Retiree Health Plan Advisory Board
Meeting Agenda

Date:	Tuesday, September 8, 2026
Time:	1:30 pm – 3:30 pm
Location:	**Join the meeting now** | ANC Atwood 19th Floor
Telephone Only:	**+1 907-202-7104, 792 843 75#**
Board Members:	Dallas Hargrave, Lorne Bretz, Paula Harrison, Michael Humphrey, Donna White

1:30 pm Call to Order

- Roll Call and Introductions
- Approval of Agenda
- Ethics Disclosure and Public Comment

1:35 pm Public Comment

1:45 pm Division Updates/ Modernization Topics

- RFPs – Upcoming or in progress
  - Pharmacy Benefit Manager
  - Oncology Support Program
  - Voluntary Supplemental Benefits
  - Political Subdivision Group Health Insurance
  - Long-Term Care
- 2027 Dental-Vision-Audio and Long-Term Care Rates
- Addition of Licensed Massage Therapists
- RPEA Request for Regulations Subcommittee Meeting

3:20 pm Public Comment

3:30 pm Wrap up/Adjourn

Segal

State of Alaska

AlaskaCare 2027 Premium Rate Development

Dental, Vision and Audio Plan
Long-Term Care Plan

September 2026

Premium Rate Development

- At its most basic level, premium rates are developed to cover claims costs as well as administrative and operational expenses
- In many plans, this is considered over a multi-year period and balances other considerations, such as:
  - Annual premium rate stability/volatility
  - Premium rate competitiveness
  - Managing risk and selection
  - Equity between plan and coverage options
  - Timing difference between premium revenue and expenses

Primary objective is the overall financial health and viability of the entire plan over the long term

Premium Rate Development - DVA

1. For the DVA plan, recent claims experience is trended forward to the next plan year to get projected claims
   - Claims are adjusted for prior, and upcoming changes
2. Add administrative and operational costs to projected claims to get initial full premium
3. Factor in long-term considerations to determine final rates

DVA Plan is now in the target funding range. Going forward the objective should be to slow the spend-down rate for a "soft-landing".

DVA Background

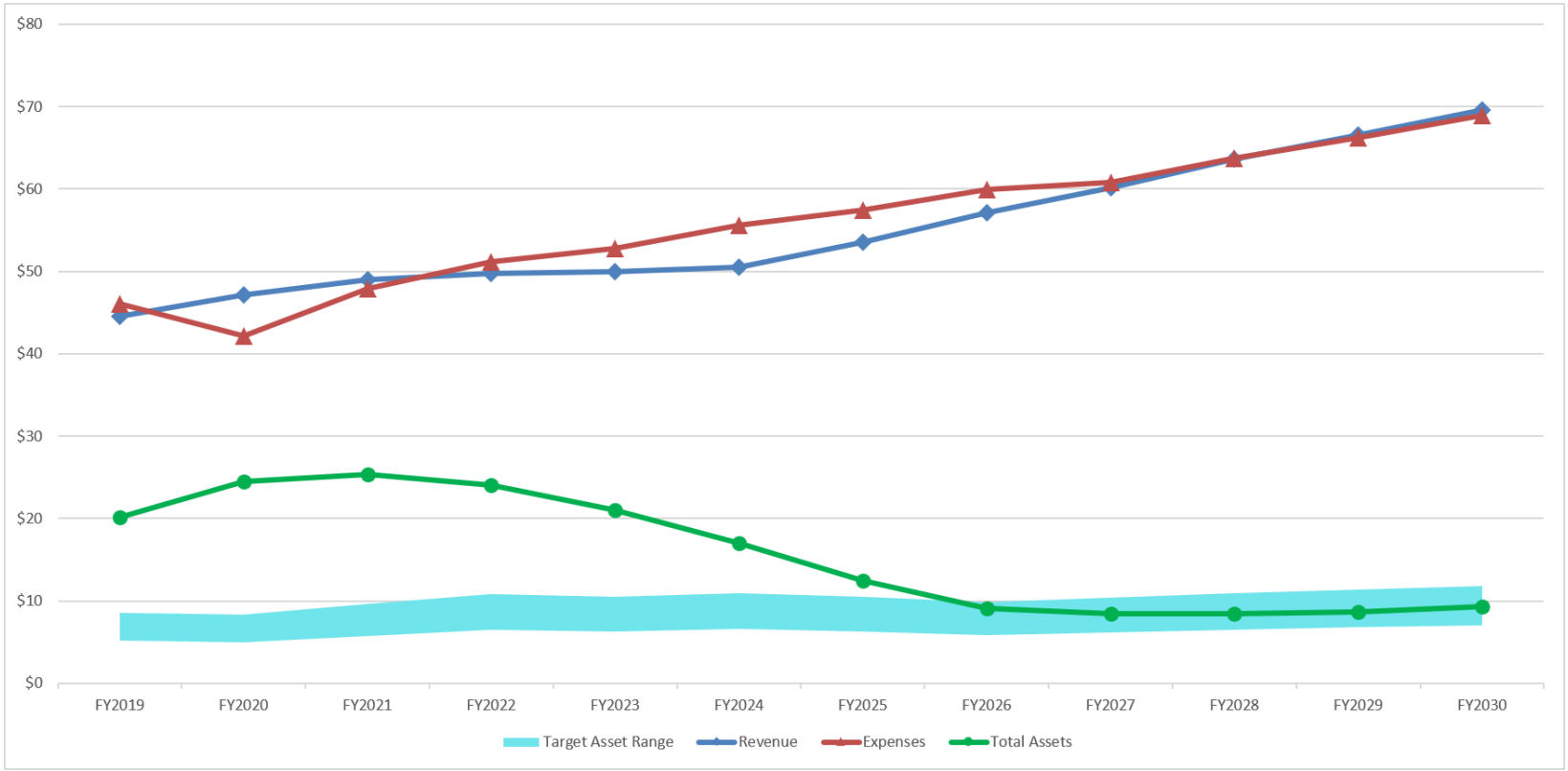
- The Legacy Plan was re-introduced effective January 1, 2020, and replicates the plan that was in effect prior to January 1, 2014. The 2020 Standard Plan reflects the benefits that were in effect beginning in 2015 with modifications to modernize the plan design.
- Effective January 1, 2026, the Standard plan expanded preventive dental coverage, added 3D imaging coverage, adjusted crown frequency and reimbursement, and broadened Class I service eligibility.
  - No changes were made to the Legacy Plan.
- No plan changes are currently proposed for the 2027 plan year.
- Based on preliminary financial statements, the total assets ($9.1M) to IBNR ($3.9M) ratio is 231% as of June 30, 2026.
  - This is a decrease from $12.4M in assets and a 297% ratio at FYE2025.
- The current target ratio is a range from 150% to 250%, which equates to $5.9M to $9.8M in assets.
- The June 30, 2026, assets utilized in this analysis are based on the initial and unaudited statements provided by DRB. Final audited statements are not anticipated to vary significantly from those already provided.
  - The assets to IBNR ratio may change as part of the updates to the audited financial statements.

2026 Plan Change Summary

The following plan changes we effective January 1, 2026, for the Standard Plan

- Preventive Cleanings: Removed Delta Dental's OHTH program, and increased Plan coverage from two, to four prophylaxis, scaling, and periodontal maintenance visits per calendar year for all members.
- X-Rays and Imaging: Allowed Plan coverage for 3D imaging.
- Crowns: Reduced the frequency limit from once per tooth every seven years, to once per tooth every five years. Updated the reimbursement allowance from the allowable amount for a metal crown, up to the allowable amount for a porcelain crown.
- Other Class I Changes: Increased the allowance for the topical application of fluoride from two times per calendar year based on age criteria, to four times per calendar year with no age limit. Removed current eligibility criteria for sealant application, sealant repair, preventive resin restoration in a moderate to high carries risk patient for a permanent tooth and allow once per tooth per year for each service.

Historical Managed Spend Down



- In recent years, expenses have exceeded revenue, as part of a planned spend-down back to the target range.
- Recent premium changes in have partially closed the funding gap, while still reducing assets in a managed process, approaching the target funding range.
- Future premium changes aim to maintain funding within the target range, slow the spend-down rate, and continue towards a “soft landing”.

Dental, Vision, and Audio Funding Rates

- The Legacy and Standard plan rates increased 6.0% and 8.5%, respectively, effective January 2026.
- Segal is recommending a rate increase of 3.5% for the Legacy and 8.0% for Standard plan. The combined increase is higher than trend, which is necessary to continue the managed spend-down and achieve a “soft landing”.
- This results in the plans having the same premiums in 2027.

Legacy Plan Rates	**2026**	**2027**	**$ Change**
Retiree	$80.00	$83.00	$3.00
Retiree & Spouse	$158.00	$164.00	$6.00
Retiree & Child	$143.00	$148.00	$5.00
Retiree & Family	$225.00	$233.00	$8.00
Standard Plan Rates	**2026**	**2027**	**$ Change**
Retiree	$77.00	$83.00	$6.00
Retiree & Spouse	$154.00	$164.00	$10.00
Retiree & Child	$140.00	$148.00	$8.00
Retiree & Family	$219.00	$233.00	$14.00

2027 DVA Projections – Proposed Premiums

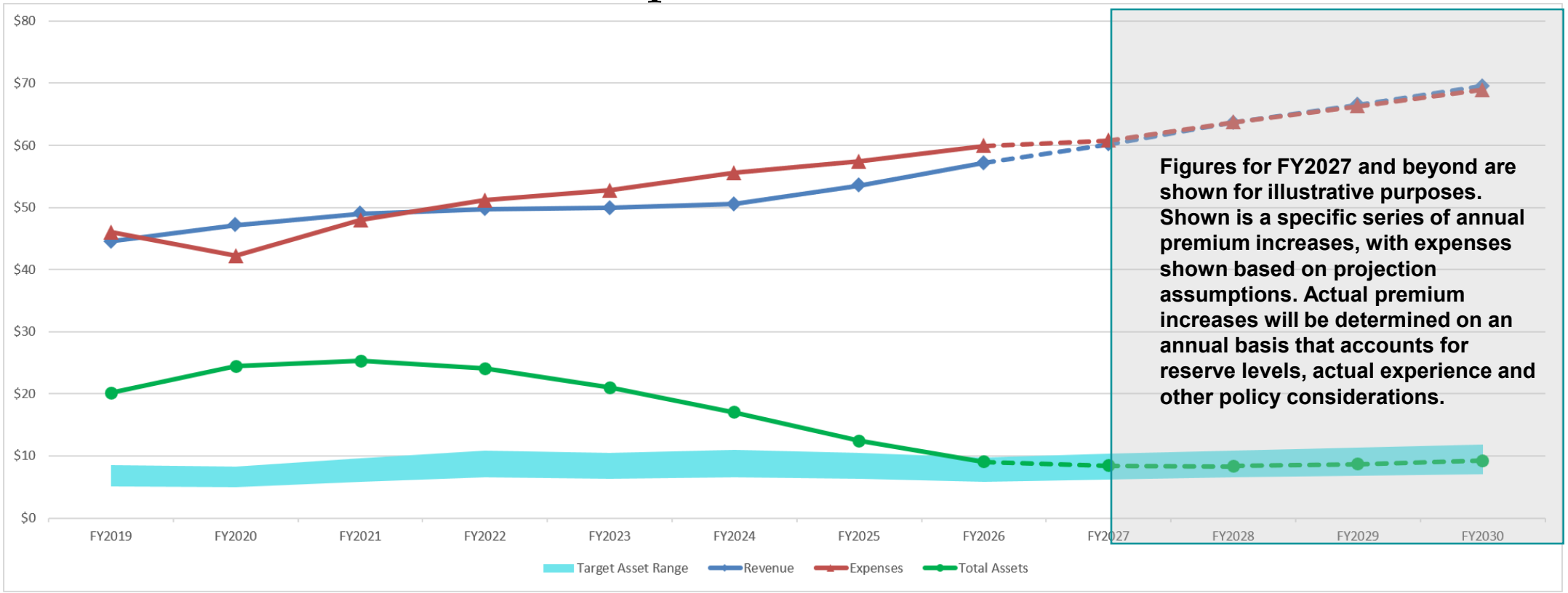
- Segal projects the following financial results for CY2027.
  - This is assuming the recommend contribution rate increases (3.5% Legacy, 8.0% Standard) effective January 1, 2027:

Description	Legacy	Standard	**Total**
Total Projected Claims	$27,153,715	$34,436,628	$61,590,343
Administration and Operational Expenses	$1,133,055	$1,320,971	$2,454,026
Total Projected Cost	$28,286,770	$35,757,599	$64,044,369
Premium Based Revenue	$28,502,955	$33,047,531	$61,550,487
$$ Funding Overage/(Gap)	$216,186	($2,710,068)	($2,493,882)
% Funding Overage/(Gap)	0.8%	(8.2%)	(4.1%)

- These rate increases will further temper the spend-down rate and are expected to maintain assets within the target funding range through FYE2027.
- Included is an **illustrative** series of future increases to manage the spend down of assets and minimize future shock increases.

The projections in this report are estimates of future costs and are based on information available to Segal at the time the projections were made. Segal has not audited the information provided. Projections are not a guarantee of future results. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, trend rates, and claims volatility. The accuracy and reliability of projections decrease as the projection period increases.

Projected DVA Revenues, Expenses, Net Assets ($millions)
Increases for CY27 and Subsequent Years



Description	Eff 1/1/2026	Eff 1/1/2027	Eff 1/1/2028	Eff 1/1/2029	Eff 1/1/2030
Legacy Plan	Actual Rates	**Illustrative Rates Only**	**Illustrative Rates Only**	**Illustrative Rates Only**	**Illustrative Rates Only**
Rate Increases	6.0%	3.5%	3.5%	3.5%	3.5%
EE	$80.00	$83.00	$86.00	$89.00	$92.00
EE+SP	$158.00	$164.00	$170.00	$176.00	$182.00
EE+CH	$143.00	$148.00	$153.00	$158.00	$164.00
EE+Fam	$225.00	$233.00	$241.00	$249.00	$258.00

Description	Eff 1/1/2026	Eff 1/1/2027	Eff 1/1/2028	Eff 1/1/2029	Eff 1/1/2030
Standard Plan	Actual Rates	**Illustrative Rates Only**	**Illustrative Rates Only**	**Illustrative Rates Only**	**Illustrative Rates Only**
Rate Increases	8.5%	8.0%	3.5%	3.5%	3.5%
EE	$77.00	$83.00	$86.00	$89.00	$92.00
EE+SP	$154.00	$164.00	$170.00	$176.00	$182.00
EE+CH	$140.00	$148.00	$153.00	$158.00	$164.00
EE+Fam	$219.00	$233.00	$241.00	$249.00	$258.00

Premium Rate Development - LTC

For the LTC plan, the benefits are paid well after the premiums are paid. Therefore, a long-term view is necessary

1. Project forward all anticipated benefits (and expenses), accounting for assumed mortality, morbidity, lapses, etc.
2. Project forward all anticipated premium revenue (at current rates), accounting for assumed mortality, morbidity, lapses, etc.
3. Add net difference between projected benefits and premiums and factor in assumed investment returns.
4. If present value of net assets is greater than $0, then current premiums are anticipated to be sufficient.

Segal recommends maintaining current premium rates through the next actuarial valuation. The 2025 valuation continues to show a funded status over 100%, and assets have increased during FY2026.

However, care should be exercised before modifying premiums rates based on short term gains (or losses).

LTC Valuation Results (June 30, 2025)

Component	6/30/2023 ($000)	6/30/2025 ($000)
1. PV of Future Benefits	$803,949	$1,075,509
2. PV of Future Expenses	$8,636	$10,048
3. PV of Future Premiums (PVFP)	$331,774	$398,957
4. Valuation Liabilities (=3 – 1- 2)	($480,538)	($686,601)
5. Valuation Assets	$681,985	$878,048
6. Valuation Margin (= 5 + 4)	$201,447	$191,439
7. Margin as a % of PVFP (= 6/3)	60.7%	48.0%
8. Funded Status (= 5/4)	141.9%	127.9%

- **$1.1B in assets as of June 30, 2026**
- **Recommending no changes in premiums**

Historical LTC Funded Status

Valuation Date	Margin ($000)
May 31, 2012	$30,289
June 30, 2015	$27,244
June 30, 2017	$7,372
June 30, 2019	$94,564
June 30, 2021	$244,205
June 30, 2023	$201,447
June 30, 2025	$191,439

Questions?

Executive Summary	Licensed Massage Therapists (R035)
Health Plan Affected	Defined Benefit Retiree Plan
Proposed Effective Date	01/01/2027
Reviewed By	RHPAB Modernization Committee
Review Date	08/28/2026

1) Background

The AlaskaCare Retiree Health Plan (Plan) provides coverage for outpatient rehabilitative care, including massage therapy, designed to restore and improve bodily functions lost due to injury or illness. According to the terms of the Plan, rehabilitative care is only a covered Plan benefit when it's part of a formal written program of care and is considered medically necessary only if significant improvement in body function is occurring and is expected to continue.

The Plan utilizes the claim administrator's current medical clinical policy bulletins (CPB) to assess medical necessity for eligible services. For massage therapy, medical necessity is reviewed under the clinical policy bulletin for physical therapy[1], which states the following regarding massage therapy:

> Massage therapy is considered medically necessary as adjunctive treatment to another therapeutic procedure on the same day, which is designed to restore muscle function, reduce edema, improve joint motion, or for relief of muscle spasm. Massage therapy is not considered medically necessary for prolonged periods and should be limited to the initial or acute phase of an injury or illness (i.e., an initial 2-week period).

The AlaskaCare Retiree Insurance Information Booklet[2] (Booklet), under Section 3.3.3 Provider Services, lists the specific licensed provider types covered by the Plan. Massage therapists were not recognized providers requiring professional licensing in the State of Alaska at the time the Plan was established, and therefore, massage therapists were not listed as recognized providers in the Plan Booklet. Legislation[3] enacted in 2014 established the Alaska Board of Massage Therapists and required massage therapists to become licensed providers with the State in order to continue practicing, effective July 1, 2015. No changes were made to the Plan to add licensed massage therapists (LMTs) to the list of recognized providers following this change.

Members have access to massage therapy as a benefit available under the Rehabilitative Care provisions. However, the services must be billed under a provider type recognized by the Plan, which limits retiree access to medically necessary massage to services provided or billed by physical therapists, occupational therapists, chiropractors, and other recognized providers.

2) Objectives

1 Aetna Clinical Policy Bulletin No. 0325: Physical Therapy
https://www.aetna.com/cpb/medical/data/300_399/0325.html
2 AlaskaCare Retiree Health Insurance Information Boolet
https://drb.alaska.gov/docs/booklets/DB-RetireeInsuranceBooklet_WEB.pdf
3 House Bill 328: Board/Licensing of Massage Therapists
https://www.akleg.gov/basis/Bill/Text/28?Hsid=HB0328A

Update the Plan to include LMTs as recognized providers to modernize the Plan and increase member access to medically necessary massage therapy.

3) Summary of Proposed Change

This proposal seeks to add LMTs to the list of recognized providers under section 3.3.3 Provider Services of the Booklet to increase access to medically necessary massage therapy. Massage therapy services would continue to be evaluated for medical necessity in accordance with the Plan provisions regarding Medically Necessary Services and Supplies and Rehabilitative Care.

4) Impacts

Actuarial Impact to AlaskaCare | Neutral

Segal, the Division's contracted benefit consultants, indicate the addition would be considered an expansion of provider options, which does not impact the actuarial value of the Plan.

Financial Impact to AlaskaCare | Increase

Segal indicated the anticipated financial impact of this change, based on the most recent retiree medical and pharmacy claims projection of $912,500,000 for 2026 (dated September 24, 2025), and trended forward for a projected cost of $974,900,000 for 2027, equates to an annual cost increase to the Plan of less than 0.1%, or $650,000 - $750,000.

Member Impact | Enhancement

It's anticipated that members of the Plan would benefit from increased access to qualified providers.

Operational Impact (DRB)| Minimal

The Division anticipates minimal operational impacts. The Division will follow the standard process for making plan changes per 2 AAC 39.390 and provide directions to the Third-Party Administrator to implement the update. Once the implementation activities are complete the Division does not anticipate any additional operational impact.

Operational Impact (TPA) | Minimal

The impact to the Third-Party Administrator (TPA) is anticipated to be low. Aetna will need to update and test their internal claim processing workflows and systems to ensure the changes are appropriately applied and implemented. After implementation, the ongoing operational impacts are anticipated to be minimal, and will include preparing reporting, fiscal impact monitoring, and updates to communication materials as appropriate.

Provider Impact | Moderate

The impact to providers is expected to be positive, as this removes potential barriers to care for their patients. LMTs will be positively impacted by the ability to bill for medically necessary massage therapy provided to Plan members.

5) Considerations

This change is anticipated to result in members having increased access to medically necessary massage therapy due to increased provider options. Since Medicare does not recognize LMTs as an eligible provider

type, the Plan will pay as primary payer for medically necessary massage received from an LMT.

6) Implementation and Communication Overview

Division staff will follow the standard process for making changes to the Plan, which includes completion of the following:

- Proposal analysis and stakeholder input
- Public comment period(s)
- Any needed language updates to the Retiree Insurance Information Booklet

7) Proposal Recommendations

DRB Recommendation

The Division recommends adopting the proposal and adding LMTs to the list of recognized providers.

RHPAB Board Recommendation

The RHPAB board voted on ##/##/## to recommend/not to recommend…

Description	Date
Proposal Drafted	August 2026
Reviewed by Modernization Committee	August 2026
Reviewed by RHPAB	

Segal

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Memorandum

To: Chris Murray, Chief Health Administrator, Division of Retirement and Benefits

From: Richard Ward, FSA, FCA, MAAA

Date: July 23, 2026

Re: **Allowing Access to Licensed Massage Therapists (Retiree Plan)**

The State is considering recognizing Licensed Massage Therapists (LMTs) as an eligible provider type to allow additional access under the Retiree Plan.

The Retiree Plan currently covers outpatient rehabilitative care designed to restore and improve bodily functions lost due to injury or illness. This includes physical therapy which may incorporate massage to provide relief using manual soft tissue manipulation. Because LMTs are not recognized as eligible providers, these services are currently being performed by physical therapists, occupational therapists, chiropractors, and other currently recognized provider types.

In order to practice, LMTs must have a state license and complete required training and examinations. By recognizing LMTs as eligible providers, retirees and their dependents would have additional access to providers. This change would bring alignment with the Employee Plan which already recognizes LMTs as eligible providers.

Below is a table outlining the current benefits offered under the Plan:

Deductibles

Description	Amount
Annual individual / family unit deductible	$150 / up to 3x per family

Coinsurance

Description	Percentage
Most medical expenses	80%
Most medical expenses after out-of-pocket limit is satisfied	100%
Second surgical opinions, Preoperative testing, Outpatient testing/surgery • No deductible applies	100%

Out-of-Pocket Limit

Description	Amount
Annual individual out-of-pocket limit • Applies after the deductible is satisfied • Expenses paid at a coinsurance rate other than 80% do not apply against the out-of-pocket limit	$800

Benefit Maximums

Description	Amount
Individual lifetime maximum • Prescription drug expenses do not apply against the lifetime maximum	$8,000,000

Prescription Drugs

Prescription Drugs	Up to 90 Day or 100 Unit Supply	
Up to 90 Day or 100 Unit Supply	Generic	Brand Name
Network pharmacy copayment	$4	$8
Mail order copayment	$0	$0

Actuarial Value

This would be considered a provider expansion change and would not impact the cost share of benefits offered to the retirees. As a result, there will be no change anticipated in the actuarial value for the plan.

Financial Impact

Segal's analysis included a comprehensive review of massage therapy claims across the Retiree and Employee plans over the past two fiscal years based on data paid through June 2026. Because the Employee Plan currently recognizes LMTs as eligible providers, we used the utilization per 1,000 and average allowed costs as a benchmark for future expectations for the Retiree Plan. The estimated increase in cost is expected to be between $650,000 and $750,000 annually.

Using the most recent retiree medical and pharmacy claims projection of $912,500,000 for 2026 (dated September 24,2025) and trended forward for a projected cost of $974,900,000 for 2027, this equates to an increase of less than 0.1% in annual costs to the Plan. For the first year, expenses may be slightly lower due to the timing lag between eligibility and when claims will first be processed and paid.

In addition, Segal assumed that coverage for massage therapy services would remain unchanged to existing coverage provisions, with the only proposed modification being the expansion of eligible providers to include LMTs.

Since Medicare does not recognize LMTs as eligible providers either, we have also assumed that the AlaskaCare plans would pay primary for care provided by LMTs.

Care provided by non-LMTs would continue to be covered by Medicare on a primary basis (for those with Medicare), resulting in that care generally continuing to be covered with little to no member out-of-pocket costs.

Additional Notes

The data used for this analysis was reviewed, but not audited, and found to be sufficient and credible.

The above projection is an estimate of future cost and is based on information available to Segal at the time the projection was made. Segal has not audited the information provided. A projection is not a guarantee of future results. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, change in demographics, overall inflation rates and claims volatility. Projection of retiree costs takes into account only the dollar value of providing benefits for current retirees during the period referred to in the projection. It does not reflect the present value of any future retiree benefits for active, disabled, or terminated employees during a period other than that which is referred to in the projection, nor does it reflect any anticipated increase in the number of those eligible for retiree benefits, or any changes that may occur in the nature of benefits over time.

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cc: Ronan Tagsip, Division of Retirement and Benefits
Elizabeth Hawkins, Division of Retirement and Benefits
Noel Cruse, Segal
Tanya Sun, Segal
Quentin Gunn, Segal

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August 4, 2026

Chris Murray, Acting Chief Health Administrator/Deputy Director
Division of Retirement and Benefits
Department of Administration
PO Box 110203
Juneau, AK 99811-0203

Dear Mr. Murray;

I am writing on behalf of the Executive Board of the Retired Public Employees of Alaska (RPEA) to request that the Division of Retirement and Benefits (DRB) repeal its outdated appeal regulations, 2 AAC 39-500 – 2 AAC 39.590 (Article 4), and 2 AAC 39.600 – 2 AAC 39.690 (Article 5). As you know, I am the RPEA representative on the Regulations Subcommittee of the Retiree Health Plan Advisory Board (RHPAB). The Subcommittee has not met since 2023, and DRB has not proposed new appeal regulations.

This request follows in response to Governor Dunleavy's issuance of Alaska Administrative Order 360, effective August 4, 2025, dealing with administrative regulations. AO 360 directs all executive branch agencies to review existing regulations to identify outdated, redundant or unclear provisions. Each agency is directed to develop proposals to revise or repeal said regulations and report to the Governor's Office.

In 2023, the DRB updated its regulations relating to the PERS and TRS retiree health plans. At the time, the RPEA identified that the appeal regulations referenced two Boards that were abolished in 2005 when their statutory authority was repealed (§ 132 ch 9 FSSLA 2005). DRB acknowledged these regulations were outdated but chose not to amend or repeal them in the regulation package being promulgated in 2023.

Now that AO 360 directs the DRB to identify and repeal outdated regulations, it seems like an appropriate time to address these outdated appeal regulations. In our view, 2 AAC 39-500 – 2 AAC 39.590 (Article 4), and 2 AAC 39.600 – 2 AAC 39.690 (Article 5) should be repealed in their entirety. However, doing so would leave retirees without any procedures or protections for appealing decisions made by the third-party health plan administrators, unless DRB simultaneously adopts new appeal regulations.

RPEA understands the DRB may not be prepared to propose updated appeal regulations. In lieu of a total rewrite of the appeal regulations (which are warranted) the DRB could amend these regulations to remove all references to the PERS and TRS Boards, which were abolished over 20 years ago.

If the DRB is not prepared to adopt new appeal language at this time, attached is proposed language to amend these regulations rather than repealing them in their entity. The proposed draft of Articles 4 and 5 removes the references to the PERS and TRS Boards, while still maintaining a process for retirees to appeal decisions of the third-party health plan administrators to the DRB. The RPEA Executive Board respectfully requests that DRB review this proposal and convene the RHPAB Regulations Subcommittee to discuss it.

Thank you for considering these comments, and I look forward to hearing from you.

Best regards,

Wendy Woolf

Wendy Woolf

Treasurer, RPEA Executive Board and
RPEA Representative
RHPAB Regulations Subcommittee

Cc (via email):

Commissioner Paula Vrana, Dept. of Administration
Director Kathy Lea, Div. of Retirement and Benefits
Retiree Health Plan Advisory Board (alaskarhpab@alaska.gov)
RPEA Executive Board

Attachments:

Proposed Language to Amend 2 AAC 39 - Articles 4 and 5
Administrative Order 360

Article 4 [1]

Appeals from Denials of Medical Claims Under the Medical Coverage Provided by the Public Employee's Retirement System

2 AAC 39.500. Applicability. The provisions of 2 AAC 39.500 - 2 AAC 39.590 apply only so long as the plan administrator determines that a self-insured program of medical coverage is provided to enrollees. If a self-insured program ceases to exist, the plan administrator [~~AND THE BOARD~~] will not hear appeals from denial of medical claims under AS 39.35.535 and AS 39.30.090.

2 AAC 39.510. Exhaustion of remedies provided by claims payer required. Before appealing to the plan administrator [~~OR TO THE BOARD~~] under 2 AAC 39.500 - 2 AAC 39.590, an enrollee must fully utilize any appeal procedures provided by a claims payer under a contract entered into under AS 39.30.090 - 39.30.095.

2 AAC 39.520. Appeal to plan administrator. (a) An enrollee may appeal to the plan administrator from a final decision by the claims payer denying the enrollee's claim in whole or in part. A "final decision by the claims payer" is a decision that is not subject to any further review by the claims payer.

(b) The enrollee's appeal must be in writing, must explain the grounds for the appeal, and must be postmarked or received by the plan administrator within 45 days of the date that the enrollee received written notice of the final decision by the claims payer. The appellant may submit documentation in support of the appeal. The filing requirement of this subsection may be waived by the plan administrator if the enrollee can show that there are extraordinary circumstances resulting in the enrollee's inability to meet the filing requirement.

(c) The plan administrator shall send a final written decision on the appeal within 30 days of the date that the appeal was received, unless the administrator determines that additional information is necessary for resolution of the appeal. If the administrator determines that additional information is necessary from the appellant, the administrator shall allow the appellant an additional 30 days to submit the additional information. If the additional information is not furnished within 30 days, the administrator may deny the appeal. If the additional information is furnished in a timely manner, the administrator shall send a final written decision on the appeal within 30 days of the date that the additional information is received. If the plan administrator determines that a medical review by an independent review organization is necessary, the administrator shall make such request and notify the appellant within 15 days of the date that the appeal is received. After the plan administrator receives the report of the independent review, the administrator shall send a final written decision on the appeal within 30 days of the date that the independent review is received.

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[1] Title 2 Administration, Chapter 39. Group Health and Life Insurance, Sec 2 AAC 39.500. Applicability.
Reference: 2 AAC 39.500 - 2 AAC 39.590
Statutory Authority: AS 39.35.040, AS 39.35.535 **(Eff. 5/28/99, Register 151)**

[~~(D) IN THE FINAL WRITTEN DECISION, THE PLAN ADMINISTRATOR SHALL INDICATE WHICH ASPECTS OF THE DECISION ARE APPEALABLE TO THE BOARD UNDER 2 AAC 39.530, AND WHICH ASPECTS ARE NOT SO APPEALABLE.~~]

[**~~2 AAC 39.530. APPEAL TO THE PUBLIC EMPLOYEE'S RETIREMENT BOARD.~~** ~~(A) EXCEPT AS PROVIDED IN (B) OF THIS SECTION, IF AN ENROLLEE IS NOT SATISFIED WITH THE DECISION OF THE PLAN ADMINISTRATOR UNDER 2 AAC 39.520(C), THE ENROLLEE MAY APPEAL TO THE BOARD WITHIN 30 DAYS AFTER RECEIVING THE PLAN ADMINISTRATOR'S DECISION. UNLESS THE RECIPIENT REQUESTS A HEARING DIRECTLY BEFORE THE BOARD AT THE TIME OF THE APPEAL, THE SECRETARY OF THE BOARD SHALL APPOINT A QUALIFIED HEARING OFFICER TO HEAR THE APPEAL.~~

~~(B) DETERMINATIONS OF THE PLAN ADMINISTRATOR RESPECTING ISSUES RELATING TO COORDINATION OF BENEFITS AND THE CALCULATION OF USUAL, CUSTOMARY AND REASONABLE CHARGES ARE NOT APPEALABLE TO THE BOARD.~~

~~(C) APPEALS TO THE BOARD ARE SUBJECT TO THE PROCEDURES SET OUT IN 2 AAC 35.160, EXCEPT THAT A PARTY TO THE APPEAL MAY BE REPRESENTED BY COUNSEL ONLY IF THE PARTY GIVES WRITTEN NOTICE TO THE BOARD SECRETARY (FOR APPEALS BEFORE THE FULL BOARD) OR THE HEARING OFFICER (FOR APPEALS BEFORE A HEARING OFFICER), WITH SERVICE UPON THE OTHER PARTY, AT LEAST 30 DAYS BEFORE THE SCHEDULED HEARING DATE.~~

~~(D) IF A HEARING IS HELD BEFORE A HEARING OFFICER, THAT OFFICER SHALL ISSUE A RECOMMENDED DECISION WITHIN 21 DAYS OF THE COMPLETION OF THE HEARING OR, IF THE RECORD IS HELD OPEN FOLLOWING COMPLETION OF THE HEARING FOR SUBMISSION OF ARGUMENT OR ADDITIONAL EVIDENCE, WITHIN 21 DAYS OF THE DATE THAT THE RECORD IS CLOSED. THE RECOMMENDED DECISION SHALL BE PRESENTED TO THE BOARD AT ITS NEXT SCHEDULED MEETING. THE BOARD WILL, IF REQUESTED, ALLOW EITHER PARTY TO SPEAK TO THE PROPOSED DECISION. THE BOARD MAY ADOPT THE RECOMMENDED DECISION IN WHOLE, MAY ADOPT THE RECOMMENDED DECISION WITH MODIFICATIONS, OR MAY REJECT THE RECOMMENDED DECISION. THE BOARD WILL, IN ITS DISCRETION, DECIDE THE APPEAL UPON THE RECORD INCLUDING THE TRANSCRIPT OR TAPE RECORDING OF THE EARLIER HEARING, WITH OR WITHOUT TAKING ADDITIONAL EVIDENCE, OR MAY REFER THE APPEAL TO THE SAME OR ANOTHER HEARING OFFICER TO TAKE ADDITIONAL EVIDENCE.~~

~~(E) IF THE APPEAL IS REFERRED TO A HEARING OFFICER FOR THE TAKING OF ADDITIONAL EVIDENCE UNDER (D) OF THIS SECTION, THE HEARING OFFICER SHALL PREPARE A PROPOSED DECISION BASED UPON THE ADDITIONAL EVIDENCE AND THE RECORD OF THE EARLIER HEARING.~~

~~(F) THE BOARD WILL, IN ITS DISCRETION, GIVE THE PARTIES THE OPPORTUNITY TO PRESENT ARGUMENT, EITHER ORAL OR WRITTEN, BEFORE THE BOARD.~~

~~(G) THE TIME LIMITS ESTABLISHED IN THIS SECTION MAY BE EXTENDED IF IT IS DETERMINED THAT THE LIMITS IMPOSE UNDUE RESTRICTIONS ON EITHER PARTY~~.]

2 AAC 39.540. Emergency procedures. (a) The plan administrator [~~AND THE BOARD~~] may review claims of an emergency nature on an expedited basis, including use of shortened schedules, telephonic proceedings, and other procedures necessary to facilitate prompt determinations. "Emergency" as used in this section is limited to determinations where a patient's life or health would be threatened by delay, and substantial deference shall be afforded to a certificate by an enrollee's treating physician that such an emergency exists.

(b) Appeals granted under emergency procedures do not have any precedential value in future appeals due to the abbreviated nature of emergency procedures, and any medical treatment approved in an emergency procedure is not thereby approved for any claimant not specifically a party to the emergency procedure.

2 AAC 39.590. Definitions. In this chapter,

[(1) ~~"BOARD" MEANS THE PUBLIC EMPLOYEES' RETIREMENT BOARD~~;]

(2) "claim" means a claim for benefits under the major medical insurance coverage provided under AS 39.35.535;

(3) "claims payer" means the third-party administrator of benefit claims and payments under a contract entered into by the plan administrator under AS 39.30.090 - 39.30.095;

(4) "day" means a calendar day;

(5) "enrollee" means a person receiving medical coverage under any provision of AS 39.35, or the legal guardian of such a person;

(6) "independent review organization" means an impartial health organization selected by the plan administrator to provide medical reviews of cases at the request of the plan administrator;

(7) "plan administrator" means the administrator appointed by the commissioner of administration under AS 39.35.050;

(8) "qualified hearing officer" means a person experienced in rendering decisions as a neutral decision-maker, and may include an employee of the state or a state agency other than the division of retirement and benefits in the Department of Administration.

Article 5 [2]

Appeals from Denials of Medical Claims Under the Medical Coverage Provided by the Teachers' Retirement System

2 AAC 39.600. Applicability. The provisions of 2 AAC 39.600 - 2 AAC 39.690 apply only so long as the plan administrator determines that a self-insured program of medical coverage is provided to enrollees. If a self-insured program ceases to exist, the plan administrator [~~AND THE BOARD~~] will not hear appeals from denials of medical claims under AS 14.25.168 and AS 39.30.090.

2 AAC 39.610. Exhaustion of remedies provided by claims payer required. Before appealing to the plan administrator [~~OR TO THE BOARD~~] under 2 AAC 39.600 - 2 AAC 39.690, an enrollee must fully utilize any appeal procedures provided by a claims payer under a contract entered into under AS 39.30.090 - 39.30.095.

2 AAC 39.620. Appeal to plan administrator. (a) An enrollee may appeal to the plan administrator from a final decision by the claims payer denying the enrollee's claim in whole or in part. A "final decision by the claims payer" is a decision that is not subject to any further review by the claims payer.

(b) The enrollee's appeal must be in writing, must explain the grounds for the appeal, and must be postmarked or received by the plan administrator within 45 days of the date that the enrollee received written notice of the final decision by the claims payer. The appellant may submit documentation in support of the appeal. The filing requirement of this subsection may be waived by the plan administrator if the enrollee can show that there are extraordinary circumstances resulting in the enrollee's inability to meet the filing requirement.

(c) The plan administrator shall send a final written decision on the appeal within 30 days of the date that the appeal is received, unless the administrator determines that additional information is necessary for resolution of the appeal. If the administrator determines that additional information is necessary from the appellant, the administrator shall allow the appellant an additional 30 days to submit the additional information. If the additional information is not furnished within 30 days, the administrator may deny the appeal. If the additional information is furnished in a timely manner, the administrator shall send a final written decision on the appeal within 30 days of the date that the additional information is received. If the plan administrator determines that a medical review by an independent review organization is necessary, the administrator shall make such request and notify the appellant within 15 days of the date that the appeal is received. After the plan administrator receives the report of the independent review, the administrator shall send a final written decision on the appeal within 30 days of the date that the independent review is received.

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[2] Title 2 Administration, Chapter 39. Group Health and Life Insurance, Sec 2 AAC 39.600.
Reference: 2 AAC 39.600 - 2 AAC 39.690
Statutory Authority: AS 14.25.035, AS 14.25.168 **(Eff. 5/27/99, Register 151)**

[~~(D) IN THE FINAL WRITTEN DECISION, THE PLAN ADMINISTRATOR SHALL INDICATE WHICH ASPECTS OF THE DECISION ARE APPEALABLE TO THE BOARD UNDER 2 AAC 39.630, AND WHICH ASPECTS ARE NOT SO APPEALABLE.~~]

[**~~2 AAC 39.630. APPEAL TO THE TEACHERS' RETIREMENT BOARD.~~** ~~(A) EXCEPT AS PROVIDED IN (B) OF THIS SECTION, IF AN ENROLLEE IS NOT SATISFIED WITH THE DECISION OF THE PLAN ADMINISTRATOR UNDER 2 AAC 39.620(C), THE ENROLLEE MAY APPEAL TO THE BOARD WITHIN 30 DAYS AFTER RECEIVING THE PLAN ADMINISTRATOR'S DECISION. UNLESS THE ENROLLEE REQUESTS A HEARING DIRECTLY BEFORE THE BOARD AT THE TIME OF THE APPEAL, THE SECRETARY OF THE BOARD SHALL APPOINT A QUALIFIED HEARING OFFICER TO HEAR THE APPEAL.~~

~~(B) DETERMINATIONS OF THE PLAN ADMINISTRATOR RESPECTING ISSUES RELATING TO COORDINATION OF BENEFITS AND THE CALCULATION OF USUAL, CUSTOMARY, AND REASONABLE CHARGES ARE NOT APPEALABLE TO THE BOARD.~~

~~(C) APPEALS TO THE BOARD ARE SUBJECT TO THE PROCEDURES SET OUT IN 2 AAC 36.120, EXCEPT THAT A PARTY TO THE APPEAL MAY BE REPRESENTED BY COUNSEL ONLY IF THE PARTY GIVES WRITTEN NOTICE TO THE BOARD SECRETARY (FOR APPEALS BEFORE THE FULL BOARD) OR THE HEARING OFFICER (FOR APPEALS BEFORE A HEARING OFFICER), WITH SERVICE UPON THE OTHER PARTY, AT LEAST 30 DAYS BEFORE THE SCHEDULED HEARING DATE.~~

~~(D) IF A HEARING IS HELD BEFORE A HEARING OFFICER, THAT OFFICER SHALL ISSUE A RECOMMENDED DECISION WITHIN 21 DAYS OF THE COMPLETION OF THE HEARING OR, IF THE RECORD IS HELD OPEN FOLLOWING COMPLETION OF THE HEARING FOR SUBMISSION OF ARGUMENT OR ADDITIONAL EVIDENCE, WITHIN 21 DAYS OF THE DATE THAT THE RECORD IS CLOSED. THE RECOMMENDED DECISION SHALL BE PRESENTED TO THE BOARD AT ITS NEXT SCHEDULED MEETING. THE BOARD WILL, IF REQUESTED, ALLOW EITHER PARTY TO SPEAK TO THE PROPOSED DECISION. THE BOARD MAY ADOPT THE RECOMMENDED DECISION IN WHOLE, MAY ADOPT THE RECOMMENDED DECISION WITH MODIFICATIONS, OR MAY REJECT THE RECOMMENDED DECISION. THE BOARD WILL, IN ITS DISCRETION, DECIDE THE APPEAL UPON THE RECORD INCLUDING THE TRANSCRIPT OR TAPE RECORDING OF THE EARLIER HEARING, WITH OR WITHOUT TAKING ADDITIONAL EVIDENCE, OR MAY REFER THE APPEAL TO THE SAME OR ANOTHER HEARING OFFICER TO TAKE ADDITIONAL EVIDENCE.~~

~~(E) IF THE APPEAL IS REFERRED TO A HEARING OFFICER FOR THE TAKING OF ADDITIONAL EVIDENCE UNDER (D) OF THIS SECTION, THE HEARING OFFICER SHALL PREPARE A PROPOSED DECISION BASED UPON THE ADDITIONAL EVIDENCE AND THE RECORD OF THE EARLIER HEARING.~~

~~(F) THE BOARD WILL, IN ITS DISCRETION, GIVE THE PARTIES THE OPPORTUNITY TO PRESENT ARGUMENT, EITHER ORAL OR WRITTEN, BEFORE THE BOARD.~~

~~(G) THE TIME LIMITS ESTABLISHED IN THIS SECTION MAY BE EXTENDED IF IT IS DETERMINED THAT THE LIMITS IMPOSE UNDUE RESTRICTIONS ON EITHER PARTY.~~]

2 AAC 39.640. Emergency procedures. (a) The plan administrator and the board may review claims of an emergency nature on an expedited basis, including use of shortened schedules, telephonic proceedings, and other procedures necessary to facilitate prompt determinations. "Emergency" as used in this section is limited to determinations where a patient's life or health would be threatened by delay, and substantial deference shall be afforded to a certificate by an enrollee's treating physician that such an emergency exists.

(b) Appeals granted under emergency procedures do not have any precedential value in future appeals due to the abbreviated nature of emergency procedures, and any medical treatment approved in an emergency procedure is not thereby approved for any claimant not specifically a party to emergency procedure.

2 AAC 39.690. Definitions. In this chapter,

[~~(1) "BOARD" MEANS THE ALASKA TEACHERS' RETIREMENT;~~]

(2) "claim" means a claim for benefits under the major medical insurance coverage provided under AS 14.25.168;

(3) "claims payer" means the third-party administrator of benefit claims and payments under a contract entered into by the plan administrator under AS 39.30.090 - 39.30.095;

(4) "day" means a calendar day;

(5) "enrollee" means a person receiving medical coverage under any provision of AS 14.25, or the legal guardian of such a person;

(6) "independent review organization" means an impartial health organization selected by the plan administrator to provide medical reviews of cases at the request of the plan administrator;

(7) "plan administrator" means the administrator appointed by the commissioner of administration under AS 14.25.015;

(8) "qualified hearing officer" means a person experienced in rendering decisions as a neutral decision-maker, and may include an employee of the state or a state agency other than the division of retirement and benefits in the Department of Administration.

Administrative Order No. 360

I, Mike Dunleavy, Governor of the State of Alaska, under the authority of Article III, Sections 1, 23, and 24 of the Constitution of the State of Alaska, hereby rescind Administrative Order 157 (Directives regarding Administrative Regulations in order to accomplish objectives) and Administrative Order 266 (establishing regulatory efficiency guidelines) and replace them with Administrative Order 360, the purpose of which is to improve the quality, transparency, and efficiency of the State's regulatory environment.

BACKGROUND AND PURPOSE

The State of Alaska is committed to growing its economic base, increasing its gross domestic product ("GDP"), and ensuring Alaskans have the freedom to do business, innovate, and pursue opportunities while complying with state and federal laws. Regulations are essential for interpreting and implementing these laws. However, the state's regulatory system has expanded over time, often adding layers of requirements without considering the burden imposed on Alaska's citizens and businesses. Alaska must be competitive on the world stage – including its regulatory framework – to attract investment and grow its economic base.

The public is best served when regulations are up-to-date, clearly written, account for impact on individual Alaskans and those doing business in the state and allow state agencies to facilitate implementation of laws in the most reasonable and cost-effective manner.

In light of the steady expansion of state regulatory requirements, I am announcing a statewide review of all existing regulations, guidance documents [1], and materials incorporated by reference to reduce unnecessary burdens on Alaska's citizens and businesses. I am also directing that all current guidance documents be published on the Alaska Online Public Notice System to ensure transparency and accountability.

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[1] The term "guidance document" in this Order refers to documentation other than regulations produced by an agency often referred to as guidance documents, policies, interpretive bulletins, and the like.

GOALS

This Order is issued to achieve the following goals:

- Promote growth and investment in Alaska by reducing administrative and economic burdens associated with regulatory compliance, including removing barriers, finding solutions, and identifying alternative pathways.
- Streamline permitting processes and improve coordination and efficiency within all permitting departments, including the Department of Natural Resources ("DNR"), the Department of Environmental Conservation ("DEC"), and the Department of Fish and Game ("DFG").

- Ensure boards and commissions adjust regulatory structures as necessary to maintain critical consumer protection while eliminating unnecessary barriers to entry for new professionals.
- Engage stakeholders early and continuously in the regulatory development and reform process.
- Ensure all regulations are clearly written, legally sound, and supported by a demonstrated need.
- Regularly evaluate existing regulations for effectiveness, redundancy, clarity, and impact.
- Reduce the regulatory burden on all Alaskans.

APPLICABILITY

This Order applies to all executive branch agencies, including departments, boards, commissions, and public corporations (hereafter referred to as "agencies").

RESPONSIBILITY FOR IMPLEMENTATION

The following agencies ("implementing agencies") are responsible for ensuring agency compliance with this Order:

- **The Office of the Governor.** This office will provide oversight and ensure interagency cooperation.
- **The Department of Law.** This department will coordinate the implementation of and ensure compliance with this Order pursuant to its role under AS 44.62. The Department of Law will provide the training and documentation to be used in implementing this Order.

ORDER

REGULATORY REDUCTION

Each agency shall:

Review existing regulations, guidance documents, and materials incorporated by reference to identify provisions that are outdated, redundant, or unclear.

Develop proposals for the revision, repeal, or streamlining of the regulations, guidance documents, and materials incorporated by reference identified above.

Reduce the number of regulatory requirements by 15 percent by December 31, 2026, and 25 percent (cumulative) by December 31, 2027.

AGENCY REGULATORY LIAISON

The **commissioner of each state department** shall designate an **Agency Regulatory Liaison** ("ARL") to oversee regulatory reform for agencies housed within their department.

Commissioners may designate more than one ARL when approved to do so by the Office of the Governor.

Each department's ARL shall submit a quarterly progress report to the Office of the Governor, with copies to the Department of Law.

STAKEHOLDER AND PUBLIC ENGAGEMENT

Stakeholder feedback is essential and required at all stages of regulatory reform. Accordingly, each agency shall:

Solicit written and oral input from the public, affected industries, and community organizations regarding which regulations are the most burdensome and should be prioritized for reform, and how the agency's regulatory system could be reorganized or simplified.

Document and publish stakeholder and public feedback and agency responses.

PERMITTING REFORM

To improve the efficiency and responsiveness of Alaska's permitting systems, and to support responsible resource and economic development while protecting environmental and public interests, DNR, DEC, and DFG shall focus their initial regulatory reform efforts on permitting process reform. Accordingly, DNR, DEC, and DFG shall:

Review and revise permitting procedures to eliminate unnecessary steps, reduce duplicative reviews, simplify application requirements, streamline internal workflows, and clarify interagency roles to reduce inefficiencies and delays.

Adopt, in regulation, clear timelines and deadlines for permit application processing, review of milestones, and final decision making, including provisions for automatic approval if deadlines are not met.

Ensure transparent processes by making permit application statuses, timelines, and decision rationales available to applicants and the public, to the extent allowable by law.

Promote predictability in decision-making by applying regulatory standards consistently.

Leverage technology, such as artificial intelligence ("AI"), to support digitization, automation, and public access to permitting information.

GUIDANCE DOCUMENTS

Agencies may not utilize or issue guidance documents unless the Department of Law has reviewed the documents and verified the documents (or portions thereof) are not required to be promulgated as a regulation.

Agencies shall post all guidance documents on the Alaska Online Public Notice System.

STATE UNIFIED REGULATORY PLAN

Annually, all agencies shall submit to the Office of the Governor a projected regulatory plan that lists all anticipated rulemaking actions during the subsequent state fiscal year. The Office of the Governor shall approve individual agency plans. The Department of Law shall compile the approved agency plans into a single State Unified Regulatory Plan and post the plan on the Alaska Online Public Notice System.

DURATION

This Administrative Order takes effect immediately and remains in effect until revoked.

DATED this 4th day of August 2025.