AlaskaCare Retiree Health Plan

Plan Amendment 2022-01 | Public Comments

The Department of Administration, Division of Retirement and Benefits, proposed Plan Amendment 2022-01 to the AlaskaCare Defined Benefit Health Plans, effective June 1, 2022. The plan amendment was posted for a 60-day public comment period, and a redacted copy of the 82 public comments received is below.

Amendment 2022-01 Summary:

1. Amends the Contact Information section to include information related to accessing Clinical Policy Bulletins
2. Amends Section 3.3.1 *Medical Necessity*
3. Amends Section 12.14.13 *Third Level – Division of Retirement and Benefits Appeal*
4. Amends Section 14.4 *Applicable Law and Venue*
5. Adds new Definitions section

Contents

From: n weidner
Sent: Friday, May 20, 2022 4:32 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Re:proposed changes to the AlaskaCare Retiree Health Plan

To :Plan Administrator
Div. of Ret. and Benefits

I am responding to your request that AlaskaCare Plan members “share their thoughts” about the proposed Plan amendment scheduled to take effect June 1, 2022.

There isn’t enough information on your website for retirees to understand and make informed comments and decisions about these plan changes.
I hope your responses to my questions will help me understand the effects of your proposed plan changes on my retirement medical benefits:

1. Since 2003, our Plan has stated that coverage will be provided for medical services and supplies that are "medically necessary" and that are not specifically excluded from coverage by the Plan.

According to the terms of the plan that have been in effect since 2003, prescribed medical treatment is considered “medically necessary” when it is "expected to improve or maintain health" or "to ease pain or suffering without aggravating the condition or causing other serious health problems."

The Plan also states that diagnostic procedures are medically necessary when they are "expected to provide information to determine the course of treatment without aggravating the condition or causing additional health problems."

A medical treatment will not be considered medically necessary if there is an equally effective treatment or procedure that costs less than the one prescribed.

These standards of medical necessity are clear, straightforward, and easy to understand.

What are the reasons for changing the Plan's provisions concerning "medical necessity" and how would those changes affect coverages for types of medical treatments and procedures that the Plan has covered since 2003?

2. If these proposed Plan changes are adopted, would the Aetna Clinical Policy Bulletins be used only if/when there is a good faith basis for questioning whether the prescribed medical treatment, procedure, or equipment satisfies the Plan's standards for determining medical necessity as described in my Question 1?

3. When my doctor prescribes a medical treatment, procedure, or piece of equipment that A) helps cure or control my disease or condition or ease my pain or suffering without aggravating the condition or causing other health problems; B) has no alternative that is equally effective and costs less; and C) is not subject to any plan exclusion, does the Plan Administrator still have the discretion to deny coverage on the grounds of lack of medical necessity? If so, what other factors does the claims administrator (Aetna)

or the Plan Administrator (the Division) consider in exercising its discretion whether a prescribed medical treatment, procedure, or equipment is medically necessary?

4. If a claim for a medical benefit is denied, I think I should be given a clear explanation of the reason for the denial so I can decide whether to appeal. If these proposed Plan changes are adopted and a medical claim is denied because Aetna does not consider it to be "medically necessary," would the Explanation of Benefits provide a clear explanation the Plan administrator does not consider it to be "medically necessary"?

Would the Explanation of Benefits tell me which Aetna Clinical Policy Bulletin and/or other reason was relied on by the claims administrator (TPA) or the Plan Administrator in exercising its "discretion" to deny coverage based on lack of medical necessity? If not, why not?

5. If these Plan changes are adopted and the Plan Administrator (the Division) has the discretion to decide if a prescribed medical treatment, procedure, or piece of equipment is medically necessary, and if the DRB delegates that authority to another person, what methods would the Plan administrator use to monitor and ensure that that person is making correct decisions?

6. Can the claims administrator (TPA) eliminate or reduce any coverages and/or other Plan benefits simply by changing one or more of its clinical policy bulletins to state that a prescribed medical treatment, procedure, or piece of equipment is no longer considered medically necessary? If the answer is yes, please answer these two questions:
A) Does the claims administrator (Aetna) need to get the permission of the Plan Administrator (DRB) to make that kind of change to our Plan?

B) Does the claims administrator or the Plan Administrator DRB have to give Plan members notice of those changes in advance? If not, why not? And if Plan members will be given advance notice, how much advance notice will we be given and how will it be given?

7. If these Plan changes are adopted, will any new coverages or other Plan benefits be added to the Plan? If so, please tell me what those are and why they were not covered or provided under the terms of the Plan as it was written in 2003.

8. If these Plan changes are adopted, would any types of medical treatments, procedures, or supplies that have been covered at any time since 2003 no longer be covered or have reduced coverage? If so, what coverages and other Plan benefits would be eliminated or reduced and why?

9. "Section 12.14.13 Third Level" states that if a Plan member "does not file a Plan Administrator appeal timely, ... the second level of appeal will be the final decision, and will be final, conclusive and binding on all persons."

This would eliminate an existing appeal right under subsection (e) of 2 AAC 35.100 of the Alaska Administrative Code. It states that a Plan member may be permitted to file a late appeal if he/she provides a reasonable explanation of extraordinary circumstances that excuse the late filing. If the DRB then rejects the explanation for the late filing, the regulation also requires the DRB to notify the Plan member of his or her right to appeal the decision to reject the late-filed claim. It states:

The division shall return the notice of appeal to the person, and inform the person that the person may resubmit the notice with an explanation of why it was not timely filed. If the person resubmits the notice of appeal with an explanation or if the original untimely notice of appeal contained an explanation of untimeliness, and the administrator in either situation found that the explanation did not establish extraordinary circumstances excusing the untimeliness under (d) of this section, the person may file a new notice of appeal within 30 days of the date that the person receives notice of the decision refusing to accept the untimely first appeal.

Why does the proposed Plan section not inform Plan members of their rights to file an appeal after the deadline as allowed by 2 AAC 100(e)?

10. The document containing the proposed Plan amendment on the DRB website states that it is a "draft" and that it would be effective on June 1, 2022.

Please tell me if the words highlighted green on that DRB webpage are the proposed amendments, whether there will be any more changes made to the draft before June 1, 2022, and, if so, whether we will have a reasonable opportunity to read and comment on any other changes before you enact the amendment and, if so, that will be provided.

Thank you for providing me with the answers to my questions and more information about my health plan.

Neera Weidner

From: Robert Wild
Sent: Friday, May 20, 2022 4:19 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Subject: Questions re proposed changes to the AlaskaCare Retiree Health Plan

Dear Plan Administrator/Div. of Ret. and Benefits:

This is a reply to your request that AlaskaCare Plan members “share their thoughts” about the proposed Plan amendment scheduled to take effect June 1, 2022.

You have not provided enough information on your website necessary for retirees to understand and make informed comments and decisions about your proposed plan changes.

Please provide, as soon as possible, the answers to the following questions and requests for information. I hope your responses will help me understand the effects of your proposed plan changes on my retirement medical benefits:

1. Since 2003, our Plan has stated that coverage will be provided for medical services and supplies that are "medically necessary" and that are not specifically excluded from coverage by the Plan.

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What are the reasons for changing the Plan's provisions concerning "medical necessity" and how would those changes affect coverages for types of medical treatments and procedures that the Plan has covered since 2003?

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3. When my doctor prescribes a medical treatment, procedure, or piece of equipment that A) helps cure or control my disease or condition or ease my pain or suffering without aggravating the condition or causing other health problems; B) has no alternative that is equally effective and costs less; and C) is not subject to any plan exclusion, does the Plan Administrator still have the discretion to deny coverage on the grounds of lack of medical necessity? If so, what other factors does the claims administrator (Aetna) or the Plan Administrator (the Division) consider in exercising its discretion whether a prescribed medical treatment, procedure, or equipment is medically necessary?

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Would the Explanation of Benefits tell me which Aetna Clinical Policy Bulletin and/or other reason was relied on by the claims administrator (TPA) or the Plan Administrator in exercising its "discretion" to deny coverage based on lack of medical necessity? If not, why not?

5. If these Plan changes are adopted and the Plan Administrator (the Division) has the discretion to decide if a prescribed medical treatment, procedure, or piece of equipment is medically necessary, and if the DRB delegates that authority to another person, what methods would the Plan administrator use to monitor and ensure that that person is making correct decisions?

6. Can the claims administrator (TPA) eliminate or reduce any coverages and/or other Plan benefits simply by changing one or more of its clinical policy bulletins to state that a prescribed medical treatment,

procedure, or piece of equipment is no longer considered medically necessary? If the answer is yes, please answer these two questions:

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Why does the proposed Plan section not inform Plan members of their rights to file an appeal after the deadline as allowed by 2 AAC 100(e)?

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Please tell me if the words highlighted green on that DRB webpage are the proposed amendments, whether there will be any more changes made to the draft before June 1, 2022, and, if so, whether we will have a reasonable opportunity to read and comment on any other changes before you enact the amendment and, if so, that will be provided.

I look forward to receiving the answers and information I have requested.

Thank you.

From: Arthur Peterson
Sent: Friday, May 20, 2022 3:23 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Cc: Ajay Desai
Subject: Proposed changes to the retirement benefits

Dear Plan Administrator/Div. of Ret. and Benefits:

This is a reply to your request that AlaskaCare Plan members “share their thoughts” about the proposed Plan amendment scheduled to take effect June 1, 2022.

You have not provided enough information on your website necessary for retirees to understand and make informed comments and decisions about your proposed plan changes.

Please provide, as soon as possible, the answers to the following questions and requests for information. I hope your responses will help me understand the effects of your proposed plan changes on my retirement medical benefits:

1. Since 2003, our Plan has stated that coverage will be provided for medical services and supplies that are "medically necessary" and that are not specifically excluded from coverage by the Plan.

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Why does the proposed Plan section not inform Plan members of their rights to file an appeal after the deadline as allowed by 2 AAC 100(e)? (Oops, I can't quickly find the full citation.)

10. The document containing the proposed Plan amendment on the DRB website states that it is a "draft" and that it would be effective on June 1, 2022.

Please tell me if the words highlighted green on that DRB webpage are the proposed amendments, whether there will be any more changes made to the draft before June 1, 2022, and, if so, whether we will have a reasonable opportunity to read and comment on any other changes before you adopt the amendment and, if so, that will be provided.

I look forward to receiving the answers and information I have requested.

Thank you.

Art Peterson

From: R Duran
Sent: Friday, May 20, 2022 2:55 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Changes to my Tier 1 plan

I'm not in agreement with any changes to my future medical benefits as recently proposed. I am not, nor have ever been, a member of a union, so any such group does not speak for me.
Please update your records to reflect below contact info. as I have not received any communication regarding proposed changes. I've only learned of a comment deadline expiring in an hour—minutes ago, through a second hand source.

I'd appreciate any documents surrounding the issue emailed to me asap.

Thank you
Rose Duran

From: Marla Patrias
Sent: Friday, May 20, 2022 1:18:13 PM
To: Member Svcs Contact Center Queue, DOA DRB (DOA sponsored)
Subject: Questions re proposed changes to the AlaskaCare Retiree Health Plan

Dear Plan Administrator/Div. of Ret. and Benefits:

This is a reply to your request that AlaskaCare Plan members "share their thoughts" about the proposed Plan amendment scheduled to take effect June 1, 2022.

You have not provided enough information on your website necessary for retirees to understand and make informed comments and decisions about your proposed plan changes.

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I look forward to receiving the answers and information I have requested.

Thank you.
Marla Huss Patrias
Alaska Retiree

From: Sylvia S
Sent: Friday, May 20, 2022 2:22 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Please consider our comments as attached
The attached comments are submitted regarding the proposed amendments of the AlaskaCare Defined Benefit Retiree Health Plan.

Thank you.

May 20, 2022

State of Alaska Department of Administration
Division of Retirement and Benefits
PO Box 110203
Juneau AK 99811-0203
doa.drb.alaskacare.retiree.plan@alaska.gov
No later than 4:30 pm on May 20, 2022, submit comments to:

Please consider the attached public comments. Thank you.

Gary and Sylvia Schultz, members
AlaskaCare Defined Benefit Retiree Health Plan

The following comments are submitted for consideration on the proposed amendments to the AlaskaCare Defined Benefit Retiree Health Plan.

Amendment Summary (from https://drb.alaska.gov/news/2022/0318-notice.html)

1. Amends the Contact Information section to include information related to accessing Clinical Policy Bulletins
2. Amends Section 3.3.1 *Medical Necessity*
3. Amends Section 12.14.13 *Third Level – Division of Retirement and Benefits Appeal*
4. Amends Section 14.4 *Applicable Law and Venue*
5. Adds new Definitions section

Links to proposed amendment:

https://drb.alaska.gov/news/2022/0318-notice.html

https://drb.alaska.gov/docs/materials/AlaskaCareRetireePlanAmendment_Settlement.pdf

Current Retiree Health Plan:

https://drb.alaska.gov/docs/booklets/DB-RetireeInsuranceBooklet_WEB.pdf

I. Comments regarding the Division's public notice

1. The Division's public notice for the proposed amendments is inadequate. The public notice must be started over with a new deadline for comments to ensure adequate opportunity for review and comment on the proposed amendments.

Links to the draft amendments were not accessible from the notice or media provided by the Division of Retirement and Benefits.

A. I received two emails from the Division regarding the proposed amendment. Both contained a broken link to the proposed amendment that made it impossible to access the amendment from the emailed link. These two emails were the only communications I received regarding the Division's proposed amendments.

4/27/2022 Email

From: Alaska Division of Retirement and Benefits Alaska.DOA.DRB@public.govdelivery.com
Subject: AlaskaCare Retiree Health News | Monthly e-newsletter | April 2022
Date: Apr 27, 2022, 11:02 AM

Volume 47| April 2022

"The proposed amendment is available here for review. You may comment on the proposed Plan Amendment by submitting written comments:"

Above "here" is a link to:
https://nks.gd/l/eyJhbGciOiJIUzI1NiJ9.eyJidWxsZXRpbiBzaWZrX2lkIjoxMTEsInVyaSI6ImJwMjpjb GIjaylsImJ1bGxldGluX2lkIjoiMjAyMjA0MjcuNTcwNjg0ODEiLCJ1cmwiOiJodHRwczovL2RvY55hbGFza2EuZ292LzRyYi9oZWFkbGluZXMvMjAyMi8wMy9wcm9wb3NlZGFtZW5kbWVudC5odG1sIn0.BTFTfkyiSn3tqhgv_z8DYnXc4nKP50UdvB6emSKxt6c/s/346883927/br/130462105569-l

The link redirects to:
https://drb.alaska.gov/headlines/2022/03/proposedamendment.html

On 3/10/2022 at 8:21 pm, the web page shown was:

3/18/2022 Email

From: Alaska Division of Retirement and Benefits Alaska.DOA.DRB@public.govdelivery.com
Subject: Proposed Amendment to the AlaskaCare Defined Benefit Retiree Health Plan—Please Share Your Thoughts!
Date: Mar 18, 2022, 10:01 AM

"The proposed amendment is available here for review. You may comment on the proposed Plan Amendment by submitting written comments:"

Above "here" is a link to:
https://nks.gd/l/eyJhbGciOiJIUzI1NiJ9.eyJidWxsZXRpbiBzaWZrX2lkIjoxMDAsInVyaSI6ImJwMjpjb GIjaylsImJ1bGxldGluX2lkIjoiMjAyMjAzMTguNTUxMjY1MjEiLCJ1cmwiOiJodHRwczovL2RvY55hbGFza2EuZ292LzRyYi9oZWFkbGluZXMvMjAyMi8wMy9wcm9wb3NlZGFtZW5kbWVudC5odG1sIn0.Jc7ZpDQGqHBzWy7fyMZUIBIu3yxeupNys_-lrbk9xhA/s/346883927/br/128340112473-l

Link redirects to: https://drb.alaska.gov/headlines/2022/03/proposedamendment.html

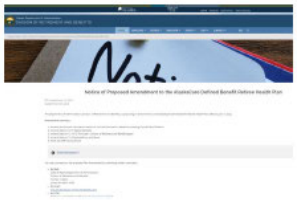
On 3/10/2022 at 8:22 pm, the web page shown was:

B. The public notice posted by the Division went to a broken public comment link on the Online Public Notices (OPN) page, making the proposed amendments unavailable for review on the linked OPN page. In addition, no notice to the proposed amendments was available on the Division homepage on 3/10/2022 at 8:31 pm.

In an effort to find the proposed amendments, I searched the Division webpage and finally found an article on the News page, "Notice of Proposed Amendment to the AlaskaCare Defined Benefit Retiree Health Plan"
https://drb.alaska.gov/news/2022/0318-notice.html.

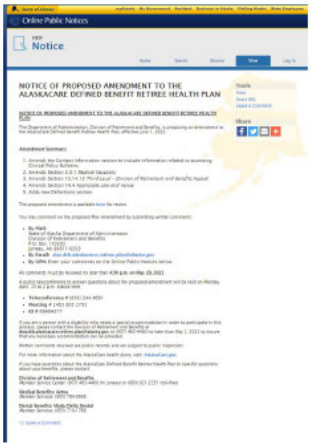
The article contained a link to submit comments on the Online Public Notices page as shown in the text and image below:

"By OPN:
Enter your comments on the Online Public Notices page."



On 3/10/2022 at 9:04 pm the link to OPN opened the public notice for the proposed amendments

https://aws.state.ak.us/OnlinePublicNotices/Notices/View.aspx?id=203834, shown on the image below:



I attempted to access the link to the proposed amendments by clicking on the text in the Notice, "The proposed amendment is available here for review." The link in "here" opened the page:

https://dop.alaska.gov/drp/headlines/2022/03/proposedamendment.html

However, again, the link to the proposed amendments led instead to a 404 message, shown in the image below taken 5/10/2022 at 9:16 pm.

Therefore, three attempts to review the proposed amendments were all met with 404 PAGE NOT FOUND notices.

I do not believe the public notice has been conducted properly. As a result, links should be fixed. Once that has been done the deadline should be extended and the comment period started over to ensure the public has adequate opportunity to examine the proposed amendments to the AlaskaCare Retiree Health Plan and to be able to submit comments for consideration.

2. Amendment 2 as published does not make clear whether the last four paragraphs of Section 3.3.1 are proposed to be deleted or not.

As of 5/18/2022 at 6:46 pm, the following is Section 3.3.1 from Amendment 2 published on https://drp.alaska.gov/docs/materials/AlaskaCareRetireePlanAmendment_Settlement.pdf

2) Amends Section 3.3.1 Medically Necessary Services and Supplies

3.3.1 Medically Necessary Services and Supplies

The medical plan pays only for medically necessary services and supplies, as defined in Section 3.3, "Covered Medical Expenses." The medical plan will utilize Aetna's the Claims Administrator's current Medical and Pharmacy Clinical Policy Bulletins for purposes of determining medical necessity for services covered under the medical plan; provided, however, that the Plan Administrator retains the authority to determine, in their discretion, whether a service or supply is medically necessary. In exercising such discretion, the Plan Administrator shall consider: (a) information provided on the affected person's health status; (b) reports in peer-reviewed medical literature; (c) reports and guidelines

published by nationally recognized health care organizations that include supporting scientific data; (d) generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment; (e) the opinion of health professionals in the generally recognized health specialty involved; and (f) any other relevant information brought to the Plan Administrator's attention. See section 4.6, *Medical Necessity* for services covered under the prescription drug benefits. See page 1 for information on accessing the Claims Administrator's Clinical Policy Bulletins. ~~You may access Aetna's Clinical Policy Bulletins at: www.aetna.com/healthcare-professionals/policyguidelines/clinical_policy_bulletins.html~~

When ~~Aetna's~~ the Claims Administrator's Clinical Policy Bulletins do not address the specific service or supply under review, a determination of medical necessity will be made when ~~Aetna~~ the Claims Administrator determines that the medical services and supplies or prescription drugs would be given to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, an injury, a disease, or its symptoms by a physician or other health care provider, exercising prudent clinical judgment.

The convention used in the proposed amendment is text to be deleted is highlighted in light orange and is marked with strikethrough, text to be added is highlighted in green, and text to be retained is not highlighted, e.g. "will be made when ~~Aetna~~ the Claims Administrator."

On 5/18/2022 at 6:52 pm, I copied Section 3.3.1 which contains six paragraphs from the current January 2022 Retiree Insurance Information Booklet, pages 28 to 30:
https://drp.alaska.gov/docs/booklets/DB-RetireeInsuranceBooklet_WEB.pdf

Of these six paragraphs of Section 3.3.1 in the current plan, the last four are omitted from Amendment 2. These four omitted paragraphs are not designated as deleted with light orange highlighter and marked with strikethrough. These paragraphs are not indicated as retained by being left unhighlighted. The four paragraphs are just omitted from Amendment 2 as though they never existed.

If the intent of the Division is to delete the last four paragraphs, Amendment 2 should indicate this intent using a method consistent with that used in the other proposed amendments. As an example, I incorporated the Division's method that was used in the other proposed amendments to show the last four paragraphs as deleted; however, it is unclear if omitting these four paragraphs is the Division's intent. (See example below.)

3.3.1 Medically Necessary Services and Supplies
The medical plan pays only for medically necessary services and supplies as defined in Section 3.3, "Covered Medical Expenses." The medical plan will utilize ~~Aetna's~~ the Claims Administrator's current Medical and Pharmacy Clinical Policy Bulletins for purposes of determining medical necessity for services covered under the medical plan; provided, however, that the Plan Administrator retains the authority to determine, in their discretion, whether a service or supply is medically necessary. In exercising such discretion, the Plan Administrator shall consider: (a) information provided on the affected person's health status; (b) reports in peer-reviewed medical literature; (c) reports and guidelines published by nationally recognized health care organizations that include supporting scientific data; (d) generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment; (e) the opinion of health professionals in the generally recognized health specialty involved; and (f) any other relevant information brought to the Plan Administrator's attention. See *section 4.6, Medical Necessity* for services covered under the prescription drug benefits. See page 1 for information on accessing the Claims Administrator's Clinical Policy Bulletins. ~~You may access Aetna's Clinical Policy Bulletins at: www.aetna.com/healthcare-professionals/policyguidelines/clinical_policy_bulletins.html~~

When ~~Aetna's~~ the Claims Administrator's Clinical Policy Bulletins do not address the specific service or supply under review, a determination of medical necessity will be made when ~~Aetna~~ the Claims Administrator determines that the medical services and supplies or prescription drugs would be given to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, an injury, a disease, or its symptoms by a physician or other health care provider, exercising prudent clinical judgment.

~~In making a determination of medical necessity, when there is no applicable Clinical Policy Bulletin, the provision of the service, supply or prescription drug covered under the medical plan must be:~~
~~a) In accordance with generally accepted standards of medical practice;~~
~~b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease;~~
~~c) Not mainly for the convenience of the patient or physician or other health care provider; and~~
~~d) Not more costly than an alternative service or sequence of services at least as likely to produce the same therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.~~

~~"Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community. Otherwise, the standards must be consistent with physician specialty society recommendations. They must be consistent with the views of physicians practicing in relevant clinical areas and any other relevant factors.~~

~~IMPORTANT: Not every service, supply or prescription drug that fits the definition of medical necessity is covered by the medical plan. Exclusions and limitations apply to certain medical services, supplies and expenses. For example, some benefits are limited to a certain number of days, visits, or a dollar maximum.~~

~~In no event will the following services or supplies be considered medically necessary:~~
~~a) Those that do not require the technical skills of a medical professional who is acting within the scope of his or her license;~~
~~b) Those furnished mainly for the comfort or convenience of the person, the person's family, anyone who cares for him or her, a health care provider or health care facility;~~
~~c) Those furnished only because the person is in the hospital on a day when the person could safely and adequately be diagnosed or treated while not in the hospital; or~~
~~d) Those furnished only because of the setting if the service or supply can be furnished in a doctor's office or other less costly setting.~~

3. The Division as the Commissioner's designee agreed to proposed amendments to be approved according to a predetermined outcome, uses a short review timeline, and relies on the Division's misleading media to communicate with members impacted by the proposed amendments:

A. Public comment cannot be adequately weighed and considered because, as described in the 4/27/2022 Division newsletter (below), the amendments are the result of a prior agreement between the Division and RPEA.

An email sent on 4/27/2022, states:

> On March 18 2022, the Division of Retirement and Benefits (the Division) issued a proposed amendment to the AlaskaCare Defined Benefit Retiree Health Plan (the Plan). This amendment was agreed to as part of the final settlement agreement negotiated between the Division and the Retired Public Employees of Alaska, Inc. (RPEA).
>
> The proposed amendment, which still must be formally adopted by the Commissioner of Administration (the Commissioner), is an important component of the Division's and

RPEA's agreement to end year's long litigation on mutually acceptable terms. The amendment's purpose is to clarify certain parts of the plan's medical necessity provisions.

Specifically, the amendment offers a neutral reference to the term Claims Administrator, recognizing that the entity contracted to provide this service has, and will, change over time as the Division engages in competitive procurements. In some cases, such as in the case of pharmacy or dental claims, the Claims Administrator may be different than the medical claims administrator. The proposed amendment reflects that reality.

In addition, the proposed amendment confirms that as Plan Administrator, the Commissioner, or their designee, has final authority to determine if a claim should be paid under the terms of the plan. The proposed amendment restates the factors that the Plan Administrator will consider when evaluating a claim within this provision. On an individual basis, this evaluation occurs through the appeals process, specifically when a member reaches the third level appeal to the Division.

Nothing in this amendment is intended to rescind or remove the use of Claims Administrator's clinical policies in determining medical necessity when adjudicating claims. Nor is the intent of the amendment to change the current process members may undertake when they believe a claim has been inappropriately denied.

The amendments were not the result of a judicial ruling but the result of a settlement between parties. According to the 4/27/2022 email (see above), the amendment "still must be formally adopted by the Commissioner." Although the Commissioner of the Department of Administration herself is not a party of the settlement, the Commissioner's designee was a party. It is a conflict of interest to have the proposed amendments approved by the Commissioner when her designee already agreed to the proposed amendments. The Division's process for approval is lacking an independent review and approval process. The hand-in-glove relationship between the parties in the settlement and the Office of the Commissioner appears to show that the Commissioner of Administration, through its agent, already committed to accepting the amendments, thus is not independent or fully able to consider public comment. A predetermined outcome does not square with the intent of a public comment opportunity. A predetermined outcome makes a mockery of the public comment period so that the review of public comments is rendered perfunctory and public comments have no viable path to affect the outcome of the proposal.

Was the Commissioner or her representative involved in the drafting of the settlement? The first paragraph of Amendment 2 includes the phrase "**in their discretion**" with the letters "t" and "i" in underlined, blue font. The blue letters appear to have been added to make the word "her" from the original settlement language—possibly a pointed reference to the current commissioner—into the gender neutral "their."

B. The public notice does not allow adequate time to consider comments received.

The public notice https://aws.state.ak.us/OnlinePublicNotices/Notices/View.aspx?id=205834 (see I.1.B. above) contains the following statement:

> The Department of Administration, Division of Retirement and Benefits, is proposing an amendment to the AlaskaCare Defined Benefit Retiree Health Plan, effective June 1, 2022.

The notice sets "June 1, 2022" as the date the proposed amendments will be finalized and incorporated in the revised Plan. Thus, seven working days are allowed for the Commissioner to consider public comments submitted by the 5/20/2022 deadline. Seven working days makes the Commissioner's review of the comment period appear perfunctory. The brief review period in conjunction with the lack of an independent entity to review the public comments undermines the credibility of the process and legitimacy of the Commissioner of Administration's role in adopting the proposed amendments.

C. A communication from the Division misleadingly characterizes the effect of the proposed amendments by omitting context.

The Division has unique access to members who may choose to comment on the proposed amendment. The Division abused this access by using the 4/27/2022 newsletter to misleadingly characterize the proposed amendment. As shown (see I.2.A. above), the newsletter states, "Nothing in this amendment is intended to rescind or remove the use of Claims Administrator's clinical policies in determining medical necessity when adjudicating claims."

The description omits an explanation that the Claims Administrator already has the authority and discretion to rescind or remove clinical policies. The description that the amendment is not "intended to rescind or remove the use of" clinical policies is meaningless because the Claims Administrator already has the sole authority to issue, retract, amend, and not to issue clinical policies. A reasonable understanding of the meaning of "Nothing in this amendment is intended to rescind or remove the use of Claims Administrator's clinical policies…." would be that the Claims Administrator cannot rescind or remove clinical policies. However, that is incorrect. While strictly correct that "[n]othing in this amendment" allows the Claims Administrator to rescind or remove clinical policy bulletins, the context that the Claims Administrator already has that discretion is obscured, making the "is intended to" deceitful. AlaskaCare members reasonably want to know whether the Claims Administrator may rescind or remove clinical policies. For the Division to respond that "the amendment" does not give that power—knowing the Claims Administrator already has the power to rescind or remove clinical policies—is using their exclusive communication access to mislead affected members.

The Division's statement lacked proper context. I suggest the Division publish a new notice to members that states:

> "In addition to powers currently held by the Claims Administrator to retract or amend existing clinical policies and issue or decline to issue new clinical policies at their own discretion, the amendment limits the Claims Administrator medical necessity

> determinations to the clinical policy process it already controls and to 'prudent clinical judgment," a term that is not defined."

The Division has a duty to clearly describe the effect of Amendment 2. If properly informed, members will be able to understand the impact of the proposed amendments that will make the Claims Administrator's medical necessity decisions under clinical policies managed solely by the Claims Administrator.

II. Specific comments for the proposed amendments

Section 1, Amendment 1 Amended Provisions: Amends the Contact Information section to include information related to accessing Clinical Policy Bulletins.

Amends the Contact Information section to add a web link to the Aetna Clinical Policy:

> Bulletins.
> Aetna Clinical Policy Bulletins ..... www.aetna.com/health-care-professionals/clinical-policy-bulletins.html

Amendment 1 proposes to move a web link that was already confusing to members. Clinical policy bulletins are not just for "health care professionals." They are for every member as well. Whether the link is relocated or not, please revise the description by adding to the phrase, "Aetna Clinical Policy Bulletins" a statement to clarify that clinical policy bulletins are available to every member, medical professionals, and the public.

Section 1, Amendment 2 Amended Provisions: Amends Section 3.3.1 Medical Necessity

The proposed amendment of Section 3.3.1, limits the Claims Administrator's consideration to current clinical policy bulletins and "prudent clinical judgment." "Prudent clinical judgment" is vague and subject to interpretation, giving the Claims Administrator broad discretion.

When a member appeal eventually reaches the Plan Administrator, the amendment adds other factors to be considered, including the members health, peer-reviewed medical literature, guidelines by nationally recognized health care organizations, and professional standards of safety and effectiveness used in the United States. Before an appeal has reached external review, a process that can take months, solely the Claims Administrator's clinical policies will be used to decide medical necessity.

The significance of this amendment is that members have a lifeline beyond the Claims Administrator's clinical policies but only after pursuing an appeal up to the Plan Administrator. Delays themselves can be medically harmful. Of this, I will share a current example of how the Claims Administrator's reliance only on existing clinical policies harms the health of members.

Apparent deletion of substantive paragraphs from Section 3.3.1

Section 3.3.1 in the current plan has six paragraphs. It appears Amendment 2 deletes the last four paragraphs, with significant effects on the clarity of the meaning and protection of members' interests in health care coverage.

The first paragraph that appears removed begins, "In making a determination of medical necessity when there is no applicable Clinical Policy Bulletin, the provision of the service, supply or prescription drug covered under the medical plan must be…." A list of required considerations follows including: "generally accepted standards of medical practice" and "clinically appropriate" treatments apparently will no longer be required in determinations of medical necessity made by the Claims Administrator.

The following paragraph, fourth in the current Section 3.3.1, is also apparently deleted. This paragraph defines "generally accepted standards of medical practice" such as peer-reviewed studies and physician specialty practice guidelines. If correct that the second paragraph is deleted, the meaning of "generally accepted standards of medical practice" is not defined. As stated above, the Claims Administrator could no longer be compelled in initial member appeals to consider factors outside of existing clinical policies. Clinical policies may or may not be updated, accurate, or complete and members have no process to appeal clinical policies.

The next two omitted paragraphs, fifth and sixth in the current Section 3.3.1, are also apparently deleted. These paragraphs describe cautions and limitations to members. It is unclear what the impact of removing this caution or limitation will be or whether the paragraphs are replicated in other another sections of the plan.

Later, in the last stage of an administrative appeal when it reaches the Plan Administrator, Amendment 2 states considerations of medical necessity will include other sources of information such as specialist practices, health care organizations' recommendations, academic studies, and other considerations beyond the clinical policy bulletins. I do support clearly giving the Plans Administrator that broad authority, which I believe is already present in the current plan.

The effect of Amendment 2 is to prevent the Claims Administrator from considering outside information to make determinations of medical necessity. Essentially, only existing clinical policy bulletins would be assessed. Clinical policy bulletins are fallible. When they fail, an appeal to the Plan Administrator will be the only avenue to incorporate consideration of medical information beyond the Claims Administrator's clinical policies.

Harms members' interests and health

There are multiple reasons why Amendment 2 weakens benefits for members.

First, medicine is a rapidly evolving field. Aetna or any Claims Administrator's clinical policy bulletins are always behind the newest information. The proposed amendment freezes claims processing in the past. No amount of effort to update clinical policy bulletins changes the fact that they lag behind effective advancements in medicine.

Second, by tying the Claims Administrators hands, so that they may only consider current clinical policy bulletins, the proposed amendment creates a strong incentive to not update those bulletins. The lag will worsen. Effective advancements will not be brought into the bulletins and members will be harmed

because they will need to appeal as they find medications and procedures that should be covered are denied.

Third, the remedy of appeal is inadequate to address the problem that the Claims Administrator can consider nothing beyond existing clinical policies. As a result, there may be more appeals, as members receive more denials. Also, members may be denied coverage but not appeal, losing the opportunity to have the medication or procedure covered. For those who appeal, the process harms members' interests. Members appeal because they want care. The appeal process is often a dispute for high-level hospital care and surgeries. It must be understood that these are members seeking high-level care which may mean they are quite ill, in pain, and/or desperate. Delay is not their friend. Amendment 2 removes the option to have the Claims Administrator recognize an error early in the appeal process. If approved, errors from denials of medical necessity will be unable to be corrected in early appeals and will be pushed off to the Plan Administrator to rectify. These errors are costly to members. Many denials are over hospital stays that require precertification. These denials may harm members by delaying essential health care, causing increased pain and disability, cost members income and educational opportunities, and create emotional distress. Members often have multiple health conditions. When treatment for one is unnecessarily delayed, a dangerous cascade of consequences may result. These costs of improper denials are fully on members, not on the Claims or Plan administrators.

Interferes with the Claims Administrator's existing use of outside sources of information

In addition, Amendment 2 may end the Claims Administrator's ability to use sources other than clinical policies that they relied on in the past. [redacted] Claims Administrator denied a request [redacted] as not medically necessary by citing criteria from an external publication, [redacted]. It appears Aetna does not have clinical policies for inpatient hospital stays. If that is correct and Amendment 2 is approved, how can the Claims Administrator issue precertification approvals of inpatient hospital stays? With no clinical policy regarding inpatient hospital stays, will all requests for inpatient stays be found "not medically necessary"? Regardless of other impacts of Amendment 2, the effect of Amendment 2 on inpatient hospital stays may be the most sweeping. The Claims Administrator may move all inpatient hospital care decisions to an ad-hock approval process that is managed day-by-day <u>after</u> surgeries. Careful consideration should be made how to protect members from the abuse of such a system and from errors made because decisions will always be time constrained. Who is able to review the overall effectiveness of ad-hock, post-hospitalization approvals?

Beyond MCG Health, there may be guideline publications the Claims Administrator has depended on that are not addressed by clinical policies.

The swift approval process intended for these amendments allows little time to examine the ramifications of tying Claims Administrator medical necessity determinations to existing clinical policies. Even if Aetna wanted to create a new policy, the June 1 adoption schedule is not enough time for Aetna to follow a careful process to develop a new clinical policy.

[redacted] <u>one family's experience</u>

[redacted]

[redacted]

Current plan requires Aetna to consider accepted standards and peer-reviewed studies

Aetna erred in assessing [redacted] they have no clinical policy that applies. Under the current Plan standards of medical practice and peer-reviewed studies are required to be considered throughout the process (see excerpt from 3.3.1 in current plan below). It appears Amendment 2 deletes these two paragraphs below:

In making a determination of medical necessity when there is no applicable Clinical Policy Bulletin, the provision of the service, supply or prescription drug covered under the medical plan must be:

a) In accordance with generally accepted standards of medical practice;

b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease;

c) Not mostly for the convenience of the patient or physician or other health care provider; and

d) Not more costly than an alternative service or sequence of services at least as likely to produce the same therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

"Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community. Otherwise, the standards must be consistent with physician specialty society recommendations. They must be consistent with the views of physicians practicing in relevant clinical areas and any other relevant factors.

Yet, if restricted by Amendment 2 to consider only their own clinical policies, Aetna would have no choice but to deny. Under Amendment 2, only after further appeals would the Plan Administrator be able to step in and overturn denials by considering standards of care and peer-reviewed studies.

[redacted]

[redacted] If Amendment 2 is approved, the outcome of a final appeal to the Claims Administrator will be a repeat of the last. [redacted] Existing clinical policies are a one-size-fits-all: There is no mechanism to require a new clinical policy to be developed. There is no way to go outside clinical policies for other treatments. [redacted]

Why did this happen? Because Aetna can. The Claims Administrator is allowed three denials to the provider and two or three more to the member. The cost of delay falls financially on members and their providers and leads to increased costs for procedures needing precertification. The delay is costly to members' health, occupation/education, and emotional well-being. If members are able to pursue a fight through the appeal process, they may win a decision to approve precertification, but time when treatment was needed was lost. [redacted]

Members interests are harmed by removing protections from "medical necessity"

If Amendment 2 is approved, the Claims Administrator will be prevented from considering valuable input from AlaskaCare members that will limit treatments and medications allowed as "medical necessity." Clinical policy bulletins can never keep up with the increasing pace of medical advances and cannot be assumed to be a complete set of every medically necessary procedure or medication. Claims administrators are not bound by mandates to include credible and compelling information in clinical policies; they are allowed to leave it out indefinitely at their sole discretion. Claims administrators may withdraw medically necessary FDA-approved treatments, [redacted] (see https://www.aetna.com/cpb/medical/data/500_599/0591.html). Amendment 2 will prohibit the Claims Administrator from considering information beyond the Claims Administrator's own clinical policies. Consideration of information beyond the clinical policies will be left to the latter stages of an appeal, after the final denial by the Claims Administrator, when the member appeals to the Plan Administrator who can consider a broader set of data in determining medical necessity. [redacted] is an example of what happened to one member that may become routine when the Claims Administrator does not have clinical policies for a particular treatment. Amendment 2 punishes members when it is the Claims Administrator who has not bothered to write a clinical policy for a procedure long in use by surgeons that is supported by numerous studies showing efficacy and high success for reducing pain and restoring mobility. Amendment 2 makes it easier for the Claims Administrator to deny treatments and medications and reduces coverage that is available to members without a lengthy appeal process.

In effect, Amendment 2 creates two standards for medical necessity, with the Claims Administrator restricted to clinical policies that they write themselves and the Plan Administrator that may consider standards of practice and published peer-reviewed studies. Why have two different standards? Is it for the convenience of the Claims Administrator so they have one set of documents to consider and can ignore all others? In exchange for this convenience, AlaskaCare members will be forced to appeal to a greater extent to have consideration given to standards of practice and published peer-reviewed studies.

Burdens members who are sick, in pain, and lacking proper medical care

Appeals involve delays in receiving care and in many cases, individuals who are ill are poorly equipped to appeal. In addition, it is important to understand that providers for complicated, costly procedures tend to offer to submit precertification requests on behalf of members. These requests will be dealt with entirely on the standard for the Claims Administrator, that is, exclusively based on clinical policies. When providers have exhausted their appeals, the next phase of appeals are all on the responsibility of the member who appeals directly on their own behalf. So, when there are medical therapies that have proven up in studies and become the standard of care, but Aetna has not incorporated in their clinical policies, the job of appealing falls on members. Members will have to do their own research, write their appeals, and follow through to ensure these relevant sources of information are considered. It is a special kind of problem where a parent must appeal on behalf of their child. It is perhaps worse for members who are adults needing treatment and in pain who do not have a significant other who is trusted and capable of all the research and documentation necessary to file an appeal on their own behalf. [redacted] It must be understood that blocking early consideration of information that demonstrates a requested treatment is proper and beneficial will only lead to more appeals. Many cannot appeal for personal reasons, such as that the process is complicated and has deadlines that if not met terminate the member's right of appeal and that members needing to appeal are likely struggling with serious health conditions and without treatment. The last thing a sick person needs is to have an additional burden of stress due to the withholding of proper care and treatment. Amendment 2 will result in the withholding of proper treatment by refusing to consider relevant information during the initial appeal process with the Claims Administrator.

Section 5.1 "experimental or investigational"

Further, Amendment 2 does nothing to limit the Claims Administrator's ability to designate treatments and medications "experimental or investigational." As described in the Plan for Medical Expenses Not Covered, Section 5.1 Limitations and Exclusions, "insufficient data" is available from published "controlled clinical trials" to substantiate its safety and effectiveness for the disease or injury involved."

- Services or supplies that are, as determined by the claims administrator, experimental or investigational. A drug, device, procedure, or treatment will be determined to be experimental or investigational if:
  - There is insufficient data available from controlled clinical trials published in peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved;
  - Approval, as required by the FDA, has not been granted for marketing;

For some treatments, researchers are ethically or physically unable to perform controlled experiments. For example, to compare outcomes [redacted] versus no treatment, a researcher would need to take a group of subjects who are eligible [redacted] and randomly assign subjects to two groups: one receives a placebo surgery, the other receives fixation to repair the fracture. Such a controlled experiment would not be allowed for ethical reasons. There are many studies where the "control" arm does not receive surgery but receives some other treatment such as physical therapy, but in fact this is not a fully controlled study as the treatment group knows they received surgery and the physical therapy group knows they did not which may influence their satisfaction with the outcomes. Studies of the outcomes of [redacted], but subjects were not randomly assigned to each treatment for ethical reasons. Numerous retrospective studies assess the outcomes [redacted] while meeting ethical standards of clinical research. It appears likely that the Plan's standard of "controlled clinical trials" is one many current treatments could not meet. Take heart bypass surgery. Are there controlled studies with subjects randomly assigned to a treatment arm to receive bypass surgery, the other assigned to the placebo arm where they received sham surgeries? How many areas of medical advancement, even those that are FDA-approved, could meet the "controlled clinical trials" standard required not to be determined to be experimental or investigational?

Section 5.1 "experimental or investigational" treatments and medications may have greater influence on coverage decisions under Amendment 2 because once the Claims Administrator designates a treatment or medication "experimental or investigational," the Plan Administrator has no ability to overturn the designation without "controlled clinical trials." In the current plan, the lists of "experimental or investigational" treatments are long and complex. Amendment 2 does nothing to limit the expansion of the category of denial of coverage as "experimental or investigational" and may empower the Claims Administrator to expand lists of treatments that are unavailable to members.

Section 1, Amendment 3 Amended Provisions: Section 12.14.13 Third Level – Division of Retirement and Benefits Appeal

No comment related to the proposed amendment.

Section 1, Amendment 4 Amended Provisions: Section 14.4 Applicable Law and Venue

No comment related to the proposed amendment.

Section 1, Amendment 5: Adds new Definitions section

No comment related to the proposed amendment.

From: Peter Andruss
Sent: Friday, May 20, 2022 2:08 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Benefits

To: doa.drb.alaskacare.retiree.plan@alaska.gov

Subject: Questions re proposed changes to the AlaskaCare Retiree Health Plan

Dear Plan Administrator/Div. of Ret. and Benefits:

This is a reply to your request that AlaskaCare Plan members "share their thoughts" about the proposed Plan amendment scheduled to take effect June 1, 2022.

You have not provided enough information on your website necessary for retirees to understand and make informed comments and decisions about your proposed plan changes.

Please provide, as soon as possible, the answers to the following questions and requests for information. I hope your responses will help me understand the effects of your proposed plan changes on my retirement medical benefits:

1. Since 2003, our Plan has stated that coverage will be provided for medical services and supplies that are "medically necessary" and that are not specifically excluded from coverage by the Plan.

According to the terms of the plan that have been in effect since 2003, prescribed medical treatment is considered "medically necessary" when it is "expected to improve or maintain health" or "to ease pain or suffering without aggravating the condition or causing other serious health problems."

The Plan also states that diagnostic procedures are medically necessary when they are "expected to provide information to determine the course of treatment without aggravating the condition or causing additional health problems."

A medical treatment will not be considered medically necessary if there is an equally effective treatment or procedure that costs less than the one prescribed.

These standards of medical necessity are clear, straightforward, and easy to understand.

What are the reasons for changing the Plan's provisions concerning "medical necessity" and how would those changes affect coverages for types of medical treatments and procedures that the Plan has covered since 2003?

2. If these proposed Plan changes are adopted, would the Aetna Clinical Policy Bulletins be used only if/when there is a good faith basis for questioning whether the prescribed medical treatment, procedure, or equipment satisfies the Plan's standards for determining medical necessity as described in my Question 1?

3. When my doctor prescribes a medical treatment, procedure, or piece of equipment that A) helps cure or control my disease or condition or ease my pain or suffering without aggravating the condition or causing other health problems; B) has no alternative that is equally effective and costs less; and C) is not subject to any plan exclusion, does the Plan Administrator still have the discretion to deny coverage on the grounds of lack of medical necessity? If so, what other factors does the claims administrator (Aetna) or the Plan Administrator (the Division) consider in exercising its discretion whether a prescribed medical treatment, procedure, or equipment is medically necessary?

4. If a claim for a medical benefit is denied, I think I should be given a clear explanation of the reason for the denial so I can decide whether to appeal. If these proposed Plan changes are adopted and a medical claim is denied because Aetna does not consider it to be "medically necessary," would the Explanation of Benefits provide a clear explanation the Plan administrator does not consider it to be "medically necessary"?

Would the Explanation of Benefits tell me which Aetna Clinical Policy Bulletin and/or other reason was relied on by the claims administrator (TPA) or the Plan Administrator in exercising its "discretion" to deny coverage based on lack of medical necessity? If not, why not?

5. If these Plan changes are adopted and the Plan Administrator (the Division) has the discretion to decide if a prescribed medical treatment, procedure, or piece of equipment is medically necessary, and if the DRB delegates that authority to another person, what methods would the Plan administrator use to monitor and ensure that that person is making correct decisions?

6. Can the claims administrator (TPA) eliminate or reduce any coverages and/or other Plan benefits simply by changing one or more of its clinical policy bulletins to state that a prescribed medical treatment, procedure, or piece of equipment is no longer considered medically necessary? If the answer is yes, please answer these two questions:

A) Does the claims administrator (Aetna) need to get the permission of the Plan Administrator (DRB) to make that kind of change to our Plan?

B) Does the claims administrator or the Plan Administrator DRB have to give Plan members notice of those changes in advance? If not, why not? And if Plan members will be given advance notice, how much advance notice will we be given and how will it be given?

7. If these Plan changes are adopted, will any new coverages or other Plan benefits be added to the Plan? If so, please tell me what those are and why they were not covered or provided under the terms of the Plan as it was written in 2003.

8. If these Plan changes are adopted, would any types of medical treatments, procedures, or supplies that have been covered at any time since 2003 no longer be covered or have reduced coverage? If so, what coverages and other Plan benefits would be eliminated or reduced and why?

9. "Section 12.14.13 Third Level" states that if a Plan member "does not file a Plan Administrator appeal timely, ... the second level of appeal will be the final decision, and will be final, conclusive and binding on all persons."
This would eliminate an existing appeal right under subsection (e) of 2 AAC 35.100 of the Alaska Administrative Code. It states that a Plan member may be permitted to file a late appeal if he/she provides a reasonable explanation of extraordinary circumstances that excuse the late filing. If the DRB then rejects the explanation for the late filing, the regulation also requires the DRB to notify the Plan member of his or her right to appeal the decision to reject the late-filed claim. It states:

The division shall return the notice of appeal to the person, and inform the person that the person may resubmit the notice with an explanation of why it was not timely filed. If the person resubmits the notice of appeal with an explanation or if the original untimely notice of appeal contained an explanation of untimeliness, and the administrator in either situation found that the explanation did not establish extraordinary circumstances excusing the untimeliness under (d) of this section, the person may file a new notice of appeal within 30 days of the date that the person receives notice of the decision refusing to accept the untimely first appeal.

Why does the proposed Plan section not inform Plan members of their rights to file an appeal after the deadline as allowed by 2 AAC 100(e)?

10. The document containing the proposed Plan amendment on the DRB website states that it is a "draft" and that it would be effective on June 1, 2022.

Please tell me if the words highlighted green on that DRB webpage are the proposed amendments, whether there will be any more changes made to the draft before June 1, 2022, and, if so, whether we will have a reasonable opportunity to read and comment on any other changes before you enact the amendment and, if so, that will be provided.

I look forward to receiving the answers and information I have requested.

Thank you.

From: raweln kinnat
Sent: Friday, May 20, 2022 1:44 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Cc: Lisa Shrestha
Subject: Subject: Questions re proposed changes to the AlaskaCare Retiree Health Plan

Dear Plan Administrator/Div. of Ret. and Benefits:

This is a reply to your request that AlaskaCare Plan members “share their thoughts” about the proposed Plan amendment scheduled to take effect June 1, 2022.

You have not provided enough information on your website necessary for retirees to understand and

make informed comments and decisions about your proposed plan changes.

Please provide, as soon as possible, the answers to the following questions and requests for information. I hope your responses will help me understand the effects of your proposed plan changes on my retirement medical benefits:

1. Since 2003, our Plan has stated that coverage will be provided for medical services and supplies that are "medically necessary" and that are not specifically excluded from coverage by the Plan.

According to the terms of the plan that have been in effect since 2003, prescribed medical treatment is considered “medically necessary” when it is "expected to improve or maintain health" or "to ease pain or suffering without aggravating the condition or causing other serious health problems."

The Plan also states that diagnostic procedures are medically necessary when they are "expected to provide information to determine the course of treatment without aggravating the condition or causing additional health problems."

A medical treatment will not be considered medically necessary if there is an equally effective treatment or procedure that costs less than the one prescribed.

These standards of medical necessity are clear, straightforward, and easy to understand.

What are the reasons for changing the Plan's provisions concerning "medical necessity" and how would those changes affect coverages for types of medical treatments and procedures that the Plan has covered since 2003?

2. If these proposed Plan changes are adopted, would the Aetna Clinical Policy Bulletins be used only if/when there is a good faith basis for questioning whether the prescribed medical treatment, procedure, or equipment satisfies the Plan's standards for determining medical necessity as described in my Question 1?

3. When my doctor prescribes a medical treatment, procedure, or piece of equipment that A) helps cure or control my disease or condition or ease my pain or suffering without aggravating the condition or causing other health problems; B) has no alternative that is equally effective and costs less; and C) is not subject to any plan exclusion, does the Plan Administrator still have the discretion to deny coverage on the grounds of lack of medical necessity? If so, what other factors does the claims administrator (Aetna) or the Plan Administrator (the Division) consider in exercising its discretion whether a prescribed medical treatment, procedure, or equipment is medically necessary?

4. If a claim for a medical benefit is denied, I think I should be given a clear explanation of the reason for the denial so I can decide whether to appeal. If these proposed Plan changes are adopted and a medical claim is denied because Aetna does not consider it to be "medically necessary," would the Explanation of Benefits provide a clear explanation the Plan administrator does not consider it to be "medically necessary"?

Would the Explanation of Benefits tell me which Aetna Clinical Policy Bulletin and/or other reason was relied on by the claims administrator (TPA) or the Plan Administrator in exercising its "discretion" to deny coverage based on lack of medical necessity? If not, why not?

5. If these Plan changes are adopted and the Plan Administrator (the Division) has the discretion to decide if a prescribed medical treatment, procedure, or piece of equipment is medically necessary, and if the DRB delegates that authority to another person, what methods would the Plan administrator use to monitor and ensure that that person is making correct decisions?

6. Can the claims administrator (TPA) eliminate or reduce any coverages and/or other Plan benefits simply by changing one or more of its clinical policy bulletins to state that a prescribed medical treatment, procedure, or piece of equipment is no longer considered medically necessary? If the answer is yes, please answer these two questions:
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B) Does the claims administrator or the Plan Administrator DRB have to give Plan members notice of those changes in advance? If not, why not? And if Plan members will be given advance notice, how much advance notice will we be given and how will it be given?

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8. If these Plan changes are adopted, would any types of medical treatments, procedures, or supplies that have been covered at any time since 2003 no longer be covered or have reduced coverage? If so, what coverages and other Plan benefits would be eliminated or reduced and why?

9. "Section 12.14.13 Third Level" states that if a Plan member "does not file a Plan Administrator appeal timely, ... the second level of appeal will be the final decision, and will be final, conclusive and binding on all persons."

This would eliminate an existing appeal right under subsection (e) of 2 AAC 35.100 of the Alaska Administrative Code. It states that a Plan member may be permitted to file a late appeal if he/she provides a reasonable explanation of extraordinary circumstances that excuse the late filing. If the DRB then rejects the explanation for the late filing, the regulation also requires the DRB to notify the Plan member of his or her right to appeal the decision to reject the late-filed claim. It states:

The division shall return the notice of appeal to the person, and inform the person that the person may resubmit the notice with an explanation of why it was not timely filed. If the person resubmits the notice of appeal with an explanation or if the original untimely notice of appeal contained an explanation of untimeliness, and the administrator in either situation found that the explanation did not establish extraordinary circumstances excusing the untimeliness under (d) of this section, the person may file a

new notice of appeal within 30 days of the date that the person receives notice of the decision refusing to accept the untimely first appeal.

Why does the proposed Plan section not inform Plan members of their rights to file an appeal after the deadline as allowed by 2 AAC 100(e)?

10. The document containing the proposed Plan amendment on the DRB website states that it is a "draft" and that it would be effective on June 1, 2022.

Please tell me if the words highlighted green on that DRB webpage are the proposed amendments, whether there will be any more changes made to the draft before June 1, 2022, and, if so, whether we will have a reasonable opportunity to read and comment on any other changes before you enact the amendment and, if so, that will be provided.

I look forward to receiving the answers and information I have requested.

Thank you.

Naresh and Lisa shrestha

From: Rotte
Sent: Friday, May 20, 2022 12:39 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Questions Re:Proposed changes to Alaskacare Retiree health plan

Dear Plan Administrator/Div. of Ret. and Benefits:

This is a reply to your request that AlaskaCare Plan members “share their thoughts” about the proposed Plan amendment scheduled to take effect June 1, 2022.

You have not provided enough information on your website necessary for retirees to understand and make informed comments and decisions about your proposed plan changes.

Please provide, as soon as possible, the answers to the following questions and requests for information. I hope your responses will help me understand the effects of your proposed plan changes on my retirement medical benefits:

1. Since 2003, our Plan has stated that coverage will be provided for medical services and supplies that are "medically necessary" and that are not specifically excluded from coverage by the Plan.

According to the terms of the plan that have been in effect since 2003, prescribed medical treatment is considered “medically necessary” when it is "expected to improve or maintain health" or "to ease pain or suffering without aggravating the condition or causing other serious health problems."

The Plan also states that diagnostic procedures are medically necessary when they are "expected to provide information to determine the course of treatment without aggravating the condition or causing additional health problems."

A medical treatment will not be considered medically necessary if there is an equally effective treatment or procedure that costs less than the one prescribed.

These standards of medical necessity are clear, straightforward, and easy to understand.

What are the reasons for changing the Plan's provisions concerning "medical necessity" and how would those changes affect coverages for types of medical treatments and procedures that the Plan has covered since 2003?

2. If these proposed Plan changes are adopted, would the Aetna Clinical Policy Bulletins be used only if/when there is a good faith basis for questioning whether the prescribed medical treatment, procedure, or equipment satisfies the Plan's standards for determining medical necessity as described in my Question 1?

3. When my doctor prescribes a medical treatment, procedure, or piece of equipment that A) helps cure or control my disease or condition or ease my pain or suffering without aggravating the condition or causing other health problems; B) has no alternative that is equally effective and costs less; and C) is not subject to any plan exclusion, does the Plan Administrator still have the discretion to deny coverage on the grounds of lack of medical necessity? If so, what other factors does the claims administrator (Aetna) or the Plan Administrator (the Division) consider in exercising its discretion whether a prescribed medical treatment, procedure, or equipment is medically necessary?

4. If a claim for a medical benefit is denied, I think I should be given a clear explanation of the reason for the denial so I can decide whether to appeal. If these proposed Plan changes are adopted and a medical claim is denied because Aetna does not consider it to be "medically necessary," would the Explanation of Benefits provide a clear explanation the Plan administrator does not consider it to be "medically necessary"?

Would the Explanation of Benefits tell me which Aetna Clinical Policy Bulletin and/or other reason was relied on by the claims administrator (TPA) or the Plan Administrator in exercising its "discretion" to deny coverage based on lack of medical necessity? If not, why not?

5. If these Plan changes are adopted and the Plan Administrator (the Division) has the discretion to decide if a prescribed medical treatment, procedure, or piece of equipment is medically necessary, and if the DRB delegates that authority to another person, what methods would the Plan administrator use to monitor and ensure that that person is making correct decisions?

6. Can the claims administrator (TPA) eliminate or reduce any coverages and/or other Plan benefits simply by changing one or more of its clinical policy bulletins to state that a prescribed medical treatment,

procedure, or piece of equipment is no longer considered medically necessary? If the answer is yes, please answer these two questions:

A) Does the claims administrator (Aetna) need to get the permission of the Plan Administrator (DRB) to make that kind of change to our Plan?

B) Does the claims administrator or the Plan Administrator DRB have to give Plan members notice of those changes in advance? If not, why not? And if Plan members will be given advance notice, how much advance notice will we be given and how will it be given?

7. If these Plan changes are adopted, will any new coverages or other Plan benefits be added to the Plan? If so, please tell me what those are and why they were not covered or provided under the terms of the Plan as it was written in 2003.

8. If these Plan changes are adopted, would any types of medical treatments, procedures, or supplies that have been covered at any time since 2003 no longer be covered or have reduced coverage? If so, what coverages and other Plan benefits would be eliminated or reduced and why?

9. "Section 12.14.13 Third Level" states that if a Plan member "does not file a Plan Administrator appeal timely, ... the second level of appeal will be the final decision, and will be final, conclusive and binding on all persons."
This would eliminate an existing appeal right under subsection (e) of 2 AAC 35.100 of the Alaska Administrative Code. It states that a Plan member may be permitted to file a late appeal if he/she provides a reasonable explanation of extraordinary circumstances that excuse the late filing. If the DRB then rejects the explanation for the late filing, the regulation also requires the DRB to notify the Plan member of his or her right to appeal the decision to reject the late-filed claim. It states:

The division shall return the notice of appeal to the person, and inform the person that the person may resubmit the notice with an explanation of why it was not timely filed. If the person resubmits the notice of appeal with an explanation or if the original untimely notice of appeal contained an explanation of untimeliness, and the administrator in either situation found that the explanation did not establish extraordinary circumstances excusing the untimeliness under (d) of this section, the person may file a new notice of appeal within 30 days of the date that the person receives notice of the decision refusing to accept the untimely first appeal.

Why does the proposed Plan section not inform Plan members of their rights to file an appeal after the deadline as allowed by 2 AAC 100(e)?

10. The document containing the proposed Plan amendment on the DRB website states that it is a "draft" and that it would be effective on June 1, 2022.

Please tell me if the words highlighted green on that DRB webpage are the proposed amendments, whether there will be any more changes made to the draft before June 1, 2022, and, if so, whether we will have a reasonable opportunity to read and comment on any other changes before you enact the amendment and, if so, that will be provided.

I look forward to receiving the answers and information I have requested.

Thank you

From: Kate Tesar
Sent: Friday, May 20, 2022 12:16 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Questions re: proposed changes to AlaskaCare Retiree Health Plan

Dear Plan Administrator/Div. of Ret. and Benefits:

This is a reply to your request that AlaskaCare Plan members “share their thoughts” about the proposed Plan amendment scheduled to take effect June 1, 2022.

You have not provided enough information on your website necessary for retirees to understand and make informed comments and decisions about your proposed plan changes.

Please provide, as soon as possible, the answers to the following questions and requests for information. I hope your responses will help me understand the effects of your proposed plan changes on my retirement medical benefits:

1. Since 2003, our Plan has stated that coverage will be provided for medical services and supplies that are "medically necessary" and that are not specifically excluded from coverage by the Plan.

According to the terms of the plan that have been in effect since 2003, prescribed medical treatment is considered “medically necessary” when it is "expected to improve or maintain health" or "to ease pain or suffering without aggravating the condition or causing other serious health problems."

The Plan also states that diagnostic procedures are medically necessary when they are "expected to provide information to determine the course of treatment without aggravating the condition or causing additional health problems."

A medical treatment will not be considered medically necessary if there is an equally effective treatment or procedure that costs less than the one prescribed.

These standards of medical necessity are clear, straightforward, and easy to understand.

What are the reasons for changing the Plan's provisions concerning "medical necessity" and how would those changes affect coverages for types of medical treatments and procedures that the Plan has covered since 2003?

2. If these proposed Plan changes are adopted, would the Aetna Clinical Policy Bulletins be used only if/when there is a good faith basis for questioning whether the prescribed medical treatment, procedure,

or equipment satisfies the Plan's standards for determining medical necessity as described in my Question 1?

3. When my doctor prescribes a medical treatment, procedure, or piece of equipment that A) helps cure or control my disease or condition or ease my pain or suffering without aggravating the condition or causing other health problems; B) has no alternative that is equally effective and costs less; and C) is not subject to any plan exclusion, does the Plan Administrator still have the discretion to deny coverage on the grounds of lack of medical necessity? If so, what other factors does the claims administrator (Aetna) or the Plan Administrator (the Division) consider in exercising its discretion whether a prescribed medical treatment, procedure, or equipment is medically necessary?

4. If a claim for a medical benefit is denied, I think I should be given a clear explanation of the reason for the denial so I can decide whether to appeal. If these proposed Plan changes are adopted and a medical claim is denied because Aetna does not consider it to be "medically necessary," would the Explanation of Benefits provide a clear explanation the Plan administrator does not consider it to be "medically necessary"?

Would the Explanation of Benefits tell me which Aetna Clinical Policy Bulletin and/or other reason was relied on by the claims administrator (TPA) or the Plan Administrator in exercising its "discretion" to deny coverage based on lack of medical necessity? If not, why not?

5. If these Plan changes are adopted and the Plan Administrator (the Division) has the discretion to decide if a prescribed medical treatment, procedure, or piece of equipment is medically necessary, and if the DRB delegates that authority to another person, what methods would the Plan administrator use to monitor and ensure that that person is making correct decisions?

6. Can the claims administrator (TPA) eliminate or reduce any coverages and/or other Plan benefits simply by changing one or more of its clinical policy bulletins to state that a prescribed medical treatment, procedure, or piece of equipment is no longer considered medically necessary? If the answer is yes, please answer these two questions:

A) Does the claims administrator (Aetna) need to get the permission of the Plan Administrator (DRB) to make that kind of change to our Plan?

B) Does the claims administrator or the Plan Administrator DRB have to give Plan members notice of those changes in advance? If not, why not? And if Plan members will be given advance notice, how much advance notice will we be given and how will it be given?

7. If these Plan changes are adopted, will any new coverages or other Plan benefits be added to the Plan? If so, please tell me what those are and why they were not covered or provided under the terms of the Plan as it was written in 2003.

8. If these Plan changes are adopted, would any types of medical treatments, procedures, or supplies that have been covered at any time since 2003 no longer be covered or have reduced coverage? If so, what coverages and other Plan benefits would be eliminated or reduced and why?

9. "Section 12.14.13 Third Level" states that if a Plan member "does not file a Plan Administrator appeal timely, ... the second level of appeal will be the final decision, and will be final, conclusive and binding on all persons."
This would eliminate an existing appeal right under subsection (e) of 2 AAC 35.100 of the Alaska Administrative Code. It states that a Plan member may be permitted to file a late appeal if he/she provides a reasonable explanation of extraordinary circumstances that excuse the late filing. If the DRB then rejects the explanation for the late filing, the regulation also requires the DRB to notify the Plan member of his or her right to appeal the decision to reject the late-filed claim. It states:

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Why does the proposed Plan section not inform Plan members of their rights to file an appeal after the deadline as allowed by 2 AAC 100(e)?

10. The document containing the proposed Plan amendment on the DRB website states that it is a "draft" and that it would be effective on June 1, 2022.

Please tell me if the words highlighted green on that DRB webpage are the proposed amendments, whether there will be any more changes made to the draft before June 1, 2022, and, if so, whether we will have a reasonable opportunity to read and comment on any other changes before you enact the amendment and, if so, when that will be provided.

I look forward to receiving these answers and information I have requested.

Thank you.
Katherine Tesar

From: Steve Haavig
Sent: Friday, May 20, 2022 11:47 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Proposed changes to medical insurance

I was not aware of the proposed changes concerning medically necessary procedures until I was informed of them by Ms. [redacted]

Her comments to the department explained the issues in far more greater detail than anything that I received from the department through the mail, email, or meetings.

The issues and concerns raised by Ms. [redacted] warrant a delay in adoption of these changes until the ramifications and likely confusion in implementing the changes are more fully evaluated.

Please keep me directly informed on any further changes and public proceedings on this matter.

Thank you
Steven Haavig

From: N S W
Sent: Friday, May 20, 2022 11:43 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Questions: changes to the AlaskaCare Retiree Health Plan

Good morning Plan Administrator/Div. of Ret. and Benefits:

These questions address the proposed Plan amendment scheduled to take effect June 1, 2022.

While I appreciate the opportunity to comment, there is insufficient information on your website for me to effectively comment on the proposed changes. Once additional information is provided, I would like the opportunity to comment based on that information.

If I can receive the information requested below, I will be able to better understand the proposed changes. I look forward to your responses.

1. Since 2003, our Plan has stated that coverage will be provided for medical services and supplies that are "medically necessary" and that are not specifically excluded from coverage by the Plan.

According to the terms of the plan that have been in effect since 2003, prescribed medical treatment is considered “medically necessary” when it is "expected to improve or maintain health" or "to ease pain or suffering without aggravating the condition or causing other serious health problems."

The Plan also states that diagnostic procedures are medically necessary when they are "expected to provide information to determine the course of treatment without aggravating the condition or causing additional health problems."

A medical treatment will not be considered medically necessary if there is an equally effective treatment or procedure that costs less than the one prescribed.

The current medical necessity standards are clear, straightforward, and easy to understand.

What are the reasons for changing the Plan's provisions concerning "medical necessity" and how would those changes affect coverages for types of medical treatments and procedures that the Plan has covered since 2003?

2. If these proposed Plan changes are adopted, would the Aetna Clinical Policy Bulletins be used only if/when there is a good faith basis for questioning whether the prescribed medical treatment, procedure, or equipment satisfies the Plan's standards for determining medical necessity as described in my Question 1?

3. When a doctor prescribes a medical treatment, procedure, or piece of equipment that A) helps cure or control my disease or condition or ease my pain or suffering without aggravating the condition or causing other health problems; B) has no alternative that is equally effective and costs less; and C) is not subject to any plan exclusion, does the Plan Administrator nevertheless have the discretion to deny coverage on the grounds of lack of medical necessity? If so, what other factors does the claims administrator (Aetna) or the Plan Administrator (the Division) consider in exercising its discretion to determine whether a prescribed medical treatment, procedure, or equipment is medically necessary?

4. If these proposed Plan changes are adopted and a medical claim is denied because Aetna does not consider it to be "medically necessary," would the Explanation of Benefits provide a clear explanation of why the Plan administrator does not consider it to be "medically necessary?" How will that decision be transmitted? For example, would the Explanation of Benefits identify which Aetna Clinical Policy Bulletin and/or other reason was relied on by the claims administrator (TPA) or the Plan Administrator in exercising its "discretion" to deny coverage based on lack of medical necessity? If not, why not?

5. If these Plan changes are adopted and the Plan Administrator (the Division) has the discretion to decide if a prescribed medical treatment, procedure, or piece of equipment is medically necessary, and if the DRB delegates that authority to another person, what oversight will the Plan administrator exercise to ensure that the delegated individual is making correct "medically necessary" decisions?

6. Can the claims administrator (TPA) eliminate or reduce any coverages and/or other Plan benefits by changing one or more of its clinical policy bulletins to state that a prescribed medical treatment, procedure, or piece of equipment is no longer considered medically necessary? If the answer is yes, please answer these two questions:

> A) Does the claims administrator (Aetna) need to get the permission of the Plan Administrator (DRB) to make that kind of change to our Plan?
>
> B) Will the claims administrator or the Plan Administrator DRB provide Plan members notice of those changes in advance and provide an opportunity to comment? How much advance notice will we be provided and how will it be given?

7. If these Plan changes are adopted, will any new coverages or other Plan benefits be added to the Plan?

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Why does the proposed Plan section not inform Plan members of their rights to file an appeal after the deadline as allowed by 2 AAC 100(e)?

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Please tell me if the words highlighted green on that DRB webpage are the proposed amendments, whether there will be any more changes made to the draft before June 1, 2022, and, if so, whether members will have a reasonable opportunity to read and comment on any other changes before you enact the amendment.

Thank you for your consideration and response to these questions.

Nancy Wainwright

From: Dave Hunsaker
Sent: Friday, May 20, 2022 11:37 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Alaska Care Health Plan

Dear Plan Administrator/Division of Retirements and Benefits:

This is a reply to your request that AlaskaCare Plan members "*share their thoughts"* about the proposed Plan amendment scheduled to take effect June 1, 2022.

You have not provided enough information on your website necessary for retirees to understand and make informed comments and decisions about your proposed plan changes.

Please provide, as soon as possible, the answers to the following questions and requests for information. I hope your responses will help me understand the effects of your proposed plan changes on my retirement medical benefits:

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What are the reasons for changing the Plan's provisions concerning "medical necessity" and how would those changes affect coverages for types of medical treatments and procedures that the Plan has covered since 2003?

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4. If a claim for a medical benefit is denied, I think I should be given a clear explanation of the reason for the denial so I can decide whether to appeal. If these proposed Plan changes are adopted and a medical claim is denied because Aetna does not consider it to be "medically necessary," would the Explanation of

Benefits provide a clear explanation the Plan administrator does not consider it to be "medically necessary"?

Would the Explanation of Benefits tell me which Aetna Clinical Policy Bulletin and/or other reason was relied on by the claims administrator (TPA) or the Plan Administrator in exercising its "discretion" to deny coverage based on lack of medical necessity? If not, why not?

5. If these Plan changes are adopted and the Plan Administrator (the Division) has the discretion to decide if a prescribed medical treatment, procedure, or piece of equipment is medically necessary, and if the DRB delegates that authority to another person, what methods would the Plan administrator use to monitor and ensure that that person is making correct decisions?

6. Can the claims administrator (TPA) eliminate or reduce any coverages and/or other Plan benefits simply by changing one or more of its clinical policy bulletins to state that a prescribed medical treatment, procedure, or piece of equipment is no longer considered medically necessary? If the answer is yes, please answer these two questions:

A) Does the claims administrator (Aetna) need to get the permission of the Plan Administrator (DRB) to make that kind of change to our Plan?

B) Does the claims administrator or the Plan Administrator DRB have to give Plan members notice of those changes in advance? If not, why not? And if Plan members will be given advance notice, how much advance notice will we be given and how will it be given?

7. If these Plan changes are adopted, will any new coverages or other Plan benefits be added to the Plan? If so, please tell me what those are and why they were not covered or provided under the terms of the Plan as it was written in 2003.

8. If these Plan changes are adopted, would any types of medical treatments, procedures, or supplies that have been covered at any time since 2003 no longer be covered or have reduced coverage? If so, what coverages and other Plan benefits would be eliminated or reduced and why?

9. "Section 12.14.13 Third Level" states that if a Plan member "does not file a Plan Administrator appeal timely, ... the second level of appeal will be the final decision, and will be final, conclusive and binding on all persons."
This would eliminate an existing appeal right under subsection (e) of 2 AAC 35.100 of the Alaska Administrative Code. It states that a Plan member may be permitted to file a late appeal if he/she provides a reasonable explanation of extraordinary circumstances that excuse the late filing. If the DRB then rejects the explanation for the late filing, the regulation also requires the DRB to notify the Plan member of his or her right to appeal the decision to reject the late-filed claim. It states:

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extraordinary circumstances excusing the untimeliness under (d) of this section, the person may file a new notice of appeal within 30 days of the date that the person receives notice of the decision refusing to accept the untimely first appeal.

Why does the proposed Plan section not inform Plan members of their rights to file an appeal after the deadline as allowed by 2 AAC 100(e)?

10. The document containing the proposed Plan amendment on the DRB website states that it is a "draft" and that it would be effective on June 1, 2022.

Please tell me if the words highlighted green on that DRB webpage are the proposed amendments, whether there will be any more changes made to the draft before June 1, 2022, and, if so, whether we retirees will have a reasonable opportunity to read and comment on any other changes before you enact the amendment and, if so, that will be provided.

I look forward to receiving the answers and information I have requested.

Thank you,

Dave Hunsaker

From: Annie Calkins
Sent: Friday, May 20, 2022 11:28 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Questions Concerning the Proposed Changes to AlaskaCare Retiree Health Plan

Dear Plan Administrator/Division of Retirements and Benefits:

This is a reply to your request that AlaskaCare Plan members "*share their thoughts"* about the proposed Plan amendment scheduled to take effect June 1, 2022.

You have not provided enough information on your website necessary for retirees to understand and make informed comments and decisions about your proposed plan changes.

Please provide, as soon as possible, the answers to the following questions and requests for information. I hope your responses will help me understand the effects of your proposed plan changes on my retirement medical benefits:

1. Since 2003, our Plan has stated that coverage will be provided for medical services and supplies that are "medically necessary" and that are not specifically excluded from coverage by the Plan.

According to the terms of the plan that have been in effect since 2003, prescribed medical treatment is considered "medically necessary" when it is "expected to improve or maintain health" or "to ease pain or suffering without aggravating the condition or causing other serious health problems."

The Plan also states that diagnostic procedures are medically necessary when they are "expected to provide information to determine the course of treatment without aggravating the condition or causing additional health problems."

A medical treatment will not be considered medically necessary if there is an equally effective treatment or procedure that costs less than the one prescribed.

These standards of medical necessity are clear, straightforward, and easy to understand.

What are the reasons for changing the Plan's provisions concerning "medical necessity" and how would those changes affect coverages for types of medical treatments and procedures that the Plan has covered since 2003?

2. If these proposed Plan changes are adopted, would the Aetna Clinical Policy Bulletins be used only if/when there is a good faith basis for questioning whether the prescribed medical treatment, procedure, or equipment satisfies the Plan's standards for determining medical necessity as described in my Question 1?

3. When my doctor prescribes a medical treatment, procedure, or piece of equipment that A) helps cure or control my disease or condition or ease my pain or suffering without aggravating the condition or causing other health problems; B) has no alternative that is equally effective and costs less; and C) is not subject to any plan exclusion, does the Plan Administrator still have the discretion to deny coverage on the grounds of lack of medical necessity? If so, what other factors does the claims administrator (Aetna) or the Plan Administrator (the Division) consider in exercising its discretion whether a prescribed medical treatment, procedure, or equipment is medically necessary?

4. If a claim for a medical benefit is denied, I think I should be given a clear explanation of the reason for the denial so I can decide whether to appeal. If these proposed Plan changes are adopted and a medical claim is denied because Aetna does not consider it to be "medically necessary," would the Explanation of Benefits provide a clear explanation the Plan administrator does not consider it to be "medically necessary"?

Would the Explanation of Benefits tell me which Aetna Clinical Policy Bulletin and/or other reason was relied on by the claims administrator (TPA) or the Plan Administrator in exercising its "discretion" to deny coverage based on lack of medical necessity? If not, why not?

5. If these Plan changes are adopted and the Plan Administrator (the Division) has the discretion to decide if a prescribed medical treatment, procedure, or piece of equipment is medically necessary, and if the DRB delegates that authority to another person, what methods would the Plan administrator use to monitor and ensure that that person is making correct decisions?

6. Can the claims administrator (TPA) eliminate or reduce any coverages and/or other Plan benefits simply by changing one or more of its clinical policy bulletins to state that a prescribed medical treatment,

procedure, or piece of equipment is no longer considered medically necessary? If the answer is yes, please answer these two questions:

A) Does the claims administrator (Aetna) need to get the permission of the Plan Administrator (DRB) to make that kind of change to our Plan?

B) Does the claims administrator or the Plan Administrator DRB have to give Plan members notice of those changes in advance? If not, why not? And if Plan members will be given advance notice, how much advance notice will we be given and how will it be given?

7. If these Plan changes are adopted, **will any new coverages or other Plan benefits be added to the Plan?** If so, please tell me what those are and why they were not covered or provided under the terms of the Plan as it was written in 2003.

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Why does the proposed Plan section not inform Plan members of their rights to file an appeal after the deadline as allowed by 2 AAC 100(e)?

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Please tell me if the words highlighted green on that DRB webpage are the proposed amendments, whether there will be any more changes made to the draft before June 1, 2022, and, if so, whether we retirees will have a reasonable opportunity to read and comment on any other changes before you enact the amendment and, if so, that will be provided.

I look forward to receiving the answers and information I have requested.

Thank you.
Annie Calkins

From: Beth Kerttula
Sent: Friday, May 20, 2022 11:19 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Cc: Jim Powell
Subject: Seeking answers to your Plan Amendment

Dear Plan Administrator/Div. of Ret. and Benefits:

This is a reply to your request that AlaskaCare Plan members “share their thoughts” about the proposed Plan amendment scheduled to take effect June 1, 2022.

You have not provided enough information on your website necessary for retirees to understand and make informed comments and decisions about your proposed plan changes.

Please provide, as soon as possible, the answers to the following questions and requests for information. I hope your responses will help me understand the effects of your proposed plan changes on my retirement medical benefits:

1. Since 2003, our Plan has stated that coverage will be provided for medical services and supplies that are "medically necessary" and that are not specifically excluded from coverage by the Plan.

According to the terms of the plan that have been in effect since 2003, prescribed medical treatment is considered “medically necessary” when it is "expected to improve or maintain health" or "to ease pain or suffering without aggravating the condition or causing other serious health problems."

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What are the reasons for changing the Plan's provisions concerning "medical necessity" and how would those changes affect coverages for types of medical treatments and procedures that the Plan has covered since 2003?

2. If these proposed Plan changes are adopted, would the Aetna Clinical Policy Bulletins be used only if/when there is a good faith basis for questioning whether the prescribed medical treatment, procedure, or equipment satisfies the Plan's standards for determining medical necessity as described in my Question 1?

3. When my doctor prescribes a medical treatment, procedure, or piece of equipment that A) helps cure or control my disease or condition or ease my pain or suffering without aggravating the condition or causing other health problems; B) has no alternative that is equally effective and costs less; and C) is not subject to any plan exclusion, does the Plan Administrator still have the discretion to deny coverage on the grounds of lack of medical necessity? If so, what other factors does the claims administrator (Aetna) or the Plan Administrator (the Division) consider in exercising its discretion whether a prescribed medical treatment, procedure, or equipment is medically necessary?

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Would the Explanation of Benefits tell me which Aetna Clinical Policy Bulletin and/or other reason was relied on by the claims administrator (TPA) or the Plan Administrator in exercising its "discretion" to deny coverage based on lack of medical necessity? If not, why not?

5. If these Plan changes are adopted and the Plan Administrator (the Division) has the discretion to decide if a prescribed medical treatment, procedure, or piece of equipment is medically necessary, and if the DRB delegates that authority to another person, what methods would the Plan administrator use to monitor and ensure that that person is making correct decisions?

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Why does the proposed Plan section not inform Plan members of their rights to file an appeal after the deadline as allowed by 2 AAC 100(e)?

10. The document containing the proposed Plan amendment on the DRB website states that it is a "draft" and that it would be effective on June 1, 2022.

Please tell me if the words highlighted green on that DRB webpage are the proposed amendments, whether there will be any more changes made to the draft before June 1, 2022, and, if so, whether we will have a reasonable opportunity to read and comment on any other changes before you enact the amendment and, if so, that will be provided.

We look forward to receiving the and information We have requested.

Thank you,
Elizabeth J. Kerttula
James E. Powell

From: Go Fish
Sent: Friday, May 20, 2022 10:29 AM

To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Questions re proposed changes to the AlaskaCare Retiree Health Plan

Dear Plan Administrator/Div. Of Retirement and Benefits,

Please see my thoughts and questions below regarding changes DRB is proposing with their Amendment to Tier I retiree health.

I don't feel enough transparency has been shown to retirees to make changes at this point.

We know nothing about the reasons for the and, more to the point, the actual effects on benefits.

The DRB states that it needs to "modernize" the Plan to make it consistent with "mainstream" public employee health plans around the country. That is doublespeak for the DRB wanting to turn the Alaska Plan from the comparatively excellent Plan it was until 2014 to probably the quality of average or below average plans of other states that are arguable at the shallow end of the "mainstream.".

For those of us who are covered by Medicare, the Plan provides supplemental coverage. But that coverage can be VERY important to those of us who are unfortunate enough to develop a serious illness and need expensive diagnostic procedures and treatments not fully covered by Medicare.

I implore the DRB to provide complete, candid and understandable answers, such that retirees will learn the reasons why the changes are being made and, more importantly, how our medical benefits will be affected (i.e., reduced).

Your website does not provide enough information to know how our retirement medical benefits will be affected.

Retirees are already in the midst of a financial crisis with the state of the economy and rising costs to live in Alaska. Please do not further increase that burden to me and my family. It would be detrimental to our financial budget. We would need to consider if living in Alaska would be viable if our healthcare rights are diminished. These changes/reductions will greatly impact me, my husband and son in college.

The Alaska Constitution contains a separate section devoted solely and specifically to stating that the accrued retirement benefits of public employees of Alaska "shall not be diminished or impaired." That is a constitutional command, promise, and guarantee.

You have not provided enough information on your website necessary for retirees to understand and make informed comments and decisions about your proposed plan changes.

Please provide, as soon as possible, the answers to the following questions and requests for information. I hope your responses will help me understand the effects of your proposed plan changes on my retirement medical benefits:

1. Since 2003, our Plan has stated that coverage will be provided for medical services and supplies that are "medically necessary" and that are not specifically excluded from coverage by the Plan.

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Please tell me if the words highlighted green on that DRB webpage are the proposed amendments, whether there will be any more changes made to the draft before June 1, 2022, and, if so, whether we will have a reasonable opportunity to read and comment on any other changes before you enact the amendment and, if so, that will be provided.

Since healthcare and diagnostic testing in Alaska is already cost prohibitive as compared with the same services provided by Doctors, labs, facilities in the Lower 48, I would suggest that an alternative and cheaper method would be to allow members a reasonable accommodation to go South for comparable healthcare services with an allowance for travel and lodging.

I look forward to receiving the answers and information I have requested.

Thank you.
Debby, Paul and Niko Tomaro

From: Linda Wild
Sent: Friday, May 20, 2022 10:25 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Subject: Questions re proposed changes to the AlaskaCare Retiree Health Plan
Dear Plan Administrator/Div. of Ret. and Benefits:
This is a reply to your request that AlaskaCare Plan members “share their thoughts” about the proposed Plan amendment scheduled to take effect June 1, 2022.

You have not provided enough information on your website necessary for retirees to understand and make informed comments and decisions about your proposed plan changes.

Please provide, as soon as possible, the answers to the following questions and requests for information. I hope your responses will help me understand the effects of your proposed plan changes on my retirement medical benefits:

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I look forward to receiving the answers and information I have requested.

Thank you.

From: daniel deroux
Sent: Friday, May 20, 2022 9:54 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: planned changes to plan

Dear Plan Administrator/Div. of Ret. and Benefits:

This is a reply to your request that AlaskaCare Plan members “share their thoughts” about the proposed Plan amendment scheduled to take effect June 1, 2022.

You have not provided enough information on your website necessary for retirees to understand and make informed comments and decisions about your proposed plan changes.

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3. When my doctor prescribes a medical treatment, procedure, or piece of equipment that A) helps cure or control my disease or condition or ease my pain or suffering without aggravating the condition or causing other health problems; B) has no alternative that is equally effective and costs less; and C) is not subject to any plan exclusion, does the Plan Administrator still have the discretion to deny coverage on the grounds of lack of medical necessity? If so, what other factors does the claims administrator (Aetna) or the Plan Administrator (the Division) consider in exercising its discretion whether a prescribed medical treatment, procedure, or equipment is medically necessary?

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Would the Explanation of Benefits tell me which Aetna Clinical Policy Bulletin and/or other reason was relied on by the claims administrator (TPA) or the Plan Administrator in exercising its "discretion" to deny coverage based on lack of medical necessity? If not, why not?

5. If these Plan changes are adopted and the Plan Administrator (the Division) has the discretion to decide if a prescribed medical treatment, procedure, or piece of equipment is medically necessary, and if the DRB delegates that authority to another person, what methods would the Plan administrator use to monitor and ensure that that person is making correct decisions?

6. Can the claims administrator (TPA) eliminate or reduce any coverages and/or other Plan benefits simply by changing one or more of its clinical policy bulletins to state that a prescribed medical treatment, procedure, or piece of equipment is no longer considered medically necessary? If the answer is yes, please answer these two questions:

A) Does the claims administrator (Aetna) need to get the permission of the Plan Administrator (DRB) to make that kind of change to our Plan?

B) Does the claims administrator or the Plan Administrator DRB have to give Plan members notice of those changes in advance? If not, why not? And if Plan members will be given advance notice, how much advance notice will we be given and how will it be given?

7. If these Plan changes are adopted, will any new coverages or other Plan benefits be added to the Plan? If so, please tell me what those are and why they were not covered or provided under the terms of the Plan as it was written in 2003.

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9. "Section 12.14.13 Third Level" states that if a Plan member "does not file a Plan Administrator appeal timely, ... the second level of appeal will be the final decision, and will be final, conclusive and binding on all persons."

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Why does the proposed Plan section not inform Plan members of their rights to file an appeal after the deadline as allowed by 2 AAC 100(e)?

10. The document containing the proposed Plan amendment on the DRB website states that it is a "draft" and that it would be effective on June 1, 2022.

Please tell me if the words highlighted green on that DRB webpage are the proposed amendments, whether there will be any more changes made to the draft before June 1, 2022, and, if so, whether we will have a reasonable opportunity to read and comment on any other changes before you enact the amendment and, if so, that will be provided.

I look forward to receiving the answers and information I have requested.

Thank you.
Daniel DeRoux

From: Mary Manning
Sent: Friday, May 20, 2022 9:16 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Questions re proposed changes to the AlaskaCare Retiree Health Plan

Dear Plan Administrator/Div. of Ret. and Benefits:

I am sending this email due the request that AlaskaCare Plan members “share their thoughts” about the proposed Plan amendment scheduled to take effect June 1, 2022. I am greatly concerned because I believe that the State Division of Retirement & Benefits has neglected to provide sufficient information necessary, either on your website or in any other format, to enable retirees to understand and make informed comments and decisions about proposed plan changes.

Please provide, as soon as possible, the answers to the following questions and requests for information so that I may better understand the impact that your proposed plan changes will have on my retirement medical benefits:

1. Since 2003, our Plan has stated that coverage will be provided for medical services and supplies that are "medically necessary" and that are not specifically excluded from coverage by the Plan.

According to the terms of the plan that have been in effect since 2003, prescribed medical treatment is considered “medically necessary” when it is "expected to improve or maintain health" or "to ease pain or suffering without aggravating the condition or causing other serious health problems."

The Plan also states that diagnostic procedures are medically necessary when they are "expected to provide information to determine the course of treatment without aggravating the condition or causing additional health problems."

A medical treatment will not be considered medically necessary if there is an equally effective treatment or procedure that costs less than the one prescribed.

These standards of medical necessity are clear, straightforward, and easy to understand.

What are the reasons for changing the Plan's provisions concerning "medical necessity" and how would those changes affect coverages for types of medical treatments and procedures that the Plan has covered since 2003?

2. If these proposed Plan changes are adopted, would the Aetna Clinical Policy Bulletins be used only if/when there is a good faith basis for questioning whether the prescribed medical treatment, procedure, or equipment satisfies the Plan's standards for determining medical necessity as described in my Question 1?

3. When my doctor prescribes a medical treatment, procedure, or piece of equipment that A) helps cure or control my disease or condition or ease my pain or suffering without aggravating the condition or causing other health problems; B) has no alternative that is equally effective and costs less; and C) is not subject to any plan exclusion, does the Plan Administrator still have the discretion to deny coverage on the grounds of lack of medical necessity? If so, what other factors does the claims administrator (Aetna) or the Plan Administrator (the Division) consider in exercising its discretion whether a prescribed medical treatment, procedure, or equipment is medically necessary?

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Would the Explanation of Benefits tell me which Aetna Clinical Policy Bulletin and/or other reason was relied on by the claims administrator (TPA) or the Plan Administrator in exercising its "discretion" to deny coverage based on lack of medical necessity? If not, why not?

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Why does the proposed Plan section not inform Plan members of their rights to file an appeal after the deadline as allowed by 2 AAC 100(e)?

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Please tell me if the words highlighted green on that DRB webpage are the proposed amendments, whether there will be any more changes made to the draft before June 1, 2022, and, if so, whether we will have a reasonable opportunity to read and comment on any other changes before you enact the amendment and, if so, that will be provided.

I am extremely concerned and look forward to receiving the answers and information I have requested.

Thank you,
Mary Manning

From: Karen Peska
Sent: Friday, May 20, 2022 9:01 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Fwd: Subject: Questions re proposed changes to the AlaskaCare Retiree Health Plan

Dear Plan Administrator/Div. of Ret. and Benefits:

This is a reply to your request that AlaskaCare Plan members “share their thoughts” about the proposed Plan amendment scheduled to take effect June 1, 2022.

You have not provided enough information on your website necessary for retirees to understand and make informed comments and decisions about your proposed plan changes.

Please provide, as soon as possible, the answers to the following questions and requests for information. I hope your responses will help me understand the effects of your proposed plan changes on my retirement medical benefits:

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I look forward to receiving the answers and information I have requested.

Thank you,

Karen Peska

From: Garrey Peska
Sent: Friday, May 20, 2022 8:53 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Re: Subject: Questions re proposed changes to the AlaskaCare Retiree Health Plan

Dear Plan Administrator/Division of Retirement & Benefits:
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I look forward to receiving the answers and information I have requested.

Thank you,
Garrey Peska
[redacted]

From: Kent Dawson
Sent: Friday, May 20, 2022 8:47 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Cc: jennylyndawson
Subject: Proposed Changes AlaskaCare Retiree Health Plan

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We look forward to receiving the answers and information that we have requested.

Thank you.

Van Kent Dawson
Jenny L Dawson

From: maryanne slemmons
Sent: Friday, May 20, 2022 8:02 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Questions re proposed changes to the AlaskaCare Retiree Health Plan

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3. When my doctor prescribes a medical treatment, procedure, or piece of equipment that A) helps cure or control my disease or condition or ease my pain or suffering without aggravating the condition or causing other health problems; B) has no alternative that is equally effective and costs less; and C) is not subject to any plan exclusion, does the Plan Administrator still have the discretion to deny coverage on the grounds of lack of medical necessity? If so, what other factors does the claims administrator (Aetna) or the Plan Administrator (the Division) consider in exercising its discretion whether a prescribed medical treatment, procedure, or equipment is medically necessary?

4. If a claim for a medical benefit is denied, I think I should be given a clear explanation of the reason for the denial so I can decide whether to appeal. If these proposed Plan changes are adopted and a medical claim is denied because Aetna does not consider it to be "medically necessary," would the Explanation of Benefits provide a clear explanation the Plan administrator does not consider it to be "medically necessary"?

Would the Explanation of Benefits tell me which Aetna Clinical Policy Bulletin and/or other reason was relied on by the claims administrator (TPA) or the Plan Administrator in exercising its "discretion" to deny coverage based on lack of medical necessity? If not, why not?

5. If these Plan changes are adopted and the Plan Administrator (the Division) has the discretion to decide if a prescribed medical treatment, procedure, or piece of equipment is medically necessary, and if the DRB delegates that authority to another person, what methods would the Plan administrator use to monitor and ensure that that person is making correct decisions?

6. Can the claims administrator (TPA) eliminate or reduce any coverages and/or other Plan benefits simply by changing one or more of its clinical policy bulletins to state that a prescribed medical treatment,

procedure, or piece of equipment is no longer considered medically necessary? If the answer is yes, please answer these two questions:

A) Does the claims administrator (Aetna) need to get the permission of the Plan Administrator (DRB) to make that kind of change to our Plan?

B) Does the claims administrator or the Plan Administrator DRB have to give Plan members notice of those changes in advance? If not, why not? And if Plan members will be given advance notice, how much advance notice will we be given and how will it be given?

7. If these Plan changes are adopted, will any new coverages or other Plan benefits be added to the Plan? If so, please tell me what those are and why they were not covered or provided under the terms of the Plan as it was written in 2003.

8. If these Plan changes are adopted, would any types of medical treatments, procedures, or supplies that have been covered at any time since 2003 no longer be covered or have reduced coverage? If so, what coverages and other Plan benefits would be eliminated or reduced and why?

9. "Section 12.14.13 Third Level" states that if a Plan member "does not file a Plan Administrator appeal timely, ... the second level of appeal will be the final decision, and will be final, conclusive and binding on all persons."
This would eliminate an existing appeal right under subsection (e) of 2 AAC 35.100 of the Alaska Administrative Code. It states that a Plan member may be permitted to file a late appeal if he/she provides a reasonable explanation of extraordinary circumstances that excuse the late filing. If the DRB then rejects the explanation for the late filing, the regulation also requires the DRB to notify the Plan member of his or her right to appeal the decision to reject the late-filed claim. It states:

The division shall return the notice of appeal to the person, and inform the person that the person may resubmit the notice with an explanation of why it was not timely filed. If the person resubmits the notice of appeal with an explanation or if the original untimely notice of appeal contained an explanation of untimeliness, and the administrator in either situation found that the explanation did not establish extraordinary circumstances excusing the untimeliness under (d) of this section, the person may file a new notice of appeal within 30 days of the date that the person receives notice of the decision refusing to accept the untimely first appeal.

Why does the proposed Plan section not inform Plan members of their rights to file an appeal after the deadline as allowed by 2 AAC 100(e)?

10. The document containing the proposed Plan amendment on the DRB website states that it is a "draft" and that it would be effective on June 1, 2022.

Please tell me if the words highlighted green on that DRB webpage are the proposed amendments, whether there will be any more changes made to the draft before June 1, 2022, and, if so, whether we will have a reasonable opportunity to read and comment on any other changes before you enact the amendment and, if so, that will be provided.

I look forward to receiving the answers and information I have requested.

Thank you.
Mary Anne Slemmons

From: DOUGLAS MERTZ
Sent: Thursday, May 19, 2022 10:27 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Changes to AlaskaCare Retiree Health Plan

Dear Plan Administrator/Div. of Ret. and Benefits:

This is a reply to your request that AlaskaCare Plan members "share their thoughts" about the proposed Plan amendment scheduled to take effect June 1, 2022. I am a tier one retiree, dependent on the plan remaining substantially unchanged.

You have not provided enough information on your website necessary for retirees to understand and make informed comments and decisions about your proposed plan changes.

Please provide, as soon as possible, the answers to the following questions and requests for information. I hope your responses will help me understand the effects of your proposed plan changes on my retirement medical benefits:

1. Since 2003, our Plan has stated that coverage will be provided for medical services and supplies that are "medically necessary" and that are not specifically excluded from coverage by the Plan.

According to the terms of the plan that have been in effect since 2003, prescribed medical treatment is considered "medically necessary" when it is "expected to improve or maintain health" or "to ease pain or suffering without aggravating the condition or causing other serious health problems."

The Plan also states that diagnostic procedures are medically necessary when they are "expected to provide information to determine the course of treatment without aggravating the condition or causing additional health problems."

A medical treatment will not be considered medically necessary if there is an equally effective treatment or procedure that costs less than the one prescribed.

These standards of medical necessity are clear, straightforward, and easy to understand.

What are the reasons for changing the Plan's provisions concerning "medical necessity" and how would those changes affect coverages for types of medical treatments and procedures that the Plan has covered since 2003?

2. If these proposed Plan changes are adopted, would the Aetna Clinical Policy Bulletins be used only if/when there is a good faith basis for questioning whether the prescribed medical treatment, procedure, or equipment satisfies the Plan's standards for determining medical necessity as described in my Question 1?

3. When my doctor prescribes a medical treatment, procedure, or piece of equipment that A) helps cure or control my disease or condition or ease my pain or suffering without aggravating the condition or causing other health problems; B) has no alternative that is equally effective and costs less; and C) is not subject to any plan exclusion, does the Plan Administrator still have the discretion to deny coverage on the grounds of lack of medical necessity? If so, what other factors does the claims administrator (Aetna) or the Plan Administrator (the Division) consider in exercising its discretion whether a prescribed medical treatment, procedure, or equipment is medically necessary?

4. If a claim for a medical benefit is denied, I think I should be given a clear explanation of the reason for the denial so I can decide whether to appeal. If these proposed Plan changes are adopted and a medical claim is denied because Aetna does not consider it to be "medically necessary," would the Explanation of Benefits provide a clear explanation the Plan administrator does not consider it to be "medically necessary"?

Would the Explanation of Benefits tell me which Aetna Clinical Policy Bulletin and/or other reason was relied on by the claims administrator (TPA) or the Plan Administrator in exercising its "discretion" to deny coverage based on lack of medical necessity? If not, why not?

5. If these Plan changes are adopted and the Plan Administrator (the Division) has the discretion to decide if a prescribed medical treatment, procedure, or piece of equipment is medically necessary, and if the DRB delegates that authority to another person, what methods would the Plan administrator use to monitor and ensure that that person is making correct decisions?

6. Can the claims administrator (TPA) eliminate or reduce any coverages and/or other Plan benefits simply by changing one or more of its clinical policy bulletins to state that a prescribed medical treatment, procedure, or piece of equipment is no longer considered medically necessary? If the answer is yes, please answer these two questions:

> A) Does the claims administrator (Aetna) need to get the permission of the Plan Administrator (DRB) to make that kind of change to our Plan?
>
> B) Does the claims administrator or the Plan Administrator DRB have to give Plan members notice of those changes in advance? If not, why not? And if Plan members will be given advance notice, how much advance notice will we be given and how will it be given?

7. If these Plan changes are adopted, will any new coverages or other Plan benefits be added to the Plan? If so, please tell me what those are and why they were not covered or provided under the terms of the Plan as it was written in 2003.

8. If these Plan changes are adopted, would any types of medical treatments, procedures, or supplies that have been covered at any time since 2003 no longer be covered or have reduced coverage? If so, what coverages and other Plan benefits would be eliminated or reduced and why?

9. "Section 12.14.13 Third Level" states that if a Plan member "does not file a Plan Administrator appeal timely, ... the second level of appeal will be the final decision, and will be final, conclusive and binding on all persons."
This would eliminate an existing appeal right under subsection (e) of 2 AAC 35.100 of the Alaska Administrative Code. It states that a Plan member may be permitted to file a late appeal if he/she provides a reasonable explanation of extraordinary circumstances that excuse the late filing. If the DRB then rejects the explanation for the late filing, the regulation also requires the DRB to notify the Plan member of his or her right to appeal the decision to reject the late-filed claim. It states:

The division shall return the notice of appeal to the person, and inform the person that the person may resubmit the notice with an explanation of why it was not timely filed. If the person resubmits the notice of appeal with an explanation or if the original untimely notice of appeal contained an explanation of untimeliness, and the administrator in either situation found that the explanation did not establish extraordinary circumstances excusing the untimeliness under (d) of this section, the person may file a new notice of appeal within 30 days of the date that the person receives notice of the decision refusing to accept the untimely first appeal.

Why does the proposed Plan section not inform Plan members of their rights to file an appeal after the deadline as allowed by 2 AAC 100(e)?

10. I question whether DRB has provided reasonable notice to retirees of these proposed changes. I have not received any notice that would indicate a substantial change, and zero explanations of the changes and how they would affect me. This goes contrary to the terms of the settlement of the recent litigation and is inconsistent with the trust duty you owe to plan beneficiaries. So, my question is, what does the Division intend to do to provide proper notice, full explanation, and full opportunity for informed comment?

11. The document containing the proposed Plan amendment on the DRB website states that it is a "draft" and that it would be effective on June 1, 2022.

Please tell me if the words highlighted green on that DRB webpage are the proposed amendments, whether there will be any more changes made to the draft before June 1, 2022, and, if so, whether we will have a reasonable opportunity to read and comment on any other changes before you enact the amendment and, if so, that will be provided.

I look forward to receiving the answers and information I have requested.

Thank you.

From: John Harman
Sent: Thursday, May 19, 2022 4:30 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Plan Changes

Dear Plan Administrator/Div. of Ret. and Benefits:

This is a reply to your request that AlaskaCare Plan members “share their thoughts” about the proposed Plan amendment scheduled to take effect June 1, 2022.

You have not provided enough information on your website necessary for retirees to understand and make informed comments and decisions about your proposed plan changes.

Please provide, as soon as possible, the answers to the following questions and requests for information. I hope your responses will help me understand the effects of your proposed plan changes on my retirement medical benefits:

1. Since 2003, our Plan has stated that coverage will be provided for medical services and supplies that are "medically necessary" and that are not specifically excluded from coverage by the Plan.

According to the terms of the plan that have been in effect since 2003, a prescribed medical treatment is considered “medically necessary” when it is "expected to improve or maintain health" or "to ease pain or suffering without aggravating the condition or causing other serious health problems."

The Plan also states that diagnostic procedures are medically necessary when they are "expected to provide information to determine the course of treatment without aggravating the condition or causing additional health problems."

A medical treatment will not be considered medically necessary if there is an equally effective treatment or procedure that costs less than the one prescribed.

These standards of medical necessity are clear and easy to understand.

What are the reasons for changing the Plan's provisions concerning "medical necessity" and how would those changes affect coverages for types of medical treatments and procedures that the Plan has covered since 2003?

2. If these proposed Plan changes are adopted, would the Aetna Clinical Policy Bulletins be used only if/when there is a good faith basis for questioning whether the prescribed medical treatment, procedure or equipment satisfies the Plan's standards for determining medical necessity as described in my Question 1?

3. When my doctor prescribes a medical treatment, procedure or piece of equipment for a disease or medical condition that A) helps cure or control my disease or condition or ease my pain or suffering

without aggravating the condition or causing other health problems; B) has no alternative that is equally effective and costs less; and C) is not subject to any plan exclusion, does the Plan Administrator still have the discretion to deny coverage on the grounds of lack of medical necessity? If so, what other factors does the claims administrator (Aetna) or the Plan Administrator (the Division) consider in exercising its discretion whether a prescribed medical treatment, procedure or equipment is medically necessary?

4. If a claim for a medical benefit is denied, I think I should be given a clear explanation of the reason for the denial so I can decide whether to appeal. If these proposed Plan changes are adopted and a medical claim is denied based on lack of medical necessity, would the Explanation of Benefits provide a clear explanation why the claim was denied?

Would the Explanation of Benefits tell me which Aetna Clinical Policy Bulletin and/or other reason was relied on by the claims administrator (TPA) or the Plan Administrator in exercising its "discretion" to deny coverage based on lack of medical necessity? If not, why not?

5. If these Plan changes are adopted and the Plan Administrator (the Division) has the discretion to decide if a prescribed medical treatment, procedure or piece of equipment is medically necessary, and if the DRB delegates that authority to another person, what methods would the Plan administrator use to monitor and ensure that that person is making correct decisions?

6. Can the claims administrator (TPA) eliminate or reduce any coverages and/or other Plan benefits simply by changing one or more of its clinical policy bulletins to state that a prescribed medical treatment, procedure or piece of equipment is no longer considered medically necessary? If the answer is yes, please answer these two questions:
A) Does the claims administrator (Aetna) need to get the permission of the Plan Administrator to make that kind of change to our Plan?

B) Does the claims administrator or the Plan Administrator DRB have to give Plan members notice of the change in advance? IF not, why not? And if Plan members will be given advance notice, how much advance notice will we be given and how will it be given?

7. If these Plan changes are adopted, will any new coverages or other Plan benefits be added to the Plan? If so, please tell me what those are and why they were not now covered or provided under the terms of the current Plan.

8. If these Plan changes are adopted, would any types of medical treatments, procedures or supplies that have been covered at any time since 2003 no longer be covered or have reduced coverage? If so, what coverages and other Plan benefits would be eliminated or reduced and why?

9. "Section 12.14.13 Third Level" states that if a Plan member "does not file a Plan Administrator appeal timely, ... the second level of appeal will be the final decision, and will be final, conclusive and binding on all persons."

This conflicts with subsection (e) of 2 AAC 35.100 of the Alaska Administrative Code. It states that a Plan member may be permitted to file a late appeal if he/she provides a reasonable explanation of extraordinary circumstances that excuse late-filing. It also requires the DRB to notify the Plan member of his or her right to appeal the denial of the late-filed claim. It states:

The division shall return the notice of appeal to the person, and inform the person that the person may resubmit the notice with an explanation of why it was not timely filed. If the person resubmits the notice of appeal with an explanation or if the original untimely notice of appeal contained an explanation of untimeliness, and the administrator in either situation found that the explanation did not establish extraordinary circumstances excusing the untimeliness under (d) of this section, the person may file a new notice of appeal within 30 days of the date that the person receives notice of the decision refusing to accept the untimely first appeal.

Why does that Plan section not inform Plan members of their rights to file an appeal after the deadline as allowed by 2 AAC 100(e)?

10. The document containing the proposed Plan amendment on the DRB website states that it is a "draft" and that it would be effective on June 1, 2022.

Please tell me if the words highlighted green on that page are the proposed amendments, whether there will be any more changes made to the draft before June 1, 2022 and, if so, whether we will have a reasonable opportunity to read and comment on any other changes before you enact the amendment and, if so, that will be provided.

I look forward to receiving the answers and information I have requested.

Thank you
John Harman Jr
Tier 1 Retiree

From: Lynda Giguere
Sent: Thursday, May 19, 2022 4:27 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: DRB Retiree Plan Amendment

This is a reply to your request that AlaskaCare Plan members “share their thoughts” about the proposed Plan amendment scheduled to take effect June 1, 2022. This has only come to my attention today. (Did the Division send a notice to retirees receiving benefits? If so, I do not recall seeing anything.)

You have not provided enough information on your website necessary for retirees to understand and make informed comments and decisions about your proposed plan changes.

Please provide, as soon as possible, the answers to the following questions and requests for information. I hope your responses will help me understand the effects of your proposed plan changes on my retirement medical benefits:

1. Since 2003, our Plan has stated that coverage will be provided for medical services and supplies that are "medically necessary" and that are not specifically excluded from coverage by the Plan.

According to the terms of the plan that have been in effect since 2003, prescribed medical treatment is considered “medically necessary” when it is "expected to improve or maintain health" or "to ease pain or suffering without aggravating the condition or causing other serious health problems."

The Plan also states that diagnostic procedures are medically necessary when they are "expected to provide information to determine the course of treatment without aggravating the condition or causing additional health problems."

A medical treatment will not be considered medically necessary if there is an equally effective treatment or procedure that costs less than the one prescribed.

These standards of medical necessity are clear, straightforward, and easy to understand.

What are the reasons for changing the Plan's provisions concerning "medical necessity" and how would those changes affect coverages for types of medical treatments and procedures that the Plan has covered since 2003?

2. If these proposed Plan changes are adopted, would the Aetna Clinical Policy Bulletins be used only if/when there is a good faith basis for questioning whether the prescribed medical treatment, procedure, or equipment satisfies the Plan's standards for determining medical necessity as described in my Question 1?

3. When my doctor prescribes a medical treatment, procedure, or piece of equipment that A) helps cure or control my disease or condition or ease my pain or suffering without aggravating the condition or causing other health problems; B) has no alternative that is equally effective and costs less; and C) is not subject to any plan exclusion, does the Plan Administrator still have the discretion to deny coverage on the grounds of lack of medical necessity? If so, what other factors does the claims administrator (Aetna) or the Plan Administrator (the Division) consider in exercising its discretion whether a prescribed medical treatment, procedure, or equipment is medically necessary?

4. If a claim for a medical benefit is denied, I think I should be given a clear explanation of the reason for the denial so I can decide whether to appeal. If these proposed Plan changes are adopted and a medical claim is denied because Aetna does not consider it to be "medically necessary," would the Explanation of Benefits provide a clear explanation the Plan administrator does not consider it to be "medically necessary"?

Would the Explanation of Benefits tell me which Aetna Clinical Policy Bulletin and/or other reason was relied on by the claims administrator (TPA) or the Plan Administrator in exercising its "discretion" to deny coverage based on lack of medical necessity? If not, why not?

5. If these Plan changes are adopted and the Plan Administrator (the Division) has the discretion to decide if a prescribed medical treatment, procedure, or piece of equipment is medically necessary, and if the DRB delegates that authority to another person, what methods would the Plan administrator use to monitor and ensure that that person is making correct decisions?

6. Can the claims administrator (TPA) eliminate or reduce any coverages and/or other Plan benefits simply by changing one or more of its clinical policy bulletins to state that a prescribed medical treatment, procedure, or piece of equipment is no longer considered medically necessary? If the answer is yes, please answer these two questions:

A) Does the claims administrator (Aetna) need to get the permission of the Plan Administrator (DRB) to make that kind of change to our Plan?

B) Does the claims administrator or the Plan Administrator DRB have to give Plan members notice of those changes in advance? If not, why not? And if Plan members will be given advance notice, how much advance notice will we be given and how will it be given?

7. If these Plan changes are adopted, will any new coverages or other Plan benefits be added to the Plan? If so, please tell me what those are and why they were not covered or provided under the terms of the Plan as it was written in 2003.

8. If these Plan changes are adopted, would any types of medical treatments, procedures, or supplies that have been covered at any time since 2003 no longer be covered or have reduced coverage? If so, what coverages and other Plan benefits would be eliminated or reduced and why?

9. "Section 12.14.13 Third Level" states that if a Plan member "does not file a Plan Administrator appeal timely, ... the second level of appeal will be the final decision, and will be final, conclusive and binding on all persons."

This would eliminate an existing appeal right under subsection (e) of 2 AAC 35.100 of the Alaska Administrative Code. It states that a Plan member may be permitted to file a late appeal if he/she provides a reasonable explanation of extraordinary circumstances that excuse the late filing. If the DRB then rejects the explanation for the late filing, the regulation also requires the DRB to notify the Plan member of his or her right to appeal the decision to reject the late-filed claim. It states:

The division shall return the notice of appeal to the person, and inform the person that the person may resubmit the notice with an explanation of why it was not timely filed. If the person resubmits the notice of appeal with an explanation or if the original untimely notice of appeal contained an explanation of untimeliness, and the administrator in either situation found that the explanation did not establish extraordinary circumstances excusing the untimeliness under (d) of this section, the person may file a new notice of appeal within 30 days of the date that the person receives notice of the decision refusing to accept the untimely first appeal.

Why does the proposed Plan section not inform Plan members of their rights to file an appeal after the deadline as allowed by 2 AAC 100(e)?

10. The document containing the proposed Plan amendment on the DRB website states that it is a "draft" and that it would be effective on June 1, 2022.

Please tell me if the words highlighted green on that DRB webpage are the proposed amendments, whether there will be any more changes made to the draft before June 1, 2022, and, if so, whether we will have a reasonable opportunity to read and comment on any other changes before you enact the amendment and, if so, that will be provided.

I look forward to receiving the answers and information I have requested.

Sincerely,
Lynda Giguere
[redacted]

From: fannlklj
Sent: Thursday, May 19, 2022 3:58 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Questions about proposed changes to AlaskaCare Retirement Health Plan

Dear Plan Administrator/Div. of Ret. and Benefits:

This is a reply to your request that AlaskaCare Plan members “share their thoughts” about the proposed Plan amendment scheduled to take effect June 1, 2022.

You have not provided enough information on your website necessary for retirees to understand and make informed comments and decisions about your proposed plan changes.

Please provide, as soon as possible, the answers to the following questions and requests for information. I hope your responses will help me understand the effects of your proposed plan changes on my retirement medical benefits:

1. Since 2003, our Plan has stated that coverage will be provided for medical services and supplies that are "medically necessary" and that are not specifically excluded from coverage by the Plan.

According to the terms of the plan that have been in effect since 2003, prescribed medical treatment is considered “medically necessary” when it is "expected to improve or maintain health" or "to ease pain or suffering without aggravating the condition or causing other serious health problems."

The Plan also states that diagnostic procedures are medically necessary when they are "expected to provide information to determine the course of treatment without aggravating the condition or causing additional health problems."

A medical treatment will not be considered medically necessary if there is an equally effective treatment or procedure that costs less than the one prescribed.

These standards of medical necessity are clear, straightforward, and easy to understand.

What are the reasons for changing the Plan's provisions concerning "medical necessity" and how would those changes affect coverages for types of medical treatments and procedures that the Plan has covered since 2003?

2. If these proposed Plan changes are adopted, would the Aetna Clinical Policy Bulletins be used only if/when there is a good faith basis for questioning whether the prescribed medical treatment, procedure, or equipment satisfies the Plan's standards for determining medical necessity as described in my Question 1?

3. When my doctor prescribes a medical treatment, procedure, or piece of equipment that A) helps cure or control my disease or condition or ease my pain or suffering without aggravating the condition or causing other health problems; B) has no alternative that is equally effective and costs less; and C) is not subject to any plan exclusion, does the Plan Administrator still have the discretion to deny coverage on the grounds of lack of medical necessity? If so, what other factors does the claims administrator (Aetna) or the Plan Administrator (the Division) consider in exercising its discretion whether a prescribed medical treatment, procedure, or equipment is medically necessary?

4. If a claim for a medical benefit is denied, I think I should be given a clear explanation of the reason for the denial so I can decide whether to appeal. If these proposed Plan changes are adopted and a medical claim is denied because Aetna does not consider it to be "medically necessary," would the Explanation of Benefits provide a clear explanation the Plan administrator does not consider it to be "medically necessary"?

Would the Explanation of Benefits tell me which Aetna Clinical Policy Bulletin and/or other reason was relied on by the claims administrator (TPA) or the Plan Administrator in exercising its "discretion" to deny coverage based on lack of medical necessity? If not, why not?

5. If these Plan changes are adopted and the Plan Administrator (the Division) has the discretion to decide if a prescribed medical treatment, procedure, or piece of equipment is medically necessary, and if the DRB delegates that authority to another person, what methods would the Plan administrator use to monitor and ensure that that person is making correct decisions?

6. Can the claims administrator (TPA) eliminate or reduce any coverages and/or other Plan benefits simply by changing one or more of its clinical policy bulletins to state that a prescribed medical treatment, procedure, or piece of equipment is no longer considered medically necessary? If the answer is yes, please answer these two questions:

> A) Does the claims administrator (Aetna) need to get the permission of the Plan Administrator (DRB) to make that kind of change to our Plan?

B) Does the claims administrator or the Plan Administrator DRB have to give Plan members notice of those changes in advance? If not, why not? And if Plan members will be given advance notice, how much advance notice will we be given and how will it be given?

7. If these Plan changes are adopted, will any new coverages or other Plan benefits be added to the Plan? If so, please tell me what those are and why they were not covered or provided under the terms of the Plan as it was written in 2003.

8. If these Plan changes are adopted, would any types of medical treatments, procedures, or supplies that have been covered at any time since 2003 no longer be covered or have reduced coverage? If so, what coverages and other Plan benefits would be eliminated or reduced and why?

9. "Section 12.14.13 Third Level" states that if a Plan member "does not file a Plan Administrator appeal timely, ... the second level of appeal will be the final decision, and will be final, conclusive and binding on all persons."
This would eliminate an existing appeal right under subsection (e) of 2 AAC 35.100 of the Alaska Administrative Code. It states that a Plan member may be permitted to file a late appeal if he/she provides a reasonable explanation of extraordinary circumstances that excuse the late filing. If the DRB then rejects the explanation for the late filing, the regulation also requires the DRB to notify the Plan member of his or her right to appeal the decision to reject the late-filed claim. It states:

The division shall return the notice of appeal to the person, and inform the person that the person may resubmit the notice with an explanation of why it was not timely filed. If the person resubmits the notice of appeal with an explanation or if the original untimely notice of appeal contained an explanation of untimeliness, and the administrator in either situation found that the explanation did not establish extraordinary circumstances excusing the untimeliness under (d) of this section, the person may file a new notice of appeal within 30 days of the date that the person receives notice of the decision refusing to accept the untimely first appeal.

Why does the proposed Plan section not inform Plan members of their rights to file an appeal after the deadline as allowed by 2 AAC 100(e)?

10. The document containing the proposed Plan amendment on the DRB website states that it is a "draft" and that it would be effective on June 1, 2022.

Please tell me if the words highlighted green on that DRB webpage are the proposed amendments, whether there will be any more changes made to the draft before June 1, 2022, and, if so, whether we will have a reasonable opportunity to read and comment on any other changes before you enact the amendment and, if so, that will be provided.

I look forward to receiving the answers and information I have requested.

Thank you.

From: MARK ROWLAND
Sent: Thursday, May 19, 2022 3:39 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Questions which deserve complete and candid answers consistent with the fiduciary you owe to my wife and myself

Dear Plan Administrator/Div. of Ret. and Benefits:

This is a reply to your request that AlaskaCare Plan members “share their thoughts” about the proposed Plan amendment scheduled to take effect June 1, 2022.

You have not provided enough information on your website necessary for retirees to understand and make informed comments and decisions about your proposed plan changes.

Please provide, as soon as possible, the answers to the following questions and requests for information. I hope your responses will help me understand the effects of your proposed plan changes on my retirement medical benefits:

1. Since 2003, our Plan has stated that coverage will be provided for medical services and supplies that are "medically necessary" and that are not specifically excluded from coverage by the Plan.

According to the terms of the plan that have been in effect since 2003, prescribed medical treatment is considered “medically necessary” when it is "expected to improve or maintain health" or "to ease pain or suffering without aggravating the condition or causing other serious health problems."

The Plan also states that diagnostic procedures are medically necessary when they are "expected to provide information to determine the course of treatment without aggravating the condition or causing additional health problems."

A medical treatment will not be considered medically necessary if there is an equally effective treatment or procedure that costs less than the one prescribed.

These standards of medical necessity are clear, straightforward, and easy to understand.

What are the reasons for changing the Plan's provisions concerning "medical necessity" and how would those changes affect coverages for types of medical treatments and procedures that the Plan has covered since 2003?

2. If these proposed Plan changes are adopted, would the Aetna Clinical Policy Bulletins be used only if/when there is a good faith basis for questioning whether the prescribed medical treatment, procedure, or equipment satisfies the Plan's standards for determining medical necessity as described in my Question 1?

3. When my doctor prescribes a medical treatment, procedure, or piece of equipment that A) helps cure or control my disease or condition or ease my pain or suffering without aggravating the condition or causing other health problems; B) has no alternative that is equally effective and costs less; and C) is not subject to any plan exclusion, does the Plan Administrator still have the discretion to deny coverage on the grounds of lack of medical necessity? If so, what other factors does the claims administrator (Aetna) or the Plan Administrator (the Division) consider in exercising its discretion whether a prescribed medical treatment, procedure, or equipment is medically necessary?

4. If a claim for a medical benefit is denied, I think I should be given a clear explanation of the reason for the denial so I can decide whether to appeal. If these proposed Plan changes are adopted and a medical claim is denied because Aetna does not consider it to be "medically necessary," would the Explanation of Benefits provide a clear explanation the Plan administrator does not consider it to be "medically necessary"?

Would the Explanation of Benefits tell me which Aetna Clinical Policy Bulletin and/or other reason was relied on by the claims administrator (TPA) or the Plan Administrator in exercising its "discretion" to deny coverage based on lack of medical necessity? If not, why not?

5. If these Plan changes are adopted and the Plan Administrator (the Division) has the discretion to decide if a prescribed medical treatment, procedure, or piece of equipment is medically necessary, and if the DRB delegates that authority to another person, what methods would the Plan administrator use to monitor and ensure that that person is making correct decisions?

6. Can the claims administrator (TPA) eliminate or reduce any coverages and/or other Plan benefits simply by changing one or more of its clinical policy bulletins to state that a prescribed medical treatment, procedure, or piece of equipment is no longer considered medically necessary? If the answer is yes, please answer these two questions:

A) Does the claims administrator (Aetna) need to get the permission of the Plan Administrator (DRB) to make that kind of change to our Plan?

B) Does the claims administrator or the Plan Administrator DRB have to give Plan members notice of those changes in advance? If not, why not? And if Plan members will be given advance notice, how much advance notice will we be given and how will it be given?

7. If these Plan changes are adopted, will any new coverages or other Plan benefits be added to the Plan? If so, please tell me what those are and why they were not covered or provided under the terms of the Plan as it was written in 2003.

8. If these Plan changes are adopted, would any types of medical treatments, procedures, or supplies that have been covered at any time since 2003 no longer be covered or have reduced coverage? If so, what coverages and other Plan benefits would be eliminated or reduced and why?

9. "Section 12.14.13 Third Level" states that if a Plan member "does not file a Plan Administrator appeal timely, ... the second level of appeal will be the final decision, and will be final, conclusive and binding on all persons."
This would eliminate an existing appeal right under subsection (e) of 2 AAC 35.100 of the Alaska Administrative Code. It states that a Plan member may be permitted to file a late appeal if he/she provides a reasonable explanation of extraordinary circumstances that excuse the late filing. If the DRB then rejects the explanation for the late filing, the regulation also requires the DRB to notify the Plan member of his or her right to appeal the decision to reject the late-filed claim. It states:

The division shall return the notice of appeal to the person, and inform the person that the person may resubmit the notice with an explanation of why it was not timely filed. If the person resubmits the notice of appeal with an explanation or if the original untimely notice of appeal contained an explanation of untimeliness, and the administrator in either situation found that the explanation did not establish extraordinary circumstances excusing the untimeliness under (d) of this section, the person may file a new notice of appeal within 30 days of the date that the person receives notice of the decision refusing to accept the untimely first appeal.

Why does the proposed Plan section not inform Plan members of their rights to file an appeal after the deadline as allowed by 2 AAC 100(e)?

10. The document containing the proposed Plan amendment on the DRB website states that it is a "draft" and that it would be effective on June 1, 2022.

Please tell me if the words highlighted green on that DRB webpage are the proposed amendments, whether there will be any more changes made to the draft before June 1, 2022, and, if so, whether we will have a reasonable opportunity to read and comment on any other changes before you enact the amendment and, if so, that will be provided.

I look forward to receiving the answers and information I have requested.

Thank you. Mark C. Rowland, Retired Superior Court Judge

From: Deborah Craig
Sent: Thursday, May 19, 2022 3:02 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Questions Regarding Downgrading of Tier I Benefits

Dear Plan Administrator/Div. of Ret. and Benefits:

This is a reply to your request that AlaskaCare Plan members “share their thoughts” about the proposed Plan amendment scheduled to take effect June 1, 2022.

You have not provided enough information on your website necessary for retirees to understand and make informed comments and decisions about your proposed plan changes.

Please provide, as soon as possible, the answers to the following questions and requests for information. I hope your responses will help me understand the effects of your proposed plan changes on my retirement medical benefits:

1. Since 2003, our Plan has stated that coverage will be provided for medical services and supplies that are "medically necessary" and that are not specifically excluded from coverage by the Plan.

According to the terms of the plan that have been in effect since 2003, prescribed medical treatment is considered “medically necessary” when it is "expected to improve or maintain health" or "to ease pain or suffering without aggravating the condition or causing other serious health problems."

The Plan also states that diagnostic procedures are medically necessary when they are "expected to provide information to determine the course of treatment without aggravating the condition or causing additional health problems."

A medical treatment will not be considered medically necessary if there is an equally effective treatment or procedure that costs less than the one prescribed.

These standards of medical necessity are clear, straightforward, and easy to understand.

What are the reasons for changing the Plan's provisions concerning "medical necessity" and how would those changes affect coverages for types of medical treatments and procedures that the Plan has covered since 2003?

2. If these proposed Plan changes are adopted, would the Aetna Clinical Policy Bulletins be used only if/when there is a good faith basis for questioning whether the prescribed medical treatment, procedure, or equipment satisfies the Plan's standards for determining medical necessity as described in my Question 1?

3. When my doctor prescribes a medical treatment, procedure, or piece of equipment that A) helps cure or control my disease or condition or ease my pain or suffering without aggravating the condition or causing other health problems; B) has no alternative that is equally effective and costs less; and C) is not subject to any plan exclusion, does the Plan Administrator still have the discretion to deny coverage on the grounds of lack of medical necessity? If so, what other factors does the claims administrator (Aetna) or the Plan Administrator (the Division) consider in exercising its discretion whether a prescribed medical treatment, procedure, or equipment is medically necessary?

4. If a claim for a medical benefit is denied, I think I should be given a clear explanation of the reason for the denial so I can decide whether to appeal. If these proposed Plan changes are adopted and a medical claim is denied because Aetna does not consider it to be "medically necessary," would the Explanation of

Benefits provide a clear explanation the Plan administrator does not consider it to be "medically necessary"?

Would the Explanation of Benefits tell me which Aetna Clinical Policy Bulletin and/or other reason was relied on by the claims administrator (TPA) or the Plan Administrator in exercising its "discretion" to deny coverage based on lack of medical necessity? If not, why not?

5. If these Plan changes are adopted and the Plan Administrator (the Division) has the discretion to decide if a prescribed medical treatment, procedure, or piece of equipment is medically necessary, and if the DRB delegates that authority to another person, what methods would the Plan administrator use to monitor and ensure that that person is making correct decisions?

6. Can the claims administrator (TPA) eliminate or reduce any coverages and/or other Plan benefits simply by changing one or more of its clinical policy bulletins to state that a prescribed medical treatment, procedure, or piece of equipment is no longer considered medically necessary? If the answer is yes, please answer these two questions:

A) Does the claims administrator (Aetna) need to get the permission of the Plan Administrator (DRB) to make that kind of change to our Plan?

B) Does the claims administrator or the Plan Administrator DRB have to give Plan members notice of those changes in advance? If not, why not? And if Plan members will be given advance notice, how much advance notice will we be given and how will it be given?

7. If these Plan changes are adopted, will any new coverages or other Plan benefits be added to the Plan? If so, please tell me what those are and why they were not covered or provided under the terms of the Plan as it was written in 2003.

8. If these Plan changes are adopted, would any types of medical treatments, procedures, or supplies that have been covered at any time since 2003 no longer be covered or have reduced coverage? If so, what coverages and other Plan benefits would be eliminated or reduced and why?

9. "Section 12.14.13 Third Level" states that if a Plan member "does not file a Plan Administrator appeal timely, ... the second level of appeal will be the final decision, and will be final, conclusive and binding on all persons."
This would eliminate an existing appeal right under subsection (e) of 2 AAC 35.100 of the Alaska Administrative Code. It states that a Plan member may be permitted to file a late appeal if he/she provides a reasonable explanation of extraordinary circumstances that excuse the late filing. If the DRB then rejects the explanation for the late filing, the regulation also requires the DRB to notify the Plan member of his or her right to appeal the decision to reject the late-filed claim. It states:

The division shall return the notice of appeal to the person, and inform the person that the person may resubmit the notice with an explanation of why it was not timely filed. If the person resubmits the notice of appeal with an explanation or if the original untimely notice of appeal contained an explanation of untimeliness, and the administrator in either situation found that the explanation did not establish extraordinary circumstances excusing the untimeliness under (d) of this section, the person may file a

new notice of appeal within 30 days of the date that the person receives notice of the decision refusing to accept the untimely first appeal.

Why does the proposed Plan section not inform Plan members of their rights to file an appeal after the deadline as allowed by 2 AAC 100(e)?

10. The document containing the proposed Plan amendment on the DRB website states that it is a "draft" and that it would be effective on June 1, 2022.

Please tell me if the words highlighted green on that DRB webpage are the proposed amendments, whether there will be any more changes made to the draft before June 1, 2022, and, if so, whether we will have a reasonable opportunity to read and comment on any other changes before you enact the amendment and, if so, that will be provided.

I look forward to receiving the answers and information I have requested.

Thank you,
Deborah Craig

From: Patricia Macklin
Sent: Thursday, May 19, 2022 2:43 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Proposed changes to the AlaskaCare Retiree Health Plan

This is in reply to your request that AlaskaCare Plan members "share their thoughts" about the proposed Plan amendment scheduled to take effect June 1, 2022.

If these Plan changes are adopted, would any types of medical treatments, procedures, or supplies that have been covered at any time since 2003 no longer be covered or have reduced coverage? If so, what coverages and other Plan benefits would be eliminated or reduced and why?

Sincerely,

Patricia Macklin

From: D Sundberg
Sent: Thursday, May 19, 2022 2:12 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Proposed Plan revisions

Dear Plan Administrator:

I had no idea you are proposing to change coverage for things currently considered “medically necessary”, let Aetna make arbitrary decisions on necessary equipment and procedures, and to cut back on (streamline?) the appeal process.
I share the concerns of countless Plan members expressed in the questions below:

Dear Plan Administrator/Div. of Ret. and Benefits:

This is a reply to your request that AlaskaCare Plan members “share their thoughts” about the proposed Plan amendment scheduled to take effect June 1, 2022.

You have not provided enough information on your website necessary for retirees to understand and make informed comments and decisions about your proposed plan changes.

Please provide, as soon as possible, the answers to the following questions and requests for information. I hope your responses will help me understand the effects of your proposed plan changes on my retirement medical benefits:

1. Since 2003, our Plan has stated that coverage will be provided for medical services and supplies that are "medically necessary" and that are not specifically excluded from coverage by the Plan.

According to the terms of the plan that have been in effect since 2003, prescribed medical treatment is considered “medically necessary” when it is "expected to improve or maintain health" or "to ease pain or suffering without aggravating the condition or causing other serious health problems."

The Plan also states that diagnostic procedures are medically necessary when they are "expected to provide information to determine the course of treatment without aggravating the condition or causing additional health problems."

A medical treatment will not be considered medically necessary if there is an equally effective treatment or procedure that costs less than the one prescribed.

These standards of medical necessity are clear, straightforward, and easy to understand.

What are the reasons for changing the Plan's provisions concerning "medical necessity" and how would those changes affect coverages for types of medical treatments and procedures that the Plan has covered since 2003?

2. If these proposed Plan changes are adopted, would the Aetna Clinical Policy Bulletins be used only if/when there is a good faith basis for questioning whether the prescribed medical treatment, procedure, or equipment satisfies the Plan's standards for determining medical necessity as described in my Question 1?

3. When my doctor prescribes a medical treatment, procedure, or piece of equipment that A) helps cure or control my disease or condition or ease my pain or suffering without aggravating the condition or

causing other health problems; B) has no alternative that is equally effective and costs less; and C) is not subject to any plan exclusion, does the Plan Administrator still have the discretion to deny coverage on the grounds of lack of medical necessity? If so, what other factors does the claims administrator (Aetna) or the Plan Administrator (the Division) consider in exercising its discretion whether a prescribed medical treatment, procedure, or equipment is medically necessary?

4. If a claim for a medical benefit is denied, I think I should be given a clear explanation of the reason for the denial so I can decide whether to appeal. If these proposed Plan changes are adopted and a medical claim is denied because Aetna does not consider it to be "medically necessary," would the Explanation of Benefits provide a clear explanation the Plan administrator does not consider it to be "medically necessary"?

Would the Explanation of Benefits tell me which Aetna Clinical Policy Bulletin and/or other reason was relied on by the claims administrator (TPA) or the Plan Administrator in exercising its "discretion" to deny coverage based on lack of medical necessity? If not, why not?

5. If these Plan changes are adopted and the Plan Administrator (the Division) has the discretion to decide if a prescribed medical treatment, procedure, or piece of equipment is medically necessary, and if the DRB delegates that authority to another person, what methods would the Plan administrator use to monitor and ensure that that person is making correct decisions?

6. Can the claims administrator (TPA) eliminate or reduce any coverages and/or other Plan benefits simply by changing one or more of its clinical policy bulletins to state that a prescribed medical treatment, procedure, or piece of equipment is no longer considered medically necessary? If the answer is yes, please answer these two questions:

A) Does the claims administrator (Aetna) need to get the permission of the Plan Administrator (DRB) to make that kind of change to our Plan?

B) Does the claims administrator or the Plan Administrator DRB have to give Plan members notice of those changes in advance? If not, why not? And if Plan members will be given advance notice, how much advance notice will we be given and how will it be given?

7. If these Plan changes are adopted, will any new coverages or other Plan benefits be added to the Plan? If so, please tell me what those are and why they were not covered or provided under the terms of the Plan as it was written in 2003.

8. If these Plan changes are adopted, would any types of medical treatments, procedures, or supplies that have been covered at any time since 2003 no longer be covered or have reduced coverage? If so, what coverages and other Plan benefits would be eliminated or reduced and why?

9. "Section 12.14.13 Third Level" states that if a Plan member "does not file a Plan Administrator appeal timely, ... the second level of appeal will be the final decision, and will be final, conclusive and binding on all persons."
This would eliminate an existing appeal right under subsection (e) of 2 AAC 35.100 of the Alaska Administrative Code. It states that a Plan member may be permitted to file a late appeal if he/she

provides a reasonable explanation of extraordinary circumstances that excuse the late filing. If the DRB then rejects the explanation for the late filing, the regulation also requires the DRB to notify the Plan member of his or her right to appeal the decision to reject the late-filed claim. It states:

The division shall return the notice of appeal to the person, and inform the person that the person may resubmit the notice with an explanation of why it was not timely filed. If the person resubmits the notice of appeal with an explanation or if the original untimely notice of appeal contained an explanation of untimeliness, and the administrator in either situation found that the explanation did not establish extraordinary circumstances excusing the untimeliness under (d) of this section, the person may file a new notice of appeal within 30 days of the date that the person receives notice of the decision refusing to accept the untimely first appeal.

Why does the proposed Plan section not inform Plan members of their rights to file an appeal after the deadline as allowed by 2 AAC 100(e)?

10. The document containing the proposed Plan amendment on the DRB website states that it is a "draft" and that it would be effective on June 1, 2022.

Please tell me if the words highlighted green on that DRB webpage are the proposed amendments, whether there will be any more changes made to the draft before June 1, 2022, and, if so, whether we will have a reasonable opportunity to read and comment on any other changes before you enact the amendment and, if so, that will be provided.

I look forward to receiving the answers and information I have requested.

Thank you.

From: Laura Fleming
Sent: Thursday, May 19, 2022 2:03 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Questions re proposed changes to the AlaskaCare Retiree Health Care Plan

Dear Plan Administrator/Div. of Ret. and Benefits:

This is a reply to your request that AlaskaCare Plan members “share their thoughts” about the proposed Plan amendment scheduled to take effect June 1, 2022.

You have not provided enough information on your website necessary for retirees to understand and make informed comments and decisions about your proposed plan changes.

Please provide, as soon as possible, the answers to the following questions and requests for information. I hope your responses will help me understand the effects of your proposed plan changes on my retirement medical benefits:

1. Since 2003, our Plan has stated that coverage will be provided for medical services and supplies that are "medically necessary" and that are not specifically excluded from coverage by the Plan.

According to the terms of the plan that have been in effect since 2003, prescribed medical treatment is considered “medically necessary” when it is "expected to improve or maintain health" or "to ease pain or suffering without aggravating the condition or causing other serious health problems."

The Plan also states that diagnostic procedures are medically necessary when they are "expected to provide information to determine the course of treatment without aggravating the condition or causing additional health problems."

A medical treatment will not be considered medically necessary if there is an equally effective treatment or procedure that costs less than the one prescribed.

These standards of medical necessity are clear, straightforward, and easy to understand.

What are the reasons for changing the Plan's provisions concerning "medical necessity" and how would those changes affect coverages for types of medical treatments and procedures that the Plan has covered since 2003?

2. If these proposed Plan changes are adopted, would the Aetna Clinical Policy Bulletins be used only if/when there is a good faith basis for questioning whether the prescribed medical treatment, procedure, or equipment satisfies the Plan's standards for determining medical necessity as described in my Question 1?

3. When my doctor prescribes a medical treatment, procedure, or piece of equipment that A) helps cure or control my disease or condition or ease my pain or suffering without aggravating the condition or causing other health problems; B) has no alternative that is equally effective and costs less; and C) is not subject to any plan exclusion, does the Plan Administrator still have the discretion to deny coverage on the grounds of lack of medical necessity? If so, what other factors does the claims administrator (Aetna) or the Plan Administrator (the Division) consider in exercising its discretion whether a prescribed medical treatment, procedure, or equipment is medically necessary?

4. If a claim for a medical benefit is denied, I think I should be given a clear explanation of the reason for the denial so I can decide whether to appeal. If these proposed Plan changes are adopted and a medical claim is denied because Aetna does not consider it to be "medically necessary," would the Explanation of Benefits provide a clear explanation the Plan administrator does not consider it to be "medically necessary"?

Would the Explanation of Benefits tell me which Aetna Clinical Policy Bulletin and/or other reason was relied on by the claims administrator (TPA) or the Plan Administrator in exercising its "discretion" to deny coverage based on lack of medical necessity? If not, why not?

5. If these Plan changes are adopted and the Plan Administrator (the Division) has the discretion to decide if a prescribed medical treatment, procedure, or piece of equipment is medically necessary, and if the DRB delegates that authority to another person, what methods would the Plan administrator use to monitor and ensure that that person is making correct decisions?

6. Can the claims administrator (TPA) eliminate or reduce any coverages and/or other Plan benefits simply by changing one or more of its clinical policy bulletins to state that a prescribed medical treatment, procedure, or piece of equipment is no longer considered medically necessary? If the answer is yes, please answer these two questions:

A) Does the claims administrator (Aetna) need to get the permission of the Plan Administrator (DRB) to make that kind of change to our Plan?

B) Does the claims administrator or the Plan Administrator DRB have to give Plan members notice of those changes in advance? If not, why not? And if Plan members will be given advance notice, how much advance notice will we be given and how will it be given?

7. If these Plan changes are adopted, will any new coverages or other Plan benefits be added to the Plan? If so, please tell me what those are and why they were not covered or provided under the terms of the Plan as it was written in 2003.

8. If these Plan changes are adopted, would any types of medical treatments, procedures, or supplies that have been covered at any time since 2003 no longer be covered or have reduced coverage? If so, what coverages and other Plan benefits would be eliminated or reduced and why?

9. "Section 12.14.13 Third Level" states that if a Plan member "does not file a Plan Administrator appeal timely, ... the second level of appeal will be the final decision, and will be final, conclusive and binding on all persons."
This would eliminate an existing appeal right under subsection (e) of 2 AAC 35.100 of the Alaska Administrative Code. It states that a Plan member may be permitted to file a late appeal if he/she provides a reasonable explanation of extraordinary circumstances that excuse the late filing. If the DRB then rejects the explanation for the late filing, the regulation also requires the DRB to notify the Plan member of his or her right to appeal the decision to reject the late-filed claim. It states:

The division shall return the notice of appeal to the person, and inform the person that the person may resubmit the notice with an explanation of why it was not timely filed. <u>If the person resubmits the notice of appeal with an explanation or if the original untimely notice of appeal contained an explanation of untimeliness, and the administrator in either situation found that the explanation did not establish extraordinary circumstances excusing the untimeliness under (d) of this section, the person may file a new notice of appeal within 30 days of the date that the person receives notice of the decision refusing to accept the untimely first appeal</u>.

Why does the proposed Plan section not inform Plan members of their rights to file an appeal after the deadline as allowed by 2 AAC 100(e)?

10. The document containing the proposed Plan amendment on the DRB website states that it is a "draft" and that it would be effective on June 1, 2022.

Please tell me if the words highlighted green on that DRB webpage are the proposed amendments, whether there will be any more changes made to the draft before June 1, 2022, and, if so, whether we will have a reasonable opportunity to read and comment on any other changes before you enact the amendment and, if so, that will be provided.

I look forward to receiving the answers and information I have requested.

Thank you.
Laura Fleming
[redacted]

From: Doug Baily
Sent: Thursday, May 19, 2022 1:47 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Proposed change to PERS medical coverage

I am not an insurance expert and have no training in evaluation of plan language. Please tell us in detail just what the proposed changes mean to our coverage.Also please tell us in detail how the proposed changes affect the cost to the State of providing this coverage.Are cost factors and part of the consideration for the proposed changes?

Doug Baily
Tier 1

From: Margo Waring
Sent: Thursday, May 19, 2022 1:36 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Proposed changes to AlaskaCare Retiree benefits taking effect 6/1/22

Dear Plan Administrator/Div. of Ret. and Benefits:

This is a reply to your request that AlaskaCare Plan members “share their thoughts” about the proposed Plan amendment scheduled to take effect June 1, 2022.

You have not provided enough information on your website necessary for retirees to understand and make informed comments and decisions about your proposed plan changes.

Please provide, as soon as possible, the answers to the following questions and requests for information. I hope your responses will help me understand the effects of your proposed plan changes on my retirement medical benefits:

1. Since 2003, our Plan has stated that coverage will be provided for medical services and supplies that are "medically necessary" and that are not specifically excluded from coverage by the Plan.

According to the terms of the plan that have been in effect since 2003, prescribed medical treatment is considered “medically necessary” when it is "expected to improve or maintain health" or "to ease pain or suffering without aggravating the condition or causing other serious health problems."

The Plan also states that diagnostic procedures are medically necessary when they are "expected to provide information to determine the course of treatment without aggravating the condition or causing additional health problems."

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These standards of medical necessity are clear, straightforward, and easy to understand.

What are the reasons for changing the Plan's provisions concerning "medical necessity" and how would those changes affect coverages for types of medical treatments and procedures that the Plan has covered since 2003?

2. If these proposed Plan changes are adopted, would the Aetna Clinical Policy Bulletins be used only if/when there is a good faith basis for questioning whether the prescribed medical treatment, procedure, or equipment satisfies the Plan's standards for determining medical necessity as described in my Question 1?

3. When my doctor prescribes a medical treatment, procedure, or piece of equipment that A) helps cure or control my disease or condition or ease my pain or suffering without aggravating the condition or causing other health problems; B) has no alternative that is equally effective and costs less; and C) is not subject to any plan exclusion, does the Plan Administrator still have the discretion to deny coverage on the grounds of lack of medical necessity? If so, what other factors does the claims administrator (Aetna) or the Plan Administrator (the Division) consider in exercising its discretion whether a prescribed medical treatment, procedure, or equipment is medically necessary?

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Would the Explanation of Benefits tell me which Aetna Clinical Policy Bulletin and/or other reason was relied on by the claims administrator (TPA) or the Plan Administrator in exercising its "discretion" to deny coverage based on lack of medical necessity? If not, why not?

5. If these Plan changes are adopted and the Plan Administrator (the Division) has the discretion to decide if a prescribed medical treatment, procedure, or piece of equipment is medically necessary, and if the DRB delegates that authority to another person, what methods would the Plan administrator use to monitor and ensure that that person is making correct decisions?

6. Can the claims administrator (TPA) eliminate or reduce any coverages and/or other Plan benefits simply by changing one or more of its clinical policy bulletins to state that a prescribed medical treatment, procedure, or piece of equipment is no longer considered medically necessary? If the answer is yes, please answer these two questions:

A) Does the claims administrator (Aetna) need to get the permission of the Plan Administrator (DRB) to make that kind of change to our Plan?

B) Does the claims administrator or the Plan Administrator DRB have to give Plan members notice of those changes in advance? If not, why not? And if Plan members will be given advance notice, how much advance notice will we be given and how will it be given?

7. If these Plan changes are adopted, will any new coverages or other Plan benefits be added to the Plan? If so, please tell me what those are and why they were not covered or provided under the terms of the Plan as it was written in 2003.

8. If these Plan changes are adopted, would any types of medical treatments, procedures, or supplies that have been covered at any time since 2003 no longer be covered or have reduced coverage? If so, what coverages and other Plan benefits would be eliminated or reduced and why?

9. "Section 12.14.13 Third Level" states that if a Plan member "does not file a Plan Administrator appeal timely, ... the second level of appeal will be the final decision, and will be final, conclusive and binding on all persons."
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The division shall return the notice of appeal to the person, and inform the person that the person may resubmit the notice with an explanation of why it was not timely filed. If the person resubmits the notice of appeal with an explanation or if the original untimely notice of appeal contained an explanation of untimeliness, and the administrator in either situation found that the explanation did not establish extraordinary circumstances excusing the untimeliness under (d) of this section, the person may file a new notice of appeal within 30 days of the date that the person receives notice of the decision refusing to accept the untimely first appeal.

Why does the proposed Plan section not inform Plan members of their rights to file an appeal after the deadline as allowed by 2 AAC 100(e)?

10. The document containing the proposed Plan amendment on the DRB website states that it is a "draft" and that it would be effective on June 1, 2022.

Please tell me if the words highlighted green on that DRB webpage are the proposed amendments, whether there will be any more changes made to the draft before June 1, 2022, and, if so, whether we will have a reasonable opportunity to read and comment on any other changes before you enact the amendment and, if so, that will be provided.

I look forward to receiving the answers and information I have requested.

Thank you.

From: Bill Britt
Sent: Thursday, May 19, 2022 12:15 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Proposed Changes to the AlaskaCare Retiree Health Plan

I understand you are considering changes to the plan, yet again. I have a few questions:

Will there be changes to the Plan's provisions concerning "medical necessity", why are they being considered, and how would those changes affect coverages for types of medical treatments and procedures that the Plan has covered since 2003?

When my doctor prescribes a medical treatment, procedure, or piece of equipment that helps cure or control my disease or condition or ease my pain or suffering without aggravating the condition or causing other health problems; has no alternative that is equally effective and costs less; and is not subject to any plan exclusion, does the Plan Administrator still have the discretion to deny coverage on the grounds of lack of medical necessity? If so, what other factors can the administrator (Aetna) or the Plan Administrator (the Division) consider in deciding that a prescribed medical treatment, procedure, or equipment is not medically necessary?

If a claim for a medical benefit is denied, will I be given a clear explanation of the reason for the denial so I can decide whether to appeal? If yes, what level of detail will be provided? Will the Explanation of Benefits tell me which Aetna Clinical Policy Bulletin and/or other reason was relied on by the claims administrator (TPA) or the Plan Administrator in exercising its "discretion" to deny coverage based on lack of medical necessity? If not, why not?

If these Plan changes are adopted and the Plan Administrator (the Division) has the discretion to decide if a prescribed medical treatment, procedure, or piece of equipment is medically necessary, and if the DRB delegates that authority to another person, what methods would the Plan administrator use to monitor and ensure that that person is making correct decisions?

Can the claims administrator eliminate or reduce any coverages and/or other Plan benefits simply by changing one or more of its clinical policy bulletins to state that a prescribed medical treatment, procedure, or piece of equipment is no longer considered medically necessary? If yes, does the claims administrator need to get the permission of the Plan Administrator to make the change to the Plan? Will the claims administrator or the Plan Administrator give Plan members notice of those changes in advance?

If these Plan changes are adopted, will any new coverages or other Plan benefits be added to the Plan? If so, what are they and why they were not covered or provided under the terms of the Plan in 2003.

If these Plan changes are adopted, would any types of medical treatments, procedures, or supplies that have been covered at any time since 2003 no longer be covered or have reduced coverage? If so, what coverages and other Plan benefits would be eliminated or reduced and why?

Thank you.

Bill Britt

From: Landa Baily
Sent: Thursday, May 19, 2022 12:07 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Cc: Sen. Gary Stevens <sen.gary.stevens@akleg.gov>; Kiehl, Jesse W (LEG) <sen.jesse.kiehl@akleg.gov>
Subject: URGENT: Questions re proposed changes to the AlaskaCare Retiree Health Plan

Dear Plan Administrator/Div. of Ret. and Benefits:

This is a reply to your request that AlaskaCare Plan members "share their thoughts" about the proposed Plan amendment scheduled to take effect June 1, 2022.

You have not provided enough information on your website necessary for retirees to understand and make informed comments and decisions about your proposed plan changes.

Please provide, as soon as possible, the answers to the following questions and requests for information. I hope your responses will help me understand the effects of your proposed plan changes on my retirement medical benefits:

1. Since 2003, our Plan has stated that coverage will be provided for medical services and supplies that are "medically necessary" and that are not specifically excluded from coverage by the Plan.

According to the terms of the plan that have been in effect since 2003, prescribed medical treatment is considered "medically necessary" when it is "expected to improve or maintain health" or "to ease pain or suffering without aggravating the condition or causing other serious health problems."

The Plan also states that diagnostic procedures are medically necessary when they are "expected to provide information to determine the course of treatment without aggravating the condition or causing additional health problems."

A medical treatment will not be considered medically necessary if there is an equally effective treatment or procedure that costs less than the one prescribed.

These standards of medical necessity are clear, straightforward, and easy to understand.

What are the reasons for changing the Plan's provisions concerning "medical necessity" and how would those changes affect coverages for types of medical treatments and procedures that the Plan has covered since 2003?

2. If these proposed Plan changes are adopted, would the Aetna Clinical Policy Bulletins be used only if/when there is a good faith basis for questioning whether the prescribed medical treatment, procedure, or equipment satisfies the Plan's standards for determining medical necessity as described in my Question 1?

3. When my doctor prescribes a medical treatment, procedure, or piece of equipment that A) helps cure or control my disease or condition or ease my pain or suffering without aggravating the condition or causing other health problems; B) has no alternative that is equally effective and costs less; and C) is not subject to any plan exclusion, does the Plan Administrator still have the discretion to deny coverage on the grounds of lack of medical necessity? If so, what other factors does the claims administrator (Aetna) or the Plan Administrator (the Division) consider in exercising its discretion whether a prescribed medical treatment, procedure, or equipment is medically necessary?

4. If a claim for a medical benefit is denied, I think I should be given a clear explanation of the reason for the denial so I can decide whether to appeal. If these proposed Plan changes are adopted and a medical claim is denied because Aetna does not consider it to be "medically necessary," would the Explanation of Benefits provide a clear explanation the Plan administrator does not consider it to be "medically necessary"?

Would the Explanation of Benefits tell me which Aetna Clinical Policy Bulletin and/or other reason was relied on by the claims administrator (TPA) or the Plan Administrator in exercising its "discretion" to deny coverage based on lack of medical necessity? If not, why not?

5. If these Plan changes are adopted and the Plan Administrator (the Division) has the discretion to decide if a prescribed medical treatment, procedure, or piece of equipment is medically necessary, and if the DRB delegates that authority to another person, what methods would the Plan administrator use to monitor and ensure that that person is making correct decisions?

6. Can the claims administrator (TPA) eliminate or reduce any coverages and/or other Plan benefits simply by changing one or more of its clinical policy bulletins to state that a prescribed medical treatment, procedure, or piece of equipment is no longer considered medically necessary? If the answer is yes, please answer these two questions:

> A) Does the claims administrator (Aetna) need to get the permission of the Plan Administrator (DRB) to make that kind of change to our Plan?
>
> B) Does the claims administrator or the Plan Administrator DRB have to give Plan members notice of those changes in advance? If not, why not? And if Plan members will be given advance notice, how much advance notice will we be given and how will it be given?

7. If these Plan changes are adopted, will any new coverages or other Plan benefits be added to the Plan? If so, please tell me what those are and why they were not covered or provided under the terms of the Plan as it was written in 2003.

8. If these Plan changes are adopted, would any types of medical treatments, procedures, or supplies that have been covered at any time since 2003 no longer be covered or have reduced coverage? If so, what coverages and other Plan benefits would be eliminated or reduced and why?

9. "Section 12.14.13 Third Level" states that if a Plan member "does not file a Plan Administrator appeal timely, ... the second level of appeal will be the final decision, and will be final, conclusive and binding on all persons."
This would eliminate an existing appeal right under subsection (e) of 2 AAC 35.100 of the Alaska Administrative Code. It states that a Plan member may be permitted to file a late appeal if he/she provides a reasonable explanation of extraordinary circumstances that excuse the late filing. If the DRB then rejects the explanation for the late filing, the regulation also requires the DRB to notify the Plan member of his or her right to appeal the decision to reject the late-filed claim. It states:

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Why does the proposed Plan section not inform Plan members of their rights to file an appeal after the deadline as allowed by 2 AAC 100(e)?

10. The document containing the proposed Plan amendment on the DRB website states that it is a "draft" and that it would be effective on June 1, 2022.

Please tell me if the words highlighted green on that DRB webpage are the proposed amendments, whether there will be any more changes made to the draft before June 1, 2022, and, if so, whether we will have a reasonable opportunity to read and comment on any other changes before you enact the amendment and, if so, that will be provided.

I look forward to receiving the answers and information I have requested.

Thank you.
Landa B. Baily

From: Grant Callow
Sent: Thursday, May 19, 2022 11:50 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Questions re proposed changes to the AlaskaCare Retiree Health Plan

Dear Plan Administrator/Div. of Ret. and Benefits:

This is a reply to your request that AlaskaCare Plan members "share their thoughts" about the proposed Plan amendment scheduled to take effect June 1, 2022.

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Please provide, as soon as possible, the answers to the following questions and requests for information. I hope your responses will help me understand the effects of your proposed plan changes on my retirement medical benefits:

1. Since 2003, our Plan has stated that coverage will be provided for medical services and supplies that are "medically necessary" and that are not specifically excluded from coverage by the Plan.

According to the terms of the plan that have been in effect since 2003, prescribed medical treatment is considered "medically necessary" when it is "expected to improve or maintain health" or "to ease pain or suffering without aggravating the condition or causing other serious health problems."

The Plan also states that diagnostic procedures are medically necessary when they are "expected to provide information to determine the course of treatment without aggravating the condition or causing additional health problems."

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2. If these proposed Plan changes are adopted, would the Aetna Clinical Policy Bulletins be used only if/when there is a good faith basis for questioning whether the prescribed medical treatment, procedure, or equipment satisfies the Plan's standards for determining medical necessity as described in my Question 1?

3. When my doctor prescribes a medical treatment, procedure, or piece of equipment that A) helps cure or control my disease or condition or ease my pain or suffering without aggravating the condition or causing other health problems; B) has no alternative that is equally effective and costs less; and C) is not

subject to any plan exclusion, does the Plan Administrator still have the discretion to deny coverage on the grounds of lack of medical necessity? If so, what other factors does the claims administrator (Aetna) or the Plan Administrator (the Division) consider in exercising its discretion whether a prescribed medical treatment, procedure, or equipment is medically necessary?

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Would the Explanation of Benefits tell me which Aetna Clinical Policy Bulletin and/or other reason was relied on by the claims administrator (TPA) or the Plan Administrator in exercising its "discretion" to deny coverage based on lack of medical necessity? If not, why not?

5. If these Plan changes are adopted and the Plan Administrator (the Division) has the discretion to decide if a prescribed medical treatment, procedure, or piece of equipment is medically necessary, and if the DRB delegates that authority to another person, what methods would the Plan administrator use to monitor and ensure that that person is making correct decisions?

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A) Does the claims administrator (Aetna) need to get the permission of the Plan Administrator (DRB) to make that kind of change to our Plan?

B) Does the claims administrator or the Plan Administrator DRB have to give Plan members notice of those changes in advance? If not, why not? And if Plan members will be given advance notice, how much advance notice will we be given and how will it be given?

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then rejects the explanation for the late filing, the regulation also requires the DRB to notify the Plan member of his or her right to appeal the decision to reject the late-filed claim. It states:

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Why does the proposed Plan section not inform Plan members of their rights to file an appeal after the deadline as allowed by 2 AAC 100(e)?

10. The document containing the proposed Plan amendment on the DRB website states that it is a "draft" and that it would be effective on June 1, 2022.

Please tell me if the words highlighted green on that DRB webpage are the proposed amendments, whether there will be any more changes made to the draft before June 1, 2022, and, if so, whether we will have a reasonable opportunity to read and comment on any other changes before you enact the amendment and, if so, that will be provided.

I look forward to receiving the answers and information I have requested.

Thank you.
William G Callow

From: Nancy Nolan
Sent: Thursday, May 19, 2022 11:38 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Questions about Proposed Changes to AlaskaCare Retiree Health Care plan

Dear Plan Administrator/Div. of Ret. and Benefits:

This is a reply to your request that AlaskaCare Plan members “share their thoughts” about the proposed Plan amendment scheduled to take effect June 1, 2022.

You have not provided enough information on your website necessary for retirees to understand and make informed comments and decisions about your proposed plan changes.

Please provide, as soon as possible, the answers to the following questions and requests for information. I hope your responses will help me understand the effects of your proposed plan changes on my retirement medical benefits:

1. Since 2003, our Plan has stated that coverage will be provided for medical services and supplies that are "medically necessary" and that are not specifically excluded from coverage by the Plan.

According to the terms of the plan that have been in effect since 2003, prescribed medical treatment is considered “medically necessary” when it is "expected to improve or maintain health" or "to ease pain or suffering without aggravating the condition or causing other serious health problems."

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2. If these proposed Plan changes are adopted, would the Aetna Clinical Policy Bulletins be used only if/when there is a good faith basis for questioning whether the prescribed medical treatment, procedure, or equipment satisfies the Plan's standards for determining medical necessity as described in my Question 1?

3. When my doctor prescribes a medical treatment, procedure, or piece of equipment that A) helps cure or control my disease or condition or ease my pain or suffering without aggravating the condition or causing other health problems; B) has no alternative that is equally effective and costs less; and C) is not subject to any plan exclusion, does the Plan Administrator still have the discretion to deny coverage on the grounds of lack of medical necessity? If so, what other factors does the claims administrator (Aetna) or the Plan Administrator (the Division) consider in exercising its discretion whether a prescribed medical treatment, procedure, or equipment is medically necessary?

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Would the Explanation of Benefits tell me which Aetna Clinical Policy Bulletin and/or other reason was relied on by the claims administrator (TPA) or the Plan Administrator in exercising its "discretion" to deny coverage based on lack of medical necessity? If not, why not?

5. If these Plan changes are adopted and the Plan Administrator (the Division) has the discretion to decide if a prescribed medical treatment, procedure, or piece of equipment is medically necessary, and if the DRB delegates that authority to another person, what methods would the Plan administrator use to monitor and ensure that that person is making correct decisions?

6. Can the claims administrator (TPA) eliminate or reduce any coverages and/or other Plan benefits simply by changing one or more of its clinical policy bulletins to state that a prescribed medical treatment, procedure, or piece of equipment is no longer considered medically necessary? If the answer is yes, please answer these two questions:

A) Does the claims administrator (Aetna) need to get the permission of the Plan Administrator (DRB) to make that kind of change to our Plan?

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Why does the proposed Plan section not inform Plan members of their rights to file an appeal after the deadline as allowed by 2 AAC 100(e)?

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Please tell me if the words highlighted green on that DRB webpage are the proposed amendments, whether there will be any more changes made to the draft before June 1, 2022, and, if so, whether we will have a reasonable opportunity to read and comment on any other changes before you enact the amendment and, if so, that will be provided.

I look forward to receiving the answers and information I have requested.

Thank you.
Nancy Nolan.
SOA Retiree

From: Jerry McEwen
Sent: Wednesday, May 18, 2022 8:28 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Questions re proposed changes to the AlaskaCare Retiree Health Plan

Dear Plan Administrator/Div. of Ret. and Benefits:

This is a reply to your request that AlaskaCare Plan members “share their thoughts” about the proposed Plan amendment scheduled to take effect June 1, 2022.

You have not provided enough information on your website necessary for retirees to understand and make informed comments and decisions about your proposed plan changes.

Please provide, as soon as possible, the answers to the following questions and requests for information. I hope your responses will help me understand the effects of your proposed plan changes on my retirement medical benefits:

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Would the Explanation of Benefits tell me which Aetna Clinical Policy Bulletin and/or other reason was relied on by the claims administrator (TPA) or the Plan Administrator in exercising its "discretion" to deny coverage based on lack of medical necessity? If not, why not?

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I look forward to receiving the answers and information I have requested.

Thank you.

Jerry McEwen
Spouse of retiree

From: Victor Carlson
Sent: Wednesday, May 18, 2022 8:25 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Questions re proposed changes to the AlaskaCare Retiree Health Plan

Dear Plan Administrator/Div. of Ret. and Benefits:

This is a reply to your request that AlaskaCare Plan members “share their thoughts” about the proposed Plan amendment scheduled to take effect June 1, 2022.

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I look forward to receiving the answers and information I have requested.

Thank you.

Victor Carlson
Superior Court Judge, Retired

From: paul olson
Sent: Wednesday, May 18, 2022 10:10 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Questions about proposed changes to AlaskaCare

Dear Plan Administrator/Div. of Ret. and Benefits:

This is a reply to your request that AlaskaCare Plan members “share their thoughts” about the proposed Plan amendment scheduled to take effect June 1, 2022.

You have not provided enough information on your website necessary for retirees to understand and make informed comments and decisions about your proposed plan changes.

Please provide, as soon as possible, the answers to the following questions and requests for information. I hope your responses will help me understand the effects of your proposed plan changes on my retirement medical benefits:

1. Since 2003, our Plan has stated that coverage will be provided for medical services and supplies that are "medically necessary" and that are not specifically excluded from coverage by the Plan.

According to the terms of the plan that have been in effect since 2003, a prescribed medical treatment is considered “medically necessary” when it is "expected to improve or maintain health" or "to ease pain or suffering without aggravating the condition or causing other serious health problems."

The Plan also states that diagnostic procedures are medically necessary when they are "expected to provide information to determine the course of treatment without aggravating the condition or causing additional health problems."

A medical treatment will not be considered medically necessary if there is an equally effective treatment or procedure that costs less than the one prescribed.

These standards of medical necessity are clear and easy to understand.

What are the reasons for changing the Plan's provisions concerning "medical necessity" and how would those changes affect coverages for types of medical treatments and procedures that the Plan has covered since 2003?

2. If these proposed Plan changes are adopted, would the Aetna Clinical Policy Bulletins be used only if/when there is a good faith basis for questioning whether the prescribed medical treatment, procedure or equipment satisfies the Plan's standards for determining medical necessity as described in my Question 1?

3. When my doctor prescribes a medical treatment, procedure or piece of equipment for a disease or medical condition that A) helps cure or control my disease or condition or ease my pain or suffering without aggravating the condition or causing other health problems; B) has no alternative that is equally effective and costs less; and C) is not subject to any plan exclusion, does the Plan Administrator still have the discretion to deny coverage on the grounds of lack of medical necessity? If so, what other factors does the claims administrator (Aetna) or the Plan Administrator (the Division) consider in exercising its discretion whether a prescribed medical treatment, procedure or equipment is medically necessary?

4. If a claim for a medical benefit is denied, I think I should be given a clear explanation of the reason for the denial so I can decide whether to appeal. If these proposed Plan changes are adopted and a medical claim is denied based on lack of medical necessity, would the Explanation of Benefits provide a clear explanation why the claim was denied?

Would the Explanation of Benefits tell me which Aetna Clinical Policy Bulletin and/or other reason was relied on by the claims administrator (TPA) or the Plan Administrator in exercising its "discretion" to deny coverage based on lack of medical necessity? If not, why not?

5. If these Plan changes are adopted and the Plan Administrator (the Division) has the discretion to decide if a prescribed medical treatment, procedure or piece of equipment is medically necessary, and if the DRB delegates that authority to another person, what methods would the Plan administrator use to monitor and ensure that that person is making correct decisions?

6. Can the claims administrator (TPA) eliminate or reduce any coverages and/or other Plan benefits simply by changing one or more of its clinical policy bulletins to state that a prescribed medical treatment, procedure or piece of equipment is no longer considered medically necessary? If the answer is yes, please answer these two questions:
A) Does the claims administrator (Aetna) need to get the permission of the Plan Administrator to make that kind of change to our Plan?

B) Does the claims administrator or the Plan Administrator DRB have to give Plan members notice of the change in advance? IF not, why not? And if Plan members will be given advance notice, how much advance notice will we be given and how will it be given?

7. If these Plan changes are adopted, will any new coverages or other Plan benefits be added to the Plan? If so, please tell me what those are and why they were not now covered or provided under the terms of the current Plan.

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9. "Section 12.14.13 Third Level" states that if a Plan member "does not file a Plan Administrator appeal timely, ... the second level of appeal will be the final decision, and will be final, conclusive and binding on all persons."

This conflicts with subsection (e) of 2 AAC 35.100 of the Alaska Administrative Code. It states that a Plan member may be permitted to file a late appeal if he/she provides a reasonable explanation of extraordinary circumstances that excuse late-filing. It also requires the DRB to notify the Plan member of his or her right to appeal the denial of the late-filed claim. It states:

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Why does that Plan section not inform Plan members of their rights to file an appeal after the deadline as allowed by 2 AAC 100(e)?

10. The document containing the proposed Plan amendment on the DRB website states that it is a "draft" and that it would be effective on June 1, 2022.

Please tell me if the words highlighted green on that page are the proposed amendments, whether there will be any more changes made to the draft before June 1, 2022 and, if so, whether we will have a reasonable opportunity to read and comment on any other changes before you enact the amendment and, if so, that will be provided.

I look forward to receiving the answers and information I have requested.

Thank you.
Paul Olson
SOA Tier 1 Retiree

From: maurice mcclure
Sent: Monday, May 16, 2022 8:36 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Questions re proposed changes to the AlaskaCare Retiree Health Plan

Dear Plan Administrator/Div. of Ret. and Benefits:

This is a reply to your request that AlaskaCare Plan members “share their thoughts” about the proposed Plan amendment scheduled to take effect June 1, 2022.

You have not provided enough information on your website necessary for retirees to understand and make informed comments and decisions about your proposed plan changes.

Please provide, as soon as possible, the answers to the following questions and requests for information. I hope your responses will help me understand the effects of your proposed plan changes on my retirement medical benefits:

1. Since 2003, our Plan has stated that coverage will be provided for medical services and supplies that are "medically necessary" and that are not specifically excluded from coverage by the Plan.

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Would the Explanation of Benefits tell me which Aetna Clinical Policy Bulletin and/or other reason was relied on by the claims administrator (TPA) or the Plan Administrator in exercising its "discretion" to deny coverage based on lack of medical necessity? If not, why not?

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I look forward to receiving the answers and information I have requested.

Thank you.
Maurice McClure
SOA Tier 1 Retiree

From: Peter Bradshaw
Mon 5/16/2022 7:29 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored)

Dear Plan Administrator/Div. of Ret. and Benefits:

This is a reply to your request that AlaskaCare Plan members “share their thoughts” about the proposed Plan amendment scheduled to take effect June 1, 2022.

You have not provided enough information on your website necessary for retirees to understand and make informed comments and decisions about your proposed plan changes.

Please provide, as soon as possible, the answers to the following questions and requests for information. I hope your responses will help me understand the effects of your proposed plan changes on my retirement medical benefits:

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Would the Explanation of Benefits tell me which Aetna Clinical Policy Bulletin and/or other reason was relied on by the claims administrator (TPA) or the Plan Administrator in exercising its "discretion" to deny coverage based on lack of medical necessity? If not, why not?

5. If these Plan changes are adopted and the Plan Administrator (the Division) has the discretion to decide if a prescribed medical treatment, procedure or piece of equipment is medically necessary, and if the DRB delegates that authority to another person, what methods would the Plan administrator use to monitor and ensure that that person is making correct decisions?

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member of his or her right to appeal the decision to reject the late-filed claim. It states:

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I look forward to receiving the answers and information I have requested.

Thank you.
Peter M. Bradshaw

From: Peter and Toby Bradshaw-Steinberger
Sent: Sunday, May 15, 2022 3:57 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Questions re proposed changes to the AlaskaCare Retiree Health Plan

Dear Plan Administrator/Division of Retirement and Benefits:

I am a Tier I member. This is a reply to your request that AlaskaCare Plan members "share their thoughts" about the proposed Plan amendment scheduled to take effect June 1, 2022, which amends the new January 2002 booklet.

You have not provided enough information on your website necessary for retirees to understand and make informed comments and decisions about your proposed plan changes.

Please provide, as soon as possible, the answers to the following questions and requests for information. I hope your responses will help me understand the effects of your proposed plan changes on my retirement medical benefits:

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Would the Explanation of Benefits tell me which Aetna Clinical Policy Bulletin and/or other reason was relied on by the claims administrator (TPA) or the Plan Administrator in exercising its "discretion" to deny coverage based on lack of medical necessity? If not, why not?

5. If these Plan changes are adopted and the Plan Administrator (the Division) has the discretion to decide if a prescribed medical treatment, procedure or piece of equipment is medically necessary, and if the DRB delegates that authority to another person, what methods would the Plan administrator use to monitor and ensure that that person is making correct decisions?

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Why does the proposed Plan section not inform Plan members of their rights to file an appeal after the deadline as allowed by 2 AAC 100(e)?

10. The document containing the proposed Plan amendment on the DRB website states that it is a "draft" and that it would be effective on June 1, 2022.

Please tell me if the words highlighted green on that DRB webpage are the proposed amendments, whether there will be any more changes made to the draft before June 1, 2022 and, if so, whether we will have a reasonable opportunity to read and comment on any other changes before you enact the amendment and, if so, that will be provided.

11. Unaware of the new January 2022, I have relied on my hard copy of the 2003 Retiree Health Plan Booklet. Will the Division send out by **regular mail** a revised health plan booklet to replace the 2003 booklet. Many members may not have access to a computer.

I look forward to receiving the answers and information I have requested.

Thank you.

Toby N. Steinberger

From: Rich Curtner
Tue 5/10/2022 11:37 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored)
Dear Plan Administrator/Div. of Ret. and Benefits:

This is a reply to your request that AlaskaCare Plan members “share their thoughts” about the proposed Plan amendment scheduled to take effect June 1, 2022.

You have not provided enough information on your website necessary for retirees to understand and make informed comments and decisions about your proposed plan changes.

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Why does the proposed Plan section not inform Plan members of their rights to file an appeal after the deadline as allowed by 2 AAC 100(e)?

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I look forward to receiving the answers and information I have requested.

Thank you.

From: Rebecca Paul

Mon 5/9/2022 2:06 PM

To:AlaskaCare Retiree Plan, DOA DRB (DOA sponsored)
State of Alaska Department of Administration
Division of Retirement and Benefits
PO Box 110203
Juneau AK 99811-0203
doa.drb.alaskacare.retiree.plan@alaska.gov

Dear Commissioner Vrana,

Please consider my comments, below, regarding the Division of Retirement and Benefits' proposed amendment to the AlaskaCare Defined Benefit Retiree Health Plan, effective June 1, 2022.

Accessing Clinical Policy Bulletins

Please retain, "You may access…Clinical Policy Bulletins at…" which serves as the Plan Administrator's promise that members may, indeed, access the CPBs. Since the Claims Administrator uses CPBs to determine medical necessity, members and their medical providers must enjoy access to the CPBs. As Aetna's website (at https://www.aetna.com/health-care-professionals/clinical-policy-bulletins/medical-clinical-policy-bulletins.html#) advises, "members should review these Bulletins with their providers so they may fully understand our policies." Members can't review or discuss CPBs with their providers if we lack access the CPBs. Aetna has not always published all CPBs at the link provided in the booklet. As of the date of this writing, Aetna has not posted CPB 0499 on their website, but they use CPB 0499 to deny claims.

Thank you.
Rebecca Paul
[redacted]

From: Jerry and Nancy Wertzbaugher
Sat 5/7/2022 7:07 PM
To:AlaskaCare Retiree Plan, DOA DRB (DOA sponsored)

Dear Plan Administrator/Div. of Ret. and Benefits:

This is a reply to your request that AlaskaCare Plan members "share their thoughts" about the proposed Plan amendment scheduled to take effect June 1, 2022.

You have not provided enough information on your website necessary for retirees to understand and make informed comments and decisions about your proposed plan changes.

Please provide, as soon as possible, the answers to the following questions and requests for information. I hope your responses will help me understand the effects of your proposed plan changes on my retirement medical benefits:

1. Since 2003, our Plan has stated that coverage will be provided for medical services and supplies that are "medically necessary" and that are not specifically excluded from coverage by the Plan.

According to the terms of the plan that have been in effect since 2003, prescribed medical treatment is considered “medically necessary” when it is "expected to improve or maintain health" or "to ease pain or suffering without aggravating the condition or causing other serious health problems."

The Plan also states that diagnostic procedures are medically necessary when they are "expected to provide information to determine the course of treatment without aggravating the condition or causing additional health problems."

A medical treatment will not be considered medically necessary if there is an equally effective treatment or procedure that costs less than the one prescribed.

These standards of medical necessity are clear, straightforward, and easy to understand.

What are the reasons for changing the Plan's provisions concerning "medical necessity" and how would those changes affect coverages for types of medical treatments and procedures that the Plan has covered since 2003?

2. If these proposed Plan changes are adopted, would the Aetna Clinical Policy Bulletins be used only if/when there is a good faith basis for questioning whether the prescribed medical treatment, procedure, or equipment satisfies the Plan's standards for determining medical necessity as described in my Question 1?

3. When my doctor prescribes a medical treatment, procedure, or piece of equipment that A) helps cure or control my disease or condition or ease my pain or suffering without aggravating the condition or causing other health problems; B) has no alternative that is equally effective and costs less; and C) is not subject to any plan exclusion, does the Plan Administrator still have the discretion to deny coverage on the grounds of lack of medical necessity? If so, what other factors does the claims administrator (Aetna) or the Plan Administrator (the Division) consider in exercising its discretion whether a prescribed medical treatment, procedure, or equipment is medically necessary?

4. If a claim for a medical benefit is denied, I think I should be given a clear explanation of the reason for the denial so I can decide whether to appeal. If these proposed Plan changes are adopted and a medical claim is denied because Aetna does not consider it to be "medically necessary," would the Explanation of Benefits provide a clear explanation the Plan administrator does not consider it to be "medically necessary"?

Would the Explanation of Benefits tell me which Aetna Clinical Policy Bulletin and/or other reason was relied on by the claims administrator (TPA) or the Plan Administrator in exercising its "discretion" to deny coverage based on lack of medical necessity? If not, why not?

5. If these Plan changes are adopted and the Plan Administrator (the Division) has the discretion to decide if a prescribed medical treatment, procedure, or piece of equipment is medically necessary, and if the DRB delegates that authority to another person, what methods would the Plan administrator use to monitor and ensure that that person is making correct decisions?

6. Can the claims administrator (TPA) eliminate or reduce any coverages and/or other Plan benefits simply by changing one or more of its clinical policy bulletins to state that a prescribed medical treatment, procedure, or piece of equipment is no longer considered medically necessary? If the answer is yes, please answer these two questions:

A) Does the claims administrator (Aetna) need to get the permission of the Plan Administrator (DRB) to make that kind of change to our Plan?

B) Does the claims administrator or the Plan Administrator DRB have to give Plan members notice of those changes in advance? If not, why not? And if Plan members will be given advance notice, how much advance notice will we be given and how will it be given?

7. If these Plan changes are adopted, will any new coverages or other Plan benefits be added to the Plan? If so, please tell me what those are and why they were not covered or provided under the terms of the Plan as it was written in 2003.

8. If these Plan changes are adopted, would any types of medical treatments, procedures, or supplies that have been covered at any time since 2003 no longer be covered or have reduced coverage? If so, what coverages and other Plan benefits would be eliminated or reduced and why?

9. "Section 12.14.13 Third Level" states that if a Plan member "does not file a Plan Administrator appeal timely, ... the second level of appeal will be the final decision, and will be final, conclusive and binding on all persons."

This would eliminate an existing appeal right under subsection (e) of 2 AAC 35.100 of the Alaska Administrative Code. It states that a Plan member may be permitted to file a late appeal if he/she provides a reasonable explanation of extraordinary circumstances that excuse the late filing. If the DRB then rejects the explanation for the late filing, the regulation also requires the DRB to notify the Plan member of his or her right to appeal the decision to reject the late-filed claim. It states:

The division shall return the notice of appeal to the person, and inform the person that the person may resubmit the notice with an explanation of why it was not timely filed. <u>If the person resubmits the notice of appeal with an explanation or if the original untimely notice of appeal contained an explanation of untimeliness, and the administrator in either situation found that the explanation did not establish extraordinary circumstances excusing the untimeliness under (d) of this section, the person may file a new notice of appeal within 30 days of the date that the person receives notice of the decision refusing to accept the untimely first appeal</u>.

Why does the proposed Plan section not inform Plan members of their rights to file an appeal after the deadline as allowed by 2 AAC 100(e)?

10. The document containing the proposed Plan amendment on the DRB website states that it is a "draft" and that it would be effective on June 1, 2022.

Please tell me if the words highlighted green on that DRB webpage are the proposed amendments, whether there will be any more changes made to the draft before June 1, 2022, and, if so, whether we

will have a reasonable opportunity to read and comment on any other changes before you enact the amendment and, if so, that will be provided.

I look forward to receiving the answers and information I have requested.

Thank you.
Nancy and Jerry Wertzbaugher

From: Thomas A Atkinson
[redacted]
Anonymous User

5/9/2022 8:10:32 AM

Comment:State of Alaska Department of Administration
Division of Retirement and Benefits
PO Box 110203
Juneau AK 99811-0203
doa.drb.alaskacare.retiree.plan@alaska.gov.

Dear Commissioner Vrana,
Please consider my comments, below, regarding the Division of Retirement and Benefits' proposed amendment to the AlaskaCare Defined Benefit Retiree Health Plan, effective June 1, 2022.
Accessing Clinical Policy Bulletins
Please retain, "You may access…Clinical Policy Bulletins at…" which serves as the Plan Administrator's promise that members may, indeed, access the CPBs. Since the Claims Administrator uses CPBs to determine medical necessity, members and their medical providers must enjoy access to the CPBs. As Aetna's website (at https://www.aetna.com/health-care-professionals/clinical-policy-bulletins/medical-clinical-policy-bulletins.html#) advises, "members should review these Bulletins with their providers so they may fully understand our policies." Members can't review or discuss CPBs with their providers if we lack access the CPBs. Aetna has not always published all CPBs at the link provided in the booklet. As of the date of this writing, Aetna has not posted CPB 0499 on their website, but they use CPB 0499 to deny claims.
Thank you for considering my comments.
Thomas Atkinson

From: Susan Rogers
Sent: Wednesday, April 27, 2022 3:14 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Comments on proposed changes to health plan

TWIMC—I generally find no argument with the proposed amendments to the retiree health plan as outlined on the Division RB website. I would just point out a couple of points, my opinion only:

1) In the contact info suggestion of a link to Aetna's clinical policies, the would of necessity be changed if Aetna were no longer the Claims Administrator.
2) In Definitions, mentioning Aetna again brings up the point of needing further revisions if Aetna is not the Claims Administrator.

Thank you for reading my opinion.

Susan Rogers

From: Pamela Provost
Sent: Wednesday, April 27, 2022 12:40 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Proposed changes to Defined Benefit Retiree Health Plan

I object to the proposed changes that allow some one other than my doctor to make the final determination on what is best for my health care - especially considering that the decision maker may not be a licensed physician. That change is a significant departure from our current health care benefits. Furthermore, RPEA represents less than 10% of all PERS retirees. That is hardly representative of the affected group.

Regards

From: rpea.ak.president
Sent: Wednesday, April 27, 2022 10:33 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Cc: Randall Burns
Subject: Suggested Change to the Proposed Health Plan Changes Presently Under Consideration

To Whom It May Concern:
The Retired Public Employees of Alaska (RPEA) clearly supports the proposed changes to the Plan presently under consideration by the Division of Retirement and Benefits (DRB). However, we do have one suggested change to the proposal that we think makes sense and should be supported by the Division of Retirement and Benefits.

The RPEA recommends that the proposed Section 1 amendment read as follows [the new language is in bold and underlined]:

Section 1 Amended Provisions

1) Amends the Contact Information section to add a web link to the Aetna Clinical Policy Bulletins.

You may access the Aetna Clinical Policy Bulletins at……*www.aetna.com/health-care-professionals/clinical-policy-bulletins.html*

Thank you for your consideration of this suggestion.
Randall Burns
President
Retired Public Employees of Alaska

From: Pam Mcintire
Sent: Tuesday, April 26, 2022 7:38 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Questions regarding the proposed changes to the Alaska Care Retiree Health Plan
Dear Plan Administrator/Div. of Ret. and Benefits:

This is a reply to your request that AlaskaCare Plan members “share their thoughts” about the proposed Plan amendment scheduled to take effect June 1, 2022.

You have not provided enough information on your website necessary for retirees to understand and make informed comments and decisions about your proposed plan changes.

Please provide, as soon as possible, the answers to the following questions and requests for information. I hope your responses will help me understand the effects of your proposed plan changes on my retirement medical benefits:

1. Since 2003, our Plan has stated that coverage will be provided for medical services and supplies that are "medically necessary" and that are not specifically excluded from coverage by the Plan.

According to the terms of the plan that have been in effect since 2003, a prescribed medical treatment is considered “medically necessary” when it is "expected to improve or maintain health" or "to ease pain or suffering without aggravating the condition or causing other serious health problems."

The Plan also states that diagnostic procedures are medically necessary when they are "expected to provide information to determine the course of treatment without aggravating the condition or causing additional health problems."

A medical treatment will not be considered medically necessary if there is an equally effective treatment or procedure that costs less than the one prescribed.

These standards of medical necessity are clear and easy to understand.

What are the reasons for changing the Plan's provisions concerning "medical necessity" and how would those changes affect coverages for types of medical treatments and procedures that the Plan has covered since 2003?

2. If these proposed Plan changes are adopted, would the Aetna Clinical Policy Bulletins be used only if/when there is a good faith basis for questioning whether the prescribed medical treatment, procedure

or equipment satisfies the Plan's standards for determining medical necessity as described in my Question 1?

3. When my doctor prescribes a medical treatment, procedure or piece of equipment for a disease or medical condition that A) helps cure or control my disease or condition or ease my pain or suffering without aggravating the condition or causing other health problems; B) has no alternative that is equally effective and costs less; and C) is not subject to any plan exclusion, does the Plan Administrator still have the discretion to deny coverage on the grounds of lack of medical necessity? If so, what other factors does the claims administrator (Aetna) or the Plan Administrator (the Division) consider in exercising its discretion whether a prescribed medical treatment, procedure or equipment is medically necessary?

4. If a claim for a medical benefit is denied, I think I should be given a clear explanation of the reason for the denial so I can decide whether to appeal. If these proposed Plan changes are adopted and a medical claim is denied based on lack of medical necessity, would the Explanation of Benefits provide a clear explanation why the claim was denied?

Would the Explanation of Benefits tell me which Aetna Clinical Policy Bulletin and/or other reason was relied on by the claims administrator (TPA) or the Plan Administrator in exercising its "discretion" to deny coverage based on lack of medical necessity? If not, why not?

5. If these Plan changes are adopted and the Plan Administrator (the Division) has the discretion to decide if a prescribed medical treatment, procedure or piece of equipment is medically necessary, and if the DRB delegates that authority to another person, what methods would the Plan administrator use to monitor and ensure that that person is making correct decisions?

6. Can the claims administrator (TPA) eliminate or reduce any coverages and/or other Plan benefits simply by changing one or more of its clinical policy bulletins to state that a prescribed medical treatment, procedure or piece of equipment is no longer considered medically necessary? If the answer is yes, please answer these two questions:

> A) Does the claims administrator (Aetna) need to get the permission of the Plan Administrator to make that kind of change to our Plan?
>
> B) Does the claims administrator or the Plan Administrator DRB have to give Plan members notice of the change in advance? IF not, why not? And if Plan members will be given advance notice, how much advance notice will we be given and how will it be given?

7. If these Plan changes are adopted, will any new coverages or other Plan benefits be added to the Plan? If so, please tell me what those are and why they were not now covered or provided under the terms of the current Plan.

8. If these Plan changes are adopted, would any types of medical treatments, procedures or supplies that have been covered at any time since 2003 no longer be covered or have reduced coverage? If so, what coverages and other Plan benefits would be eliminated or reduced and why?

9. "Section 12.14.13 Third Level" states that if a Plan member "does not file a Plan Administrator appeal timely, ... the second level of appeal will be the final decision, and will be final, conclusive and binding on all persons."

This conflicts with subsection (e) of 2 AAC 35.100 of the Alaska Administrative Code. It states that a Plan member may be permitted to file a late appeal if he/she provides a reasonable explanation of extraordinary circumstances that excuse late-filing. It also requires the DRB to notify the Plan member of his or her right to appeal the denial of the late-filed claim. It states:

The division shall return the notice of appeal to the person, and inform the person that the person may resubmit the notice with an explanation of why it was not timely filed. If the person resubmits the notice of appeal with an explanation or if the original untimely notice of appeal contained an explanation of untimeliness, and the administrator in either situation found that the explanation did not establish extraordinary circumstances excusing the untimeliness under (d) of this section, the person may file a new notice of appeal within 30 days of the date that the person receives notice of the decision refusing to accept the untimely first appeal.

Why does that Plan section not inform Plan members of their rights to file an appeal after the deadline as allowed by 2 AAC 100(e)?

10. The document containing the proposed Plan amendment on the DRB website states that it is a "draft" and that it would be effective on June 1, 2022.

Please tell me if the words highlighted green on that page are the proposed amendments, whether there will be any more changes made to the draft before June 1, 2022 and, if so, whether we will have a reasonable opportunity to read and comment on any other changes before you enact the amendment and, if so, that will be provided.

I look forward to receiving the answers and information I have requested.

Thank you.
Pam

From: Karen & Jed Dinnan

Sent: Friday, April 22, 2022 9:17 PM
To: Ricci, Emily K (DOA) <emily.ricci@alaska.gov>; Alaska Retiree Health Plan Advisory Board (DOA sponsored) <alaskarhpab@alaska.gov>; manager@rpea-ak.org
Subject: Response to Notice of Proposed Amendment to the DB Retiree AlaskaCare Plan posted March 26, 2022

I am submitting my comments regarding the proposed amendment to the plan, as I have concerns about the language being changed. Why is it being changed? Is it tightening up the language so that our benefits will NOT be diminished?

After having won the lawsuit, what issues needed to be mediated? Since we won, did the mediation change the plan language to benefit the retirees so that in the future, the reasons that precipitated and instigated the RPEA lawsuit cannot occur again? Does the new language securely protect retiree benefits that have been in place since 2003?

Or is the new language added to the plan written in such a way to create new loopholes to diminish benefits and to disallow future litigation?

Will there be another opportunity for comment once language is finalized -or- is the language that is stated to be a draft copy, the finalized language?

I emailed our RPEA President with questions about the details regarding mediation, but never received a response. I would like to see further clarification in layman's language to explain what this all means and why mediation was needed.

Sincerely,

Karen S Dinnan

From: Sandra Lemke Nesvick

Sent: Friday, April 22, 2022 12:10 PM
To: Ricci, Emily K (DOA) <emily.ricci@alaska.gov>; Alaska Retiree Health Plan Advisory Board (DOA sponsored) <alaskarhpab@alaska.gov>; manager@rpea-ak.org
Subject: Comments on the health plan debackle

First off I'm very disappointed in the shenanigans that seem to have become the norm of the day with the RPEA Board as it stands now. I'm sure this doesn't make any of the people involved happy to see this but please take a step back and pretend that you are a member of an organization that seemed to be trying to work for the membership; and suddenly it changes directions and seems to be looking out for the big guy with the money to fund it (the State of Alaska).

So far with the settlements, without going to trial, seem okay but in 5 years or less how will they look? Most of us retirees don't have the resources to keep our health on an even keel that's one reason why we worked for the State of Alaska. The State had a pretty good retirement system and we were looking for work and decided that this would be a good place to work at that time and it gave us an incentive to continue till we could retire and have hopefully a decent retirement in the future.

I'm concerned about the settlements taking the place of lawsuits in many instances, The State set the system up and of course they want to keep as low a cost as possible. That sounds like they are being frugal but who hurts in the long run? With allowing the current health organization manage the costs and

diminish our coverage isn't a good move in my book. They focus on lower costs for their company and we need someone looking out for the retirees and families who benefit from the coverage the state initially provided.
Please keep our health coverage covering our problems without diminishing our coverage.
Sandra L Nesvick
Department of Labor retiree

From: Lela Grogan
Sent: Tuesday, April 19, 2022 3:29 AM
To: Ricci, Emily K (DOA) <emily.ricci@alaska.gov>
Subject: Amendments to the DB Retiree AlaskaCare Plan posted March 26, 2022
Greetings:
I strongly object to having an insurance company determine whether I need treatment or not. If Brad Owens resigned because he thought retirees were getting a raw deal, then I believe we are. I vote no on the mediation results.
Thank you for your consideration.
Lela Grogan
Alaska Teachers' Retirement
Amendment to the DB Retiree AlaskaCare Plan posted March 26, 2022

I would like to submit the following response and questions concerning the above referenced proposed amendment to the retiree AlaskaCare Health Plan.

Since 2003 the AlaskaCare Retiree Health Plan has stated that coverage will be provided for medical services and supplies that are "medically necessary" and not otherwise excluded.

The criteria are very clear, concise and easy to understand.

It states that to be medically necessary, the prescribed treatment must be "expected to improve or maintain health" or "to ease pain or suffering without aggravating the condition or causing other serious health problems."

Please answer the following questions:

1. The document containing the proposed retiree AlaskaCare Health Plan amendments on the DRB website states that it is a "draft" and that it would be effective on June 1, 2022.

Please tell me:

a. *if the words highlighted green are the proposed amendments,*

b. *whether there will be any more changes made to the draft before June 1 and,*

c. *if so, whether we will have a chance to see and comment on those.*

2. Since 2003 the Plan has specified that a prescribed medical treatment, procedure, or piece of equipment ("medical service or supply") is "medically necessary" if:

a. it helps cure or control a disease or condition or ease pain or suffering without aggravating the condition or causing other health problems, and

b. it is expected to provide information to determine the course of treatment without aggravating the condition or causing additional health problems.

These standards are simple, straightforward and easy to understand.

What are the reasons for amending the Plan's provisions concerning "medical necessity?" They are currently extremely well written and can be understood by the lay person.

3. When my doctor prescribes a medical treatment, procedure or piece of equipment for a disease or medical condition that:
a. helps cure or control my disease or condition,
b. ease my pain or suffering without aggravating the condition or causing other health problems, and
c. is not subject to any plan exclusion--

Does the Plan Administrator (DRB) or TPA (Aetna) still have the discretion to ignore my doctor's course of treatment that is based on her/his firsthand evaluation of my condition and instead use a secondhand evaluation by someonein the DRB or at Aetna, and deny coverage on the grounds of lack of medical necessity?

If so, what other factors does the claims administrator (Aetna) or Plan Administrator (DRB) consider in exercising its discretion whether a prescribed medical treatment, procedure or equipment is medically necessary?

4. *If these Plan changes are adopted, would Aetna's Clinical Policy Bulletins be used only if/when there is a good faith basis for questioning whether the prescribed medical treatment, procedure or equipment satisfies the Plan's standards for determining medical necessity as described in Question 2, above?*

5. *If these Plan changes are adopted, would any types of prescribed medical treatments, procedures or pieces of equipment that have been covered at any time since 2003 no longer be covered or have reduced coverage? If so, what coverages or other Plan benefits would be eliminated or reduced?*

6. *If these Plan changes are adopted and a claim is denied based on the lack of medical necessity, will the Explanation of Benefits tell me specifically and in language that can be easily understood by the lay person, which Aetna Clinical Policy Bulletin or other factor was relied on by the TPA or Plan administrator in exercising its "discretion" to deny coverage based on lack of medical necessity? If not, why not?*

7. *If these Plan changes are adopted and the Plan Administrator (DRB) has the discretion to decide if a prescribed medical treatment, procedure or piece of equipment is medically necessary, and if the DRB delegates that authority to another person, what methods would the DRB use to monitor and ensure that the person is making correct decisions?*

8. *Aetna is the current Third Party Administrator (TPA) for the retiree AlaskaCare health plan. It's Clinical Policy Bulletins (CPBs) are written to support the commercial insurance product that they sell, and not the retiree AlaskaCare health plan. These CPBs often conflict with the retiree AlaskaCare health plan.*

Can the Third Party Administrator(TPA) eliminate or reduce any coverages and/or other Plan benefits simply by changing one or more of its clinical policy bulletins to state that a prescribed medical treatment, procedure or piece of equipment is no longer considered medically necessary?

If so, then please answer these two questions:

A. *Does the TPA (Aetna) need to get the permission of the DRB to make that kind of change to the retiree AlaskaCare health plan?*

B. *Does the TPA or the DRB have to give Plan members (retirees) notice of the change <u>in advance</u> and, if so, how much advance notice will we be given and how will it be given?*

9. If *these Plan changes are adopted, will any new coverages or other Plan benefits be added to the Plan? If so, please tell me what those are and why they were not now covered or provided under the terms of the current Plan.*

10. "Section 12.14.13 Third Level" states that if a Plan member "does not file a Plan Administrator appeal timely [sic] ... the second level of appeal will be the final decision, and will be final, conclusive and binding on all persons."

<u>This conflicts with subsection (e) of 2 AAC 35.100 of the Alaska Administrative Code</u>, which provides that a Plan member may be permitted to file a late appeal if he/she provides a reasonable explanation of extraordinary circumstances that excuse the untimeliness and also requires the DRB to notify the Plan member if the right to appeal the denial of the late-filed claim. It states:

[T]he division shall return the notice of appeal to the person, and inform the person that the person may resubmit the notice with an explanation of why it was not timely filed. If the person resubmits the notice of appeal with an explanation or if the original untimely notice of appeal contained an explanation of untimeliness, and the administrator in either situation found that the explanation did not establish extraordinary circumstances excusing the untimeliness under (d) of this section, the person may file a new notice of appeal within 30 days of the date that the person receives notice of the decision refusing to accept the untimely first appeal.

<u>Why does that Plan section not advise Plan members of their rights to file an appeal after the deadline as provided by 2 AAC 100(e)?</u>

11. *Have the proposed amendments had an equivalency analysis done per the below ruling in Duncan v. RPEA?*

- *If so, please timely provide the analysis for review.*
- *If not, please explain why not.*

Per the 'Duncan' ruling below, if the proposed amendment is implemented on June 1, 2022, how will retirees who can show a serious hardship that is not offset by comparable advantages, be notified that they are allowed to retain existing coverage?

Duncan Equivalency Test—71 P .3d 882, 892:

At the outset, we reiterate Hoffbeck's admonition that equivalent value must be proven by reliable evidence. Just as with an individual comparative analysis, offsetting advantages and disadvantages should be established under the group approach by solid, statistical data drawn from actual experience-including accepted actuarial sources-rather than by unsupported hypothetical projections. We also believe that, apart from the individualized approach, the other guidelines concerning equivalency analysis set out in Hoffbeck should continue to be generally applicable. Further, we reiterate that equivalent value must be proven by a comparison of benefits provided-merely comparing old and new premium costs does not establish equivalency.

Where there is an individual showing that a change results in a serious hardship that is not offset by comparable advantages, the affected individual should be allowed to retain existing coverage. This is suggested by a distinction between Hoffbeck and the present case. In Hoffbeck the detrimental change resulted in clear and specific "serious hardship" to certain individuals. By contrast, the examples that have been offered in the present case amount to detriments of at most several hundred dollars a year, without consideration of benefits. We believe that if there were an individual showing that substantial detriments were not offset by comparable advantages and that this resulted in a serious hardship, the affected individual should be protected from the change by article XII, section 7. Further, our opinion in this case should not be interpreted as approving major deletions in the types of coverage offered during an employee's term. Coverage of a particular disease or condition should not be deleted, even though other coverage might be improved, if the deletion would result in serious hardship to those who suffer from the disease or condition in question. Moreover, if there should be changes that will predictably cause hardship to a significant number of beneficiaries who cannot at the time of the change be specifically identified, we believe that the option of providing an election to beneficiaries to retain existing coverage should be available, at least in the absence of a showing by the state of a compelling need for the change and the impracticability of providing for an election. Finally, changes that substantially reconfigure the mix of benefits to beneficiaries should be approved only upon a strong showing of justification. Unusual gaps in coverage should be avoided.

From: Michael Dekreon
Sent: Tuesday, April 19, 2022 11:10 AM
To: Ricci, Emily K (DOA) <emily.ricci@alaska.gov>
Subject: RPEA

My name is Michael J Dekreon. My wife's name is Rhonda J. Dekreon. We are life long Alaskans and are retired State of Alaska Employees.

We are NOT members of RPEA and they do not represent us.

We strongly object to RPEA claiming to represent us with the Alaska Division of Retirement and Benefits.

We are not sheep.

When we retired, we signed a contract with the State of Alaska, not RPEA.

Before you make changes in our retirement system, you had better contact the tens of thousands of retired employees and tell them what you are planning to do.

Michael J Dekreon
Rhonda J Dekreon

From: Jim Morrison
[redacted]
Anonymous User

4/17/2022 5:13:15 AM

Comment:
These changes were agreed to by the Union that is supposed to represent all retirees, buy is destroying our hard fought health insurance. These changes were agreed to WITHOUT polling all retirees. I think these changes are illegal to bind all retired persons, and if a lawsuit against the Union or the administration was started, I would join. This is wrong

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From: Sharon Hoffbeck

Sent: Thursday, April 14, 2022 3:24 PM
To: Ricci, Emily K (DOA) <emily.ricci@alaska.gov>
Cc: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <alaskarhpab@alaska.gov>; manager@rpea-ak.org
Subject: Comments re Proposed Plan Changes

Attached please find my comments to the proposed plan changes.

Thank you
Sharon Hoffbeck
PERS Retiree
Former RPEA President

RE: Response to Notice of Proposed Amendment to the DB Retiree AlaskaCare Plan posted March 26, 2022
I would like to submit the following response and questions concerning the above referenced proposed amendment to the retiree AlaskaCare Health Plan.
It is stated that the proposed amendment will be implemented June 1, 2022. I request a timely response so that I may have the opportunity to submit additional comments/questions if necessary before the deadline.

Thank you for your attention to this extremely critical plan amendment.
Respectfully,
Sharon Hoffbeck

Since 2003 the AlaskaCare Retiree Health Plan has stated that coverage will be provided for medical services and supplies that are "medically necessary" and not otherwise excluded.
The criteria are very clear, concise and easy to understand.
It states that to be medically necessary, the prescribed treatment must be "expected to improve or maintain health" or "to ease pain or suffering without aggravating the condition or causing other serious health problems."
Please answer the following questions:
1. The document containing the proposed retiree AlaskaCare Health Plan amendments on the DRB website states that it is a "draft" and that it would be effective on June 1, 2022.

Please tell me:
a. if the words highlighted green are the proposed amendments,
b. whether there will be any more changes made to the draft before June 1 and,
c. if so, whether we will have a chance to see and comment on those.

2. Since 2003 the Plan has specified that a prescribed medical treatment, procedure, or piece of equipment ("medical service or supply") is "medically necessary" if:

a. it helps cure or control a disease or condition or ease pain or suffering without aggravating the condition or causing other health problems, and

b. it is expected to provide information to determine the course of treatment without aggravating the condition or causing additional health problems.

These standards are simple, straightforward and easy to understand.
What are the reasons for amending the Plan's provisions concerning "medical necessity?" They are currently extremely well written and can be understood by the lay person.
3. When my doctor prescribes a medical treatment, procedure or piece of equipment for a disease or medical condition that:
a. helps cure or control my disease or condition,
b. ease my pain or suffering without aggravating the condition or causing other health problems, and
c. is not subject to any plan exclusion--

Does the Plan Administrator (DRB) or TPA (Aetna) still have the discretion to ignore my doctor's course of treatment that is based on her/his firsthand evaluation of my condition and instead use a secondhand evaluation by someone in the DRB or at Aetna, and deny coverage on the grounds of lack of medical necessity?
If so, what other factors does the claims administrator (Aetna) or Plan Administrator (DRB) consider in exercising its discretion whether a prescribed medical treatment, procedure or equipment is medically necessary?

4. If these Plan changes are adopted, would Aetna's Clinical Policy Bulletins be used only if/when there is a good faith basis for questioning whether the prescribed medical treatment, procedure or equipment satisfies the Plan's standards for determining medical necessity as described in Question 2, above?

5. If these Plan changes are adopted, would any types of prescribed medical treatments, procedures or pieces of equipment that have been covered at any time since 2003 no longer be covered or have reduced coverage? If so, what coverages or other Plan benefits would be eliminated or reduced?

6. If these Plan changes are adopted and a claim is denied based on the lack of medical necessity, will the Explanation of Benefits tell me specifically and in language that can be easily understood by the lay person, which Aetna Clinical Policy Bulletin or other factor was relied on by the TPA or Plan administrator in exercising its "discretion" to deny coverage based on lack of medical necessity? If not, why not?

7. If these Plan changes are adopted and the Plan Administrator (DRB) has the discretion to decide if a prescribed medical treatment, procedure or piece of equipment is medically necessary, and if the DRB delegates that authority to another person, what methods would the DRB use to monitor and ensure that the person is making correct decisions?

8. Aetna is the current Third Party Administrator (TPA) for the retiree AlaskaCare health plan. It's Clinical Policy Bulletins (CPBs) are written to support the commercial insurance product that they sell, and not the retiree AlaskaCare health plan. These CPBs often conflict with the retiree AlaskaCare health plan.

Can the Third Party Administrator (TPA) eliminate or reduce any coverages and/or other Plan benefits simply by changing one or more of its clinical policy bulletins to state that a prescribed medical treatment, procedure or piece of equipment is no longer considered medically necessary?
If so, then please answer these two questions:
A. Does the TPA (Aetna) need to get the permission of the DRB to make that kind of change to the retiree AlaskaCare health plan?
B. Does the TPA or the DRB have to give Plan members (retirees) notice of the change in advance and, if so, how much advance notice will we be given and how will it be given?

9. If *these Plan changes are adopted, will any new coverages or other Plan benefits be added to the Plan? If so, please tell me what those are and why they were not now covered or provided under the terms of the current Plan.*

10. "Section 12.14.13 Third Level" states that if a Plan member "does not file a Plan Administrator appeal timely [sic] ... the second level of appeal will be the final decision, and will be final, conclusive and binding on all persons."

This conflicts with subsection (e) of 2 AAC 35.100 of the Alaska Administrative Code, which provides that a Plan member may be permitted to file a late appeal if he/she provides a reasonable explanation of

extraordinary circumstances that excuse the untimeliness and also requires the DRB to notify the Plan member if the right to appeal the denial of the late-filed claim. It states:
[T]he division shall return the notice of appeal to the person, and inform the person that the person may resubmit the notice with an explanation of why it was not timely filed. If the person resubmits the notice of appeal with an explanation or if the original untimely notice of appeal contained an explanation of untimeliness, and the administrator in either situation found that the explanation did not establish extraordinary circumstances excusing the untimeliness under (d) of this section, the person may file a new notice of appeal within 30 days of the date that the person receives notice of the decision refusing to accept the untimely first appeal.
Why does that Plan section not advise Plan members of their rights to file an appeal after the deadline as provided by 2 AAC 100(e)?

11. Have the proposed amendments had an equivalency analysis done per the below ruling in Duncan v. RPEA?

- *If so, please timely provide the analysis for review.*
- If not, please explain why not.

Per the 'Duncan' ruling below, if the proposed amendment is implemented on June 1, 2022, how will retirees who can show a serious hardship that is not offset by comparable advantages, be notified that they are allowed to retain existing coverage?
Duncan Equivalency Test—71 P .3d 882, 892:
At the outset, we reiterate Hoffbeck's admonition that equivalent value must be proven by reliable evidence. Just as with an individual comparative analysis, offsetting advantages and disadvantages should be established under the group approach by solid, statistical data drawn from actual experience-including accepted actuarial sources-rather than by unsupported hypothetical projections. We also believe that, apart from the individualized approach, the other guidelines concerning equivalency analysis set out in Hoffbeck should continue to be generally applicable. Further, we reiterate that equivalent value must be proven by a comparison of benefits provided-merely comparing old and new premium costs does not establish equivalency.
Where there is an individual showing that a change results in a serious hardship that is not offset by comparable advantages, the affected individual should be allowed to retain existing coverage. This is suggested by a distinction between Hoffbeck and the present case. In Hoffbeck the detrimental change resulted in clear and specific "serious hardship" to certain individuals. By contrast, the examples that have been offered in the present case amount to detriments of at most several hundred dollars a year, without consideration of benefits. We believe that if there were an individual showing that substantial detriments were not offset by comparable advantages and that this resulted
in a serious hardship, the affected individual should be protected from the change by article XII, section 7. Further, our opinion in this case should not be interpreted as approving major deletions in the types of coverage offered during an employee's term. Coverage of a particular disease or condition should not be deleted, even
though other coverage might be improved, if the deletion would result in serious hardship to those who suffer from the disease or condition in question. Moreover, if there should be changes that will predictably cause hardship to a significant number of beneficiaries who cannot at the time of the change

be specifically identified, we believe that the option of providing an election to beneficiaries to retain existing coverage should be available, at least in the absence of a showing by the state of a compelling need for the change and the impracticability of providing for an election. Finally, changes that substantially reconfigure the mix of benefits to beneficiaries should be approved only upon a strong showing of justification. Unusual gaps in coverage should be avoided

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From: Brad Owens
Sent: Wednesday, April 13, 2022 11:56 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Cc: Randall Burns <rpea.ak.president@gmail.com>
Subject: Response to Notice of Proposed Amendment to the DB Retiree HealthCare Plan posted March 26, 2022
I wish to submit the following response and questions concerning the above referenced proposed amendment.

Since 2003 the Plan has stated that coverage will be provided for medical services and supplies that are "medically necessary" and not otherwise excluded. It also states that to be medically necessary, the prescribed treatment must be "expected to improve or maintain health" or "to ease pain or suffering without aggravating the condition or causing other serious health problems." It also states that a treatment will not be considered medically necessary if there is a an equally effective treatment or procedure that costs less than the one prescribed. These criteria are clear and easy to understand.

Please answer the following questions:

1. The document containing the proposed Plan amendments on the DRB website states that it is a "draft" and that it would be effective on June 1, 2022. Please tell me if the words highlighted green are the proposed amendments, whether there will be any more changes made to the draft before June 1 and, if so, whether we will have a chance to see and comment on those.

2. Since 2003 the Plan has specified that a prescribed medical treatment, procedure, or piece of equipment ("medical service or supply") is "medically necessary" if a) it helps cure or control my disease or condition or ease my pain or suffering without aggravating the condition or causing other health problems; b) it is expected to provide information to determine the course of treatment without aggravating the condition or causing additional health problems; and c) has no alternative that is equally effective and costs less. These standards are simple, straightforward and easy to understand. What are the reasons for amending the Plan's provisions concerning "medical necessity?"

2. When my doctor prescribes a medical treatment, procedure or piece of equipment for a disease or medical condition that a) helps cure or control my disease or condition or ease my pain or suffering without aggravating the condition or causing other health problems; b) has no alternative that is equally effective and costs less; and c) is not subject to any plan exclusion, does the Plan Administrator still have the discretion to deny coverage on the grounds of lack of medical necessity? If so, what other factors does the claims administrator (Aetna) or Plan Administrator (DRB) consider in exercising its discretion whether a prescribed medical treatment, procedure or equipment is medically necessary?

3. If these Plan changes are adopted, would the Clinical Policy Bulletins be used only if/when there is a good faith basis for questioning whether the prescribed medical treatment, procedure or equipment satisfies the Plan's standards for determining medical necessity as described in Question 2, above?

4. I If these Plan changes are adopted, would any types of prescribed medical treatments, procedures or pieces of equipment that have been covered at any time since 2003 no longer be covered or have reduced coverage? If so, what coverages or other Plan benefits would be eliminated or reduced?

5. If these Plan changes are adopted and a claim is denied based on the lack of medical necessity, will the Explanation of Benefits tell me specifically which Clinical Policy Bulletin or other factor was relied on by the claim or Plan administrator in exercising its "discretion" to deny coverage based on lack of medical necessity? If not, why not?

6. If these Plan changes are adopted and the Plan Administrator (DRB) has the discretion to decide if a prescribed medical treatment, procedure or piece of equipment is medically necessary, and if the DRB delegates that authority to another person, what methods would the DRB use to monitor and ensure that the person is are making correct decisions?

7. Can the claims administrator (TPA) eliminate or reduce any coverages and/or other Plan benefits simply by changing one or more of its clinical policy bulletins to state that a prescribed medical treatment, procedure or piece of equipment is no longer considered medically necessary? If so, then please answer these two questions:
A.) Does the claims administrator (Aetna) need to get the permission of the DRB to make that kind of change?
B.) Does the claims administrator or the DRB have to give Plan members notice of the change in advance and, if so, how much advance notice will we be given and how will it be given?

8. If these Plan changes are adopted, will any new coverages or other Plan benefits be added to the Plan? If so, please tell me what those are and why they were not now covered or provided under the terms of the current Plan.

9. "Section 12.14.13 Third Level" states that if a Plan member "does not file a Plan Administrator appeal timely [sic] ... the second level of appeal will be the final decision, and will be final, conclusive and binding on all persons." This conflicts with subsection (e) of 2 AAC 35.100 of the Alaska Administrative Code, which provides that a Plan member may be permitted to file a late appeal if he/she provides a reasonable explanation of extraordinary circumstances that excuse the untimeliness and also requires the DRB to notify the Plan member if the right to appeal the denial of the late-filed claim. It states:

[T]he division shall return the notice of appeal to the person, and inform the person that the person may resubmit the notice with an explanation of why it was not timely filed. If the person resubmits the notice of appeal with an explanation or if the original untimely notice of appeal contained an explanation of untimeliness, and the administrator in either situation found that the explanation did not establish extraordinary circumstances excusing the untimeliness under (d) of this section, the person may file a

new notice of appeal within 30 days of the date that the person receives notice of the decision refusing to accept the untimely first appeal.

Why does that Plan section not advise Plan members of their rights to file an appeal after the deadline as provided by 2 AAC 100(e)?

From: Dan Motley
Sent: Tuesday, March 29, 2022 2:45 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Proposed Amendment to the AlaskaCare Defined Benefit Retiree Health Plan
RE: Section 12.14.13 -

I find the proposed changes disingenuous at best. There has not been and will not be, despite an ideal opportunity to add one or more, any punitive measure(s) to any part of the appeal process regarding the Plan Administrator (or anyone else connected with the appeal process) for a failure to act or to act in good faith. The appellant loses their ability to pursue if they fail to meet some arbitrary deadline, but the State can simply not act, thus killing the appeal, with impunity.

This change appears to be a change only for the sake of change and not to rectify a glaring equity issue. Spoken by someone who has been through the appeals process and never received a formal, final response despite following every rule requirement.

Sincerely,
Dan Motley

From: Carlton Erikson
Sent: Saturday, March 26, 2022 8:28 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Notice of Proposed AlaskaCare Defined Benefit Retiree Health Plan

To Whom It May Concern,

I have read your proposed amendment to the AlaskaCare defined Benefit Retiree Health Plan and have the following suggestion(s):

In Section 3.3.1, Medically Necessary Services and Supplies

In the second sentence, “ClaimsAdminstrator’s” appears to be one word – needs a space

In the second sentence, I recommend replacing “, in their discretion,” with “discretionary authority” so that it might read better and avoid the need to add the gender-neutral pronouns.

Suggested Example:

The medical plan will utilize the Claims Administrator's current Medical and Pharmacy Clinical Policy Bulletins for purposes of determining medical necessity for services covered under the medical plan; provided, however, that The Plan Administrator retains discretionary authority to determine whether a service or supply is medically necessary.

In Section 12.14.13 Third Level – Division of Retirement and Benefits Appeal

At the beginning of the last sentence, instead of using "…a Plan Administrator appeal timely,…" I would suggest:

"If you do not file a timely appeal with the Plan Administrator, to the extent available under this section, …"

In the proposed definitions section, for "Plan Administrator" you might be able to avoid the gender-neutral pronoun(s) by replacing "their" with "authorized designee acting on behalf of the Commissioner" so that it might read:

"Plan Administrator" shall mean the Commissioner of the Department of Administration, State of Alaska, or authorized designee acting on behalf of the Commissioner.

Respectfully submitted,
Carlton Erikson

From: James Browning
Sent: Sunday, March 20, 2022 8:11 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Rule change

I wish to receive the text copy of the proposed changes to retiree benefits!

From: Judith Anderegg
Sent: Saturday, March 19, 2022 4:29 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Cc: rpea state of alaska <manager@rpea-ak.org>
Subject: Amendment to Alaska Care Defined Benefit Retiree Health Plan

Having read through the amendment, it looks to me to be basically an effort by the state to clean up the language of the AlaskaCare Defined Benefit Retiree Health Plan, to be effective June 1, 2022.

It seems to me that a lot of the changes are related to acknowledging that our health care plan's implementation is the responsibility of the state not a private insurance company. I am very glad to see that. However there are still references to Aetna in this particular section of the health care plan and probably other parts as well- specifically a web link is added to Aetna Clinical Policy Bulletins. So my question is, when the state decides to award the contract for the health care plan to someone else, who

will retirees turn to for help during the period of time it takes the state to revise the particular references to Aetna for us retirees.
Thank you for this opportunity to comment.

From: Diane Lex
Sent: Saturday, March 19, 2022 12:56 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Current RPEA board does NOT represent me

I do NOT agree to nor support the Proposed Amendment to the AlaskaCare Defined Benefit Retiree Health Plan, nor do I agree with the opinions and actions of the RPEA board as it is presently constituted (particularly Wendy Woolf and Stephanie Rhoades); they do NOT represent my views.

Diane Lex
retired teacher

From: Michael C Hawker
[redacted]
Anonymous User

Submitted: 3/19/2022 6:24:21 AM

Comment:

Regarding proposed changes to 3.3.1: The changes essentially remove the specific reference to AETNA and offer generic plan administrator language. Okay, that's fine. However, a comment on AETNA clinical policy bulletins. These bulletins can, in specific important cases, be demonstrated to be woefully out-of-date, anecdotal, and do NOT reflect current best practices or clinical practices.

In specific cases that particularly affect the early and precise diagnosis and treatment of cancer, the AETNA CPB are over 20 years out-of-date and are wholly inconsistent with contemporary medical science, all other major US administrators, and MEDICARE approved services and practices. AETNA should be criminally culpable for their actions in these cases that cause unnecessary hardship, suffering, and possibly death to Alaska beneficiaries. Call me anytime for details. ~ Former Representative Mike Hawker

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From: darlindrx
Sent: Friday, March 18, 2022 3:07 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Amendments to the retiree health plan

Good afternoon

In reading section 3.3.1 Medical necessity, it would seem that the language change is a bit ambiguous. I am wondering what has prompted the requested change.

We have seen during this past year a lot of discussion regarding appropriate treatments for covid. Some better than others. As we have all or almost all have weathered covid, I have reservations as how this amendment might affect certain treatments for other variants or diseases that may arise in the future. Would this change say preclude the use of monoclonal antibodies or hydroxychloroquine? After reviewing all of the information/misinformation regarding covid and actions of the CDC and FDA regarding "alternative" treatments this past year, I have apprehensions regarding *"generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment; (e) the opinion of health professionals in the generally recognized health specialty involved; and (f) any other relevant information brought to the Plan Administrator's attention."*

We have seen and heard a lot this past year, and in the past might have said ok, I will listen to the government but now have severe doubts as to what is really going on. I have seen "scientific data" supposing driving decisions only the opposite is true.

With this amendment, you are asking me to trust the very sources that I have reservations about. I am fortunate to live in Arizona and the hospital here if I need it provides alternate solutions to the disease care.

I do not want to lose the opportunity for care just because of supposed "scientific data".

Thank you
Linda Rexwinkel

From: William Lex
Sent: Friday, March 18, 2022 1:59 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Proposed changes to "medical necessity" in plan

Dear Dept. of Retirement & Benefits

I am not in favor of the proposed changes shifting authorization of "medical necessity" to a plan or claims administrator. While this might make it easier to manage the plan and reduce costs, it also is likely to disadvantage plan members making it more difficult, cumbersome, and bureaucratic to receive services and retain benefits. What's wrong with the current plan that these changes will address? Explain the rationale for the changes and I might change my mind. Without understanding the reasons for the proposed changes, I cannot evaluate how it would effect plan members benefits. Without that information I am opposed to modifying the plan.

Please respond to my comment, if possible.

William Lex

From: Daniel H Zobrist
[redacted]
Anonymous User

Submitted: 3/18/2022 12:02:25 PM

Comment: I strongly oppose these amendments. A reading appears to give too much power to a political appointee, rather than the medical consensus, in determining a medical condition or procedure that deemed covered by the plan.

I strongly oppose.

From: Donald Thieman
Sent: Friday, March 18, 2022 11:59 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Comments re: Proposed Amendment to the AlaskaCare Defined Benefit Retiree Health Plan

Besides being a dependent member in the AlaskaCare retiree health plan, I am an insurance medical director since 1998 with experience as the Regence BlueCross BlueShield of Oregon VP in charge of the medical affairs department, and medical coverage policy, for six of those years. My comments come from that perspective.

These changes appear well-drafted and appropriate. Specifically, the attention to the various nuances of "medical necessity," recognizing that only a share of medical care can be covered by policy bulletins or other medical policy, and only part of clinical practice is supported by what we would consider strong evidence. The other aspects of judging what is medically reasonable and necessary are addressed nicely in your draft.

Donald Thieman MD

Currently a part-time semi-retired medical director [redacted] [redacted]

From: Lorilyn Boone Lane
[redacted]
Anonymous User

Submitted: 3/18/2022 11:51:23 AM

Comment: WHY are we making these changes, please?

From: ken uzzell
Sent: Friday, March 18, 2022 11:01 AM

To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Comment on proposed amendment to retiree plan

I am somewhat dismayed to see a 60 day limit for Alaska Retirees to enter into a disagreement or appeal regarding what is medically necessary.

Everything seems to be available via digital means, when we have never really approved the cessation of paper means. **Sixty days doesn't seem like enough time for basically viewing the documents, or realizing the long reaching effects.**

I base my comments on recent health issues our family has experienced. It took many, many weeks to recover enough to even think about determinations of hospitalization/care/treatments that happen in a very intense and compressed time. The addition of Medicare who **reports ONLY QUARTERLY via paper** adds another level of delay for anyone to realize what is happening. Not all of us have legal advocates with the time to look up EOB's and determine what should or should not be contested.

Feel free to contact me via email if you require any further explanation.

From: Mary Henderson
Sent: Friday, March 18, 2022 10:56 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Proposed amendment

The proposed amendment is a workable solution for our retirees. Thanks for defining it.

Mary Henderson

From: Dave Wilson
Sent: Friday, March 18, 2022 10:43 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Optical
I have no comment on the proposed amendments at this point.

I would like to share a suggestion that has been on my mind for some time so I'll feel better after relieving myself of the weight.🙂

Many folks, especially the retired are getting their eyewear from Costco. Costco is a fourth of the price of the price charged in other shops.

Why not wave the member's 20% on frames and lenses if purchased at Costco. This would encourage even more members to purchase there and it saves Alaska Care money as well. A win-win.

Thank you,
Dave Wilson
Retired-[redacted]

From: Greg Motyka
Sent: Friday, March 18, 2022 10:31 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Notice of draft amendments

You email was pretty much useless; there was no context provided that would help people understand what the amendments would entail.

From: Tim Joyce
Sent: Friday, March 18, 2022 10:20 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: health plan amendments

After reading the draft amendments to the plan, it appears to be simple clarification of how the plan is administered. Unless I am missing something< it does not appeaar to change teh way hte plan functions.

Tim Joyce

From: Daphne Hofschulte
Sent: Friday, March 18, 2022 10:02 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Comment on proposed amendments

Thank you for the information.

Regarding section 2. relating to determination of medical necessity, it does not appear that the member's medical provider has sufficient input to the final decision.

The claims administrator only needs to consider the sources of information listed, and then retains authority to decide. These sources of information probably speak to generic, average, hypothetical, historic or aggregate situations, not the individual member's specific case.

What assures us that the administrator is making tbe best medical decision to benefit the member, and not a financial decision benefitting the insurance carrier?

Respectfully,
Daphne Hofschulte

From: James Cochran
Sent: Friday, March 18, 2022 9:41 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Draft Amendment to the AlaskCare Defined Benefit Retiree Health Plan (Plan)

1. You have a link to Aetna's medical policy bulletins. Either it is the State's intent to continue with Aetna as the Plan Administrator indefinitely or this link should include language that allows the link to be changed to the contracted Administrator in the future without requiring a regulatory amendment.

2. It appears you are trying to achieve generalizing the regulations regarding the Claims Administrator, but a strict reading of the proposed regulations finds places where Aetna is still mentioned, which would require new regulations should a different Claims Administrator be selected.

Other than generalizing the proposed regulations to preclude the need for going through the extensive process of finalizing new regulations should a new Claims Administrator be selected, we have no further comments or concerns.

/s/ James O. Cochran

From: Dianne Kocer
Sent: Friday, March 18, 2022 9:37 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Proposed changes to health plan

"Claims administrator?" I understand the reason to keep medical care costs reasonable. This is not the way. There is nothing that I have yet seen that defines the qualifications of this "claims administrator." A better approach would be to still have a non-biased administrator who understands health care....like Aetna....and perhaps determine more definitive guidelines or parameters for reimbursement.

Submitted: 3/18/2022 9:31:32 AM
From: Ewin Frothingham
Homer, AK, US
Anonymous User

Comment: I've got a bit of a problem with, "in their discretion", in the below paragraph. That gives a lot of latitude to the plan administrator, even with all the guidelines. Might read better, if the administrator were to be required follow a set of medical guidelines. If there is a problem with the guidelines, then the discretion part could come into play.

2) Amends Section 3.3.1 Medically Necessary Services and Supplies
3.3.1 Medically Necessary Services and Supplies
The medical plan pays only for medically necessary services and supplies, as defined in Section 3.3, "Covered Medical Expenses." The medical plan will utilize Aetna's the Claims Administrator's current Medical and Pharmacy Clinical Policy Bulletins for purposes of determining medical necessity for services covered under the medical plan; provided, however, that the Plan Administrator retains the authority to determine, in their discretion, whether a service or supply is medically necessary. In exercising such discretion, the Plan Administrator shall consider: (a) information provided on the affected person's health status; (b) reports in peer-reviewed medical literature; (c) reports and guidelines.

From: sandy notes
Sent: Friday, March 18, 2022 9:27 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Proposed Plan amendments

Just a general question:

Now that Aetna has been purchased by CVS, will we be required to use only CVS pharmacies?

Sandra Notestine

From: Shelley Szipszky
Sent: Friday, March 18, 2022 9:11 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Proposed amendment to the Alaska Care Benefit Retiree Health Plan Thoughts

My only concern is whether or not the Claims Administrator is a Certified Medical Doctor who would understand all the different types of evidence which supports or contra indicates whether a procedure or supply is medically necessary.

Shelley

Submitted: 3/18/2022 9:09:04 AM

From: Barbara Daniels
Grants Pass, OR, US
Anonymous User

Comment: I definitely approve of the removal of Aetna from making these determinations!