

Retiree Health Plan Advisory Board Meeting Agenda

Date: Thursday, May 05, 2022
Time: 9:00am – 04:00pm [OnlinePublicNotices](#)
Location: [Join meeting](#)
ANC Atwood 19th Floor | JNU 6th Floor DRB Conference Room
Teleconference: (650) 479-3207
Access Code: 2468 467 4904
Password: RHPAB0522 (74722052 from phones)
Board Members: Judy Salo (chair), Lorne Bretz, 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
 - Quarterly - 02/10/22
 - Special – 03/25/22
 - Modernization – 04/11/22
 - Regulation – 04/20/22
- Ethics Disclosure and Public Comment Script

9:15 am Public Comment

9:30 am Department & Division Update

- Legal/Regulatory Update
- Preventive Care Birthday Cards
- New Website Overview
- Benefit Clarification – Musculoskeletal

10:00 am Preliminary Prior Authorization Reporting

10:30 am Gene-Based, Cellular, and Other Innovative Therapies (GCIT) Network

12:00 pm Lunch

1:00 pm Subcommittee Reports & Next Steps

- Modernization
- Regulations
- Bylaws

Public Comment

Retiree Health Plan Advisory Board

Quarterly Board Meeting Minutes

Date: Thursday, February 10, 2022 9:00 to 11:30 a.m.

Location: Atwood Building, Anchorage; HSS Building, Juneau; WebEx (virtual)

Meeting Attendance

Name of Attendee	Title of Attendee	
<i>Retiree Health Plan Advisory Board (RHPAB) Members</i>		
Judy Salo	Chair	Present
Cammy Taylor	Vice Chair	Present
Lorne Bretz	Member	Present
Dallas Hargrave	Member	Present
Paula Harrison	Member	Present
Nan Thompson	Member	Present
<i>State of Alaska, Department of Administration Staff</i>		
Ajay Desai	Division Director, Retirement + Benefits	
Emily Ricci	Chief Health Policy 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	
Erika Burkhouse	Assistant Vendor Manager, Retirement + Benefits	
Michael Gamble	Economist, Retirement + Benefits	
Chris Murray	Member Liaison, Retirement + Benefits	
Christina Fantasia	Appeals Specialist, Retirement + Benefits	
Elizabeth Hawkins	Appeals Specialist, Retirement + Benefits	
Kathy Oleary	Office Assistant, Retirement + Benefits	
<i>Others Present + Members of the Public</i>		
Andrew Bocanumenth	Assistant Attorney General, Alaska Department of Law	
Ben Hofmeister	Assistant Attorney General, Alaska Department of Law	
Hali Duran	Aetna (medical third-party administrator)	
Jill Fratello	Aetna (medical third-party administrator)	
Kimberly Krebs	Aetna (medical third-party administrator)	
Sara Guidry	OptumRx (pharmacy third party administrator)	
Sherry Johnston	OptumRx (pharmacy third party administrator)	
Jennifer Riordan	OptumRx (pharmacy third party administrator)	
Carrie Sather	OptumRx (pharmacy third party administrator)	
Noel Cruse	Segal Consulting (contracted actuarial)	
Stephanie Messier	Segal Consulting (contracted actuarial)	
Richard Ward	Segal Consulting (contracted actuarial)	
Kautook Vyas	Segal Consulting (contracted actuarial)	
Anna Brawley	Agnew::Beck Consulting (contracted support)	
Stephanie Rhoades	Retired Public Employees of Alaska (RPEA)	
Wendy Woolf	Retired Public Employees of Alaska (RPEA)	
Delisa Culpepper	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, and the retiree health trust
- 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 2/10/22 RHPAB 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.

Approval of Previous Meeting Minutes

- **Motion** by Cammy Taylor to approve the November 4, 2021 meeting. **Second** by Nan Thompson.
 - **Discussion:** None.
 - **Result:** No objection to approval of minutes as presented. Minutes 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 would stop testimony if any individual shares protected health information.

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

Public Comments

- No one in the meeting wished to provide public comment.

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

Chair Salo asked Emily Ricci to share updates.

Legal + Regulatory Updates

Emily Ricci asked Ben Hofmeister, Department of Law, to give an update.

Ben introduced himself and noted that he is also attorney for the Alaska Retirement Management Board (ARMB) board and provides legal services to DRB. He shared updates on current litigation:

- *Tshibaka vs. RPEA*: This is the “DVA Case.” One of two RPEA cases dealing with the Diminishment clause of the Alaska Constitution; this one is related to the Dental, Vision and Audio plans. Changes to the DVA plan, which resulted in lower premiums but changes to the benefits offered, is at issue. The Supreme Court found that the option of paying into the dental plan (paid by member premiums) is a benefit. They found that the Superior court’s decision was incorrect and did find that the actual plan is diminished by those changes. Because this options value is affected by both the plans coverage and purchase price, analysis of its potential diminishment should incorporate both of these dimensions. The superior court only analyzed whether the coverage was diminished, and did not consider if the premium decrease was an offset. However, it also means that the State may need to offer this plan with significantly higher premiums, to be able to provide the same benefits.
- *RPEA vs State*: This case has been moved to arbitration. It involves changes in prior years (2014, 2016, 2018) to the retiree health plan. Mediation will begin this Friday, February 11; the discussion will include both this case and the DVA case, since both revolve around the diminishment clause.

- Judy Salo asked if Ben is involved with mediation of these cases?
 - No, he is not on the mediation team, the State has a Special Litigation team who is participating.
- Nan Thompson asked who is the mediator, is it Judge Elaine Andrews?
 - Ben confirmed Ms. Andrews is the mediator. She is considered a very skilled mediator, and the State is satisfied with the choice. He anticipates that after the initial conversation, they will have a better idea of whether and how this can be resolved, the meeting is scheduled for a full day. It may take multiple days of conversation, or communication in writing to resolve issues. He also confirmed that if it is resolved by mediation, it will still need to go to Superior Court to be accepted and signed.
- Judy asked if Emily would like to share additional comments from the Division on these cases?
 - Emily noted she is hopeful issues can be resolved by mediation; the medical plan case also still has a trial scheduled for June or July, if it cannot be resolved by mediation, so it would move forward this summer if necessary. She thanked the Dept. of Law team for their work and hopes mediation will be successful.

EGWP and IRMAA Update

Chair Salo invited Andrea Mueca to share updates:

Andrea shared that IRMAA, the premium surcharge for high-income retirees enrolled in the EGWP pharmacy plan, and which is reimbursed to those retirees by the plan, is continuing to operate normally. The enrollment process for reimbursement needs to be completed every year; members eligible for reimbursement need to provide their Social Security annual letter to confirm what they are being charged as a premium surcharge, to claim reimbursement.

The Division sent letters to all 2021 enrollees, reminding members to complete the process for reimbursement in 2022. Letters can be submitted electronically or on paper; there is an online system managed by OptumRx to submit, or members can email or fax the letter. Payments are made to members through ETF (electronic transfer), either as a monthly amount or as a lump sum. Members have a full year (December 31, 2022) to seek reimbursement for the prior year (2021). There are approximately 2,100 submissions for 2022 so far, about half of the total who sought reimbursement in 2021. She also noted that most retirees submit the paperwork electronically at this point!

- Lorne Bretz asked whether the language on the website button can be changed: it currently says “Medicare Part D IRMAA” which doesn’t suggest retirees should click on it. He recommended adding the word “reimbursement,” or something to indicate to members that it could be of interest to them. He described the location on the website (right-hand panel).

DVA Open Enrollment Update

Andrea also provided an update on the Dental, Vision, Audio plan enrollment:

2022 open enrollment ended in the fall and members have now completed their elections for 2022. Members should have received new ID cards in the mail earlier this year; they can download ID cards electronically, or request a new ID card from Delta Dental, if they haven’t received one.

There are 40,000 total enrollees in the DVA plan, only a portion completed the enrollment process. There has been a general shift from the Legacy plan to the Standard plan in terms of enrollments; for new retirees, about twice as many choose the Standard plan over the Legacy plan for their first election.

- Judy asked whether open enrollment is closed?
 - Andrea responded yes, the period is from early October to around Thanksgiving (November), so it closes before the end of the calendar year.

New DRB Website

Materials: Website flyer on page 18-19 in 2/10/22 agenda packet

Teri Rasmussen shared an update:

The Division is working on website updates across the Division’s pages (including AlaskaCare). The goal for the website redesign is to more quickly direct members—retirees and employees—to the specific information they are looking for. The team looked at the web pages accessed most often and prioritizing them on the site. The screenshot provided will be updated but is an example of the new website layout (there is also an error, it says “employees” but should say “retirees”).

Staff plan to inform members about the planned changes to the site, knowing that it will take time for people to get used to the change. The team will provide a “preview” of the new site and outreach to members, with videos and/or live demonstrations that are recorded, to illustrate how to use the new site. The website redesign will launch this spring, after further testing and the preview period.

Betsy Wood added that having feedback from members about the website design, especially if there is confusing wording, better ways to describe things, and generally making sure it works well for the intended users (AlaskaCare members). Please share feedback, and ask other retirees for feedback, about how to make the website work better!

- (See above, Lorne recommended adding “reimbursement” to the IRMAA link)

- Nan recommended having the list of topics in alphabetical order, so it's easy to browse.
- Judy requested staff walk the board through the website when it's ready for a preview.
 - Teri agreed, staff will work to schedule this. They are also anticipating scheduling one or more electronic meetings to demonstrate the new site for members and will make sure board members are aware of this.
- Judy also suggested providing a preview of the website at an upcoming Tele Town Hall.
 - Teri noted that the events are by phone only (audio, no video), but this will be a topic for an upcoming Town Hall as well.

Preventive Care (New Policy) Update

Emily noted that it is day 41 of providing new preventive care benefits to retirees! She asked Kimberly Krebs with Aetna to provide an update:

Kimberly shared that 1253 preventive benefits claims have been submitted in January so far, including for bone density screenings, mammograms, vaccines and other services. Emily added that this is definitely not the full picture, because there is always delay in claims being submitted after services rendered—there will likely be several more for the month of January, that won't be received until days or weeks later. This is a promising sign so far that people are utilizing these benefits.

Prior Authorization for Specialty Medications (New Policy) Update

Emily invited Sara Guidry to provide an update:

Sara noted that there were several aspects to putting this new policy in place, including the new codes for the plan, testing the system, providing letters to members as notice, including members already using these medications and members who would be newly in treatment. The letters were not sent on original planned schedule. They also provided two letter notifications to pharmacies as well, alerting them that this system will now be in place. OptumRx had also been asked to reach out to prescribers (physicians) to notify them of the change. While they were not able to reach all providers, they did contact providers already included in the OptumRx specialty pharmacy system, who are many of the prescribers already utilizing these medications.

The team also updated the formulary information of which medications are subject to this policy; they included a combined list of medications (covered by Medicare Part D, EGWP and covered by the AlaskaCare "wrap" benefits). OptumRx also added the prior authorization (PA) requirements (when a medication PA is required, for what diagnoses and circumstances). There has also been a transition override in place, so members would not be interrupted in receiving their current medications if they have not completed the PA paperwork by the start date. Members were also able to start the process prior to January 1, before it officially took effect, so they could have it in place.

Sara also shared her experience quality testing and reviewing the initial claims: of the claims she reviewed, the ones that were denied were medications that needed prior authorization, versus an error or incorrect denial. The ones denied were a medication new to the patient, and which would require prior authorization. She noted that there are many reasons for a denial, often it can be corrected with more information or addressing an error. Of those claims submitted in January, 98% were able to successfully complete a prior authorization—either the original medication, or prior authorization for a different medication, according to the guidelines. Only 2% were denied and had no follow-up action from the member (so far), but they may submit an updated prior authorization in future.

About 58% of members who need a prior authorization haven't completed the process yet—OptumRx reviewed the list and found that these members have current medications on hand, and likely don't need a refill at the pharmacy until March or later. Members have been notified but need to take action to submit PA paperwork soon in order to complete the process to avoid an interruption.

- Paula Harrison asked how this is handled when AlaskaCare is secondary insurance? Does this require prior authorization from OptumRx as well, or is this addressed by the member's primary insurance?
 - Sara responded the PA requirement is the same, regardless of whether the plan is primary or secondary. Many insurance plans already have this kind of policy in place.
 - Paula responded this seems problematic: having to file the paperwork twice seems redundant, and if the primary insurance is paying most of the cost, this doesn't seem necessary, especially if there is a low co-pay.
 - Emily responded staff will work with OptumRx to discuss the secondary payer issue, it is complex and needs more thought. She will follow up with the board about this topic.
- Cammy thanked staff and OptumRx for answering questions yesterday in the quarterly vendor meeting. She noted that one specific medication is coded as a specialty medication needing a PA in the formulary, that is not listed that way in the EGWP formulary. She noted that if there are some medications that are considered specialty medications, that may need or not need PA, it is helpful to distinguish between the two. She also appreciates that generic drug names are listed in the formulary as well.
- Cammy asked the difference between a 6-month and 12-month approval, if a person has been taking this medication for a while?
 - Sara responded there are several factors for the length of time for the medication, not just the individual medication, but also the member's circumstances, other medications, and whether they are new to treatment or have been using it for a while. For example, an initial approval might only be 6 months, but later may be approved for 12 months once you are established and not having problems. But it is specific for every medication and individual patient and can change over time.

Emily noted that so far, there has not been feedback or member concerns about the prior authorization process: they anticipated potentially an increase in calls with problems, but so far things have been quiet. She noted that with the expiration of 90-day prescription fills and the number of members who still need to complete the process this spring, there may still be issues. However, so far the system seems to be working well; she reiterated that 98% approval of PAs is a positive result, it seems to be working as intended. She especially thanked Sara Guidry for her work to implement this system.

COVID Updates: OTC Test Kits

Betsy Wood provided an update: there has been discussion about coverage for over-the-counter (OTC) COVID test kits (the home swab kits). There was recently a federal law change requiring insurance companies to cover these test kits; this is one of the policy areas that the retiree plan is technically exempt, although they do also apply to the retiree plan. However, the Division discussed temporarily extending this benefit (coverage of OTC test kits) for retirees as well and will provide this. The policy will cover 8 tests (a 2-pack counts as tests) per month per person, provided that they are FDA-approved home tests. Members can be reimbursed in several ways: pharmacies with a relationship with OptumRx can do this directly, by asking if the pharmacy has OTC kits and receive them without having to pay and get reimbursed. These include Walgreens, Walmart, and other pharmacies; a list is available on the

Division website. Members can also be reimbursed after purchasing test kits, with an electronic or paper form. Reimbursement is up to \$12 per test (will reimburse for actual cost).

Information about how to access home test kits, and other COVID policies:

<http://doa.alaska.gov/drb/headlines/2020/03/coronavirus/index.html#hometest>

Medicare has also been considering coverage of home test kits, likely through Part B (outpatient services) not Part D (pharmacy). The Division does not yet have details yet but will be sharing with members when they know more. It will likely not be something the Division handles directly, since Medicare Part B is not part of AlaskaCare, but they will inform members how to access tests if and when CMS updates its Medicare coverage policy.

Emily added that payers (insurance and health plans) were told this new coverage requirement for tests at short notice, it is still being figured out and is difficult to administer, since it is a retail product. Members should contact the Division with questions, but given the very short timeframe, they have worked to get the new policy in place, not by the process they would normally use to do so.

Betsy added one clarification: initially, Aetna offered reimbursement and encouraged members to save receipts for reimbursement; however, after the Division talked with Aetna and OptumRx, and determined that this benefit makes the most sense as a pharmacy benefit, since these tests are mostly purchased at a retail pharmacy and the reimbursement better matches a medication claim, not a claim for medical services. The Division directs members to submit claims for reimbursement to OptumRx.

- Cammy asked how members who enrolled in Medicare should access tests, until Medicare covers it?
 - Betsy responded the Division is covering this benefit through the EGWP plan, as part of the wrap benefits; it is also covered under the regular pharmacy plan. She also noted that there are other places where people can access free tests: they are available for free in City Hall in Juneau, and other locations across the U.S. may have other ways to access free tests.
- Judy asked which pharmacies are participating so far with OptumRx?
 - Betsy reiterated the list: Rite-Aid, Walgreens, Walmart and Sam's Club, Kinney. She noted that Optum is in discussion with other entities, but in the meantime, the Division's website has the most current list of participating pharmacies, and how to seek reimbursement if the member purchased the tests at another location.

The Board took a break at 10:25 a.m., and returned to the meeting at 10:35 a.m.

Chair Salo called the meeting back to order.

Item 4. Gene-Based, Cellular and Other Innovative Therapies (GCIT) Network

Materials: Draft policy proposal for GCIT Network Benefits beginning page 20 in 2/10/22 agenda packet

Emily Ricci provided an update: the Division is not asking the board for a vote today but will share a draft proposal with the group for discussion. These therapies are very new, complex and costly, and currently only available by a small group of providers. Prior board meetings have included informational presentations about these therapies.

The proposal is to provide coverage for these benefits, within a network of providers, and include travel benefits for members, since these therapies are only available in limited locations. Because these are new but have potential to expand significantly over time, the Division would like to put a coverage policy

in place early and can be updated over time as this type of health care will continue to grow over time. The Division intends to bring this to the board for a vote in the future, and in the meantime would like to work through the proposal in more detail, either with the full board or at the modernization committee.

Betsy provided an overview of the initial proposal, included in the packet: this is a first draft, and they ask board members to start asking questions, identify areas of concern, and otherwise provide feedback that will help inform future drafts. This is “cutting edge” and have potential to treat or cure very difficult to treat diseases and will have huge impacts on our population. They are also extremely costly, because they are a new technology and can have lifetime impacts. The plan needs to determine how to facilitate access to these therapies for members with certain conditions that the therapies have been effective with, and also how to manage utilization and cost of these treatments, with financial implications for both the plan and the member.

Many plans and contracts with network providers do not address or include these treatments, so payers like Aetna need to negotiate prices with providers. There may be, for example, a \$1.5 million treatment that does not have an agreed-on price in the plan. This not only represents significant cost to the plan, but also given the scale of the price of these treatments, can also quickly impact a member because of any applicable co-pays, as well as the existing \$2 million lifetime maximum in the retiree plan. The plans have already seen claims for these treatments, both retiree and employee plan—an employee claim was \$2.1 million, and a retiree claim for a treatment that costs \$128,000 per treatment. This will continue to grow, and needs to be addressed in terms of access, coverage and how it interacts with the retiree plan’s current lifetime maximum. There is also risk with these treatments, both clinical and in terms of cost, so the Division is anxious to address this in the plan as a coverage policy.

- Judy commented there is both risk to the plan, and risk to the member—finding these services, and determining if it is the right course of treatment? For example, when discussing the SurgeryPlus travel benefit, she appreciated the quality control aspect.
 - Betsy noted that these are new treatments, and certainly are complex, and generally aren’t self-administered. She gave examples of medications that require administration by someone who is experienced and knows how to do this (e.g. eye injection). She agreed that this is an important part of the process, not only whether it is the appropriate medication or treatment for the member, but also administered by a qualified provider. Manufacturers of these drugs are also starting to maintain lists of approved providers, who know how to use these treatments. The Division is also working to define how an approved provider is determined, such as the “Center of Excellence” model used with SurgeryPlus.
- Cammy asked whether it is unusual to have manufacturers “approving” providers or putting forward requirements, and whether the FDA or another entity is approving them?
 - Kimberly clarified that for Aetna’s network of therapies (GCIT), they cover treatments that are also FDA approved. There are a total of 16 treatments, so far 3 are FDA approved and the others run through the standard approval process.
 - Betsy added that they are working with Aetna to define this further, through a “Center of Excellence” model or beyond whether the manufacturer has approved the provider for administering the drug. They are still working to define this.
- Paula Harrison asked whether the Division has made a decision about whether to remove the lifetime maximum on the retiree plan, as discussed last year?

- Betsy confirmed the Division did not make a change to this policy, it was discussed and certainly still up for consideration as a plan change. However, in the meantime, this policy is still in place, and will impact people who utilize expensive therapies like these, as they could quickly reach that maximum.

Betsy continued: the actual policy proposed is to only cover in-network GCIT services, i.e., from a provider who is in this network, and not covering therapies outside this network. This would be different than other coverage, where they do cover out-of-network services. She also noted that many of the treatments contemplated for coverage would be for children, so they will not apply to many members on the retiree plan, but there are plan members to whom this would apply.

The policy would also cover travel, for the member receiving care and a companion, because there are no Alaska-based network providers at this time, so most if not all of these treatments would need to take place in another location. The Division and Aetna have been discussing with providers in state who may provide these treatments and become part of the network in future; currently this is not an option.

Betsy also shared the benefit coverage includes a care coordination function, through Aetna: the provider who would like to seek this treatment for a member would need to connect with Aetna and any other applicable providers to coordinate, seek precertification. The care team at Aetna will conduct its usual functions, including coordinating with the member, their providers, and the hospital (as an example) to ensure this is a medically necessary and appropriate approach.

Kim confirmed this is accurate: when a provider wishes to initiate this treatment process, they contact Aetna, who begins the care coordination process. If the facility who provides the treatment is not currently in network, Aetna would work to negotiate an agreed price, which protects the member as well as the plan. Because there is no network contract, it is not guaranteed that they will be able to secure that agreed price, but to date Aetna has generally been able to secure agreements with providers who offer these new GCIT treatments.

Page 22 lists details 3 therapies that would be covered in the GCIT network: Zolgensma, Luxturna and Spinraza. These are primarily for children but have had claims so far. These drugs would be provided with an approximate 17% discount from the regular price, and more could be added in future. She gave an example of how the lifetime maximum would impact a member: for example, if a member receives a treatment, the plan is billed a total of \$5 million for that treatment, and the plan says it will only pay \$2 million (recognized charge), the member would be potentially billed the remaining \$3 million. This is an extreme case and has not happened yet in the AlaskaCare plan but has happened to other people in the U.S. to date, having extremely high bills that their plan does not cover.

Betsy also confirmed that anyone currently receiving these therapies would not be impacted by this plan and would still have their costs covered even after this policy is in place. For members who seek this treatment after the policy in place, they would need to follow the plan coverage and utilize treatment within the GCIT network and would have the care coordination and travel benefits available as well. The travel benefit would be available to all members, not just in Alaska, as there are limited locations where this is available.

Betsy also clarified that the out-of-pocket costs for members would not change, it would be covered under the existing coverage plan, as long as it is provided by a GCIT network provider. The issue is with the lifetime maximum for this plan. She also noted there is no additional administrative cost to

participate in this new GCIT network, it is a program they can opt into with the existing contract. This may have long-term financial benefit for the plan as it will protect against some high costs out of network, but no additional upfront cost. She noted that like any policy change, there will be an implementation cost, but this is relatively easy to opt into. The biggest cost/need for implementation will be the time and resources to outreach to members about this new policy and ensuring that impacted members can easily transition to the GCIT network, or to confirm that they can continue to access their existing therapy if they are being treated before this policy is in place. Going forward, it should not add additional administrative burden or cost to the plan.

She summarized the sections in the draft proposal and noted that they still need to work further on the Clinical and Provider Considerations section. She encouraged board members to identify questions, provide feedback, and help the Division round out this proposal to ensure they are considering all necessary aspects of this plan change.

- Nan asked about how implementation in the employee plan has gone so far?
 - Betsy confirmed this policy began January 1, 2022 for employees; so far, there have not been any claims in the employee plan, just the retiree plan. Aetna did notify the Division about the claim, and were notified during the precertification process, instead of after the claim is processed, which is the normal procedure. Since this program is not in place, Aetna was able to successfully negotiate a price with the facility because it is not in network, but otherwise this could have had a worse (and costlier) outcome.
- Cammy asked how the network provision works? For example, if a member needs a GCIT treatment, and has an Alaska-based provider who does not participate in the GCIT network, would there still be an opportunity to utilize this in-state provider, and negotiate the price?
 - Kimberly confirmed: this has happened in Alaska: the provider decided they do not want to join the network but will honor the negotiated price for this treatment going forward, with Aetna. So, it depends on the provider willing to participate, but it is possible.
- Cammy asked about the approved providers—it differs by medication, but she noted that there is an increasing number. How many providers who are approved by manufacturers not covered in the Aetna GCIT network?
 - Kimberly responded they are actively working to expand their network; it is new and still has a small number of providers. There are, for example, 130 manufacturer-approved providers for one treatment, so far Aetna has almost 80 in-network. Aetna is negotiating with providers to join the network and are trying to expand as much as possible.

Betsy concluded, reiterating that they are seeking board input on this proposal, especially questions that the board would like staff to research and answer.

Emily added that the Division's intent is to implement this in the retiree plan, ideally January 1, 2023; and would like to continue this conversation. She asked the board what their preferred timeline is, what information or process they would like to use to vet this plan, as they want to make sure there is time to address and work out an implementation plan.

- Judy commented that this item should definitely be included on the May meeting agenda, whether or not it is up for a vote. She anticipates needing time to discuss this and fully understand it, that it impacts a lower number of members (so far) but is complex and a new policy to consider.

- Emily noted that the Division anticipates this would be relatively less time and effort to implement than some other policies, they could even implement it sooner than January 1, if the board agrees; they want to work on the timeline that works for the board and members. The next 2 regular meetings are in May and August; they could aim for having further discussion and a vote in May. If it goes into the fall, it could be difficult to have turnaround for January 1 implementation; approval of the preventive benefits and prior authorization changes were done at a special meeting in early September, but this was a tight turnaround.
- Board questions for follow-up:
 - Nan asked what the criteria for manufacturers to approve facilities for these treatments? It appears to be an institution/facility, not individual provider.
 - Cammy asked what would happen with treatments not covered in network, or providers who are not in network? This seems to leave a gap in treatment, she would like to discuss the implications of that further.
 - Judy would like to further discuss how providers could be added to the network and address any unusual circumstances: there will be many unique situations, with a low-volume, high-cost treatment type. She would like to discuss a waiver or exception process, or how to handle issues on a case-by-case basis, but still have consistent policy.
 - Judy asked for sources members can use to get more information generally about gene therapy: there were suggestions for online searches, but more specific sources would be beneficial for members.

Item 5. Closing Thoughts + Meeting Adjournment

Closing Thoughts

Chair Salo invited Board members to make closing remarks: no comments.

She also thanked staff and vendors (Aetna, OptumRx) for preparing information for these meetings, and for providing thorough information to the board and AlaskaCare members about these policies, from discussion of proposed policies to implementation of changes. She also looks forward to when the board and staff can meet together around the same table, in person!

Motion by Cammy Taylor to adjourn the meeting. **Second** by Nan Thompson.

Result: No objection to adjournment. The meeting was adjourned at 11:30 a.m.

The next Retiree Health Plan Advisory Board meeting will be Thursday, May 5, 2022.

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

Retiree Health Plan Advisory Board

Special Board Meeting Minutes

Date: Friday, March 25, 2022, 9:00 a.m. to 12:00 p.m.

Location: Atwood Building, Anchorage; HSS Building, Juneau; WebEx (virtual)

Meeting Attendance

Name of Attendee	Title of Attendee	
<i>Retiree Health Plan Advisory Board (RHPAB) Members</i>		
Judy Salo	Chair	Present
Cammy Taylor	Vice Chair	Present
Lorne Bretz	Member	Present
Dallas Hargrave	Member	Present
Paula Harrison	Member	Present
Nan Thompson	Member	Present
<i>State of Alaska, Department of Administration Staff</i>		
Ajay Desai	Division Director, Retirement + Benefits	
Emily Ricci	Chief Health Policy 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	
Erika Burkhouse	Assistant Vendor Manager, Retirement + Benefits	
Chris Murray	Member Liaison, Retirement + Benefits	
Elizabeth Hawkins	Appeals Specialist, Retirement + Benefits	
Kathy O'Leary	Administrative Support, Retirement + Benefits	
<i>Others Present + Members of the Public</i>		
Chris Robison	Assistant Attorney General, Alaska Department of Law	
Jeff Pickett	Assistant Attorney General, Alaska Department of Law	
Miranda Roberts	Aetna (medical third-party administrator)	
Kimberly Krebs	Aetna (medical third-party administrator)	
Stacy Carmichael	Delta Dental	
Anna Brawley	Agnew::Beck Consulting (contracted support)	
Stephanie Rhoades	Retired Public Employees of Alaska (RPEA)	
Randall Burns	Retired Public Employees of Alaska (RPEA)	
Wendy Woolf	Retired Public Employees of Alaska (RPEA)	
Delisa Culpepper	Retired Public Employees of Alaska (RPEA)	

Common Acronyms

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

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- 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, and the retiree health trust
- 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 9:04 a.m. A quorum was present.

Approval of Meeting Agenda

Materials: Agenda packet for 3/25/22 RHPAB Special 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

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

- No one in the meeting wished to give public comment.

Item 3. Mediation Settlement Agreement

Chair Salo asked Emily Ricci to share an overview.

Emily shared the items in today's meeting are an update on the health plan settlement agreement, and recommendations to the Board for action to implement portions of the settlement. The components of the recommendations are listed as numbered items below.

Summary Presentation

Materials: Presentation provided as a supplement to the 3/25/22 RHPAB Meeting

The slides provided in the meeting have a detailed outline of the issue, summarized below.

In February, the Division and Retired Public Employees of Alaska (RPEA) reached a settlement after over 6 years of litigation. This addresses multiple suits against the State for prior changes to health plans. There were 3 actions that were the basis of this action: in 2013, the Division competitively procured third party administrator (TPA) services for the AlaskaCare medical, vision and audio plans, as well as the dental plan. In 2014, new vendors were selected, and the plan was transitioned including a plan amendment. There were also changes to the dental plan in 2014.

In response, RPEA filed two lawsuits in 2016 and 2018, alleging diminishment of the Constitutionally-protected retiree health plan benefits. At issue is the fact that the value of the plan is protected, so if there are changes made to the plan that are considered diminishments (lowering value) must be offset by additional or enhanced benefits. This does not take into account an individual's benefits or circumstances, but overall, the plan value and benefits offered. The value and changes in value must be established by actuarial or other statistical methods.

Dental, Vision and Audio (DVA) case: the 2014 changes to the dental plan were argued to be a diminishment in RPEA's case in 2016. The State argued that because the plan is optional, it is not included in the Constitutional benefits; and if it is determined to be part of the protected benefits, the specific changes are not a diminishment. The plan went to trial in 2018, with a decision in 2019 that was appealed. The 2019 ruling by the Superior Court determined it was a diminishment, but after appeal, the Supreme Court vacated this ruling because the lower court did not take into account the value of the reduction of premiums. The court also found that valuation of benefits must use statistical valuation on a group level, not on an individual basis, and that the burden of proof is on the plaintiff to show diminishment. The ruling determined that it was not possible to comparatively measure the value of the old and new plans, but it provides general guidance that a court should look to whether the State's plan changes make a good faith effort to provide a viable health plan for retirees.

Aetna Plan Amendment case: the 2014 plan amendment change adopting Aetna's clinical policy bulletins in the plan without prior notice to beneficiaries, as well as a number of other components of the plan were changed. The lawsuit was brought by RPEA in 2018, with a long discovery process (2019-2021) and there were some summary judgments on components of the case. In early 2022, both parties agreed to mediation of this case; when the Supreme Court issued a ruling on the DVA case as well, it was added to the scope of mediation.

Settlement agreement: In February 2022, the State and RPEA engaged in mediation, and were able to successfully reach a settlement agreement. In addition to settling a number of issues in the cases, the groups also discussed and agreed to continue the processes of engaging with retirees: public notice and engagement with retirees; continued reliance on the Board (RHPAB) to discuss and review proposed changes to plan benefits and other components of the plans; and to memorialize these processes going forward, so that they remain the standard process by which these changes are addressed in the plan. Additionally, both sides have agreed to cover their own legal fees.

Slide 16 illustrates the key components of the settlement for the DVA plan: members will retain access to both dental plans, the Standard and Legacy plans. However, the plans must be viable; if the Legacy plan's premiums increase to a certain monthly dollar threshold to make the plan self-funding, it may be terminated because it would no longer be able to provide the level of benefits the plan funds. The

Standard plan will become the default plan for new retiree members. The process for setting premiums year to year will be done transparently, and plan changes will follow the same process as the medical plan’s change process. There are some gaps in data, from the early 2010s and the atypical year of claims in 2020 but going forward they anticipate having better data from which to set premiums.

The settlement terms for the medical plan include: adopt a plan amendment clarifying portions of the medical plan; issue a benefit clarification about maintenance care visits for musculoskeletal disorders; recommend extension and adding an additional seat designating an RPEA seat on the Retiree Health Plan Advisory Board; creating two standing subcommittees, including an RPEA member on each. These are recommended bylaws changes for RHPAB. Additionally, the Division will create a regulation identifying the process for making plan changes, including the multi-faceted analysis they have been using to discuss potential plan changes over the last few years; this will follow the standard regulation review and public comment process.

The Board itself has a role in the process going forward, including a series of actions and timeline for the Board, to consider recommendations and to implement those changes. The Division recommends 2 additional meetings in April, a modernization subcommittee meeting and creating the regulations subcommittee, before the Board’s regular May 5 meeting.

1. Memorandum: Recommendation to Alaska Retiree Health Plan Advisory Board

Materials: Memo starting page 2 of 3/25/22 RHPAB Meeting

This document outlines the recommended actions to the Board as a result of the settlement.

2. Bylaws

Materials: Bylaws starting page 4 of 3/25/22 RHPAB Meeting

The packet includes the current bylaws. There are multiple changes needed to enact the agreements in the settlement: adding a Board member, formalizing the two proposed committees, and possibly other conforming changes. Chair Salo asked that member Dallas Hargrave work with Division staff to review the bylaws and draft proposed changes that would enact the settlement terms.

- **Motion** by Cammy Taylor to direct the Division to draft the changes required to the bylaws to enact the changes proposed through the settlement agreement, and to bring those changes to the Board for review at the May 5 meeting. Second by Lorne Bretz.

Discussion:

- Judy thanked Dallas for being willing to reconstitute the bylaws committee if needed and asked that he plan to review the draft as an individual member before it goes to the Board.
- She also reminded the group that there is a minimum 30-day notice period before they can adopt any changes, and it will likely be longer because the draft needs to be created, reviewed and will need to be brought to the Board.
- Emily added that staff will not be able to bring the draft bylaws 30 days before the meeting (April 5); they will be able to bring a draft to the Board, but not with the required notice that is needed for a vote. The Board could then plan a special meeting in the summer or vote on the changes at the August regular meeting.

Vote: Motion passes.

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

3. RHPAB Subcommittees

The memo on page 2 outlines the recommended 2 subcommittees to be created as standing committees to the Board: the modernization committee already exists but is not memorialized in the bylaws, and the regulations subcommittee would be new.

Regulations Subcommittee

This new committee is intended to first support the process for two proposed regulations packages, as well as working with the Division on any future regulations on an ongoing basis.

- **Motion** by Lorne Bretz to create a Regulations subcommittee. Second by Cammy Taylor.

Discussion:

- Cammy asked whether the group should also include proposed membership in the motion?
- Judy recommended the group first vote on the initial motion, and then address the specifics in a subsequent motion.

Vote: Motion passes.

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

Lorne volunteered to serve and chair on the new subcommittee. The committee would have at least 3 members, including 2 board members (Bretz and another member) and 1 member of RPEA. Board members are always welcome to join the committee but must have minimum membership. Nan Thompson volunteered to serve as the second board member.

Emily shared the overall timeline for these committees: first, the modernization subcommittee would need to meet in April to discuss proposed plan changes. Second, the regulation subcommittee should aim to meet the week of April 11th to discuss the proposed regulations changes.

- **Motion** by Cammy Taylor to create a third member for the regulations subcommittee, who must be an RPEA member in good standing, to be approved by the Board from a list submitted by RPEA of 3 qualified members to the Division. Second by Nan Thompson.

Discussion:

- Cammy stated that the intent is to continue engaging with retirees in discussions of the retiree health plan and related regulations and having participation on this committee is an effective way to keep retirees engaged. This committee is advisory only and cannot take action on behalf of the Board.

Cammy also clarified this is separate from selecting individual members for those committees from the candidates RPEA put forward, which would be a separate action.

Vote: Motion passes.

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

Modernization Subcommittee

This committee was already formed and has been meeting for a few years, working on proposed changes to health benefits and other updates to modernize the plan.

- RPEA member Randall Burns asked who is on the committee currently?

- Cammy responded she is chair, along with Nan. Joelle Hall was on the committee previously but is no longer a board member, Judy has been attending regularly. Other members have also attended in the past.

The group has a list of candidates for each committee provided by RPEA, along with their qualifications. To discuss proposed members before selection, the Board intends to enter executive session.

- **Motion** by Cammy Taylor for the Board to enter executive session, for purposes of discussing the proposed RPEA candidates put forward for the modernization and regulations subcommittees. Second by Lorne Bretz.

Discussion:

- The group clarified the process for entering and returning from executive session.
- Cammy also clarified that no action can be taken in executive session, only discussion.

Vote: Motion passes.

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

[The Board entered executive session, which is not subject to documentation in the minutes. The Board returned to meeting on the record with the following motion.]

- **Motion** by Cammy Taylor for the Board to leave executive session. Second by Lorne Bretz.
No objection.
- **Motion** by Lorne Bretz for appoint RPEA-submitted candidates Mauri Long to the Modernization subcommittee, and Wendy Woolf to the Regulations subcommittee. Second by Cammy Taylor.
No objection; motion passes.

Emily shared that the Division requests the Modernization subcommittee meet the week of April 11, and that the Regulations subcommittee the week of April 18. Staff will find time for each meeting.

- Randall Burns requested RPEA be able to notify the selected and not selected committee members through end of day (Friday), before staff or Board members reach out. The Board agreed.

Emily Ricci recommended a brief discussion of the plan amendment in today’s meeting, but to postpone discussion of the benefit clarification until the May meeting.

4. Plan Amendment #2022-01

Materials: Plan amendment starting page 9 of 3/25/22 RHPAB Meeting

Emily shared the plan amendment was published on Friday, March 18, which would put into place portions of the settlement agreement, clarifying portions of the “medical necessity” provisions in the plan. The amendment includes a neutral reference to the claims administrator (page 29 of settlement packet, page 9 of the Board packet), amends the contact information section with a reference to Aetna’s clinical policy bulletins; amending section 3.3.1 to remove the name “Aetna” and instead include “claim administrator,” this term is defined in the booklet along with plan administrator. It also defines the plan administrator as the Dept. of Administration commissioner, who retains the authority to determine medical necessity. This is not a policy change, but clarifies whose responsibility this is, and also notes the factors used for consideration whether to pay the claims.

The plan administrator’s evaluation happens during the third level of the appeals process. This does not remove the claims administrator’s ability to review and adjudicate claims on a routine basis, and those

the clinical policy bulletins are used first. The plan administrator still also has the ability to review not only the claims administrator's policies, but other plan terms that may be relevant, if an item is appealed to that level. There is also a change in section 14.4, removing the requirement to file a claim in any judicial district (4 total), not just District 1 (Juneau).

- Cammy noted this returns the standard practice of reviewing medical necessity that was in place before 2013 and outlines respective roles of the clinical policy bulletins versus plan administrator. She asked the Division: how would a new claims administrator be informed that this is a standard practice and requirement for TPAs that these must be made available? Is this memorialized in writing? Or is this one of several practices not yet officially documented?
 - Emily responded it is not specifically included in a regulation, but it is included in the required terms in the RFP, a bidder must agree to meet those terms if they are to be considered responsive. There are other legal considerations, but this could be discussed at another point.

Public Comment Period

Materials: Public comment period timeline starting page 12 of 3/25/22 RHPAB Meeting

Teri Rasmussen shared that the public comment period was opened March 18 at 8 a.m., and will be open through May 20 at 4:30 p.m. The public comment item is included on the Public Notices site, and in local newspapers. Comments will be collected through that site or can be emailed or mailed to the Division. There will also be a teleconference on April 25, 2 p.m. to discuss the proposed changes. Once the public comment period closes, there is a short period for staff to turn around any additional changes, and these changes would take effect June 1 as written.

- Judy asked how public comments are being tracked, are they reviewed as they are received?
 - Teri shared she copies comments as they are received into a document, which will be redacted and used to publish the full set of public comments received.
- Judy asked whether the Board will be able to receive the public comment to date at the May 5 meeting, since it is in process?
 - Emily shared that staff and the Board have opted in the past not to publish public comment directly while the comment period is open, as they need to redact and prepare a full packet. She recommended that staff share general themes they hear to date in the comment period up to that point, to provide that in writing to the Board, and that later (after the public comment period closes) the Division will publish the redacted comment document.

5. Benefit Clarification

Materials: Benefit clarification starting page 15 of 3/25/22 RHPAB Meeting

This item was tabled for discussion and will be discussed at the May 5 quarterly meeting.

Item 5. Meeting Adjournment

Motion by Nan Thompson to adjourn the meeting. **Second** by Cammy Taylor.

Result: No objection to adjournment. The meeting was adjourned at 10:47 a.m.

The next Retiree Health Plan Advisory Board quarterly meeting will be Thursday, May 5, 2022.

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/drbr/alaskacare/retiree/advisory.html>.

Retiree Health Plan Advisory Board

Modernization Committee Meeting Minutes

Date: Monday, April 11, 2022 1:00 to 3:00 p.m.

Location: Atwood Building, Anchorage; HSS Building, Juneau; WebEx (virtual)

Meeting Attendance

Name of Attendee	Title of Attendee	
<i>Retiree Health Plan Advisory Board (RHPAB), Modernization Committee Members</i>		
Cammy Taylor	Committee Chair (RHPAB)	Present
Nanette (Nan) Thompson	Committee Member (RHPAB)	Present
Mauri Long	Committee Member (RPEA)	Present
Paula Harrison	Board Member	Present
<i>State of Alaska, Department of Administration Staff</i>		
Ajay Desai	Division Director, Retirement + Benefits	
Emily Ricci	Chief Health Policy Administrator, Retirement + Benefits	
Betsy Wood	Deputy Health Official, Retirement + Benefits	
Teri Rasmussen	Program Coordinator, Retirement + Benefits	
Andrea Mueca	Health Operations Manager, Retirement + Benefits	
Kathy O’Leary	Administrative Support, Retirement + Benefits	
<i>Others Present + Members of the Public</i>		
Kimberly Krebs	Aetna (medical third-party administrator)	
Andrew Robison	Aetna (medical third-party administrator)	
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Randall Burns	Retired Public Employees of Alaska (RPEA)	
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- RPEA = Retired Public Employees of Alaska
- 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 committee meeting to order at 1:14 p.m. after resolving technical issues.

Approval of Meeting Agenda

Materials: Agenda packet for 4/11/22 RHPAB Modernization Committee Meeting

1. **Motion** by Mauri Long to approve the agenda as presented. **Second** by Nan Thompson.
 - Cammy proposed adding Public Comment following the work session item, no objection.
 - **Result:** No objection to approval of agenda as amended. 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. Work Session: Establishing Scope and Process for Committee Review

Materials: Documents beginning on page 2 of the 4/11/22 agenda packet

Cammy Taylor shared the purpose of today's meeting is to establish the scope, timeline and sequencing of review for 3 items identified on the agenda, included as topics in the settlement agreement.

1. Coverage for experimental & investigational services and supplies.
2. Precertification process.
3. Travel penalty when precertification has not been secured.

She invited Division staff to present:

Emily Ricci reminded the group the purpose of this committee is to work with the Board to discuss potential changes to the retiree health plan, and that these items have been identified by the RPEA board and Division staff as needing research, identifying potential problems, and resolving if possible. The Division recommended using the same process as with other potential plan changes, using the Board and subcommittee process. There are 3 items for discussion that have been implemented at different times in the plan: these are what the Division proposes discussing with the committee.

1. Coverage for experimental & investigational services and supplies:
 - a. What current plan language includes, how it is applied;
 - b. How the process is completed, including internal processes;
 - c. And what if any problems or impacts need to be mitigated, including participation in clinical trials, and how the plan interacts with these trials.
2. Precertification process overall:
 - a. Requirements for precertification, how they are being applied;
 - b. Whether the process is consistent with language across the plan booklet;
 - c. Potential timing and process issues related to applying for and addressing denials of precertification, some of which were implemented during the 2014 transition to Aetna, for services such as inpatient mental health or chemical dependency treatment;
3. Travel penalty, meaning travel and services incurred without precertification, which are not covered by the plan if not approved.

Cammy invited comments and questions from Board members:

- Mauri Long commented she is interested in more regular review of policies, such as the issues identified here, and documenting the details in writing. She would like to see, for example, updated policy guidance for policies like those identified.
 - Emily asked for clarification.
 - Mauri clarified: she would like to see better documentation for members of their responsibilities, so it is clear when they need to seek precertification and what the member needs to do to access care. Reviewing more regularly would be useful and could be a responsibility of the third-party administrator to write information about their policies.
- Emily noted precertification can be a protection for members, especially for new procedures where there is risk of a provider doing it incorrectly, or without regard to other factors. Some documentation is already the responsibility of the third-party administrator (Aetna, for the medical plan) and incorporated into the health plan. She stated there are existing review processes, but also

new opportunities for collaboration and open discussion about potential changes, with a more cooperative and positive environment to work with the Division, Board and members.

- Delisa Culpepper asked whether this would be best in regulation, rather than being the responsibility of the third-party administrator? This would also make it more clear for members, and this is an appropriate role for the State as the plan administrator.
 - Emily noted that the Division has been reluctant to make changes to any aspect of the plan, including the plan booklet, but is optimistic that this is more feasible, and could be reviewed more holistically to improve understanding and clarity for members.
 - Delisa added that having it in writing, such as regulations, members would feel less uncertainty or surprise about future changes. She believes this would improve members' perception of the plan policies and make the process more well-defined.
- Nan Thompson agreed it would be helpful to conduct a regular review, and that this is good practice to institute, similar to an organization reviewing its bylaws.
- Cammy noted that after the many changes in 2014 to the plan, there were widespread concerns about understanding and having a process for changes. The Board (RHPAB) was formed in 2018 as part of the effort to better engage with retirees, and involve them in the process of discussing, crafting, implementing and communicating about changes.

Cammy asked the committee members: what would you prioritize? What information do you need or want to inform the discussion, at the next meeting? For example, some items are likely more complex than others, and there are other likely pressing things the Division and Board need to attend to in the settlement, so this may be a lower priority until those other items are addressed.

- Nan asked what required timelines the Board and Division need to work within, as a result of the settlement agreement?
 - Emily shared an excerpt from the settlement: there were few time requirements. *"Within 60 days of the Effective Date, the Commissioner will request the Board's Modernization Subcommittee review the Plan's provisions regarding coverage for experimental and investigational services and supplies, the precertification process, and travel penalty."* This meeting can be considered to meet that requirement, with the intent to work on these topics this year. Resolving these is likely not possible within those 60 days, but staff would like to set a timeline with the committee to work through the process.
- Cammy asked for a recommendation for the timeline and sequencing: is it best to focus on one item at a time?
 - Emily responded all 3 topics are complex and will take time to review. She recommends that the group take up one item at a time, and work through sequentially. She asked the subcommittee to consider priorities, which topic(s) to take up first. The preparation and background work before the discussions in meetings need to be done by the Division and Aetna staff.
- Mauri Long, the RPEA-affiliated member of the committee, said she has limited knowledge of these topics, even from her prior time on the Board; she would defer to others in terms of priorities.
- Nan Thompson shared a similar perspective; she would also look for guidance on which to prioritize. She was interested in what RPEA saw as the biggest problems, which based on Mauri's comments there does not seem to be an urgent problem among these, that they know of; the group could

work on the simplest one first, anticipating the others need more time to prepare. She does not have a strong preference, but also did not know enough about them to prioritize now.

- Mauri added that generally, penalties and precertification requirements seem like important topics based on potential impacts to members, and what members have expressed frustration about. She asked whether the items brought forward, such as which services require certification, specifically defined from the AlaskaCare plan, or from Aetna's book of business generally?
- Emily shared that Division staff recommend prioritizing precertification process and requirements:
 - 3 areas related to the precertification process:
 - What services require precertification;
 - Timing of precertification, related to the actual procedure and approval;
 - How precertification penalties are applied, and if they are uniformly applied;
 - She also recommends discussing member education about precertification, when it is required and what members need to do, as a fourth area. And having an overview of why the precertification policy and process is useful, to give context for these policies.
 - She also noted that discussion of the travel penalties could be included in this first item.
 - She reminded the group that all changes would require a plan booklet amendment, which has a set public process. Additionally, she stated that experimental and investigation services and supplies is more complex and will take more time to prepare, so that would be a secondary priority.
- Cammy asked if Aetna has a national precertification list that they use for these services under all plans, similar to the list of vaccines, screenings and other preventive care services from the USPSTF? How does Aetna handle these services in other plans, and would it possible or feasible to make changes specifically to the AlaskaCare plan?
 - Emily confirmed there is a standard national precertification list similar to preventive care, it is part of the company's network contracts, and is typically approached the similarly across the industry. The National Pre-Certification i is subject to regular review, similar to the clinical policy bulletin process that Aetna and other carriers produce to maintain current guidance for their plans. She noted that any changes specific to the AlaskaCare plan should be vetted carefully, given the amount of effort goes into establishing the national precertification list, and that it is standardized across carriers.
 - Cammy confirmed that the list is not only a national standard, but typical across carriers.
 - Emily reiterated that these policies are built into provider contracts, so any proposed changes for the AlaskaCare plan should be carefully vetted.
- Cammy asked why the list of precertification items was reduced in 2014?
 - Emily did not have specific information but noted that she believes it does not serve members to have a limited list, given the protection precertification provides to members.
- Randall Burns asked whether there are external resources, such as Robert Wood Johnson Foundation or another entity, who could offer an outside perspective or best practices in this area? Having this information from a third party may be useful for members to understand. He noted that precertification is seen as a limitation, and makes members feel frustrated when it's required.
 - Cammy responded individual Board members have been staying educated, but she agrees this may be beneficial, and help answer questions or provide larger context and understanding for why these policies matter. She noted that this is one of the responsibilities of Board members as well, to help them understand the health plan policies.

The group agreed to begin with the pre-certification process, and supports prioritizing this first, followed by review of the precertification travel penalty, then experimental and investigational services.

Cammy recommended not meeting again until after the Board's May 5 meeting; she noted she is aware the Regulations subcommittee is meeting next Wednesday, April 20, and that group has been tasked with more time-sensitive deadlines regarding regulation changes and implementing other aspects of the settlement agreement. Discussion of these items can be scheduled after addressing the other issues, looking for a time for the committee to meet after May.

Emily agreed and noted Division staff will benefit from having time to prepare for these discussions.

- Mauri asked what the subcommittee can expect to see at the next meeting, and where to start?
 - Emily proposed the next meeting should likely begin with a general overview of precertification and why it exists; including the national precertification list; and setting the stage for the more targeted discussion. Staff will also work on an overview of the precertification process, timing between seeking certification and receiving services, but this may require two meetings because both are complex topics.
 - Nan and Mauri also requested including a summary of members' issues to date with these processes, such as feedback about problems with the current system. For example: how often precertifications are requested, and how often are they denied? What percent are denied? How often do members appeal, and how many have been successful or denied at appeal?
 - Emily confirmed staff will work with Aetna to collect data and describe the issues. If needed, The Division can also leverage the benefit consultants on hand (Segal, etc.) to inform the discussion.

Item 3. Public Comment

Before beginning public comment, the Chair established who was present on the phone or online, and who intended to provide public comments, and reiterated reminders about these comments being part of the public record, and that commenters cannot share protected health information (PHI).

- **Stephanie Rhoades, RPEA.** Stephanie shared it is positive to see collaboration among the Division, the Board and RPEA, she agrees with the proposed order of addressing these issues. She also appreciates the focus on education and communicating with members: she noted it is an ongoing challenge for members to understand their benefits, identify how to comply with the rules, and making sense of complex health care policies.

Item 4. Closing Thoughts + Meeting Adjournment

Cammy thanked the Division for preparing today's discussion, and collaborating on plan improvements!

Upcoming meetings:

- The Regulations Subcommittee will meet on Wednesday, April 20, 2022, 1 to 4 p.m.
- The Retiree Health Plan Advisory Board's next quarterly meeting on Thursday, May 5, 2022.
- The Modernization Subcommittee will meet again in May, when staff are ready to present.

1. **Motion** by Nan Thompson adjourn the meeting. **Second** by Mauri Long.
 - **Result:** No objection to adjournment. The meeting was adjourned at 2:01 p.m.

Retiree Health Plan Advisory Board

Modernization Committee Meeting Minutes

Date: Wednesday, April 20, 2022 1:00 to 3:00 p.m.

Location: Atwood Building, Anchorage; HSS Building, Juneau; WebEx (virtual)

Meeting Attendance

Name of Attendee	Title of Attendee	
<i>Retiree Health Plan Advisory Board (RHPAB), Modernization Committee Members</i>		
Lorne Bretz	Committee Chair (RHPAB)	Present
Nanette (Nan) Thompson	Committee Member (RHPAB)	Present
Wendy Woolf	Committee Member (RPEA)	Present
Paula Harrison	Board Member	Present
Dallas Hargrave	Board Member	
<i>State of Alaska, Department of Administration Staff</i>		
Emily Ricci	Chief Health Policy Administrator, Retirement + Benefits	
Betsy Wood	Deputy Health Official, Retirement + Benefits	
Teri Rasmussen	Program Coordinator, Retirement + Benefits	
Andrea Mueca	Health Operations Manager, Retirement + Benefits	
Elizabeth Hawkins	Lead Appeals Specialist, Retirement + Benefits	
Christina Fantasia	Appeals Specialist, Retirement + Benefits	
Kathy O’Leary	Administrative Support, Retirement + Benefits	
<i>Others Present + Members of the Public</i>		
Anna Brawley	Agnew::Beck Consulting (contracted support)	

Common Acronyms

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

- ACA = Affordable Care Act (formal name: Patient Protection and Affordable Care Act)
- 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, Tier 1, 2 TRS employees, and JRS 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, and the retiree health trust
- 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
- RPEA = Retired Public Employees of Alaska
- TPA = Third Party Administrator
- USPSTF: U.S. Preventive Services Task Force

Meeting Minutes

Item 1. Call to Order + Introductory Business

Chair Lorne Bretz called the committee meeting to order at 1:06 p.m.

Approval of Meeting Agenda

Materials: Agenda packet for 4/20/22 RHPAB Regulations Committee Meeting

- **Motion** by Wendy Woolf to approve the agenda as presented. **Second** by Nan Thompson.
 - **Result:** No objection to approval of agenda as amended. Agenda is approved.

Chair Bretz stated intent to include public comment at the end of the meeting before adjournment, if any members of the public join the meeting before adjournment.

Ethics Disclosure

Lorne Bretz requested that committee members state any ethics disclosures in the meeting.

- No members made ethics disclosures.

Item 2. Work Session: AlaskaCare Retiree Health Plan Regulations Process

Materials: Documents beginning on page 2 of the 4/20/22 agenda packet

Current Regulations Process

Lorne Bretz shared the purpose of today's meeting is to hold the first meeting of the newly established Regulations Subcommittee, including two RHPAB members (Bretz and Thompson) and one RPEA member (Woolf). This committee is intended to help implement some of the settlement agreement provisions, and outline the committee and Board's role in reviewing, adopting and updating regulations.

He invited Division staff to present:

Emily Ricci shared that the committee will discuss the regulations process for the Defined Benefit retiree health plan, and how the Division intends to implement changes negotiated in the settlement process. The presentation includes an outline of the current regulations process, as well as a framework for a proposed regulations update about the process of making changes to the health plan in the future.

Betsy Wood shared an overview of the current regulations process (slides 4-10). The regulations governing the health plans are specifically exempted from the Alaska Administrative Procedure Act, which applies to most other regulations enacted by a State agency. There are statutes (slide 4) specific to the health plan describing the regulatory process. There are statutory requirements for making changes to or enacting these regulations (slide 5): they must be published, they must follow the State's drafting manual format and style, and must have a public process including a 30 day notice and a public hearing. The regulations are not required to be adopted by the Lieutenant Governor, but are instead adopted by the Department of Administration Commissioner and take effect 30 days after adoption. There is also a process for emergency regulations, which have a public notice requirement (within 10 days) but can take effect immediately.

There are four general steps in the process: preparation work including drafting; public comment period, and revisions based on comments; finalizing the language and formal adoption; and implementation once the regulations take effect, including final legal review and publication.

1. **Preparation (slide 7):** Division staff work closely with Department of Law, with designated agency attorneys as well as attorneys in the Regulations section, to ensure the regulations are legally sound and appropriately worded. Once the language is fully drafted, including the public notice and any applicable fiscal notes, staff submit a request to open a new regulations file with the Division of Regulations Section, which is required to initiate the public process.
2. **Public Comment (slide 8):** The Division posts notice through multiple channels, including publication in major Alaska newspapers, via e-mail, e-newsletter subscription and on the Division website, mailed notice to members if possible and appropriate (a letter or postcard), and information about how to provide comments. Comments are accepted by e-mail and mail. If there is a public hearing (meeting), comments can also be accepted verbally. Comments are tracked and documented as they are received, to keep accurate record of what was provided.

Betsy also reiterated that the agency is committed to receiving public comments at any time, not just during public comment periods—members are always welcome to share comments with the Division, in writing or by calling Division staff. The public comment periods discussed are the required process for specific regulations process, but this does not limit the Division’s ability to accept comments.

- Lorne asked for more information about the retiree e-newsletter? How are people added to the list?
 - Betsy shared retirees can opt into a monthly e-newsletter from the Division. There is not a way to add e-mail addresses without someone opting in to receive the e-newsletter, since they need to agree to be signed up. The Division continues to encourage retirees to sign up for updates.
 - Teri added the e-newsletter is published monthly, along with other notifications such as the “save the date” announcements about Town Halls, upcoming board meetings, and other updates. Members can subscribe or unsubscribe at any time.
 - Lorne asked what the percent of readership is for the e-newsletter, how many open it?
 - Teri did not have the statistics on hand, but staff does closely track the click-open rates (how many people actually open and read the e-mails), and the response is generally strong. Staff also look at which web pages are visited most often. They work to tailor communications where people are seeking information, or where they are most likely to pay attention.
 - Wendy Woolf asked whether Health Matters is also provided to retiree members?
 - Emily responded yes, this is mailed annually. The publication is no longer sent quarterly. It could be a place to provide notice for items such as regulation changes, but is not as frequent and would not be appropriate depending on the timing.
 - Teri added the e-newsletters are monthly, while Health Matters is mailed twice per year.
 - Lorne asked how a member can sign up for the e-newsletter?
 - Teri responded there is a link on the Division website, or members can request to be added during Tele Town Halls, can contact the call center, or e-mail to ask to be added. Any communication method to reach the Division would work to be added to the e-newsletter list.
 - Wendy Woolf shared that RPEA publishes the sign-up link for the e-newsletter in their meeting agendas and other communications, to help members sign up and stay informed.
 - Wendy Woolf asked whether the regulations or public comment process have a requirement to participate or comment in order to have standing to oppose a regulation change? She offered an example of another department where this is required.
 - Emily Ricci shared staff will discuss this with Department of Law to ensure this is correct, but she does not believe this applies: the Division is subject to litigation at any time, and there is no specific requirement to have participated in a public process. But she will consult with Department of Law for an official answer.
 - Wendy Woolf commented that typically this language would be in the enabling statutes, if it is not defined there, it would not apply.
 - Emily confirmed that she is not aware of this language being in the enabling statutes.
3. **Finalization (slide 9):** The final package for regulations is prepared by staff and includes the final version of the regulations, a copy of public comments received and changes made as a result, and the Commissioner signs paperwork for formal adoption. The package is reviewed by the agency’s attorneys, then the package is transmitted to Department of Law, Division of Regulations, to conduct a final review and prepare the regulations for adoption and publication.

4. **Regulations Take Effect (slide 10):** Once sent to the Department of Law, there is a final legal review and ensuring that the Division has the statutory authority to adopt the regulations and that they are worded correctly. Once adopted, the regulations are effective after 30 days. A copy is provided to the Lieutenant Governor's office as well, for filing and preservation as part of code.
- Wendy Woolf asked when the discussion about what is allowed under statutes, and whether the Division has legal authority to adopt these regulations, occurs? Are there any last-minute surprises identified late in the process?
 - Betsy confirmed they work closely with attorneys throughout the process, including early during drafting to express their intent, whether and how this is achievable in the law. This helps ensure there are few, ideally no, "surprises" or issues at the end of this process. The final review becomes more of a formality, since issues would have been worked out earlier in the process.

Proposed Regulation: Process for Making Changes to the Defined Benefit Retiree Health Plan

Emily presented an overview of the settlement terms (slide 12) and the requirement to create this draft regulation about future plan changes. She also noted that the terms of the agreement, and this regulation process, are not negotiated rule-making, and also do not change the Commissioner's authority to administer the health plan.

Slide 13 illustrates what the process regulation needs to include: it must document the Division's current process for evaluating proposed plan changes, including the analysis components the Division uses (financial impacts, actuarial impacts, operational impacts, impacts to members, etc.). The regulation must also account for flexibility for the Division to respond to emergencies (such as the COVID-19 pandemic in 2020) as well as changing technologies and other health-related trends. The regulation must also document the requirement to provide members an opportunity to comment, and also include the notice and outreach requirements about proposed changes. Additionally, the settlement agreement states that the Commissioner will support adoption of this regulation, RPEA will also support adoption of this regulation. There will be a 60 day public comment period, including a public teleconference hearing.

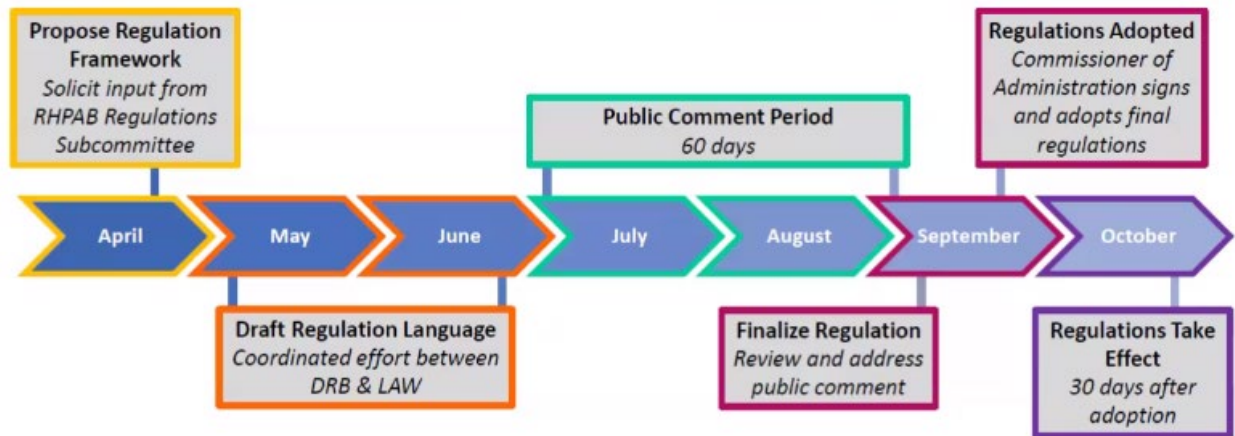
Slide 15 outlines the typical stakeholders involved in the process, including health plan members, Division staff, the Commissioner, Department of Law, and RHPAB.

Slide 16 outlines the analysis and steps involved in preparing a proposal for a plan change; this is consistent with the many potential plan changes that have been reviewed in recent years through the Modernization project. There are multiple components to the analysis, including financial and actuarial impacts, impacts to members and beneficiaries, and operational impact, to ensure they are feasible to implement and will achieve the intended objectives.

Slide 17 outlines the process for reviewing proposed changes, including the role of the Modernization Subcommittee, staff and vendors, and other agencies. Emily stressed that the process is iterative and takes a great deal of resources to review proposed changes, so they only undertake this process if an idea for a potential change has merit and potential benefits for the plan and members. This slide briefly summarizes the multi-step process that will be memorialized in the regulation.

Slide 18 details the proposed timeline for adopting this process regulation: Emily noted that staff will request the modernization subcommittee also meet periodically with the committee to review and discuss proposed changes to the regulation draft during the comment period, to be ready to update and

finalize the draft regulation after the comment period ends. The tentative goal is to be able to finalize the regulations in late September, adopt the final versions in October, and they take effect 30 days later.



- Lorne asked during the public comment period, would the committee also review comments while the comment period is still open?
 - Emily responded comments would be gathered during the period, and not released prior to it closing. Typically, the Division does not post comments while the period is open, but will review and compile all comments, redact any contact and personal health information that should not be public, and publish the full list of comments received after the period closes. The modernization committee would meet to review the draft and consider additional changes, but not directly discuss the public comments to date.
- Wendy Woolf commented on the timeline: in past years, members were frustrated with a public comment period that occurred during summer months, since many people are unavailable during the summer. She suggested extending the public comment period into September, to avoid frustration with this process.
 - Emily responded staff are open to extending the public comment period beyond 60 days to accommodate the summer schedule.
 - Betsy noted she is not aware of an issue with extending the comment period beyond that date.
 - Wendy clarified that it is more confusing to have an extended comment period (meaning, the end date extended beyond the original period to be open longer), she recommends having a longer comment period upfront, so members can plan for this in advance. She noted that with summer months and issues in August such as statewide elections, she wants to ensure members have adequate notice and time to review.
- Nan asked generally how detailed the regulations will be, and how this will be reflected in maintaining flexibility for the Division. She noted that in the development of proposed changes, it has been very useful to be able to pivot and be able to respond to changing needs or situations, such as various modernization proposals. She appreciates the need for clearly documenting this process, but also does not want to hamper the Division’s ability to be
 - Emily agreed: having flexibility is useful, and she has identified this as an area of concern as well. It will be important to consider issues such as defining the scope or magnitude of a plan change, and what should be subject to this formal process, versus policies or procedures that would not

be considered a significant change subject to this regulation process. This is one of several areas they will need to talk through and find the best approach.

Discussion

Page 20 includes a proposed framework. Emily noted RHPAB is not in statute, so it cannot be referenced in the regulation directly, they will need to work through that. She highlighted some items for future discussion, such as allowing for limited exceptions to the 30 day public comment period, in situations such as emergencies or if a more immediate plan change may be needed. Similarly, the Division would like to have an exception to the final public comment period of 30 days, such as adopting Teladoc which would be an added benefit for members and take relatively little implementation.

- Lorne Bretz commented the outline presented in the document is a good start.
- Wendy Woolf provided several comments:
 - The process is focused on requirements for notice and communication with members, which is providing information and what will be provided. It would be difficult to define and document more details about the analysis, what factors to be considered, and other aspects.
 - She also understands the complication of the fact that RHPAB (the Board) only exists as an executive order, and cannot be referenced in statute. She also recommends defining “stakeholders” in the regulations, and include RHPAB as a defined stakeholder, as well as any other groups to be consulted.
 - She noted it is possible to create a working group, other departments utilize this.
 - Additionally, she recommends defining an “emergency” clearly and when that would apply, to avoid perception that this exception to the 30-day comment period would be used inappropriately to avoid notice.
 - She also recommends clearly defining “plan change” versus “plan clarification” to be clear when this process is needed, or not needed, and when a change is being made.
- Nan offered several comments:
 - She recommended clearly defining “emergency” or “good cause” in terms of being able to alter the default timeline for comment and adoption, as that could be an area of confusion or concern, or people perceiving that as a way to side-step this process. She noted there is case law about “good cause.”
 - As an overall goal for the committee, having commitment from the Division and committee to provide adequate notice and opportunity to comment should be clearly stated, since this is the purpose of defining this process. She would like to see intent language making clear the purpose is for members to know in advance when changes are being proposed, given opportunity to be able to comment, and having a generally defined timeline for this process. That should be a priority to include in the regulations project.
 - She agreed with the distinction between plan change and clarification, but believes this will be complex to define.
- Wendy asked whether, after the regulation comment period is closed and before it is formally adopted by the Commissioner, there is an opportunity for the Board to officially review or take an advisory vote on the change?
 - Emily noted this as an area for discussion, this would likely be feasible but would require consideration of timing.
- Wendy asked whether staff anticipate a fiscal note with this regulation change?

- Emily commented at this time they do not anticipate a fiscal note, but this could change.
- Wendy noted if there is a working group associated with the change, if RHPAB no longer exists, that could trigger a fiscal note.

Emily thanked the committee for these initial comments and questions, and encouraged committee members, Board members and others to submit comments in writing! What was shared today was documented, but having written comments is helpful, as well as other thoughts. Comments can be sent to the Board's e-mail address at alaskarhpab@alaska.gov and teri.rasmussen@alaska.gov.

Item 3. Closing Thoughts + Meeting Adjournment

Lorne thanked the Division for preparing today's discussion!

Upcoming meetings:

- The Retiree Health Plan Advisory Board's next quarterly meeting on Thursday, May 5, 2022.
- The Modernization Subcommittee will meet in May, when staff are ready to present, date TBD.
- The Regulations Subcommittee will meet after the draft regulation is prepared, date TBD.
- **Motion** by Wendy Woolf to adjourn the meeting. **Second** by Nan Thompson.
 - **Result:** No objection to adjournment. The meeting was adjourned at 2:20 p.m.



AlaskaCare Benefit Clarification 2022-01

Benefit Title	Maintenance Care for Musculoskeletal Disorders	Group Number	866219
Effective Date	01 June 2022	Date Submitted	31 March 2022

Applicable Benefit Plan (check all that apply):

- Active
 Retiree Defined Benefit
 Retiree Defined Cont.
 Long-Term Care
 Medical
 Dental
 Vision
 Audio
 Pharmacy
 Other

Benefit Description:

The AlaskaCare Retiree Defined Benefit Health Plan (Plan) currently covers medically necessary outpatient rehabilitative care designed to restore and improve bodily functions lost due to injury or illness. This care is considered medically necessary only if significant improvement in body function is occurring and is expected to continue.

The Plan does not contain an annual service limit for medically necessary outpatient rehabilitative care. After the 20th claim for services from the same provider for a specific episode of care, the Claims Administrator will request chart notes. Starting at the 26th visit, the Claims Administrator will begin to pend payment for claims that do not have accompanying chart notes that demonstrate the care is medically necessary, and thus, eligible for coverage.

To continue Plan coverage, the provider must submit clinical records that sufficiently document the patient’s response to treatment. If the records are not provided to the Claims Administrator within 45 days or fail to demonstrate significant improvement in accordance with the established clinical criteria, the services will be denied.

The 25-visit counter is reset annually at the start of the new plan year.

AlaskaCare Retiree Insurance Information Booklet (January 2022) Reference:

3.3.12 Rehabilitative Care

The Medical Plan covers **outpatient** rehabilitative care designed to restore and improve bodily functions lost due to injury or illness. This care is considered medically necessary only if significant improvement in body function is occurring and is expected to continue. Care (excluding speech therapy) aimed at slowing deterioration of body functions caused by neurological disease is also covered.

Rehabilitative care includes:

- a) Physical therapy and occupational therapy.



- b) Speech therapy if existing speech function (the ability to express thoughts, speak words, and form sentences) has been lost and the speech therapy is expected to restore the level of speech the individual had attained before the onset of the disease or injury.
- c) Rehabilitative counseling or other help needed to return the patient to activities of daily living but excluding maintenance care or educational, vocational, or social adjustment services.

Rehabilitative care must be part of a formal written program of services consistent with your condition. Your physician or therapist must submit a statement to the Claims Administrator outlining the goals of therapy, type of program, and frequency and duration of therapy.

Benefit Clarification:

When the medical necessity review is performed after the 25th visit for therapy visits for musculoskeletal disorders for a specific episode of care, if the treatment is determined to be maintenance care, the beneficiary will receive coverage for up to 10 additional visits per year for that specific episode of care.

Plan Administrator Approval:

Signature	Paula Vrana	}	Digitally signed by Paula Vrana Date: 2022.04.01 09:48:57 -08'00'	Title: Paula Vrana, Commissioner Department of Administration
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Comments: Approved

This benefit clarification applies to the AlaskaCare Defined Benefit Retiree Health Plan effective June 1, 2022.

A benefit clarification is one mechanism by which the Plan Administrator provides guidance to a Third-Party Administrator (TPA) as to the proper adjudication of a specific provision of the AlaskaCare Health Plan(s). A benefit clarification does not amend the AlaskaCare Health Plan(s); rather, it provides clarification as to the Plan Administrator's intent with regard to a specific provision of the plan document. No covered person will have any vested interest in a benefit clarification. The Commissioner of Administration, as administrator of the AlaskaCare Health Plans, reserves the right, in their sole discretion, to alter, amend, delete, cancel or otherwise modify this benefit clarification at any time and from time to time, and to any extent that they deem advisable.

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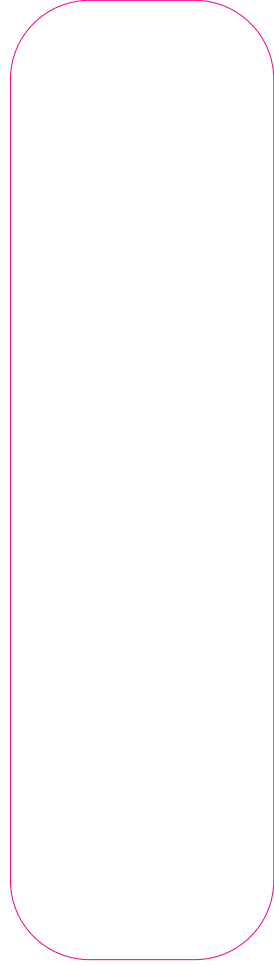


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FPO FSC

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Retiree Prior Authorization Program

An Early Look at 1st Quarter 2022 Data

Sara Guidry, PharmD, CSP, AAHIVP
Senior Clinical Consultant
May 5th, 2022



Cases Breakout

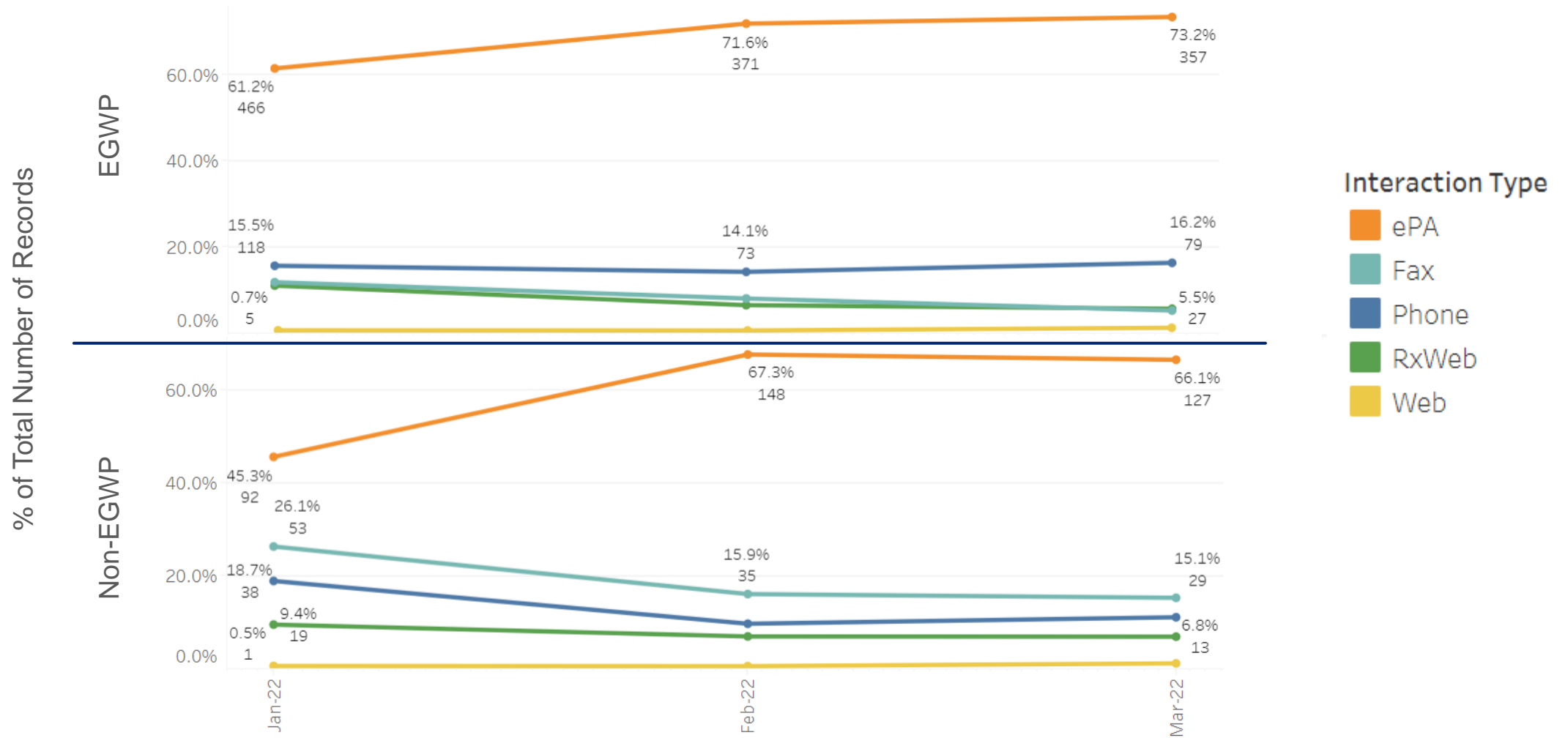
Plan	Total Cases	Approved	Denied*	Overtured	Upheld*
EGWP	1,927	1,213 (62.95%)	560 (29.06%)	117 (6.07%)	37 (1.92%)
Non-EGWP	653	415 (63.55%)	202 (30.93%)	27 (4.13%)	9 (1.38%)
All Retirees	2,580	1,628 (63.10%)	762 (29.53%)	144 (5.58%)	46 (1.78%)

*Does not indicate lack of treatment. Members with denied and/or upheld reviews are provided specific explanation on the reason (ex: clinical criteria not met; safety concern) as well as alternative options. Members that attempt an appeal and/or switch to a different medication and gain approval for that medication would be counted as a second case.

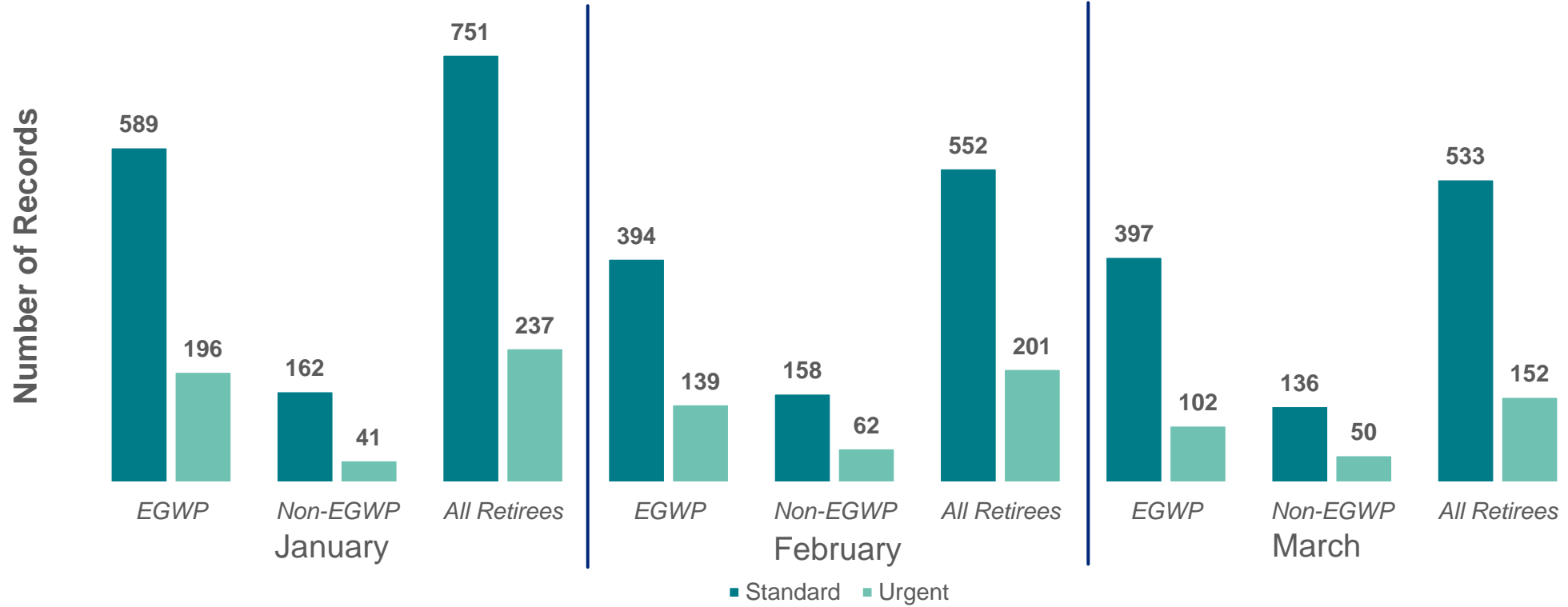
Prior Authorization Review Types

PA Type	EGWP	Non-EGWP	All Retirees
PA Required	1,788 (92.79%)	611 (93.57%)	2,399 (92.98%)
Quantity Limit Review	117 (6.07%)	27 (4.13%)	144 (5.58%)
Exclusion	22 (1.14%)	15 (2.30%)	37 (1.43%)
All PAs	1,927	653	2,580

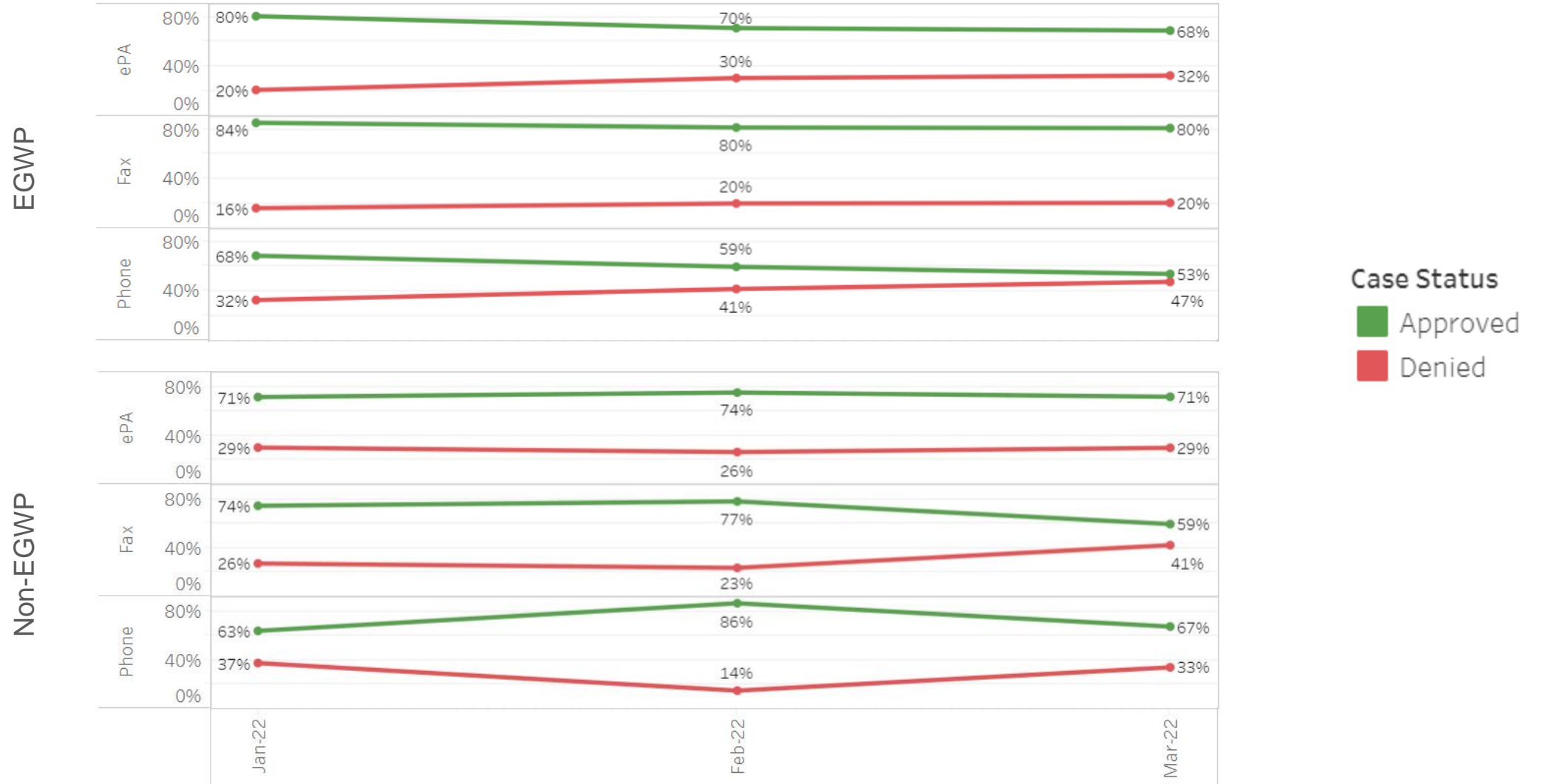
Prior Authorizations By Interaction Type



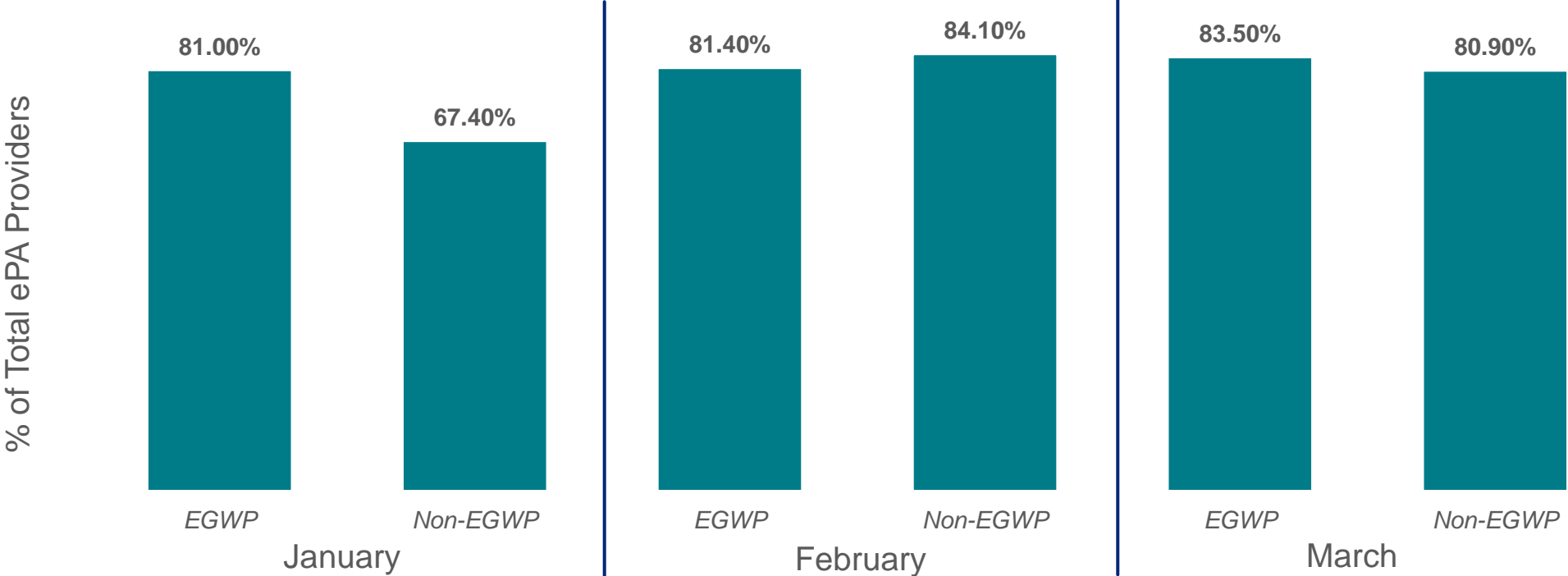
Case Volume by Priority



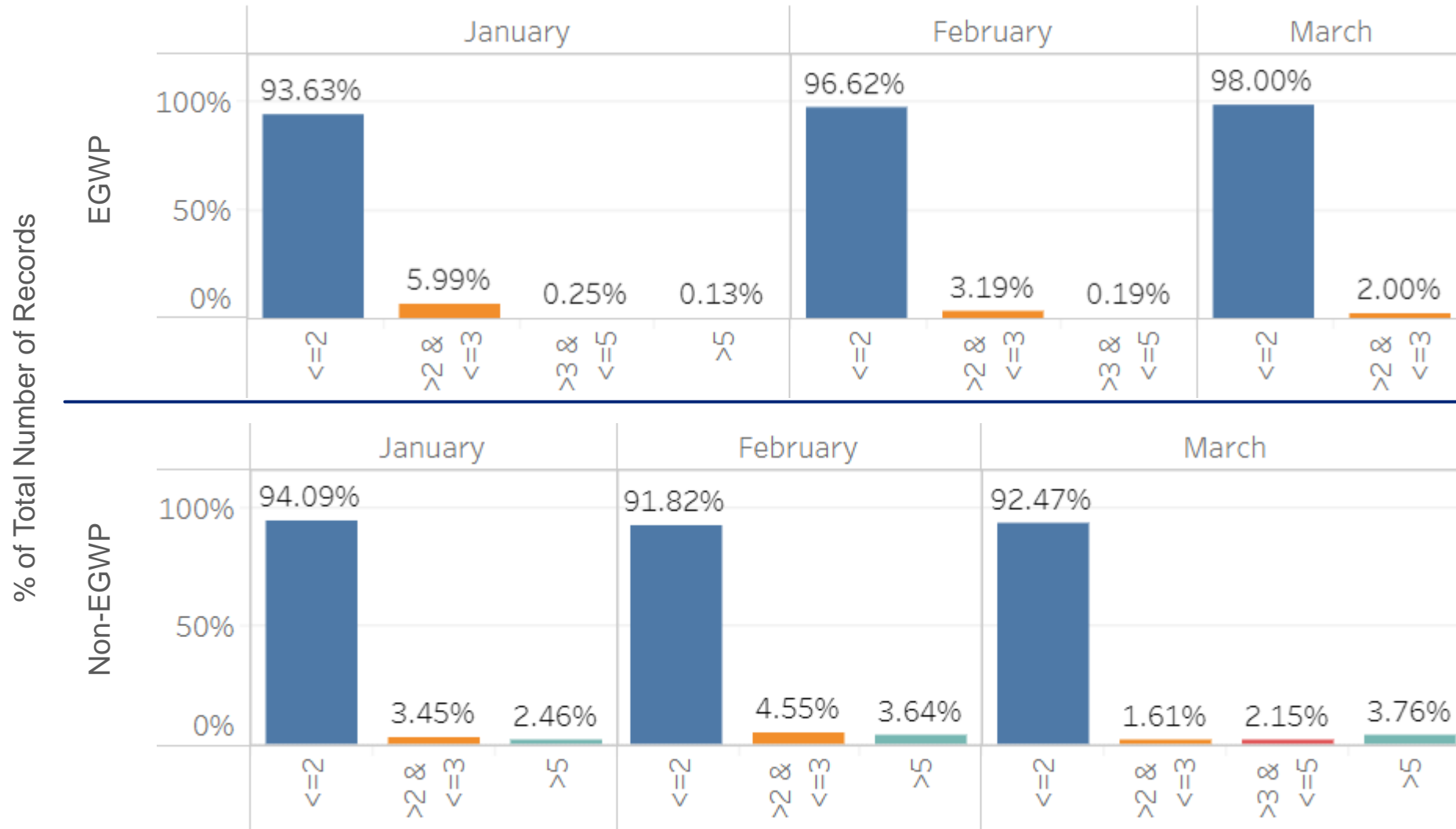
Approved vs Denied by Interaction Type



Provider ePA Adoption Rate



% Cases by Turnaround Time in Days



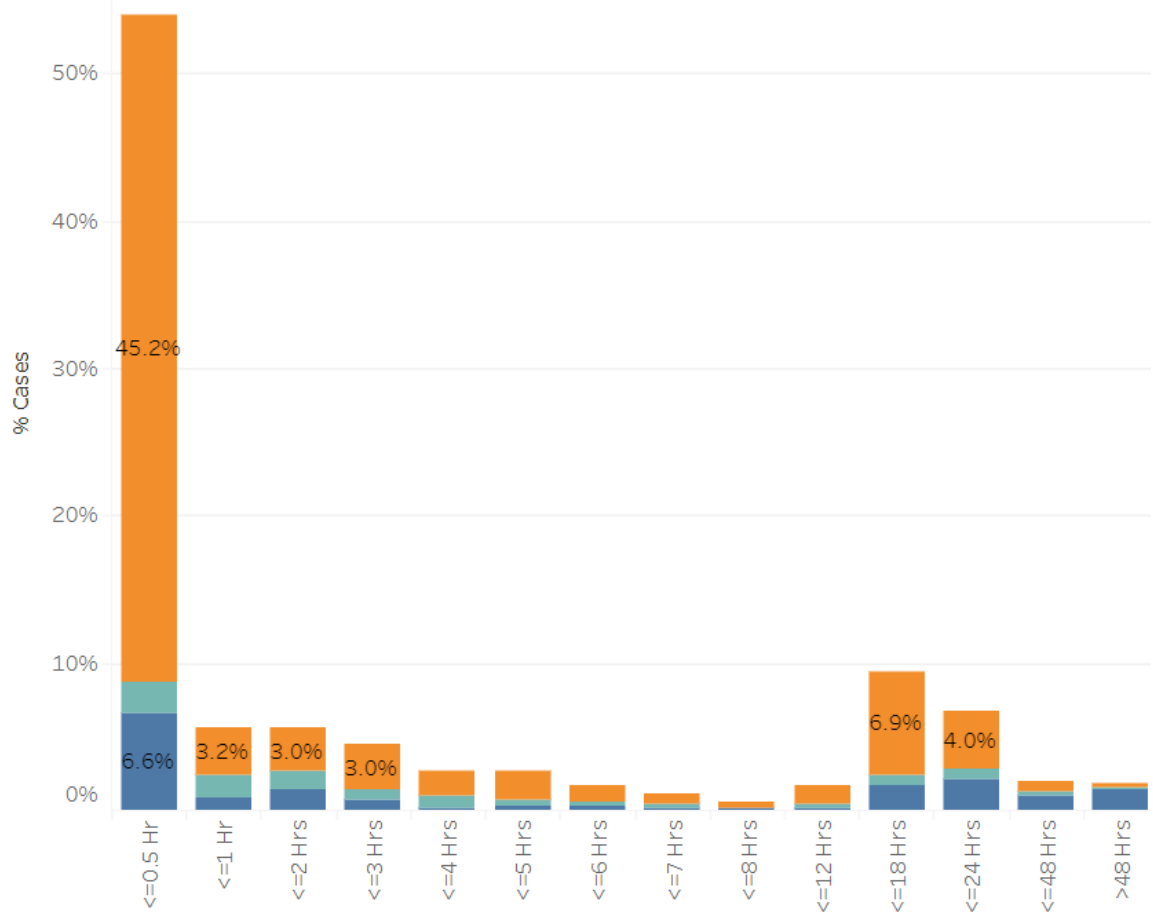
Days	Definition
<=2	2 or fewer days
>2 & <=3	More than 2 days, but no more than 3 days
>3 & <=5	More than 3 days, but no more than 5 days
>5	Greater than 5 days

Turnaround Time in Hours by PA Type

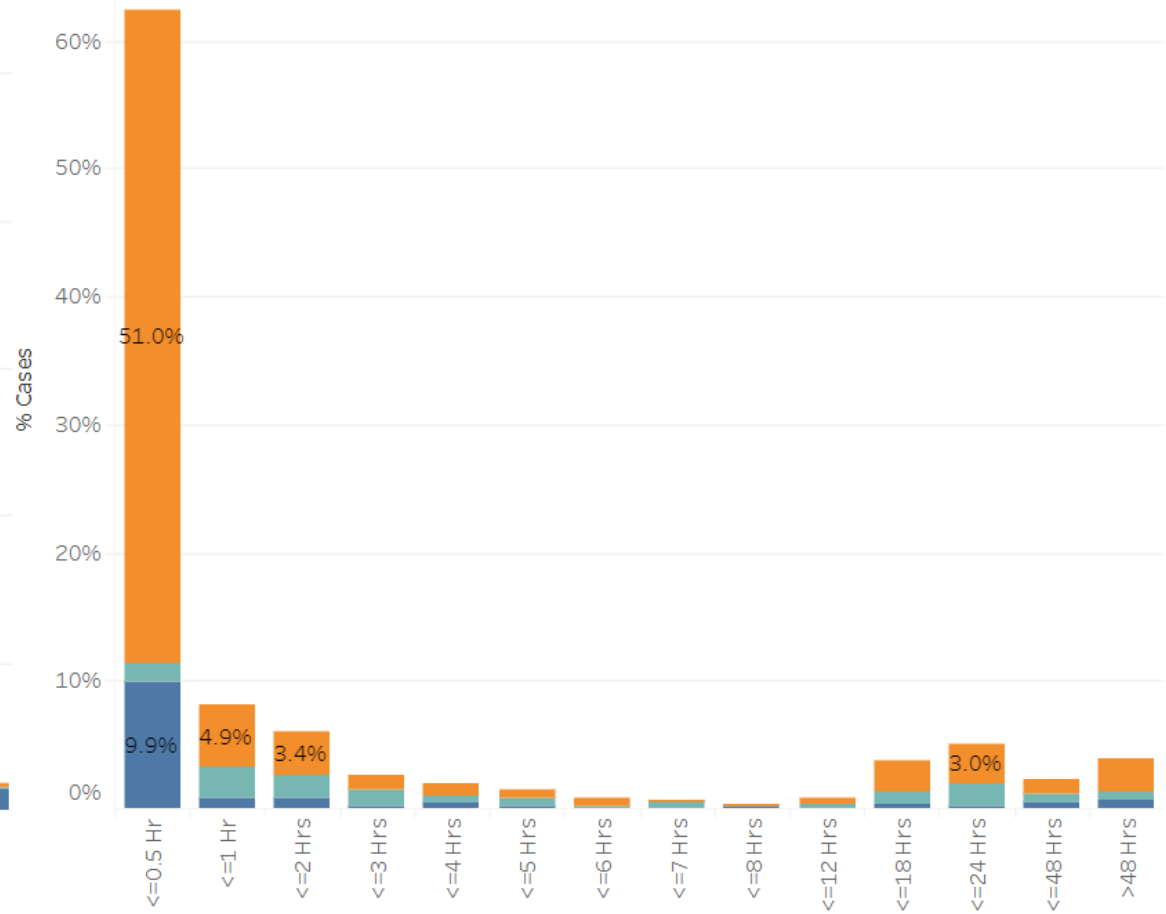
Interaction Type

- ePA
- Fax
- Ph

EGWP



Non-EGWP



Q&A

Thank you for your time



Proposal Title	GCIT Network Benefits - DRAFT
Health Plan Affected	AlaskaCare Retiree Health Plan
Proposed Effective Date	January 1, 2023
Reviewed By	Retiree Health Plan Advisory Board
Review Date	May 4, 2022

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1) Background

Gene-Based, Cellular, and Other Innovative Therapies

Gene-based, Cellular, and other Innovative Therapies (GCIT) are a relatively new and rapidly advancing area of medical treatment that work by replacing or repairing defective genetic material within a cell. GCIT products are distinct in that they are highly specific, engineered using genetic material, and may require harvesting the patient’s cells (or a donor cell population) to be modified in a laboratory setting before being used to treat the patient.

GCIT services include:

- Cellular immunotherapy
- Genetically modified viral therapy
- Cell and tissue therapy, and more

GCIT products are U.S. Food and Drug Administration (FDA) approved therapies that are intended to treat or cure previously untreatable or difficult to treat conditions such as hemophilia, spinal muscular atrophy, and retinal disease. However, GCIT therapies are typically extremely expensive ranging in cost from \$600,000 to \$2.5 million. Because many of these therapies are new to market, many traditional cost controls and network agreements do not apply, leaving the plan and members with little financial protection and oversight.

Current AlaskaCare Coverage

Currently, the Plan covers GCIT services from both network and non-network providers and facilities. However, because these therapies are so new, charges for these services are not contemplated by many standard network agreements, meaning Aetna and most network providers have not previously established an agreed-upon price.

In limited circumstances, some plans may cover portions of GCIT therapies under both medical and pharmacy plans. However, these treatments are typically complex to administer, requiring specialized equipment, clinical expertise, and specific facility capabilities. Because of these requirements, GCIT therapies are most commonly and appropriately billed through medical plans.

The AlaskaCare Plan currently includes an individual lifetime medical benefit maximum of \$2 million.¹ As a result, GCIT services that are paid through the medical benefit may move retiree plan members closer to meeting their lifetime maximum. While the AlaskaCare Plan has not experienced prices of this magnitude, Aetna has reported other plans have seen charges nearing \$12 million for one course of treatment.

AlaskaCare Gene Therapy Experience

Though conditions treated by GCIT services are usually very rare, the AlaskaCare Employee Plan and the AlaskaCare Retiree Plan have already experienced claims for some of these novel therapies. For example, in early 2020 the Employee Plan paid approximately \$2.1 million for a member's Zolgensma treatment regimen. In 2021 a retiree plan member began a Spinraza treatment regimen (covered through the member's medical benefit): four initial doses administered in close succession and maintenance doses recommended every four months thereafter. Each Spinraza treatment carries a cost of approximately \$128,000. Both are gene therapy treatments indicated for spinal muscular atrophy, a hereditary condition that most often affects babies and children and causes muscles to become weak and waste away.

2) Goals and Objectives

Implementing the Aetna GCIT network and associated patient support program is intended to:

1. Ensure members maintain access to necessary treatments
2. Provide members with appropriate logistical and clinical support
3. Reduce member and plan risk and add cost controls for emerging high-cost treatments.

¹ 2022 AlaskaCare Retiree Insurance Information Booklet, *Section 1.1 Medical Benefits*, and *Section 3.1.5 Lifetime Maximum*. <https://doa.alaska.gov/drb/pdf/ghlb/retiree/AlaskaCareDBRetireeBooklet2022.pdf>

3) Summary of Proposed Changes

The proposed change ensures these therapies are covered through network GCIT-designated providers who have been manufacturer-approved to administer the drugs and who have agreed to contractual pricing terms for the therapies. Members receiving GCIT services from a network medical provider would have access to care coordination and support from a dedicated clinical team with specific GCIT experience. The care coordination team will help AlaskaCare members with the pre-certification process, ensure the member seeking treatment finds the most appropriate facility and provider, work directly with hospitals on claims, and provide answers to any questions that arise.

Steering utilization to manufacturer-approved providers helps to ensure that member receive GCIT services from providers that have the right skills and capabilities to safely administer these therapies. Given that GCIT services are highly specialized, most manufacturers will certify centers where their product can be administered safely. Some GCIT products require personalization and specialist care available at a select few sites around the country. GCIT product manufacturers provide on-site training and technical assistance with machine use and calibration where applicable. They also confirm that the facility can handle and store the specific GCIT product in accordance with their guidelines (*e.g.*, proper sterilization techniques or cold storage levels).

Because this area of medicine is relatively new, there are not currently any independent GCIT accrediting organizations. As the industry grows, a more formalized accrediting organization may develop.

Under the proposed program, the Plan would only provide medical plan coverage for GCIT services received from a GCIT-designated provider or facility. No medical plan benefit would be provided for GCIT services received from an out-of-network provider. In addition to plan coverage for the GCIT therapy and associated medical charges, covered services would also include travel and lodging expenses (lodging: \$50 per night per person) up to \$10,000 per course of treatment for the member and a companion if the care must be administered away from the patient's home. Under the current plan benefits only limited travel costs would be reimbursable.

This proposal would amend the plan to clarify that these products are covered under the medical plan, rather than the pharmacy plan. This would align with the current plan language, emerging industry standards, and ensure members are accessing these benefits through a coordinated approach.

Use of the GCIT-designated network is expected to save the plan an average of 17% below the listed Average Wholesale Price (AWP) for applicable drugs and may include drug rebates in eligible circumstances. The plan will have additional cost protection due to Aetna and the GCIT providers having an agreed upon contractual price for services. The GCIT network program would initially apply to three products, though more products will likely be added to the program as it matures, and as new drugs come onto the market. Initial products include:

Zolgensma

- Approved by the FDA for infants born with Spinal Muscular Atrophy type 1.
- One time infusion; must be received before age 2.
- Infusions administered sooner (closer to birth) have better outcomes.
- AWP: \$2.5 million
- Average savings: \$425,000

Luxturna

- Approved by the FDA to treat children and adult patients with an inherited form of vision loss that may result in blindness.
- Only available at a few sites across the country.
- A pre-treatment visit is required, including a treatment and examination. After the product is administered, the patient must return within a specified time frame for a post-dose visit.
- AWP: \$1.02 million
- Average savings: \$170,000

Spinraza

- Approved by the FDA for children less with spinal muscular atrophy.
- Several initial loading doses are administered to an infant or child via spinal tap, then three doses per year for life or as long as a benefit from the product is demonstrated.
- AWP: \$612,000
- Average savings: \$100,000

4) Impacts

Member Impact | Minimal

The Retiree Plan has experienced fewer than five claims for some of these novel therapies. Current utilizers would not be adversely impacted by the addition of the GCIT network program.

Any new utilizers would be connected with the care coordination and member support aspects of the program (described above) when the precertification request for their medication is submitted to Aetna.

Future utilizing members would have dedicated support from the GCIT Network program team at Aetna to help with identifying the most appropriate provider and facility, coordinating claims, and obtaining approval for payment of associated travel and lodging claims.

The FDA has approved administration of these therapies in very limited circumstances. Many patients who qualify to receive GCIT therapies have underlying genetic defects and therefore may be experiencing many medical needs. Even so, most patients are able to travel to a facility where it is safe and cost-effective to administer the therapy. If patient travel is not possible, Aetna's GCIT Network program team will work with the member and the facility where the patient is admitted to secure an exception so that the appropriate care may be delivered at network rates.

Currently there are no facilities or providers in Alaska participating in Aetna's GCIT network, meaning it is likely members residing in Alaska will travel to receive care.² While the manufacturer-approved list of facilities that can administer GCIT services does not perfectly align with Aetna's provider network, there is a great deal of overlap. Aetna works closely with their network facilities approved to administer GCIT services to negotiated specific discounts. To further support members who need to travel to receive care, the GCIT Network program covers travel costs beyond those typically available, providing important financial support for members.

² See attached "Aetna Institutes™ Gene Based, Cellular and Other Innovative Therapy (GCIT™) Designated Centers" for current list of providers.

Some members may wish to seek care in state if possible. Aetna has already demonstrated success in negotiating single case agreements for GCIT services to be administered by an Alaska provider at an Alaska facility on an individual basis. Single case rate negotiations are initiated when a pre-authorization request is submitted to Aetna for a GCIT product to be administered at a facility that is not part of the GCIT Network. When this occurs, Aetna reaches out to the facility to discuss capabilities and options. Whenever possible and appropriate, Aetna will continue to pursue negotiation of single case agreements in Alaska.

While members will not experience a change to their out-of-pocket costs for GCIT services obtained through the medical plan, the reduction in the total cost of the services will result in the member using less of their lifetime medical benefit maximum.

Financial Impact to AlaskaCare | **Cost Savings**

There is no additional administrative cost to the plan associated with implementation of the GCIT network program.

Due to the rare nature of the conditions treated by GCIT therapies, it is difficult to estimate how much future utilization (if any) should be expected. However, should any claims be incurred for impacted medications, the plan would be protected from artificially inflated prices and would realize cost savings through the discounted rates available through the program.

Operational Impact (DRB) | **Minimal**

The Division anticipates minimal operational impacts associated with implementation and member communication as follows:

- Staff will need to review and distribute communications to educate and increase awareness of the GCIT Network program.
- Staff will need to update the Plan Booklet to ensure the benefit is appropriately described.
- Staff will need to coordinate and oversee implementation of the changes with Aetna.

After implementation, the ongoing operational impacts are anticipated to be minimal, and will include reporting, program monitoring, and updates to the booklet language and communication materials as appropriate.

Operational Impact (TPA) | **Minimal**

The initial impact to the Third-Party Administrator (TPA), Aetna, is anticipated to be minimal, primarily because Aetna already offers this program for their fully-insured book of business and for other self-insured customers who elect to participate:

- Aetna will update, code, and test their system to ensure that the changes associated with the program have been properly loaded.
- Aetna will ensure that their concierge staff are aware of the change and can properly communicate about and articulate specifics of the programs to members.
- Aetna will ensure internal channels are in place to connect any utilizing members with the appropriate care team as needed.
- Aetna will produce reporting on the utilization, impacts, and any savings associated with the program.

After implementation, the ongoing operational impacts are anticipated to be minimal and will include maintenance of the network and regular updates to the list of drugs included in the program.

5) Considerations

Clinical and Provider Considerations

Ensures patients receive GCIT benefit in facilities committed to cost and quality management. A dedicated clinical team guides the members through precertification to aftercare.

6) Proposal Recommendations

DRB Recommendation

The Division of Retirement and Benefits recommends implementation of this proposal, effective January 1, 2023.

RHPAB Board Recommendation

Insert the RHPAB recommendation here when final along with any appropriate comments.

Description	Date
Reviewed by Modernization Subcommittee	
Reviewed by RHPAB	11/01/2021, 02/10/2022, 05/05/2022