line for this year is acceptable. Using 2020 as a baseline, for future years the discussion will be: how much has the trend

changed? Do premiums need to be increased, at what rate, or remain flat for the short term? For example, closing the gap gradually over time would include 1-2 years of flat premiums, followed by a modest increase in future years.

Richard demonstrated a live Excel model showing impacts of changing assumptions on what the estimated premium rates would be over time: this is the analytical basis for the summary chart in the presentation. The model allows for projection over the next 10 years (2030). The ongoing goal is to move the current net assets (reserve) to match the ideal range of reserve from year to year, and continually adjusting (or leaving the same) rates to manage this from year to year. Toggling percent increase of premium rates from year to year shows how these impact net assets over time.

- Dallas Hargrave commented that for other self-insured plans he is familiar with, he's familiar with the method of using a percent of projected expenses. Is the IBNR estimate method similar?
 - Richard responded yes, these are two methods to achieve the same general result. It is important to have some cushion for any volatility in the plan's cost from year to year. Either method has similar approach, they use IBNR but percent of projected expenses would be similar. (This is equivalent to 15-20% of projected expenses).
- Dallas also asked, why is the fund balance so much higher now, how did this occur?
 - Richard noted that Segal began working with the State in 2014, with the first projection in 2016. The previous estimate was likely too high given the current trend, and he also noted that this is when the network changes were introduced in the dental plan, which had a lowering effect on expenses compared with premiums. Previously, premiums had been increasing year over year; then they became flat.
 - Emily commented that when she started with the Division in 2012, the asset level was high at that time, so this is not a new phenomenon.
 - Richard added that previously, there was no target for net assets; since that time, a management target was put in place, so now the goal is to draw down the fund balance to be within that target.
- Dallas asked, if the target expenses are increasing, does the IBNR trend increase at the same rate? Why are they different?
 - Richard responded that the trend utilizes number of claims as well as dollar amount, and that there is a lag in the change in IBNR versus enrollment. They are related, just not necessarily the same rate of change.

Richard continued: this analysis resulted in the recommendation to keep premiums flat for the coming year. The trend still anticipates a 4% increase in expenses. Emily added that this is looking at the revenue projection: it is also important to manage the expenses over time, which can offset need for future premium increases, or manage the amount of increase. The first scenario displayed shows the assumptions used for flat funding amount.

Board members commented that the version in the printed packet looks different than the one presented on the screen. The group clarified that it is likely a scaling issue; Scenario 1 does match what is in the printed packet.

Richard presented Scenario 2: this assumes flat premiums as long as possible, spending down below the target range for a time, and then premiums are increased more sharply 3-4 years out (15% and 10% per

year) to compensate and restore the fund to target levels again. Premiums again have less increase, with an average increase each future year of 4%. The goal is not to recommend flat premiums, followed by a steep increase the following year. Using current premiums, a 15% is approximately \$9-10 per month. Emily clarified that this is a fiscal year basis, while the claims data is on a calendar year basis.

- Mauri asked how the estimates were determined for rate of increase for revenue and expenses?
 - Richard responded both categories use per capita trends (total divided by number of members): dental 4%, vision and audio 3 to 3.5%, and plan administration cost of 2%. The administrative contract has a fixed (per member per month) cost, and variable costs for other services. This provides a per capita cost, multiplied by enrollment projections over time, and this provides an aggregate total expenses. For revenue, the number of projected members multiplied by premiums collected.
- Mauri asked how net assets are calculated over time?
 - Richard responded this is the difference between revenue and expenses from year to year; the bigger the difference between revenue and expenses, the more net assets will grow or shrink, depending on which is larger.

Richard directed the group back to the next slide, about setting rates for Long Term Care.

Emily added that to date, the Board has not discussed the Long-Term Care plan: at a future meeting, staff intend to provide a more detailed presentation about the plan. The LTC plan is an optional retiree benefit, with premiums paid by members directly, similar to the DVA plan. There are four LTC plans available under this benefit, with one being retired (Bronze Legacy plan) 10 years ago: currently enrolled members can remain in this plan, but it is closed to new enrollees. There are three currently available for enrollment: Silver, Gold, Platinum, which increasing premium amounts and increasing benefits. This is a one-time opt-in for retirees, and premiums also change based on age.

Richard shared national context: a self-insured LTC plan for public employees is rare. California, Oregon, Virginia and Alaska have one. Most other states use a fully-insured plan; however, being self-insured has been a smart decision because the LTC insurance market has been volatile over the last several years. Premium increases have been significant (10-20% at renewal) for insured states, or they have not found a new insurance carrier. Being self-insured (with a third party administrator) is lower risk for a vendor, and to date has been effective for Alaska. As a result, Alaska's premiums have been relatively stable.

Because it is a longer period between premiums being collected and estimated utilization of the benefits by each individual (most use it relatively late in life), a longer time frame is needed to project required assets over time. The costs do not change as much year over year, but it is similar to a pension plan, that needs to be considered over a much longer term. Changes must be made slowly and well in advance, quick corrections are difficult—for example, reducing premiums now could have long-term problems.

- Dallas Hargrave asked for clarification, is the Board being asked for a recommendation at this point, or is this the purview of staff?
 - Emily clarified that the Administration Commissioner sets rates; however, every two years, valuations are developed for the LTC plan, most recently this year, so the Board will be involved in a discussion and potentially asked for input on these documents during the rate setting process.

Richard continued: unlike the DVA plan, where rates are set from year to year, the LTC plan has a longer timeframe, and most people using the benefits will do so years or decades in advance. Additionally, people may eventually opt out of the plan over time, so this should be factored in. The projections include all projected revenue and expenses, and factor in mortality, payment lapses, etc. over the long term. Using a discount rate, the plan's value is converted to a present value based on those future projections and future cash flow. This present value is added to current assets, then subtracts projected expenses, to determine whether the plan is positively or negatively funded (whether there are sufficient reserves and premiums collected over time at the current rate, or if there a deficit over time, whether higher premiums are needed). This helps answer the question: do premiums need to increased, by how much and when? When would the plan run out of funds? If it is decades from now, smaller increases would be needed; if it is more immediately projected to run out of funds, then premiums need to be increased more. It is also possible that premiums would need to be decreased, if it is over-resourced.

Based on current analysis, the fund is over-resourced at 121% of estimated expenses. There are currently \$526 million in assets in the fund today, compared with \$431 present value of all projected expenses over time. This is a good position to be in at this moment. The policy question is, should the premiums be decreased, given the robust resources in the trust? However, there are other considerations: are the assumptions out of date or incomplete, are there reasons to assume that expenses would go up over previous trend in the future. Expenses have not significantly increased over time recently; the increased asset value has primarily been from investment earnings. This means, in weaker investment years, earnings could be less. Currently, the recommendation is not to decrease premiums, but monitor the trend.

- Gayle asked what the asset investment allocations are for the DVA trust and the LTC trust?
 - Staff did not have this information at hand, but will research this with the CFO. They speculated that the LTC trust is invested following similar policies as the pension trust, since it is a long term plan. The DVA plan has likely more liquid assets, since it is utilized more from year to year and needs access to cash for payments.
- Cammy asked how the DVA and LTC trusts are managed? The ARMB manages the health trust.
 - Staff did not have this information, but will follow up.
 - Emily added that valuations can be volatile, given the performance in the market. She noted that in 2013, there was a significantly different valuation due to projected investments. Therefore, valuation can change over time, so it is important not to act simply on one year's valuation for a long-term managed trusts. Additionally, there are relatively few members utilizing benefits now; this is the beginning of a larger wave of utilization in the plan, as more members continue to age and access LTC services.
- Judy asked how many members currently reach the maximum utilization of their LTC benefits? Have there been any to date?
 - Staff did not have this information at hand, but speculated there must be some who reached the maximum. Emily noted that costs can be very high, depending on intensity of care, and there is a daily limit as well as a maximum benefit for all services. For someone in palliative care at end of life, for example, there would be an intensive but limited term use of benefits.
 - Judy commented with increasing LTC costs, there is likely a diminishing value of the maximum daily benefit compared with costs, relative to when the limit was put in place.

- Steve Ramos offered to share information about the plan benefits. For the Platinum plan, the maximum benefit does change with age, a 5% compound up to age 85, and the table on page 21 of the packet shows the current rates, not projected rates over time; it is the baseline.
- Judy clarified her concern: if the maximum benefit is increased over time, but the daily limit doesn't also change, the costs would still significantly increase over time for members because the plan would not cover increased costs. Does the compound rate increase for coverage stated also apply to daily rates, or just maximum benefit?
 - Steve clarified that yes, the rates do increase for daily rates also, all daily and lifetime maximums.

Emily summarized: there will be a competitive bid for third party administrator services, the current contract will end in 2021. Staff recommend undertaking more thorough review among staff as well as with the Board, and discussions about future premium rates to manage the plan more closely, as utilization of benefits will increase in the coming years.

Judy agreed, and recommended work sessions to help the Board and public understand: she also recommends more detailed information and analysis about each tier (Bronze, Silver, Gold, Platinum) to help members understand the implications for their specific plan. She noted that cost of long-term care services is significantly higher and increasing, so there is a great deal of public interest in this topic. Emily agreed, and added that there is significant variation within Alaska and out of state in terms of cost.

- Cammy noted the report states an assumption of no membership growth—is this common?
 - Brian Rankin shared that Lewis & Ellis has worked with Segal for the last three valuations: 2015, 2017 and now 2019. He responded that the assumption is standard to use only current membership; it is common to utilize only existing members to project costs over time, rather than assuming new members for comparison over time.
- Cammy also asked, is the assumption based on number of members submitting claims, versus number of claims?
 - Brian responded yes, this is the number of people who submitted claims, as multiple claims may be submitted over time for what is basically one episode of care.
- Cammy also asked why there was such a significant change in the valuation since 2012?
 - Emily responded that this was based on changes to morbidity and mortality estimates, which changed since the previous valuation.
 - Brian added that all assumptions can impact the analysis significantly—the analysis is very sensitive to change. Administrative expenses are small compared with many other programs, and investment returns have been good. But a small change in any of the assumptions, and especially future claims, will have significant impact.
- Cammy asked, if more people are added to the plan, is there a reason to do valuation annually instead of every two years?
 - Brian commented that commercial insurance typically does a valuation every year. Currently the plan is stable, but it may be useful to do an annual valuation.
- Joelle commented that there is a double-check system for validating assumptions for the pension program. Is there a double-check system for this plan?

- Brian responded no, but after the 2017 valuation there was a significant audit of the firm's work, so this could be considered a check on their work. The auditor was KPMG.
- Cammy thanked staff and the consultant team for their work on the projections and presentation and appreciated the depth of information.

The Board took a lunch break at 12:05 p.m., and returned to the meeting at 1:30 p.m.

Item 1 (Continued). Approval of Minutes (Postponed from Morning)

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

Approval of Previous Meeting's Minutes

Materials: Draft minutes from 8/7/19 RHPAB Meeting.

- **Motion** by Gayle Harbo to approve the previous meeting (8/7/19) minutes. **Second** by Mauri Long.
 - **Discussion:** None.
 - **Result:** No objection to approval of minutes. Minutes are approved.

Item 5. Education Session: Petersburg Medical Center

Materials: Presentation slides provided as a separate document in the meeting

Emily Ricci provided context for the presentation: as the Division moves forward and considers new policy directions, they want to look at what other health organizations are doing and stay informed of what innovations and efforts are happening across Alaska. For example, Petersburg Medical Center (PMC) has invested in some innovations as a rural health provider, and these are useful to share as education for Division staff and the Board. She invited PMC CEO Phil Hofstetter to present.

Dr. Hofstetter shared an overview: he is CEO of the hospital, and is an audiologist by training, educated and previously practiced in upstate New York. He moved to Nome and practiced with Norton Sound Health Corporation in the early 2000s. He then moved into hospital administration, where he remains today. He is interested in telehealth in particular. As an example: an audiologist works with an ENT (ear, nose and throat specialist), with the former referring cases to the latter. While he had a regular ENT he had a working referral relationship with in New York state, he experienced frustration working with an itinerant ENT from Alaska Native Medical Center, specifically that infrequent visits did not allow for consistent referrals. He saw the same conditions over and over. He learned about telehealth around this time, specifically a program allowing for imaging equipment to document patients' conditions and send them to a specialist for analysis. This allowed for earlier diagnosis, less waiting time for patients during itinerant clinics. The program was very successful. He saw tangible impacts in his patients' quality of life.

This motivated him to pursue a career in hospital administration, and talk about the benefits of this kind of program, specifically a provider-to-provider telehealth program, which provided better and more efficient referrals from a physician to a specialist, and reduced the number of in-person consults needed to manage patients' conditions. Consults became focused on post-operations and complex issues and reduced the backlog of needed appointments with an ENT.

Petersburg Medical Center is a critical access hospital with 12 inpatient beds, 15 long term care beds, emergency services, primary care and other typical services, based in Petersburg, a community of 3,200

people on an island in Southeast Alaska. They are a community hospital but do not receive direct funding from the city; their revenue is from payments and any other subsidies or funds secured that can support rural hospitals.

An ongoing issue for hospitals is the share of emergency department care visits, compared with primary care: ED care is costly, not the best care for patients, and makes the overall cost of care increase. PMC has about 90% (10,000 visits per year) utilization in primary care, 7% (70 per month) in the ED, and 3% in acute care and skilled nursing. They try to keep ED visits to those who need it and feel this is a good ratio of care utilization for a hospital of their size and type. Petersburg has typical mix of chronic diseases and mental health conditions in the community, population is comparable to other communities. There is relatively low turnover among employees, and about 2,500 patients each year. 70% of visits are follow-up visits. However, wait times can be significant.

PMC takes a team-based approach to health care: as an example, they provide medication assisted treatment (MAT) for substance use disorders, usually suboxone for opioid addiction. There are several follow-ups and requirements to be in the program, including behavioral health. PMC has found that ED visits have reduced significantly for those maintained on suboxone, and also are managing other diseases (related or unrelated) through primary care visits. This also reduces incidence of emergency or inpatient acute care. This has significantly driven down costs. Additionally, data on patients who left the program and again present to the ED or inpatient, or have complications of chronic diseases, the costs go up: this shows that staying in the program creates cost avoidance. However, there is an intensive staffing model for this: the staff team for other conditions would look similar but requires a lot of staff. But, it does drive overall costs down, based on the data they have. The trouble is reimbursement: because they cannot bill for each service provided on a fee for service basis, they find other revenue.

Slide 6 provides an overview of AlaskaCare retirees in Petersburg, showing estimated claims and costs. Emily noted that this is preliminary data; they will be doing additional data analysis with PMC in future.

Phil continued: as a rural, isolated community, Petersburg cannot afford to hire specialty staff to handle all patients' health needs. Patients travel to another community (Anchorage, Seattle, etc.) for specialty care, but there is not a clear line of communication between PMC and those specialists, and no care coordination for the most part. There are options for local follow-ups and other consults needed that could be done in the community.

He requested that the Board review cost information and utilization of specialty care for retirees outside Alaska or outside the patients' home communities overall, as well as reviewing the largest/most common registries for chronic diseases most common in the retiree population, to give a sense of which specialty care areas have the most impact on plan costs if telehealth solutions were implemented. The most common referrals from PMC: orthopedics, radiology, ENT, cardiologists, mental health, OB/GYN.

Slide 8 provides a summary of benefits of telehealth, including better communications; better access to care; more consistent follow-up care; reduces redundancy; and improved efficiency. The data from PMC in previous years has shown overall cost savings, but has also seen telehealth visits and consults increase; this shift in utilization should be factored into estimates of cost savings. Slide 11 provides an example patient experience with a positive outcome, working with Bartlett Hospital (Juneau) for a patient's telepsychiatry care, rather than transporting the person out of the community. He noted PMC does not have a tertiary care network and does not have a direct partner, they are a standalone

organization; however, they established a (video) telepsychiatry contract directly with Bartlett. So far, he has seen similar success with tele-mental health, as he previously saw with tele-ENT consults.

He noted that there are costs to implementing this system, and it takes time to put the system into place: in addition to the technology, he noted that the payer mix and the lack of managed care makes it challenging, including reliance on a fee for service model, because it provides incentive for in-person care versus telehealth visits. He also commented that it is helpful to find a willing partner, such as a payer, to help pilot the project and structure the program in a way that it's financially feasible. He provided two examples of patients who had likely avoidable, high-cost incidents because of the long wait times to see a specialist in another community, involving travel or Medevac services. Slide 17 provides example metrics, to be developed between the facility and partner specialists. Slide 19 notes recommended next steps for exploring putting an effective telehealth system in place. He reiterated that in the current reimbursement system, for most payers, there is no good reimbursement model for the staff-intensive team approach that is effective in coordinating patients' care, but difficult to pay for. He also clarified that consumer-direct telehealth (a patient talking to a provider) is one type of telehealth; he has experience with and is presenting data on provider-to-provider telehealth, where two physicians can coordinate on a patient's case with each other on a remote basis.

- Judy Salo thanked Phil for the presentation. She noted there is a 15-bed long term care unit, is there a long waiting list for the unit?
 - Phil responded that no, they do not typically have a long wait. There is a Borough-owned assisted living facility in the community, but it can be difficult to get into that facility and it is expensive, requiring people to spend down their own savings before they qualify for Medicaid. It is a challenge, this care is costly and staff-intensive.
- Joelle Hall asked whether PMC has access to any kind of existing network or system of telehealth partners? Or is he simply making individual phone calls to establish one?
 - Phil responded that no, there is not a system of providers to tap into, he is building individual relationships and agreements.
 - Joelle commented that the State, as a plan payer, could help facilitate relationships with various providers they work with, and make connections between primary care and specialist providers, at least with the organizations the State does business with.
 - Phil agreed that yes, this could be a potential role for the State. He is working to create a “virtual provider network” in the absence of a traditional network, so that there are options to multiple specialty providers. He stressed the importance of establishing good quality metrics and choice as much as possible.

Emily shared that the Division is working to identify members in Petersburg and helping develop a model with PMC and others, to be able to incentivize provision of telehealth and give patients in that community more access to other specialty care. They are interested in finding a way to make the model work for all parties: the plan, the members, and PMC to mutually benefit. She noted that to date, conversations have focused on consumer-direct care, they have not yet explored provider-to-provider care but this is a great opportunity to increase access to specialists for care.

- Mauri Long commented that she is interested in learning more about this model, particularly given the national challenge of affordable health care for so many people. She is interested in whether this can be built into the TPA contract, incentives for that vendor to develop or build

connections with these types of networks and services. How could the State further build this into the way they do business, in the health plan and for communities statewide?

- Phil commented that one missing piece is the technology for providers to engage in telehealth, as well as having a virtual network to be able to connect with specialty providers. He agrees that it is important to scale and replicate the program.
- Judy asked if Phil knows of other organizations using this model, in Alaska or elsewhere?
 - Phil is not aware of specific organizations in Alaska, but noted there are several efforts to put these systems in place. One significant barrier: telehealth is not considered a standard of care, so it is not consistently used or not all providers or payers see it as valuable. This needs to change, along with developing a sustainable payment model.
 - He recommends focusing not on the highest-cost diseases at first, but conditions that require a great deal of follow-up and end up with redundancy of care. Looking for places where a quick follow-up or consult can be done using available technology, and this is a place to reduce redundant care or free up resources for more complex cases.
 - Emily added that from a health policy perspective, she is interested in aligning the incentives of paying for care with the care and outcomes that we want: we currently incentivize high-cost acute care, not preventive care or primary care or management of conditions before they become urgent. But, this requires a new payment model that recognizes the value of those interventions.
 - Phil added that it is important to consider not only the short-term costs or outcomes, but also the long-term investment value of these interventions to control costs.
- Joelle Hall asked whether the State (the payer) or the TPA vendor (the administrator) controls whether and how these processes develop, and how to put these in place?
 - Emily responded that ultimately the State has control of this, but they utilize the contract with the vendor to put these systems in place now. However, they are looking at contracting directly with various providers to develop this model, and coordinating with the administrator (TPA) to ensure claims can be processed and handled correctly. They cannot do this with all providers but are working to put some direct contracts into place will potentially help create this system.
- Judy asked for examples of provider direct contracts?
 - Emily noted that since 2009, there is a direct contract between the State and Alaska Regional Hospital in Anchorage, with a set fee schedule. Services are administered by Aetna, who understands the terms of the contract, but the member is not necessarily aware of this when utilizing care. Similar arrangements could give leverage to the State to promote this model and control costs.
 - Judy commented: she sees value in this model, but is it applicable to rural communities, given limited provider options and the necessity of using local providers or traveling?
 - Emily acknowledged some value is being competitive on price in a larger market like Anchorage. Working on this type of contract in a smaller community is new territory, but she imagines the arrangement could be a fee for care coordination for members in for example Petersburg, and/or for specific conditions or on an episodic basis. They could change the payment structure for services from that organization, as well as providing support for Petersburg to sustain these types of programs and stand up a model that could be replicated if it's successful.

- Phil provided an example: PMC has set up a payment arrangement (not a contract) with another specialty provider to pay \$50 per case, outside their main billing procedures. This could be built into an ongoing contract, with tiers of payment by intensity of service. The encounter number is the same, so there no additional administrative burden than the current system; it allows for a higher reimbursement. Specialists may be more willing to participate if they have the same or less administrative burden in billing. It could also save some travel costs. Additionally, there is benefit to having better care coordination, resulting in more appropriate care and avoiding other costs.

Emily noted that in this model, the coordination would be between the payer and provider: the member would not necessarily be aware of the arrangement, and it would not change their costs or level of care. Some options require changes to benefit design, but not necessarily: it is more a matter of how the plan makes payment and interacts with providers to provide the benefits as they are designed today.

Shane Francis added that this model is attractive from a management point of view, as it uses data-driven decision making based on utilization of follow-up visits for various conditions and can pinpoint where cost savings or cost avoidance could be realized. Additionally, the State could use plan data to review who is not currently accessing follow-up care and figure out how to increase access for those members to reduce complications due to lack of follow-up visits. He also appreciates the ability to create clear metrics for monitoring performance of the model.

- Judy commented that she sees potential for this in the form of enhanced networks, relationships with providers and facilitating these connections via telehealth.
- Ajay commented that he previously worked in the entertainment industry. TIHN (“The Industry Health Network”) has been successful in serving this sector, as it is a defined network of specialists and encourages utilization of the same providers for certain conditions. TIHN has been successful in directing care to specialists and not spreading those interactions over a large PPO network. In Alaska, the challenge is geography and a spread of providers, but he sees great potential in this model to meet Alaska’s needs as well.
- Mauri complimented PMC on being able to have such a high percentage of hospital utilization being primary care, versus emergency or inpatient care. She agrees that we need to better value care upfront (preventive, routine care) to avoid complications later, which are more expensive and result in worse outcomes often. She sees ways to encourage primary care use and make it easier for patients as one of the best-value interventions the plan could provide to members.
- Members agreed this is a promising and exciting model, and look forward to hearing updates.

Judy thanked Phil for his presentation and providing an overview of PMC’s innovative model.

The Board took a 15-minute break at 2:45 p.m., returning at 3:00 p.m.

Item 6. Retiree Health Plan Modernization Project Update + Next Steps

Chair Judy Salo called the meeting back to order.

[Modernization Project Updates](#)

Materials: Documents beginning page 30 in 11/14/19 meeting packet.

Emily Ricci shared that Division staff have been extremely busy with a number of efforts, including the DVA plan lawsuit and open enrollment, TPA negotiations, and other projects. Staff prepared a summary of the modernization project to date, including which analyses have been completed. She recommended, rather than moving forward with all potential plan changes as originally discussed, the Division and the Board consider focus on a few high-priority items in the next year, potentially to put in place if they are advantageous and ready to implement. Other items would be tabled for the future.

Key questions:

- What are the highest-priority changes to make to the retiree health plan? (This is the list of proposals considered to date, that the Board has been reviewing over time).
- How would these changes be rolled out: by changing the existing plan, or potentially offering an alternative plan? (for example, the idea to allow retirees to opt into the employee plan).

The list on page 30 provides a summary of items discussed to date, and recommendation of four topics to focus on for the next year. Page 31 shows a proposed timeline, assuming that this moves forward, including completing updated analysis, member engagement and education, discussing whether and how to implement these, and the process for moving forward on these key decisions.

- Judy noted that the group was previously at this juncture earlier in 2019, when they discussed the option for opting into the employee plan.
- Cammy Taylor commented that the proposals being discussed are, for the most part, added benefits for a subset of people, or primarily for people who are not Medicare eligible (under 65), while the offsets would be borne by all members if they involve increased cost to members or less coverage by the plan for some services. She is unsure the breakdown of who would benefit, and which proposals benefit both Medicare eligible and not Medicare eligible. Some would apply for all: travel benefits, network incentives would impact all members. Preventive benefits, covering youth under age 26, and other provisions would primarily help members who are not yet Medicare eligible. Is the Division anticipating further discussion on this as a committee?
 - Emily acknowledged those are all important considerations—but she is looking for direction in today’s meeting about where to focus energy and staff time for the next year. Looking at the Medicare eligible and non-Medicare eligible populations is important, but she also noted that some proposals have more urgency than others: lifetime maximum and preventive services are becoming increasing problems for members, while network provisions would be very advantageous for better value from providers. She reiterated, if we had to prioritize, which would the Board choose?
- Judy commented that she sees the four on the list (preventive, lifetime max, enhanced travel, network) as priorities, and adding telehealth.
- Mauri commented that she would like to finish Board discussion of all proposals, she does not feel that the Board has spent sufficient time to discuss each proposal. She commented that there isn’t sufficient discussion time in the Board meetings generally, most of the meeting is information sharing and less time for dialogue. She requests more time and space to have discussion, and utilize Board members’ expertise and perspectives in a robust discussion during these meetings. While there has been discussion among the modernization committee members in previous meetings, she does not feel there has been sufficient review of the options and deliberation on the part of the full Board.

- Judy noted that there was discussion of a two-day work session, all in person, to thoroughly review and discuss these as a group. She reiterated the importance of having an in-person meeting and adequate time for review. She also noted that Emily is correct in that these are all significant discussions, and there is not time to give focus to all of them at once. She added that the Board has very limited resources, including travel, and Board members have used their own resources to travel to Anchorage in person, including from Hawaii and California. The Board has consistently requested at least one in-person meeting per year, and reiterated that request that to the State for an upcoming meeting or work session.
- Gayle commented that additionally, Board members have spent considerable time on reviewing the proposals in meetings, and between meetings. She would like further discussion about all the options, before endorsing only these four priorities.
- Cammy asked about the status of the original proposal of creating an optional alternative plan to the retiree plan? Would that end up having equal or more cost (time, effort, etc.) compared with making changes to the existing plan?
 - Emily responded that the biggest barrier to making any changes is building consensus and common understanding with the membership: this assisted with approval of EGWP in 2018, when people understood the value of making that change. She noted that ongoing uncertainty, such as current or potential litigation, adds additional difficulty to building consensus. Communications are important; when ideas are perceived as or characterized as threatening, it is difficult to achieve meaningful conversation that can lead to agreement and potential change. Members' feedback and questions and concerns are very important, and will help hone the proposals to address any possible problems and be able to mitigate. She believes that positive communications are critical to moving forward with anything, and is concerned about the current environment in which it is difficult to have open conversations about change.
- Cammy reiterated her question: is either approach to "how" (changing the existing plan or providing an alternative plan) preferred by the Division at this point?
 - Emily responded at this point, they do not have a preference at this point. Allowing for an alternative plan is good for members' choice, but also does not solve underlying issues such as preventive care and lifetime maximum, which can impact all members.
- Mauri commented that in her career as an attorney, she engaged in litigation but commented that it is best to have open communications, and a clear process, rather than fearing of doing the wrong thing or making the wrong decision. This keeps open communications and provides a basis for showing they are acting in good faith. She appreciates the staff's efforts to be open and neutral on the options presented, and not simply directing the Board to "rubber stamp" an already-preferred outcome. She noted, however, that more discussion needs to be had on each of the proposals, so there is adequate due diligence on the part of the Board having open and public discussion about these proposals.
- Dallas Hargrave asked to what degree the group needs to consider actuarial value and impacts on the existing plan, if they consider an alternative plan instead? Would there be a way to be efficient in reviewing this option, and how does it relate to the legal considerations?
 - Emily noted there are still issues to work out with that proposal, and needed discussion about the merits. There are unresolved legal issues related to current litigation. The alternative plan idea has not been fully developed or vetted, it needs more work.

Emily proposed that the Board dedicate a one-day work session in February 2020 (around the next quarterly meeting) to further develop and discuss these proposals, with the goal of a list of priorities.

- Judy commented that the Tele Town Hall has been very effective as a communications method, a way to get feedback from members, and to engage them directly. She recommended there are perhaps more ways to gather feedback, such as surveys or other tools for members.
- Cammy Taylor asked whether staff would like to schedule a Modernization Committee meeting, and/or a teleconference of the full Board, between now and early February?
 - Emily noted that there are many deadlines and tasks to take care of before the end of the year, including mailing new ID cards for retirees in the DVA plan. She recommends a meeting in January at the earliest, but not have new materials prepared by that point.
 - Cammy agreed, she was thinking January, and that there wouldn't be new materials. She noted that the discussion could be about how to move forward, about process, and about what information is needed for the Board.
- Cammy noted that Item #8 refers to dental implants for periodontal disease; the Board had recommended that be expanded further. She requested it be updated in the materials.
- Judy concurred with this: a meeting could be used as preparation for the February meeting.
- Joelle commented that it will be important to consider the fairness issues for retirees who are or are not Medicare eligible, and what the balance of these interests should be. She would like to develop a balanced rubric of how the decision will be made, what metrics will be made to ensure it is balanced for all parties and interests, and what is the goal and objectives that guided the decisions. Not only is this a good way to document decision making, but also allows for a clear conversation about how this decision will be made, among the Board.
- Cammy reiterated that EGWP is a great example: while there was considerable fear and apprehension about implementing that change, the result has not only been significant cost savings in subsidies, but also overall member satisfaction with the PBM and the program.
- Judy acknowledged that change management is always hard, particularly given the legal boundaries, that the current plan requires a higher standard of demonstrating value of a change. She also noted she would not want to see members miss out on opportunities to modernize the plan, given known issues with the current plan and benefits not available now.
- Joelle reiterated the need to how to present this in a balanced way, and clearly articulating the tradeoffs between adding benefits and needing to have offsets. That will be critical for the public's understanding of what's at stake, what the options are, and what the implications are for making these choices.

Item 7. Public Comment

See Item 2 in the minutes for public comment guidelines.

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

Public Comments

- **Barbara Stack, NEA-Alaska.** Barbara commented that she has spoken with several other retirees about the DVA plan; she has also mentioned in those conversations the proposals in the Modernization Project. For example, speaking with one person about the Lifetime Maximum

and Preventive Care proposals, she found that person was receptive to these ideas. She is in favor of moving forward with the modernization, whatever the final proposals look like, and strongly supports communications about the new benefits and offsets to be clear with members what the implications are. She noted that in her organization's experience (NEA-Alaska), they use surveys to ask their members to prioritize what benefits they prefer. She encouraged use of such a survey or similar tool, including explanation of each proposal, clear articulation of the goals and objectives, and ask people for input prior to the February 2020 meeting.

Item 8. Closing Thoughts + Meeting Adjournment

Closing Thoughts

- Judy Salo reiterated that there is an upcoming Tele Town Hall on Friday, November 22. What is the topic, will it focus on the DVA plan?
 - The DVA plan will be discussed, but this is the regularly scheduled monthly event (rescheduled from Thursday, November 21) it was not advertised to focus on the DVA plan.
- Joelle Hall asked whether the February meeting is hosted in Anchorage, or Juneau?
 - Judy Salo noted that at this time, they anticipate meeting in Anchorage, but encouraged the Division to allow for travel for members to meet in Juneau with staff.
- Judy asked whether there will be a December Tele Town Hall?
 - Teri Rasmussen responded that the regular schedule is the third Thursday of the month at 10 a.m., scheduled for December 19.
- Judy recommended holding the Modernization Committee meeting prior to the January Tele Town Hall (scheduled for January 16), and to make modernization the focus of that event.
 - Emily agreed that staff can provide brief information at that event, but usually the events are focused on answering questions rather than providing information that members do not have time to respond to. They would anticipate having a more coordinated communication effort after the February Board meeting, so she recommended beginning this engagement after that point, when more is known about what is moving forward.
- Cammy invited staff to coordinate about the date of the January committee meeting.

Motion by Gayle Harbo to adjourn the meeting. **Second** by Mauri Long.

- **Discussion:** None.
- **Result:** No objection to adjournment. The meeting was adjourned at 3:53.

The next Retiree Health Plan Advisory Board meeting is planned for Thursday, February 6, 2020. Check RHPAB's web page closer to the meeting to confirm the schedule, location and to download materials for upcoming meetings. <http://doa.alaska.gov/dr/askacare/retiree/advisory.html>.

Retiree Health Plan Advisory Board

Modernization Committee Meeting Minutes

Date: Wednesday, January 15, 2020 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, 19th Floor, Anchorage, AK 99501

Please Note: Due to technical difficulties, the morning session of this meeting was not recorded.

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
Nanette (Nan) Thompson	Committee Member	Present
Mauri Long	Committee Member	Present
Dallas Hargrave	Board Member	Present
Gayle Harbo	Board Member	Present
Judy Salo	Board Chair	Present
<i>State of Alaska, Department of Administration Staff</i>		
Ajay Desai	Director, Division of Retirement + Benefits	
Emily Ricci	Chief Health Policy Administrator, Retirement + Benefits	
Betsy Wood	Deputy Health Official, Retirement + Benefits	
Andrea Mueca	Health Operations Manager, Retirement + Benefits	
Steve Ramos	Vendor Manager, 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>		
Noel Cruse	Segal Consulting (contracted actuarial)	
Anna Brawley	Agnew::Beck Consulting (contracted support)	
Sharon Hoffbeck	Retired Public Employees of Alaska (RPEA)	
Brad Owens	Retired Public Employees of Alaska (RPEA)	
Wendy Woolf	Retired Public Employees of Alaska (RPEA)	
Bonnie Barber	Retiree / public member	
Margaret Duggan	RPEA Medical Information Committee director	

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

Meeting Minutes

Item 1. Call to Order + Introductory Business

Chair Cammy Taylor called the meeting to order at 9:09 a.m.

Approval of Meeting Agenda

Materials: Agenda packet for 1/15/20 RHPAB Modernization Committee Meeting

- **Motion** by Gayle Harbo to approve the agenda as presented. **Second** by Nan Thompson.
 - **Discussion:** Mauri Long noted that the committee chair calls the meeting to order, the agenda stated otherwise but Cammy rather than Judy began the meeting.
 - **Result:** No objection to approval of agenda as presented. Agenda is approved.

Ethics Disclosure

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

- Mauri Long stated that she owns stock in Teladoc, totaling more than \$10,000, and has previously made this disclosure when the telehealth proposal has been on the agenda for discussion.

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

- Brad Owens wishes to provide public comment during the afternoon portion of the meeting.
- No others present wished to make comments.

Item 3. Work Session: Review Modernization Proposals

Materials: materials on each topic in 1/15/20 meeting agenda packet

Cammy Taylor stated the purpose of today's meeting: there are several proposals to make changes the retiree plan, several of which retirees have requested over the years, and which the Board and specifically this committee have been working on for about a year and a half. Today is a working session.

Emily Ricci shared that the proposals shared in the meeting are ideas, not decisions, for discussion, and reiterated that today's meeting will not include in any decisions about plan changes. The proposals have been shared with the Board over the last year and a half as Cammy stated, and the versions shared today have not been updated additionally since each was shared in previous meetings. Division staff have presented all of these for discussion, but not with the expectation that all would be implemented: these are drafts for the Board to review and discuss and decide which if any to move forward as potential changes. Implementation dates or timelines are also draft, so any dates that indicate a proposal will be rolled out at a specific time is not accurate, and likely reflects potential timelines from when it was originally drafted or updated.

Emily reiterated that the drafts are for discussion, and that the Division is seeking direction from the Board (via this committee, and at the upcoming Board meeting in February) on which proposals to set aside or move forward. Staff do not anticipate that all proposals would move forward and would like discussion by the committee and the Board about which to set aside. The purpose of today's meeting is to refresh the committee and other Board members attending on each proposal on the agenda.

Cammy directed the group to the table on page 2 listing each proposal and the estimated actuarial and fiscal impacts of the proposal, based on the analysis. She agreed with the goal of reviewing all proposals presented to date, discuss which should be considered further and which should be set aside, and the Board indicated they agree with this process. She also reminded members present and all retirees that part of the discussion is what offsets must be considered, as well as offering additional benefits or enhancing existing benefits, to arrive at a list of proposals that overall has balanced actuarial and financial impact to the plan. Some proposals would incur additional cost, while others would result in cost avoidance, such as avoiding more expensive care or securing more competitive pricing.

- Gayle Harbo asked for confirmation, which concept on the list of proposals has gotten the most public comment so far?
 - Cammy responded that the travel benefits and concierge service has been of great interest, but there are multiple changes or additional benefits that retirees have requested over time, such as wellness programs or covering dependents up to age 26, rather than age 23 as the plan does today (per state statute).

Emily added there are some proposals that Division staff are interested in implementing, such as changing the lifetime maximum of medical benefits, but they will analyze all proposals of interest to the Board to provide information about each, and potential impacts to the plan and members.

- Cammy asked whether the Division has identified any specific proposals that they would prioritize to implement?
 - Emily responded that Division staff reviewed the list and discussed what they believe would be most feasible and impactful: #7 Preventive benefits, #8 changing lifetime maximum, #1a and #1b enhanced travel benefits, #2 and #5 network incentives and changes to out of network reimbursement. They believe that these proposals together would deliver additional benefits as well as offsets for those benefits through changes to

network incentives, as well as giving the plan more leverage to negotiate effective rates by strengthening network coverage.

- Cammy asked how staff want to proceed in today's meeting, and the February RHPAB meeting?
 - Emily that the committee identify any proposals that should be set aside, at least for this set of proposed changes to the plan, and any additional questions or adjustments to the proposals to bring forward in February. This does not mean staff will complete analysis before the meeting but will help them prioritize follow-up work.
- Cammy asked which proposals Division recommends setting aside?
 - Emily responded that #10 changing coverage of drugs available over the counter, and #4 enhanced clinical review have been discussed but are not priorities at this time.
 - Emily also noted the group discussed whether to address #13 dental implants, and whether they are covered under the medical or dental plan as coverage has historically been confusing. Originally the proposal was to exclude these from the medical plan, but the Division has considered covering these under medical plan instead because of the high cost of this procedure and the limited benefit level in the dental plan. *(See later in the meeting where this is discussed in more detail).*

Emily also noted that the Division has been meeting with chiropractors, so they may make progress on some aspects of #9 coverage of rehabilitative services in coming months.

- Cammy asked whether the proposal would change based on the outcome of that work? Should it be removed from the list for consideration?
 - Emily responded it should still be considered, but the work they are doing with the chiropractor community may change this proposal in the near future, so it will need to be rewritten.
 - Mauri Long commented she would like acupuncture, which is not covered today, to still be discussed as being added as a covered service. She recommends separating the proposal to add acupuncture to the plan and leave chiropractic and physical therapy out of that proposal. Adding and changing benefits are different proposals.
 - Gayle Harbo recommended also including rolfing in the separate proposal. Committee members agreed, for discussion. #9 will be split into two proposals.
- Mauri also asked whether there were issues to address for physical therapy, and whether that should be included? She asked for clarification on what would be in the proposal that the group will move forward with discussion.
 - Emily noted that currently the plan covers these services for restorative services after an injury or specific need like post-surgery, and not for maintenance. She proposed it is similar enough to chiropractic benefits that physical therapy should also be set aside for the time being, for further discussion about whether to add maintenance care as a covered benefit for those services. The separate proposal would include whether to cover acupuncture and rolfing in the plan under current rules.
- Mauri asked for clarification: why not consider coverage of maintenance services in the proposal we discuss today?
 - Emily responded there are questions to sort out regarding diagnosis codes for these services, and guidelines for frequency and type of care. She recommends separating those conversations, into what services are covered with current guidelines re:

rehabilitation rather than maintenance, to ensure the benefits are utilized in a way that brings therapeutic value (and not just, for example, because a person enjoys massages). Staff will do more work on this proposal for future discussion.

Topic: #7 Preventive Care

Materials: starting page 96 in 1/15/20 meeting agenda packet

Cammy Taylor noted that the current preventive benefits covered in the plan are limited to Pap smears, mammograms, one prostate screening method, and vaccines covered under Medicare (e.g. shingles).

Emily Ricci confirmed this is correct: Medicare eligible retirees have access to some preventive benefits, but for those who are not yet Medicare eligible, preventive care is very limited. Preventive care is also beneficial because it helps retirees catch health issues, including serious health problems, early rather than letting them progress untreated. For those who are not Medicare eligible, this is important because they do not have access to those services.

The proposal is to cover preventive services that are identified as best practices by the U.S. Preventive Services Task Force (USPSTF), which publishes and maintains a list of evidence-based services including screenings, vaccines and other preventive care. Many health plans cover services classified as “A” or “B” (strongest evidence base) and not other services. The proposal is to adopt coverage of any service classified as effective in these categories, rather than identifying specific services in the plan, because best practices for care changes over time as we learn more. The USPSTF reviews each study and determines how legitimate or robust the study was, and whether it is sufficient quality to be a recommendation. Recommendations also differ based on age or other risk factors, so this would also influence cover of the services. Recommendations can change over time: in the last 5 years, mammogram recommendations have changed significantly, and some have criticized USPSTF for not updating their recommendations quickly enough.

Shane Francis added that evaluating health studies is very important, not all studies are being conducted to the same standards. The field is moving toward evaluating quality of studies better, but there are still many unreliable or insufficient studies that should be reviewed carefully before assuming they provide a strong evidence base.

Emily noted that coverage for preventive services would also depend on whether the provider is in network, with a waiver option for those without network providers in their area to receive services at the in-network covered rate. For in-network providers, preventive care as currently proposed would be covered at the standard 80% coinsurance subject to deductible and out of pocket maximum. There is an additional actuarial cost for this proposal, primarily due to cost of colonoscopies.

- Cammy Taylor noted that coverage of colonoscopies has been requested by many retirees, so there may not be net savings if most people will end up using that service.
 - Judy Salo commented that the estimated cost is \$5 million per year, that is a lot of colonoscopies if that is generating most of the cost!
- Mauri Long shared that there is an alternative screening method, Cologuard, that is lower cost and more convenient because it is done at home. Would this be covered in the plan as well?
 - Emily responded that she will review the list of covered services to see if that is covered as an A/B service. There may be other reasons why it is not covered, such as if it

generates many false positive results, but it is worth considering. She noted that from an administrative perspective, customizing covered services beyond the USPSTF list adds cost because it requires maintaining a separate list of covered services, so she cautions customizing the list unless there is a compelling reason for the retiree population.

- Judy Salo asked, given that Medicare covers colonoscopies up to age 75 as preventive, would the plan cover it in this way as well?
 - Mauri responded that on the USPSTF list, colon screenings are covered up to age 75 as an A/B service, but a C service after that age: Medicare likely follows these guidelines.
- Joelle Hall asked for clarification, if a person goes to an in-network provider for preventive services, and if the services are on the USPSTF list, are they covered 100% or not?
 - Emily responded the original proposal was 80% co-insurance in network, 50% co-insurance out of network. However, she noted other plans cover preventive care at 100%, so the Board could recommend this instead, up to age 75.
 - Joelle asked whether the estimated \$5 million annual cost reflects the original proposal of 80% / 50% coverage?
 - Emily confirmed that the estimate is based on the original proposal.
- Nan Thompson asked staff to update the estimated cost of this proposal to reflect 100% coverage before the February meeting, so the Board can understand the differential in cost if increasing coverage to 100%?
- Judy Salo noted that it is difficult, from an actuarial perspective, modeling avoided costs for preventive care since it requires assuming hypothetical diseases or diagnoses avoided. Were these avoided costs included in the actuarial analysis?
 - Emily confirmed that Segal Consulting did include this in their analysis, using industry standards for morbidity rates for various conditions estimated in the retiree population. She also noted the original analysis assumed coverage of vaccines that are now covered under EGWP, and are paid for through Medicare instead of the state plan.
 - Joelle asked for clarification, this is primarily the shingles vaccine?
 - Emily confirmed this includes any vaccine (including shingles) that is covered under Medicare Part D (pharmacy plan). However, the flu and pneumonia vaccines are covered under Medicare Part B (medical plan), so they were not added.
 - Joelle asked for examples of other vaccines now covered?
 - Emily responded this includes tetanus, TDAP, some other infectious diseases.

Topic: #8 Lifetime Benefit Maximum

Materials: starting page 62 in 1/15/20 meeting agenda packet

Emily Ricci shared the proposal is to increase or remove the lifetime maximum, which is currently \$2 million for medical services (excluding prescription drugs). Additionally, Medicare covers many services and has its own reimbursement rates lower than the AlaskaCare plan, so because it becomes primary when someone is Medicare eligible, retirees who are enrolled in Medicare are less likely to reach this maximum. For those who are not Medicare eligible, however, more retirees are reaching this maximum, particularly with an expensive crisis-level health incident, so this is very stressful at a difficult point in their life. Often, the retiree is within 1 year to 6 months of becoming Medicare eligible, so the maximum takes effect not long before it will be less impactful to the retiree. There are other programs, such as Medicaid, for low-income retirees, but it is still problematic, and staff are aware of the difficulties it

causes for the relatively few retirees who meet this amount. Additionally, higher health care costs have made it more likely that people reach this limit. However, many expensive treatments are drug regimens, that may be \$250,000 or more per year for a prescription. The lifetime maximum does not include pharmacy benefits, so it is also not relevant to addressing prescription drug spending.

Originally the Division proposed increasing the maximum to a higher threshold, but this may require revisiting the higher limit in future as costs rise over time. Emily proposed to the group that the Board also consider whether to remove the lifetime maximum altogether.

- Nan Thompson commented that she understands the rationale of having no lifetime maximum, but also noted that this seems contrary to the goal of reducing health care costs by reducing incentives to raise prices. However, she understands there are good reasons to do this, and this particular change may not have a significant impact on that larger issue.
 - Cammy Taylor commented the proposal states there are 5 people who currently at this maximum; she personally knows 3, she believes the number is higher. She believes this should be addressed, for the few members who end up in this situation. She also noted that because the plan gives a \$5,000 credit at the beginning of the year in that situation, it complicates the ability to apply for other subsidies, even if someone already met the limit and is not having their care covered.
 - Emily added there are 7 in their system currently identified as having met the maximum. It is also a problem because health insurance is intended to cover catastrophic costs, so a limit is counterproductive to this purpose.
- Cammy asked whether drugs administered in a hospital setting, such as a drip during an inpatient stay, are charged to the medical plan? Some of these drugs are expensive as well, but because they are covered in the medical plan would contribute to this problem.
 - Emily confirmed yes, this would be the case, and it may be addressed on a case by case basis whether to the services falls under the medical plan which has the \$2 million limit or under the pharmacy plan to which the limit does not apply.

Emily commented that from the Division's perspective, this policy is not focused on cost control, given it only affects a few members in situations where they have stressful and complex medical care for a serious condition. From a cost control perspective, the Division is more focused on network incentives and being able to effectively negotiate rates, so they are more interested in those proposals than maintaining this limit. She also noted that limits on care are more useful for non-emergency, more discretionary care like massages: a person would potentially seek more massages per month if there is no limit, but would not seek a life-saving emergency surgery just because it is covered. The situations where the maximum applies are often the latter, so limits are less helpful to control costs.

- Mauri Long commented that she understands the reasons to consider this proposal and does not believe people should be denied necessary care. She asked at what point in time individual members started reaching the lifetime maximum? She also shared her concern that removing the maximum altogether would create a significantly higher actuarial value of the plan and would not want that to require much higher offsets to the plan to compensate. What if the plan is increased to \$3 million lifetime maximum, which would have the same practical effect but would not have as much impact on actuarial?

- Emily responded that a full analysis of historical data would be time consuming but could provide useful insight. This would be a time consuming and complex analysis and staff can work with the actuarial team to identify the difference to the plan between these two policies, and whether removing the limit is significantly more expensive.
- Mauri clarified that she is not proposing a full review of all cases, but wants to generally understand how many people were impacted in the past when the limit was raised, to identify an appropriate new limit, and how the increased limits were chosen when it was raised before. She supports an increased maximum if it has less actuarial impact but has the same beneficial impact.
- Gayle commented that back when the lifetime maximum was raised to \$1 million, it was a significant event in 1999 and brought up at the TERS meeting as a notable impact. That was 20 years ago, and health costs have continued to go up.
- Emily added the risk or chance that a member will reach the lifetime maximum is still small, presenting little risk to the plan. It is most likely to happen to someone who is not yet Medicare eligible, so the risk to the plan also reduces significantly at that point. To date, no one on Medicare has reached that maximum to the staff's knowledge.

The Committee took a break at 10:30 a.m., and returned to the meeting at 10:35 a.m.

Topic: #1(a and b) Enhanced Travel Benefit

Materials: starting page 36 in 1/15/20 meeting agenda packet

Emily shared two related proposals, both in the packet: #1a is providing travel benefits for SurgeryPlus, which was already implemented in the employee plan. #1b is to expand those services beyond SurgeryPlus's network to provide concierge benefits for travel for other services. There are currently very limited benefits for travel when care is not available locally, but because the benefit is limited and does not cover all the costs of travel, it is limiting for members who cannot afford to pay for those services out of pocket. This would help members who are deferring care or paying for these already. It also provides value to the plan, by giving members access to high-quality providers with a good track record, and at lower cost than may be available locally.

The service would cover both in-state and out-of-state travel for care, which is particularly beneficial for members in rural areas or who have limited care options where they live. Because SurgeryPlus's network is limited to certain procedures and thoroughly vets providers in the network, including quality metrics that are primarily based on volume or number of procedures performed. There are currently no SurgeryPlus network providers in Alaska, mainly because they have not met the threshold for volume of procedures. In both proposals, covered benefits would include flight or travel costs, per diem, hotel, and others such as allowing a companion, and would be prospective (paid for or provided upfront) rather than a retrospective reimbursement where the member shoulders the cost upfront.

Proposal #1a would be limited to SurgeryPlus's procedures and network. #1b adds additional concierge services for travel and researching then selecting a provider, outside the company's usual services. This would add additional cost but would still help members seek quality care and would remove some of the barriers to traveling, particularly to seek specialty care not available in most places. By having this service in the plan, this would improve the plan's ability to negotiate with providers in Alaska and elsewhere to be able to provide this service.

- Joelle Hall asked how this impacts the Medicare eligible population? Does this proposal cover all retiree members? She noted that people may want to travel to a location near other family to help them during recovery, or other reasons.
 - Emily responded Medicare does not cover travel, so this would be a covered service in for all retiree populations. Medicare’s fee schedule would apply, so the difference in cost would be less for this population because their rates are set no matter what location (there are local differences in rates). However, there is still potentially cost savings depending on where the member travels, whether they can access care that isn’t available locally or they want different options. The cost differential to the plan is likely to be more for non-Medicare eligible, but it could generate savings for all retirees.
- Nan Thompson asked for clarification: #1b would cover the travel and the process of selecting a provider for a service, even if it is outside SurgeryPlus’s network?
 - Emily confirmed it covers both travel and selecting and negotiating with a provider. She added staff would like to do additional analysis of the impacts on the Medicare vs non-Medicare population.
- Joelle asked whether #1a and #1b are separate, or #1b also includes the proposal in #1a?
 - Emily confirmed that #1b includes the proposal in #1a, and additional concierge services. She recommended the committee consider treating these as separate proposals, and itemizing costs for #1a only and the cost of adding the services in #1b.
 - The group confirmed that adding the concierge service is an additional cost, so it would offset some of the savings by only implementing #1a.
 - Emily added staff are considering how to model the costs (e.g., per user versus per all members), and noted the Division does not want to write a proposal tailored for one vendor: they would need to design the benefit to be vendor-neutral.
- Cammy Taylor asked staff to share the current feedback on the employee plan’s service?
 - Emily responded employees have generally found this to be a positive. Sometimes coordination has been difficult and time consuming to get local doctors’ records released to the provider, but this seems to be common in this type of service. Additionally, the providers may disagree on whether the surgery should be outpatient or inpatient; the specialist may recommend other lifestyle changes or interventions before the surgery, once the patient actually goes to see the specialist. There can be difficulties coming to agreement on the course of action, whether the patient needs the procedure, or when. But general feedback among employees has been positive.
- Gayle asked where most people have elected to go so far, are most traveling to the same regions or providers?
 - Emily responded many people are going to Seattle for care, but also Texas for some procedures. She added that staff are independently verifying the return on investment estimates, given that some costs have gone down in Alaska for elective surgeries, so the actual ROI may change over time if the savings are less. But so far, there is still significant positive return on investment.
- Judy Salo asked whether there has been pushback or comments from in-state providers?
 - Emily recalled testimony from the CEO of Bartlett Hospital (Juneau) with their concerns about this proposal, staff followed up and had a conversation about their goals and why they believe this is a good move. The Division is open to other ways to add value and

work with local providers, but there needs to be changes to the status quo because it is not currently financial sustainable. She also noted, as an example, that Bartlett does not have an anesthesiologist in network, so it is difficult to direct members to the local facility knowing it will be more costly. The Division continue to look for ways to negotiate and get the best value for the plan and for members.

- Judy commented this is also an opportunity for those local providers to review and change their fee schedule accordingly.
- Joelle asked whether there is also no in-network obstetrician in Juneau? This is another situation where the patient has no choice but to use an out of network provider.
 - Emily confirmed there is now one obstetrician in network in Juneau. She agrees that it is difficult to justify such high prices. She also reminded the group that not all providers are similar and some struggle in the current environment, especially in rural areas. Some providers charge exorbitant prices and should change, but others have difficulty financially even with high prices in the system we have.

Topic: #2 and #5 Network Incentives

Materials: starting page 11, page 71 and page 81 in 1/15/20 meeting agenda packet

The group discussed which proposals to consider regarding network incentives.

- Cammy Taylor noted that in previous discussions, the group discussed how this would have limited savings in the plan because of low deductibles and out of pocket limits. Should this still be considered?
 - Emily Ricci confirmed this is the case, but the Division is interested in exploring options to change network incentives and encourage members to use in-network rather than out-of-network providers. She recommends keeping these for discussion today.

Emily shared an overview: a network is a group of providers that have negotiated certain provisions with an insurer (reimbursement rates, covered services, etc.) Providers offer generally lower prices in exchange for the volume guaranteed by being in network: they have more potential customers if there is an agreement and better coverage of services from those in-network providers. Network providers also agree, generally, to not balance-bill members if the plan does not cover the original amount of services billed: the provider will not bill the member for additional costs.

A person who goes to an out of network provider is not protected by any of those contract provisions and could be balance billed by that provider if the insurer does not cover the billed cost. Reimbursement rates are set in the plan by recognized charge: this is an aggregate of all charges for that service in that geographic area, to develop a range of prices for that service. The plan currently reimburses up to the 90th percentile of the recognized charge.

This does not provide sufficient incentive to use network providers, because being out of network may be better financially for providers. It also incentivizes providers to keep increasing prices over time, even if they do not reimburse at that rate, and it will over time make the actual reimbursement rate increase. The Division of Insurance reimburses up to the 80th percentile, less than the AlaskaCare plan, and has also been criticized for providing incentives to increase prices and remain out of network. This is important for member protection as well as the plan: members can be balanced billed and will incur

more out of pocket costs, and to the extent prices increase because of the current system, it impacts overall health care costs. Implementing more network provisions in the plan, such as reducing the reimbursement rate for out of network care, can also give the plan significant leverage to negotiate competitive rates with providers and insurers.

- Cammy Taylor commented this is one of the more recent proposals, with less detail: there are several aspects of this proposal to analyze further. For example, she pointed out that the proposal distinguishes between Medicare eligible and enrolled in Medicare, with implications for what rates are being charged.
 - Emily agreed, this does need more analysis, staff had to set work on this aside for the time being to address other priorities. However, she believes there is great potential in this. In the employee plan they made network changes within Anchorage and outside Alaska. For employees, going to an out of network provider means 20% less co-insurance from the plan; a higher out of pocket maximum; and the recognized charge is lower, so the reimbursement is less. The employee plan is limited to 185% of Medicare for out of network care, for those facilities only. Staff do not recommend these same changes for the retiree plan, but the changes in the employee plan have greatly strengthened the plan's negotiating position. She also noted providers in Alaska know the retiree population is larger than the employee population, and that the current plan does not have sufficient steerage to incentivize retirees to go to network providers. This has hampered the plan's ability to reduce rates further with local providers.
- The group clarified that AlaskaCare becomes secondary once a person is eligible for Medicare, regardless of the reason the person qualifies, including people under 65 who are disabled or have renal disease.
- Joelle Hall pointed out the proposal states that in 2018, 84% of care provided to retirees was in network, and 16% out of network. It is not realistic to get to 100% in network, but what is the proposed target increase? 84% is already a large number. Is the goal to increase in-network by 10%, 5%, another number?
 - Emily acknowledged this is already a large proportion, but there are serious disincentives for providers with the current plan design. She believes the greatest benefit is to negotiate additional providers joining the network and what their rates will be—this change would not necessarily greatly increase the share of in network care, although this would also be desirable. It would help negotiate better rates and reduce what the state (and members) pay in billed charges, and to get more providers in network because they will be paid less if they do not join a network.
 - Joelle commented that if 84% of members are already in network even without these incentives, what is the marginal benefit of this change, and balanced against what costs to make this change? If members are already complying now, is this worth the change?
 - Emily acknowledged this point but offered clarification. To date, in Alaska, the effort has been to get providers in network at any cost: this means the provider is still being reimbursed at a high rate, and not with competitive pricing. The question is not just how large the network is, but how effective, and if they are getting the best prices—this is primarily about negotiation between providers and the plan. She noted that another option is a tiered network: preferred (in network), non-preferred (in network), and out of network, with additional

benefits to the member for using preferred providers. This could also provide more nuance in the network system and incentives for providers to negotiate lower prices. The overall goal is still to bring better value to the plan and to members for the price of care.

- Mauri noted there is a significant difference between costs for longtime members versus recent retirees: members do not want to change their doctor and would choose to stay with the same provider. She also noted that the changes to the employee plan are relatively recent, the retiree plan has been in place for a long time, so it may be more difficult to implement in this plan. Additionally, people who become Medicare eligible may have to switch providers, so those who are not eligible for Medicare may not want to switch providers prior to turning 65. As the population ages and more people enroll in Medicare, would the network issue resolve itself?
 - Emily agreed this is a good point: there would need to be significant additional analysis, and engagement with retirees about the implications of this change, and the benefits from using a network provider. She also noted that Medicare eligible retirees are already having problems accessing primary care in Alaska, few providers still take Medicare because the reimbursement rate is so much lower.
- Nan asked how the waiver would work: would it be automatic for people living in rural areas known to have limited providers, or would a person need to apply on a case by case basis?
 - Emily responded this will take time to sort out, but the current system is narrow and easier to administer. In the employee plan, the out of network reimbursement as a percent of Medicare rates applies to facilities in Anchorage and outside Alaska: it is easy to determine when the network provisions apply. For professional services, it is more complicated for providers with multiple locations or who is not specific to that facility. Staff continue to work on how best to apply waivers

The Committee took a lunch break at 11:35 a.m., and returned to the meeting at 1:07 p.m.

Cammy called the meeting to order and asked for any additional comments and questions from the group, especially anything to address prior to the February 6 meeting.

- Joelle Hall asked whether staff have enough guidance from the committee based on the discussion this morning?
 - Cammy reiterated that staff said they would not have time to do additional analysis before February—today they are collecting feedback for future work on these ideas.
- Cammy described two issues that should be clarified: 1) How does this impact Medicare eligible versus non-Medicare eligible people, and to be able to articulate that more clearly, since it appears the proposal would mostly impact those not on Medicare. And 2) whether and how to determine that networks are robust enough to be considered areas that do not need a waiver—i.e., if there are 12 providers in a community but only 1 is in network, is this an adequate network? Or would it merit a waiver since there isn't any choice?
 - Emily noted these questions and suggested that staff prepare a revised proposal to more clearly articulate what the Division's goals are, and where the most impact would be based on their analysis. She also commented the employee plan network is not necessarily the best approach for this plan, and suggested staff could describe the tiered network approach instead: increase access to a network as well as additional benefits

for using preferred providers, which provides a stronger negotiating position for the plan. Would the committee support this approach instead?

- Cammy asked for clarification, rather than simply tabling #2, would these be combined?
 - Emily confirmed the proposals could be combined in concept, with the addition of a tiered network of preferred providers for additional discussion.
- Joelle commented that decreasing the deductible for in-network care is also an option.
 - Emily agreed, but noted there are many different options for positive or negative incentives for in network or out of network care, staff will consider these options when drafting a new plan design.
- Judy Salo asked when this could be completed, would it be ready by February?
 - Emily offered that staff complete a conceptual outline by the February 6 meeting, they will not have time to do data analysis but could clarify their goals and what is being proposed, for further discussion, and to gather questions from the Board for follow-up research.

Topic: Telehealth

Materials: starting page 133 in 1/15/20 meeting agenda packet

Emily shared an overview: this proposal would cover telehealth services for retirees. Telehealth is a broad term, including services direct to providers as well as telehealth consultations between providers. The original proposal is modeled on the employee plan for services provided by Teladoc, which focuses on non-emergent situations for which an initial consult can be done remotely, consultation with a specialist remotely, and/or services provided outside normal business hours to avoid having to go to urgent care or the emergency room. However, there are other vendors and models available in the market, including CirrusMD who also provides a telehealth service using chat and text to interact with primary care and specialist doctors. Technology changes quickly, so these may change over time: the goal is not to be vendor specific but design the plan in a way that is more general.

There is financial cost for these services: often there is a per member per month cost to subscribe to the service, and a cost per episode of care, with varying co-pays for member and plan depending on the service. The financial savings would come from whether enough more-expensive care is avoided, such as an ER visit or the member not getting routine care and ending up in crisis, and whether those offset the costs of providing this service to all members. There is also an issue of access, separate from cost: this would increase access to care for members and possibly avoid travel costs or deferred care.

- Nan Thompson suggested, as another model, negotiating with existing providers to be able to provide some services remotely (phone or Internet), rather than purchasing a new service? This could be a way to expand access without as much additional cost.
 - Emily agreed this is a good idea to consider.
- Cammy Taylor asked whether the plan currently covers a phone or video consultation for an existing provider, rather than the person traveling for care? How is this handled now?
 - Emily responded it is limited now and depends on the service, it also depends on the billing codes and what is reimbursable in what circumstances. Additionally, she noted that there needs to be some controls over what is reimbursed and at what rate, to avoid risk of inappropriate billing and to establish standards of care.
- Joelle Hall asked if Medicare covers telephone or remote consultations?

- The group was not sure of the answer, but there are some covered services today, such as behavioral health.
- Shane Francis shared that Medicare is reimbursing in some situations as pilot programs, such as consultation for inpatient/outpatient care for certain conditions, but it is not comprehensive now. Everyone is still figuring out how to make this work. He confirmed that as of 2019, Medicare is accepting reimbursement for some telehealth services.
- Emily added some of these services have been available for a while, but now consumers are demanding this service. Expectations are higher that this is available from providers.
- Cammy asked if Teladoc accepts Medicare?
 - Emily responded not at this time, but it seems like a major business opportunity.
- Joelle commented that in the Tribal health system and in rural communities, this is already the standard of care: people are used to using these services, and they have already been developed for those communities. She added that the VA system has also been increasing telehealth services for veterans.
 - Emily added this is a good point, she is curious how this works for AlaskaCare members who are also IHS beneficiaries (Alaska Native individuals). This is worth understanding better, and how they are treated under the plan today.

Topic: #3 Deductible & Out of Pocket Maximum

Materials: starting page 11 in 1/15/20 meeting agenda packet

Emily thanked the group for continued attention to the idea of balance: that adding benefits will require considering offsets. This proposal is one of the possible offsets. The proposal outlines some options for the increase of deductible and out of pocket maximums at different levels, and the actuarial impact of each of those options.

- Joelle asked for clarification about the estimated actuarial impacts presented.
 - Emily explained that Segal Consulting was not available for this meeting, but generally the actuarial value is actual dollar costs to the plan. For example, the \$5 million increase in value for colonoscopies translates into a higher actuarial value of the plan for covering these at a higher rate. She will ask Segal to explain this more fully.

Emily proposed this remain for consideration, but to remove Option 3 (the highest proposed increase) and keep the other two options for discussion.

- Cammy agreed this is a good approach, and noted the data provided for 2017 showed that almost 80% of members met their deductible, and 30% met the out of pocket maximum.
- Mauri Long commented the data for most of these proposals is now out of date and may have changed significantly due to other changes in the health system. She requested updated analysis with the most recent data available, as it will provide a better basis for decision making with more current information, especially in areas where prices have changed, as staff noted.
- Cammy asked staff to clarify the estimated 2019 total claims, both \$590 million and \$680 million are listed. She believes the \$590 number is the more updated estimate, but asked staff to correct this throughout when they are making other updates or replace with current data.

Topic: Three-Tier Pharmacy Benefits

Materials: starting page 3 in 1/15/20 meeting agenda packet

Emily Ricci provided an overview: this would institute a three-tier coverage policy for pharmacy benefits, with the tiers corresponding with level of coverage and cost-share. There are increasing costs for many drugs, and health plans have responded by instituting multiple tiers of pharmacy benefits, depending on whether the medication is generic or brand name, or if it is preferred (negotiated better rate) versus non preferred. Some plans also have a fourth tier of specialty drugs, or even 5 tiers (preferred and non-preferred specialty tiers) due to the very high costs of many specialty drugs.

The proposal creates the following in the pharmacy plan:

- Tier 1: generic drugs – these are the most widely available, identical to brand name medications, and lowest cost. This would have the lowest co-payment, as is true today.
- Tier 2: preferred brand-name drugs – these are brand name drugs and therefore typically more expensive than generic drugs but would include those without a generic alternative available. This would have a higher co-payment, also as is true today.
- Tier 3: non-preferred brand-name drugs – this is the proposed new tier and would include brand-name medications that do not have an available generic equivalent, or preferred brand-name drug. This would have the highest co-payment, reflecting the patient’s choice to not use lower-cost alternatives.
- Mail order co-pay for all 3 tiers would be \$0, as is true today.

Emily noted this is another way to negotiate better drug prices, and this has been the state’s experience in the employee plan: the tiers allowed for negotiation of better rates for several drugs because they are considered preferred brands. There would also be a waiver system, allowing for a non-preferred drug at the same cost if there is medical necessity (an allergy or other health consideration, determined by a physician). In general, this would be an offset for members if they take non-preferred brand drugs because of the higher co-pay, but they can also utilize mail order.

- Cammy asked whether there is data enumerating the percent of prescriptions paid that are considered maintenance or long-term medications, versus one-time medications that are expensive and addressing an acute episode of care? She explained, a maintenance drug can be received regularly in the mail, but a drug to treat a specific condition may be needed immediately or is not worth setting up a mail order for a one-time prescription fill. Additionally, if mail-order is \$0 co-pay, they can avoid the higher cost.
 - Emily responded staff does not have the data available but can research this. She noted creating the tiers in the plan design gives the state the opportunity to negotiate better pricing across the board, this is more likely where savings to the plan would come from.
- Cammy noted the proposal currently references both the Defined Benefit (DB) and Defined Contribution (DC) retirees, this should be separated into separate populations. Additionally, she is concerned whether this will have the intended result, receiving the drug through mail order saves the member money but costs the same to the plan.

- Mauri noted that the savings appears to come mostly from the discounts on the drug prices themselves, not whether the member uses mail order pharmacy, if they are preferred drugs on the list and have negotiated discounts .
- Emily confirmed this is correct and noted that the act of implementing the tier system in the employee plan has resulted in lower prices. She can provide examples of the price differential.
- Cammy noted she understands drug pricing also has to do with a pharmacy benefit manager manufacturing with drug companies and distributors, and this will change from year to year. She is aware of a proposal in Medicare to allow for tiered pricing and can share articles about this with staff and the Board. There are also different rules related to which categories drugs are placed in, and how many drugs are in each category, related to how many options people have for choosing a preferred drug.
 - Emily is aware of that proposal, and noted it has a similar effect to allow more leverage in negotiating discounts. Manufacturers are highly motivated to have their products listed as preferred drugs, because more people will use them.
 - Shane added that it is also difficult to structure pricing for drugs because many fall in multiple categories, and manufacturers have pushed to include their products in as many categories as possible.
 - Emily noted it may be possible to include tiers, or other customized rules, in the EGWP: this was not contemplated previously, but it would be another way to implement this program without limiting access to medications for drugs for which there are few options or only one choice. She also noted pricing is not always the driving force between preferred and non-preferred: it is more the therapeutic value of the drug, whether there are interchangeable options. She added that the formulary is updated periodically, but they negotiated to not have it updated too frequently so that people do not suddenly lose access to a drug. For the employee plan, staff addressed the formulary updates as well as how many drugs are added to or shifted from preferred to non-preferred or vice versa, to mitigate negative impacts on employees with those prescriptions.
- Cammy asked how often the formulary is updated, particularly moving products from preferred to non-preferred? This would be helpful information.
 - Staff will research this.

Topic: [Limit Coverage of Compound Medications to a Network of High-Quality Pharmacists](#)

This item has not been prepared as a written proposal and was discussed in the meeting.

Emily shared an overview of this concept: compound medications are those mixed manually by a pharmacist, either a specialty medication or responding to a person’s allergy or other problem taking the medication that is available in commercial form. This is a valuable service for the people who need it, but it is also controversial because some providers have abused this in terms of billing, such as preparing an expensive compound medication when a much cheaper equivalent is available commercially and performs equally well. Another concern is safety: if the pharmacist adds other substances to the medication, or medications such as pain relief which can be easily misused.

There were cases in the AlaskaCare plan regarding bioidentical hormones (example: estrogen to manage menopause symptoms) which are not FDA approved, but are biosimilar and closely related. By not

covering the non-FDA approved biosimilar options, this impacted members who relied on those hormone treatments. The state reversed its decision and covers those biosimilar products now.

Another major concern was one specific pharmacy in Oregon: this was the primary source of compound pharmacy costs, which were approximately \$2 million in a recent year in total for employees and retirees. Most was coming from this pharmacy, who was investigated for inappropriate billing practices. The state plan carved them out of their network and do not cover that pharmacy; this resulted in a reduction in spending on compound medications down to \$250,000 per year. The state met with independent pharmacists and OptumRx to resolve any remaining issues; they have considered other plan design issues but at this point, the current system is working well and the pharmacists have agreed to certain rules for preparing compounds and for reimbursement, to ensure patient safety.

The group agreed to set this proposal aside, as the primary issues have been addressed in the last year.

Topic: #11 High Value Pharmacy Network for Certain Medications

This item has not been prepared as a written proposal and was discussed in the meeting.

Emily shared that this is also a work in progress with independent pharmacists, who are concerned about being able to compete with high-volume, lower-cost chain pharmacies. This addresses situations where someone has very specific medications or would benefit from packaging options, such as a blister pack to track their daily medication, and to be able to pay for this. The pharmacists and the state have been discussing this and other options and are determining how this could be implemented in a way that makes sense for all involved. Additionally, other major payers such as Medicare are interested in programs like this, so there is growing demand. Pharmacists are working through these issues; when they are ready, this could be implemented as an option.

- Judy asked if OptumRx provides or covers packaging services now? She is aware of Geneva Woods, a local pharmacy who provides compound medications, and perhaps this can be available through OptumRx.
 - Staff will ask OptumRx whether they provide this service.

Emily also noted that there is emerging policy around pharmacogenetics, a new field that evaluates potential drug interactions based on a person's genetic composition and which can ensure more tailored prescriptions and treatments based on a person's genes. She noted that this is a new field, but some public sector plans (University of Kentucky) are already including this in health plans. She suggests this be monitored now and listed for future discussion. Shane added there are many implications for this for the medical field overall, as the current approach is to consider the average impact across the larger population and not necessarily to publish results or recommendations based on a person's demographics or other characteristics.

Topic: Expanded Coverage of Dental Implants in the Medical and/or Dental Plan

Cammy commented this topic has not been discussed in detail, but earlier this morning the idea was shared cover implants under the medical plan, rather than just clarifying when it is covered.

- Joelle asked whether dental implants are covered under the medical or dental plan?
 - Cammy responded implants are covered under the medical plan if it is the result of injury or disease, since it is a surgery; but in other cases, including periodontal disease, it is a dental plan benefit. She also commented that newer research shows this is a more

effective treatment than some of the other, older interventions, so this is more recommended and more common than in the past.

- Emily noted that staff are not aware if this is a commonly covered benefit in other medical plans beyond the injury or disease situation, but it is very costly (several thousand dollars) and often exceeds the annual benefit limit for dental plans. She believes many plans do not cover it as medical, or even at all, but this should be considered.
- The group commented costs for dental implants are typically cheaper outside Alaska.
- Judy commented that it may also be possible to stagger treatments by allowing for work on one tooth to be billed at separate times, and not require it to be done all at once: a person could plan the implant and associated work over multiple calendar years,

Topic: Wellness Benefits Such as Gym Membership or Silver Sneakers

This item has not been prepared as a written proposal but was discussed in the meeting.

Emily described this is a common benefit in other health plans, that many retirees have asked for: however, their research to date shows that the state cannot offer this type of benefit without having tax implications for members, even if they use an HRA or similar model. The plan can consider other options to incentivize wellness, such as participating in certain programs and reducing costs, but so far retirees have most often requested gym membership as a benefit.

- Judy commented her understanding of Silver Sneakers is not as a gym membership or reimbursement, but it is a program that someone with a Silver Sneakers card can utilize to get fees waived or a discount at participating fitness programs, this could be an alternative design.
 - Betsy Wood noted that Silver Sneakers, a national program, can leverage a large number of participants and is recognized nationally. Their plan cannot great a program this large, and would not be able to reimburse or provide discounts to participating gyms, fitness classes, etc. to make this work.
- Judy commented that this has been a popular request and asked the group if it is a priority; the group did not feel it is a current priority, given the limitations on the plan.
- Joelle encouraged the Board and staff to develop an explanation and more information about the wellness benefit, to respond to public comment, since so many people have asked about some of these proposals. She recommends, for all proposals, describing the status of each proposal, and if it is being set aside, to explain why this is and whether it can be revisited in the future. This would increase communications back to retirees, help them understand that they were heard, but also understand why the proposal isn't currently feasible.
- Judy commented, on a separate proposal brought up previously to allow retirees to participate in the active employee plan, there have been several requests to allow coverage of dependents in college or otherwise, consistent with the Affordable Care Act's limit of age 26.
 - Emily responded the limit is statutory: it is specified in state law that the retiree plan does not cover dependents beyond age 23. This could be changed, but would be difficult and require building support for that change. In the past, there has been hesitation to reopen this statute for any changes.
 - Emily added that the Division has not discussed or recommended that statute change and would need to consider.

- Nan agreed with Joelle’s suggestion to publish responses or explanations for the various proposals on the table and communicate back with retirees.
 - Mauri agreed and noted there are several other proposals discussed that have been set aside already, not on this list. She also recommended grouping the proposals under topical categories, to understand them easier: example, pharmacy provisions; network provisions; etc. There should also be a list of proposals that have been considered but have been set aside for various reasons, and supported Joelle’s suggestion.
- Cammy reminded Board members to carefully review each proposal, including impacts to members, and to pay attention to the financial as well as actuarial impact. She asked staff to prepare an updated estimate of Medicare eligible and non-Medicare eligible members: previously, it was 30% non and 70% Medicare, but the trend is an increasing share of Medicare eligible members.

Item 4. Public Comment

The Chair reiterated the rules for public comment prior to inviting members of the public to speak.

Public Comments

- **Brad Owens, Executive Vice President, RPEA.** Brad appreciated Joelle’s recommendation to clearly communicate the status or any decisions on each proposal back to members, and suggested it also be included in the Health Matters publication. He also recommended the financial or actuarial cost to the plan be clarified to note whether it is cost savings, or additional revenue to the plan. Additionally, he believes it is important to understand how many people are impacted currently as well as in the future, and to understand this when making decisions. He favors incrementally increasing the lifetime maximum over removing the maximum, if in the future there is a risk of many more people exceeding that limit and greatly increasing the cost to the plan. He thanked the Board and staff for their work, including all the materials they prepare and making that information public to understand what is being discussed, the process for discussion and decision making, and keeping members informed.

The committee had additional time before the meeting adjournment, and continued discussion.

Item 5. Continued Discussion of Proposals

Topic: #16 Medically Necessary Treatment for Gender Dysphoria, Including Surgery

This item has not been prepared as a written proposal, but was discussed in the meeting.

This proposal was brought via public comment, the Division has not completed analysis to date. In 2018, the employee and retiree plan was updated to cover hormone replacement therapy for gender dysphoria, but does not cover surgery. This is also a topic of ongoing litigation in the employee plan.

- Joelle asked if this is currently covered under Medicare? She is aware of some requirements to cover this surgery in some situations, but not whether it is state or federal.
 - Emily was not aware of which payers cover this service, but noted that there were proposed federal rules under the Obama administration that have not been carried forward by the Trump administration.

- Dallas Hargrave asked staff to monitor this issue and any legal or policy developments, and to inform the Board if and when there is new information that impacts the discussion.
- Mauri Long asked whether the current litigation against the state is an appeal by a specific individual, or whether it is a general civil matter?
 - Staff confirmed the case involves a specific individual, and it is currently being addressed in the Superior Court.

Topic: #17 Implement a Co-payment for Primary Care

This item has not been prepared as a written proposal, but was discussed in the meeting.

This proposal had mixed reaction with employees, with many concerned that the co-payment instead of co-insurance would make it more difficult to meet their annual deductible. The data to date shows a savings to the member's out of pocket cost for making this change, but it is very new (only two weeks, since January 1, 2020), staff will have more information about how it works after more time has passed.

- Cammy asked about the co-payment for primary care in the employee plan?
 - Emily responded for the Economy plan it is \$35 for primary care, \$55 for specialty visit. For the Standard plan it is \$25 for primary care, \$45 for specialty. Preventive care is covered at 100%, so this would apply to other office visits. She noted that unlike a co-pay, members pay a larger amount upfront for the deductible and this can be a barrier to care, if people put off going to a specialist to save the cost. Co-pays do not entirely remove costs, but it makes costs more predictable for routine care.
 - Joelle noted this means paying smaller amounts over time for care in the course of a year, minus any catastrophic or other high-cost procedures, versus paying more upfront by meeting a deductible each calendar year. (The deductible would still apply for other services, separate from the co-pays for primary care visits).
 - Betsy added this applies for in-network providers only; out of network primary care providers are still subject to co-insurance and the deductible.
 - Emily added for behavioral health services such as counseling, co-pays also make it more accessible. The goal is to find a cost where the co-pay is the same or lower than the member's co-insurance amount for that service, to make the change worthwhile for the plan and the member.
- Judy and Cammy asked how co-pays work for coordinated benefits? Are co-pays waived?
 - Andrea confirmed that for coordinated benefits, this is determined during the claims process. Members are asked to be aware of their status and not pay a co-pay upfront, because it then requires a reimbursement back to the member from the provider.

Item 6. Closing Thoughts + Meeting Adjournment

- **Motion** by Joelle Hall to adjourn the meeting. **Second** by Judy Salo.

Result: No objection to adjournment. The meeting was adjourned at 3:01 p.m.

The Retiree Health Plan Advisory Board will meet on Wednesday, February 6, 2020.

Common Acronyms

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

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

RHPAB Takeaways

DRB To-Dos Prior to February Meeting

1. Update dental implant wording in table – intent is to consider expanding coverage for implants, rather than simply clarifying. “Expand coverage of dental implants” **Completed 1/22/2020**
2. Add a “status” column to the table to indicate if the proposal is under active consideration or has been set aside/pended. **Completed 1/22/2020**
3. Add a column to indicate whether or not we’ve drafted a proposal. **Completed 1/22/2020**
4. Correct OOP Maximum/Deductible Proposal Summary Sheet – Option 1 Family Deductible should be \$600, not \$800. **Completed 1/22/2020**
5. Update “health concierge” in proposal 1b title to care coordination. **Completed 1/22/2020**

To-Dos Items from February Meeting

1. Once the Division receives direction from the committee as to which proposals to focus on moving forward, DRB will update and refresh proposals with current data.
2. Include a write-up for all proposals including those that do not already have a formal proposal document and/or have been set aside or pended. Intent is to outline for the public considerations that contributed to the decision to set certain proposals aside (e.g. increasing age of covered dependents to age 26 requires a statutory change, not a Plan Administrator decision).

Proposal-Specific Committee Recommendations/Questions/Direction

1. Enhance Travel Benefits
 - a. Clarify travel proposal options
2. Network steerage: 70% out-of-network and 90% in-network
 - a. Set aside current proposal.
 - b. Restructure/revise to consider a tiered network approach.
3. OOP Maximum/Deductible Proposal
 - a. Request from the committee to walk through the actuarial impact again, possibly update for clarity.
4. Out-of-network reimbursement as a percentage of Medicare
 - a. Update with more detailed analysis.
5. In-network enhanced clinical review of high-tech imaging and testing
 - a. Pend proposal. **Completed 1/22/2020**
6. Expanded Telehealth Services
 - a. Update proposal to be vendor neutral.
 - b. Update with information on how Medicare covers (or does not cover) telehealth services.
 - c. Update proposal to clarify how Medicare-eligible members would access at telehealth vendor such as Teladoc.
7. Expand preventive coverage to add full suite of preventive services Add information on Cologuard-type screenings to proposal including how these types of screenings are classified by the USPSTF.
 - a. Update analysis to contemplate 100% coverage of preventive services received from in-network providers as an option.
 - b. Update proposal to reflect that Medicare Part D-covered vaccines are covered through the pharmacy benefit for both the U-65 and O-65 population.

8. Lifetime Maximum Proposal
 - a. Update with more information on number of members who have hit the maximum, or who are close (historic lookback as well as current point-in-time).
 - b. Consider impact of lifting the maximum to \$3,000,000 (or another amount) rather than eliminating as an option.
 - c. If possible, consider actuarial impact to the plan each time the maximum was raised in the past.
9. Implement clear service limits for rehabilitative care such as chiropractic, physical therapy, occupational therapy, etc. and expand rehabilitative services to include rolfing, acupuncture, and/or acupressure
Pend services limits for rehabilitative care services proposal.
 - a. Pend services limits proposal.
 - b. Separate out proposal to add coverage for acupuncture, acupressure, and rolfing.
10. Exclude coverage for drugs with over-the-counter (OTC) equivalents.
 - a. Pend proposal. [Completed 1/22/2020](#)
11. Implement high-value pharmacy network with lower copays for chronic meds, medical synchronization, counseling, and packaging options for participating members.
 - a. Need direction.
12. Add wellness benefits such as gym membership or program like Silver Sneakers
 - a. Produce write-up describing challenges with implementation of this proposal.
13. Implant Coverage Proposal
 - a. Update/overhaul proposal
14. Implement 3-tier pharmacy benefit; change out-of-network pharmacy benefits
 - a. Need direction on cost elements to evaluate impacts.
 - b. Update proposal with more information regarding maintenance medication utilization.
 - c. Remove DCR members from the analysis.
15. Limit compound coverage to high-quality, narrow network of pharmacies
 - a. Pend [Completed 1/22/2020](#)
16. Add medically necessary treatment of gender dysphoria including surgery
 - a. Maintain, update as needed.
17. Copayment for Primary Care
 - a. Need Direction
18. Copayment for primary care
 - a. Consider removing and separating housekeeping items from modernization topics.
19. ****Not listed previously**** Increase age to which eligible children may be covered from 23 to 26.
 - a. Create write-up outlining considerations.



Impact on Actuarial Value vs. Impact on Financial Value

Alaska Retiree Health Plan Advisory Board

February 6, 2020 / Richard Ward, FSA, FCA, MAAA

Actuarial Value

Actuarial value is generally defined to be the portion of total discounted claims costs paid by the plan on average across the full membership.

- If total average claims costs are \$1,000 per member per month (pmpm), then a plan with a 90% actuarial value would be expected to be \$900 pmpm
 - Member would be expected to pay \$100 in deductibles, copays, coinsurance, etc
- No set industry wide standard
- Based on cost sharing provisions: deductibles, copays, out-of-pocket limits, benefit maximums, etc
- Does not directly account for wellness, disease management and provider payment levels
- Usually determined prospectively, but can be determined with retrospective data review
 - Group specific data is preferred
 - Rating manuals and valuation models also utilized

Actuarial Value

Actuarial value is utilized in a number of settings:

- Retiree Drug Subsidy
- When it is necessary to measure whether coverage is “sufficient”. Examples include:
 - Kentucky and the Kurtzinger case
 - Tennessee Local Education Plan
- The Affordable Care Act (ACA) of 2012 categorizes plans into different metal levels based on actuarial value
 - Platinum: 90%
 - Gold: 80%
 - Silver 70%
 - Bronze: 60%
- ACA determination of actuarial value focuses on network benefits; non-network benefits are not included
- ACA also defines “essential benefits” to be valued

Impact of Time on Actuarial Value

Fixed dollar benefit provision affect actuarial value over time

- Deductibles increase actuarial value – so called “deductible leveraging”
- Benefit maximums decrease actuarial value
- The following example illustrates how a fixed dollar benefit provision leverages annual overall trend from 3% to 6% for the plan. In this example, the trend for member costs is 0%

	Year One	Year Two	Change
Total Cost	\$100	\$103	3%
Deductible	\$50	\$50	0%
Plan Pays	\$50	\$53	6%
Plan %	50%	51.5%	

Financial Value

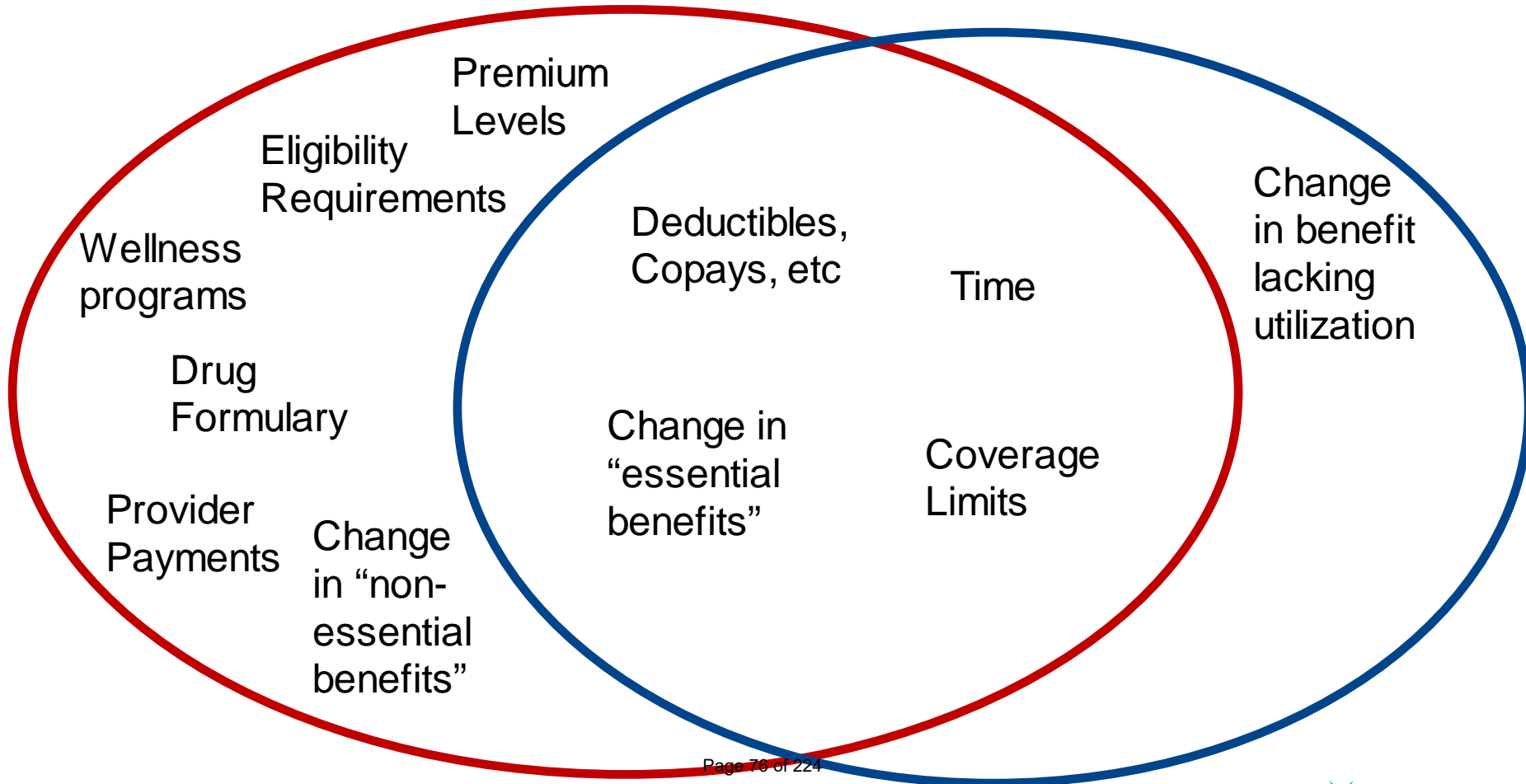
Simply put, anything that affects the cost of the plan impacts the financial value

- Deductibles, copays, coinsurance, benefit limits
- Provider payment levels (network contracts, non-network recognized charges)
- Wellness and health management programs
- Incentives that promote more efficient care (telemedicine, travel programs, etc)
- Federal subsidies (RDS, EGWP, etc)
- Drug formulary
- Non-essential benefits coverage
- Eligibility requirements

Actuarial Value and Financial Value Comparison

Financial Value

Actuarial Value



Thank You!

Richard Ward
Senior Vice President, West Region Public Sector Market Leader





Retiree Health Plan Advisory Board

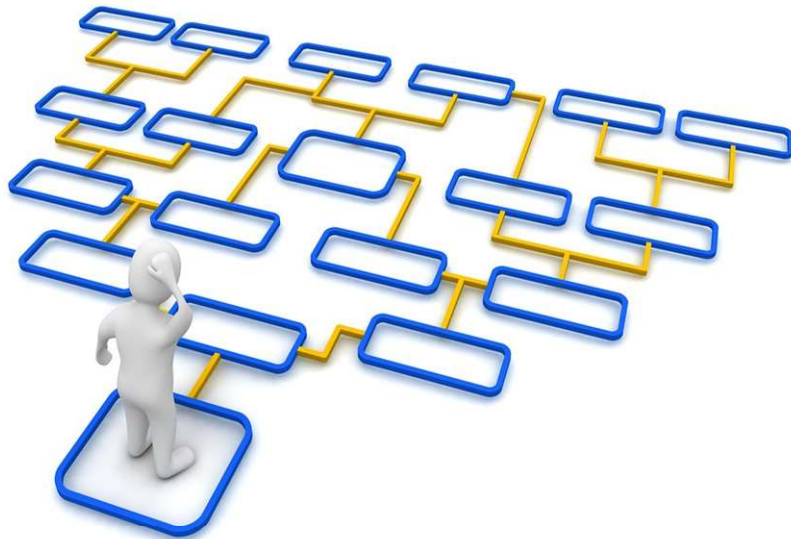
Modernization Work Group Guide

February 2020



RHPAB Meeting Objective

Provide recommendations to the Division regarding AlaskaCare Retiree Health Plan modernization proposals for further evaluation and analysis.



RHPAB: Purpose

The Retiree Health Plan Advisory Board (RHPAB) was established in 2017 via Administrative Order (AO) 288.

The purpose of the board is to

“...facilitate regular engagement, communication, and cooperation between the Office of the Governor, the ARMB, the Commissioner, and retirement system members regarding the administration and management of the State’s retirement systems.”



RHPAB: Duties & Responsibilities

From AO 288 Establishing Retiree Health Plan Advisory Board:

- The Board shall review available non-confidential information, hold public meetings, and provide periodic reports to the Commissioner.
- The periodic reports may include recommendations to the Commissioner related to the health care plans of the State's retirement systems, including optional life insurance, long-term care insurance, and optional dental-visual-audio programs.



RHPAB: Recommendation Guidelines

From *AO 288 Establishing Retiree Health Plan Advisory Board*:

“The recommendations must consider:

- 1.** the cost of the service or changes relative to the long-term and short-term fiscal viability of the plans, including policies to retain prudent reserves in the plans;
- 2.** the affordability to the health care plans from the perspective of plan sponsors, participating employers, and plan beneficiaries, including the effect of premiums assessed to beneficiaries; and
- 3.** the clarity of the plan to beneficiaries; and the Department's ability to offer consistent, transparent direction and oversight to third-party plan administrators.”



Retiree Health Plan Modernization: Goal

From the May 2018 RHPAB meeting materials:

“The goal of the modernization project is to provide value to the member through incorporating common benefits not currently available while preserving the overall benefit of the plan and implementing standard cost saving mechanisms.”



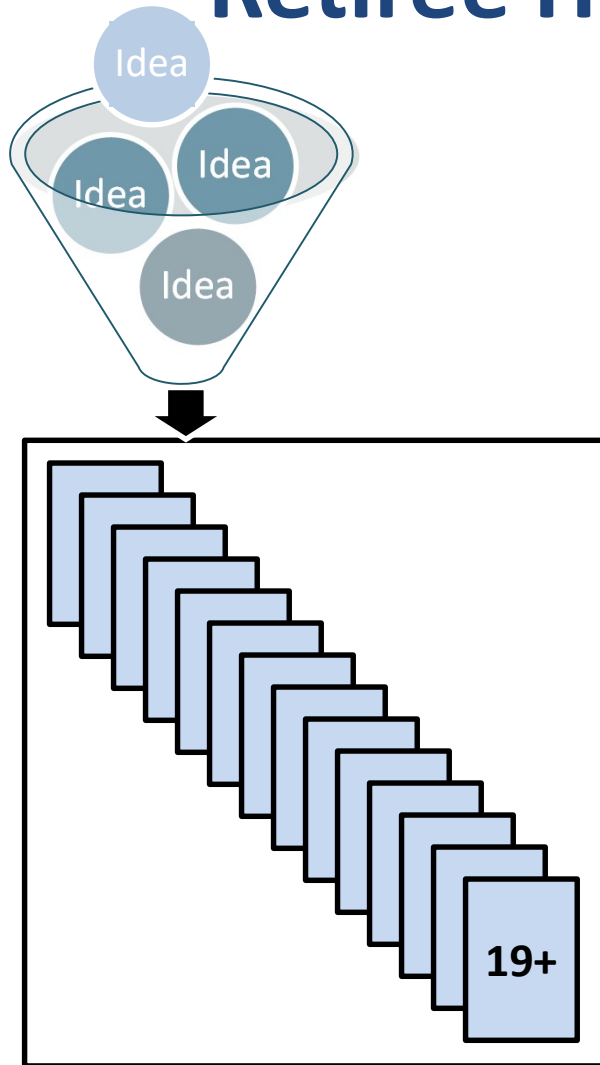
Retiree Health Plan Modernization

What changes should we evaluate?

How should they be implemented?

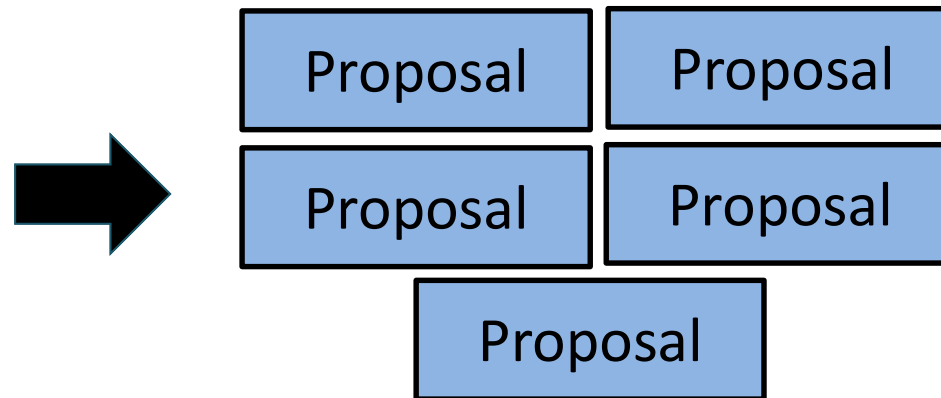


Retiree Health Plan Modernization



Our Ask of You

We are asking the board to identify the proposals to focus our resources on.



Retiree Health Plan Modernization

Some Questions to Consider

What is the purpose of medical insurance?

- How is “lifetime major medical coverage” perceived?
- How essential is each proposal to providing “lifetime major medical insurance?”

What are the plan’s short term and long-term goals?

- How do the changes support the plans’ goals?
- Is the change financially sustainable?

What are the challenges facing members today?

- How does the change impact members today and in the future?



Retiree Health Plan Modernization

Next Steps for DRB

DRB will fully develop each proposal to include:



- » Member Impact
- » Financial Analysis
- » Actuarial Analysis
- » Implementation Options



- » Communication Plan
- » Timeline
- » Division Recommendation



Retiree Health Plan Modernization

Next Steps for RHPAB



Evaluate the proposals

- Is there value in creating an evaluation framework?
- Important to note this may be an iterative process.



Advisory Vote and Recommendation

- How can DRB best support the RHPAB as they reach consensus?



DRAFT

Retiree Health Plan Modernization Topics*

#	Draft Proposal	Estimated Actuarial Impact	Estimated Fiscal Impact	Status (Active or Pended)	Proposal Drafted Y/N
R001a	Enhance travel benefits	=0.00%	-\$2,800,000/yr	Active	Y
R001b	Enhance travel benefits, add health concierge	=0.00%	-\$2,500,000/yr	Active	Y
R002	Network Incentive: 70% out-of-network and 90% in-network	+0.14%	+\$800,000/yr	Active	Y
R003	Increase deductible and out-of-pocket maximum	-0.50% -1.60%	-\$2,900,000/yr -\$9,300,000/yr	Active	Y
R004	In-network enhanced clinical review of high-tech imaging and testing	=0.00%	-\$250,000/yr	Pended 1/15/2020	Y
R005	Out-of-network reimbursement as a percentage of Medicare			Active	Y
R006	Expanded telehealth services	=0.00%	-\$250,000/yr	Active	Y
R007	Expand preventive coverage to add full suite of preventive services	+0.75%	+\$5,000,000/yr	Active	Y
R008	Remove or increase lifetime maximum (currently \$2M)	+0.40%	+\$2,700,000/yr	Active	Y
R009	Implement clear service limits for rehabilitative care such as chiropractic, physical therapy, occupational therapy, etc. and expand rehabilitative services to include rolfing, acupuncture, and/or acupressure – <i>public comment proposal</i>			Active	Y
R010	Exclude coverage for drugs with over the counter (OTC) equivalents			Pended 1/15/2020	Y
R011	Implement high-value pharmacy network with lower copays for chronic meds, medical synchronization, counseling, and packaging options for participating members.				N
R012	Add wellness benefits such as gym membership or program like Silver Sneakers - <i>public comment proposal</i>				N
R013	Consider expanding coverage for implants related to periodontal disease under the medical plan and/or under the dental plan				N
R014	Implement 3-tier pharmacy benefit; change out-of-network pharmacy benefits		-\$3,000,000/yr	Active	Y
R015	Limit compound coverage to high-quality, narrow network of pharmacies			Pended 1/15/2020	Y
R016	Add medically necessary treatment of gender dysphoria including surgery – <i>public comment proposal</i>				N
R017	Copayment for primary care				N
Plan Housekeeping Items					
R018	Clarify reimbursement policies for surgical assistants in the plan booklet				N

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

Proposal Title	Enhanced Travel & Health Concierge (R001A)	
Health Plan Affected	Defined Benefit Retiree Plan	
Proposed Effective Date	January 1 st , 2020	
Reviewed By	Retiree Health Plan Advisory Board	
Proposal Drafted	October 2018	
Status of Proposal	Under Consideration	

Summary of Current State

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

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

Objectives

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

Summary of Proposed Change

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

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

DRAFT-Summary of Responses to Proposed Plan Design Change

Proposed change: Enhancing travel benefits (R001a)

Plans affected: DB Retiree Plan

Reviewed by: Retiree Health Plan Advisory Board

Proposed implementation date: TBD

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

Table 1. Plan Design Changes

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

Description of proposed change:

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

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

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

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

DRAFT-Summary of Responses to Proposed Plan Design Change

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

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

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

Background:

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

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

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

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

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

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

⁴ Page 41, Ibid.

⁵ Page xxxvii-xl. Ibid.

⁶ Page 43, Ibid.

⁷ Page 42, Ibid.

⁸ Page 44, Ibid.

DRAFT-Summary of Responses to Proposed Plan Design Change

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

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

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

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

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

⁹ Page 42-43, Ibid.

¹⁰ Page 42, Ibid.

¹¹ Page xxxvii, Ibid.

DRAFT-Summary of Responses to Proposed Plan Design Change

Circumstance	Current	Proposed
Travel for minor	<ul style="list-style-type: none"> -Minor and companion -Transportation covered¹² 	<ul style="list-style-type: none"> -Add overnight lodging benefit of \$80/night of 3-star or above hotel within 30 minutes of appointments, up to 14-day maximum; -Add per diem benefit of \$31 60 per patient/day; or \$62 120 per patient & companion/day to reflect State of Alaska per diem rates.¹³per diem rates for state employees during work travel.
Second surgical opinion	<ul style="list-style-type: none"> -Transportation covered for member only 	<ul style="list-style-type: none"> -Add lodging and per diem benefit as described above.
Treatment and diagnostic services not available locally	<ul style="list-style-type: none"> -Transportation, lodging and per diem covered for member only. -Limited to treatment only -Limited to the following visit per benefit year: <ul style="list-style-type: none"> -1 treatment for condition -1 for follow-up -1 pre- or post-natal care -1 for maternity delivery -1 pre- or post-surgery -1 per surgical procedure -1 per allergic condition 	<ul style="list-style-type: none"> -Restrict to services received from a network provider. -Add lodging and per diem benefit as described above to cover the member's entire length of stay subject to medical necessity. -Allow for both pre- and post-op visit coverage if post-op received within 60-days of discharge. -Add companion benefit if procedure requires general anesthesia (as well as minors, or members with physical disabilities requiring a travel companion (requires medical necessity) or when appropriate or necessary (e.g. minors, members with physical disabilities, etc. subject to medical necessity);

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

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

DRAFT-Summary of Responses to Proposed Plan Design Change

Circumstance	Current	Proposed
Surgery and diagnostic services in other locations less expensive	<ul style="list-style-type: none"> -Only applicable for surgery. -Transportation covered for member only. -Total cost may not exceed the recognized charge for same expenses received locally. -Total cost must include: <ul style="list-style-type: none"> -surgery -hospital room and board -travel to another location 	<ul style="list-style-type: none"> -Restrict to services received from a network provider. <u>-Restrict to services over \$2,000 locally (including 2nd opinions) measured using EDH data and floor of 200% of Anchorage Medicare.</u> -Add “if not available through the SurgeryPlus program.” -Add coverage for companion if procedure requires general anesthesia as described above. -Add lodging and per diem benefit as described- above. <u>above to cover the member’s entire length of stay subject to medical necessity.</u>
SurgeryPlus Program	-Not currently available to retiree members	<ul style="list-style-type: none"> -All travel includes member and companion -Travel costs arranged for and covered up front by SurgeryPlus. -Hotels arranged and paid for by plan. -State of Alaska per diem rate for meals & incidentals. -Companion travel covered if medically necessary as described above. \$31-60 per diem for member/\$12062 with companion -Members receive pre-loaded debit card in advance of trip.
<u>Long-term stay</u>		<ul style="list-style-type: none"> Requires additional review. Suggested per diem rate of \$33. -Defined as more than 30 days. -Long term lodging and meals and incidental rates apply as

DRAFT-Summary of Responses to Proposed Plan Design Change

Circumstance	Current	Proposed
		<u>outlined in State of Alaska Per Diem Rates.</u>
<u>Maximum Reimbursement</u>	<u>None</u>	<u>-No more than \$10,000 per diagnosis episode of care.¹⁴</u>

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

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

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

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

DRAFT-Summary of Responses to Proposed Plan Design Change

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

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

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

Member Impact:

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

WHO IS IMPACTED:

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

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

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

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

DRAFT-Summary of Responses to Proposed Plan Design Change

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

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

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

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

Actuarial Impact

Neutral / Enhancement / Diminishment

Table 2: Actuarial Impact

Actuarial Impact	
Current	N/A
Proposed	No actuarial impact ¹⁶

DRB Operational Impacts

The Division anticipates minimal operational impacts as follows:

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

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

DRAFT-Summary of Responses to Proposed Plan Design Change

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

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

Financial Impact to the plan:

The financial impact to the plan for the addition of the SurgeryPlus travel network and services is estimated to be savings of \$2.8 million annually. This is based on members using the SurgeryPlus network for 400 procedures per year. The total savings is net of the administrative costs for SurgeryPlus and the estimated cost per member per trip of \$3,000.¹⁷ ~~The fiscal impact of the expanded travel wrap is under analysis.~~

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

Clinical Considerations:

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

Access to SurgeryPlus program- Provider quality is a distinguishing feature of the SurgeryPlus network which reports complication rates of 0.82% among members using their network¹⁹ compared to the 14.1% average for AlaskaCare retirees living in Alaska but seeking care outside of the state in 2017 (13.8% for professional services, 17.1% for outpatient care and 27.6% for inpatient care).

Third Party Administrator (TPA) operational impacts:

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

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

¹⁷ See Attachment A

¹⁸ ibid.

DRAFT-Summary of Responses to Proposed Plan Design Change

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

Provider considerations:

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

Documents attached include:

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



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MEMORANDUM

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

From: Richard Ward, FSA, FCA, MAAA

Date: January 31, 2019

Re: Travel Benefits (R001A) – Focus on Actuarial and Financial Impact for the Retiree Plan

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

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

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

Out-of-Pocket Limit		
Annual individual out-of-pocket limit <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • Prescription drug expenses do not apply against the lifetime maximum 	\$2,000,000	
Individual limit per benefit year on substance abuse treatment without precertification. Subject to change every three years	\$12,715	
Individual lifetime maximum on substance abuse treatment without precertification. Subject to change every three years	\$25,430	
Prescription Drugs	Up to 90 Day or 100 Unit Supply	
	Generic	Brand Name
Network pharmacy copayment	\$4	\$8
Mail order copayment	\$0	\$0

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

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

Circumstance	Current Benefit	Proposed Benefit
Treatment and diagnostic services not available locally	<ul style="list-style-type: none"> -Transportation, lodging and per diem covered for member only. -Limited to treatment only -Limited to the following visit per benefit year: <ul style="list-style-type: none"> -1 treatment for condition -1 for follow-up -1 pre- or post-natal care -1 for maternity delivery -1 pre- or post-surgery -1 per surgical procedure -1 per allergic condition 	<ul style="list-style-type: none"> -Restrict to services received from a network provider. -Add lodging and per diem benefit as described above to cover the member's entire length of stay subject to medical necessity. -Allow for both pre- and post-op visit coverage if post-op received within 60-days of discharge. -Add companion benefit if procedure requires general anesthesia.
Surgery and diagnostic services in other locations less expensive	<ul style="list-style-type: none"> -Only applicable for surgery. -Transportation covered for member only. -Total cost may not exceed the recognized charge for same expenses received locally. -Total cost must include: <ul style="list-style-type: none"> -surgery -hospital room and board -travel to another location 	<ul style="list-style-type: none"> -Restrict to services received from a network provider. -Add "if not available through the SurgeryPlus program." -Add coverage for companion if procedure requires general anesthesia. -Add lodging and per diem benefit as described above to cover the member's entire length of stay subject to medical necessity.
SurgeryPlus Program	<ul style="list-style-type: none"> -Not currently available to retiree members 	<ul style="list-style-type: none"> -All travel includes member and companion. -Travel costs arranged for and covered up front by SurgeryPlus. -Hotels arranged and paid for by plan. -\$31 per diem for member/\$62 with companion. -Members receive pre-loaded debit card in advance of trip.

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

Actuarial Value

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

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

Financial Impact

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

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

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

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

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DRAFT-Summary of Responses to Proposed Plan Design Change

Proposed change: Enhancing travel benefits with health concierge services (R001b)

Plans affected: DB Retiree Plan

Reviewed by: Retiree Health Plan Advisory Board

Proposed implementation date: TBD

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

Table 1. Plan Design Changes

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

Description of proposed change:

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

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

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

DRAFT-Summary of Responses to Proposed Plan Design Change

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

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

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

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

Background:

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

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

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

¹ See attachment A; Segal Consulting Memorandum, ~~July 25, 2018~~ January 31, 2019.

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

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

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

⁴ Page 41, Ibid.

⁵ Page xxxvii-xl. Ibid.

⁶ Page 43, Ibid.

⁷ Page 42, Ibid.

⁸ Page 44, Ibid.

DRAFT-Summary of Responses to Proposed Plan Design Change

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

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

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

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

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

⁹ Page 42-43, Ibid.

¹⁰ Page 42, Ibid.

¹¹ Page xxxvii, Ibid.

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Circumstance	Current	Proposed
Travel for minor	<ul style="list-style-type: none"> -Minor and companion -Transportation covered¹² 	<ul style="list-style-type: none"> -Add overnight lodging benefit of \$80/night of 3-star or above hotel within 30 minutes of appointments, up to 14-day maximum; -Add per diem benefit of \$31 60 per patient/day; or \$62 120 per patient & companion/day to reflect State of Alaska per diem rates.¹³per diem rates for state employees during work travel.
Second surgical opinion	<ul style="list-style-type: none"> -Transportation covered for member only 	<ul style="list-style-type: none"> -Add lodging and per diem benefit as described above.
Treatment and diagnostic services not available locally	<ul style="list-style-type: none"> -Transportation, lodging and per diem covered for member only. -Limited to treatment only -Limited to the following visit per benefit year: <ul style="list-style-type: none"> -1 treatment for condition -1 for follow-up -1 pre- or post-natal care -1 for maternity delivery -1 pre- or post-surgery -1 per surgical procedure -1 per allergic condition 	<ul style="list-style-type: none"> -Restrict to services received from a network provider. -Add lodging and per diem benefit as described above to cover the member's entire length of stay subject to medical necessity. -Allow for both pre- and post-op visit coverage if post-op received within 60-days of discharge. -Add companion benefit if procedure requires general anesthesia (as well as minors, or members with physical disabilities requiring a travel companion (requires medical necessity) or when appropriate or necessary (e.g. minors, members with physical disabilities, etc. subject to medical necessity);

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

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

DRAFT-Summary of Responses to Proposed Plan Design Change

Circumstance	Current	Proposed
Surgery and diagnostic services in other locations less expensive	<ul style="list-style-type: none"> -Only applicable for surgery. -Transportation covered for member only. -Total cost may not exceed the recognized charge for same expenses received locally. -Total cost must include: <ul style="list-style-type: none"> -surgery -hospital room and board -travel to another location 	<ul style="list-style-type: none"> -Restrict to services received from a network provider. <u>-Restrict to services over \$2,000 locally (including 2nd opinions) measured using EDH data and floor of 200% of Anchorage Medicare.</u> -Add “if not available through the SurgeryPlus program.” -Add coverage for companion if procedure requires general anesthesia as described above. -Add lodging and per diem benefit as described- above. <u>above to cover the member’s entire length of stay subject to medical necessity.</u>
SurgeryPlus Program	-Not currently available to retiree members	<ul style="list-style-type: none"> -All travel includes member and companion -Travel costs arranged for and covered up front by SurgeryPlus. -Hotels arranged and paid for by plan. -State of Alaska per diem rate for meals & incidentals. -Companion travel covered if medically necessary as described above. \$31-60 per diem for member/\$12062 with companion -Members receive pre-loaded debit card in advance of trip.
<u>Long-term stay</u>		<ul style="list-style-type: none"> Requires additional review. Suggested per diem rate of \$33. -Defined as more than 30 days. -Long term lodging and meals and incidental rates apply as

DRAFT-Summary of Responses to Proposed Plan Design Change

Circumstance	Current	Proposed
		<u>outlined in State of Alaska Per Diem Rates.</u>
<u>Maximum Reimbursement</u>	<u>None</u>	<u>-No more than \$10,000 per diagnosis episode of care.¹⁴</u>

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

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

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

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

DRAFT-Summary of Responses to Proposed Plan Design Change

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

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

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

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

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

Member Impact:

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

DRAFT-Summary of Responses to Proposed Plan Design Change

WHO IS IMPACTED:

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

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

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

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

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

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

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

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

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

DRAFT-Summary of Responses to Proposed Plan Design Change

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

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

Actuarial Impact

Neutral / Enhancement / Diminishment

Table 2: Actuarial Impact

Actuarial Impact	
Current	N/A
Proposed	No actuarial impact ¹⁶

DRB Operational Impacts

The Division anticipates minimal operational impacts as follows:

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

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

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

DRAFT-Summary of Responses to Proposed Plan Design Change

Financial Impact to the plan:

The financial impact to the plan for the addition of the SurgeryPlus travel network and services is estimated to be savings of \$2.8 million annually. This is based on members using the SurgeryPlus network for 400 procedures per year. The total savings is net of the administrative costs for SurgeryPlus and the estimated cost per member per trip of \$3,000.¹⁷

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

Clinical Considerations:

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

Access to SurgeryPlus program- Provider quality is a distinguishing feature of the SurgeryPlus network which reports complication rates of 0.82% among members using their network¹⁹ compared to the 14.1% average for AlaskaCare retirees living in Alaska but seeking care outside of the state in 2017 (13.8% for professional services, 17.1% for outpatient care and 27.6% for inpatient care).

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

Third Party Administrator (TPA) operational impacts:

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

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

¹⁷ See Attachment A

¹⁸ See Attachment A

DRAFT-Summary of Responses to Proposed Plan Design Change


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

Provider considerations:

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

Documents attached include:

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

Proposal Title	Network Incentive (R002)	
Health Plan Affected	Defined Benefit Retiree Plan	
Proposed Effective Date	January 1 st , 2020	
Reviewed By	Retiree Health Plan Advisory Board	
Proposal Drafted	October 2018	
Status of Proposal	Under Consideration	

Summary of Current State

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

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

The recognized charge is, with very few exceptions, higher than the negotiated charge, meaning both the plan and the member are paying more for the same service than they would if the service was received through a network provider. Uniquely, the retiree health plan does not differentiate between care received from network providers and non-network providers when paying benefits. Once a member reaches their deductible (\$150/individual, limited to no more than \$750/family) the plan pays a flat 80% coinsurance, regardless of provider status, until the member reaches their annual out-of-pocket limit (\$800/individual).

Objectives

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

Summary of Proposed Change

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

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

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

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

DRAFT-Summary of Responses to Proposed Plan Design Change

Proposed change: Adding a network incentive (R002)

Plans affected: DB Retiree Plan

Reviewed by: Retiree Health Plan Advisory Board

Proposed implementation date: TBD

Review Date: October 30, 2018

Table 1: Plan Design Changes

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

Description of proposed change:

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

Background:

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

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

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

DRAFT-Summary of Responses to Proposed Plan Design Change

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

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

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

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

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

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

Table 1. AlaskaCare Retiree Medical Claims Incurred Calendar Year 2017

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

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

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

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

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

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

Member impact:

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

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

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

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

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

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

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

Actuarial impact:

Neutral / **Enhancement** / Diminishment

Table 2: Actuarial Impact

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

DRB operational impacts:

The Division anticipates minimal operational impacts as follows:

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

² See Attachment A

³ See Attachment A

DRAFT-Summary of Responses to Proposed Plan Design Change

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

Financial impact to the plan:

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

From Segal Consulting Group, Attachment A:

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

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

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

Clinical considerations:

These changes not anticipated to impact any clinical considerations.

Third Party Administrator (TPA) operational impacts:

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

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

Provider considerations:

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

Documents attached include:

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

DRAFT-Summary of Responses to Proposed Plan Design Change

Public Comments	C	Under development
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DRAFT



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MEMORANDUM

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

From: Richard Ward, FSA, FCA, MAAA

Date: October 25, 2018

Re: Coinsurance Change 90%/70% In-Network/Out-of-Network – Focus on Actuarial and Financial Impact for the Retiree Plan (R002)

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

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

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

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

Actuarial Value

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

Financial Impact

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


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

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

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

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

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

Proposal Title	Deductible & Out of Pocket Maximum (R003)	
Health Plan Affected	Defined Benefit Retiree Plan	
Proposed Effective Date	January 1 st , 2020	
Reviewed By	Retiree Health Plan Advisory Board	
Next Review Date	August 7th, 2019	

Summary of Current State

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

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

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

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

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

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

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

Objectives

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

Summary of Proposed Change

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

- Option 1 – Increase deductible by \$50 per individual and the OOP limit by \$100
- Option 2 – Increase deductible by \$150 per individual and the OOP limit by \$300
- Option 3 – Increase deductible by \$500 per individual and the OOP by \$1,000

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

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

	Current	Option 1	Option 2	Option 3
Deductible Individual	\$150	\$200	\$300	\$650
Deductible Family (up to 3x individual)	\$450	\$600	\$900	\$1,950
OOP Individual	\$800	\$900	\$1,100	\$1,800
OOP Family	Unlimited	\$2,700	\$3,300	\$5,400
Actuarial Impact³	None	-0.5%	-1.6%	-4.6%
Plan Savings⁴	None	\$2.9 million	\$9.3 million	\$27.3 million

Proposal Revision History

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

³ Segal Memorandum dated December 10, 2018

⁴ Segal Memorandum dated December 10, 2018

DRAFT-Summary of Responses to Proposed Plan Design Change

Proposed change: Increase deductible and OOP maximum (R003)

Plans affected: DB Retiree Plan

Reviewed by: Retiree Health Plan Advisory Board

Proposed implementation date: TBD

Review Date: ~~December 12, 2018~~ [February 6, 2019](#)

Table 1: Plan Design Changes

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

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

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

Description of proposed change:

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

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

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

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

DRAFT-Summary of Responses to Proposed Plan Design Change

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

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

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

This change could:

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

Background:

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

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

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

¹ Attachment A: Segal Memorandum dated December 10, 2018

² Ibid.

³ Kaiser Family Foundation, 2018 Employer Health Benefits Survey – Section 7: Employee Cost Sharing. Retrieved from <https://www.kff.org/report-section/2018-employer-health-benefits-survey-section-7-employee-cost-sharing/attachment/table-7-9/>

DRAFT-Summary of Responses to Proposed Plan Design Change

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

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

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

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

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

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

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

DRAFT-Summary of Responses to Proposed Plan Design Change

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

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

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

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

Member impact:

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

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

⁵ Page 15, AlaskaCare Retiree Health Insurance Information Booklet.
<http://doa.alaska.gov/dr/p/ghlb/retiree/RetireeInsuranceBooklet2018final.pdf>

DRAFT-Summary of Responses to Proposed Plan Design Change

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

Table 3: Comparison of estimated member impact across options

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

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

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

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

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

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

Actuarial impact:

Neutral / Enhancement / Diminishment

Table 4: Actuarial Impact

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

DRB operational impacts:

The Division anticipates minimal operational impacts as follows:

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

DRAFT-Summary of Responses to Proposed Plan Design Change

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

Financial impact to the plan:

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

Table 5: Financial savings to the health plan

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

Clinical considerations:

These changes not anticipated to impact any clinical considerations.

Third Party Administrator (TPA) operational impacts:

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

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

Provider considerations:

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

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

DRAFT-Summary of Responses to Proposed Plan Design Change

Documents attached include:

<u>Document Name</u>	<u>Attachment</u>	<u>Notes</u>
Segal Memorandum; December 10, 2018	A	

DRAFT



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MEMORANDUM

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

From: Richard Ward, FSA, FCA, MAAA

Date: December 10, 2018

Re: Deductible and Out-of-Pocket Maximum Change (R003) – Focus on Actuarial and Financial Impact for the Retiree Plan - **UPDATED**

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

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

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

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

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

Actuarial Value

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

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

Financial Impact

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

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

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

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

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


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

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

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

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

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

Proposal Title	Enhanced Clinical Review (R004)	
Health Plan Affected	Defined Benefit Retiree Plan	
Proposed Effective Date	January 1 st , 2020	
Reviewed By	Retiree Health Plan Advisory Board	
Proposal Drafted	December 2018	
Status of Proposal	Set Aside	

Summary of Current State

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

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

Objectives

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

Summary of Proposed Change

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

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

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

DRAFT-Summary of Responses to Proposed Plan Design Change

Proposed change: Enhanced Clinical Review for High-Tech Imaging (R004)

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 (R004)

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

Proposal Title	Out-Of-Network Reimbursement (R005)	
Health Plan Affected	Defined Benefit Retiree Plan	
Proposed Effective Date	January 1 st , 2020	
Reviewed By	Retiree Health Plan Advisory Board	
Proposal Drafted	March 2019	
Status of Proposal	Under Consideration	

Summary of Current State

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

Objectives

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

Summary of Proposed Change

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

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

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

DRAFT-Summary of Responses to Proposed Plan Design Change

Proposed change: Determine non-network recognized charge as a percentage of Medicare’s fee schedule (R005)

Plans affected: DB Retiree Plan

Reviewed by: Retiree Health Plan Advisory Board

Proposed implementation date: TBD

Review Date: ~~March 20~~, 2019

Table 1: Plan Design Changes

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

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

Description of proposed change:

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

Background:

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

DRAFT-Summary of Responses to Proposed Plan Design Change

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

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

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

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

When non-network providers and facilities are reimbursed at substantially higher rates than in-network providers, it can be difficult to incentivize providers and facilities to join the network.

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

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

¹ Page 16, AlaskaCare Retiree Health Insurance Information Booklet.
<http://doa.alaska.gov/dr/pd/ghlb/retiree/DBRetireeInsuranceBooklet-01012019.pdf>

DRAFT-Summary of Responses to Proposed Plan Design Change

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

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

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

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

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

Member impact:

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

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

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

DRAFT-Summary of Responses to Proposed Plan Design Change

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

Table 2. AlaskaCare Non-Medicare Eligible Retiree Medical Claims Incurred Calendar Year 2018³

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

Amongst non-Medicare eligible retirees:

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

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

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

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

⁴ Ibid.

DRAFT-Summary of Responses to Proposed Plan Design Change

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

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

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

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

Actuarial impact:

Neutral / Enhancement / Diminishment

Table 2: Actuarial Impact

Actuarial Impact	
Current	N/A
Proposed	N/A

[Actuarial analysis forthcoming.](#)

DRB operational impacts:

The Division anticipates minimal operational impacts as follows:

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

DRAFT-Summary of Responses to Proposed Plan Design Change

Financial impact to the plan:

The financial analysis is forthcoming.

Clinical considerations:

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

Third Party Administrator (TPA) operational impacts:

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


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


Provider considerations:

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

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

Documents attached include:

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

Proposal Title	Telehealth Services (R006)	
Health Plan Affected	Defined Benefit Retiree Plan	
Proposed Effective Date	January 1 st , 2020	
Reviewed By	Retiree Health Plan Advisory Board	
Next Review Date	August 7th, 2019	

1) Summary of Current State

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

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

In 2017, low severity care¹ accounted for 31% (\$237 million) of health care spend across both the AlaskaCare employee and retiree health plans. Low severity care encompasses non-emergency and minimally invasive services. Many Alaska communities do not have an after-hours or Urgent Care option, often necessitating a trip to the Emergency Room. Knowing that telemedicine is becoming an increasing need, convenience and cost-saver, this proposal would incorporate this service in order to increase patient care options for the AlaskaCare members.

2) Objective

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

3) Summary of Proposed Change

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

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

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

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

4) Proposal Revision History

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

DRAFT-Summary of Responses to Proposed Plan Design Change

Proposed change: Expanding Telehealth Services to AlaskaCare Retirees (R006)

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

Reviewed by: Retiree Health Plan Advisory Board

Proposed implementation date: TBD

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

Table 1: Plan Design Changes

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

Description of proposed change:

This proposal would expand access to Teladoc, a telehealth services for members covered under the AlaskaCare defined benefit retiree health plan. Access would be expanded by providing reurrently used by AlaskaCare active employees to the retiree health plan. This proposal would provide 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.

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

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

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

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

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

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

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

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

³ Teladoc Health Presentation dated May 8, 2019

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

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).

⁴ CirrusMD Presentation: Attachment C.

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

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

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

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

Background:

In 2017, low severity 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 Under-65 Dermatology Costs 2017-2018

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

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

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 [source of access point](#) to care.

Actuarial impact: [UNDER DEVELOPMENT](#)

[Neutral](#) / Enhancement / Diminishment

Table 42: Actuarial Impact⁶

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

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

DRB operational impacts:

⁶ Segal Memorandum dated April 19, 2018

DRAFT-Summary of Responses to Proposed Plan Design Change

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

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

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

Financial impact to the plan:

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

~~The savings estimates are under development.~~

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

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

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

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

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

⁷ Segal Memorandum dated April 19, 2018

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

DRAFT-Summary of Responses to Proposed Plan Design Change

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

Table 54: Evaluation of Avoidable, Low-Severity 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.](#)

Clinical considerations:

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

Third Party Administrator (TPA) operational impacts:

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

Provider considerations:





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

Documents attached include:

Document Name	Attachment	Notes
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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

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

DRAFT



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MEMORANDUM

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

From: Richard Ward, FSA, FCA, MAAA

Date: April 19, 2019

Re: Telemedicine – Focus on Actuarial and Financial Impact for the Retiree Plan (R006)

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

Proposal Title	Preventive Services (R007)	
Health Plan Affected	Retiree Defined Benefit Health Plan	
Proposed Effective Date	January 1, 2020	
Reviewed By	Retiree Health Plan Advisory Board	
Proposal Drafted	August 29, 2018	
Status of Proposal	Under Consideration	

Summary of Current State

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

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

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

Objectives

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

Summary of Proposed Change

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

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

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

DRAFT-Summary of Responses to Proposed Plan Design Change

Proposed change: Expanded preventive services subject to network steerage (R007).

Plans affected: DB Retiree Plan

Reviewed by: Retiree Health Plan Advisory Board, Alaska Retirement

Proposed implementation date: January 1, 2019

Review Date: August 29, 2018

Table 1: Plan Design Changes

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

Description of proposed change:

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

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

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

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

DRAFT-Summary of Responses to Proposed Plan Design Change

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

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

“It is unlikely that substantial cost savings can be achieved by increasing the level of investment in clinical preventive care measures. On the other hand, research suggests that many preventive measures deliver substantial health benefits given their costs.

Moreover, while the achievement of cost savings is beneficial, it is important to keep in mind that the goal of prevention, like that of other health initiatives, is to improve health. Even those interventions that cost more than they save can still be desirable. Because health care resources are finite, however, it is useful to identify those interventions that deliver the greatest health benefits relative to their incremental costs.”³

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

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

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

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

³ Ibid.

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

The Division proposes that preventive services would be subject to normal cost-share provisions (annual deductibles, coinsurance, copay and annual maximum out-of-pocket limits, etc.), with the exception that the coinsurance paid by the plan will be reduced by 20% when the preventive care services are provided by an out-of-network provider.

[WBR(1)] Further, those out-of-network expenses will not count towards the annual out-of-pocket maximum.

Table 2: Comparison of Current to Proposed Change

Benefit	Current	Proposed in-network	Proposed out-of-network
Coinsurance / Out-of-Pocket Limits	<ul style="list-style-type: none"> 80% after deductible. (100% after annual out-of-pocket reached.) 	<ul style="list-style-type: none"> 80% coinsurance after deductible. (100% after annual out-of-pocket reached.) 	<ul style="list-style-type: none"> 60% coinsurance after deductible. (Does not apply if no network access) <p>Not subject to the individual out-of-pocket maximum (exception if no network access)</p>

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

DRAFT-Summary of Responses to Proposed Plan Design Change

Benefit	Current Covered Preventive Services	Proposed Covered Preventive Services
Mammograms	<ul style="list-style-type: none"> • One baseline between age 35-40. • One every two years between age 40-50. • Annually at age 50 and above and for those with a personal or family history of breast cancer. 	<ul style="list-style-type: none"> • Biennial screening between age 50-74 • Earlier or additional screenings for those at high risk⁵
Pap Smear	One per year for women 18 years of age and older. Also includes limited office visit to collect the pap smear.	One every 3 years for women age 21 to 65, or every 5 years with a combination of cytology and HPV testing.
Prostate specific antigen (PSA)	<ul style="list-style-type: none"> • One annual screening test for men between ages 35 and 50 with a personal or family history of prostate cancer, • One annual screening test for men 50 years and older. 	The [DRB2] Task Force gave a “C” recommendation to men ages 55 to 69, encouraging them to make an individual decision about prostate cancer screening with their clinician. The Task Force recommends against routine screening for men age 70 and older. ⁶

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

⁶ <https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/prostate-cancer-screening1>

DRAFT-Summary of Responses to Proposed Plan Design Change

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

⁷ <https://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf>
<https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf>

⁸Includes breast cancer, cervical cancer, colorectal cancer, lung cancer, and skin cancer screenings:
<https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/>

⁹ <https://www.hrsa.gov/womens-guidelines/index.html>

DRAFT-Summary of Responses to Proposed Plan Design Change

Member impact:

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

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

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

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

Actuarial impact

Neutral Enhancement Diminishment

Table 3: Actuarial Impact

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

DRB operational impacts:

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

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

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

DRAFT-Summary of Responses to Proposed Plan Design Change

Financial impact to the plan:

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

Segal's analysis looked at 2016 and 2017 medical and pharmacy claims data, and projected to 2019 at 3.0% and 6.0% annual trends respectively. For Medicare member, Medicare covers many of these services, including colonoscopies, at 100%. For these member, no change in utilization is assumed and the impact on the Plan is anticipated to be negligible. The analysis for non-Medicare members focused on the approximate 20,000 members between age 50 and 65.¹²

Clinical considerations:

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

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

Third Party Administrator (TPA) operational impacts:

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

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

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

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

¹² *Ibid.*


DRAFT-Summary of Responses to Proposed Plan Design Change

Provider considerations:

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

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

Documents attached include:

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

MEMORANDUM

To: Ajay Desai, Director, Division of Retirement and Benefits
From: Richard Ward, FSA, FCA, MAAA
Date: July 25, 2018
Re: Preventive Care Benefits – Focus on Actuarial and Financial Impact for the Retiree Plan (R007)

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

- One pap smear per year for all women age 18 or older. Charges for a limited office visit to collect the pap smear are also covered.
- Prostate specific antigen (PSA) tests as follows:
 - One annual screening PSA test for men between ages 35 and 50 with a personal or family history of prostate cancer, and
 - One annual screening PSA test for men 50 years and older
- Mammograms as follows:
 - One baseline mammogram between age 35 and 40
 - One mammogram every two years between ages 40 and 50, and
 - One annual mammogram at age 50 years and above, and for those with a personal or family history of breast cancer.

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

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

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

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

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

Actuarial Value

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

Financial Impact


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

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

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

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

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

Proposal Title	Lifetime Maximum (R008)	
Health Plan Affected	Defined Benefit Retiree Plan	
Proposed Effective Date	January 1 st , 2020	
Reviewed By	Retiree Health Plan Advisory Board	
Next Review Date	August 7th, 2019	

1) Summary of Current State

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

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

2) Objectives

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

3) Summary of Proposed Change

The proposed change would eliminate the lifetime maximum limit.²

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

4) Proposal Revision History

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

¹ As a retiree plan, the AlaskaCare retiree plan is exempt from this ACA provision.

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

DRAFT-Summary of Responses to Proposed Plan Design Change

Proposed change: Increasing or removing the lifetime maximum (R008)

Plans affected: DB Retiree Plan

Reviewed by: Retiree Health Plan Advisory Board

Proposed implementation date: January 1, 2019

Review Date: July 26, 2018

Table 1: Plan Design Changes

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

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

“The maximum lifetime benefit for each person for all covered medical expenses is \$2,000,000.

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

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

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

¹ <http://doa.alaska.gov/drb/pdf/ghlb/retiree/RetireeInsuranceBooklet2003with2018amendment.pdf>

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

DRAFT-Summary of Responses to Proposed Plan Design Change

- 3) Increase the overall actuarial value of the health plan by 0.40%; and
- 4) Increase annual plan expenditures by an estimated \$2,700,000.³

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

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

Background:

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

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

Member impact:

WHO IS IMPACTED-

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

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

³ Attachment A: *Removal of the Retiree Plan Lifetime Maximum*, Segal Consulting memo dated July 25, 2018.

⁴ As a retiree plan, the AlaskaCare retiree plan is exempt from this ACA provision.

⁵ A member could be termed for several reasons including death, loss of coverage due to lack of premium payment if they are not eligible for premium-free health benefits, or loss of coverage through divorce or other special circumstances.

DRAFT-Summary of Responses to Proposed Plan Design Change

Table 2: Overview of current member lifetime accumulators – 2018⁶

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

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

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

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

- 1) Medicaid- for those who meet certain eligibility or income thresholds.⁷
- 2) Federally Facilitated Marketplace (e.g. “Individual market”)- members may qualify for participating in the special enrollment period; but the regulations are unclear in this specific circumstance and the \$5,000 reinstatement creates complexity for members requiring special approval and/or review.

Alaska Comprehensive Health Insurance Association⁸ – this has been a resource for some members who have reached their lifetime maximum, but premiums range depending on age with an individual who is 60 years of age paying \$3,089 per month for a plan with \$1,000 deductible to \$1,153 per month for a plan with a \$15,000 deductible.⁹

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

⁶ Summarized from an Aetna report from June 29, 2018.

⁷ Alaska Department of Health and Social Services [DHSS], Division of Public Assistance, Medicaid Eligibility Standards: http://dpaweb.hss.state.ak.us/POLICY/PDF/Medicaid_standards.pdf

⁸ Alaska Comprehensive Health Insurance Association [ACHIA]: <http://www.achia.com/premiums.asp>

⁹ ACHIA 2018 Monthly Individual Premiums Rates: <http://www.achia.com/docs/PPO%20ACHIA%202018%20Premium%20Rates%20rev11.10.2017.pdf>

DRAFT-Summary of Responses to Proposed Plan Design Change

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

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

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

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

Actuarial impact

Neutral Enhancement Diminishment

Table 2: Actuarial Impact

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

Note: The claims data was not a credible source for the analysis, given the relatively small number of occurrences. For this reason, Segal used the Apex Actuarial Rate Modeling System¹¹, calibrated to account for the current membership demographics, geography and overall cost structure to determine the impact of removing the lifetime maximum.

DRB operational impacts:

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

¹⁰ Attachment A: *Removal of the Retiree Plan Lifetime Maximum*, Segal Consulting memo dated July 25, 2018.

¹¹ The Apex Actuarial Rate Modeling System provides comprehensive plan design and rate modeling capabilities, and is widely utilized throughout the industry by consulting actuaries.

DRAFT-Summary of Responses to Proposed Plan Design Change

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

Financial impact to the plan:

Based on a preliminary retiree claims projection of \$680,000,000 for 2019, the anticipated fiscal impact is estimated to be approximately \$2,700,000 or 0.4% in additional annual costs.¹²

Clinical considerations:

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


Third Party Administrator (TPA) operational impacts:

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

Provider considerations:

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

Documents attached include:

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

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

MEMORANDUM

To: Ajay Desai, Director, Division of Retirement and Benefits
From: Richard Ward, FSA, FCA, MAAA
Date: July 25, 2018
Re: Removal of the Retiree Plan Lifetime Maximum (R008)

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

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

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

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

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

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

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


Therefore, we utilized the Apex Actuarial Rate Modeling System¹ to determine the impact of removing the lifetime maximum. Apex indicates that removing the maximum will increase the Plan's actuarial value by 0.40%. The model was calibrated to account for the current membership's demographics, geography and overall cost structure. Our results are representative of the average anticipated increase for a typical year under typical circumstances.

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

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

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

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

Proposal Title	Rehabilitative Care (R009)	
Health Plan Affected	Defined Benefit Retiree Plan	
Proposed Effective Date	January 1 st , 2020	
Reviewed By	Retiree Health Plan Advisory Board	
Proposal Drafted	July 2018	
Status of Proposal	Under Consideration	

Summary of Current State

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

Objectives

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

Summary of Proposed Change

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

The proposed benefit change will cover rehabilitative care received from an in-network provider without a visit limit, and cover chiropractic care received from an in-network provider without a visit limit. Removing the limit will reduce the requirement for claim chart note review and allow for maintenance and preventive therapies of chronic conditions. The proposed benefit will continue to have a visit limit on rehabilitative and chiropractic care received from an out-of-network provider. However, the limit amount will be increased and an option to reset the visit count at the start of each benefit year will be added. If care is received from an out-of-network provider, the member would be provided up to 45 visits per benefit year for outpatient rehabilitative care, and up to 20 visits for chiropractic care. The out-of-network provider visit limits would reset at the start of each benefit year.

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

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

DRAFT-Summary of Responses to Proposed Plan Design Change

Proposed change: ~~Fixed Visit Cap on Coverage of~~ Treatment of Spinal Disorders, Acupuncture and Physical/ Occupational/Speech Therapy (R009)

Plans affected: DB Retiree Plan

Reviewed by: Retiree Health Plan Advisory Board, Alaska Retirement **Proposed**

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

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

Table 1. Plan Design Changes

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

Description of proposed change:

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

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

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

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

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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

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

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

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

The proposed change would benefit change will:

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

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

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

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

The proposed change would also provide coverage for:

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

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

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

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

Table 2: Comparison of Current to Proposed Change

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

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<p>Information Booklet, as amended</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 statement to the claims administrator outlining the goals of therapy, type of program, and frequency and duration of therapy.</p>
<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="text-align: center;">...</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.
<p>Proposed</p>	<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 Outpatient benefits are limited to 45 visits per benefit year. Covered expenses include charges made by a physician on an outpatient basis for physical therapy, occupational therapy and speech therapy. Inpatient services will be covered under inpatient hospital and skilled nursing facility benefits.</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>

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

Chiropractic

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

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

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

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

Acupuncture

Covered expenses are limited to 10 visits per benefit year.

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

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

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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.

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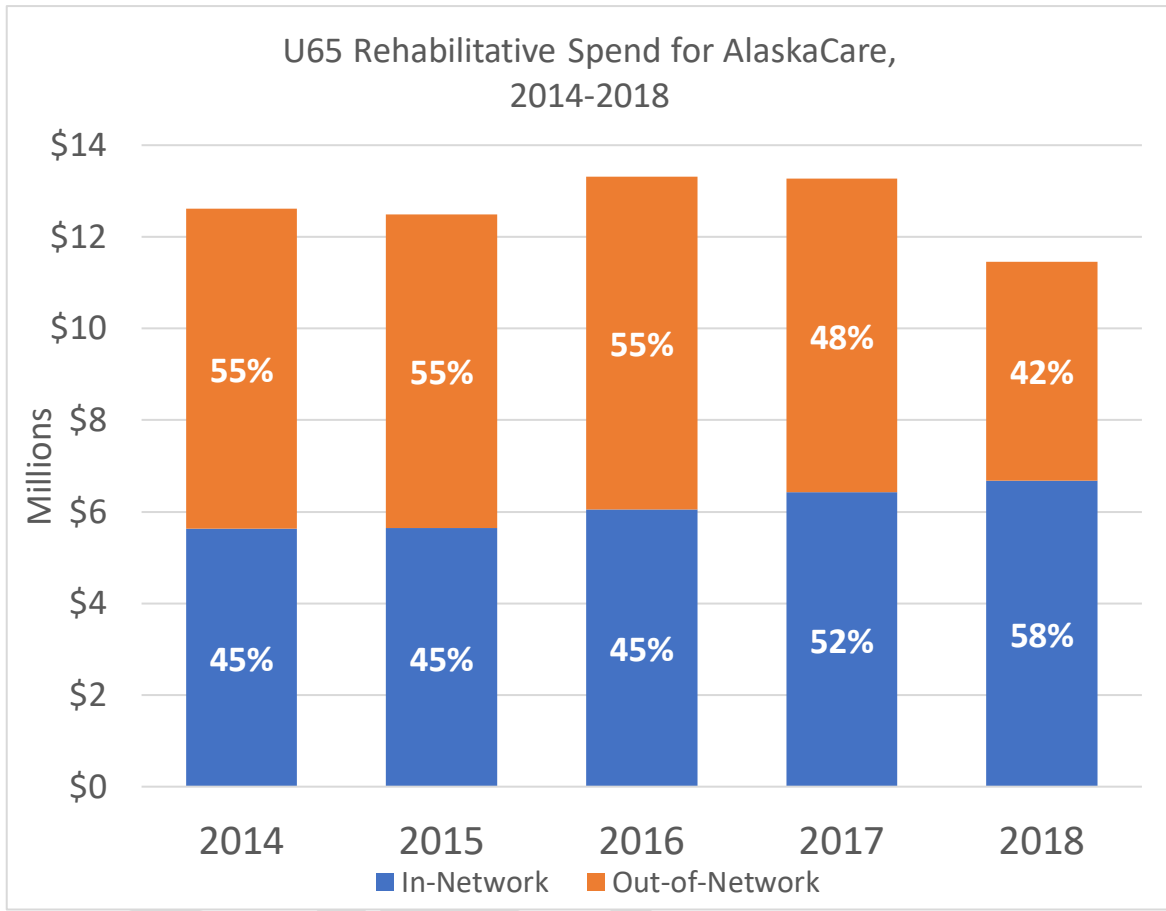
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Table 3: Rehabilitative Care Spend in AlaskaCare for Non-Medicare Retirees



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%.

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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.

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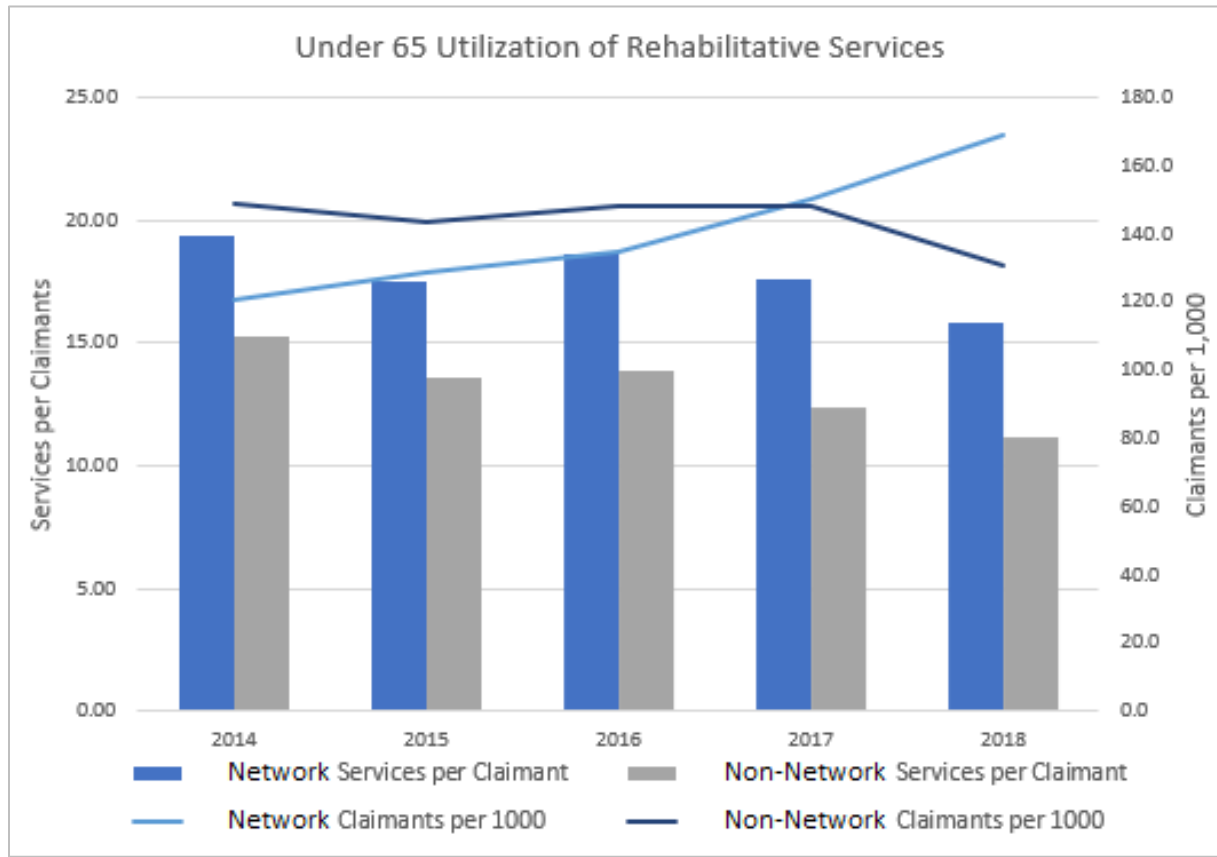
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Table 4: Rehabilitative Care Spend in AlaskaCare for Non-Medicare Retirees



Member Impact:

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

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

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

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

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

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

Neutral / Enhancement / Diminishment



Table 3: Actuarial Impact

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

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

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

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

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

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

DRB operational impacts:

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

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

Table 4, Estimated Savings

Proposed Change	Estimated Annual Financial Impact⁵
10 visit-limit for acupuncture	\$ 65,000 in additional cost
10 visit limit for rolf therapy	\$ 30,000 in additional cost
20 visit-limit for chiropractic	\$120,000 in savings
45 visit-limit for rehabilitative care	\$300,000 in savings

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

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

Clinical considerations:

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

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


Third Party Administrator (TPA) operational impacts:

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

Provider considerations:

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

Author: ~~Michele Michaud~~ [Division of Retirement and Benefits](#)

~~September 26, 2018~~ [May 8](#) [June 12, 2019](#)

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



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MEMORANDUM

To: Ajay Desai, Director, Division of Retirement and Benefits
From: Richard Ward, FSA, FCA, MAAA
Date: September 26, 2018
Re: Therapy Benefits (R009) – 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.

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

Proposal Title	Over the Counter Equivalent Drugs (R010)	
Health Plan Affected	Defined Benefit Retiree Plan	
Proposed Effective Date	January 1 st , 2020	
Reviewed By	Retiree Health Plan Advisory Board	
Proposal Drafted	July 2018	
Status of Proposal	Set Aside	

Summary of Current State

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

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

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

- Brand-Name Prescription (40mg): \$500 for a 90-day supply
- Generic Prescription (40 mg): \$287 for a 90-day supply
- OTC Equivalent (20mg, can be taken twice): \$19.80 for 90ct⁴, \$39.60 for 40mg, 90-day equivalent.

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

Objectives

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

Summary of Proposed Change

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

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

³ p. 70, <http://doa.alaska.gov/drb/pdf/ghlb/retiree/DBRetireeInsuranceBooklet-01012019.pdf>

⁴ Safeway, Kroger, Carrs, Walmart) with manufacturer coupon

DRAFT-Summary of Responses to Proposed Plan Design Change

Proposed change: Removing Coverage of OTC-Equivalent Drugs (R010)

Plans affected: DB Retiree Plan

Reviewed by: Retiree Health Plan Advisory Board

Proposed implementation date: TBD

Review Date: April 23, 2019

Table 1: Plan Design Changes

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

* The financial impact varies between the two proposed options

Description of proposed change:

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

Option A

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

Option B

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

Both Options:

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

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

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

Background:

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

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

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

- Brand-Name Prescription (40mg): \$500 for a 90-day supply
- Generic Prescription (40 mg): \$287 for a 90-day supply
- OTC Equivalent (20mg, can be taken twice): \$19.80 for 90ct³, \$39.60 for 40mg, 90-day equivalent.

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

Member impact:

Option A

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

¹ The means of drug comparison in both proposals are lifted from the FDA

² p. 70, <http://doa.alaska.gov/dr/pd/ghlb/retiree/DBRetireeInsuranceBooklet-01012019.pdf>

³ Safeway, Kroger, Carrs, Walmart) with manufacturer coupon

DRAFT-Summary of Responses to Proposed Plan Design Change

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

Option B

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

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

Actuarial impact:

Neutral / Enhancement / Diminishment - Forthcoming

Table 2: Actuarial Impact

Actuarial Impact	
Current	
Proposed	

DRB operational impacts:

Options A & B

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

DRAFT-Summary of Responses to Proposed Plan Design Change

Financial impact to the plan:

Option A

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

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

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

A full financial analysis is forthcoming

Option B

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

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

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

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

A full financial analysis is forthcoming.

DRAFT-Summary of Responses to Proposed Plan Design Change

Clinical considerations:

Options A & B

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

Third Party Administrator (TPA) operational impacts:

Options A & B

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

Provider considerations:

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



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MEMORANDUM

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

From: Richard Ward, FSA, FCA, MAAA

Date: July 25, 2018

Re: Coverage for Medications Available Over-the-Counter (R010) – Focus on Actuarial and Financial Impact for the Retiree Plan

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

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

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

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

Actuarial Value

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

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

Financial Impact

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

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


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

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

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

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

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

Proposal Title	Three-Tier Pharmacy Benefit (R014)	
Health Plan Affected	Defined Benefit Retiree Plan	
Proposed Effective Date	January 1 st , 2020	
Reviewed By	Retiree Health Plan Advisory Board	
Proposal Drafted	April 2019	
Status of Proposal	Under Consideration	

Summary of Current State

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

Objectives

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

Summary of Proposed Change

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

Tier 1: Generic Drugs – lowest cost tier

Generic medications are therapeutically, and often chemically, identical to brand medications and are widely available at competitive prices.

Tier 2: Preferred Brand-Name Drugs – slightly higher cost tier

Preferred brand-name drugs are brand-name medications for which a generic option is not available.

Tier 3: Non-Preferred Brand-Name Drugs – highest cost tier

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

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

DRAFT-Summary of Responses to Proposed Plan Design Change

Proposed change: Implement Three-Tier Pharmacy Benefit (R014)

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.

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

DRB operational impacts:

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

Actuarial Impact

Neutral / Enhancement / Diminishment

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

Financial Impact to the plan:

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

Clinical considerations:

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

⁴ Ibid.

DRAFT-Summary of Responses to Proposed Plan Design Change

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

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

Third Party Administrator (TPA) operational impacts:

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

Provider considerations:

The impact to providers is anticipated to be minimal. Providers may receive additional inquiries from patients about the 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:

<u>Document Name</u>		<u>Notes</u>
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 (R014)– 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
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