Retiree Health Plan Advisory Board
Meeting Agenda

Date:	Thursday, November 03, 2022
Time:	9:00am – 03:00pm Online Public Notice
Location:	Video Teleconference | ANC Atwood 19th Floor Conference Room
	Click here to join the meeting
Teleconference:	(907) 202-7104 ID 118 254 963 2
Board Members:	Judy Salo (chair), Lorne Bretz, Dallas Hargrave, Paula Harrison, Cammy Taylor, Michael Humphrey and Nanette Thompson

9:00 am **Call to Order – Judy Salo, Board Chair**
- Roll Call and Introductions
- Approval of Agenda
- Ethics Disclosure and Public Comment Script

9:15 am **Public Comment**

9:30 am **Department & Division Update**
- DVA Open Enrollment
- Retiree Insurance Information Booklet public comment period
- Meeting dates for 2023

10:00 am **Inflation Reduction Act: Impact on AlaskaCare Retiree Plans**

10:30 am **Break**

10:40 am **Modernization Topics/Priorities**

11:00 am **SurgeryPlus Overview**
John Zutter (SurgeryPlus)

12:00 pm **Lunch**

1:00 pm **Educational Session: Value Based Arrangements & Medicare Advantage**
Shellie Gansz & Michael Dorward (Aetna)

2:30 pm **Public Comment**

2:45 pm **Wrap up/Adjourn**

The next Retiree Health Plan Advisory Board meeting is scheduled for Thursday February 9, 2023.

AlaskaCare Retiree DB Insurance Information Booklet

Summary of Updates for Plan Year 2023

Contents

Legend	Items highlighted in green were added.	Items highlighted in orange were removed.

Clarified Provisions

1. Clarifies Section 1.2.1 Standard Benefit

	~~Supply Limit~~
~~Depo-Provera (injectable contraceptive)~~	~~5 vials per benefit year~~

2. Clarifies section 3. Medical Plan Highlights

- Requires that after the AlaskaCare deductible is met, the member is responsible for coinsurance of 20% until the $800 out-of-pocket maximum is met. ~~Pays 80% of first $4,000 in covered expenses for each person.~~ Then the plan pays 100% of ~~all~~ covered expenses for the remainder of the benefit year.
- Requires precertification from the claims administrator for all inpatient stays, ~~home health care~~, and other services and procedures as outlined in *section 3.2, Precertification*.

3. Clarifies section 3.3.11 Preventive Care and Screening Services

Covered expenses include the following:

- The rental of a **hospital**-grade electric pump for a newborn **child** when the newborn **child** is confined in a **hospital**.
- The purchase of:

An electric breast pump (non-hospital grade). A purchase will be covered once every 12 months ~~three years~~;

4. Clarifies section 4.2 Mail Order Program

The mail order copayment will apply to specialty medication obtained through the pharmacy benefit manager's specialty pharmacy~~, BriovaRx~~.

5. Clarifies section 4.3 Medicare Prescription Drug Plan

c) A United States citizen or lawfully present in the United States

There will be no interruption in coverage when a retiree or dependent becomes eligible for Medicare and is enrolled in the enhanced EGWP. However, you will be sent a new ID card that you should present to your pharmacy when purchasing your first prescription after receipt of the card ~~(but no earlier than January 1, 2019)~~.

6. Clarifies section 4.3.4 Premium Surcharge

Retirees with an income that exceeds an individual or household Monthly Gross Income Amount (MAGI) level set by Social Security, will be required by Medicare to pay an additional premium based on your income called the Part D Income Related Monthly Adjustment Amount (IRMAA). You will be notified of this requirement in the same way you are notified of your Medicare B IRMAA, through an annual letter sent by Social Security each November. ~~It is important you share a copy of this annual letter with the Division of Retirement and Benefits as soon as possible after receipt.~~ The MAGI and IRMAA surcharge amounts are set by Social Security and are subject to change annually.

~~Once the Division has the letter, a tax advantaged Health Reimbursement Arrangement (HRA) account will be established and prefunded by the Plan. You can access the HRA to be reimbursed monthly for the Part D IRMAA either by mail or through an electronic direct deposit into your bank account.~~

For all Medicare plans, the IRMAA will be deducted directly from your monthly Social Security check (if you qualify for Social Security) or will otherwise be invoiced to you directly each month. If you are charged a Medicare Part D IRMAA for your prescription drug coverage, the Division of Retirement and Benefits will reimburse you for the full cost of the Medicare Part D premium surcharge each month, through a tax-advantaged Health Reimbursement Arrangement (HRA) account. If you receive a bill from Medicare, you should pay the bill timely, and contact the Division to learn about your reimbursement options.
To receive reimbursement for the Part D IRMAA surcharge, you should submit the HRA claim as soon as possible, but not later than 12 months after the date you incurred the expenses.

7. Clarifies section 4.6 Medical Necessity

To be covered under the plan, prescription drugs must be medically necessary and clinically appropriate. Determination of medical necessity will be based on recommendations by the federal Food and Drug Administration (FDA), combined with the pharmacy benefit manager's standard coverage policies designed to ensure the medication prescribed is safe and effective. ~~This provision does not require the use of generic drugs~~.

The plan will cover some drugs only if prescribed for certain uses, or durations. Certain medications have specific dispensing limitations for quantity, age, gender and maximum dose. ~~Determination of medical necessity will be based on recommendations by the federal Food and Drug Administration (FDA), combined with the pharmacy benefit manager's standard coverage policies designed to ensure the medication prescribed is safe and effective~~. For this reason, some prescription medications may be subject to prior authorization to determine that the requested prescription drug is medically necessary. The prior authorization ensures you are getting the most appropriate care and will occur in the best setting. This helps produce improved health outcomes and lower health care costs by reducing duplication, waste, and unnecessary treatments.

This provision does not require the use of generic drugs.

8. Clarifies section 4.7 Definitions

Prescription drugs are medical substances that, in accordance with 20 U.S.C. § 353(b)(1) and (4)(A), must bear a label that states, "Rx only." The drug or active ingredient must be assigned a valid unique National Drug Code (NDC) identifier number by the FDA to be considered for coverage. If a prescription drug is prescribed and obtained outside of the United States and the drug or active ingredient does not have an NDC identifier number, it must have the same active ingredient as a drug with a valid NDC identifier number to be considered for coverage. ~~which must bear a label that states, "Caution: Federal law prohibits dispensing without a prescription."~~ Coverage includes prescription drugs, prescribed by a provider that may have an over-the-counter (OTC) equivalent, or covered medical foods that bear the same label. The plan may cover prescription compounds that contain a bioidentical hormone, an active ingredient that is a bulk chemical powder which is not an FDA approved medication, and thyroid compounds containing a bulk chemical active ingredient.

Active ingredients are the chemical component(s) responsible for a drug's intended therapeutic effect.

9. Clarifies section 4.8 Pharmacy Exclusions

j) Cosmetic drugs, medications or preparations used for cosmetic purposes or to promote hair growth

k) Drugs with active ingredients that do not have a valid NDC identifier number, or drugs prescribed and obtained outside the United States that do not have the same active ingredient as a drug with a valid NDC identifier number.

l) Products that meet all the following criteria are considered medical treatments and are not covered through the prescription drug benefit:

- designated as an orphan drug or exhibits Gene Therapy technology; and
- annual drug cost is over $500,000; and
- is not self-administered; and
- the first dose may be administered in an inpatient setting.

Products meeting the above criteria that appear on the Medicare Part D formulary (list of covered drugs) may still be eligible for coverage under the AlaskaCare EGWP benefit.

10. Clarifies section 7.2.1 Who May Be Covered and Premium Payment

b) People receiving a benefit from the Marine Engineers Beneficial Association (MEBA) who retired from the State of Alaska after July 1, 1983. If coverage is elected, the DVA premiums are paid to the plan on a monthly basis through the direct bill administrator ~~PayFlex~~.

11. Clarifies section 7.3 How to Elect Coverage

If you elect dental-vision-audio coverage you must apply for that coverage on a form provided by the Division of Retirement and Benefits. The submittal date on the form will be ~~of~~ the date of the postmark of the application, or if the postmark is illegible or the application does not bear a dated postmark, the postmark is rebuttably presumed to be five working days before the date the application is received by the Division of Retirement and Benefits.

A benefit recipient with multiple retirement accounts may elect dental-vision-audio insurance under each retirement account. If a benefit recipient elects coverage under multiple retirement accounts, different coverage tiers may be elected for each separate account so long as the same plan option (Standard or Legacy) is elected for all accounts.

12. Clarifies section 7.4.4 Dependents

If you increase your coverage to include dependents following a qualifying life event or a qualified change in family structure, their coverage begins on the first of the month following receipt of your written request, assuming the level of coverage you elect covers the new dependent.

To enroll your eligible dependent(s), you must complete and return the Retiree Health Dependent Change form to the Division within 120 days of the qualifying event.

13. Clarifies section 7.6 Changing Your DVA Coverage

Your written request to increase coverage must be postmarked or received within 120 days after the date one of the above events occurs. You should state the level of coverage you would like, the reason for the change, and the date the event occurred. Coverage will be effective the date of the qualified event and the Division will collect past due premiums, if applicable. Coverage will be effective the date of the qualified event and the

Division will collect past due premiums, if applicable.

~~Changes in coverage based on an application that is postmarked or received on or before the 15th of a month are effective on the first of the month following the receipt of your written request. A change in coverage based on an application that is postmarked or received after the 15th of a month, will be effective no later than the first day of the second month after the date of postmark or receipt of the application. The division will make retroactive adjustments to premiums if necessary.~~

14. Clarifies section 8.1.3 Deductible

Each covered person must meet the annual individual deductible before the dental plan begins to pay benefits for that covered person. The deductible is waived for Class I preventive services. You pay a $50 deductible per person for Class II restorative and Class III prosthetic services each benefit year.

Updates to Support Retiree Health Plan Advisory Board *Resolution 2022-02*

15. Updates section 3.2 Precertification

You do not need to pre-certify services if the plan is secondary to coverage you have from another health plan, including Medicare. If you receive a service that is not covered by your other health plan coverage and your AlaskaCare coverage will be paying as primary, you or your provider need to obtain any necessary pre-certification.

16. Updates section 3.2.1 The Precertification Process

You are responsible for requesting pre-certification for eligible travel expenses. See *Section 3.3.18 Travel*. Your provider (both network and out-of-network) is not responsible for requesting pre-certification for any eligible travel expenses.

17. Updates 3.2.2 Services Requiring Pre-certification

Precertification is handled by the medical claims administrator and the list of services requiring precertification can be located at: *https://www.aetna.com/health-care-professionals/precertification/precertification-lists.html*.

All in-patient hospital, rehabilitation facility, and skilled nursing facility admissions require precertification. Certain outpatient surgery and other outpatient services may also require precertification.

In addition to the medical services listed on the medical claims administrator's website, travel expenses must be precertified. You are responsible for requesting pre-certification for eligible travel expenses. See *Section 3.3.18 Travel*.

The following list identifies ~~those~~ some, but not all, of the medical services and supplies requiring precertification under the medical plan. ~~Language set forth in parenthesis in the precertification list is provided for descriptive purposes only and does not serve as a limitation on when precertification is required.~~ Services requiring precertification are subject to change. Refer to the website listed above for the full and most current list.

Precertification is required for the following types of medical expenses:

- Stays in a hospital
- Stays in a skilled nursing facility
- Stays in a rehabilitation facility
- ~~Stays in a hospice facility~~
- ~~Outpatient hospice care~~
- ~~Home health care~~
- Private duty nursing care
- Transportation ~~(non-emergent)~~ by fixed wing aircraft (plane)
- ~~Transportation (non-emergent) by ground ambulance~~
- ~~Applied Behavioral Analysis (early intensive behavioral intervention for children with pervasive developmental delays)~~
- Arthroscopic hip surgery to repair impingement syndrome including labral repair
- Autologous chondrocyte implantation, Carticel (injection into the knee of cartilage cells grown from tissue cultures)
- Chiari malformation decompression surgery
- Cochlear implant (surgical implant of a device into the ear to try to improve hearing)
- ~~Cognitive skills development~~
- ~~Customized braces (physical – i.e., non-orthodontic braces)~~
- Dental implants and oral appliances
- Dialysis visits
- Dorsal column (lumbar) neurostimulators: trial or implantation (for relief of severe pain)
- Electric or motorized wheelchairs and scooters
- ~~Gastrointestinal tract imaging through capsule endoscopy~~
- Endoscopic nasal balloon dilation procedures
- Functional endoscopic sinus surgery (FESS)
- Gender affirmation surgery
- Hyperbaric oxygen therapy
- Infertility services and pre-implantation genetic testing
- Limb prosthetics
- Nonparticipating freestanding ambulatory surgical facility services, when referred by a participating provider
- ~~Oncotype DX (a method for testing for genes that are in cancer cells)~~
- Orthognathic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint (reconstructive surgeries to attempt to correct structural abnormalities of the jaw bones)
- Organ transplants
- Osseointegrated implants
- Osteochondral allograft/knee (grafting of cartilage and bone from a cadaver to the knee joint)
- Proton beam radiotherapy
- Reconstructive~~on~~ or other procedures that may be considered cosmetic
- Shoulder arthroplasty including revision procedures
- Surgical spinal procedures
- Uvulopalatopharyngoplasty, including laser-assisted procedures (surgery to reconfigure the soft palate to try to help with sleep apnea)

- Ventricular assist devices
- ~~Travel~~
- Use of an out-of-network provider for preventive care services.
- Whole exome sequencing

18. Updates section 3.2.3 How Failure to Pre-certify Affects Your Benefits

~~A precertification benefit reduction will be applied to the benefits paid~~ If you fail to obtain a required precertification prior to incurring medical expenses from an out-of-network provider, ~~This means that Aetna will reduce the amount paid towards your coverage, or~~ your expenses may not be covered. You will be responsible for ~~the unpaid balance of the bills~~ all expenses that are not covered.

You are responsible for obtaining the necessary precertification from the medical claims administrator ~~Aetna~~ prior to receiving services from an out-of-network provider. Your provider may pre-certify your treatment for you; however, you should verify with Aetna prior to the procedure that the provider has obtained precertification from the medical claims administrator ~~Aetna~~. ~~If your treatment is not pre-certified by you or your provider, the benefit payable will be reduced as follows:~~

~~Except as otherwise provided below, Aetna will apply a $400 benefit reduction for failure to obtain precertification for the medical services listed in *section 3.2.2, Services Requiring Precertification*.~~

~~If precertification of inpatient treatment for a mental disorder was not requested, your coinsurance for mental disorder benefits will be 50%.~~

If precertification of travel expenses was not requested, ~~no travel benefits will be paid.~~ maximum reimbursement for travel expenses will be limited to $500 per round trip travel claim, not to exceed eligible travel costs.

19. Updates section 3.3.5 Hospitalization

Important: Precertification is required for all hospital stays. (This requirement is waived if the patient is covered by another health plan that pays primary to AlaskaCare, including Medicare.) If precertification is not obtained, your expenses may not be covered. ~~A $400 penalty will be assessed before any benefits may be paid.~~ Please refer to *section 3.2, Pre-certification* for additional information.

20. Updates section 3.3.6 Home Health Care

~~Important: Precertification is required before any home health care is received. (This requirement is waived if the patient is covered by Medicare.) If precertification is not obtained, a $400 penalty will be assessed before any benefits may be paid. Please refer to *section 3.2, Precertification* for additional information.~~

21. Updates section 3.3.7 Hospice Services

~~Important: Precertification is required before any hospice service is received. (This requirement is waived if the patient is covered by Medicare.) If precertification is not obtained, a $400 penalty will be assessed before any benefits may be paid. Please refer to *section 3.2, Pre-certification* for additional information~~.

22. Updates section 3.3.8 Skilled Nursing Care

Important: Precertification is required before any skilled nursing care is received. (This requirement is waived if

the patient is covered by another health plan that pays primary to AlaskaCare, including Medicare.) If precertification is not obtained, your expenses may not be covered ~~a $400 penalty will be assessed before any benefits may be paid~~. Please refer to *section 3.2, Pre-certification* for additional information.

23. Updates section 3.3.9 Skilled Nursing Facility

Important: Precertification is required before any skilled nursing facility care is received. (This requirement is waived if the patient is covered by another health plan that pays primary to AlaskaCare, including Medicare.) If precertification is not obtained, your expenses may not be covered ~~a $400 penalty will be assessed before any benefits may be paid~~. Please refer to *section 3.2, Pre-certification* for additional information.

24. Updates section 3.3.18 Travel

Travel must be pre-certified to receive reimbursement under the Medical Plan. Contact the claims administrator for pre-certification before you or your dependent travel.

You are responsible for pre-certifying your travel expenses. If precertification of travel expenses was not requested, maximum reimbursement for travel expenses will be limited to $500 per round trip travel claim, not to exceed eligible travel costs.

25. Updates section 3.3.19 Mental Disorder, Habilitative Therapy, and Chemical Dependency Treatment

Important: Precertification is required for all treatment ~~listed~~ detailed in *section 3.2.2, Services Requiring Pre-certification* ~~in order to receive maximum Plan benefits.~~ If precertification is not obtained for these services, your expenses may not be covered ~~benefits will be reduced~~. Please refer to *section 3.2, Pre-certification* for additional information.

Mental Disorders

~~Provider services that are pre-certified in accordance with *section 3.2.2, Services Requiring Pre-certification*, are covered at normal plan benefits following the deductible. Provider services received without precertification are covered at normal plan benefit after a $400 penalty and the deductible.~~

~~Inpatient treatment that is pre-certified, excluding provider services which are described above, is covered at normal plan benefits. Inpatient treatment received without precertification is paid at 50% after the deductible~~.

Chemical Dependency

Treatment of chemical dependency is paid at normal Plan benefits following the deductible. If treatment is received without precertification as ~~outlined~~ detailed in section *3.2.2, Services Requiring Pre-certification*, your expenses may not be covered ~~the first $400 of inpatient treatment expenses and outpatient treatment expenses will not be covered.~~

~~Benefits for chemical dependency treatment received are limited to the maximums shown in the Benefit Summary.~~

~~These amounts are subject to change. Please check with the claims administrator or the Division for the most current maximum~~.

~~Treatment of medical complications of chemical dependency does not count towards the maximum~~.

26. Updates section 3.3.24 Transplant Services

Important: Precertification is required before any transplant services are received. (This requirement is waived if the patient is covered by another health plan that pays primary to AlaskaCare, including Medicare.) If precertification is not obtained, your expenses may not be covered ~~a $400 penalty will be assessed before any benefits may be paid~~.

New Section to Support Retiree Health Plan Advisory Board *Resolution 2022-01*

27. Adds section 3.3.26 Gene-Based, Cellular, and other Innovative Therapies (GCIT)

GCIT services help patients who have been diagnosed with certain genetic conditions that may be treated with the use of innovative FDA-approved GCIT products. GCIT services include cellular immunotherapy, genetically modified viral therapy, and cell and tissue therapy.

GCIT Designated Network Program

The medical claims administrator's GCIT Designated Network program provides benefits for specific GCIT services at GCIT-designated facilities as well as additional care coordination and support from a clinical team with specific GCIT experience. The medical claims administrator's GCIT Designated Network program's covered services include charges incurred for certain GCIT services and supplies provided by GCIT-designated facilities and providers and travel and lodging expenses as specified below.

GCIT therapies covered by the medical claims administrator's GCIT Designated Network program include, but are not limited to, the following:

- Zolgensma
- Spinraza
- Luxturna

For the current list of services included in the medical claims administrator's GCIT Designated Network program, call the number on the back of your insurance ID card.

The medical claims administrator's GCIT Designated Network program's covered services also include:

- Travel and lodging expenses
  - If you receive care at a GCIT-designated facility that is 100 or more miles away from where you live, travel and lodging expenses are covered services for you and a companion, for travel between home and the GCIT facility.
  - Expenses incurred by the patient and one adult companion for lodging is reimbursed at a rate of $50 per night per person ($100 per night total). The total travel and lodging benefit payable will not exceed $10,000 per episode of care.

The cost of GCIT products obtained through the medical claims administrator's GCIT Designated Network program do not accrue towards the plan's lifetime maximum. All other associated expenses, such as any inpatient charges or travel expenses are subject to all plan provisions.

Other GCIT Services

Some GCIT services are not included in the medical claims administrator's GCIT Designated Network program. These services will be covered according to the plan's provisions.

GCIT products that appear on the Medicare Part D formulary (list of covered drugs) may still be eligible for coverage under the AlaskaCare EGWP benefit.

Limitations

Any GCIT services included in the medical claims administrator's GCIT Designated Network program are only covered when received from a GCIT Designated Network service provider.

AlaskaCare Quarterly Meeting Dates for 2023

Meetings Sorted by Type

AlaskaCare Quarterly Meeting Employee Plan

- ☑ Tuesday, February 7, 2023
- ☑ Tuesday, May 2, 2023
- ☑ Tuesday, August 7, 2023
- ☑ Tuesday, November 7, 2023

AlaskaCare Quarterly Meeting Retiree Plan

- ☑ Wednesday February 8, 2023
- ☑ Wednesday, May 3, 2023
- ☑ Wednesday, August 8, 2023
- ☑ Wednesday, November 8, 2023

Retiree Health Plan Advisory Board Meeting

- ☑ Thursday February 9, 2023
- ☑ Thursday, May 4, 2023
- ☑ Thursday, August 9, 2023
- ☑ Thursday, November 9, 2023

Health Benefit Evaluation Committee Meeting

- ☑ Thursday, February 16, 2023
- ☑ Friday, May 11, 2023
- ☑ Friday, August 17, 2023
- ☑ Thursday, November 16, 2023

Meetings Sorted by Month

AlaskaCare Quarterly Meeting – Q3 of 2021

- ☑ Employee Plan -Tuesday, February 7, 2023
- ☑ Retiree Plan - Wednesday February 8, 2023
- ☑ RHPAB - Thursday February 9, 2023
- ☑ HBEC - Thursday, February 16, 2023

AlaskaCare Quarterly Meeting – Q4 of 2021

- ☑ Employee Plan - Tuesday, May 2, 2023
- ☑ Retiree Plan - Wednesday, May 3, 2023
- ☑ RHPAB - Thursday, May 4, 2023
- ☑ HBEC - Thursday, May 11, 2023

AlaskaCare Quarterly Meeting – Q1 of 2022

- ☑ Employee Plan - Tuesday, August 7, 2023
- ☑ Retiree Plan - Wednesday, August 8, 2023
- ☑ RHPAB - Thursday, August 9, 2023
- ☑ HBEC - Friday, August 17, 2023

AlaskaCare Quarterly Meeting – Q2 of 2022

- ☑ Employee Plan - Tuesday, November 7, 2023
- ☑ Retiree Plan-Wednesday, November 8, 2023
- ☑ RHPAB - Thursday, November 9, 2023
- ☑ HBEC - Thursday, November 16, 2023

Inflation Reduction Act

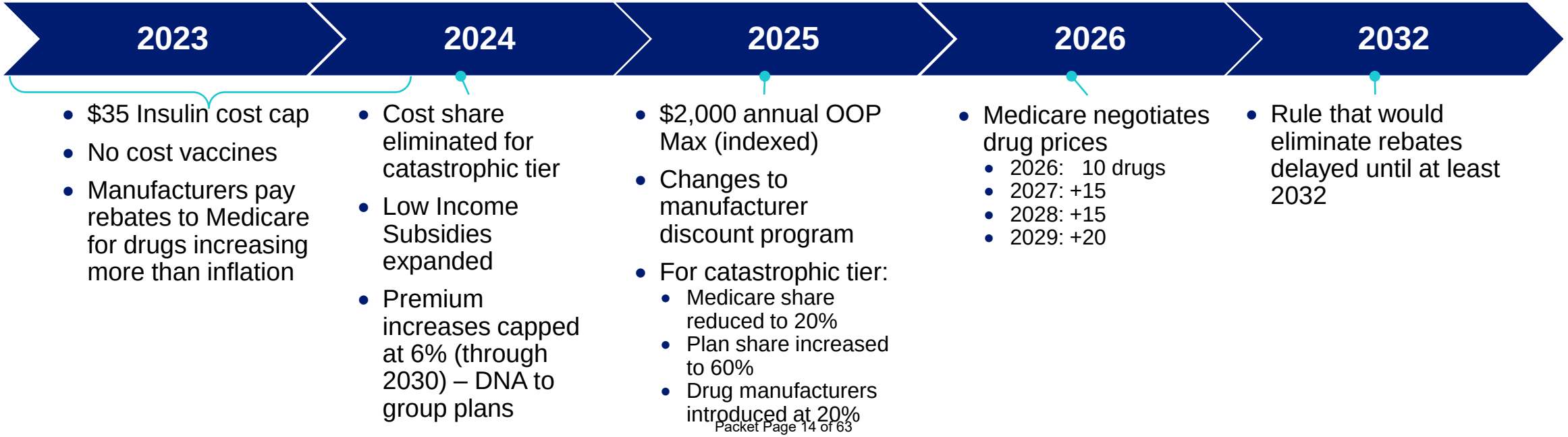
Impact on AlaskaCare Retiree Plans

November 3, 2022

Segal

Background

- The Inflation Reduction Act of 2022 (Act) was signed into law on August 16, 2022
- Changes to Medicare drug coverage over the next decade
- Emphasis appears to be on individual market Part D plans
- No impact to plans receiving the Retiree Drug Subsidy



DB Plan

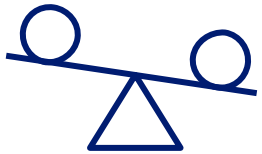
- 2023 impact anticipated to be minimal
- 2023 changes will limit copays for insulin and eliminate cost-sharing for adult vaccines. The current AlaskaCare benefits provisions already meet these requirements for outpatient medications.
  - There may be a small amount of insulin covered under Part B that would be affected
  - CMS subsidies available to plans affected by 2023 caps
- Low fixed dollar copays minimize direct effect on retirees
  - Plan document should be updated for Part B insulin coverage caps and Max OOP (for 2025)
  - Other benefit changes will not impact retirees (catastrophic cost share, coverage gap discounts, etc)
- Negotiated drug pricing may benefit group plans over time
- Premium increase caps will have no impact
- Changes in EGWP subsidies will likely impact net costs for group plans

DC Plan

- 2023 changes will limit copays for insulin and eliminate cost-sharing for adult vaccines.
  - Member coinsurance cost share caps should be reduced to $35 for insulin
  - There may be a small amount of insulin covered under Part B that would be affected
  - CMS subsidies available to plans affected by 2023 caps
- Plan document should be updated for Part B/D insulin coverage caps
  - Other benefit changes will not impact retirees (catastrophic cost share, coverage gap discounts, etc)
- Some retirees may benefit from enhanced Low Income Subsidies
- Negotiated drug pricing may benefit group plans over time
- Premium increase caps will have no impact
- Changes in EGWP subsidies will likely impact net costs for group plans

Initial Observations

- Changes in Basic Part D coverage and EGWP subsidies may increase net group plan EGWP costs
- EGWPs expected to remain a better value than RDS
- Impact to DB Plan retirees anticipated to be minimal
- Some DC Plan retirees will see lower outpatient insulin costs
- Negotiated drug prices may benefit group and individual Medicare drug plans, much like the Medicare allowed schedule for medical care
- Role of traditional manufacturer rebates remains unchanged
- Need to monitor as final rules and regulations are provided



Thank You

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AlaskaCare Retiree Health Plan Modernization Topics*

1. Active Topics

Proposal Number	Plan	Description	Priority
R001a/b	Medical	Enhance travel benefits (a); add health concierge (b)	1
R006	Medical	Expanded telehealth services	1
R008	Medical	Remove or increase lifetime maximum (currently $2M)	1
R009A	Medical	Rehabilitative Care - Clear Service Limits: Implement clear service limits for rehabilitative care	2
R009C	Medical	Rehabilitative Care – New Coverage: Add coverage for acupuncture/acupressure/rolfing	2
R012	Medical	Add wellness benefits such as gym memberships or program like Silver Sneakers	2
R014	Rx	Implement 3 tier pharmacy benefit; review out-of-network benefits	2
R005	Medical	Out-of-network reimbursement as a percentage of Medicare	Division
R019	Medical	Tiered network benefits for certain services	Division
R018	Multiple	Plan Housekeeping (ex., clarify reimbursement policies for surgical assistants, DVA standalone booklet)	Division
R***	Medical	Medicare Advantage	Division
R***	Medical	Virtual musculoskeletal condition treatment (Hinge Health)	Division
R***	DVA	Add “Preventive First” coverage to DVA Standard Plan	Division
R***	DVA	DVA Standard Plan annual benefit maximum (currently $2,000)	Division
R***	DVA	Enhance DVA Standard Plan vision benefits - VSP	Division
R***	DVA	Review DVA Standard Plan audio benefits	Division
R***		Add coverage for orthodontic braces to treat cleft palate – *member request*	

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

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AlaskaCare Retiree Health Plan Modernization Topics*

2. Pended Topics

Proposal Number	Plan	Description
R001a	Medical	Enhance travel benefits
R002	Medical	Network Incentive: 70% out-of-network and 90% in-network
R003	Medical	Increase deductible, out-of-pocket maximum
R004	Medical	In-network enhanced clinical review of high-tech imaging and testing
R010	Rx	Drugs with over the counter (OTC) equivalents
R011	Rx	Implement high-value pharmacy network with lower copays for chronic meds, medical synchronization, counseling, and packaging options for participating members.
R013	DVA/Medical	Consider expanding coverage for implants related to periodontal disease under the medical plan and/or under the dental plan
R015	Rx	Limit compound coverage to high-quality, narrow network of pharmacies
R017	Medical	Copayment for primary care

3. Completed Topics

Proposal Number	Plan	Description	Effective Date
R022	Medical/Rx	GCIT designated network benefits	1/1/2023
R023	Medical	Remove penalty for failure to precertify certain services	1/1/2023
R007	Medical	Expand preventive coverage to add full suite of preventive services	1/1/2022
R020	Rx	Add prior authorizations for certain specialty medications	1/1/2022
R016	Medical	Add medically necessary treatment of gender dysphoria including surgery – *public comment proposal*	1/1/2021

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

AlaskaCare Retiree Health Plan Modernization Effort
DRAFT 2024 Priority Topics

Enhanced Travel Benefits [SurgeryPlus] (R001a/b)

Proposal contemplates adding enhanced travel benefits and access to a high-value network of surgeons for non-emergent surgeries (version a) and travel concierge services (b).

This program would provide retiree plan members with access to a high-value network of providers who meet stringent quality and cost requirements, and supplemental travel benefits for non-emergency surgeries, including increased coverage for travel associated with procedures scheduled through the supplemental benefit program. Currently, the Division has contracted with SurgeryPlus to administer this program for active employee plan members. This proposal contemplates initially expanding the SurgeryPlus' service offering to retiree plan members

The SurgeryPlus benefit would provide additional financial assistance in covering the cost of travel for the member and a companion. It may facilitate increased access for members requiring care from specialists that are not available locally and the overall number of members seeking care outside of their community. It may also result in better outcomes through reduced complication rates based on the provider quality of the SurgeryPlus network. The additional physician credentialing and recommendations along with scheduling assistance and records transfer can greatly assist members who are seeking care both within their community as well as outside.

A secondary iteration of this proposal (version b) has contemplated extending travel coordination and concierge services for other travel circumstances not included in the standard SurgeryPlus offering.

Lifetime Maximum (R008)

Proposal contemplates increasing the lifetime maximum insurance benefit.
The lifetime benefit maximum is the maximum dollar amount that AlaskaCare retiree health plan will pay out during a member's lifetime for healthcare services. The AlaskaCare retiree defined benefit health plan currently contains a $2 million lifetime maximum.

The lifetime maximum provision currently in the plan represents an increase from the initial plan provision which set the limit at $250,000. In 1985, the $250,000 lifetime max was increased to $1 million, and in 1999 it was increased again to the present limit of $2 million. More members are reaching the lifetime maximum due to the significant growth of health care costs over the past decade, due to a variety of factors including access to new technological advancements.

Virtual Musculoskeletal Condition Treatment [Hinge Health] (R***)

Proposal contemplates adding musculoskeletal care and treatment via Hinge Health.
Providing members access to virtual/digital musculoskeletal (MSK) care program is intended to offer a cost-effective, easy-to-access, highly personalized MSK care and treatment options. Currently, the Division has contracted with Hinge Health (via SurgeryPlus) to administer this program for active employee plan members. Hinge Health's program is meant to aid in MSK condition prevention, result in surgical avoidance, contribute to better surgical recovery outcomes, and provide members with access to a wider range of medical experts for consultations and advice. The program should result in reduced costs to the plan and to members and should support better health outcomes for patients.

AlaskaCare Retiree Health Plan Modernization Effort
DRAFT 2024 Priority Topics

Dental Preventive First Program [DVA Standard Plan] (R***)

Proposal contemplates adding the Dental Preventive First program to the Dental-Vision-Audio (DVA) Standard Plan.
With the Preventive First program, preventive dental services will not count against the DVA plan's annual individual dental benefit maximum of $2,000. Preventive services may include routine exams and x-rays, regular cleanings, and periodontal maintenance. This helps members benefits go further, reserving the annual dental benefit maximum for other services including fillings, oral surgeries, crowns, dentures, and bridges. Not only will members get more value out of their dental benefits, but regular preventive care can help members avoid potentially painful and costly restorative treatments down the road.

Dental Annual Benefit Maximum [DVA Standard Plan] (R***)

Proposal contemplates increasing the annual dental benefit maximum in the DVA Standard Plan.
The annual dental benefit maximum is the maximum dollar amount that AlaskaCare retiree DVA plan will pay out during a benefit year for dental services. The AlaskaCare DVA Standard Plan currently contains a $2,000 annual dental benefit maximum. Costly dental procedures such as dental implants can cause a member to exhaust their annual benefit maximum quickly, leaving members responsible for any remaining costs associated with their dental care in that benefit year.

Value Based Arrangements (VBAs) & Medicare Advantage

Presented by: Shellie Gansz & Michael Dorward

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November 2022

Agenda

Value-Based Arrangements (VBAs)

- Strategy
- Commercial Clinically Integrated Network
- Existing VBAs
  - Envoy
  - Pinnacle Integrated Medicine
  - Providence
  - Pinnacle Women's Health
- Pipeline

Medicare Advantage Overview

Value-Based Arrangements

Shellie Gansz

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Commercial and Medicare Value-Based Arrangement Strategy

Advancing our strategy and elevating the member experience

Build on success

Optimize our network to ensure consumers have access to high-quality, affordable care

Extend the network

Expand and strengthen provider relationships to support medical and non-medical care needs that impact member health and well-being

Invest in primary care

Develop capabilities to help providers deliver quality, coordinated care for patients

Innovate for impact

Accelerate our ability to improve outcomes and experiences, lower the cost of care with new capabilities and better sharing of medical information

A different approach

	Today	Enhanced Approach
Model	**Provider-centric** model **Payer-led** care management telephonic model	**Member-centric** model **Provider/payer collaborative** care management activity at the point of care, supported with payer data, experience
People	**Focus on** sick patients only **Lack of** comprehensive care coordination	**Focus on** population health **Robust care coordination** across the continuum of care **Patient engagement** through digital technology
Technology	**Early stages of** Clinically Integrated Network (CIN), multiple separate systems	**Data-driven** clinical decision making: • **Standardized** evidence based medicine • **Predictive analytics** identify patient and provider focus • **Smart segmentation** across the population • **Improved** care coordination workflows
Economics	**Focus on discounts only**	**Competitive total cost of care** based on strategies designed to reduce waste: • Improve quality • Efficient care at best site of service • Lower prices

Our ACO studies show **progress**

Medical cost trends are **lower**[1]

Quality is maintained or **improved**[1]

[1]ACO Product Evaluation Study results, October 2018, for members with 2016 effective dates and claims data from 2015-2017. Study included a retrospective matched cohort design to compare Aetna members who elected the ACO product (Aetna Whole Health members) to Aetna members from the same zip codes using the same or similar healthcare systems (Control group). Aetna Consumer Health & Services Clinical Analytics, Evaluation and Value Demonstration. Actual results may vary; savings may be less when compared to other value-based network plans.

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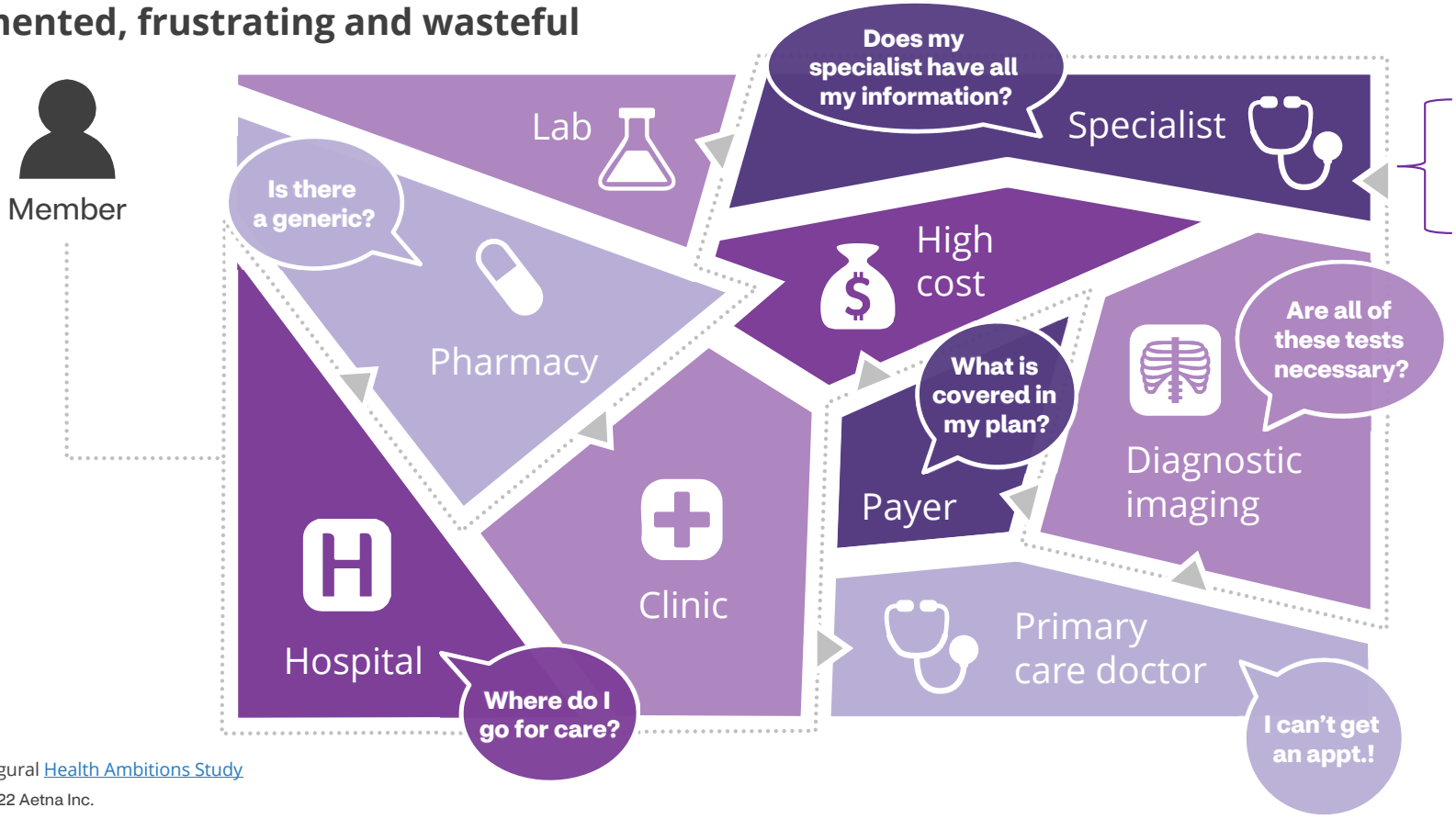
The patient experience needs improvement, too

Fragmented, frustrating and wasteful



68% of consumers view coordination among their health care providers as very important to their overall health[1]

[1]Aetna inaugural Health Ambitions Study

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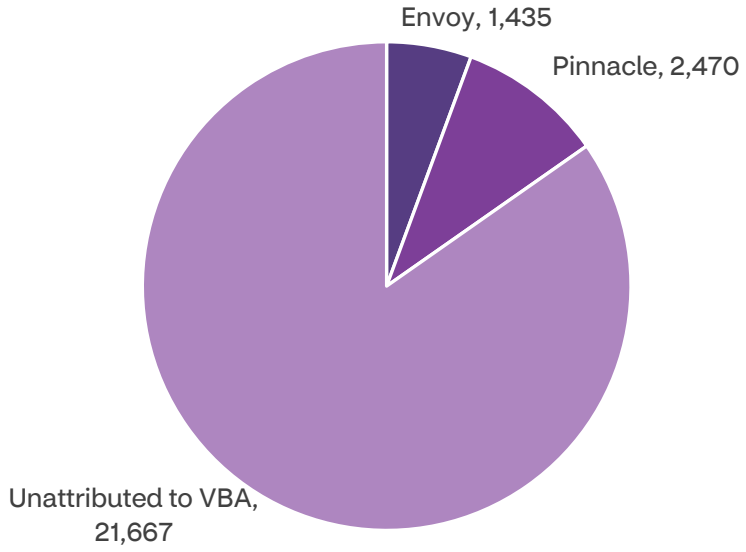
Create accessibility, improve quality and affordability

- Design value-based arrangement incentive models that reward providers for better outcomes
  - Certain quality and efficiency targets are set that determine potential incentive payouts

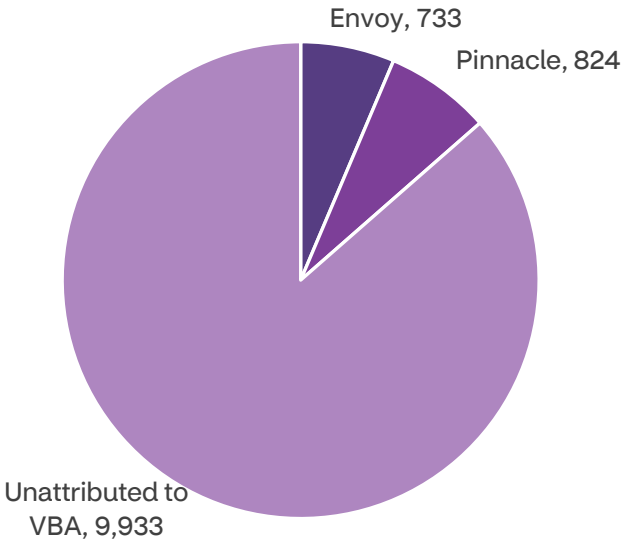
- Providers are accountable for a designated population that they serve
  - Attribution happens behind the scenes. This is how the member becomes part of the population that the provider is accountable and measured
    1. Claim attributed PCP in most recent 12 months
    2. Claim attributed PCP in most recent 24 months
    3. Claim attributed specialist in most recent 12/24 months

AlaskaCare Membership Attribution Overview (in Alaska)

AlaskaCare Actives & U65 Retirees



U65 Retirees



[1] State of Alaska Attribution data as of 9/30/2022
[2] Attribution is defined as membership that is assigned to a provider population to manage
[3] 555 Under 65 Retirees are attributing to a VBA outside of Alaska

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2022 Quality Measure Examples

Measure Grouping	Measure Description
Controlling High Blood Pressure	Controlling High Blood Pressure
Cancer	Breast Cancer Screening
Cancer	Cervical Cancer
Cancer	Colorectal Cancer
Diabetes	Comprehensive Diabetes Care: HBA1C Testing
Diabetes	Comprehensive Diabetes Care: HbA1c poor control >9.0%
Diabetes	Comprehensive Diabetes Care: Retinal Eye exam
Diabetes	Comprehensive Diabetes Care: Medical attention for Nephropathy
Readmission	Plan All-Cause Readmission Hospital

2022 Efficiency Metric Examples

Efficiency Description
Potentially impactable acute inpatient admissions per 1,000/year
Potentially avoidable ER visits per 1,000/year (based on NYU guidance)
Outpatient procedures performed in a free-standing ambulatory surgery center
Radiology services performed in a physician office or free- standing radiology center
Radiology utilization per 1,000/year
Laboratory services performed in a participating free-standing laboratory
Generic prescribing of selected drug groups

Clinically Integrated Network (CIN) Defined
Three C's: Care – Connectivity - Contracting

Care Coordination

- Identify patients at risk
- Educate each patient on their course of treatment
- Engage each patient in the management of their disease state

Data Sharing

- Combine claims and clinical data for use by physicians and clinical providers
- Develop evidence-based protocols

Population Health Management

- Aggregate patient data across multiple health information technology resources
- Develop patient-specific action plans

Physician Engagement

- Physicians incentivized to improve quality, improve outcomes, and decrease cost
- Physicians at the table in the formation of the health plan

Wellness and Health Promotion

- Increase member awareness of key health issues
- Identify disease early or preventing disease from occurring
- Assist in long-term commitment between the plan sponsor and the member

Existing Commercial Value-Based Arrangements

Envoy

Effective 1/1/2022
VBA Model: Pay For Performance - Attribution
State of Alaska Members: 1,435
Number of providers: 151

Key Features:

100% physician owned and led

Supports providers ability to stay independent but still participate in value-based arrangements

Major providers included:

- Orthopedic Physicians Alaska
- Internal Medicine Associates
- LaTouche Pediatrics
- Alaska Heart and Vascular Institute
- ENT Specialists of Alaska
- Anchorage Fracture and Orthopedic Clinic
- Peak Neurology and Sleep Medicine
- Primary Care Associates

Value Based Incentive Model
Pay for Performance - Attribution

- Shift a portion of FFS to earned incentives based on improvements or maintenance of high performing groups
- Goal is to improve cost and quality
  - Payout is adjusted based on quality and efficiency performance
  - Includes upfront accountable care payments as a pre-funded bonus to support infrastructure and collaboration and offset any earned payout

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Pinnacle Integrated Medicine

Effective 10/1/2016
VBA Model: Patient Centered Medical Home - Attribution
State of Alaska Members: 2,472
Number of providers: 55

Key Features:

Physician owned and directed clinical care

Major providers included:

- Capstone Family Medicine
- Capstone Urgent Care
- Arete Family Medicine
- Alaska Center for Pediatrics

Value Based Incentive Model
Patient Centered Medical Home - Attribution

- Shift a portion of FFS to earned incentives based on improvements or maintenance of high performing groups
- Goal is to improve cost and quality
- Gain share incentive available
  - Determined based on quality and efficiency performance
- Includes upfront pre-funded accountable care payments to support infrastructure and collaboration

Providence

Effective 1/1/2021
VBA Model: Pay For Performance

Key Features:

Physician-led organization

Includes the state's largest and highest-ranking hospital

Value Based Incentive Model
Pay for Performance - Claims Based

- Shift a portion of FFS earning to earned incentives based on improvements
- FFS offset based on quality and efficiency performance – Lump sum incentive or rate increase

Pinnacle Women's Health OBGYN

Effective 1/1/2018
VBA Model: Pay For Performance
Number of providers: 11

Key Features:

Physician-led organization

Major provider included:
- Alaska Women's Health

Value Based Incentive Model
Pay for Performance - Claims based

- Shift a portion of FFS earning to earned incentives based on improvements
- FFS offset based on quality and efficiency performance – Lump sum incentive or rate increase

Commercial Pipeline

Anchorage

Alaska Health Alliance (Providence)

Fairbanks

Fairbanks Memorial

Tanana Valley Med Surg

Juneau

Valley Medical (currently OON)

Kenai Peninsula

Central Peninsula Community Hospital

Vera Whole Health – AlaskaCare Retirees

Services include *Primary Care (preventive, chronic, acute) (physical and mental), Care Navigation, onsite lab, medication dispensary, coaching and more*

- **Eager to serve the State of Alaska retiree population**
  - Two clinics in Anchorage that will help provide additional access to primary care
  - Vera will be a participating provider with Aetna; but not with CMS Medicare
  - CMS Medicare reimbursement rates are low which elevates the importance of value-based arrangements as it helps to bolster reimbursement and attract providers
- **A bridge approach:**
  - Available to Under 65 Retirees to start
  - Individual Medicare participation 2024 with Aetna Medicare expansion creating availability to all Medicare eligible in Anchorage

Value Based Incentive Model

Vera is paid a capitation-like payment for the services covered under the benefit instead of fee-for-service payments.

1. State of Alaska only **pays for members who attribute** with Vera Whole Health
   - Attribution triggered by a PCP visit
2. Vera **delivers on redirecting medical spend** – reducing FFS claims to offset capitation-like payment
3. Shared savings is gated by quality performance.

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How do Value-Based Arrangements fit together with Medicare Advantage?

Medicare Expansion

Strategic Goal:
Combine Fee-For-Service and Value-Based Arrangements to offer a competitive network while getting members to their best health.

Key Milestone:
Develop a CMS adequate Network completed by end of Q4 2022 for January 1st, 2024 effective date

Value Based Arrangements:
- Align on a value-based arrangement that will provide additional incentives that help support providers signing a Medicare Advantage FFS agreement with Aetna

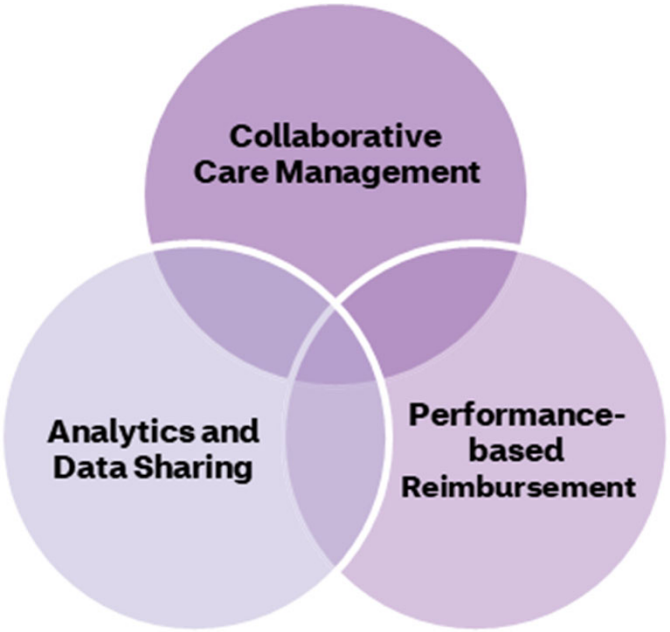
Recruitment efforts underway
- Building Medicare network i.e. recruiting targeted facilities and physician groups; added staff in Anchorage to help support recruitment efforts
  - Value Based Arrangement Pipeline:
    - Envoy
    - Vera Whole Health
    - Alaska Health Alliance
    - Pinnacle

Medicare Advantage & VBA Value Proposition

Performance-Based Reimbursement:
- Encourages provider participation and accessibility
- Incentives that encourage care in-between office visits and bolsters the CMS FFS payment

Analytics and Data Sharing:
- Actionable data and aligned incentives that promote and reward providers to close care gaps
- Providers are held accountable to improving certain quality metrics

Collaborative Care Management:
- Provide care management resources – online tools, case management support and other multidisciplinary support for select groups (Clinical Pharmacy and Behavioral Health) – to train, educate and collaborate with physicians and assist in coordinating care for members



What is Medicare Advantage?

Aetna Medicare Advantage informational meeting

Michael Dorward

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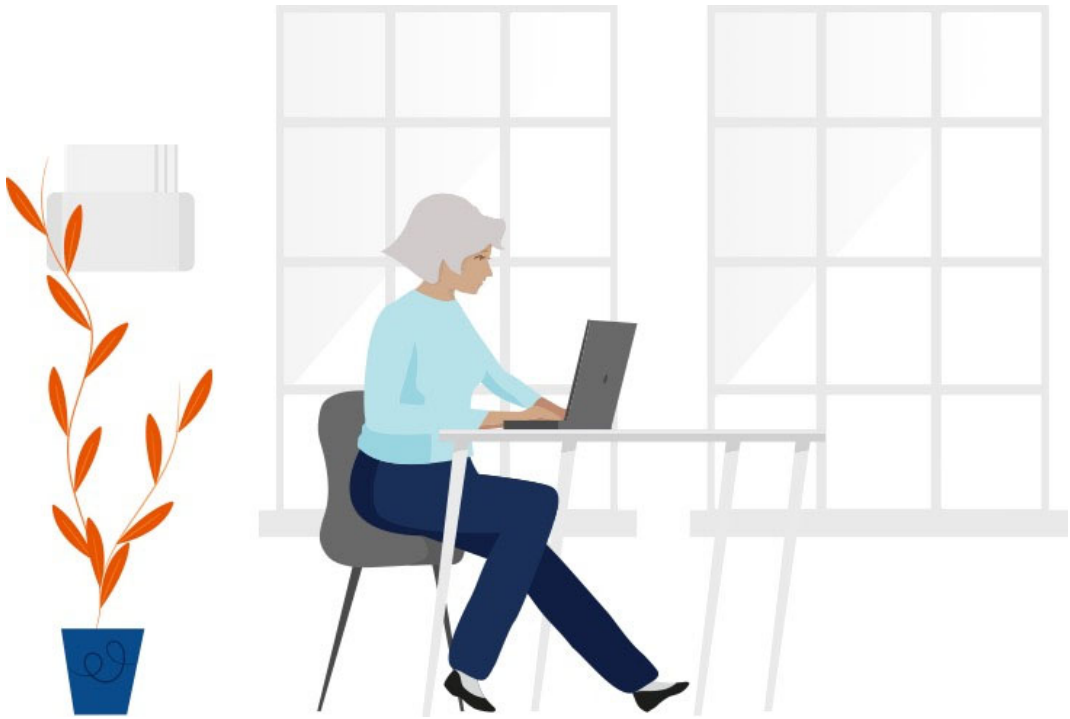
What we'll cover

- Seeing an in network provider
- The different parts of Medicare
- What is Medicare Advantage
- How a passive Medicare Advantage (PPO) plan works
- Additional benefits you get through Medicare Advantage



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How we make it simple to see your doctors

The provider landscape - approximately 1.4 Million providers[1]

Three types of providers in relation to Medicare Advantage:

1. Accepts Medicare assignment ***– or –***
2. Charges the Medicare limiting charge ***– or –***
3. Opted out of the Federal Medicare program
   - About 1% of providers across the country have opted out of Medicare[2]
   - 28,100+ total providers have opted out of Medicare[3]
   - 42% of all providers that have opted out are psychiatrists[2]
   - Only 3 states have higher than 2% - Alaska, Colorado, and Wyoming[2]
   - Alaska leads the country with 3.3% of providers opting out of Medicare[2]

With Medicare Advantage, members must see providers who accept Medicare.

The MAO cannot pay providers who have opted out of the federal Medicare program.

Neither Original Medicare or the MA plan would pay those providers.

1 https://data.cms.gov/browse-data-categories
2 https://www.kff.org/medicare/issue-brief/how-many-physicians-have-opted-out-of-the-medicare-program/
3 https://data.cms.gov/provider-characteristics/medicare-provider-supplier-enrollment/opt-out-affidavits

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The parts of Medicare

A simple view

Government plans Original Medicare		Private plans		
Medicare Part A	**Medicare Part B**	**Medicare Part C**	**Medicare Part D**	**Supplement Plans**
Helps with hospital costs	Helps with doctor costs	**Medicare Advantage plan** Combines Parts A + B and sometimes Part D benefits in *one* plan	**Prescription drug plan** Helps with Rx costs	Helps cost gaps in Part A and Part B

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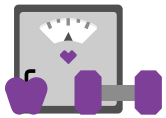
What is Medicare Advantage?

Benefits that go beyond Original Medicare

- Approved by Medicare and administered by an insurance carrier.

- Provides the same Original Medicare Part A (hospital) and Part B (medical) benefits.

- Includes additional benefits, such as health advocacy programs, personalized nurse support and more, at **no extra cost.**



- A yearly limit on out-of-pocket costs for covered medical services, unlike Original Medicare.

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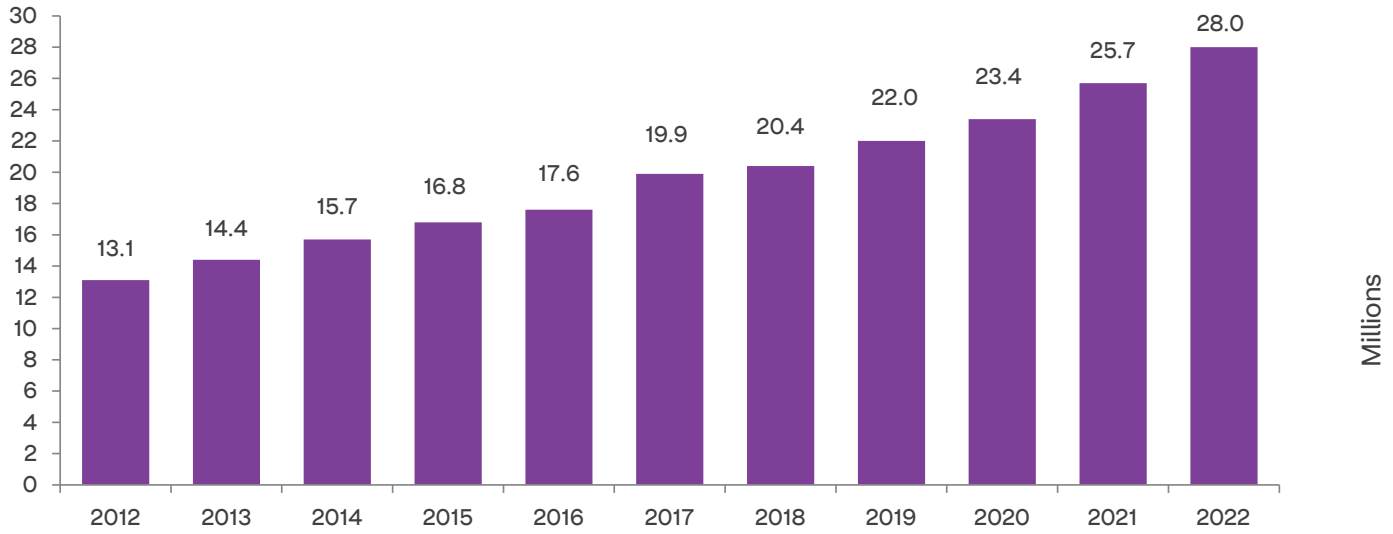
Trust in Medicare Advantage continues to grow: 48 percent of Medicare beneficiaries have chosen MA or MAPD

National Medicare Advantage membership growth[1]



1 CMS Medicare Advantage enrollment files, July 2022.

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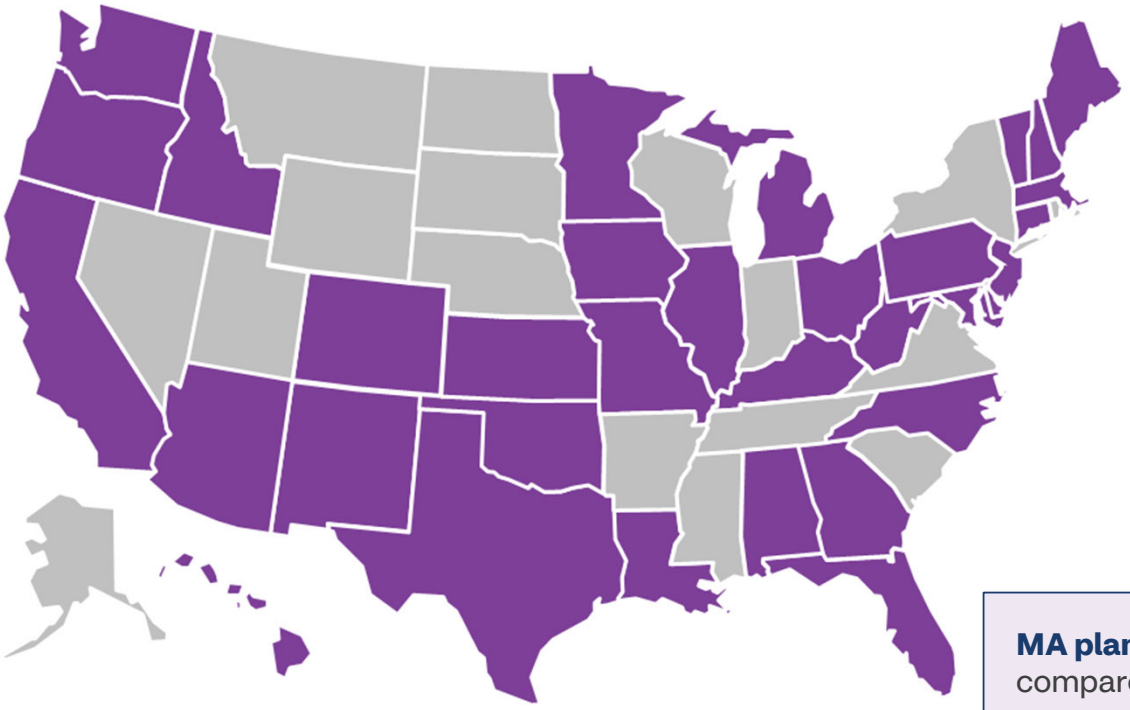
2021 Medicare Advantage adoption by state retiree plans/systems



- Offer MA plans
- Do not yet offer MA plans

MA plans create better health outcomes compared to traditional FFS....\[3]

... they also offer **better care and cost protection to racially and ethnically diverse beneficiaries**.[3]

Estimate as of 2021 plan year research. Based on internal analysis of current clients, prior quotes completed, FOIA requests and publicly available plan documents.

1 https://www.pewtrusts.org/en/research-and-analysis/articles/2016/09/07/how-states-provide-health-benefits-to-retired-workers
2 https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/MA-State-County-Penetration
3 https://bettermedicarealliance.org/news/new-analysis-medicare-advantage-achieves-better-outcomes-for-high-need-high-cost-beneficiaries/
4 https://bettermedicarealliance.org/publication/data-brief-medicare-advantage-offers-high-quality-care-and-cost-protections-to-racially-and-ethnically-diverse-beneficiaries/

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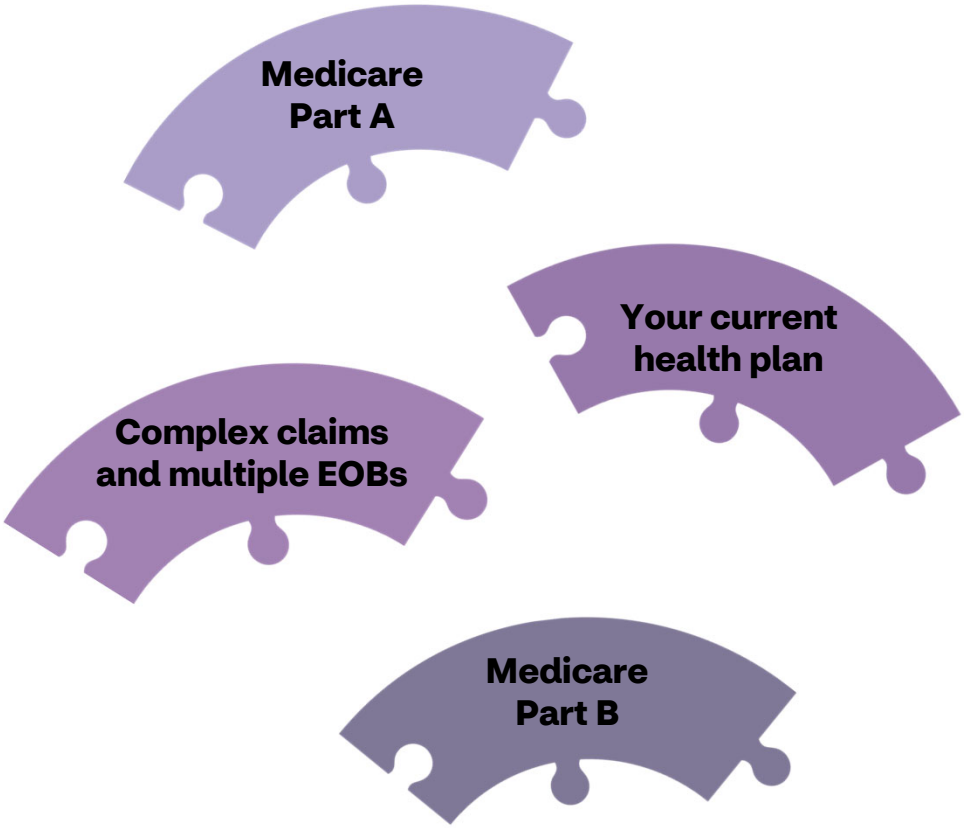
How Medicare Advantage plans are simple and efficient to use

How traditional Medicare COB works

- A payment process with many steps
- Two medical ID cards (traditional Medicare plan + health plan card(s))
- Lots of paperwork from:
  - Health care providers
  - Medicare
  - Current medical plan
- Multiple bills and Explanation of Benefits



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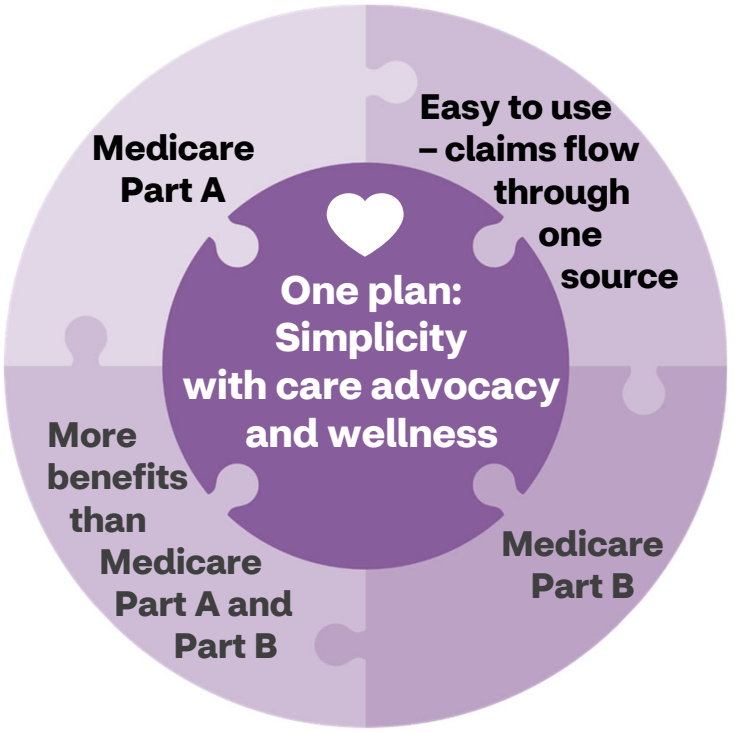
How the Medicare Advantage plan works

- Easy to use
- One medical ID card
- More benefits than Original Medicare Part A and Part B
- One monthly Explanation of Benefits for medical services
- Programs to help you reach your health goals, at no extra cost

Medicare Advantage plans must cover all Medicare-approved services.



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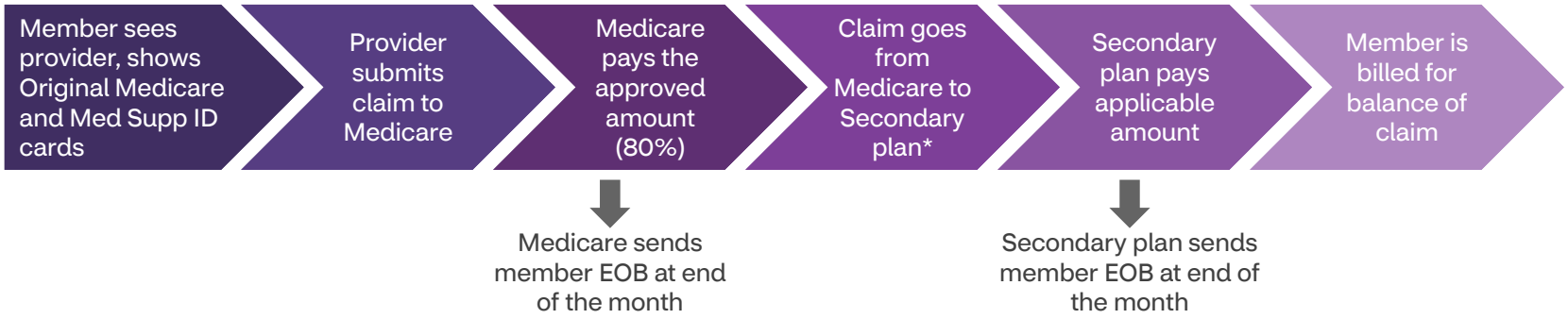
Comparing the claim payment process

Medicare Secondary plan scenario



Medicare Advantage plan scenario

*If the member has elected Medicare Direct

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Extras that often come with Medicare Advantage

How the plan supports the whole you

Prevention

Eye and hearing exams

Annual physicals

Flu shots and other vaccines

Women's annual health reminder

Cancer screening reminder

Wellness

Healthy Home Visits

24/7 Nurse Line

Telehealth

fitness program

Nonemergency transportation

Support

Mental Wellbeing resources

Chronic health condition support

Readmission Avoidance program

Meal Home Delivery program

Aging Support program

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Thank you

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