Retiree Health Plan Advisory Board
Meeting Agenda

Date:	Thursday, November 5, 2020
Time:	9:00am – 12:15pm
Location:	Video Teleconference Only
Teleconference:	Conf #: 855-244-8681 ID#: 133 999 8275 Password: 353 36 754 Online Public Notices Join meeting
Committee Members:	Judy Salo (chair), Lorne Bretz, Joelle Hall, Dallas Hargrave, Paula Harrison, Cammy Taylor, and G. Nanette Thompson

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9:00 am Call to Order – Judy Salo, Board Chair

- Roll Call and Introductions
- Approval of Agenda
- Approve Previous Meeting Minutes
- Ethics Disclosure

9:10 am Public Comment

9:20 am Department & Division Update

- New IRMAA Process (Page 21)
- 2021 Plan Booklet Draft (Page 23)
- DVA Open Enrollment

9:30 am Medicare Advantage RFI - Segal (Page 29)

10:30 am Break

10:45 am Prior Authorizations for High Cost Specialty Drugs - OptumRx (Page 41)

11:45 am Public Comment

12:00 pm Final Thoughts

- Discuss Board Seats/Election Planning
- Next meeting: Thursday February 4, 2021
- 2021 Meeting Calendar

12:15 pm Adjourn

https://aws.state.ak.us/OnlinePublicNotices/Notices/View.aspx?id=199470

Retiree Health Plan Advisory Board

Board Meeting Minutes

Date: Thursday, September 3, 2020 9:00 a.m. to 2:30 p.m.

Location: Virtual meeting via teleconference and WebEx only

Meeting Attendance

Name of Attendee	Title of Attendee	
Retiree Health Plan Advisory Board (RHPAB) Members		
Judy Salo	Chair	Present
Cammy Taylor	Vice Chair	Present
Lorne Bretz	Member	Present
Joelle Hall	Member	Present *joined at 10:45 a.m.
Dallas Hargrave	Member	Present
Paula Harrison	Member	Present
Nan Thompson	Member	Present
State of Alaska, Department of Administration Staff		
Ajay Desai	Director, Division of Retirement + Benefits	
Emily Ricci	Chief Health Administrator, Retirement + Benefits	
Betsy Wood	Deputy Health Official, Retirement + Benefits	
Teri Rasmussen	Program Coordinator, Retirement + Benefits	
Andrea Mueca	Health Operations Manager, Retirement + Benefits	
Steve Ramos	Vendor Manager, Retirement + Benefits	
Mike Gamble	Member Liaison, Retirement + Benefits	
Erika Burkhouse	Assistant Vendor Manager, Retirement + Benefits	
Others Present + Members of the Public		
Kevin Dilg	State of Alaska, Department of Law	
Amy Speakman	OptumRx (pharmacy third party administrator)	
Stephanie Gaffney	OptumRx (pharmacy third party administrator)	
Nicole Utley	OptumRx (pharmacy third party administrator)	
Richard Ward	Segal Consulting (contracted actuarial)	
Noel Cruse	Segal Consulting (contracted actuarial)	
Quentin Gunn	Segal Consulting (contracted actuarial)	
Anna Brawley	Agnew::Beck Consulting (contracted support)	
Brad Owens	Retired Public Employees of Alaska (RPEA)	
Sharon Hoffbeck	Retired Public Employees of Alaska (RPEA)	
Wendy Woolf	Retired Public Employees of Alaska (RPEA)	
Margaret Duggan	Retired Public Employees of Alaska (RPEA)	
Hal Homer	Retiree / public member	
Mauri Long	Retiree / public member	
Martin Fornataro	Segal Consulting (contracted actuarial)	

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
- CMO = Chief Medical Officer
- CMS = Center for Medicare and Medicaid Services
- COB = Coordination of Benefits
- COVID-19 = Novel Coronavirus Disease (identified 2019), also known as SARS-CoV-2
- 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
- MA = Medicare Advantage, a type of Medicare plan available in most states
- 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.
- PMPM = Per member per month, a feature of capitated or managed-care plans
- 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

Meeting Minutes

Item 1. Call to Order + Introductory Business

Chair Judy Salo called the meeting to order at 9:00 a.m. A quorum was present.

New Board Members

- **Paula Harrison**: Paula retired from the Matanuska-Susitna School District 13 years ago, has been involved in labor relations for several years; chair of the Alaska Labor Relations Agency. She lived for a long time in the Mat-Su region, and currently lives in Anchorage.
- **Lorne Bretz**: Current member of the Alaska Retirement Management Board (representing this seat on RHPAB). He currently lives in Wasilla. He looks forward to helping the Division smoothly administer the plan.

Approval of Meeting Agenda

Materials: Agenda packet for 9/3/20 RHPAB Meeting

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

Approval of Previous Meetings' Minutes

Materials: Draft minutes from the previous (5/27/20) RHPAB Meeting.

- **Motion** by Cammy Taylor to approve May 27, 2020 meeting minutes. **Second** by Nan Thompson.
    - **Discussion**: None.
    - **Result**: No objection to approval of minutes. Minutes are approved.

Ethics Disclosure

Judy Salo requested that Board members state any ethics disclosures in the meeting and reminded members of the disclosure form available from staff, to keep any necessary disclosures on file.

No disclosures were stated by members.

Item 2. Public Comment

Materials: Public comment guidelines beginning page 19 in 9/3/20 meeting packet.

Before beginning public comment, the Board established who was present 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

- **Brad Owens, RPEA**. He requested to hold his comments until the end of the meeting.
- **Hal Homer, Palmer**. Hal stated that he is a Tier 1 PERS retiree. He is unhappy with the health insurance he receives through state retirement and has talked to other retirees with similar concerns. He went for his yearly physical and was surprised to learn that it was not covered by the retiree plan. The plan also does not cover colonoscopies. He believes that the coverage he anticipated having under this plan is not what he has today. He also stated that his wife, also a PERS retiree, cannot find a primary care provider in their community who will accept Medicare.
- **Mauri Long**. Mauri stated she was previously a member of the Retiree Health Plan Advisory Board. As a member of the public, she intends to stay directly involved in the board's work and discussions regarding changes to the retiree plan.

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

Materials: Presentation beginning page 20 in 9/3/20 meeting packet

Emily Ricci and staff provided several updates:

COVID-19 Response

The Division has extended temporary telemedicine coverage expansions until the end of the Alaska public health disaster emergency. The temporary expanded coverage is consistent with Medicare and many other payers. Telemedicine was already anticipated to be a significant new way to receive and provide care, and COVID-19 has made this more of a necessity and more common. The Division will continue to monitor the latest information about the pandemic and communicate with retirees about any additional temporary changes or extensions of benefits.

AlaskaCare has also extended temporary coverage of influenza (flu) shots for retirees, which are not normally covered. The State is strongly recommending retirees get the flu shot, particularly this year, as it will assist with reducing strain on the health care system. The Division plans to widely outreach and communicate about how to get the vaccine. The Division is also looking ahead to when a COVID-19 vaccine is available and starting to make plans about distribution and coverage of the new vaccine. While specifics are not yet available, when a vaccine is available, there will need to be concerted effort to distribute this safely and widely, particularly for retirees.

Health Fair Update

As a result of the COVID-19 pandemic, the Division has opted to not participate in health fairs this year, because of concerns about risk of exposure at a large in-person event. Flu shots are temporarily 100% covered under AlaskaCare, provided they are administered at a network pharmacy and not a doctor's office. Standard cost sharing applies when administered at a doctor's office.

- Judy Salo asked whether flu shots are available now?

- Emily responded most places do not yet have flu vaccine available, it is early in the typical seasonal cycle, but it will depend on the location (state, region). However, the CDC and others are recommending getting the vaccine earlier than normal this year, in September when it is available, and to not wait until the end of the year. It is especially important this year to vaccinate against flu. The Division will share information when the vaccine is more available, how to get it, and how to ensure it is covered.

- Judy asked whether there will be a difference between Medicare vs non-Medicare coverage?
  - Emily responded Medicare is primary for those enrolled in Medicare, so a flu shot administered at a doctor's office would be considered a doctor visit and covered first by Medicare. If a person goes to a network pharmacy, it will be covered by AlaskaCare, regardless of Medicare coverage. If the flu shot is administered at a doctor's office for someone who is not Medicare enrolled, this would be covered under standard cost-sharing. The Division is encouraging everyone to go to a network pharmacy to ensure it is 100% covered under the plan.

EGWP and IRMAA Update

Emily shared that the Division is making changes to the reimbursement process for the Income Related Monthly Adjustment Amount (IRMAA) – a surcharge assessed by the Centers for Medicare & Medicaid Services (CMS) for Medicare Part D (prescription drug) coverage to high-income individuals (at least $87,000 for an individual, or $174,000 for a household of two or more). The Division adopted the Employer Group Waiver Plan (EGWP) for pharmacy benefits in 2019, and covers IRMAA surcharges for high-income retirees, but cannot pay IRMAA surcharges directly to CMS. Therefore, the Division instituted a Health Reimbursement Arrangement (HRA) account to reimburse retirees in an amount equal to their IRMAA surcharge, provided retirees submit the required paperwork demonstrating they are subject to this surcharge. This surcharge is determined based on two years' prior income, which is why it is important to submit paperwork every year as people's situations change from year to year. The current process is time consuming for staff and can be frustrating for members. Staff have been seeking alternatives to the current manual and time intensive process to make the process easier and free up staff capacity.

Andrea Mueca shared that beginning in 2021, the Division has partnered with OptumRx to provide this service and automate it to the extent possible: members who are enrolled can submit their paperwork and fill out an online form to begin receiving reimbursement. The retiree can upload the Medicare paperwork online or continue to submit on paper, and OptumRx will verify eligibility and initiate the reimbursement process. The Division will communicate about this new method in multiple ways, including e-newsletters, at the monthly Tele Town Halls, on the website and via a letter mailed to all members currently receiving IRMAA reimbursement to provide information about these changes and how to submit for reimbursement via OptumRx by the new method. Staff are very excited to partner with Optum to provide this service, and to significantly reduce the demand on staff time to manually process the IRMAA documents for members.

Emily reminded that this change will be implemented for 2021 and is not available yet. The Division will communicate with retirees when this change is made and when the new process is available. Letters containing members' 2021 IRMAA amounts will begin to arrive from Social Security / Medicare in November and December.

To learn more, see the Division's website: search "IRMAA" to find the page with current information.

- Paula Harrison asked whether retirees have the option to opt out of the EGWP plan?
    - Emily responded yes; members may opt out of the plan. Depending on the reason they are opting out, they may have access to a different plan. If they have other Medicare Part D coverage already, they will be placed in the non-EGWP standard retiree prescription benefits for retirees who are not Medicare eligible. Members who do not have other Medicare Part D coverage and opt out of the AlaskaCare EGWP are placed into a different plan with higher co-pays and more cost sharing. The rationale for this alternative plan: the EGWP plan represents the same benefits that retiree members have had, and also represents significant cost savings to the plan for the additional subsidies available to the State by participating in this plan. Emily offered to provide background information to the new Board members about EGWP, why the decision was made, and financial savings that have accrued to date.
- Paula asked when the opportunity to opt out occurs?
    - Emily shared that the timeline is annual, but also depends on when the member becomes eligible for Medicare. If a member opts out, and it takes a period of time to make this change, the member still has access to benefits in an alternative plan to ensure no loss of coverage.

Staff Announcement

Betsy Wood shared that she will be on maternity leave beginning in October 2020! She will be out for several weeks (anticipating returning to work early January, or possibly late December) and will not be participating in the next RHPAB meeting in November. In her absence, Teri Rasmussen will cover her duties and continue to be the primary point of contact for the Board.

Update on Potential Benefit Changes

Anticipated New Option: Second Opinion for Surgeries and Other Procedures

Emily shared that staff are researching options for retirees to access a second opinion for a complex diagnosis, or potentially a serious surgery. After understanding options, staff will develop objectives and priorities for providing this kind of service, and how members can access this benefit if they are in the situation of making a significant decision regarding treatment. Because members live across the U.S., it is complicated and needs to include options for people in Alaska and across the U.S.

- Judy Salo asked staff to provide documentation about previous discussions by the Board about this topic, including SurgeryPlus services and other discussion about this issue.
    - Staff will follow up and provide background documents to the new members.

Medicare Advantage Option

Betsy shared that staff are in process of drafting a Request for Information (RFI) requesting responses from potential vendors who could offer a Medicare Advantage Plan, and what that could look like. (This is not a full procurement for services or RFP, but truly a request for information to help the Division in gauging the market's interest in and ability to offer a Medicare Advantage Plan). The Division will release the RFI shortly and anticipates having some more information—depending on response of interested vendors—to share at the November RHPAB meeting. This information can provide a clearer basis for any future decisions regarding potential implementation of Medicare Advantage plans for retirees.

Emily provided context for this potential change: as part of the modernization project, the Division and the Board have been exploring ways to provide benefits for retirees such as preventive care and other

benefits not currently covered in the plan. She also noted that the Division is deeply aware of issues Medicare eligible members face when seeking primary care, as many providers do not accept Medicare, and a Medicare Advantage plan could be a way to expand access for members. Other requests for benefits such as the Silver Sneakers program could be met by a Medicare Advantage plan. Because the AlaskaCare retiree plan represents a large portion of covered lives in Alaska and elsewhere, there is potential for this to be feasible; there are no current Medicare Advantage plans offered in Alaska. The Division will continue to explore this issue and provide updates on their findings from the RFI.

Item 4. Plan Year 2021 Open Enrollment

Dental, Vision and Audio (DVA) Plan Update

Proposed Regulation Changes

Betsy shared that last year, the Division offered a choice of two dental plans as part of the overall DVA plan, implemented for the 2020 plan year. Open enrollment will be opening again soon this year, for eligible retirees to choose the Standard or Legacy dental plan. Currently there is a public notice for regulation change; draft regulations and instructions for submitting public comments is included in the meeting packet. Comments can also be provided verbally via a teleconference meeting on Wednesday, September 9, as well as in writing (mail, e-mail).

Emily provided a summary of the regulation changes:

- Allows for members to increase or decrease coverage for themselves and dependents (including spouse and others). Staff were concerned about the implications of adverse selection, i.e. choosing a lower plan, and increasing. The Division consulted with the benefit consultant and health actuary and determined that given the annual benefit maximums in the plan, the impacts of these choices would be minimal and not sufficient to require restricting it. This allows for subscribers to elect different coverage tiers within the plan from year to year to best reflect their current family demographics.
- The Division also considered the fact that some benefits, such as Audio benefit maximums, stretch over a 36-month period, which can be impacted if the member disenrolls in the plan and re-enrolls. Example: spouse participates in the plan Year 1, drops coverage in Year 2, then re-enrolls Year 3. The intent is for the plan not to “reset” the benefit maximum for Year 3, but to consider it over the entire rolling 36-month period as detailed in the plan. Aetna, who administers this benefit has confirmed that they are able to track the audio benefit maximums for dependents, even if they are on the plan one year, off the plan the next, and back on the plan the third year.
- As a reminder, state statute allows coverage of eligible dependents in the retiree plan up to 23 years. The retiree plan is exempt from portion of the Affordable Care Act provision which requires coverage up to age 26. The regulation changes allows the Division to proactively take steps to disenroll a dependent from DVA coverage if the Division becomes aware that a dependent no longer meets eligibility requirements.
- Betsy added that retirees who are dual covered by multiple AlaskaCare retirement plans, must choose the same plan (Legacy or Standard) under all of their coverage. The member can still select different tiers under the plan (for example, higher coverage under one plan than the other) but must be within one of the two plan options.

- Also clarifies the definition of "family structure change" to not only include a "first" child but also adoption or birth of any child.
- Also clarifies that a person covered under multiple plans can still make changes to their original DVA coverage—for example, if a member is already retired under PERS and has DVA coverage, then later retires under TRS, they can make changes to their PERS DVA plan at the time of their TRS retirement.

Emily concluded by thanking retirees and members of the public for submitting comments and for staying involved. She welcomed comments on these proposed regulation changes, in whatever format members prefer, detailed on the public notice.

- Cammy Taylor asked the rationale for requiring a person to opt into the same DVA plan for dual coverage?
    - Emily responded staff considered whether this is feasible to coordinate multiple plans for the same member and worked with DVA administrators to determine if it is feasible. However, there are too many administrative challenges to offer coverage under the two different plans for the same member/household, so they concluded it is not feasible.
    - Cammy thanked staff for their work, and appreciates retirees having more options through this decision.
- Judy asked about the process for approving regulations changes, and how it is different than statutory change?
    - Emily responded the Commissioner is the administrator of the plan, so unlike other regulations, the adoption of DVA regulations occurs when the Commissioner of Administration signs the changes, rather than the Lieutenant Governor, who signs most other regulations. Regulations are reviewed by Division staff as well as Department of Law, and subject to a public comment process unless adopted as emergency regulations. Most parts of the process are similar. Statutory changes are ultimately the purview of the Legislature, but changes recommended by the executive branch have an internal review process as well, including the Department or Division of origin and Department of Law. The level and process of review varies by administration, but essentially follows the same process. The Legislature also follows a process of discussing and voting on proposed legislation, regardless of whether it was introduced by the governor or filed by a legislator or legislative committee. The process is similar across state government.
- Judy followed up: what is the process for making a recommendation or initiating a potential statute or regulation change. She noted the modernization project has highlighted some potential law changes or regulation changes, and the Board would need to know next steps if any of these were brought forward as actual recommendations.
    - Emily responded the process is similar across departments and can be initiated by staff to begin an internal review process. She noted that one advantage of regulations being subject to approval by the Commissioner allows for clearer understanding of the purpose and impact of the regulation change, and potentially less delay than requiring signature by the Lt. Governor, which can be a lengthy process. This allows the Division to be responsive to regulatory issues and needs.

Open Enrollment Period

Betsy shared an overview of the open enrollment process for the DVA 2021 plan year:

DVA Open Enrollment begins Tuesday, October 20 (the day after Alaska Day, a state holiday) and closes Wednesday, November 25, 2020. This ensures staff will be available and working during opening day. Open enrollment this year will be passive: that is, if retirees take no action, they will remain enrolled in the same plan as this year. If a retiree would like to make a change to their plan, they will need to take action during this period. Retirees are also welcome to re-affirm participation in the same plan using the same process, but do not need to do this if they do not want to make changes to their enrollment.

Staff are finalizing enrollment materials including the website for enrollment, paper forms, and other information such as the benefit comparison table to illustrate choices. There are no significant changes to the actual plan benefits, so the choice is the same as last year. The process is the same as last year.

Andrea added the website will also include the ability for retirees with multiple retirements and multiple DVA coverages to make elections specific to each of their coverages. The Division will communicate with retirees before and throughout the enrollment process (see page 26 of packet for the timeframe and key dates). Retirees will receive a mailing in advance of open enrollment sharing their options; can attend a dedicated Tele Town Hall about enrollment; and will receive a series of reminder e-mails, e-newsletter articles, and additional postcards. Staff will also be available to assist retirees via phone to ensure members can get enrolled.

Emily asked Board members to comment whether the communications plan is sufficient, or if members feel there should be additional mailings or information? She noted that increasing mailed materials (such as the benefit comparison and enrollment guide) has an additional cost, but that this is an option to ensure members receive the information they need to make a choice.

- Judy commented she finds the comparison table useful, will this be mailed out to members, and available online? She understands the materials will be online, like last year.
    - Emily noted that the plan is not currently to mail out this table, but that it is a useful reference and helpful to have a hard copy. She and staff will determine whether and when this could be mailed.
- Cammy asked whether it is possible to determine which retirees do not already have e-mail or online access, and mail only to these retirees?
    - Emily responded this is not currently feasible, particularly as it involves figuring out eligibility as well as whether they have an e-mail address in the system already. She noted that Ajay Desai is leading a multi-year effort to upgrade and modernize the Division's computer system, which will allow for more automation and systems such as those banks use regarding preferred communications (e.g., paper statements versus electronic statements). They are not ready to implement yet but anticipate that in the next 3-5 years these kinds of functions will finally be available to the Division, and retirees. At that point, communications with retirees can be much more tailored.
- Judy asked whether there will be FAQs available online?
    - Emily responded yes; these will be online, consistent with last year. There are already a number of FAQs maintained on the website, for the DVA plan and other topics.

Emily also noted staff intend to make targeted updates to the plan booklet following adoption of the final version of the regulation changes, to ensure it is aligned with current regulations. Plan booklet changes will be limited to what is necessary for the regulation changes.

Emily further noted that staff are also ensuring that call center staff and all Division staff fielding calls will have detailed information available in advance of open enrollment, to ensure that everyone has the information they need to share back with members. However, they are not ready yet; a person calling the Division today will only be able to get the same information shared in this meeting. Please be patient and wait until more information is available, so that staff are fully informed and can answer members' questions! Staff are preparing to provide this information before starting full-scale communications about this topic.

The Board took a 20-minute break at 10:25 a.m., and returned to the meeting at 10:45 a.m.

Premium Rates for Plan Year 2021

Materials: Presentation beginning page 27 in 9/3/20 meeting packet

Emily provided an overview of the rates discussion generally: this includes premium rates for the medical plan—which is covered by the State for most retirees, but not all—as well as rates for the Dental, Vision and Audio (DVA) plan and Long Term Care (LTC) plan, both of which are supplemental plans that retirees opt into and are funded directly by member premiums, unlike the medical plan. Additionally, Emily reminded the group that the Commissioner sets rates and has authority to do so, but input and feedback is sought from the Board and retirees generally about rates. The presentation and discussion will likely focus on DVA plan rates, and to a lesser extent medical and LTC rates.

Emily invited Richard Ward to present an overview about rates:

Overall, premiums are payments made toward the insurance plan, to cover the cost of payments/claims made to cover care under that plan. The goal is to balance covering the long-term costs of this plan with ensuring the premiums are not higher than needed to be, to cover costs. It is similar to the funding of a pension plan: members typically pay premiums for a long period of time and may not utilize the same level of benefit until potentially years later, particularly for LTC.

Another goal is to minimize or smooth out rate changes over time: rate increases or decreases are periodically needed to ensure the plan remains adequately funded against the costs incurred over time, but it is best to avoid sharp increases and decreases over time (e.g., 5% decrease one year, 15% increase the next year). Planned, modest changes to plan rates over several years are a best practice for minimizing disruption to members and the plan.

One significant impact to all health care plans, and the entire health care industry (as well as all other sectors) is COVID-19, meaning the pandemic was obviously not anticipated in advance, but has had widespread impacts on every health plan and employer providing coverage. Richard underscored that there were multiple significant impacts—the direct impacts of COVID-19 to health, but also sudden changes to benefits (such as new temporary expanded coverage of telehealth, COVID testing and related services) and mandates that restricted non-emergency care to preserve the capacity of the health care system to respond to the pandemic and minimize non-essential interaction to prevent the spread of the disease. (See page 30 for details). As a result, there was a significant drop-in routine care, either canceled or deferred appointments, and is likely to have a corresponding increase or bump in care as people seek out care they deferred or canceled. This requires projecting additional future impacts to the

plan over the next year or more and will impact the rate decisions—in many ways, 2020 is a major outlier.

Medical Plan Rates

Typically, there are minimal year to year adjustments, as the medical plan has remained the same for more than 20 years in most aspects. Out of 60,000 retirees covered under the medical plan, only about 150 to 160 employees pay premiums directly. Other retiree premiums are funded by contributions from relevant employers and the State. Therefore, the premiums for the medical plan are determined according to this small number of retirees' required contributions. However, this year (for plan year 2021) adjustments in the actuarial assumptions need to be made to reflect COVID-19 impacts.

Richard provided an overview of projected medical and pharmacy claims, as well as projected subsidies (rebates, federal payments) for the EGWP and RDS pharmacy plans. The table below is excerpted from page 31: this includes assumptions that a small number of retirees opt out of EGWP.

- Segal projects the following financial results for Calendar Year (CY) 2021:

	2021
Total Projected Claims	$633,211,578
Administration and Operational Expenses	$28,964,200
Pharmacy Contract Renegotiation/RFP	($5,100,000)
Rx Rebates	($59,200,000)
EGWP/RDS Subsidy	($57,360,000)
Total Projected Cost	$540,515,778
Premium Based Revenue*	$590,708,520
$$ Funding Overage/(Gap)	$50,192,742
% Funding Overage/(Gap)	9.3%
Est. IBNR Liability As Of Dec 31, 2021	$53,349,000

* Medical/Rx revenue is based on all participants at the Retiree composite rate (as counts by Tier II/Tier III rate tiers were not available) x 12. Retirees that pay premiums pay these rates. State and Employer contributions are payroll based.

Based on these assumptions, there is an estimated overage of approximately $50 million. This can be attributed to the fact that more retirees continue to become eligible for Medicare, which shifts some of the costs of care to Medicare as the primary plan, and offsets the degree of cost to the plan and the fact that as people age, their health care costs typically go up. Rates were reduced 10% for the 2020 plan year, reflecting a consistent trend of an overage (more revenue than expenditures). Even with this rate decrease, there is a projected overage in 2021 for the medical plan.

- Cammy commented she and the Board are interested in tracking the share of retirees who are become Medicare eligible—she noted that a large number of people in the age 61-70 cohort becoming Medicare eligible, and also a number of new members who are already age 65 and eligible. She is interested in seeing a year-to-year projection of who will become eligible for Medicare, and anticipates a large cohort in the near future, with smaller cohorts going forward with retirements going forward. She recommends this as a topic for the next meeting, with the relevant analysis prepared.
    - Richard agreed this is a relevant trend to monitor: he noted that more people are retiring later, meaning there will be a trend of fewer pre-Medicare retirees relative to past trends. People are also living longer, so retirees will remain in the system longer, including when covered by Medicare.

Based on the projection, maintaining the same premium amount will result in an overage in 2021. Considering a modest (5%) decrease in rates, which provides some relief to the small number of retirees who are subject to the premiums, still projects an overage, but by a smaller amount. A larger decrease could be warranted but should be considered against the possibility costs go significantly up in 2021, when an increase again would be necessary to compensate. Segal therefore recommends only a modest decrease of 5% (if any), or also suggests considering no changes for this year, given the level of uncertainty with COVID-19 expenditures and impacts, which will continue into 2021. Either scenario would be a prudent balancing of the need to fund the plan against the significant uncertainty of the pandemic into the foreseeable future.

Emily noted that staff's preliminary recommendation is to consider the 5% premium reduction for 2021, which will benefit the small number of members who pay premiums, with a low level of financial risk to the plan even in the current uncertain environment. She invited comment from Board members.

Dental, Vision and Audio Plan Rates

Hearing no comment, Richard continued:

For the Dental, Vision and Audio (DVA) plan, Richard noted that the 2020 implementation of two dental plan options and introduction of the Legacy plan (with benefits consistent with the plan in place prior to 2014) required changes in the projections for future premiums. When recommending rates for 2020, Segal used modeling from the performance of the Standard plan and assumptions based on the number of people who enrolled in either plan. At that time, the Standard plan was the default plan and used for primary modeling, for those who do not take action to opt into either plan. When the default plan changed to the Legacy plan near the planned end of the 2019 open enrollment period, this impacted the share of retirees assumed to be in that plan versus the other. Therefore, Segal's estimates for 2020 did not fully match the actual enrollment and performance of the plan for these two options, given the changes midstream when projecting costs for that future year.

He noted that generally, rates would increase if the costs of the plan outpace the premiums collected to fund the plan; rates would decrease if the costs grow or are reduced compared to the premiums collected. The preference is to keep premium rates stable, with only small and periodic changes to rates year to year. He also noted that the DVA plan is well reserved, meaning it can absorb an increase in costs without necessarily requiring an immediate increase in rates.

For 2020 year to date, expenses are below normal levels due to COVID-19, reflecting deferred or canceled routine care or people not utilizing benefits to the degree they would in a normal situation. He provided a personal example: he has canceled both of his routine dental cleanings for 2020, as he is in general good oral health and does not want to have unnecessary risk, so his case is one of canceled care. Others appear to be making similar choices, based on the reduction in claims/services. However, this also requires accounting for a "bump" in claims for projections when people do feel confident and safe seeking routine care, which could occur in 2021 depending on the developments in COVID-19, and an effective treatment and/or vaccine that will significantly reduce the level of risk in the current environment.

Based on Segal's projections, there is a projected gap of $4.1 million, with an increase in projected claims over 2020 levels, if no change to 2020 premiums. This would be a 7.9% gap between collected revenues (premiums) and projected costs. He also noted that there would be an approximately $3.96 million "incurred but not realized" (IBNR) liability, meaning, costs incurred in the 2021 plan year but not

filed or finalized in the system until months later, a typical lag for health care claims. This is also factored into estimated total cost of the plan per year. IBNR is used to calculated estimated targeted funding year to year, with a goal of ensuring there is approximately 1.5 to 2.5 times the IBNR rate, to ensure there is sufficient reserve funding to cover these claims, before future premiums can be collected.

Page 36 provides an illustration of a 3.5% increase, reflecting ongoing increases in the cost of care (inflation/trends in cost increases for providers and services). Premium rates have not changed for the Standard plan since 2017. The increase in costs and revenue gap will require an increase of premiums at some point, to close the "burn rate" between revenue and expenditures. Waiting to close this gap would require sharper increases in a given year, or a higher increase over several years later. Therefore, Segal recommends consideration of a modest increase in 2021 or 2022, to smooth out the curve of necessary future increases, and manage the gap before it continues to grow. It is not necessary to make up the funding gap in one year, but to illustrate the point: closing this gap in one year would represent a one-time 12% increase, which is steep.

Segal therefore projects that a rate increase will be required in the near future, whether in 2021 or the following plan year, to anticipate the need to close the funding gap and best practice to do so over time, not in a single year. Richard noted that this will need to be revisited each year, regardless of the decision this year, as it is something to monitor year to year and adjust as needed.

Another option could be a "premium holiday" (page 39) which allows for temporary relief to retirees (i.e., they would not be responsible for 1 month's premium) without impacting the long-term rates. Segal calculated that a one-month premium holiday would represent $4.1 million less revenue.

Emily added for context: this has been requested to be considered for the retiree plan and is being offered in some other states for other insurance plans (such as car insurance). The Division investigated this option and found that it would be very logistically challenging and difficult to communicate to retirees who are used to automatic deduction of premiums. Therefore, staff do not recommend this option and believe it would be very difficult to do but wanted to understand the implications. Richard added that in other states / plans who have made this decision, it has been difficult to roll out operationally and for example, run into issues such as members paying the premium that month anyway and how to account for this.

- Judy commented she also understands issues with this idea and could see where retirees might get confused about whether the reduction or suspension of premiums is permanent.
    - Richard agreed, communications for this group are complex, he can see that this would require a multi-channel effort to let retirees know about this change and that it is temporary in nature.
- Cammy asked for clarification about the impacts to the overall assets in the plan for this change, based on the projection graphic on page 38?
    - Richard confirmed that this would mean a sharper slope of net assets (higher spend-down) between 2020 and 2021. The plan still has higher assets currently than is needed for current expenses, but the gap still exists.

Emily added that several years ago in the employee health plan, significant rate increases were needed to make up the gap between revenue and expenses, and the Division is anxious to avoid this situation for retiree members. Additionally, she noted that there is no significant past data on claims for the Legacy plan, which has not been offered after 2013. Going forward more data will be available, but in

the meantime the Division recommends a cautious, conservative approach to avoid large future increases. Emily shared that the Division recommends maintain rates in 2021, closely monitoring the timing and size of the "bump" in care and the new plan experience, and revisit this discussion next year, looking ahead to 2022, 2023 and 2024, when rate increases may be necessary in at least one of those years to make up the anticipated gap.

- Lorne Bretz asked Richard: given the goal to smooth rate changes, did the actuarial methodology change significantly since the baseline done in 2019? Is it consistent?
    - Richard responded there has been a projected burn rate in previous years' projections, and the assumptions are mostly consistent with prior years, with the noted changes above. However, the expected burn rate is been higher than prior projections due to COVID impacts, and he noted that the data associated with the pandemic will be so significantly different that it will be a large outlier and shouldn't drive long-term projections. The expected deferral and changes in care will also be short term and shouldn't drive long-term assumptions. This will be an industry-wide issue in making appropriate projections.
    - Lorne commented that he anticipates wanting to have, at least in this situation, a shorter-term view in terms of smoothing out rate changes and to not over-react in what changes are needed or committing to long-term future changes.

Emily posed to the group: what timeframe (by what period of years, or by what year) should we target for achieving that ideal range of funding the plan at the target 1.5-2.5 IBNR rate? it would be helpful to have a time target as well as threshold target, to aim for changes to rates, knowing that expenses will increase over time but that a sudden increase in rates (e.g., over one year only) would not be desirable for the plan or the members.

- Judy asked Richard for a recommendation of what the timeframe should be.
    - Richard recommended having some analysis of options would be useful, showing the implications of the different timeframes, from one year to several years. This would help inform discussion and any decision about a target timeframe.
- Dallas Hargrave whether the Board has been involved in premium rate setting in the past?
    - Emily commented that the Board has not been involved in the past, the rates have not been changed since 2017. The Board has heard an educational presentation about rate setting in a recent prior meeting, and the Division would like the Board to advise on the best approach for maintaining the long-term health of the plan. The Board is not a decision-making body but can provide an advisory opinion, as it does for other aspects of administration of the retiree plan.

Emily restated that the Division recommends no DVA premium increase in 2021, but to have robust discussion about how to approach this in the next year(s). She also noted that dental plan rates need to be finalized soon, well before the next quarterly meeting, before open enrollment begins. It would be helpful to have further discussion in this meeting by the Board, to inform the Division and Commissioner's decision regarding 2021 rates for this plan.

The Board decided to continue discussion of this item after the lunch break.

The Board took a 1-hour lunch break at 12:00 p.m., and returned to the meeting at 1:00 p.m.

The Board returned to the meeting. A quorum was present.

- Judy asked whether a smaller annual decrease in rates would be considered, rather than a one-month premium holiday? To explore all possible options.
    - Richard responded that typically the rate changes are looked at as a range, as a small percentage difference may not be significant, versus a change and no change.
    - Emily directed the group to page 39 re: premium holiday: having a smaller decrease over all 12 months in a plan year, versus a one-time holiday in one month, would have the same impact to the overall assets. She also noted that it would cause a more difficult situation in 12 months, needing to address a larger gap.
- Judy clarified that she was asking about a smaller degree of increase over time, rather than the proposed one-month increase.
    - Richard noted that it would result in a gap larger than the projected 8% with baseline numbers. If a premium decrease occurred at half of the total one-month holiday (if each month is 8% of the total, then 4% reduction across 12 months would be the same). This would result in a 12% gap over time, due to lower revenue collection.
- Lorne asked about the apparent discrepancy in the fact that the net assets remain high compared to expenses for FY16-now, versus the reduction?
    - Richard commented this reflects the increase in costs over time, and projected IBNR: this needs to increase over time, with a certain amount to be built in to cover future expenses. As these increases go up over time, and the larger number of members in the plan, the large amount of net assets in the plan are still being spent down but will not continue on the trend of being in excess of the need.
    - Emily added that the Division has not developed a target regarding the timeframe over which to move toward that target. The Division is using the range of 1.5 to 2.5x IBNR as the target they use to manage the medical plan; they are open to defining the range in a different way, but not necessarily anything below the 1.5x IBNR they use as a the minimum for the medical plan.
- Judy recommended this be further discussed at the next meeting.
    - Emily noted that premiums for 2021 need to be set prior to the next quarterly meeting: this discussion for the next plan year should happen today if the Board wishes to provide input. The Board will continue discussion about target setting next meeting.
    - Emily stated the Division recommends keeping DVA plan rates for 2021 at the same rate as 2020, and to plan on addressing the gap in a rate increase likely in 2022.
    - Richard noted his recommendation is to not entertain a decrease in rates this year but keep the rates flat for an additional year (same as 2017-2020).
- Judy noted she understands the timeline for this year but would like the Board to have more time prior to August 2021 to have a larger discussion, and recommend this be planned for the February 2021 meeting to lead into 2022 planning.
- Dallas commented that using as much plan data for the current benefit year as possible is helpful for planning for the next benefit year; he suggests that it should benefit from more data, and the more recent the better.
    - Richard commented that is typically true, but COVID impacts on the data will likely continue through 2021, so it would be difficult to rely on this data for long term planning, and the claims through the rest of this year will also be outliers.

- Nan Thompson commented that she understands uncertainty will continue for several months and certainly into the next year, so she recommends that if the plan is in the position to sustain the same rate level and not increase this year, this seems like a prudent way to proceed in this uncertainty. She would support keeping the 2021 rates as is.
- Dallas commented that the City and Borough of Juneau uses a different method, about 2-3 months of expenses compared with 2-3 months of revenue but comes to a similar conclusion. He suggested that using this methodology might be useful in the short term, in addition or instead, for this period at least.

Long Term Care Plan Rates

Richard presented information about rates for the Long Term Care (LTC) plan: he noted that unlike the other plans (medical and DVA), benefits are typically not paid out for members' care until years or even decades after they have made payments year to year. LTC benefits are more like a pension plan, as they are utilized primarily when someone has a significant change in health and ability to live independently, so expenditures do not match the premiums collected that year necessarily. It requires projecting out over a longer time period, what members will utilize in the life of their enrollment in the plan (and life overall), versus year to year claims like the DVA and medical plan.

The Division reviews rates on a bi-annual (2 year) basis and makes adjustments to rates accordingly. Currently the plan is in a good position, with assets above projected need in the short term; there will be a gap in the future, but this will unfold over time and will require ongoing monitoring. Projecting needs for this plan will require the same considerations of unusual/outlier data due to COVID-19, but this has less impact year to year given the long-term nature of this plan and the projections. Currently, Segal recommends that the Division maintain the 2019 rates for the next 2-year period, given the current health of the fund, and revisit rates next time when that data is available.

- Dallas asked what further input or recommendations staff would like from the Board?
    - Emily confirmed the discussion has been helpful. Since this is the first year the Board has been involved in this process, there is no set process or ask for a recommendation, but it is appreciated. Going forward, the Division will put forward a more formal outline for Board recommendations.

- **Motion** by Lorne Bretz to adopt the Division's recommendations as presented regarding 2021 rates for the medical, DVA and LTC plans: 1) 5% premium reduction for members who pay premiums for the medical plan; 2) no change from 2020 to DVA plan rates, with potential future change in 2022; and 3) no change to LTC plan rates. **Second** by Dallas Hargrave.
    - **Discussion**:
        - Lorne stated he believes immediate changes are not needed at this time, he understands the Division and Board will revisit this in the future.
        - Dallas agreed, and recommended generally following the advice or recommendation of actuarial experts and Division staff.
    - **Result**: The board voted to approve the motion. Motion approved.

Bretz	Hall	Hargrave	Harrison	Salo	Taylor	Thompson
Yes	Yes	Yes	Yes	Yes	Yes	Yes

Item 5. COVID-19 Overview: Vaccines, Treatments, and the Future

Materials: Presentation beginning page 45 in 9/3/20 meeting packet

Emily provided an overview for the presentation: The federal government began planning for COVID-19 vaccine distribution as early as November 2020. Plans and insurance companies across the country are working to prepare. Vaccines are initially likely to be available only on a limited basis, depending on supply and speed of distribution, and likely to be prioritized for vulnerable populations, including older people and those with underlying conditions. There is already a great deal of information being shared around about vaccines, so it will also be difficult to determine what is accurate or definitive in terms of options available and what plans need to do to prepare. This is informational, from a clinical perspective, to provide context and education in advance of those future discussions. Emily invited Amy Speakman, a pharmacist with OptumRx, to present.

Amy introduced herself and noted that OptumRx is closely tracking developments and how this will impact their customers, including AlaskaCare members. She gave an overview of the coronavirus overall, noting that the virus has a series of surface "spike proteins" that can enter a cell via ACE2 receptors. It enters the cell and then reproduces in the cell and elsewhere in the body. The body's immune response seeks out the virus, envelopes the virus and flags it for other cells (T-helper cells) to evaluate it and determine if it is a part of the body or an invasive agent and needs to destroy it. Then the T cell destroys infected cells to eliminate the virus. B cells also coat the virus with antibodies to neutralize the virus's ability to enter other cells, and then also destroys it. Unfortunately, recovering from COVID-19 does not, so far, seem to result in long-term immunity: the long-lived B and T cells can "remember" this virus as they do with other viruses, but currently these do not last long in the body and therefore do not represent long-term immunity, compared with the long-term immunity associated with other diseases after getting sick.

There are many types of vaccines being explored, in four general categories:

1. Inactivated or weakened virus introduced in the body, one of the oldest vaccine methods.
2. Viral vector, using another type of disease with COVID-19 proteins. This is similar to a new Ebola vaccine and a common approach in gene therapy as well.
3. Nucleic acid (DNA, RNA) of coronavirus proteins. Because it involves genetic material only, it is safe and easy to develop, but has not been used for a vaccine to date and is unproven.
4. Protein-based (injecting coronavirus directly), the most common method being pursued.

The common denominator is to introduce a lower level of the virus/proteins to allow the body to develop a strong immune response and remember the virus for a longer period of time, preventing re-infection. Pages 50-54 illustrate each type of vaccine. Page 55 illustrates the various targets of treatments or medications:

1. Blockade of entry. This was considered promising but has not been effective.
2. Blockade of replication. This seems to be the most promising route in testing to date.
3. Promoting innate immune response. Not very promising to date, compared with other options.
4. Enhancers of innate immune response. This has been somewhat promising, less than #2.

Current efforts to develop and eventually distribute a vaccine are underway. Operation Warp Speed, a U.S. public/private partnership working to accelerate vaccine development, involves multiple agencies and firms. The FDA guidance states that the vaccine needs to be 50% more effective than the placebo to

be approved for general use. There are approximately 22 vaccines in human trials, with many more in earlier stages. For treatment, Remdesivir has promising early results and seems to have reduced mortality risk, and tests include length of treatment duration as well as efficacy. It is being tested via compassionate use for COVID patients. Dexamethasone is also being tested for recovery and has so far reduced mortality for patients on ventilators or requiring oxygen. Hydroxychloroquine and chloroquine have also been tested, but large trials have stopped due to other risks or side effects.

Other considerations related to the pandemic and the pharmaceuticals world: OptumRx is not currently experiencing shortages of other medications, but this has been a general concern. They and other companies are investing in their supply chain to minimize any disruptions to others' medications needs. They continue to monitor and plan for problems, including shortages of critical medications.

In the meantime, following basic public health guidelines to minimize or prevent the spread of the disease are important including: washing hands, wearing a mask or face covering in public, staying home if you have symptoms or feel sick, maintain social distancing, and reading any information with a critical eye to ensure it is accurate. As the medical field works to develop a viable vaccine and treatment, the public can continue to mitigate mortality and morbidity by taking other steps to protect health.

Emily thanked Amy for the presentation, and commented it is exciting to be planning ahead for an eventual vaccine and treatment plan, a significant improvement from a few months earlier.

The board had no further comments, and thanked Amy for the information.

Item 6. Public Comment, Continued

Chair Judy Salo reminded the public of the comment guidelines and invited members of the public to provide additional comment.

No members of the public were present in the meeting to provide comment.

Item 7. Closing Thoughts + Meeting Adjournment

Next Meetings

- Judy confirmed that the next meeting will be November 5, likely virtual only. She invited Board members to make comments about how to improve meeting operations, and noted that Board members can suggest agenda items, now or via e-mail. She noted that one agenda item: election of the board chair, the position she currently holds, and vice chair. She encouraged all members to consider whether they are interested in putting forward their name.
- Page 60 includes a tentative schedule for 2021 quarterly meeting dates, as well as the quarterly meetings with the health plan vendors to review plan trends and performance.
    - Thursday, February 4, 2021
    - Thursday, May 6, 2021
    - Thursday, August 5, 2021
    - Thursday, November 4, 2021

  No comment from board members on the dates. The Board will revisit the proposed dates in November and formally adopt them for the 2021 schedule.
- Judy recommended a shorter lunch break on the agenda for online meetings, since people do not need to leave lunch. This will allow for more efficient meetings, and still providing breaks.

Closing Thoughts

- Welcome again to Paula and Lorne!
- Board members thanked everyone for an effective meeting and looking forward to meeting the new members in person, when possible!

- **Motion** by Nan Thompson to adjourn the meeting. **Second** by Dallas Hargrave.
    - **Result**: No objection to adjournment. The meeting was adjourned at 2:02 p.m.

The next Retiree Health Plan Advisory Board meeting is planned for November 5, 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/drb/alaskacare/retiree/advisory.html.

THE STATE of ALASKA
GOVERNOR MIKE DUNLEAVY

Department of Administration
DIVISION OF RETIREMENT AND BENEFITS
6th Floor State Office Building
333 Willoughby Avenue
P.O. Box 110203
Juneau, AK 99811-0203
Phone: (907) 465-4460
Toll-Free: (800) 821-2251
FAX: (907) 465-3086
Alaska.gov/drb

October 26, 2020

«AddressBlock»

Re: Changes Coming in 2021 to the IRMAA Reimbursement Process

Dear
We have exciting news regarding the 2021 Income Related Monthly Adjustment Amount (IRMAA) reimbursement process! The Division of Retirement and Benefits (Division) is partnering with OptumRx and Optum Bank to create a more efficient way for members to receive reimbursement.

What is IRMAA? Certain high-income retirees are required to pay an extra IRMAA surcharge for being enrolled in the AlaskaCare Employer Group Waiver Program (EGWP) prescription drug coverage. If you are subject to the IRMAA surcharge, the Division will reimburse you for the full amount through a tax-advantaged Health Reimbursement Arrangement (HRA) account.

What do you need to know?

- Beginning in 2021, OptumRx and Optum Bank will handle IRMAA reimbursements. Instructions on how to set up your HRA account are on the second page of this letter.
- PayFlex will continue to process any IRMAA reimbursements for 2020 that are submitted before December 15, 2020.
- You need to set up your HRA account every year, since IRMAA surcharges are based on your annual income and your income may change from year to year.
- If you are not assessed a 2021 IRMAA surcharge this does not apply to you.

How do I know if this impacts me?

Please review the table below to see if your income qualifies you to be assessed an IRMAA surcharge based on your Modified Adjusted Gross Income (MAGI) from the 2019 tax year

2021 IRMAA Amounts

Individual MAGI	**Household MAGI**	**2021 Monthly IRMAA Surcharge**
Less than or equal to $87,000	Less than or equal to $174,000	Not assessed a surcharge
Greater than $87,000 and less than or equal to $109,000	Greater than $174,000 and less than or equal to $218,000	$12.20
Greater than $109,000 and less than or equal to $136,000	Greater than $218,000 and less than or equal to $272,000	$31.50

Individual MAGI	Household MAGI	2021 Monthly IRMAA Surcharge
Greater than $136,000 and less than or equal to $163,000	Greater than $272,000 and less than or equal to $326,000	$50.70
Greater than $163,000 and less than or equal to $500,000	Greater than $326,000 and less than or equal to $750,000	$70.00
Greater than $500,000	Greater than $750,000	$76.40

How to Set Up Your 2021 IRMAA Reimbursement with OptumRx:
OptumRx will handle all your 2021 IRMAA needs. You may submit your documents early to OptumRx if you have them available.

Follow these steps to establish your 2021 IRMAA HRA account **online**:

1. Register and/or log in to your OptumRx.com account either online or through the mobile app.
2. Navigate to forms by clicking on the "Information Center" tab on the Navigation bar at the top, select "Programs and Forms", then click on “IRMAA HRA Enrollment Form”.
3. Complete the online IRMAA HRA Enrollment Form.
4. Upload as an attachment a copy or image of your letter from Social Security or a Medicare Bill that shows what your 2021 Part D IRMAA surcharge will be.
5. OptumRx will confirm your eligibility and set up your Health Reimbursement Account (HRA).
6. Once your HRA has been created, Optum Bank will send you a Welcome Packet.
7. Log in to optumbank.com to view your HRA account status/balance or to sign up for Direct Deposit. Your banking information that may be with PayFlex **cannot** be transferred on your behalf to Optum Bank.

If you have any questions on how to submit your documents online or if you do not have internet access and would like to submit paper documentation, please contact OptumRx at (855) 409-6999.

Remember: The deadline to receive reimbursement for the 2020 Part D IRMAA is March 31, 2021. For steps on completing your 2020 IRMAA reimbursement please visit our IRMAA webpage at doa.alaska.gov/drb/alaskaCare/retiree/information/IRMAA.

For further assistance, please contact the Division of Retirement and Benefits Member Services Center at doa.drb.benefits@alaska.gov or at 1-800-821-2251 (907-465-4460 from Juneau).

Sincerely,

The AlaskaCare Health Team

AlaskaCare Retiree DB Insurance Information Booklet

The table below outlines updates made to the AlaskaCare Retiree DB Insurance Information booklet effective January 1, 2021. The updates were primarily in response to DVA Regulation changes, the CARES Act and a Letter of Agreement with MEBA.

Legend:	Items highlighted in green were added.
	Items highlighted in yellow were updated
	Items highlighted in orange were removed.

Summary of Updates for Plan Year 2021

2021 Plan Booklet Language	2020 Plan Booklet Language
Section 3.3.25 COVID-19 Testing and Vaccinations ☑ New section added to clarify plan coverage of COVID-19 testing and vaccinations per the CARES Act. 3.2.25 COVID-19 Testing and Vaccinations **COVID-19 Testing** The medical plan will cover medically necessary, FDA approved COVID-19 testing at 100%, subject to recognized charge. **COVID-19 Vaccinations** The medical plan will cover FDA approved COVID-19 vaccinations at 100%, subject to recognized charge.	n/a
Section 4.3.5 Covered Vaccines ☑ Moved Covered Vaccine information from under 4.3.4 Premium Surcharge to its own new section 4.3.5. ☑ Added COVID-19 Vaccine coverage information per CARES Act. **Medicare Part D-Eligible Vaccines** The pharmacy benefits under the Plan cover	Section 4.3.4 Premium Surcharge COVERED VACCINES The pharmacy benefits under the Plan cover

some vaccines regardless of whether you are eligible for Medicare. Covered vaccines are listed in the formulary available at AlaskaCare.gov under the therapeutic drug class "viral vaccine". Vaccines covered under the pharmacy plan are those that fall on the Medicare Part D covered vaccine list that are: a) Vaccines administered at the pharmacy. b) Vaccines administered in a doctor's office only if they coordinate with a pharmacy to bill the Plan for the entire cost of the vaccination, including the injection of the vaccine. c) If you receive a vaccination in a doctor's office that does not coordinate with a pharmacy, your provider will bill you for the entire cost of the vaccination. You will have to pay the entire bill up front and request reimbursement from the pharmacy benefits manager. It is important to know that your provider may charge you more than the recognized charge amount for the vaccination, but your plan will only reimburse up to the approved amount. You will be responsible for any amount you pay the provider above the recognized charge. Vaccines that are not covered by the Plan include: a) Influenza vaccines (flu shots), including seasonal flu vaccine and the H1N1 (swine flu) vaccine. b) Pneumococcal vaccine (pneumonia shot). For a complete list of vaccines and participating pharmacies contact the	some vaccines regardless of whether you are eligible for Medicare. Covered vaccines are listed in the formulary available at AlaskaCare.gov under the therapeutic drug class "viral vaccine". Vaccines covered under the pharmacy plan are those that fall on the Medicare Part D covered vaccine list that are: a) Vaccines administered at the pharmacy. b) Vaccines administered in a doctor's office only if they coordinate with a pharmacy to bill the Plan for the entire cost of the vaccination, including the injection of the vaccine. c) If you receive a vaccination in a doctor's office that does not coordinate with a pharmacy, your provider will bill you for the entire cost of the vaccination. You will have to pay the entire bill up front and request reimbursement from the pharmacy benefits manager. It is important to know that your provider may charge you more than the recognized charge amount for the vaccination, but your plan will only reimburse up to the approved amount. You will be responsible for any amount you pay the provider above the recognized charge. Vaccines that are not covered by the Plan include: a) Influenza vaccines (flu shots), including seasonal flu vaccine and the H1N1 (swine flu) vaccine. b) Pneumococcal vaccine (pneumonia shot). For a complete list of vaccines and participating pharmacies contact the

pharmacy benefit manager 24 hours a day, 7 days a week or visit the Division's website at *AlaskaCare.gov*. **COVID-19 Vaccines** The pharmacy benefits under the Plan will cover FDA approved COVID-19 vaccinations at 100%, subject to recognized charge.	pharmacy benefit manager 24 hours a day, 7 days a week or visit the Division's website at *AlaskaCare.gov*.
Section 5. Medical Expenses Not Covered ☑ Removed bullet 25.	~~Any treatment, drug (excepting hormones and hormone therapy) and, service or supply related to changing sex or sexual characteristics, including: surgical procedures to alter the appearance or function of the body, and prosthetic devices~~.
Section 7.1 Introduction ☑ Removed the plan year so that this section does not need to be updated each year. The State, through appropriate action of the Commissioner of Administration, is offering two (2) dental plan options under the voluntary Dental-Vision-Audio Plan ("Plan"): the Standard Dental Plan and the Legacy Dental Plan.	**Section 7.1 Introduction** The State, through appropriate action of the Commissioner of Administration, is offering two (2) dental plan options under the voluntary Dental-Vision-Audio Plan ("Plan") ~~for the 2020 plan year. The dental plan options for the 2020 plan year are~~ the Standard Dental Plan and the Legacy Dental Plan.
Section 7.2.1 Benefit Recipients ☑ Updated section (b) per 21-BB-031 Letter of Agreement with MEBA. (b) People receiving a benefit from the Marine Engineers Beneficial Association (MEBA) who retired from the State of Alaska after July 1, 1983. If coverage is elected, the DVA premiums are paid to the plan on a monthly basis through the direct bill administrator - PayFlex.	**Section 7.2.1 Benefit Recipients** (b) People receiving a benefit from the Marine Engineers Beneficial Association (MEBA) who retired from the State of Alaska after July 1, 1983. If coverage is elected, the premium is paid annually by the member.

Section 7.3 How to Elect Coverage ☑ Added per 2 AAC 39.210 A benefit recipient with multiple retirement accounts may elect dental-vision-audio insurance under each retirement account. If a benefit recipient elects coverage under multiple retirement accounts, different coverage tiers may be elected for each separate account so long as the same plan option is elected for all accounts.	n/a
Section 7.4.2 Open Enrollment ☑ Updated the section title.	Section 7.4.2 Open Enrollees
Section 7.4.4 Dependents ☑ Updated language to include all qualifying events. If you increase your coverage to include dependents following a qualifying life event or a qualified change in family structure, their coverage begins on the first of the month following receipt of your written request, assuming the level of coverage you elect covers the new dependent.	Section 7.4.4 Dependents If you increase your coverage to include dependents following marriage or birth of a child, their coverage begins on the first of the month following receipt of your written request, assuming the level of coverage you elect covers the new dependent.
Section 7.5.1 Failure to Pay Premium ☑ Updated section (b) per 21-BB-031 Letter of Agreement with MEBA. Coverage ends at the end of the month in which you fail to pay the required premium. If at any time your benefit check is insufficient to pay the monthly premium, you may pay the premium directly to the claims administrator. You forfeit your right to participate in the plan if a premium payment	Section 7.5.1 Failure to Pay Premium Coverage ends at the end of the month in which you fail to pay the required premium. If at any time your benefit check is insufficient to pay the monthly premium, you may pay the premium directly to the claims administrator. You forfeit your right to participate in the plan if a premium payment

is delinquent by more than 60 days, or the premium payments are delinquent twice in any one calendar year by more than 31 days. Contact the Division of Retirement and Benefits for more information. MEBA members pay premiums to the plan on a monthly basis through the direct bill administrator - PayFlex.	is delinquent by more than 60 days, or the premium payments are delinquent twice in any one calendar year by more than 31 days. Contact the Division of Retirement and Benefits for more information. MEBA members pay premiums directly to the MEBA office.
Section 7.5.4 Dependents ☑ Updated per 2 AAC 39.260 e-f-g Changes in coverage are effective only after your written request is received by the Division. If the Division becomes aware that your dependent is not eligible for coverage, the Division will automatically decrease your coverage tier and corresponding premiums to appropriately reflect the recipient's family structure.	Changes in coverage are effective only after your written request is received by the Division. Please note: The health plan cannot make changes in coverage levels for you.
Section 7.6 Changing your DVA Coverage ☑ Updated reinstate to increase. ☑ Added bullet 4 under a) per 2 AAC 39.260 (b) ☑ Added per 2 AAC 39.260 You may decrease your level of coverage at any time. For example, you may change from retiree and family coverage to retiree and spouse coverage any time. To decrease your coverage, submit a written request to the Division of Retirement and Benefits stating the level of coverage you would like. Once you decrease your coverage you cannot increase it except as described below.	Section 7.6 Changing your DVA Coverage You may decrease your level of coverage at any time. For example, you may change from retiree and family coverage to retiree and spouse coverage any time. To decrease your coverage, submit a written request to the Division of Retirement and Benefits stating the level of coverage you would like. Once you decrease your coverage you cannot reinstate it except as described below.

You may increase coverage only: a) Within 120 days after: o marriage o the birth or adoption of your child, or o becoming the legal, court appointed guardian of a dependent child o a change in your dependent's eligibility status as noted in *section 7.2.2 Dependents* b) During an open enrollment period, if you are eligible as noted in *section 7.3, How to Elect Coverage.* If you do not timely enroll your dependents in the plan, they will not be covered under the plan. Your next opportunity to enroll them is during the next open enrollment period.	You may increase coverage only: a) Within 120 days after: o marriage o the birth or adoption of your child, or o becoming the legal, court appointed guardian of a dependent child b) During an open enrollment period, if you are eligible as noted in *section 7.3, How to Elect Coverage.* If you do not timely enroll your dependents in the plan, they will not be covered under the plan until you enroll them during the next open enrollment. .
Section 7.7 Open Enrollment ☑ Added new section per 2 AAC 36.265 During the open enrollment period of each benefit year, if you are already enrolled in a dental-vision-audio plan, you may elect an offered dental-vision-audio plan option and increase or decrease your coverage tier level. Coverage premiums for elected benefits are subject to change under 2 AAC 39.280.	n/a

DRAFT

AlaskaCare

Medicare Advantage

Review of Request for Information Responses

Retiree Health Plan Advisory Board

November 5, 2020 / Richard Ward, FSA, FCA, MAAA

Segal

Medicare Advantage Overview

- Private plans offer Medicare services Parts A & B and often additional benefits
- MA carriers receive capitated payments from CMS that subsidizes the cost of coverage
- Fully insured premiums typically cover cost of benefits and enhancements above CMS payment
- CMS provides payment based on capitation rates (monthly payment) & risk-adjustment. These payments can vary:
  - By county (or borough/parish/etc)
  - By risk level of group
  - By ability of carrier to capture and report
  - Star Rating System (quality, member satisfaction for health plan)
- MA plans are filed with CMS on a county by county basis
  - Each county comprises a “service area”

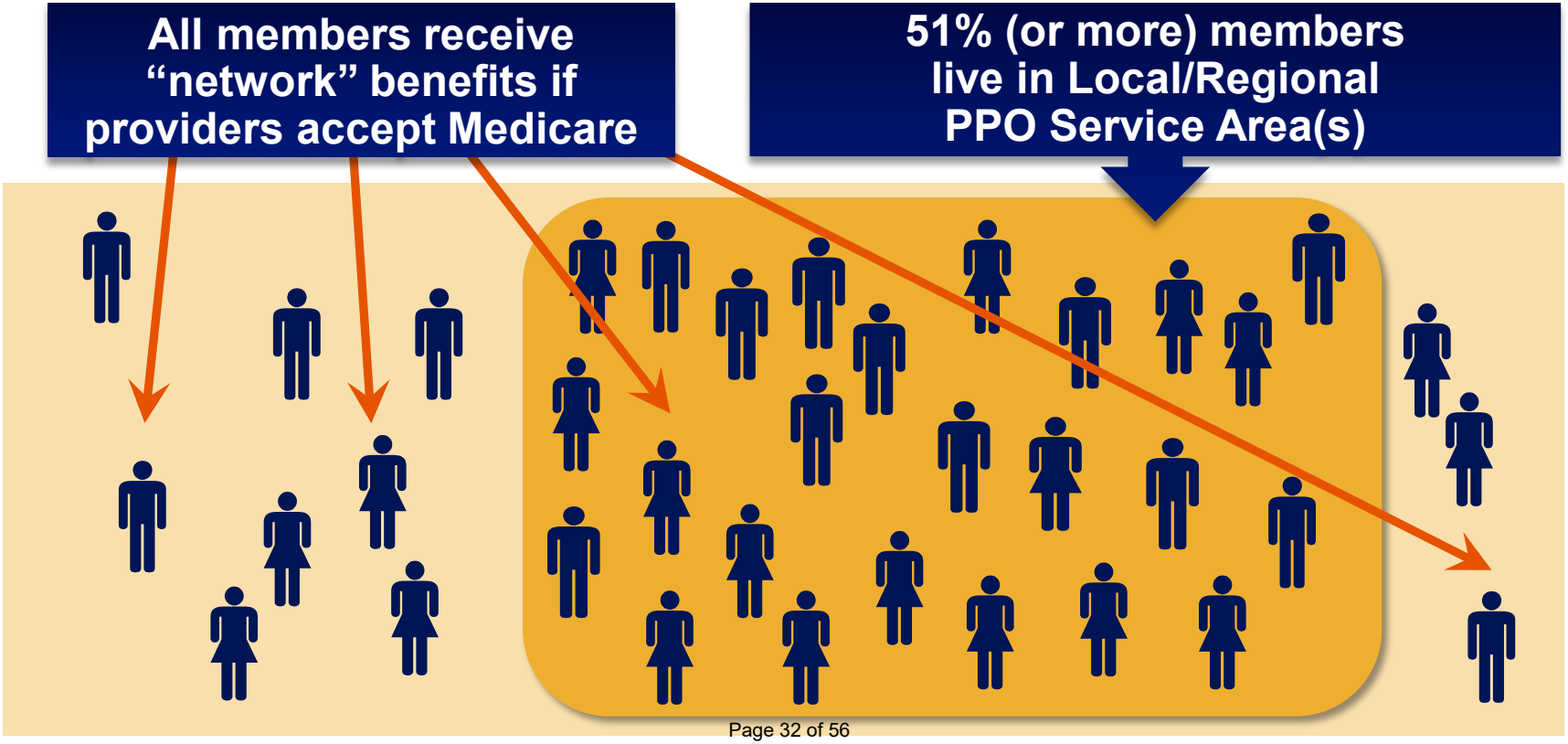
Medicare Advantage vs. Traditional Medicare

Traditional Medicare	Group Medicare Advantage PPO
Fee-for-Service	Capitation-like subsidies
Federal Government is payer	Private Insurance
Basic Medicare Part A and Part B Benefits, can purchase supplemental coverage	Medicare + Supplemental benefits integrated
“Network” = providers accepting Medicare	“Network” = providers accepting Medicare
Same benefits nationally	Same benefits nationally
No Medical Management	Medical Management and (often) Wellness
Premiums/Deductible set annually by CMS	Premiums and benefits result of competitive bidding and market forces

Medicare Advantage Plans

National Passive PPO for Groups

- If a regional PPO provides coverage to at least 51% of the members in a "service area," it can provide coverage on a national passive PPO basis
- Offers same member cost sharing and benefits whether using in-network or out-of-network providers



Request for Information

- Request for Information (RFI) was released to assess the market's Medicare Advantage (MA) capabilities and interest for the AlaskaCare Retirees
- MA does not currently exist in Alaska
- Key questions we wanted to address included:
  - Interest in building an offering in Alaska
  - How would they meet the 51% requirement
  - Would MA make financial sense for AlaskaCare
  - How would the benefits be designed under MA
- Responses were received from Aetna, Humana, Moda, and UHC

Key Takeaways From RFI Responses

1. There is interest from major MA carriers as it relates to the AK opportunity
2. Anchorage will play an important role in the 51% requirement
3. Estimated premiums appear to provide financial opportunity
4. All provided enhanced (illustrative) benefits, programs and services

Interest in the Opportunity

Received four responses to this RFI, which is more of an informal process, and with different objectives, compared to an RFP

Responses were received from the major MA carriers

The majority of responses provided specific details on the service area expansion, benefit design, and financial terms

Provider Service Area

- Since MA does not exist in Alaska, it will be necessary to contract with Alaska providers to establish a qualified service area and meet the 51% requirement
- Carriers would need to meet the 51% CMS requirement for a MAPPO program
  - Once 51% is reached all members receive the same benefits regardless of their location
- Due to the number of retirees residing in the Lower 48, about 25%-35% of retirees currently reside within an existing MAPPO service area
- Based on the carriers' assessments Anchorage would play a significant role in meeting that requirement
  - Mat-Su, Fairbanks and Juneau were also identified as strategic areas
- The carriers have existing commercial contracts and relationships with Alaska providers that could be leveraged for MA contracting
- Considered feasible to meet the 51% requirement in 1-3 years

Estimated Premiums

- Premiums and costs shown on a per member per month (PMPM) basis for 2021
- Estimated premiums are comparable to current cost on the medical side
- Pharmacy may not present the same opportunity compared to the current self-insured EGWP

	Approximate Current PMPM Cost	Estimated PMPM Premium	Opportunity Compared to Low End
Medical	$175	$130 - $310	($45 PMPM)
Pharmacy	$140 (net of rebates/subsidies)	$142 - $270	$2 PMPM
Total	$315	$272 - $580	($43 PMPM)
Medicare Members	Approximately 52,000		
Annual Opportunity	($27 Million) compared to the current program		

Benefits and Enhanced Program Offerings

- Plan design enhancements could be achieved compared to the current plan offering
- Illustrative plan designs include:
  - $50 deductible and $50 out of pocket maximum for the medical plan
  - $0 deductible and the current $800 out of pocket max with mostly 100% coverage and minimal copays
  - Plans would also cover services for preventive services
- The following is a sample of the additional programs carriers provide with their MA plan offerings:

CareGiver Support	Diabetes Outreach	Disease Management	Fitness / Silver Sneakers	Digital Engagement Platforms
At Home Chronic Care Management	Post Discharge Meal Services	Virtual Visits	In-Home Health and Well-being Assessments	End Stage Renal Disease Management
At Home Transition Programs	Decision Support Tools	Hearing Aid Discount Programs and Allowances	Transplant Management	Health Alerts

Next Steps & Considerations

Consider policy and operational needs

Stakeholder discussions and education

Coordination with the market

Evaluate impact on retiree plan(s) in aggregate

Develop preferred timing

Questions?

OptumRx:
Specialty Medication Prior Authorization Opportunities

November 5, 2020

OPTUMRx®

AlaskaCare Retiree Pharmacy Plan

Meeting Objectives

1. What is prior authorization?
2. How does OptumRx develop prior authorization?
3. Navigating complexities within specialty medications
4. AlaskaCare specialty utilization and trend
5. Case examples
6. Prescriber experience and tools
7. Member experience
8. Opportunity Outcomes

What is prior authorization?

- A pre-approval for certain medications which would benefit from clinical review before coverage is granted
    - Specific member details provided by the prescriber are used in the review process
    - Evidence-based literature is used in the review process
    - Some medications will also be reviewed for appropriate dosing limits in accordance with established guidance
- Promotes safe and effective medication use
- Helps reduce inappropriate use of medications ensuring members get the best results from their medication therapy
- Promotes prudent plan management resulting in better health outcomes for members and conservation of health trust funds

How does OptumRx develop prior authorization?

OptumRx National Pharmacy & Therapeutics Committee

Independent, multi-specialty and nationally represented group of physicians and pharmacists that provides evidence-based review and appraisal of new and existing medications and their place in therapy.

Multi Specialty

- Internal Medicine
- Epidemiology
- Cardiovascular
- Geriatrics
- Pediatrics
- Endocrinology
- Rheumatology
- Pain Medicine
- Hematology/Oncology

Nationally Represented

- Northeast
- Southeast
- Midwest
- West
- Southwest

Responsibilities

- Appraisal of new and existing drugs and drug classes
- Utilization management (prior authorization) program review
- Oversight of clinical programs

Determinations

- Unique therapeutic benefit
- Comparable safety and efficacy
- Risk of harm outweighs the benefit

How does OptumRx develop prior authorization?

Prior Authorization development process helps ensure quality

OptumRx P&T Committee Review and Approval

How PA guidelines are developed

- Peer-reviewed medical literature
- Nationally-recognized treatment guidelines
- FDA information
- Consultations
  - Healthcare providers
  - Key opinion leaders
  - Clinical specialists
- Pharmaceutical, device and/or biotech information

FDA = Food & Drug Administration, URAC = Utilization Review Accreditation Commission, CMS = Centers for Medicare and Medicaid Services

Navigating complexities within specialty medications

Complex Patient Support System

5.5 average number of providers a specialty patient sees over the course of a year

Rising Specialty Costs

40-50% of total pharmacy spend today; projecting to be **$505B+** spend by 2023

Surge in Innovative Therapies

22% of all prescription sales worldwide by 2024 for rare diseases

OPTUM Rx®

AlaskaCare specialty utilization and trend summary

EGWP Retiree

- Open specialty network for fulfilment
- Specialty Plan Paid was $39,615,073 from January through June 2020, an increase of $11,654,610 or 41.7% from January through June of 2019
- Specialty medications accounted for 34.9% of total plan paid from January through June 2020
- Specialty medications were driven by an increase of prescriptions (+20.4%) and increased use of higher cost medications (+10.0%)

Non-EGWP Retiree

- Open specialty network for fulfillment
- Specialty Plan Paid was $15,750,122 from January through June 2020, an increase of $2,880,318 or 22.4% from January through June of 2019
- Specialty medications accounted for 43.3% of total plan paid from January through June 2020
- Specialty medications were driven by an increase of prescriptions (+6.1%) and increased use of higher cost medications (+9.2%)

The most significant impact on specialty trend for both EGWP Retiree and Non-EGWP Retiree plans was from drugs in the Oncology class and the Chronic Inflammatory class

AlaskaCare Retiree Plan

Case examples

Member – Drug	Without PA	With PA
Member 1 *Uptravi* for pulmonary hypertension	Filling 240 tablets per month, 180 tablets above the standard QL $50,000 per month	Clinical prior authorization review confirms appropriate diagnosis and appropriate product use in accordance with established treatment guidelines Limits tablets to 60 per month, reducing the amount of pills per day from 8 to 2 while maintaining the same prescribed dosage for the member and cost reduction for the plan
Member 2 *Ibrance* for breast cancer	Filling without confirmation of exact diagnosis or an understanding of treatment plan $13,000 per month	Clinical prior authorization review confirms specific breast cancer diagnosis; however, it also uncovers Ibrance has not been used in conjunction with another medication in accordance with established treatment guidelines The prior authorization team works with prescriber's office to verify treatment course prior to clinical decision
Member 3 *Humira* for chronic inflammatory disease (i.e. rheumatoid arthritis, psoriatic arthritis)	Filling without confirmation of diagnosis or understanding of whether first-line medications were taken prior to progression to Humira $10,000 per month	Clinical prior authorization review confirms diagnosis of rheumatoid arthritis The information submitted by the prescriber does not show that the member has tried (or cannot take) a first-line therapy per treatment guidelines and, therefore, the member is directed to try the first-line therapy prior to approval and initiation of Humira

Prescriber experience and tools

Faster prescribing, better communication, continued access

Prior authorization (PA) capabilities work together to improve the provider and member experience

At the doctor

Electronic PA

- Electronic method for providers to quickly and easily submit PAs
- Real-time, automated PA approvals

PreCheck MyScript

- Quick access to member benefits, drug pricing and lower-cost options
- Insights delivered at the point of prescribing

At the pharmacy

SilentAuth

- Real-time coverage PAs checked and approved right at the pharmacy
- Full coverage review based on member demographics, claim history and diagnosis code

Before PA expires

Expiring PA

- Identifies expiring PA and sends system alerts to providers
- Promotes continued access for maintenance medications and eliminates point-of-sale rejects

Member experience

Prior authorization review is needed to ensure appropriate and effective medication use for the member's specific condition

Member receives notification letter 60 days in advance advising their medication will be subject to prior authorization

Member discusses the medication subject to prior authorization with their prescriber

Prescriber initiates prior authorization with OptumRx in one of three methods: electronic, phone or mail submission

Coverage is approved* and member can fill at their preferred pharmacy

Expiring Prior Authorizations

OptumRx identifies approved prior authorizations for prescriptions expiring within 30 days and initiates outreach to prescriber to extend prior authorization proactively, taking the member out the middle.

Clinical criteria is not met for coverage approval and member and prescriber are notified in writing with decision rationale and next steps for reconsideration

Provider writes new prescription for alternative medication or proceeds with next steps for reconsideration through OptumRx

*Approvals are valid for 3-36 months depending on medication

AlaskaCare Retiree Plan

Specialty Prior Authorization Program Opportunity Outcomes

Total Combined Estimated Opportunity = $12M

	Non-EGWP Retiree			EGWP Retiree		
	Utilizers	*Actual Plan Paid*	*Estimated Plan Reduction**	*Utilizers*	*Actual Plan Paid*	*Estimated Plan Reduction**
Prior Authorization of Select Specialty Medications	676	$28,628,152	$3,284,437	1,541	$64,661,460	$9,330,285

*Estimated plan reduction is a function of utilization within the time period while factoring in book of business denial and abandonment rates as well as the cost difference of a first-line alternative where applicable

Date Range: 7/1/19 – 6/30/20
Plan Paid reflects only those products assessed for utilization management edits, not the total plan paid for the year.

AlaskaCare Non-EGWP Retiree

Top 5 Specialty Class Prior Authorization Opportunities

Non-EGWP Retiree Top 5 Estimated Opportunity - $3M

	Anti-Inflammatory Biologic Agents	Multiple Sclerosis	Pulmonary Hypertension	Osteoporosis	Oncology – Oral AgentsE
Example Medications (full drug listing in appendix)	Cimzia, Cosentyx, Enbrel, Humira, Skyrizi, Stelara, Taltz, Tremfya, Xeljanz	Copaxone, Gilenya, Ocrevus, Rebif, Tecfidera, Tysabri	Letairis, Revatio, Tracleer, Tyvaso, Uptravi	Evenity, Forteo, Prolia, Tymlos	Bosulif, Gleevec, Ibrance, Imbruvica, Jakafi, Mekinist, Revlimid, Sprycel, Tagrisso, Tasigna, Verzenio, Xospata
Utilizers	292	89	4	63	81
Actual Plan Paid	$11,745,985	$4,893,709	$1,251,033	$492,922	$5,152,196
Actual Plan Paid per Rx	$7,894	$9,768	$21,203	$2,785	$10,430
Estimated Plan Reduction	$2,050,919	$443,679	$278,750	$160,123	$110,385
Estimated Reduction per Utilizer	$7,024	$4,985	$69,688	$2,542	$1,363

Date Range: 7/1/19 – 6/30/20

AlaskaCare EGWP Retiree

Top 5 Specialty Class Prior Authorization Opportunities

EGWP Retiree Top 5 Estimated Opportunity - $6M

	Anti-Inflammatory Biologic Agents	Multiple Sclerosis	Pulmonary Hypertension	Osteoporosis	Oncology – Oral AgentsE
Example Medications (full drug listing in appendix)	Cimzia, Cosentyx, Enbrel, Humira, Skyrizi, Stelara, Taltz, Tremfya, Xeljanz	Copaxone, Gilenya, Ocrevus, Rebif, Tecfidera, Tysabri	Letairis, Revatio, Tracleer, Tyvaso, Uptravi	Evenity, Forteo, Prolia, Tymlos	Bosulif, Gleevec, Ibrance, Imbruvica, Jakafi, Mekinist, Revlimid, Sprycel, Tagrisso, Tasigna, Verzenio, Xospata
Utilizers	450	84	70	221	397
Actual Plan Paid	$19,446,716	$4,416,484	$2,475,330	$1,385,417	$27,119,637
Actual Plan Paid per Rx	$8,240	$9,664	$6,583	$2,619	$11,385
Estimated Plan Reduction	$2,354,792	$448,360	$410,951	$331,187	$3,068,174
Estimated Reduction per Utilizer	$5,233	$4,861	$5,871	$1,499	$7,728

Date Range: 7/1/19 – 6/30/20

Appendix

Top 5 Specialty Class Prior Authorization Opportunities – Medication List

	Anti-Inflammatory Biologic Agents	Multiple Sclerosis	Pulmonary Hypertension	Osteoporosis	Oncology – Oral Agents
Medications	Actemra, Avsola, Cimzia, Cosentyx, Enbrel, Enbrel Mini, Entyvio, Humira, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Renflexis, Remicade, Rinvoq, Siliq, Simponi, Simponi Aria, Skyrizi, Stelara, Taltz, Tremfya, Xeljanz, Xeljanz XR	Ampyra, Avonex, Aubagio, Bafiertam, Betaseron, Extavia, Copaxone, Gilenya, Glatopa, Lemtrada, Mavenclad, Mayzent, Novantrone, Ocrevus, Plegridy, Rebif, Tecfidera, Tysabri, Vumerity, Zeposia	Adcirca, Adempas, Alyq, Flolan, Letairis, Opsumit, Orenitram, Remodulin, Revatio, Tracleer, Tyvaso, Uptravi, Veletri, Ventavis	Evenity, Forteo, Prolia, Tymlos	Afinitor, Afinitor Disperz, Alecensa, Alunbrig, Ayvakit, Balversa, Bosulif, Braftovi, Brukinsa, Cabometyx, Calquence, Caprelsa, Cometriq, Copiktra, Cotellic, Daurismo, Erivedge, Erleada, Farydak, Gilotrif, Gleevec, Ibrance, Iclusig, IDHIFA, Imbruvica, Inlyta, Inrebic, Iressa, Jakafi, Kisqali, Kisqali Femara, Koselugo, Lenvima, Lonsurf, Lorbrena, Lynparza, Mekinist, Mektovi, Nerlynx, Nexavar, Ninlara, Nubeqa, Odomzo, Pemazyre, Piqray, Pomalyst, Qinlock, Retevmo, Revlimid, Rozlytrek, Rubraca, Rydapt, Sprycel, Stivarga, Sutent, Tabrecta, Tafinlar, Tagrisso, Talzenna, Tarceva, Targretin, Tasigna, Tazverik, Temodar, Thalomid, Tibsovo, Tukysa, Turalio, Tykerb, Venclexta, Verzenio, Vitrakvi, Vizimpro, Votrient, Xalkori, Xeloda, Xospata, Xpovio, Xtandi, Yonsa, Zejula, Zelboraf, Zolinza, Zydelig, Zykadia, Zytiga

AlaskaCare Meeting Dates for 2021

Quarterly Meeting Retiree Health Plan

- ☑ Wednesday, February 3, 2021
- ☑ Wednesday, May 5, 2021
- ☑ Wednesday, August 4, 2021
- ☑ Wednesday, November 3, 2021

Retiree Health Plan Advisory Board (RHPAB) Meetings

- ☑ Thursday, February 4, 2021
- ☑ Thursday, May 6, 2021
- ☑ Thursday, August 5, 2021
- ☑ Thursday, November 4, 2021