Retiree Health Plan Advisory Board
Meeting Agenda

Date:	Thursday February 4, 2021
Time:	9:00am – 2:30pm
Location:	Video Teleconference Only
Teleconference:	Conf #: 855-244-8681 ID#:141 696 9818 Password: 47299228 Join meeting
Committee Members:	Judy Salo (chair), Lorne Bretz, Joelle Hall, Dallas Hargrave, Paula Harrison, Cammy Taylor, and G. Nanette Thompson

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

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

9:15 am **Public Comment**

9:30 am **Department & Division Update**

- EGWP Projections Update
- COVID-19
- Long-Term Care Vendor Procurement

10:00 am **Break**

10:15 am **Medicare Advantage**

- Medicare Advantage Overview
- Decision Points
- Potential Timeline

12:00 pm **Lunch**

1:00 pm **Medicare Advantage Continued**

- State of Washington

2:00 pm **Public Comment**

2:15 pm **Final Thoughts**

- 2021 Meeting Dates: May 6, August 5, November 4

2:30 pm **Adjourn**

OnlinePublicNotices

Retiree Health Plan Advisory Board

Board Meeting Minutes

Date: Thursday, November 5, 2020 9:00 a.m. to 12:30 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
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 Policy Administrator, Retirement + Benefits	
Teri Rasmussen	Program Coordinator, Retirement + Benefits	
Yasmine Habash	Program Coordinator, Retirement + Benefits	
Andrea Mueca	Health Operations Manager, Retirement + Benefits	
Erika Burkhouse	Assistant Vendor Manager, Retirement + Benefits	
Steve Ramos	Vendor Manager, Retirement + Benefits	
Mike Gamble	Member Liaison, Retirement + Benefits	
Others Present + Members of the Public		
Hali Duran	Aetna (medical third-party administrator)	
Daniel Dudley	Aetna (medical third-party administrator)	
Maridale Goff	Aetna (medical third-party administrator)	
Blythe Keller	Aetna (medical third-party administrator)	
Amy Speakman	OptumRx (pharmacy third party administrator)	
Stephanie Gaffney	OptumRx (pharmacy third party administrator)	
Richard Ward	Segal Consulting (contracted actuarial)	
Noel Cruse	Segal Consulting (contracted actuarial)	
Zach White	Segal Consulting (contracted actuarial)	
Martin Fornataro	Segal Consulting (contracted actuarial)	
Anna Brawley	Agnew::Beck Consulting (contracted support)	
Sharon Hoffbeck	Retired Public Employees of Alaska (RPEA)	
Brad Owens	Retired Public Employees of Alaska (RPEA)	
Wendy Woolf	Retired Public Employees of Alaska (RPEA)	
Jean Farone Jones	United Health Care	
Michelle Marto	United Health Care	
David Broome	Aetna (medical third-party administrator)	
Amy Jimenez	Segal Consulting (contracted actuarial)	
Stephanie Rhoades	Public member	

Carlos Rivera	OptumRx (pharmacy third party administrator)
Andrew Robison	Aetna (medical third-party administrator)
John Wagner	Aetna (medical third-party administrator)
Lauren Carney	OptumRx (pharmacy third party administrator)

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 many 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.

Approval of Meeting Agenda

Materials: Agenda packet for 11/5/20 RHPAB Meeting

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

Approval of Previous Meetings' Minutes

Materials: Draft minutes from the previous (9/3/20) RHPAB Meeting.

- **Motion** by Nan Thompson to approve September 3, 2020 minutes. **Second** by Cammy Taylor.
  - **Discussion**: None.
  - **Correction**: Page 11, change word "category" to "cohort" (describing age group 61-70).
  - **Result**: No objection to approval of minutes. Minutes are approved.

Ethics Disclosure

Chair 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

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. Chair 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 making comments at the end of the meeting.

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

Emily Ricci and staff provided several updates:

Betsy Wood is officially on maternity leave, doing well and resting at home with her new baby girl! Yasmine Habash is serving in a short-term staff position while Betsy is out of office. Betsy is expected to return at work in January 2021.

EGWP: New IRMAA Process

Materials: Presentation beginning page 21 in 11/5/20 meeting packet

For retirees enrolled in the EGWP pharmacy plan because it is a Medicare Part D plan, high-income retirees are required to pay a surcharge on their monthly premium, known as an IRMAA. AlaskaCare has committed to reimbursing members who are charged this surcharge, but the process has been challenging and required a great deal of manual work by the health team to take care of the annual paperwork. The Division has been searching for a way to reduce the administrative burden and streamline the process, and has a new process:

Andrea Mueca shared staff are working with OptumRx to process eligibility and the required paperwork to verify income and the amount of surcharge. Starting for the 2021 plan year, OptumRx will be the entity who collects and processes this paperwork, including verifying eligibility and making it easier to submit members' documentation for reimbursement online. OptumRx will also process reimbursements and work with members to set up health reimbursement accounts (HRAs) for the monthly reimbursement. The Division will send letters to all members in the EGWP plan who currently have an IRMAA account, informing them of this new process and encouraging members to set up the arrangement for 2021. Additionally, members can still request reimbursement for 2020 (including as a lump sum for the year) until March 31, 2021. OptumRx will also work with members to take care of this one-time reimbursement. As a reminder: Social Security determines Medicare premiums and income based on reported income from two years ago (2019, for the 2021 plan year) so members' eligibility and surcharge can change over time.

- Judy Salo asked if all members will receive this letter, not just those currently enrolled?
    - Andrea responded only members currently enrolled in IRMAA (about 2,000 members total) will receive the letter, encouraging them to enroll in the new process and transition out of the old system.
    - Emily added that the Division have discussed sending another postcard in the beginning of the calendar year, they are in the process of moving to the new system and anticipate some issues in the next few months as people transition to a new account.
- Cammy Taylor commented that she recommended adding specific language in the letter about how to submit documents to OptumRx, including sending paper forms and other options. She noted that some retirees do not have Internet access. She encouraged making this more option stated more clearly in the letter for some retirees.
- Paula Harrison asked about opting out of the EGWP plan: she understands that the plan was implemented in 2019—how can members opt out?
    - Andrea responded a member can opt out of the EGWP plan and into a different pharmacy plan. The process is simply to contact the Division, and staff will walk the member through the implications of this choice—the alternative plan has higher cost-

sharing for the member, since the State does not receive subsidies for members not enrolled in that plan.

- Emily added that in some circumstances, such as someone living outside of the Medicare service area or who is already in another EGWP through a Medicare Advantage plan, the Division will not necessarily place them in the alternative plan. If a member does not have a specific reason for opting out, however, they will be in the alternative plan.

Emily noted that the OptumRx team will be ready to receive phone calls starting November 15, 2020 and will work with members over the remaining six weeks of the calendar year to help existing members transition and take care of any new members' enrollment. She encouraged patience with the process, and hopefully a smooth transition to this new, less time-intensive process for members (and staff).

2021 Plan Booklet Draft

Materials: Presentation beginning page 23 in 11/5/20 meeting packet

Emily Ricci introduced the purpose of the new proposed change to the 2021 plan booklet: The updates were primarily in response to DVA regulation changes, the CARES Act and an update to the Letter of Agreement with MEBA.

Teri Rasmussen provided more details: While these changes to the plan booklet did not formally require public notice, the Division wishes to be transparent and communicative with retirees. There is a copy of the new plan booklet with side-by-side comparison of the old and new language for the sections being changed. There is also a summary list of changes as a separate document. All documents, as well as the current version of the plan booklet (applicable for 2020) is posted online here:

http://doa.alaska.gov/drb/alaskaCare/retiree/publications/booklets.html

Teri summarized the changes:

- Confirming changes related to regulation updates for the DVA plan;
- Temporary changes related to COVID-19 and the CARES Act, carried into 2021. This includes coverage of COVID-19 tests and, when available in the future, a vaccine.
- Changes to coverage for services related to changing sex or physical sexual characteristics, to comply with the rulings in an Alaska case as well as the U.S. Supreme Court.
- Several formatting changes for readability, including a new outline format (bulleted list with sub-bullets by topic) to make it easier for the reader to find a specific topic or benefit.
- Documentation of a new option for Marine Engineers Beneficial Association (MEBA) members: MEBA members have been able to opt into the DVA plan and pay a lump sum for coverage that year. Starting in 2021, they also have the option to pay premiums monthly via electronic payments.

The Division will hold a teleconference at 1:00 p.m. on Monday, November 9, 2020 to verbally explain the booklet changes. Members can submit written comments on the draft plan booklet by November 23, 2020 at 4:30pm. Members who need special accommodation or assistance in providing comments should contact the Division for help in doing so.

DVA Plan Open Enrollment

Andrea Mueca shared that the open enrollment process is going well so far and has been smooth for members. Members can call the Division to request assistance with the online enrollment process, or to request a paper form to submit instead. Many members have decided to remain in the same plan they have for the next year, based on responses so far.

- Judy Salo commented that it would be useful to remind members that if they have two plans, that they cannot choose different plans.
    - Emily confirmed this is correct but added some detail: Retirees may only select one plan option for themselves and any dependents they cover, even if the retiree holds more than one AlaskaCare DVA policy. However, if two spouses each have separate AlaskaCare DVA policies, they may each select different plans and cover each other as dependents.
    - Andrea confirmed that if a member holds multiple policies, the system allows for changing dependent coverage levels for each policy.

Item 4. Medicare Advantage RFI Responses Update – Segal

Materials: Presentation beginning page 29 in 11/5/20 meeting packet

Emily reminded the board of the work to date on this item: The Division published a Request for Information (RFI) earlier this year, asking for potential vendors to outline how they would provide a Medicare Advantage plan for AlaskaCare retiree members who are Medicare eligible. Staff worked with Segal Consulting to review the responses and summarize results, presented today.

Richard Ward provided a brief overview of Medicare Advantage plans (slide on page 30). Medicare Advantage (MA) plans are private plans that offer Medicare coverage (Parts A and B) as well as supplemental benefits, using a per member per month (capitated) payment, subsidizing the cost of coverage, in addition to what members pay for the plan. The payments are determined by market area/geography, risk level of the group, costs of services in that market, and other factors. MA plans are filed on a county basis. Coverage in Anchorage, for example, would be $1,050, with similar rates in Fairbanks and Juneau; a county in Washington state may be closer to $1,000. A Medicare Advantage plan provider may offer one or more plans in one or several counties/markets, with cost varying according to the factors noted above. A county is defined as a market area.

Overview of MA plan features: Richard noted that the "network" is, unlike commercial insurance plans, all providers that accept Medicare patients—the network is the same regardless of carrier. Additionally, the benefits are consistent nationally because it is a group plan. MA plans also allow for medical management and coverage of more preventive benefits such as wellness programs, because the capitated payment can support coverage of services that (overall) reduce members' need for downstream medical care and can help manage costs and the member's health. Because the plans are offered on the private market, the premiums and deductibles are not set by CMS like traditional Medicare but can be set by the carrier for that local market. This flexibility makes it possible to potentially offer additional services beyond those traditionally included in Parts A and B.

Richard also explained the national "passive PPO" group benefit (slide on page 32): if there is sufficient concentration of members in a group plan within a local area (at least 51%), this allows for all members to receive the same network benefits in that service area. This could be advantageous in Alaska, as there

are no current Medicare Advantage plans offered in Alaska and retirees are potentially a significantly large group. As an example: a group of 100 retirees, if 60 live in Anchorage service area, and others live outside that area, would allow the group to qualify as a group PPO. If only 40 of those 100 lived in Anchorage, they would not qualify for the PPO for Anchorage under this provision.

The purpose of the RFI issued by the Division was to determine whether it is financially feasible to set up a new Medicare Advantage plan / market, given that there is no current offering in state now. Richard noted that this was a more complex analysis since prior analyses in other states already had an existing market functioning. There were four responses to the RFI, from major MA carriers operating in the U.S.

- Cammy Taylor asked whether retirees would still be responsible for paying Part B premiums?
    - Richard answered yes, the obligations would remain for retirees. However, it is different than a plan purchased by an individual from a vendor on the general market—this would be a group plan, similar to the way that AlaskaCare designed and customized an EGWP plan, so the plan administrator has a significant role and pays a large portion.
- Paula Harrison commented that it is extremely difficult to find a provider in Southcentral Alaska who accepts Medicare. She asked what providers need to do to participate in this plan?
    - Richard responded the primary difference is providers accepting Medicare would submit claims to the MA plan carrier rather than CMS, this is common practice in other states. He also noted that providers would need to decide to accept Medicare, but there is some possibility that this will incentivize more providers to participate, to address the current issue of very limited Medicare providers in state.
    - Emily added that the limited availability of providers in Alaska is due in part to low reimbursement rates: Medicare is the lowest payer, followed by Medicaid, and much lower than commercial insurance. Because MA plans do allow for coverage of more primary care services and have a different payment structure, it may be possible to pay providers more for Medicare services, beyond CMS rates, which does have the potential to increase access to Medicare-accepting providers. Without that feature, this would not be financially feasible in Alaska—the fact that fees can be negotiated between the carrier and provider make it potentially attractive. The Division will be looking closely at this as an option if it does continue to seem financially feasible as analysis continues.

Richard continued: The State (AlaskaCare retirees) has a significant portion of the market, estimated to be as many as two-thirds of the overall Medicare eligible population in the state. Since there is no existing market, respondents were asked to develop an estimate for creating and offering this new plan. The RFI included some example claims and other data to understand the current market, determine whether it is feasible to include at least 51% of the service area to achieve the PPO threshold. The objective was to determine how much it would cost, compared to the current plan: if the current plan is more cost effective, it would not be worth creating this new plan. If there are significant cost savings and opportunity to provide the same or better benefits, then it may be worth consideration.

Many retirees live outside Alaska, and many likely live in an existing MA plan service area—this would also count toward the 51% threshold. Anchorage's retiree member population is also important for establishing a service area and would require contracting with local providers to accomplish this. RFI responses estimated that approximately 25 to 35% of retirees are already in an existing service area. In addition to Anchorage, the Juneau, Fairbanks and Mat-Su markets would be significant as local service areas with a concentration of retirees, and carriers would seek to establish contracts in these markets as

well. In some cases, they have current relationships with local providers in their network, so all respondents believed it was feasible to establish a sufficient PPO network within 1 to 3 years.

The slide on page 37 illustrates the estimated per member per month (PMPM) cost for the current plan and the estimated MA plan cost. The monthly cost of the medical plan is $175 currently, with most respondents estimating a somewhat lower premium (approx. $130, with one outlier at $310). The pharmacy plan is more well established, and the current EGWP subsidies suggest that the pharmacy plan does not have as much opportunity for savings compared to the current plan. There is more opportunity on the medical side, assuming some new contracting/network relationships can be made.

All respondents reported that they could offer a lower premium than the current $175 for medical services, and also offered potential preventive benefits and primary care at this price point. Plan designs include: $50 deductible and $50 out of pocket maximum; $0 deductible and $800 out of pocket max, with minimal co-pays; and a wide variety of other benefits outlined on the slide on page 38.

Emily noted that while some of these benefits are relatively small or only apply in certain situations, many are benefits that members have asked for or would be of value: examples include in-home health assessments, post-discharge meal service, caregiver support, and programs designed to manage chronic conditions or complex needs. She also noted that all respondents' plans had no lifetime maximum benefit threshold, unlike the current plan.

Richard concluded: the RFI responses did indicate there is interest in establishing a new MA market, and for potential vendors, having potential access to a significant market of retirees may make private carriers more open to establishing a new market. He reiterated that while more analysis is needed and this is not a current decision point, the RFI responses did confirm that this is possibly a good solution: the results did not suggest that it's infeasible or significantly worse than the status quo.

- Paula asked what if any benefit the provider would see for participating—would they receive an additional payment? What would incentivize them to accept Medicare?
    - Richard responded one benefit is to have claims paid directly by the carrier rather than first going to CMS for approval and reimbursement, so they may get paid more quickly and easily, similar to commercial insurance. Additionally, the provider may get paid more than CMS rates depending on the contract and services provided.
    - Emily added that many of the access issues for Medicare enrollees are for primary care services, less so for specialists or facility care, but there is an issue of more specialists not accepting Medicare anymore due to low reimbursement. She encouraged thinking of providers in these general categories and not all the same and focusing on access issues on the primary care side, as this is the biggest problem for Alaska retirees.
- Judy asked the next steps in this analysis, and when a decision might be made—when would the Board be asked to provide input or a recommendation?
    - Richard responded there are still several outstanding questions, and implementation would take significant time even if the decision is made in the near future. He speculated that at the earliest, this could be done for calendar year 2023, with a notice of intent to issue an RFP for services published in early 2022. He noted that it would also be a meaningful investment for any carrier who would respond to the RFP, to set up an entirely new plan and establish contracts with providers. There are also many stakeholders who would need to be consulted, and many questions needing answers.

- Nan Thompson asked, in addition to the work to stand up and implement this plan in the beginning, what if any additional work there would be for the Division to manage this on an ongoing basis?
    - Emily responded this is still an unknown. Her initial thought: this would not necessarily take a great deal more time or change how they manage vendors and assist members. However, there could be a greater or lesser commitment of time for staff long term. This could save significant staff time when the plan is fully in place; or it could create additional ongoing work. The Division needs to consider these questions. There would certainly be a significant time commitment from staff to implement the new plan and work with the new vendor, as there is with any significant change.
      She also noted that there are multiple options, from making the MA plan the primary plan to offering MA plans as optional alternatives to the current/legacy plan for members. The work to date has been primarily focused on potential changes to the existing plan, but this is a potential second or parallel option, not requiring changes to the legacy plan but offering a second option for retirees who want those benefits.
      She acknowledged this is an iterative process, and there are a number of policy decisions (in terms of coverage, whether to change the underlying plan or offer this as a second option, etc.) Staff would like to continue discussing with the Board, understanding questions and concerns, and thoroughly considering the potential impacts on individual members if this plan moves forward.

Judy encouraged Board members to think about what questions they would like to discuss further about this idea and have a brief discussion with the group during Final Thoughts today, when discussing future meetings. She noted that the modernization committee is a good place to have this discussion going forward, but open to other Board members' recommendations. She noted that when implementing the EGWP plan, there was considerable discussion, consideration, and education about how it would impact members, and she would like to have a similar discussion as this analysis moves forward, particularly given that there is such a large share of Medicare eligible retirees in the plan.

The Board took a 20-minute break at 10:35 a.m., and returned to the meeting at 10:50 a.m.

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

Judy Salo asked modernization committee chair Cammy Taylor for feedback on the MA plan discussion.

- Cammy agreed this would be an appropriate topic for the committee. She noted there is one vacancy on the committee, former member Mauri Long. In addition, all Board members are welcome to attend the committee meetings and participate in discussion; the purpose of the committee is to afford more time and detailed discussion on changes to the plan before they are brought to the Board for any formal recommendation.

Item 5. Prior Authorizations for High-Cost Specialty Drugs - OptumRx

Materials: Presentation provided as a separate document in 11/5/20 meeting packet

Emily provided context for this item: prior authorization is a common practice for medical services, in the AlaskaCare retiree plan and most other health plans. This is not a common feature in pharmacy plans, but in the last few years, the increase in use and availability of high-cost specialty medications has

continued to drive up the cost of pharmacy benefits. The goal is to continue providing members with medications they need, but also that the plan is informed about the cost of these drugs upfront and can work with members to ensure this is the best or most appropriate option. Additionally, this may include appropriate dosage and total length of time for the medication, to avoid approving an expensive medication that is ultimately not utilized.

Stephanie Gaffney (relationship manager) and Amy Speakman (pharmacist) with OptumRx presented.

Prior authorization is pre-approval by the plan administrator for a covered service or medication, to ensure that the coverage is necessary and appropriate in that situation. The plan may use diagnosis, member information, and other circumstances to approve in each case. Pharmacy prior authorization works similarly and would rely on available evidence and literature for use of that medication, dosing, and other considerations. All these factors would be considered when authorizing coverage of a patient's recommended medication. OptumRx uses a multi-disciplinary committee with a number of different specialties represented in the group, along with geographic diversity. The committee is tasked with utilization review, reviewing literature and evidence on the medication in question, and considering factors in each particular case. The committee also reviews new medications on an ongoing basis and ensuring compliance and alignment with available standards. Because new studies are published continually, and new drugs are available on the market, this process is ongoing and requires working closely with providers (physicians, specialists) to understand what appropriate recommendations should be made in each case.

Specialty medications have become an increasingly complex issue: more patients are seeing multiple providers and may have complex conditions; costs are rising disproportionately, with approximately 1 to 2% of prescriptions representing up to 50% of total pharmacy spending; and an overall increase in the number and type of specialty medications on the market for some conditions, particularly cancers.

Specific to the AlaskaCare plan: for EGWP enrollees, the 2020 (first two quarters) spending on these specialty medications was $39.6 million, an increase of $11.7 million over same period in 2019, a 41.7% increase. This is a combination of more prescriptions and higher utilization of high-cost medications. For non-EGWP retirees, the 2020 spend in this period on specialty medications was $15.8 million, a 22.4% increase ($2.9 million), and represented about 43% of total pharmacy spend in that period. Similarly, this was a combination of more prescriptions and higher utilization. This primarily included oncology (cancer) medications and medications treating chronic inflammatory conditions. Slide 8 illustrates three specific (de-identified) examples from the current AlaskaCare membership and utilization, describing how the prior authorization process would work if it were in place, compared with the status quo. Example 1 illustrates how quantity limits and dosage (number of pills and strength of pills) would reduce cost for the member and the plan. Example 2 illustrates how a medication was utilized without also prescribing a companion medication, according to current guidelines. Example 3 illustrates a process by which the member would be directed to try a different, already-established medication before utilizing a new one: the prior authorization does not require using a different therapy if there is a reason the member needs this specific medication but would allow for additional review to make that decision.

Emily added one example: a member recently filled a $75,000, 90-day prescription that had high potential for negative side effects, and started to experience those effects, so they did not use their full prescription. She emphasized that the purpose is not to prevent people from accessing medications they need, but to better manage the plan and ensure that the member is receiving the best option for their

condition. This also means the plan is aware of this utilization upfront, with an opportunity to conduct quality control and work with the member and provider to make the best choice. Currently the plan has no mechanism to be involved in the decision until the claim has already been submitted.

Slide 9 illustrates the prior authorization process at each step:

- The provider (physician's office) can submit prior authorization requests electronically while the patient is onsite, to receive an automated result where appropriate. There is also a "PreCheck MyScript" platform to provide information about pricing and alternatives for the member, similar to the information a pharmacist can access.
- The pharmacy also has access to a real-time prior authorization tool, "SilentAuth," which includes coverage review using demographics, claims history and by diagnosis code. This allows a pharmacy to receive a prior authorization at the point of sale when the member is onsite.
- The system also prompts providers to update or re-request an expiring prior authorization, to avoid disruption in coverage.

Slide 10 illustrates the member's experience:

- For existing prescriptions, members will receive a letter 60 days prior to this new policy going into place, notifying them that their prescription requires prior authorization, which prompts the member to talk with their provider.
- The provider submits prior authorization via the methods listed on slide 9. If the authorization is not approved, both the member and provider are notified in writing and given a rationale for the decision, as well as next steps or alternatives to consider. The provider would prescribe an alternative medication, or contacts OptumRx to address the issue.

Approvals will typically span between 3 and 36 months, depending on the situation and medication.

- Judy asked what situations a member could get 60 days' notice? Is this only for existing prescriptions? What happens with a new prescription?
    - Amy responded this would apply to current medications, with the goal of giving ample notice to the member and provider that they need to respond and ensure that the prior authorization is approved before the next prescription fill is needed. For a new prescription, if the prior authorization process is in place, this would be required of the provider before the member begins that new medication.
- Judy asked whether there is a rule regarding the first-time fill of a prescription, and whether that can be included? She encouraged considering a limitation on the first fill, as she is aware that patients and providers often experiment with multiple medications in order to find the best one for the patient's situation—this would avoid wasted medications and allow for the patient to try multiple options as appropriate.
    - Amy agreed this would be a good policy to consider, there is no limit in place currently.
    - Emily added that while many plan change discussions focus on cost savings, the purpose for this policy is less savings per se, and more ensuring that people are utilizing the right medications according to clinical needs, given the high cost of these drugs. Additionally, the plan has flexibility for which drugs or classes of drugs would be subject to prior authorization and could be defined narrowly or broadly. This would also be a policy decision by the plan.

Amy continued: slide 11 illustrates potential savings if these policies were in place in the plan. Of those in the EGWP plan, an estimated $9.3 million in savings could be achieved; for non-EGWP pharmacy claims, there is an estimated $3.3 million in savings.

- Cammy Taylor asked whether the potential savings are due to inappropriate prescriptions, or what other factors?
    - Stephanie responded the savings are based on estimated percent of claims denied, prescriptions that were abandoned or changed, and other specifics in the claims data.

Slides 12 (non-EGWP) and 13 (EGWP) illustrate specific classes and names of medications in the top 5 categories in terms of spending, and opportunity for better utilization management in the plan. These include anti-inflammatory biologic agents, multiple sclerosis medications, pulmonary hypertension, osteoporosis, and oncology drugs in a certain class.

- Judy asked how conflicts or appeals to denial would be handled in this system?
    - Amy shared that the process requires the plan to request more information from the provider to supplement the case, as well as opportunity for peer-to-peer review with a specialist. If the authorization is denied, there is also an appeals process.
    - Emily added that this would be subject to the multi-level appeals process already in the AlaskaCare plan for other denied claims.

Slide 15 (appendix) lists the relevant medications in each of the five categories for reference.

- Cammy commented that she is interested in the idea of narrowing or customizing the list of specialty medications for the plan, to suit retirees' needs. She also understands that some cancer drugs only work in patients with certain genetics, so requiring these tests seems appropriate to ensure it will be effective.
  She suggested the group consider two separate categories: first, whether the medication is appropriate for the condition and the patient. Second, this could be defined as or considered "step therapy," with many retirees being wary or concerned about this requirement. She gave an example of two retirees who had to try multiple medications before accessing the drug that ultimately was most effective and recommended in the first place; this took over two months and resulted in the patient becoming significantly sicker in the interim. She noted that concerns about step therapy are likely to be voiced by many retiree, and would like the group to dive further into this issue.
  She asked whether, from OptumRx's perspective and the data, the issue appears to be primarily physicians prescribing the wrong medications, or whether this will result in patients not accessing the best medications for their situation if they are required to try different ones.
    - Emily acknowledged this is a great question: she noted that managing the amount or utilization of the drug is an issue, and a separate issue is whether the plan is making appropriate therapeutic recommendations. Any decision about this policy needs to address the implications of both issues.
- Joelle Hall raised the question of how retirees who do not have ready access to pharmacy benefits? For example, if the retiree lives in a rural area, and having only a 30-day supply will be problematic. How can the plan balance access to medications they need, particularly if they need to receive medications by mail, with managing utilization?

- Emily acknowledged this is an important issue, for members with logistical challenges accessing care and/or situations where a medication is urgently needed. She believes that having automatic prior authorizations and easy access by providers would partially address this, as well as having waivers or exceptions in some situations.

Item 6. Public Comment, Continued

Chair Salo reiterated the public comment guidelines and invited the public to provide comment.

Public Comments

- **Brad Owens, RPEA**. Brad reiterated Board members' comments earlier in the meeting about the impact to individual members, and that this is of concern to him and his organization. He noted that the careful prior review process before implementing EGWP helped identify issues for members and allowed the Division and retirees to work through each of these issues and make implementation more smoothly. He noted that, for example, rather than requiring the provider to prove a drug is effective, the plan should be required to prove it is inappropriate, to ensure members have adequate access to drugs.

Item 7. Closing Thoughts + Meeting Adjournment

Board Seats + Election Planning

Judy Salo noted that the bylaws require an election of a new chair and vice chair, but the Boards and Commissions office has a backlog of appointments and re-appointments that has not been completed. The members' terms who expire this year ended on October 1. Boards and Commissions staff have asked if current members are willing to continue serving in the position until a new appointment is made (either a re-appointment or a new appointment). She encouraged the Board to consider holding off this election until the appointments are resolved, to ensure that the new chair and vice chair have been properly appointed. No objection from Board members.

2021 Board Meetings

Materials: Meeting dates on page 41 in 11/5/20 meeting packet

Tentative schedule for 2021 quarterly meetings, as well as quarterly meetings with health plan vendors to review plan trends and performance. Meetings will be held virtually for the foreseeable future.

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

No objection or comments from Board members about the upcoming year's schedule.

Next Steps for Medicare Advantage Discussion

Judy recommended that modernization committee chair Cammy Taylor work directly with Division staff to identify a date for a next meeting, tentatively January 2021. Cammy and Emily agreed; Cammy will reach out to all Board members after identifying potential meeting times. As a reminder, the committee has a defined membership, but all Board members are welcome to attend committee meetings.

- **Motion** by Joelle Hall to adjourn the meeting. **Second** by Nan Thompson.

- **Result**: No objection to adjournment. The meeting was adjourned at 11:57 a.m.

The next Retiree Health Plan Advisory Board meeting is planned for February 4, 2021.

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.

Retiree Health Plan Advisory Board

Modernization Committee Meeting Minutes

Date: Wednesday, January 20, 2021 1:00 to 4:00 p.m.

Location: Virtual meeting via teleconference and WebEx only

Meeting Attendance

Name of Attendee	Title of Attendee	
Retiree Health Plan Advisory Board (RHPAB), Modernization Committee Members		
Cammy Taylor	Committee Chair	Present
Joelle Hall	Committee Member	Absent
Nanette (Nan) Thompson	Committee Member	Present
Judy Salo	Board Chair	Present
State of Alaska, Department of Administration Staff		
Emily Ricci	Chief Health Policy Administrator, Retirement + Benefits	
Betsy Wood	Deputy Health Official, Retirement + Benefits	
Teri Rasmussen	Program Coordinator, Retirement + Benefits	
Yasmine Habash	Program Coordinator, Retirement + Benefits	
Andrea Mueca	Health Operations Manager, Retirement + Benefits	
Others Present + Members of the Public		
Richard Ward	Segal Consulting (contracted actuarial)	
Noel Cruse	Segal Consulting (contracted actuarial)	
Anna Brawley	Agnew::Beck Consulting (contracted support)	
Wendy Woolf	Retired Public Employees of Alaska (RPEA)	
Malan Paquette	Public member	

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 many 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 Cammy Taylor called the meeting to order at 1:07 p.m.

Approval of Meeting Agenda

Materials: Agenda packet for 1/20/21 RHPAB Modernization Committee Meeting

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

Ethics Disclosure

Cammy Taylor requested that Committee members state any ethics disclosures in the meeting.

- No members made ethics disclosures.

Item 2. Public Comment

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. The Chair also reminded Board members and members of the public of the following:

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

Public Comments

- Malan Paquette. She shared concerns about data breaches and how this has impacted Alaskans. She was impacted by a recent data breach from the State of Alaska and wanted to make the board aware of this issue, and that protecting members' data is very important. She also recommended attaching the agenda to the public notice, it was not available in the notice she provided. She also thanked the committee for making the meeting available telephonically.

Item 3. Working Session: Medicare Advantage Plan Concept

Materials: Decision Points document provided with the 1/20/21 agenda packet

Division staff members and contractors introduced themselves, including noting that Betsy Wood is back at work after maternity leave, and Yasmine Habash will end her temporary position after filling in. Chair Cammy Taylor asked Emily Ricci to lead discussion.

Decision Points

Emily gave an overview of the work to date: The Division and the Board have been working for several months to consider whether and how to change the current Defined Benefit retiree health plan, to modernize the plan and possibly offer additional or new benefits that retirees have requested over the years, while maintaining the financial sustainability of the plan and the state's health trust. Most of the discussion focused on changes to the existing plan, but more recently, another option was identified: a Medicare Advantage (MA) plan, for those who are Medicare eligible, as well as an equivalent potential alternative available for those who are not Medicare eligible. Most of the discussion has focused on the Medicare Advantage plan to date, but both member groups need to be considered.

There are many decision points to consider, and analysis needed to determine whether this is a net positive benefit, and what considerations and issues need to be addressed to implement this successfully. Emily speculated that the effort to implement an MA plan or equivalent alternative plan would be a similar level of effort to the EGWP implementation (the group Medicare Part D pharmacy plan, implemented in 2019) in terms of member communication and engagement, administrative and logistical issues, and transition to the new plan for those who opt into it. Another challenge is that there

are no current MA plans offered in Alaska; this would be the first, so they cannot model it or build from an existing plan in-state. The Division, with feedback and advice from the Board, still needs to determine whether this option is viable and feasible, and whether it's a sufficiently better alternative than the status quo to be worth implementing. From there, if the decision is to move forward, the team can identify issues to address, considerations for how it impacts members, and determine how to implement this concept. Staff are also interested in working with the Board to identify some objectives and desired outcomes, and broad parameters for determining whether this is worth the effort.

Emily outlined the steps in the process in the "Decision Points" document shared with the agenda packet, which summarizes the work to date, the decision points for whether to move forward to future stages in the process, and at what points members will be engaged. This includes not only whether to offer such a plan, but also selection of vendors. There also needs to be review of what is required in an MA plan, what else can be offered, and how this compares to the current AlaskaCare plan and the benefits currently included in that plan, which would serve as the baseline requirements for designing an MA plan compatible with an AlaskaCare plan.

Committee comments and feedback:

- Judy Salo pointed out that one important parameter, per the Constitution and subsequent case law (*Duncan*), is that the alternative plan offered needs to pass the test of "no diminishment of benefits." This requirement is necessary, but also hampered the previous discussions about modernizing the plan, without a clear way to measure this or evaluate the differences between the current plan and proposed changes.
- Cammy Taylor agreed, and added that diminishment of benefits needs to include not only consideration of cost, but also the overall package of benefits offered to retirees. She noted, for example, that members have consistently asked for preventive benefits and other features more common in health plans than when the retiree health plan was originally created. If it is possible to offer these benefits, this would be a benefit to members. She also appreciates the complexity involved in implementing this, especially considering what benefits could be available to non-Medicare eligible members, outside the MA plan itself. She also appreciates the difficulty of setting up a new MA plan where there isn't one already, and that this will be a challenge for vendors as well. Question: What do other states offer, are MA plans common? Is there another state or states we can use as a model? What would our network look like?
    - Richard Ward responded: most, if not all, other states offer MA plans. There is likely not a clear analog to the Alaska plan in another state retirement plan. He also confirmed that the network would simply be providers who accept Medicare, in this case a Medicare Advantage PPO plan, so the existing network in Alaska and elsewhere would be the network, unless and until additional providers accept Medicare.
      His recommendation for parameters: considering whether an MA plan is ultimately cost neutral (or cost saving), but offer additional benefits compared with the current plan. Preliminary analysis and the responses from potential vendors indicate that this might be the case, but more work is needed. The State will also need to consider what would make this type of plan more attractive to vendors, since they would only offer this type of plan if they also saw it as beneficial in business terms.
- Cammy also asked about the localized service areas, and the 51% requirement (for additional network benefits depending on local enrollment)?

    - Richard responded the service areas are at the county (in Alaska, boroughs) level, and clarified that this calculation can be made from one service area, but benefits can be extended to other geographic areas if the level is met in at least one group. Additionally, if members are also living in service areas that already meet or almost meet this threshold, this could also be beneficial for the plan. So far, potential vendors have indicated that meeting this requirement in Anchorage is critical for the viability of an Alaska-based plan. Additionally, having many retirees out of state and already living in service areas where that requirement is met, would also benefit Alaska-based retirees.
    - Emily added that she also sees potentially qualifying through enrollment of retirees living in Mat-Su Borough would be additional "cushion" in qualifying for the better network provisions. Vendors typically do a lot of proactive education and solicitation of people who are eligible in an area, to increase enrollment in their plan, highlighting features such as gym memberships or $0 co-pays to illustrate the value of the plan. The Division would anticipate any vendor offering a plan in Alaska would engage in these activities, since they have a direct interest in promoting the plan to eligible members.
- Judy Salo commented that this timeline and the process needs to anticipate or assume that there may be pushback and possibly litigation along the way, based on the experience of past plan changes. Additionally, retirees may perceive any change as frightening or undesirable, so the Division should anticipate this response and mitigate these concerns as much as possible if it moves forward. She also noted that for those living outside Alaska, they may already have experience with Medicare Advantage, and some experiences are negative. This should also be addressed.
    - Emily appreciated these comments, and agreed there are many decisions to make, and some things that will be hard to anticipate. For example, staff are not looking for feedback on whether to make the plan default or an opt-in right now but wants to step back and define (with the Board) what success looks like, what essential guidelines or thresholds or characteristics the plan needs to have, and what if any "non-starter" issues or barriers the group has. That would be sufficient to determine whether this should not move forward, if those barriers can't be overcome after exploring the options and understanding how it could be structured.
    - Richard also noted that there are significant differences between individual MA plans and group MA plans, these are different products and some aspects of individual plans that may be less desirable. He also noted that MA plans are different, some may have better benefits than others. Like EQWP, this would be a group plan, and the State has the ability to design and customize the plan to be compatible with the current health plan and what AlaskaCare offers. Some of the complaints or frustrations with other MA plans offered in other places are not necessarily features of all MA plans, but choices made for those individual plans. Alaska can make different choices.
- Nan Thompson asked whether the plan could lose qualification based on the 51% service area, if people come and go in the plan through the year? Or is this determined once per year?
    - Richard responded the plan has to qualify at some point in time, but this qualification stays through the plan year. Meeting that threshold also may be impacted if there are several plans operating in the same area, or where the plan is offered, to encourage enrollment to meet that advantageous threshold.

- Nan asked whether, if the State designs an MA plan and a vendor offers it, could other non-state-retirees who live in Alaska offer this plan to non-AlaskaCare members?
    - Richard answered yes, the vendor could offer an MA plan outside the AlaskaCare group, for people living in their service area(s). It may not be the same plan, since it would not be part of the same group, and instead have an individual plan. It would also need to be offered in a specific service area, e.g., if offered in Anchorage, a person living in Juneau could not necessarily enroll unless it's also offered in Juneau. If the vendor operates in Alaska, other employers could also offer a group plan for their retiree-age employees, and the employer(s) could design their own plan separately from the AlaskaCare plan.
    - Emily shared a current example, the Beech Street network offered services via the AlaskaCare plan, but also was able to offer a network to other clients, separately and not the same set of benefits as AlaskaCare.
    - Richard noted that Aetna also offers multiple options for Alaska coverage, separate from the contract that AlaskaCare has with that vendor. There are some benefits for the vendor, the State and other employers by having them operate in Alaska, but this would not mean that other plans offered by the vendor would directly impact the State's plan.
    - Emily reiterated that these larger opportunities to increase offerings in Alaska could benefit groups beyond AlaskaCare members; this group is the largest group of covered lives in Alaska and has considerable market power.
    - Richard noted that broadening options beyond state employees and retirees (in this case, retirees only) could benefit other Alaskans. For example, a vendor is considering offering a new plan beginning in 2022, separate from the State plan.
- Cammy asked whether spouses and dependents would have the same benefits in an MA plan?
    - Yes, the details would be determined in plan design, but this would still allow for coordination of benefits and coverage of other Medicare eligible household members. A person who isn't Medicare eligible would not be eligible for the MA plan—but the State could also consider offering an equivalent plan to non-Medicare eligible retirees.
    - Cammy noted that currently, retirees must enroll in Medicare Parts A and B when they are eligible, if their spouse is not eligible, they remain in the other retiree plan.
    - Richard confirmed that a person must also be enrolled in Parts A and B to be eligible to enroll in an MA plan.
- Cammy pointed out that, based on the information from staff about demographics of members, there are many who are or will very soon will be eligible for Medicare. Within a few years, about 90% of members will be Medicare eligible.
    - Emily noted that this is true, but there are also people who haven't retired yet or aren't currently enrolled but will be in the next several years. So, there is potentially a larger group than the current membership implies.
- Judy asked whether there are any estimates or projections for new retirees? What considerations do we need for this group?
    - Emily noted that it is difficult to speculate, but there are only approx. 200 current retirees in the Tier 4 (DCR) group, this is a separate plan. Because this group qualifies only after they turn 65, they will also be enrolled in Medicare, with a few exceptions. But generally speaking, this group would be utilizing AlaskaCare as secondary to

Medicare. Most in this group are anticipated to be active employees or otherwise not enrolled in the plan for some time.

- Judy requested the demographic information shared with the Alaska Retirement Management Board (ARMB) to understand the number of members impacted, and age cohorts.
    - Emily will follow up on this and provide to the Board in the next meeting.

Emily shared that staff certainly understand the value and necessity of health insurance for retirees and are not taking these possible changes lightly. Staff are researching other considerations but noted that they are thinking of this as an option, not a requirement, and would have opportunities for members to opt in or opt out, particularly hardship considerations.

- Cammy asked what is required year to year, does the plan need to qualify each year for the 51% threshold? Would this impact the design of the plan over time?
    - Richard responded yes, the plan needs to affirm it qualifies for the 51% each year, but the plan would be approached year over year with adjustments as needed. This will be a negotiation with the vendor as well, like other third-party administrator contracts.
    - Emily confirmed that this would also require a competitive bid from vendors periodically (whichever schedule for the contract is set), so there would be regular opportunities to improve or adjust the plan, to the mutual benefit of the plan and vendor.
- Judy commented that many people would want to see enhanced value for this option, versus the status quo, to make it worthwhile; they would also want to know that they can make changes, and that this isn't the only or default option if they are not interested.
    - Richard noted that the vendor itself also has considerations, it needs to be viable and profitable for them to offer this product in this market. Their primary interest would be in increasing the number of members, as this makes the plan financially feasible for them by increasing the pool of covered lives.
    - Emily reiterated the importance of communication and education to members, and ensuring that the product they offer (if offering an MA plan) would be consistent with and responsive to what members want, that would make it worth participating in. There are many open questions, some of which can't be answered unless this proceeds to creation of an RFP and selection of a vendor but making sure this is worthwhile to members (and feasible for the plan) is very important.
- Judy asked whether reimbursement rates to providers are also flexible under MA plans? Does this also depend on whether they meet the 51% threshold?
    - Richard responded that provider reimbursement is flexible to some extent, they can negotiate rates that may be closer to current fee for service rates than standard Medicare rates. There can be a dynamic reimbursement arrangement, since it's a contract between private parties, provisions re: more advantageous rates, premium amounts, more services offered, etc. can be built in. This can also "snowball," where more members enrolled can trigger more advantageous rates or services, which will attract more members.
- Emily asked Richard to confirm whether there are primary care access requirements?
    - Richard confirmed there are some requirements for primary care providers (minimum number of primary care providers in network), at least some need to be in-network. But

if the service area can meet that network threshold, this could "unlock" in-network rates for all primary care providers.
    - Emily noted that many primary care providers in Anchorage currently do not accept Medicare, partly due to relatively low rates compared with commercial insurance. The introduction of an MA plan could also expand options for other Medicare enrollees.
    - Richard clarified that this may have an impact, but because it would require providers to accept all Medicare patients, not just MA plans: he speculated that a vendor offering a new plan is most likely to start with providers who already accept Medicare, and only later would approach providers who aren't already accepting Medicare and convince them to opt in.

Timeline

Emily shared an overview of the document outlining phases:

1. Phase 1 (Q1 2021)
    a. Responses to the RFI indicate that there is potential interest by vendors in the market, to offer this type of plan in Alaska.
    b. Next step is to consider, broadly speaking, what an MA plan could look like (network, benefit design, cost, etc.) as well as what equivalent benefits would look like for non-Medicare eligible members, to ensure there is an offering for both groups.
    c. The team will also need to review legal considerations, related to the current plan as well as what is required for Medicare plans.
    d. The team is reaching out to equivalent entities in other states, inviting guest speakers to share their experience and lessons learned with the Board in a future meeting.

- Cammy commented that the activities make sense, but the timeline for Phase 1 may be too ambitious to complete in Q1 (by end of March).
    - Emily agreed: perhaps by end of May it would be possible to bring the findings from Phase 1 to the Board?
    - Judy noted this is still challenging, but more realistic.
    - The group also noted that working through the desired outcomes, goals and objectives may be possible to define, more so than completing the analysis and providing detailed information to move forward in future phases. That needs more time.
    - Judy proposed the February meeting is a good opportunity to bring the full Board up to speed, share what's been done to date, and discuss the big picture goals and objectives that need to guide this decision.
    - Emily clarified that the Division is not seeking a "yes/no" recommendation at the May meeting but asking for the Board's input and feedback on whether the findings in Phase 1 offer enough reason to believe this is worth pursuing further and conduct further analysis. Phase 3 will require considerable time and staff resources to analyze, so the ask is partially to confirm that this investment is warranted. During that phase, staff would be pulling together the more detailed analysis and considerations that would be necessary for the Board to make a recommendation, and the Division's ultimate decision point whether to implement an MA plan.
- Emily also asked for feedback on what's proposed for each phase.

    - Judy commented that Division staff and Segal should take the lead on risks, challenges, and other considerations, but that the Board can offer thought as well.
    - Cammy confirmed that beginning consideration of what a non-Medicare plan looks like is important to start now, even if it cannot be completed in Phase 1, since it's a significant part of the overall question, whether an MA plan is worthwhile.
    - Nan agreed, this will be iterative.
- Emily also asked for feedback about outreach and communicating with members (Phase 4)? Staff are early in the process, so it's important to begin communicating with members starting now, but there will not be significant information available yet, so it is difficult to provide detail.
    - Judy agreed this is very important, despite not having detailed information yet. She recommended drafting a press release to share at the February 4 Board meeting, for members to give feedback, that can be released soon after. She suggested member communication should start earlier than Phase 4, knowing that there are many unknowns. What other communications would be helpful?
    - Emily agreed, and noted that the Division posts FAQs, and would plan to use this format throughout the process to answer questions (as answers are available over time). Staff also utilize e-mail and e-newsletters to share information, providing periodic updates through these methods would . Staff will begin drafting FAQs to provide to members and will also draft a release with an overview of the phases and timeline, stressing that this is early in the process and much of the work involves gathering information to help make a future decision.

Emily continued outlining phases: Phase 3 would be detailed analysis about impacts to members, to the plan, and other aspects of the proposals, similar to the process used for the several Modernization proposals the group reviewed previously.

Phase 5, vendor selection, would take place at the end of 2021 or early 2022: this is not an RFP process to choose and select a vendor, but to outline detailed requirements from potential vendors for pricing, based on what plans MA vendors would be able to offer in the coming year.

- Richard noted that MA plans are typically developed in the spring, for the following calendar year, after vendors understand and shape their plans based on applicable CMS guidance. He recommends assuming that vendors would not be able answer questions re: pricing until approximately May 1 of that year.

Emily continued: Phase 6, Implementation, would ideally begin Q3 2022 and continue through the end of the year, including considerations such as whether and how to offer open enrollment, member education and communications about options, and addressing questions and concerns. This would mean an actual MA plan could be implemented in plan year 2023. She noted that this is a longer timeframe than she had hoped in terms of responding to members' requests for modernizing the plan, but this is a complex process.

- Judy shared that this document is a good start. She believes the upcoming Board meeting is an excellent opportunity to bring all members back up to speed—reminding longer-term members of the work to date and why they embarked on the process, educating the newer members

about past conversations, and reiterating the purpose and broad goals for considering modernizing the plan.

- Emily agreed: it is important to underscore that while there has been a lot of discussion about changing the plan, it is very difficult and complex to make those changes, and many legal and policy considerations in play. It is also worth emphasizing what work has been done, and why this new idea is being considered, versus changing the existing plan as was discussed before. She compared this process to EGWP, which has had a positive outcome but took much deliberation and work to implement.
- Judy commented that simplifying this proposal or being able to communicate what is being proposed—an opportunity for enhanced benefits—more simply, will be beneficial for members and help retirees evaluate whether this opportunity may benefit them.
- Cammy also offered as an example, this could also simplify dealing with claims and paperwork for members, working with one entity instead of multiple (under Medicare and AlaskaCare).

Item 6. Closing Thoughts + Meeting Adjournment

The Retiree Health Plan Advisory Board will meet on Thursday, February 4, 2021.

- **Motion** by Judy Salo to adjourn the meeting. **Second** by Nan Thompson.
  - **Result**: No objection to adjournment. The meeting was adjourned at 3:10 p.m.

EGWP

Impact of EGWP Implementation

- Dollars in Millions

	2019 Actual	2020 Actual	2021 Projection
Direct Subsidy	$1.30	$0.04	$0.05
Coverage Gap Discount	$28.80	$36.26	$38.00
Catastrophic Reinsurance	$18.20	$20.76	$23.00
Low Income Premiums Subsidy	$0.20	$0.22	$0.20
Low Income Cost Sharing Subsidy	$1.00	$1.10	$1.00
Total	**$49.50**	**$58.38**	**$62.25**

AlaskaCare

Medicare Advantage Overview

Retiree Health Plan Advisory Board

February 4, 2021 / Richard Ward, FSA, FCA, MAAA

Segal

Medicare ABCs

Medicare has Four Parts

1	**Part A**	Hospital Services
2	**Part B**	Physician Services
3	**Part C**	Medicare Advantage
4	**Part D**	Outpatient Prescription Drugs

- Each has different entitlement, enrollment, benefits and payment rules
- Medicare is administered by the Centers for Medicare & Medicaid Services (CMS), which in turn contracts with administrators, health plans, and prescription drug plans to provide various benefits

Group Medicare Coordination

- Coverage provided within the same plans as pre-Medicare members
- Medicare retirees have lower out-of-pocket costs than pre-Medicare members
- Generally covers more comprehensive services than Medicare, and covers those services as primary if not covered by Medicare.
- Complicated and lengthy claims process (less-than-straightforward EOBs)
- Generally speaking, it is not worth the investment to provide wellness, disease and case management on secondary plans; so these types of programs are not available under Medicare COB.
  - Plan would cover 100% of the cost of the program and share roughly 80% of the return with Medicare
  - Result is that the members that pose the greatest health risk are largely un-managed

Medicare Modernization Act of 2003

- Authorized government financial support to employers that provide prescription drug benefits
- Increased the types of employer-sponsored plans that could contract and coordinate with Medicare by providing for “employer group waiver plans” or “EGWPs”
- Changed Medicare Plus Choice to Medicare Advantage
- Created the Retiree Drug Subsidy (RDS)

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 & 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 claims and condition data
  - 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”
- Retirees enroll like any other group plan and are not subject to the annual enrollment period for individual MA

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

Differs from Individual MAs, which have carrier-negotiated networks that are tighter than the universe of all providers that accept Medicare.

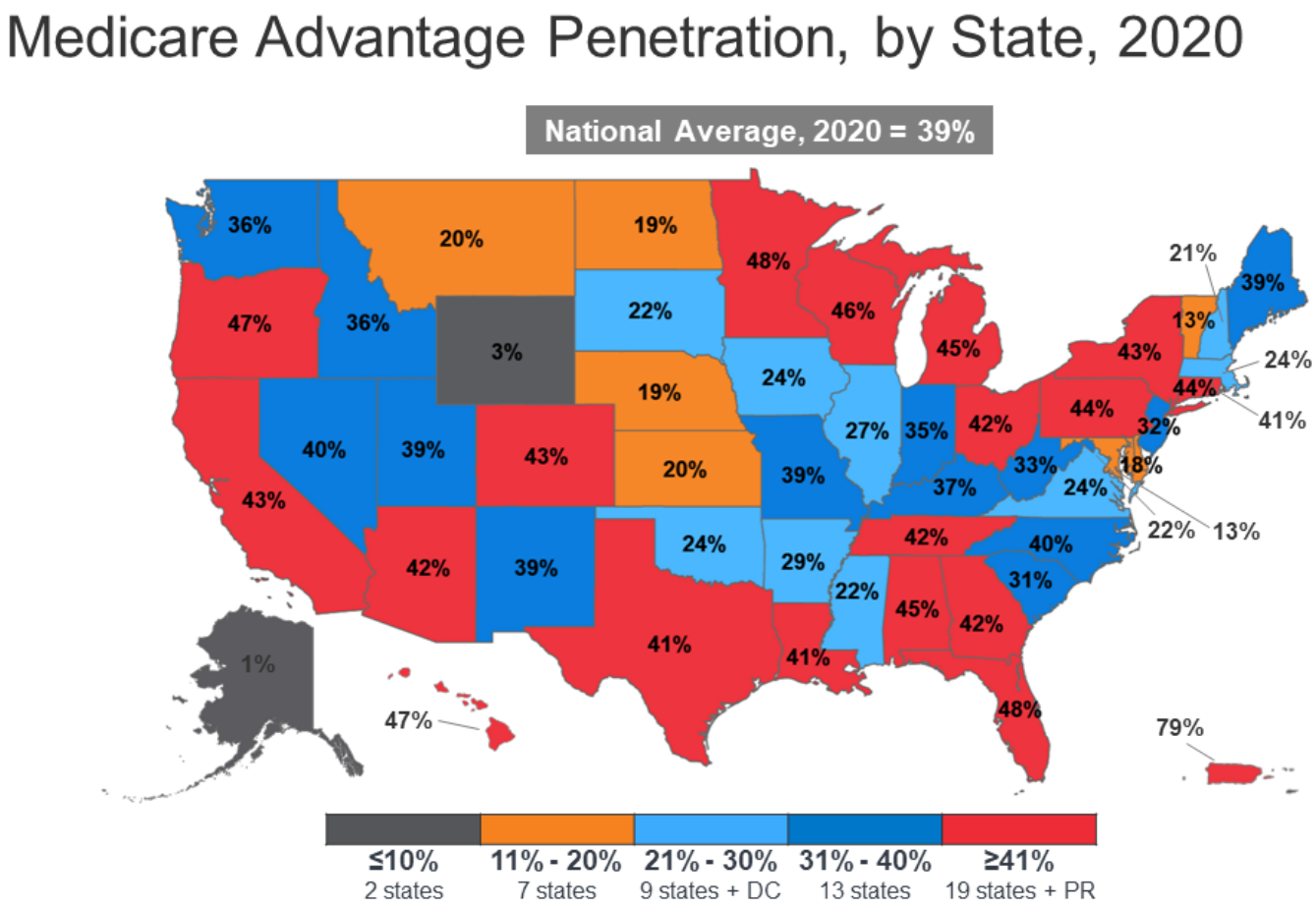
Differs from individual MAs, which are limited to CMS approved service areas and benefits may vary between service areas

MedSupp vs. MA-PPO Cost

- Health management and wellness reduce claims costs
- Can leverage CMS subsidies
- Should result in lower net costs
  - Example uses per member per month (pmpms) costs

	Current Plan (Medicare COB)	**Medicare Advantage**
Unmanaged Claims Costs	$1,000	$1,000
Effect of Medical Management	- $0	- $50
Managed Claims costs	$1,000	$950
CMS/Medicare	- $875	- $875
Net Costs	$175	$125
Savings	$50 (29%)	

Medicare Advantage Enrollment by State



NOTE: Includes cost plans, as well as other Medicare Advantage plans. Excludes beneficiaries with unknown county addresses.
SOURCE: KFF analysis of CMS State/County Market Penetration Files, 2020, and March 2020 Medicare Enrollment Dashboard Data.

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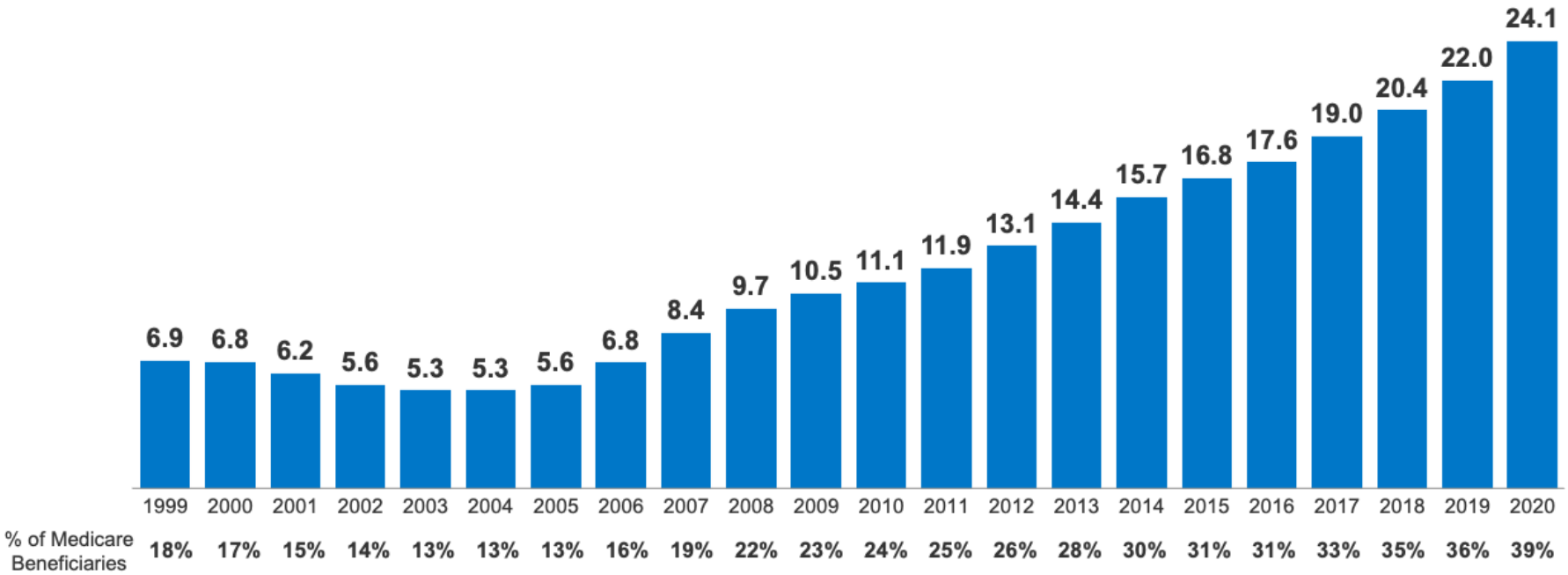
Medicare Advantage Enrollment Growth

Figure 1

Total Medicare Advantage Enrollment, 1999-2020 (in millions)



NOTE: Includes cost plans as well as Medicare Advantage plans. About 62 million people are enrolled in Medicare in 2020.

SOURCE: KFF analysis of CMS Medicare Advantage Enrollment Files 2008-2020, and MPR, 1999-2007; enrollment numbers from March of the respective year, with the exception of 2006, which is from April. Number of people eligible for Medicare comes from the CMS Medicare Advantage Penetration Files for years 2008-2009; for years 2010-2020, number of people eligible for Medicare comes from the Medicare Enrollment Dashboard.

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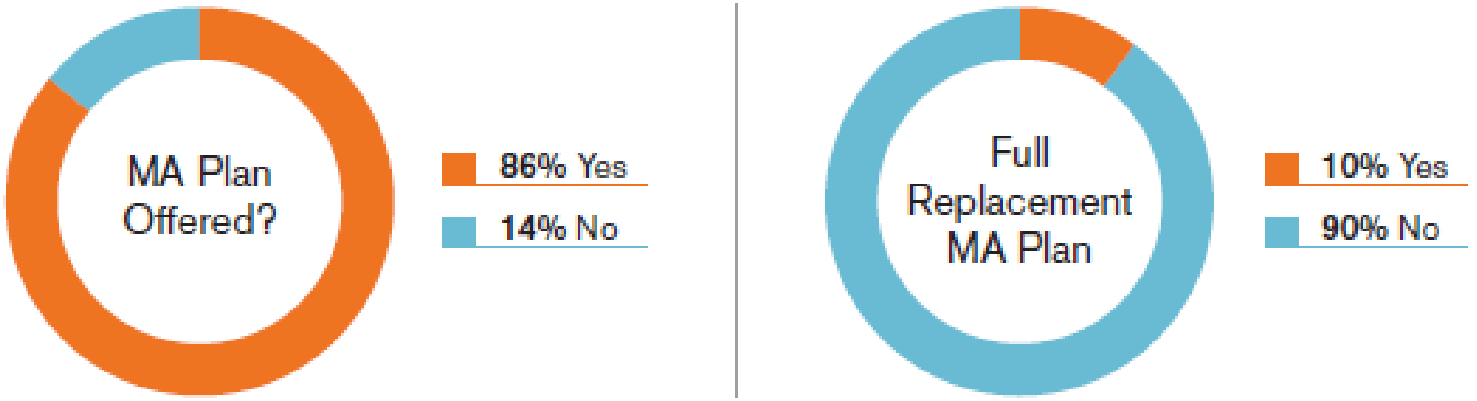
State Retiree Health Plans and Medicare Advantage

- State plans began offering group Medicare Advantage shortly after the MMA of 2003
- MA is now the norm, rather than an emerging practice
- Most states utilize Medicare Advantage, but on an optional basis

From Segal's annual study of State Health Plans:



Source: Segal Consulting, 2018

Advantages and Disadvantages

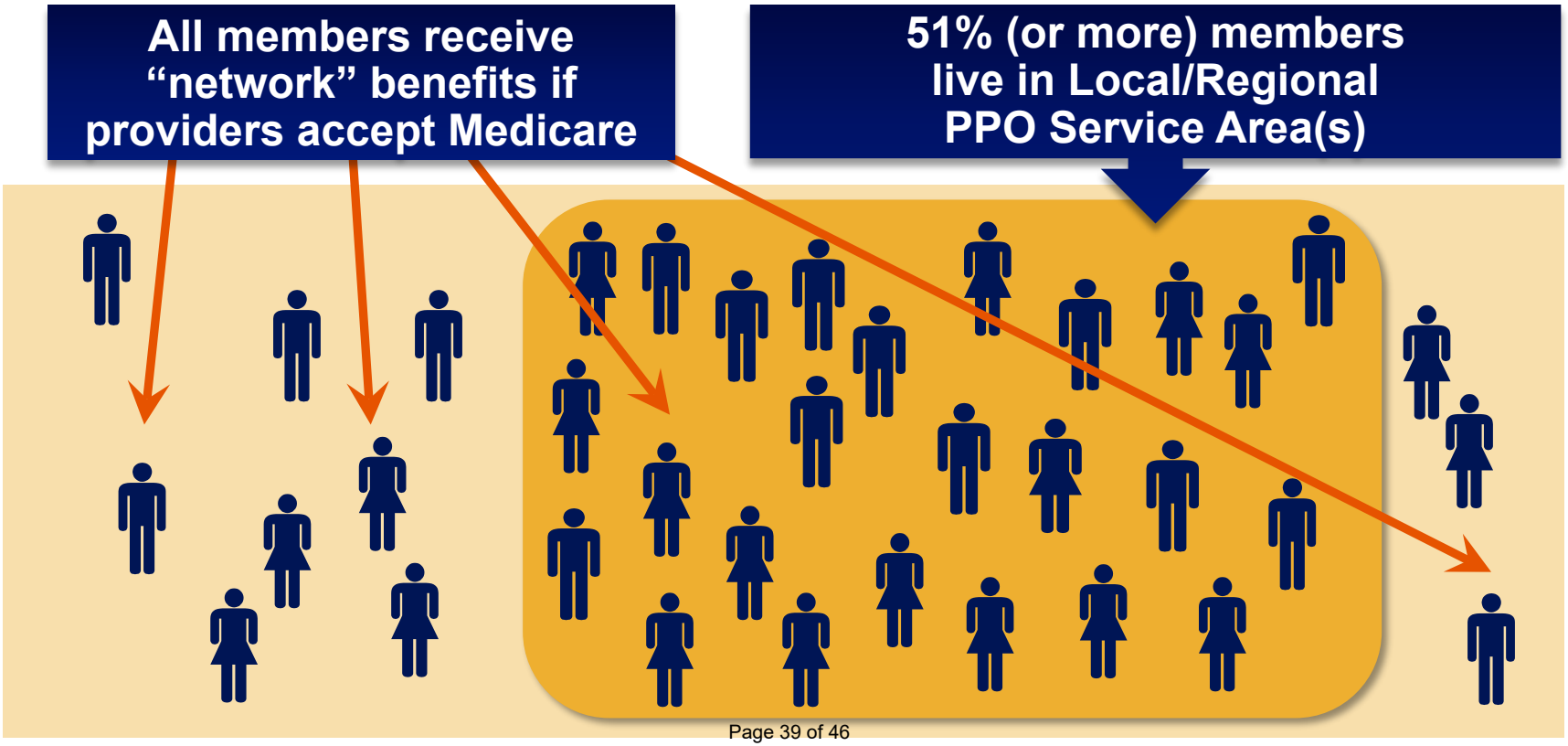
- Savings
- Supports value-based/wellness
- Can enhance benefits and/or reduce premiums
- Vendor assistance with communications/enrollment
- Passive provider discounts
- Additional benefits
  - Silver Sneakers
  - Chronic condition management
  - Discharge mean planning
  - Transplant and complex case mgmt
  - Virtual and in home care

- CMS rules/mandates
- Administrative effort
  - Eligibility
  - Compliance
  - Special cases
- Communication challenges
  - Members
  - Providers
- CMS funding set annually
  - Net premiums are leveraged
  - Annual renewal/negotiation

Medicare Advantage Plans

National Passive PPO for Groups

- If a regional PPO provides coverage to at least 51% of the ***enrolled*** 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



Alaska 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 the 51% requirement
- The carriers have existing commercial contracts and relationships with Alaska providers that could be leveraged for MA contracting

Benefits and Enhanced Program Offerings (RFI)

- 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

Estimated Premiums (RFI)

- 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		

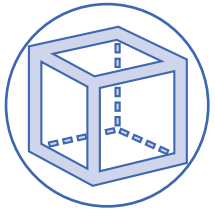
Thank You

ALASKACARE Retiree Health Plan

RHPAB Recommendation

RHPAB Recommendation

RHPAB Recommendation



Q1 2021 | Q2 2021 | Q3 2021 | Q4 2021 | Q1 2022

Phase I: Feasibility / Viability

- Evaluating market interest
- Identifying initial benefit, cost, network opportunities
- Identify alternatives, comparable offering for U65.
- Outlining initial risks, challenges, opportunities.
- Review legal considerations.
- Review program trends and experience in other states.
- Draft member communications

Phase II: Define Essential Parameters

- Goals
- Objectives
- Requirements
- Desired Outcomes

Phase III: Analysis

- Outline eligibility, benefit program, network access, participation requirements, hardship issues, enrollment requirements, etc.
- Review plan participant demographics, utilization, expected future costs.
- Develop more detailed list of risks, challenges, opportunities.
- Evaluate viable solutions.
- Updated legal analysis.

Phase IV: Member Outreach

- Develop member communication strategy.
- Solicit member feedback.

Phase V: Medicare Advantage Vendor Selection

- Draft selection requirements based on criteria from Phase I-III.
- Evaluate vendors.
- Review for alignment.

DRB Decision Point

DRB Decision Point

DRB Decision Point

DRB Decision Point

DRAFT

Possible Medicare Advantage Plan

Draft development of an alternative optional retiree health plan.

Phase I: Feasibility / Viability (Q1 2021)

1) Evaluating market interest (RFI has established there is).
2) Identifying initial benefit, cost, network opportunities for Medicare Advantage.
3) Identify alternatives, comparable offering for U65.
4) Outlining initial risks, challenges, opportunities.
5) Review legal considerations.
6) Review program trends and experience in other states.
7) Draft member communications (FAQs)

Phase II: Define Essential Parameters (Q1 2021)

1) Goals
2) Objectives
3) Requirements
4) Desired Outcomes

RHPAB Recommendation
DRB Decision Point

Phase III: Analysis (Q2 – Q3 2021)

1) Outline eligibility, benefit program, network access, participation requirements, hardship issues, enrollment requirements, etc.
2) Review plan participant demographics, utilization, expected future costs.
3) Develop more detailed list of risks, challenges, opportunities.
4) Evaluate viable solutions.
5) Updated legal analysis.

RHPAB Recommendation
DRB Decision Point

Phase IV: Member Outreach

1) Develop member communication strategy.
2) Solicit member feedback.

RHPAB Recommendation
DRB Decision Point

Phase V: Medicare Advantage Vendor Selection (Q4 2021 – Q1 2022)

1) Draft selection requirements based on criteria from Phase I-III.
2) Evaluate vendors.
3) Review for alignment.

DRB Decision Point

Phase VI: Implementation (Q3-Q4 2022)

Retiree Health Plan Modernization Topics

#	Modernization Topics
R001a	Enhance travel benefits
R001b	Enhance travel benefits, add health concierge
R002	Network Incentive: 70% out-of-network and 90% in-network
R003	Increase deductible and out-of-pocket maximum
R004	In-network enhanced clinical review of high-tech imaging and testing
R005	Out-of-network reimbursement as a percentage of Medicare
R006	Expanded telehealth services
R007	Expand preventive coverage to add full suite of preventive services
R008	Remove or increase lifetime maximum (currently $2M)
R009	Clear service limits for rehabilitative care such as chiropractic, physical therapy, occupational therapy, etc. and expand rehabilitative services to include rolfing, acupuncture, and/or acupressure - *public comment proposal*
R010	Exclude coverage for drugs with over the counter (OTC) equivalents
R011	Implement high-value pharmacy network with lower copays for chronic meds, medical synchronization, counseling, and packaging options for participating members.
R012	Add wellness benefits such as gym membership or program like Silver Sneakers - *public comment proposal*
R013	Consider expanding coverage for implants related to periodontal disease under the medical plan and/or under the dental plan
R014	Implement 3-tier pharmacy benefit; change out-of-network pharmacy benefits
R015	Limit compound coverage to high-quality, narrow network of pharmacies
R016	Add medically necessary treatment of gender dysphoria including surgery – *public comment proposal*
R017	Copayment for primary care
R018	Clarify reimbursement policies for surgical assistants in the plan booklet
R019	Tiered Network Benefits