Retiree Health Plan Advisory Board
Meeting Agenda

Date:	Thursday, November 9, 2023
Time:	9:00am – 12:00pm
Location:	Video Teleconference | ANC Atwood 19th Floor Click here to join the meeting
Telephone Only:	(907) 202-7104 877 269 598#
Board Members:	Lorne Bretz, Dallas Hargrave, Paula Harrison, Cammy Taylor, Michael Humphrey and Nanette Thompson

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9:00 am **Call to Order**

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

9:15 am **Public Comment**

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

- Dental Vision Audio – Open Enrollment update
- Plan Booklet update – public comment period
- Regulations update

10:00 am **Modernization Topics/Priorities**

11:30 am **Public Comment**

11:45 pm **Wrap up/Adjourn**

Retiree Health Plan Advisory Board
Meeting Minutes

Thursday, September 18, 2023

Board Members		DRB		Guests	
Lorne Bretz	P	Betsy Wood	P	Randall Burns	P
Dallas Hargrave	P	Ajay Desai	P	Wendy Wolfe	P
Paula Harrison	P	Andrea Mueca	P	Deborah Donaldson	P
Michael Humphrey	A	Teri Rasmussen	P	Joel Kranz (Aetna)	P
Cammy Taylor	P	Chris Murray	P	Marilyn Pillifant	P
Nan Thompson	P	Erika Burkhouse	P	Judy Salo	P
		Liz Hawkins	P	Mauri Long	P
		Richard Ward (Segal)	P		

Call to Order

The meeting was called to order at 1:04pm by vice chair Cammy Taylor.

Approval of Meeting Agenda and Minutes

The agenda was approved.

The minutes were approved with two corrections; pages 4 & 5 correct the name - Nan Thompson

Ethics Disclosure

Vice Chair Cammy Taylor requested that Board members state any ethics disclosures in the meeting and remind members of the disclosure form available from staff, to keep any necessary disclosures on file.

- No disclosures were stated by Board members.

Public Comment

Judy Salo – Introduced Marilyn Pillifant a retiree from NEA Alaska, listening in today.

Department & Division Update

1. Contracting Update

The division provided an overview of all the different TPA contracts the DRB health team manages.

The State of Alaska provides health insurance through the AlaskaCare plans and other benefit offerings to certain active State employees, retirees, and their dependents. The AlaskaCare health plans are self-insured, meaning the state is responsible for paying the claims incurred, and are managed in the Division of Retirement and Benefits (Division). The Division hires contractors, or Third-Party Administrators (TPAs), to assist in the administration of the benefits.

TPA duties may include adjudicating claims, developing a network of providers, establishing the systems necessary to process claims, providing a call center for members, and other activities necessary to carry out the functions of a health plan or benefit offering.

Periodically the Division competitively bids on these contracts through a Request For Proposal (RFP). This gives the Division an opportunity to seek better service at lower cost for members and the plan and ensure that the contracts are market competitive.

We typically offer a longer initial contract term, and then add renewal options that can be exercised at the discretion of the state. This provides us with flexibility for rebidding the services.

Supplemental Surgery and Travel services contract
DRB is currently drafting an RFP for these services in early 2024, for a new contract to take effect in 2025. We want to know who our partner will be so that we can begin the retiree plan implementation. If we have continuity of our partner, we may be able to implement sooner. Once we complete the RFP, we will be able to develop the best and the most aggressive timeline for implementation of these services. We identified some areas that will require logistical coordination between DRB, Aetna and the vendor. We need to work those items out as part of a smooth transition.

Pharmacy Benefit Manager (PBM) contract
OptumRx is our current PBM. We are through the initial contact term, and entering the renewal cycles which last through 2029. When we look at the prescription drug pricing in the market is very dynamic. It can change year to year, there is a lot of conversation nationally around the price of drugs. Industry best practice is to rebid your contract every 3-5 years, to get best in class pricing. We have been able to get good rates through negotiating pricing after-market checks. The best way to access deeper discounts is by going out to RFP. It's likely we will be releasing an RFP soon and will keep the board informed and invite a representative to join us on the proposal evaluation committee.

Voluntary Supplemental Benefits Contract
MetLife is the voluntary supplemental benefits contractor. The contract provides retiree optional life insurance, Select Life for retirees, and benefits are for the employee plan. We purchase fully insured supplemental benefit options. This contract is more relevant on the employee plan side, but wanted to review its timeline since it affects the timing of managing contracts. We will be moving forward with a renewal option in 2024, and we will need to rebid this contract by 2026.

Long Term Care Contract
Wellcove-CHCS is the long-term care benefits contractor. We will be looking to rebid this contract by 2027. Competition in the LTC market is limited.

Medical Third-Party Administrator
Aetna is the medical third-party administrator. We are approaching the end of the initial contract term; the contract was awarded in 2019. The biggest highlight is that we are entering the renewal cycle, and there are some positive items for the retiree plan related to updated care management programs. Many of the care management programs are focused on helping members seek preventive care, which is now a plan benefit. Now is a great opportunity to leverage some of the programs Aetna offers. We just started the conversations for 2025. We will invite Aetna to a future meeting to discuss some of the enhancements.

Dental Claims Administrator
Delta Dental is our dental claims administrator. We are in the initial contract term and will move into annual optional renewals in 2025. The pricing is less dynamic than on the pharmacy side. However, it's best practice to rebid these services to ensure that we have the best partner.

2. DVA Rates for 2024

Richard Ward form SEGAL – AlaskaCare 2024 Premium Rate Development
When Segal is developing premium rates, the item we are most concerned about is there are assets and revenue to cover the expenses. For many of the plans we looked at a longer period than the next year. We want to promote stability and to account for volatility, we want the premiums to be competitive, evaluate risk, equity between plan and coverage options, timing differences between premium revenues and expenses.

For the medical there is a lot of stability year to year. There are zero-dollar premiums for most retirees, and lots of consistency in the structure of the program. We have seen an ongoing shift from non-Medicare to Medicare. People are engaging in Medicare faster than they are retiring. That influences trend, non-Medicare people cost more than Medicare. The retiree health plan liability is well funded, about 130% funded. We look at projected expenses, administration and operational costs, changes that are taking effect, market check results, rebates and egwp subsidies. Our recommendation is to maintain the current premiums and continue to monitor the plan experience over the next year. Segal is recommending no change to the CY2024 contributions.

The big difference between DVA and medical is the DVA is exclusively funded by the premiums members pay. We take claims experience, make adjustment for changes, add projected operating costs, and look at this separately of the Legacy and Standard plan. The DVA has been very well reserved over the last few years. We are looking at a gradual spend down to cover future trend. The Standard and Legacy plan trend is projected to increase based on their individual rated dental experience each year. Assuming no changes in funding rates, there is a projected gap of approximately $8.0m (17%) between cost and revenue. The gap will only grow without a premium increase, and it's time to make an adjustment to manage the spend rate. We are recommending a 5% increase for both plans. For single coverage that's a $3 increase, and a family plan would be a $9 increase. We want a soft landing so that we don't have a sharp increase in the future. The goal is to keep the reserve level in the blue band and stay there. Segal is recommending a $5% increase for 2024. The board is not being asked to take any official action, we want the board to understand the division's position and recommendation.

For LTC its also 100% voluntary and funded by members premiums. The timing between when members pay premiums vs when they use the benefit is different. Money is paid into the fund now for benefit paid out later. This analysis is more of a pension approach where we are projecting out assumed mortality, morbidity, lapses, etc. and taking the present value of that. The valuation results shows that the plan remains well funded, 154% 2 years ago and 141.9% in 2023. There is no need to increase LTC premiums. We would also caution against decreasing premiums, due to risk with investment gains.

3. Plan Administrator Approval of Proposals

We have worked diligently with the board to evaluate the lifetime maximum and enhance the benefits that focus on value and efficiency.
The additional of the travel/surgical benefit and the virtual physical therapy program has been approved by the plan administrator. The division needs to rebid the contract for this service, so they will not be available on January 1, 2024. The division will provide an implementation timeline after a vendor partner is in place.

An increase in the lifetime maximum to $8m was approved by the plan administrator. The Commissioner wanted to maintain a hard dollar limit. The analysis showed that raising it to $8m provides relief to the members while maintaining the hard outer limit. This change will be effective Jan 1, 2024. The lifetime maximum will be reviewed by the Division at least every 5 years for indexing to the consumer price index (CPI) and any other information relevant to the evaluation. The reinstatement provisions will also be removed so members will not be hindered from qualifying for other medical insurance once the limit is reached.
Communications notifying members about the benefit changes will be in the upcoming newsletters and on the webpage.

4. Plan Booklet updates – public comment period

The division provided an overview of the draft list of plan booklet changes. There will be a 30-day public comment period opening in the next few weeks. A copy of the marked-up plan booklet along with a summary of the changes will be posted and members will have 30 days to provide public comment. The division will hold a teleconference to review each change.

5. DVA Open Enrollment is Oct 11 – Nov 22.

Open enrollment for the DVA plan begins on Wednesday Oct 11 and runs for 6 weeks, ending Nov 22nd. The DVA webpage is already updated with open enrollment information and an updated benefit enrollment guide and cost comparison. The division is still working on the premium rate sheet. Everyone is encouraged to review their coverage and elect the plan that works best for the upcoming year. Mailers will be arriving the week of Oct 4th. All finalized changes will be in effect January 1, 2024. We will talk about open enrollment during the retiree town hall and in the newsletter. If you don't participate, your plan election will remain the same.

6. Proposal Prioritization

The board reviewed the current list of modernization items and would like to prioritize them at the November meeting.

- R006 Expanded Telehealth Services - The board would like to remove item from the list.
- R012 Wellness Program – DRB would need a statutory change to authorize us to engage with a Medicare Advantage program. There is no bill at this time.
- R014 – Three tier pharmacy
  The plan has a 2-tier structure: generic and brand. There are options such as generic, preferred brand and non-preferred brands. It would drive financial efficiency while maintaining clinical access.
- R005 – OON reimbursement as a percentage of Medicare
  DRB implemented a change in the Employee plan in 2023.
- R018 – Plan housekeeping review
  DRB is performing this work and suggests removing this item from the list.
- R*** Pacific Health Coalition
  Employees are members, but the retirees are not. DRB would like to ask the coalition to join a future meeting and review the benefit offerings. Health fair access and primary care access are the two items DRB is interested in reviewing. The coalition clinics do not currently accept Medicare.

- R*** BH, Oncology, Chronic Disease
  We are seeing higher BH utilization, so want to explore if there are additional services we should consider. DRB completed an RFI for oncology services to see what capability there is in the market.
- R*** DVA
  Preventive first, benefit maximum and vision benefits. One option is to move away from the indemnity vision plan to VSP.

For the November meeting the board asked for the division's priority and the level of effort for each.

DRB thanked the board for the work they have done to support the division.

Public Comment

Vice chair Cammy Taylor reminded meeting attendees of the guidelines for public comments provided in the meeting and invited anyone who wishes to provide public comment at this time to speak.

Wendy Wolfe: Is there an update on the regulations project?
Randall Burns: OE, if there are changes to the rates will members know that before they enroll?

Wrap Up / Adjourn

Motion by Lorne to adjourn the meeting. Second by Nan.
The meeting adjourned at 3:16pm.

The next RHPAB meeting will be held on November 9, 2023.

Alaska Administrative Code - Title 2 - Department of Administration, Division of Retirement non-APA regulations re: Retiree Major Medical & Dental Insurance Coverage

Filing notification attached.
Title 2 - Department of Administration, Division of Retirement non-APA regulations re: Retiree Major Medical & Dental Insurance Coverage
(2 AAC 39.390 - .399, .280-.290)
Department of Law file number: 2023200515

Filed: 11/3/2023
Effective: 11/30/2023
Published in Register: 248, January 2024

Attachments, History, Details

Attachments

2023200515.pdf

Revision History

Created 11/3/2023 3:19:55 PM by alsimpson

Details

Department:	Office of the Governor
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Project/Regulation #:	2023200515
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Events/Deadlines:	2023200515 Effective Date 11/30/2023 12:00am

2 AAC 39.280 is amended by adding new subsections to read:

(b) To change the benefits provided under dental-vision-audio insurance coverage, the administrator shall

(1) propose changes to the coverage; in drafting the proposal, the administrator shall consider the

(A) background and rationale for the proposed change;

(B) details and objectives of the proposed change;

(C) potential impact on benefit recipients;

(D) actuarial, financial, and operational impacts on the dental-vision-audio insurance plan; and

(E) input from stakeholders;

(2) post notice of the proposed change on the Alaska Online Public Notice System and the administrator's public Internet website, providing a minimum 30-day public notice and comment period, during which benefit recipients may review and provide comment prior to the adoption of a final proposal; notice under this paragraph must include

(A) a summary of the proposed change;

(B) instructions for accessing the draft proposed change;

(C) a deadline for written comments on the proposed change to be submitted by the public; and

(D) the time and place of any hearings at which oral comments from the public will be accepted;

(3) provide outreach to benefit recipients about the proposed change;

(4) consider comments submitted in response to public notice under this subsection; and

(5) issue a decision to adopt or reject a final proposal to change the benefits provided under dental-vision-audio insurance coverage after the close of the public comment period.

(c) The administrator may amend the description of dental-vision-audio insurance coverage published in the plan booklet. To amend the description of dental-vision-audio insurance coverage published in the plan booklet, the administrator shall

(1) propose amendments that clarify the benefits provided under the existing dental-vision-audio insurance coverage or that implement the changes adopted under (b) of this section;

(2) post notice of the proposed amendment on the Alaska Online Public Notice System and the administrator's public Internet website, providing a minimum 30-day public notice and comment period, during which benefit recipients may review and provide comment prior to the adoption of a final amendment; notice under this paragraph must include

(A) a summary of the proposed amendment;

(B) instructions for accessing the draft proposed amendment and comparison of proposed changes to current plan booklet language;

(C) a deadline for written comments on the proposed amendment to be submitted by the public; and

(D) the time and place of any hearings at which oral comments from the public will be accepted;

(3) provide outreach to benefit recipients about the proposed amendment;

(4) consider comments submitted in response to the public notice; and

(5) issue a decision to adopt or reject a final amendment to the description of dental-vision-audio insurance coverage published in the plan booklet after the close of the public comment period.

(d) Notwithstanding (b) and (c) of this section, the administrator may adopt an emergency amendment to the description of dental-vision-audio insurance coverage published in the plan booklet. An emergency amendment to the description of dental-vision-audio insurance coverage published in the plan booklet is effective immediately. To adopt an emergency amendment to the description of dental-vision-audio insurance coverage published in the plan booklet, the administrator must find that the emergency amendment is necessary in response to

(1) a public health or other state or national emergency;

(2) emerging technology or medical treatments and services; or

(3) a need for the immediate preservation of the orderly operation of the dental-vision-audio insurance plan.

(e) The administrator shall, not later than 10 days after the adoption of an emergency amendment, give public notice of the emergency coverage in accordance with (c) of this section. (Eff. 2/1/93, Register 125; am ____/____/______, Register _____)

Authority: AS 39.30.090 AS 39.30.098

2 AAC 39.290(1) is amended to read:

(1) "administrator" means the **commissioner** [DIRECTOR OF THE DIVISION OF RETIREMENT AND BENEFITS] of the **Department of Administration** [DEPARTMENT OF ADMINISTRATION] or their designee;

2 AAC 39.290 is amended by adding new paragraphs to read:

(7) "dental-vision-audio insurance coverage" means the benefits that are provided under AS 39.30.090(10), excluding benefits provided by major medical insurance coverage under AS 14.25.168, AS 22.25.090, and AS 39.35.535;

(8) "plan booklet" means publications of the Retiree Insurance Information Booklet issued by the administrator from time to time containing a written description of dental-vision-audio insurance coverage. (Eff. 7/1/82; am 5/31/87, Register 102; am 5/11/90, Register 114; am 2/1/93, Register 125; am 10/24/2020, Register 236; am ____/____/______, Register _____)

Authority: AS 39.30.090 AS 39.30.098

2 AAC 39.390 is amended by adding new subsections to read:

(b) To change the benefits provided under major medical insurance coverage, the administrator shall

(1) propose changes to the coverage; in drafting the proposal, the administrator shall consider the

(A) background and rationale for the proposed change;

(B) details and objectives of the proposed change;

(C) potential impact on benefit recipients;

(D) actuarial, financial, and operational impacts on the major medical insurance plan; and

(E) input from stakeholders;

(2) post notice of the proposed change on the Alaska Online Public Notice System and the administrator's public Internet website, providing a minimum 30-day public notice and

comment period, during which benefit recipients may review and provide comment prior to the adoption of a final proposal; notice under this paragraph must include

(A) a summary of the proposed change;

(B) instructions for accessing the draft proposed change;

(C) a deadline for written comments on the proposed change to be submitted by the public; and

(D) the time and place of any hearings at which oral comments from the public will be accepted;

(3) provide outreach to benefit recipients about the proposed change;

(4) consider comments submitted in response to public notice under this subsection; and

(5) issue a decision to adopt or reject a final proposal to change the benefits provided under major medical insurance coverage after the close of the public comment period.

(c) The administrator may amend the description of major medical insurance coverage published in the plan booklet. To amend the description of major medical insurance coverage published in the plan booklet, the administrator shall

(1) propose amendments that clarify benefits provided under the existing major medical insurance coverage or that implement the changes adopted under (b) of this section;

(2) post notice of the proposed amendment on the Alaska Online Public Notice System and the administrator's public Internet website, providing a minimum 30-day public notice and comment period, during which benefit recipients may review and provide comment prior to the adoption of a final amendment; notice under this paragraph must include

(A) a summary of the proposed amendment;

(B) instructions for accessing the draft proposed amendment and comparison of proposed changes to current plan booklet language;

(C) a deadline for written comments on the proposed amendment to be submitted by the public; and

(D) the time and place of any hearings at which oral comments from the public will be accepted;

(3) provide outreach to benefit recipients about the proposed amendment;

(4) consider comments submitted in response to the public notice; and

(5) issue a decision to adopt or reject a final amendment to the description of major medical insurance coverage published in the plan booklet after the close of the public comment period.

(d) Notwithstanding (b) and (c) of this section, the administrator may adopt an emergency amendment to the description of major medical insurance coverage published in the plan booklet. An emergency amendment to the description of major medical insurance coverage published in the plan booklet is effective immediately. To adopt an emergency amendment to the description of major medical insurance coverage published in the plan booklet, the administrator must find that the emergency amendment is necessary in response to

(1) a public health or other state or national emergency;

(2) emerging technology or medical treatments and services; or

(3) a need for the immediate preservation of the orderly operation of the major medical insurance coverage.

(e) The administrator shall, not later than 10 days after the adoption of an emergency amendment, give public notice of the emergency coverage in accordance with (c) of this section.

(Eff. 2/1/93, Register 125; am ____/____/______, Register _____)

Authority: AS 14.25.003 AS 22.25.090 AS 39.35.003

AS 14.25.168 AS 39.30.090 AS 39.35.535

AS 22.25.027 AS 39.30.098

2 AAC 39.399 (1) is amended as follows:

(1) "administrator" means the **commissioner** [DIRECTOR OF THE DIVISION OF RETIREMENT AND BENEFITS] of the Department of Administration **or their designee**;

2 AAC 39.399 is amended by adding new paragraphs to read:

(7) "major medical insurance coverage" means the benefits that are provided under AS 14.25.168, AS 22.25.090, and AS 39.35.535, excluding the benefits provided by dental-vision-audio insurance and long-term care insurance under AS 39.30.090(a)(10) - (11);

(8) "plan booklet" means publications of the Retiree Insurance Information Booklet issued by the administrator from time to time containing a written description of major medical insurance coverage. (Eff. 2/1/93, Register 125; am ____/____/______, Register _____)

Authority: AS 14.25.003 AS 22.25.090 AS 39.35.003

AS 14.25.168 AS 39.30.090 AS 39.35.535

AS 22.25.027 AS 39.30.098

AlaskaCare Quarterly Meeting Dates for 2024

Meetings Sorted by Type

AlaskaCare Quarterly Meeting Employee Plan

- ☑ Tuesday, February 6, 2024
- ☑ Tuesday, May 7, 2024
- ☑ Tuesday, August 6, 2024
- ☑ Tuesday, November 5, 2024

AlaskaCare Quarterly Meeting Retiree Plan

- ☑ Wednesday February 7, 2024
- ☑ Wednesday, May 8, 2024
- ☑ Wednesday, August 7, 2024
- ☑ Wednesday, November 6, 2024

Retiree Health Plan Advisory Board Meeting

- ☑ Thursday February 8, 2024
- ☑ Thursday, May 9, 2024
- ☑ Thursday, September 12, 2024
- ☑ Thursday, November 7, 2024

Health Benefit Evaluation Committee Meeting

- ☑ Thursday, February 15, 2024
- ☑ Thursday, May 16, 2024
- ☑ Thursday, September 19, 2024
- ☑ Thursday, November 14, 2024

Meetings Sorted by Month

AlaskaCare Quarterly Meeting – Q3 of 2022

- ☑ Employee Plan -Tuesday, February 6, 2024
- ☑ Retiree Plan - Wednesday February 7, 2024
- ☑ RHPAB - Thursday February 8, 2024
- ☑ HBEC - Thursday, February 15, 2024

AlaskaCare Quarterly Meeting – Q4 of 2022

- ☑ Employee Plan - Tuesday, May 7, 2024
- ☑ Retiree Plan - Wednesday, May 8, 2024
- ☑ RHPAB - Thursday, May 9, 2024
- ☑ HBEC - Thursday, May 16, 2024

AlaskaCare Quarterly Meeting – Q1 of 2023

- ☑ Employee Plan - Tuesday, August 6, 2024
- ☑ Retiree Plan - Wednesday, August 7, 2024
- ☑ RHPAB - Thursday, September 12, 2024
- ☑ HBEC - Thursday, September 19, 2024

AlaskaCare Quarterly Meeting – Q2 of 2023

- ☑ Employee Plan - Tuesday, November 5, 2024
- ☑ Retiree Plan-Wednesday, November 6, 2024
- ☑ RHPAB - Thursday, November 7, 2024
- ☑ HBEC - Thursday, November 14, 2024

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AlaskaCare Retiree Health Plan Modernization Topics*

1. Active Topics

Proposal Number	Plan	Title	RHPAB Priority	Division Priority	Level Of Effort	Proposal / Actuarial
R005	Medical	Out-of-network reimbursement as a percentage of Medicare			M-H	P, A
R009A	Medical	Rehabilitative Care: Review			M	P, A
R009C	Medical	Rehabilitative Care: New Coverage			L	-
R012	Medical	Lifestyle/Wellness Program			H	-
R014	Rx	3 tier pharmacy benefit; review out-of-network benefits			H	P, A
R019	Medical	Tiered network benefits for certain services			H	-
R024	DVA	Standard Plan Preventive First coverage			L	P, A
R025	Medical	Medicare Advantage			H	-
R026	DVA	Standard DVA Plan vision benefits			M	-
R***	Medical	Pacific Health Coalition			M	-
R***	Medical	Behavioral/Mental Health Program Offerings			M	-
R***	Medical	Oncology Support Services			M	-
R***	Multiple	Chronic Disease Management Program(s)			H	-
R***	DVA	Standard DVA Plan annual benefit max			M	-
R***	DVA	Standard DVA Plan audio benefits			M	-
R***	Medical	coverage of orthodontic braces for cleft palate			M	-

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

AlaskaCare Retiree Health Plan Modernization Topics*

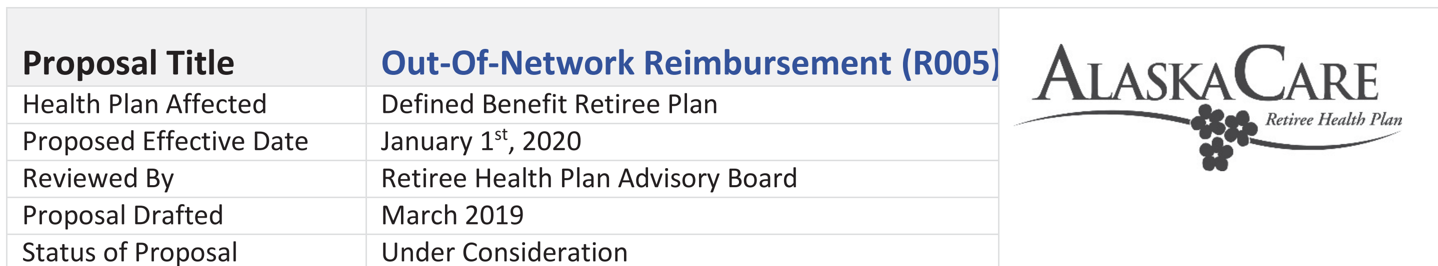
2. Pended Topics

Proposal Number	Plan	Description
R001a	Medical	Enhance standard 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
R006	Medical	Expanded Telehealth Services
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
R018		Plan Housekeeping/Review (ex., clarify reimbursement policies for surgical assistants, DVA standalone booklet)

3. Completed Topics

Proposal Number	Plan	Description	Effective Date
R001	Medical	Add supplemental non-emergent surgery and travel benefits	01/01/2025
R007	Medical	Expand preventive coverage to add full suite of preventive services	1/1/2022
R008	Medical	Raise or eliminate lifetime maximum benefit	01/01/2024
R016	Medical	Add medically necessary treatment of gender dysphoria including surgery – *public comment proposal*	1/1/2021
R020	Rx	Add prior authorizations for certain specialty medications	1/1/2022
R022	Medical/Rx	GCIT designated network benefits	1/1/2023
R023	Medical	Remove penalty for failure to precertify certain services	1/1/2023
R027	Medical	Add virtual physical therapy and musculoskeletal care program	01/01/2025

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



Proposal Title	Out-Of-Network Reimbursement (R005)
Health Plan Affected	Defined Benefit Retiree Plan
Proposed Effective Date	January 1st, 2020
Reviewed By	Retiree Health Plan Advisory Board
Proposal Drafted	March 2019
Status of Proposal	Under Consideration

Summary of Current State

The AlaskaCare retiree health plan utilizes a network of providers contracted with the plan's claims administrator to access discounted prices and to ensure certain credentialing requirements, quality metrics, and billing practices. Not only do facilities, groups, or professionals in the network agree to certain reimbursement schedules and other policies, but they also agree to write off the difference between the fee schedule and their billed charges rather than seeking the difference from the member - a practice commonly referred to as balance billing. When members use a non-network provider, the plan must determine what to pay for services, because without a network agreement, the provider and the payer have not agreed to a fee schedule or reimbursement rates. In the AlaskaCare retiree health plan, the determination of what the plan pays for out-of-network services is called the recognized charge, and "is the lesser of what the provider bills for that services or supply; or the 90th percentile of the prevailing charge rate for the geographic area where the service is furnished as determined by Aetna in accordance with Aetna reimbursement policies." Currently, the AlaskaCare retiree health plan determines the prevailing charge rates by relying on benchmarks produced by FAIR Health, a company that aggregates claims data and produces cost benchmark information based on what providers in a specific geographic area bill for services. Because the recognized charge is determined based on the amount providers bill, over time, as providers bill higher amounts, the FAIR Health benchmark can increase, resulting in a higher prevailing charge rate, and greater compensation for out-of-network providers. With very few exceptions, the recognized charge is usually higher than the negotiated charge. When out-of-network providers and facilities are reimbursed at substantially higher rates than in-network providers, it can be difficult to incentivize providers and facilities to join the network.

Objectives

a) Strengthen the health plan's purchasing power with providers.
b) Incentivize member use of network providers through benefit design.
c) Provide savings to the members and to the health trust and balance other modernization proposals.

Summary of Proposed Change

The proposed change would alter the methodology used to determine payments to out-of-network providers by changing from the 90th percentile of the prevailing charge rate for the geographic area to a percentage of the Medicare Physician Fee Schedule. This proposal offers three different reimbursement rates for out-of-network providers:

- 185% of Medicare's Fee Schedule,
- 195% of Medicare's Fee Schedule, or
- 205% of Medicare's Fee Schedule.

Members who live in areas without access to a network provider may face higher out-of-pocket costs the form of balance bills. To care for these members who do have the option to access network providers, the plan proposal includes an exception or a waiver that would reimburse out-of-network providers using the current methodology if a member cannot access a provider in their community. Alternatively, the addition of enhanced travel benefits may provide further options for members in this situation.

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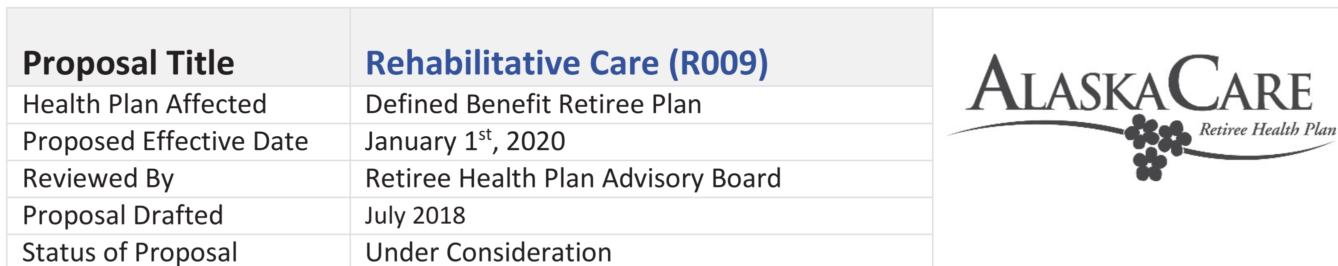


Proposal Title	Rehabilitative Care (R009)
Health Plan Affected	Defined Benefit Retiree Plan
Proposed Effective Date	January 1st, 2020
Reviewed By	Retiree Health Plan Advisory Board
Proposal Drafted	July 2018
Status of Proposal	Under Consideration

DRAFT

Summary of Current State

The AlaskaCare Defined Benefit retiree plan does not cover rehabilitative maintenance care, that is, care to maintain or prevent deterioration of a chronic condition. The plan currently covers outpatient rehabilitative care designed to restore and improve bodily functions lost due to injury or illness. This care is considered medically necessary only if significant improvement in body function is occurring and is expected to continue. Starting at the 26th visit all claims for the member are pended for review of chart notes. The provider must submit clinical records that document a member continues to experience significant improvement. If the records are not returned within 45 days or fail to demonstrate significant improvement in accordance with the established clinical criteria, the services are denied. The existing plan coverage of rehabilitative services is highly problematic and is the most frequently appealed plan provision. It accounts for approximately one third of all retiree appeals received by the Division in 2017, 2018 and 2019.

Objectives

a) Provide the ability for retirees to receive rehabilitative care that may include maintenance and preventive therapies of chronic conditions.
b) Decrease the volume of claims that are pended and require providers to send chart notes.
c) Decrease the volume of rehabilitative care appeals.

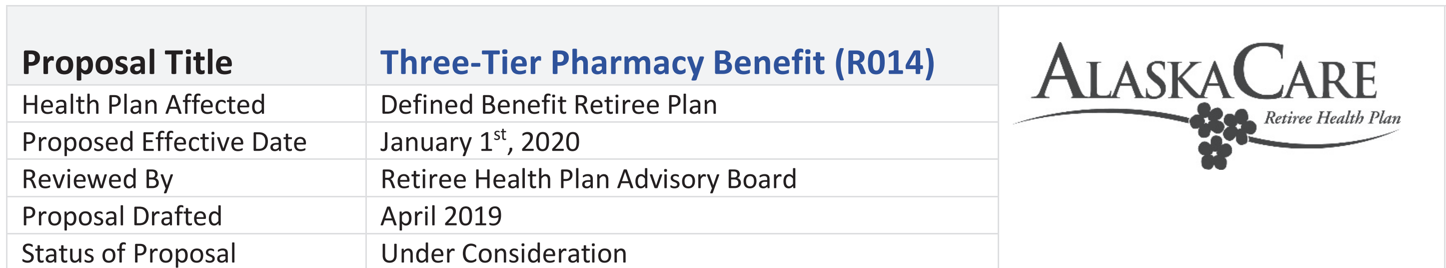
Summary of Proposed Change

The proposed amended change would update the plan language to allow for maintenance or preventive therapies of chronic conditions. It would increase and clearly define the plan's coverage of rehabilitative care, alleviating confusion amongst members and providers.

The proposed benefit change will cover rehabilitative care received from an in-network provider without a visit limit, and cover chiropractic care received from an in-network provider without a visit limit. Removing the limit will reduce the requirement for claim chart note review and allow for maintenance and preventive therapies of chronic conditions. The proposed benefit will continue to have a visit limit on rehabilitative and chiropractic care received from an out-of-network provider. However, the limit amount will be increased and an option to reset the visit count at the start of each benefit year will be added. If care is received from an out-of-network provider, the member would be provided up to 45 visits per benefit year for outpatient rehabilitative care, and up to 20 visits for chiropractic care. The out-of-network provider visit limits would reset at the start of each benefit year.

The proposed change would also provide coverage for up to 10 visits per benefit year for acupuncture regardless of the provider's network status. The acupuncture visit limits would reset at the start of each benefit year.

The increase in coverage combined with the opportunity to reset the out-of-network provider visit limit with the new benefit year would eliminate the need for visit-triggered medical necessity determinations, and the corresponding appeals if the determination found that the additional services were not medically necessary. This would provide members and their providers with clear guidelines on what the plan covers.



Proposal Title	Three-Tier Pharmacy Benefit (R014)
Health Plan Affected	Defined Benefit Retiree Plan
Proposed Effective Date	January 1st, 2020
Reviewed By	Retiree Health Plan Advisory Board
Proposal Drafted	April 2019
Status of Proposal	Under Consideration

DRAFT

Summary of Current State

The AlaskaCare defined benefit retiree pharmacy plan has an open formulary, meaning that the plan will cover drugs prescribed by a provider, acting within the scope of his or her license, for the treatment of an illness, disease, or injury. The AlaskaCare employee plan, the defined contribution retiree plan, and for those defined benefit retirees who elect to opt out of the enhanced Employer Group Waiver Program (EGWP) and instead participate in the opt-out pharmacy benefit, have a three-tier pharmacy benefit cost structure in place. With a three-tiered benefit, prescription drugs fall into one of three categories or "tiers." Each tier has a different copay or out-of-pocket cost. The first tier is for generics, the second is for preferred brand-name drugs, and the third is for nonpreferred brand-name drugs.

Objectives

a) Maintain choice for members while promoting greater use of therapeutically comparable and affordable drugs.
b) Provide savings to the members and to the health trust and balance other modernization proposals.

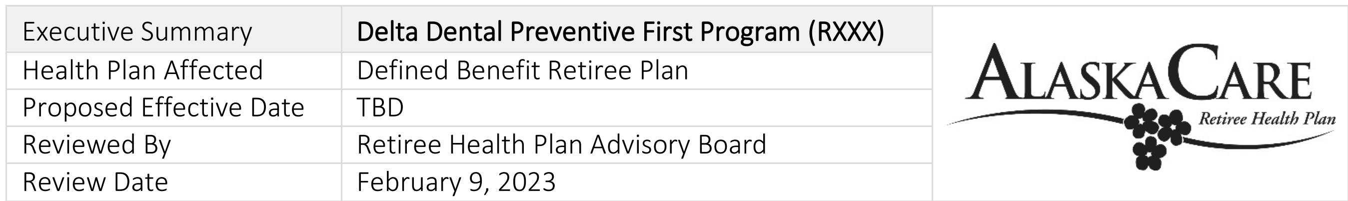
Summary of Proposed Change

This proposal would establish a three-tier pharmacy benefit cost structure in the AlaskaCare defined benefit retiree prescription drug plan to promote utilization of generic and preferred brand-name medications. The tiered formulary design can incentivize cost effective drugs that are therapeutically equivalent when there are multiple drugs available. The plan would be amended to establish different copayments for medications based on drug type:

Tier 1: Generic Drugs – lowest cost tier
Generic medications are therapeutically, and often chemically, identical to brand medications and are widely available at competitive prices.
Tier 2: Preferred Brand-Name Drugs – slightly higher cost tier
Preferred brand-name drugs are brand-name medications for which a generic option is not available.

Tier 3: Non-Preferred Brand-Name Drugs – highest cost tier
Non-preferred brand-name drugs are brand-name medications that are available in an equivalent generic form, or as a preferred brand-name drug. These drugs typically cost more than their generic or preferred brand-name equivalent. While many individuals can use generic, preferred brand-name, and non-preferred brand-name medications interchangeably, some individuals may have a medical need to utilize a non-preferred brand-name medication. In these instances, the member or his or her doctor may seek a medical exception. If the exception is granted, the drug will be available at the preferred brand-name drug copay.

This proposed change would only impact medications obtained at a retail pharmacy. Medications obtained via mail order would remain available for a $0 copay. Members who have coverage under multiple AlaskaCare plans, or who have other drug coverage that coordinates with AlaskaCare would continue to experience a reduction in their copays.



Executive Summary	Delta Dental Preventive First Program (RXXX)
Health Plan Affected	Defined Benefit Retiree Plan
Proposed Effective Date	TBD
Reviewed By	Retiree Health Plan Advisory Board
Review Date	February 9, 2023

1) Background

Upon retirement, AlaskaCare retirees may choose to participate in a voluntary Dental-Vision-Audio (DVA) plan to provide coverage for themselves and their eligible dependents. The AlaskaCare retiree Dental plan is fully funded by members' monthly premium payments, and the Division works hard to maximize the benefits members receive while keeping premiums affordable. Effective in plan year 2020, AlaskaCare began offering two retiree dental plan options, the Legacy Dental Plan, and the Standard Dental Plan which each have different dental coverage provisions. The Division contracts with Delta Dental of Alaska to assist in administration of both dental plans. The Division has committed to maintaining the Legacy plan (the DVA plan that was in place prior to 2014) as an option for members to choose during open enrollment. To ensure the Legacy Plan maintains fidelity to the plan that was in place prior to 2014, the Division is considering updates and changes to the Standard Plan only.

A frequent request the Division receives from members is a desire for improvement and modernization of the retiree dental plans. Preventive dental care can help members avoid potentially painful and costly restorative treatments down the road. In 2021, 63% of Legacy Plan members received preventive cleanings, up from 57% in 2020; while 69% of Standard Plan members received preventive cleanings; up from 65% in 2020.

The AlaskaCare Standard Dental Plan is designed to help retirees offset the cost of their dental care and to support them in maintaining good overall oral health. Oral health maintenance is why it's so important to focus on preventive care to catch signs and symptoms of dental disease early. Currently, the Plan allows for preventive dental services to be covered at 100% coinsurance with no deductible. However, claims for preventive services do count toward a member's annual maximum benefit of $2000.00. Implementing Delta Dental's *Preventive First* program (program) for the Standard retiree dental plan would provide additional coverage for dental care by exempting preventive services from accruing to the annual benefit maximum.

2) Objectives

a) Support members in maintaining their dental health.
b) Promote high-value care.
c) Provide a dental plan option that is modernized and more in line with current dental procedure costs.

3) Summary of Proposed Change

Delta Dental's Preventive First program covers preventive dental services at 100% coinsurance, and the services are not subject to the deductible, just as these services are covered today. Covered preventive services would not change; services in this category include periodic exams, x-rays, sealants, and fluoride treatment.

The program differs from current practice in that any preventive services paid by the Plan would not count toward a member's $2,000.00 annual allowance for dental services. This drives value for the member by freeing up dollars that would normally be applied towards preventive services and allow those monies to be used for more complicated oral health procedures such as treatment of diseases of the gums, fillings, oral surgeries, crowns, dentures and bridges, and other covered dental services.

With Prevention First, regular, preventive dental visits and diagnostic services (typically X-rays, exams and cleanings) don't count against the maximum benefit amount within a plan year, freeing up the annual maximum

so it may be used for other covered dental services. The exclusion of preventive services from the annual maximum does not affect coverage for restorative (Class II) or prosthetic (Class III) services.

This example is based on two routine checkups and a $2,000 annual maximum.

Class I Preventive Services	AlaskaCare Pays	Member Pays	Annual Max Remaining
Without Prevention First	$190	$0	$1,810
With Prevention First	$190	$0	$2000

4) Actuarial and Financial Impacts of Proposed Change

There would be a 1.8%-1.9% increase in claim costs.
There would no impact to the Legacy Dental Plan.