Retiree Health Plan Advisory Board

Board Meeting Minutes

Date: Tuesday, May 8, 2018 9:00 a.m. to 4:00 p.m.

Location: State Office Building 333 Willoughby Avenue 10th Floor Juneau, AK 99801 and Robert B. Atwood Building 550 West 7th Avenue Suite 1970 Anchorage, AK 99501

Meeting Attendance

Name of Attendee	Title of Attendee	
Retiree Health Plan Advisory Board (RHPAB) Members		
Judy Salo	Chair	Present
Cammy Taylor	Vice Chair	Present
Mark Foster	Member	Present
Joelle Hall	Member	Present
Gayle Harbo	Member	Present
Dallas Hargrave	Member	Present
Mauri Long	Member	Present
State of Alaska, Department of Administration Staff		
Leslie Ridle	Commissioner, Alaska Department of Administration	
Natasha Pineda	Deputy Health Official	
Vanessa Kitchen	Administrative Assistant	
Ajay Desai	Director, Retirement + Benefits	
Emily Ricci	Health Care Policy Administrator, Retirement + Benefits	
Michele Michaud	Deputy Director of Retirement + Benefits	
Andrea Mueca	Health Operations Manager, Retirement + Benefits	
Kevin Worley	CFO, Retirement + Benefits	
Others Present + Members of the Public		
Richard Ward	Segal Consulting (designated actuary for state health plans)	
Linda Gable	Manager of Client Services, Aetna	
Haley Duran	Local Representative + Associate Account Manager, Aetna	
Brad Owens	Public, representing Retired Public Employees of Alaska	
Sharon Hoffbeck	Public, representing Retired Public Employees of Alaska	
Clair Martin	Public	
Phil Mundy	Public	
Dorne Hawxhurst	Public	
Grant Callow	Public	
Lisa Fitzpatrick	Public	

Common Acronyms

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

- ACA = Affordable Care Act
- CMS = Center for Medicaid and Medicare Services
- DB = Defined Benefit plan (for Tier 1, 2, 3 PERS employees and Tier 1, 2 TRS employees)
- DCR = Defined Contribution Retirement plan (for Tier 4 PERS employees and Tier 3 TRS employees)
- DOA = State of Alaska Department of Administration
- DRB = Division of Retirement and Benefits, within State of Alaska Department of Administration
- DVA = Dental, Vision, Audio plan available to retirees
- EGWP = Employer Group Waiver Program, a federal program through Medicare Part D that provides reimbursement for retiree pharmacy benefits
- HIPAA = Health Insurance Portability and Accountability Act (1996)
- OTC = Over the counter medication, does not require a prescription to purchase
- PBM = Pharmacy Benefit Manager, a third-party vendor that performs claims adjudication and network management services
- PHI = protected health information, a term in HIPAA for any identifying health or personal information that would result in disclosure of an individual's medical situation.
- RHPAB = Retiree Health Plan Advisory Board

Meeting Minutes

Item 1. Call to Order + Introductory Business

Chair Judy Salo called the meeting to order at 9:00 a.m.

Agenda + Minutes Approval

Materials: Agenda packet for RHPAB Meeting 5/8/18; Draft minutes from RHPAB Meeting 2/7/18

- **Motion** by Gayle Harbo to approve the agenda as presented. **Second** by Cammy Taylor.
  - **Discussion**: None.
  - **Result**: No objection to approval of agenda as presented. Agenda is approved.
- **Motion** by Gayle Harbo to approve the 2/7/18 minutes as presented. **Second** by Joelle Hall.
  - **Discussion**: Board members reviewed the minutes. Judy Salo, Gayle Harbo and Dallas Hargrave identified corrections to their personal information. Natasha Pineda recorded the changes and identified she would make the necessary adjustments in the final version of the minutes.
  - **Result**: No objection to approval of minutes as presented, pending typos and other minor corrections identified. Minutes are approved.

Ethics Disclosure

Materials: Ethics Disclosure Form in 5/8/18 meeting agenda packet

Judy Salo introduced the ethics disclosure form that board members are required to complete and sign.

Calendar Review

Materials: Meeting Calendar Options in 5/8/18 meeting agenda packet

Discussion to determine which month would be best to hold future meetings. Dates in February, May, August and November were identified as quarterly meeting months and potential dates for each month were identified. The board also discussed how to align the quarterly board meetings with other required meetings, such as with quarterly Third Party Administrator meetings.

May was a concern due to expense and February a concern due to the legislature being in session. Gayle Harbo proposed that November 6, 2018 would likely be the least expensive. Judy Salo identified that at today's meeting she would like to firm up August and November 2018 meeting dates, and tentatively decide on when the 2019 in-person board meeting would be. Judy Salo stated that this discussion would be continued later in the agenda.

Upcoming board meeting: August 29, 2018 (8/29/18). Future meetings are discussed under Item 4.

Public Comment Process

Materials: Public Comment Guidelines in 5/8/18 meeting agenda packet

Discussion of public comment guidelines document for the board. Natasha Pineda led the review of the Public Comment Guidelines document, noting that recommended changes are highlighted. Ms. Pineda stressed the need to be cautious about publishing protected health information (PHI), including in public comments, because the state is the administrator for the health plan. Additionally, the board's role is advisory only and focused at the policy level related to the state's health plans. The board does not have a role in hearing medical appeals. The public comment guidelines should make this clear and encourage the public to limit sharing of their personal information on the public record, and instead use the proper channels for appeals. Staff will request legal guidance on how to handle these situations in the future and avoid sharing PHI from members of the public. Concerns regarding a specific case or administrative issues should be directed to Aetna, their concierge number is 1 (855) 784-8646. Ms. Pineda will add this to the public comment guidelines.

There was mention of the 3-minute time limit for public comment, as RHPAB had previously identified a 2-minute time limit. Judy Salo requested it be left at 3-minutes and proposed giving more time (up to 5 minutes) for someone who is speaking on behalf of an organization or group. It was clarified that the Chair is tasked with running the meeting and can grant additional time as needed.

Emily Ricci provided a brief description of protected health information: A provision under the HIPAA laws that protects any and all health information that is identifiable at an individual level (Examples given: types of coverage, types of services they are receiving, a specific diagnosis, names and addresses).

Mark Foster asked about cases when a person making a comment has been asked whether they would waive their confidentiality to share the information, and the person has indicated yes. Michele Michaud responded that this question would also be referred to Department of Law for their opinion on these issues. Emily Ricci identified specific concerns about posting transcripts online and wanting to get legal guidance in this matter.

Cammy Taylor suggested developing a form for individuals commenting to check off if they want to waive their confidentiality, so that there is a physical record regarding their comments. Natasha Pineda

identified that this has been discussed. Emily Ricci stated that this is a good solution for people testifying in-person, but this will not necessarily address the issue of people testifying by phone or online.

Cammy Taylor was concerned that written comments needing to be received thirty days prior to the board meeting may preclude people from participating in the process. The group discussed time needed to review comments, set agenda and post the board packet: staff noted that they need sufficient time to review each comment and redact any protected health information that should not be in the public record. Additional board members identified a desire to shorten the thirty-day window for written comments. Joelle Hall proposed notification for public comment and posting of the agenda thirty days prior to each board meeting and setting a schedule so the public knows they have two weeks to provide comment. Additionally, members of the public can submit comments at any time, they just may not be included in the next board meeting packet if there is not enough time to review and post the comment. The public can also attend or call into board meetings and share their comments verbally during the meeting in the public comment period. Natasha Pineda proposed using this schedule for the 8/29/18 meeting; the board agreed.

Cammy Taylor also requested that all board materials (agenda packets, minutes, additional documents) be available online, including cumulative materials from past meetings. Staff confirmed that they can implement this and make sure board meeting materials are posted and kept online as a resource, provided that they do not contain confidential or protected health information.

Item 2. Bylaws Review and Adoption

Meeting materials: Draft Retiree Health Plan Advisory Board Bylaws in 5/8/18 meeting agenda packet

Judy Salo invited Dallas Hargrave to walk the group through the bylaws.

Mr. Hargrave stated that Natasha Pineda prepared a draft of the bylaws for the Bylaws Subcommittee to review, following the guidelines in Administrative Order 288 (AO 288). Dallas Hargrave, Cammy Taylor, Judy Salo, and public member Pat Nault participated in the subcommittee meeting and reviewed the draft bylaws on 4/11/18. Joelle Hall was also a member of the subcommittee, she was unable to attend that meeting but reviewed the bylaws separately. The subcommittee decided that a second meeting was not necessary and has endorsed the draft shared with the board for approval. Dallas Hargrave led an article by article discussion of the bylaws.

- Article 1: No discussion or revisions.
- Article 2: Discussion of Section 3, regarding language "qualify as administration in support of health plan."
    - **Motion** by Mauri Long to amend Article 2, Section 3 to read "… the board is advisory only." Strike language about administration of the health plan. **Second** by Mark Foster.
        - **Discussion**: Board members discussed their advisory role and how it relates to administration of the health plan. RHPAB does not hear appeals and does not have a quasi-judicial role. However, the proposed bylaws language was taken from AO 288, which is ultimately the authority for this board.
        - **Result**: The board voted. 3 Yes, 4 No. Motion fails.

- **Motion** by Mauri Long to amend Article 2, Section 3 to read "the Board is advisory only and may not engage in activity in administration of the health plan." **Second** by Joelle Hall.
  - **Discussion**: Question from Mauri Long about whether it is appropriate to make reference to AO 288 or whether the bylaws are changing the intent of AO 288. The group agreed the administrative order itself is not changing.
  - **Result**: The board voted.

Foster	Hall	Harbo	Hargrave	Long	Salo	Taylor
Yes	Yes	Yes	Yes	Yes	N/A	Yes

Motion passes, bylaws will be amended accordingly.

- Article 2: Typos identified in Section 4, these will be corrected. No motion required.
- Article 3: No additional changes. Dallas Hargraves noted that the subcommittee discussed Section 3 regarding compensation and travel expenses, and that it should be consistent with Article 5, Section 2.
- Article 4: No additional changes. RHPAB will have a Chair and Vice Chair, chosen annually.
- Article 5: No additional changes. Committees will be established by the Chair, must have at least two board members, and will serve until discharged by the Chair.
  - Dallas Hargraves noted that the references to travel expenses is consistent with Article 3, Section 3 and that all travel is subject to approval by DOA. The purpose of organizing in-person meetings in different locations each year is to allow for members in different communities to meet in the same place, and to rotate the location periodically so it is not always in Anchorage, for example.
  - Mauri Long asked whether the language in Article 3, Section 3 and Article 5, Section 2 is repetitive, does it need to be included twice? Dallas shared that the committee's rationale was that it was included in AO 288 and is relevant in both sections. No motion.
- Article 6: The subcommittee proposed not establishing standing committees, but giving the board the authority to establish committees as needed: for example, the bylaws subcommittee performed its function and saved the board from a detailed discussion about the bylaws before this final review and approval.
- Article 7: No additional changes. The board will follow Robert's Rules of Order in meetings.
- Article 8: No additional changes. The board will follow the Alaska Executive Branch Ethics Act.
- Article 9: No additional changes. Proposed amendments to the bylaws require 30 days notice.

- **Motion** by Dallas Hargraves to adopt the bylaws as amended during the meeting, and pending technical edits and correction of typos by staff. **Second** by another board member.
  - **Discussion**: None.
  - **Result**: The board voted: Judy Salo stated that the chair typically only votes in the case of a tie. She opted to vote this time because the adoption of bylaws is important.

Foster	Hall	Harbo	Hargrave	Long	Salo	Taylor
Yes	Yes	Yes	Yes	Yes	Yes	Yes

Motion passes. Bylaws are adopted.

Item 3. Public Comment

Before beginning public comment, the board established who was present in Anchorage and Juneau, on the phone or online, and who intended to provide public comments. Sharon Hoffbeck (RPEA), Phil Mundy, Dorne Hawxhurst, Grant Callow, and Lisa Fitzpatrick attended and did not wish to testify.

Public Comments

Brad Owens, Executive Vice President of the Retired Public Employees of Alaska (RPEA). Brad stated that he is providing comments on behalf of RPEA. Mr. Owens requested that the RHPAB consider the information he provides, investigate it, and make recommendations to the Department of Administration (DOA). He provided comments on several topics:

- RPEA was created in 1996 and incorporated in 1998. Its membership includes retired public employees, current public employees, and dependents. RPEA's mission is to educate, assist and advocate on behalf of all retirees in Alaska.
- Employer Group Waiver Program (EGWP): DOA proposes to change the current pharmacy benefit subsidy program to EGWP. EGWP is a federal program under Medicare and can be modified, suspended or terminated at any time; the current subsidy program is constitutionally protected from changes. EGWP would impose a substantial burden on retirees through the complex regulations and procedures that would apply, and don't apply to the program retirees have now. It appears DOA is proposing the EGWP primarily for cost savings, which is a valid goal but should be accompanied by due diligence to make sure the changes don't hurt retirees. Additionally, DOA has stated they are proposing implementation in 2018, which is of concern.
- Retiree Health Plan Modernization: DOA says that it proposes to make changes by amendments to the plan over the next two years, but if you look at the time cycle in the materials, it looks like it is already in process for implementation in 2018. There needs to be a balancing of the costs and benefits of these changes, to make sure that they are not implemented simply for the sake of cost savings, or take away protected benefits. The materials seem focused on cost-saving efforts rather than benefits, protection, or enhancement. RPEA feels that the State has failed to perform sufficient analysis of these changes as required by the 2003 Alaska Supreme Court Case *Duncan vs. RPEA*. The case established that the State must demonstrate that the changes are not a diminishment of benefits; if it is a diminishment, they must be offset by comparable enhancements to benefits to maintain or improve the overall value of the plan.
- DOA seems to be systemically denying retirees their right to appeal denials to the DOA. They do that by settling certain claims, such as physical therapy or occupational therapy, and that the settlement resolves the case but is not applicable to future cases which would require a new appeal. RPEA believes that retirees should have the ability to take their full appeal before the Office of Administrative Hearings (OAH).

Mark Foster asked Mr. Owens whether or not specific concerns about the EGWP have been raised with the DOA? Mr. Owens identified that RPEA and other retiree organizations have been in regular contact with DOA about proposed changes over the past eight years. DOA has described the EGWP program and potential benefits in these conversations, but there has not been a discussion about or clear documentation of the process or procedures that were followed to reach the conclusion that, for example, the EGWP change will not diminish benefits.

Written comments with redacted information. Two written public comments were submitted as hardcopy documents to the board, but were not read into the record. It was identified that these comments, with redactions, would be published on the RHPAB website as part of the minutes.

A board member commented that he would like the board to consider how best to utilize public comments, especially when they raise policy issues of interest to RHPAB and the Department. Commissioner Ridle commented that these are relevant questions for the modernization project, there will be a presentation (*see 5/8/18 agenda packet*) to provide a status update. The board will continue to be involved in this project and certainly can make policy recommendations to DOA.

Clair Martin, public member (later in the meeting). Clair Martin commented that she had technical difficulties connecting during the public comment period. She commented that she wished the RHPAB would suggest to Aetna that they include preventative programs such as "Silver Sneakers" (a wellness program available through many Medicare secondary insurance programs) into retirees' benefits. She would like to see better coverage of preventive care and wellness programs, they have many physical and mental health benefits for seniors.

Judy Salo commented that preventive care is something the commissioner may bring up during the modernization discussion in the afternoon. Commissioner Ridle also invited the speaker to attend future meetings about the modernization project to learn more about what is being proposed and to stay involved in the effort.

Item 4. Scheduling Calendar of 2018 and 2019 RHPAB Meetings

Meeting materials: 2018-2019 Calendar Options in 5/8/18 meeting agenda packet

The August meetings dates have already been determined and will take place in Juneau. The quarterly retiree plan meeting will be on August 28, 2018 (8/28/18) and the RHPAB Board Meeting will be on August 29, 2018 (8/29/18).

The board and staff discussed relevant deadlines and other recurring events. Michele Michaud gave the example of quarterly review of the plan's performance with the vendors (Aetna and Moda), and reviewing actual claims data to understand cost and utilization trends. For example, some procedures or services are costly, and understanding trends for these services can help with plan design in the future. Emily Ricci added that this information is formatted like a dashboard and typically includes information about claims, demographic information about members served, and other measures.

Joelle Hall asked whether these quarterly review documents can be shared with the public? Emily Ricci noted that general, high-level information such as overviews of claims denials and customer service performance can be shared publicly, staff provides this information to stakeholder groups. The full reports can be shared with RHPAB as well, there is a lot of detailed information about the plans.

Cammy Taylor asked whether RHPAB members can participate in the quarterly review meetings with DOA staff and their vendors? Michele Michaud indicated that they can, and shared that the next meeting will be May 23, 2018. Judy Salo also noted that there is not a requirement for board members to attend, but the information may be helpful to better understand the AlaskaCare plans.

Cammy Taylor also requested that staff compile a high-level summary of information for RHPAB to review, pulled from the quarterly dashboard reports from each of the plans' vendors.

- **Motion** by Cammy Taylor to set the following RHPAB meeting for November 28, 2018 (11/28/18), coinciding with the Aetna Quarterly Retiree Plan stakeholder meeting on November 27 (11/27/18). **Second** by Joelle Hall.
    - **Discussion**: Gayle Harbo shared her rationale for the proposed dates: meeting once per quarter, during the months that the vendor will be visiting Alaska, and earlier in the month is less disruptive particularly in May and November. Judy Salo noted that she is a part year resident so she is not typically in state year round. Joelle Hall commented that she also prefers meetings not adjacent to holidays, she has children in school. Dallas Hargraves requested an electronic calendar invite from staff to reserve these dates.
    - **Result**: No objection to November date. The RHPAB will meet on 11/28/18 in Juneau.

The board then discussed potential dates for 2019: RHPAB has quarterly meetings, and the group discussed having these dates coincide with vendors' travel to Alaska for quarterly meetings.

- **Motion** by Gayle Harbo to set the following dates for 2019 RHPAB meetings: February 6, May 8, August 7 and November 6, 2019. Which meeting(s) will be in person versus telephonic will be determined later. **Second** by Judy Salo.
    - **Discussion**: None.
    - **Result**: No objection to November date. The RHPAB will meet on 11/28/18 in Juneau.

Item 5. Department Update – Leslie Ridle, Commissioner

Commissioner Leslie Ridle provided updates on several items:

Legislative Updates

- HB 240, the Pharmacy Benefit Manager Bill or PBM bill. This bill passed May 7, 2018. The bill had widespread support and an almost-unanimous vote.
- HB 306, which pertains to how tier 4 retirements would be dispersed to members. [Note: HB 306 passed on May 8, 2018 and was signed into law on June 18, 2018].

Procurement for Third Party Administrator for Some Health Plan Services

- Leslie shared an overview and status of the procurement process for each, including evaluation committees. For procurements impacting active employees, the Health Benefits Evaluation Committee was also consulted.
- Leslie noted that DOA is working on three procurements related to health care services:
    - Travel benefits (concierge service to make travel arrangements upfront rather than reimbursement). RHPAB member Cammy Taylor was an evaluation committee member.
    - Pharmacy benefit management (PBM) to manage prescription drug benefits. RHPAB member Judy Salo was an evaluation committee member.
    - Third party administrator for medical and dental benefits. DOA is currently reviewing and finalizing the RFP for this procurement. Leslie requested that one RHPAB member join the evaluation committee, which will require in-person interviews and committee

meetings to discuss the proposals. The plan is to release this RFP in the third quarter of 2018.

- Cammy Taylor commented that in 2014, the medical and dental plans were proposed as separate contracts, but this is the first time the pharmacy benefit will be carved out and managed by a vendor under a separate contract from the other benefits.

Pending Decision on 2014 Court Case Regarding Health Plan Amendments

- DOA is facing litigation connected to 2014 amendments to the dental, vision, audio (DVA) plans for retirees; retirees pay for that coverage, although it is also administered by the State. In 2016 a lawsuit was filed and RPEA won a summary judgment that ruled that dental plans are constitutionally protected and that DOA should go to court to determine if the 2014 amendments resulted in diminishment of benefits. The court case is in progress and is scheduled to be heard for two more days in June.
- Leslie noted that actuarial analysis of the changes estimated about 10 to 14 percent in annual savings, or $13 to $18 million in savings since the change. This represents additional assets for the DVA (dental, audio, vision plan) trust, which have kept premiums for the DVA lower despite an increase in the price of services due to inflation. Depending on the outcome of the court case, if the DVA plan could not maintain those savings, it would necessitate an increase in premiums to offset increasing claims costs and maintain sufficient assets.
- There will be more information once the judge makes a decision, and this item will be discussed further at the August meeting unless the case is still pending.
- Judy Salo asked whether dental coverage has always been separate from the medical plan? Michele Michaud confirmed that this benefit has been separate. Emily Ricci added that unlike other plans they administer, all members pay for this directly.
- Mauri Long asked for clarification about the court decision and how it impacts future decision making about the plans? Leslie stated that she does not know the specifics yet, but the judge could give the State a certain timeframe to address these issues, and there will hopefully be time to further discuss the implications of the changes while still complying with the court's decision.
- Board members and Commissioner Ridle generally discussed the implications of this court decision and other decisions about the health plans (such as the *Duncan* case) as it relates to the modernization project and other issues RHPAB will have a role in. What basis for comparison and decision making will the State use, and RHPAB use, to consider proposed changes to the plans?
- Mark Foster asked staff to create a template for evaluating the proposals for future decisions. Leslie agreed that this would be helpful, and that staff are still developing the process for considering these changes under the modernization project. Many of the changes being considered are benefits that members have said they want, it is a matter of following a clear process in light of the legal issues associated with plan changes.
- Judy Salo agreed that a framework would be helpful, it establishes some certainty about the future for retirees, and also will help future boards (RHPABs) when discussing future changes or issues related to the health plans.
- Mauri Long asked whether there have been significant changes to the health plan since 2000? The plan booklet has had some changes to it since then. Michele Michaud clarified that the plan

has had some specific changes, documented as amendments in the front of the booklet, but no significant changes to the plan itself. There was a comprehensive amendment to the booklet in 2014. Emily Ricci added that the purpose of clearly documenting the booklet changes is that, even if the plan itself isn't changing substantially, clearly noting changes in the booklet increases transparency to members.

Item 6. Employee Group Waiver Program (EGWP)

Materials: EGWP presentation and frequently asked questions in 5/8/18 meeting agenda packet

Emily Ricci and Michele Michaud provided an overview presentation for the Employee Group Waiver Program. The state's health benefit consultant and actuary, Richard Ward of Segal Consulting, was also available to answer questions or clarify technical issues.

Presentation

The presentation gave an overview of the Employer Group Waiver Program (EGWP) and its purpose, a group pharmacy benefit plan under Medicare Part D. This change would impact only retirees and dependents eligible for Medicare, since it is a Medicare program; retirees who do not qualify for Medicare would remain on the non-EGWP pharmacy plan.

The State is exploring use of an enhanced EGWP, which allows the State to provide coverage for additional medications beyond what is covered under Medicare Part D and maintain member's existing benefits. This subsidy program was included in the RFP for the new Pharmacy Benefit Manager (PBM) contract, so the presenters noted that many specific questions will need to be resolved with the vendor when they have been selected, since many details about plan design will depend on the vendor.

The State currently participates in the Retiree Drug Subsidy program and receives approximately $19 to $21 million per year, compared with a total expenditure of $240 million in pharmacy benefits for retirees—this is approximately 45% of total retiree health plan expenditure, much higher than the typical 20% for commercial insurance plans. EGWP has three types of subsidies: direct per member subsidy, regardless of how many benefits the individual used; coverage gap subsidy with a 50% discount on brand name drugs if the member falls into the coverage gap; and catastrophic coverage subsidy, where Medicare provides 80% reimbursement for high utilizers (pharmacy spending over $7,500 per year). The State would retain the RDS to subsidize costs for non-EGWP eligible members, but this will be a much smaller subsidy going forward.

The projected savings by changing to an EGWP do not only affect the State's health trust, it may also help decrease or offset the State's assistance payments, which could represent between $40 and $60 million in State General Fund payments. State assistance payments are funds transferred for the State's unfunded liability in the benefits system for pension, health plan, and other benefits, with the goal of making regular payments to this system to close the gap by year 2039. State assistance payments have ranged between $100 million and $500 million.

Emily Ricci and Michele Michaud also commented that the demographics of the plan are changing: more retirees are Medicare eligible. Gayle Harbo commented that she's heard the statistic, approximately 70 percent of retirees are Medicare eligible.

Staff identified additional impacts, either during the initial transition period or going forward:

- Co-pays will remain the same as the current plan, so generally members will not be impacted when filling prescriptions.
- Additional required communications from CMS, who oversees Medicare.
- Pre-authorizations for medications cannot be carried forward into the EGWP. Members will need to obtain new authorizations.
- Some members with multiple health conditions and high utilization will be enrolled in the Medicare Medication Therapy Management Program, unless they opt out. CMS considers this to be a member protection. The program will provide assistance and resources for people to better manage their medications—it does not require the patient to follow the advice.
- There is an appeal process for Medicare Part D claims, members in the enhanced EGWP will need to follow this appeal process. It is comparable to the state's current appeal process, but involves the federal court system rather than state courts.
- Per CMS rules, the benefit will require up to a 90-day supply, not 100 units. Past claims data shows that very few retirees utilize the 100 unit refill option currently.
- Medicare Part D has a formulary with specified tiers of medications, and what can be covered in each tier. The enhanced or "wrap" of benefits with EGWP allows the State to cover additional medications, which is important to maintaining members' current pharmacy benefits.
- Members may need to present two ID cards for the plan to their pharmacist, one for Medicare Part D benefits and another for the enhanced EGWP benefits. This will depend on the vendor.
- Members who opt out of the enhanced EGWP plan will be enrolled in the alternative plan, the same for those in the defined contribution (DCR) plan.
- Members who are high income (individual income over $85,000 or a married couple with income over $170,000) would be required to pay an additional premium, like other Medicare plans. The State is working on options for reimbursement so this is not an additional out of pocket expense for impacted members.
- There are additional questions to resolve with the new vendor, such as how pre-authorizations will be handled, ensuring that members are not subject to "step therapy" meaning that they have to switch to lower cost medications first, inclusion of pharmacies in the network, and accessing information about benefits (such as explanation of benefits documents).

Questions and Discussion from Board Members

Cammy Taylor asked for clarification about whether medical pharmacy and hospital pharmacy expenses are covered under this plan or separately? Hospital and medical (drugs administered at the doctor's office) pharmacy costs are typically covered under the medical plan.

Joelle Hall asked whether the recently-passed HB 240, regulating PBMs, impacts the state? Leslie Ridle commented that the bill does not pertain to the state plans, more to private insurance plans. Emily Ricci added that staff have been engaging with independent pharmacists about specific issues impacting them, such as generic versus brand name medications.

A board member asked how often subsidies are paid to the State? RDS payments are quarterly, and rely on past claims data. EGWP payments are made monthly, and because it is a per member payment, it is easier to forecast the subsidy amount. Gap coverage and catastrophic coverage payment would be more delayed, as they deal with individual claims.

Mauri Long asked about the meaning of the State being the plan fiduciary, and what this means for the new PBM contract? Is this required in statute or case law? Michele Michaud answered that because the State is considered self-insured, in statute the State is responsible as the plan fiduciary. In the enhanced EGWP, per CMS rules, the Pharmacy Benefit Manager becomes the plan fiduciary for pharmacy benefits—it is buying a fully insured product from the PBM vendor, rather than being fiduciarily responsible as an insurer.

Joelle Hall asked if and how the formulary can be adjusted, if it is set by Medicare Part D? Emily Ricci and Michele Michaud commented that the State can still work with the vendor to include or change coverage of prescription drugs—this is not being given only to the PBM to manage. Additionally, in addition to the Medicare Part D formulary, the enhanced EGWP wrap from the state can be used to cover other prescriptions or at different levels. Additionally, Joelle Hall shared a concern that the PBM will agree to cover a certain number of drugs in an initial formulary, then remove coverage over time, a "lock leader" once the plan is secured. Emily Ricci and Richard Ward explained the CMS-mandated process for establishing formularies, which requires advance filing for next year's formulary.

Joelle Hall also asked whether this shift to the enhanced EGWP would mean that the same benefit protections still apply, or does this become a different system so the question of constitutionally protected benefits would not apply in this situation? Commissioner Ridle answered that she believes it is the benefits themselves, not a specific program, that are constitutionally protected. The current RDS program is, for example, a reimbursement system not a benefit itself. EGWP would be the same, it is an administrative change, with the goal that the actual benefit (such as co-pay amount) remains the same.

A board member asked for clarification about the process of re-evaluating or changing when the state begins the EGWP? Can the State choose to discontinue the new plan? And what would happen if significant changes in federal law (such as, discontinuation or defunding of the EGWP program) occurred? How would the State ensure benefits are not disrupted? Michele Michaud and Emily Ricci responded that there is an annual renewal of EGWP so changes could be made at that time, or the State could unenroll if it is not working. Additionally, the State cannot predict what changes might happen at the federal level, the current subsidy program is also a federal program that can change. Regardless of how the pharmacy benefits are paid for, the State has an obligation to provide benefits, and the large expenditure on the pharmacy plan (either the largest in the state, or one of the largest) is an area where the State is trying to contain costs and consider options in order to continue providing these benefits.

Item 7. Introduction of Retiree Modernization Concepts

Materials: Retiree Health Plan Modernization presentation in 5/8/18 meeting agenda packet

Commissioner Ridle gave opening remarks: The Division is working on several initiatives to improve the retiree health plan and its sustainability long term, under the umbrella term of "modernization project." The State has to evaluate each proposal in terms of actuarial value and cost to the State, to ensure benefits are not diminished in the plan (retaining or gaining in actuarial value) as well as whether they have the resources to implement or offer new benefits. The comparison is not a simple trade off of "gaining four things, losing two things" because of how the health plan must be evaluated. The Division is consulting with stakeholders including retirees, legislators, the governor's office, and others. Staff will introduce the changes being considered, some of these proposed changes are benefits that retirees and members have asked for.

Emily Ricci and Michele Michaud provided an overview presentation of Retiree Health Plan Modernization. Michele clarified that the proposals being discussed relate specifically to the Defined Benefit (DB) retiree health plan, and not the Defined Contribution Retirement (DCR) plan. The goal of the modernization project is to provide value to the members by incorporating common benefits not currently available, while preserving the overall benefit of the plan and implementing standard cost-saving mechanisms. The current retiree health plan is considered an "old" plan because it does not have several common benefits in other health plans, and also does not have cost control mechanisms common in most other health plans. Balancing the quality and value of benefits offered, against the need to sustainably pay for the plan over the long term in order to meet the State's constitutional obligations, is complicated. This will take time, and the Division intends to collaborate with retirees and with the board to consider these changes. The timeline would be to begin implementation of some changes in 2019, after careful consideration and analysis, and that it would take several years to fully implement changes to the plan.

The Division has an annual cycle for reviewing and making changes to the health plan: the plan renews on January 1, and there are several steps including identifying issues or improvements, considering solutions, conducting analysis of the options, seeking public input on the proposals, and finalizing the decisions in the fall before the new plan takes effect on January 1. The Division has to follow this process and be mindful of the annual cycle for the plan, to properly time this process to go into effect in the following year if possible.

Staff gave historical background: the plan was created in 1975, and was written primarily as a plan to address illness or injury. The health care field has evolved since then, with one of the biggest changes being more of a focus on wellness and preventive care than the current plan provides for. In 1997, the State changed the plan from purchasing a fully-insured plan (like commercial insurance) to a self-insured plan, meaning the State has ultimate financial liability for health care expenditure in the plan. The presentation includes a comprehensive list of changes from 1983 to 2000. There were several changes to the plan in 1999-2000.

The Constitution and Alaska case law have established the following guidelines for changes to the plans: first, when considering the disadvantages of changes, they must be offset by new advantages, taken as a whole—not necessarily on an individual member basis. An individual's situation can, however, be considered, if an individual can demonstrate serious hardship (which is not currently defined in law).

Staff have identified 12 areas of concern that members have communicated to the Division, and the team is working on possible solutions. The table on slide 9, reproduced below, summarizes the 12 areas.

#	Concern	Possible Solution
1	Limited preventive care services	Add coverage for full suite of preventive services
2	Lifetime limit of $2M	Remove or increase limit
3	Low cost share reduces sensitivity to price & increases unnecessary services	Increase deductible and out-of-pocket maximum
4	Increasing costs of pharmacy benefits	Implement 3-tier pharmacy benefit, change out-of-network benefits
5	Outdated pharmacy design	Limit to 90 day fill, exclude OTC equivalents
6	Safety and efficacy of drugs	Limit compound coverage for non-FDA approved drugs
7	Limited travel benefits	Enhance travel benefits
8	Confusion over rehabilitative services	Implement clear service limits or hire specialized vendor
9	Confusion over dental implants	Exclude some implants from medical plan and cover under dental plan
10	High use of hi-tech imaging & testing	In-network enhanced clinical review
11	Dependent coverage limits	Statutory change
12	Confusing plan booklet	Update to include regulations, amendments & benefit clarifications

Judy Salo asked for clarification about constitutional protections for accrued benefits, and the impacts of the 1999-2000 changes? Michele Michaud explained that the lawsuit filed after these changes were made (*Duncan v. RPEA*) was the case that established the guidelines for changes to the health plan. The court ruled in that case that the changes made to the health plan were not a diminishment of benefits, but also that the health plan is constitutionally protected. The case did not give detailed guidance, however, and relied on actuarial analysis of the plan to establish that the benefits were equivalent to the old plan. More legal guidance is needed to clarify what is protected.

More information about components:

- Updating plan booklet: the booklet has not been substantially updated since 2003, and changes have been documented in the front of the book not in the sections they apply to. The Division will be publishing a new draft booklet and seek public comments—the booklet draft will highlight what changes have been made, so readers can clearly understand the revisions. The changes are not substantive to the benefits themselves, it is basically a reorganization and cleanup of the booklet to make it easier to use.
- Preventive services: the current plan covers limited preventive services, such as mammograms, and PSA tests. Members have asked for more preventive benefits. The State is considering how to expand these benefits, such as focusing on in-network care versus out-of-network, and exceptions for areas without in-network options.
    - Mauri Long asked for clarification about what full preventive services would be? Emily Ricci answered that there are established best practices available nationally, such as recommendations from the U.S. Preventive Services Task Force, that would inform what services would be covered.

    - Mauri followed up to ask, has the State analyzed the additional cost of providing these services, and compared this against additional health care costs for not covering these services that would occur? Is this change cost neutral, or what is the additional cost that needs to be offset to offer these benefits? Emily Ricci responded that the State is still conducting analysis on this, but initial work has shown that there will be an additional cost for providing this. They have not yet compared the potential savings, which can be difficult to quantify. Staff will do more analysis in this area.
- Lifetime limit: Currently the plan has a $2 million lifetime limit, but some members with extremely costly medical episodes have ended up using a quarter ($500,000) or half ($1 million) of this benefit in a short time, particularly as health care costs have increased. Staff is looking into removing the lifetime limit.
    - Mauri Long requested information about the last change of lifetime limit (from $1 million to $2 million) in 2000, and how many members have reached this limit. She would like to understand the financial implications of the higher limit, and therefore possibly removing this limit.
    - Staff commented that the number of retirees reaching this limit is increasing.
- Cost sharing (co-pays and deductibles: The retiree health plan has lower cost sharing for members than most other health plans. There is a delicate balance between keeping costs manageable and making sure people have access to necessary care, and ensuring that members remain price sensitive and utilize care appropriately (meaning, not using unnecessary services because they do not feel the impact of the costs of those services). Because Alaska only has a fee for service health care system, it is difficult to incentivize cost containment. One tool to do this in the current system is to increase deductibles or out of pocket maximum amounts. This is a controversial proposal and needs more discussion, since it impacts out of pocket costs for members, but is necessary to consider due to inflation over time, and rising health care costs.
    - Mauri Long asked how many members have more than two family members in their household? If most individuals have only two members, this is a potential area to change the plan without significant negative impact.
- Cost of pharmacy benefits: Staff analysis has found that a significant portion of members are using brand name medications when a generic or another alternative is available. One option to address this is a three-tier pharmacy plan, with incentives for using generic drugs or lower cost / preferred brands, with lower co-payments, and having a higher co-pay for those brand name drugs for which alternatives are available.
    - Joelle Hall commented that this may be an education issue, not plan design: could the plan provide focused education to members using high cost medications? They may be unaware that there is another option, or perhaps the medication options for their situation changed since they got their initial prescription.
    - Emily Ricci agreed that education is very important, but also pointed out that the Division has heard from multiple vendors that the plan design could better incentivize those choices and incentivize lower cost medications. The financial incentive to choose a different medication, as long as it is not medically necessary to use a specific brand, is an effective way to nudge members to contain costs. Emily used the analogy of in-network versus out-of-network providers: in-network providers are typically more cost effective for the plan, and members are less exposed to balance billing, where the

provider bills the patient for any costs not covered by insurance, which may be significant if the provider is out of network.

  - The group discussed comparison of the state plan (dispensing generic drugs) with other plans: Aetna shared their data, Alaska's rate is 80% generic dispensing compared with 84% in other plans. The 4% difference represents significant cost. Richard Ward added that for every percent of generic utilization (increase in generic use versus brand name), the State can save 2 to 3% in pharmacy costs, approximately $2 million for each 1%.

- Pharmacy plan design: The State is also considering other changes to the pharmacy plan, such as changing the dispensing amount from 90-day supply or 100 units to remove the 100 unit option, a standard in the Medicare Part D plan and many other plans. Most members are not filling 100-unit prescriptions. Another change would be to cease coverage of drugs with an over the counter (OTC) equivalent, since they are available without a prescription. The number of OTC medications available has increased over time. Emily Ricci added that the health plan was previously amended to make this change in 2014, but was rescinded because of pushback from members. The State would like to consider this change again, and analyze the potential costs and benefits given the increased availability of OTC medications or equivalents.
- Concerns about compounded medications: Some medications are compounded, meaning that the pharmacist mixes them onsite or adds a medication to other products to make it easier to ingest or take. The FDA and national provider groups have expressed concern about safety for patients and oversight of this practice. The retiree health plan has much higher use of compound medications than comparable plans with Aetna, for example, and it is not being sufficiently monitored to see if lower-cost options are available and protect patient safety. Other states have seen increasing fraud and misuse with compounded medications, so this is worth investigating further. There are several valid uses of compound medications, so the benefit would not go away, but may limit coverage to only some situations, or require use of approved drugs.
- Travel benefits: Currently travel benefits are limited, and members have to make their own arrangements and shoulder the costs upfront. The plan does have enhanced travel benefits for some procedures. Generally speaking, health care services are more expensive in Alaska and therefore it may be more cost effective to travel for certain procedures. Having better coverage of travel related expenses for care would benefit members and make it easier to consider travel for a non-emergency or specialty treatment. This would apply to in state travel, for example someone traveling to Anchorage or Fairbanks from their community, as well as out of state. There are already systems in place for medical travel, used by some plans in Alaska, that work with recognized high-quality providers for procedures like hip and knee replacements, to provide better service at better cost.
- Rehabilitative services: This is the top issue in plan appeals, and is very confusing for members and adds significant administrative burden to the State. These include physical therapy, occupational therapy, chiropractic, massage therapy (as part of physical therapy), and speech therapy. One solution is to limit the number of visits per year by service type, and not base coverage of those services on "significant improvement". Although the number of visits per benefit year may be restricted, it could result in enhancing benefits for people with chronic conditions that require these services as a form of maintenance.

    - Gayle Harbo asked if rolfing is included in these benefits? Rolfing is not covered in the current health plan, but it would be covered as this type of service.
    - Mauri Long asked if acupuncture is covered? Acupuncture is only covered in lieu of anesthetic during surgery, not as a general benefit.
- Dental implants: There is confusion about coverage of dental implants, due to loss from injury or disease, including periodontal disease. As of 2014, the dental plan also covers implants. The current confusion has to do with coverage of periodontal disease, whether that should be part of the medical or dental plan, and because the medical and dental plans do not coordinate benefits.
- High-tech imaging services: Members are currently utilizing high-tech, high-cost imaging services even if other alternatives are available. These include radiology, diagnostic cardiology, sleep management studies, and cardiac rhythm implant devices. Considering when and how to incentivize alternatives to these high cost imaging services is an option.
- Coverage of dependents: Currently, the plan is governed by state statute which allows coverage of dependents up to age 23. The Affordable Care Act requires most plan to cover dependents up to age 26, but the State is not subject to this as it is exempt, as are all retiree only health plans per the ACA. Members have requested expanded coverage, but this is a change that requires change to state statutes, not simply a plan change. Cammy Taylor added that the employee health plan was grandfathered under the ACA, but made changes to the plan that mean it is now subject to ACA requirements. The retiree plan remains exempt under the ACA, it is a part of that federal law. Michele Michaud added that many states include both employees and retirees in the same plan, so those states are also subject to ACA requirements for retirees.

Other questions and comments from board members

- Mauri Long asked about implications for Medicare eligible and enrolled members on the retiree plan? Michele Michaud noted that if someone is enrolled in Medicare, Medicare is their primary coverage and the state plan is secondary. They would need to go to a Medicare provider, and not necessarily follow the network for the state plan. Medicare does have some preventive care coverage, that may be separate from the state plan. Non-Medicare-eligible retirees have the state plan as primary payer. Staff are investigating the gaps between systems and figuring out how to ensure consistent coverage.
- Joelle Hall asked about the extent and quality of network coverage outside Alaska? Michele Michaud responded that Aetna has a national network, and the State works closely with the vendor to maintain a network for out of state retirees.

Staff shared some ideas for engaging with retirees and members going forward: there is an existing annual survey, but the Division would like to do a more in depth survey and get a representative sample of members to better understand the impacts of these changes. Only a subset of retirees contact the Division and usually to address a specific issue or problem. The Division is still working on the proposed process to analyze and discuss each of the options presented, and has not prioritized the options at this time, other than highlighting possible changes to the plan that can be done sooner and will enhance the package of benefits in the retiree health plan.

The board discussed forming subcommittees to work further on each topic, and what additional research will be helpful. While some of these changes could just be executed by staff, such as the

revision of the booklet, the Division wants to engage the board and other interested stakeholders in discussion to communicate the purpose of the modernization project, and let people know that changes are happening, such as to the booklet. The Division has encountered a great deal of resistance to change in the past, which has prevented more improvements to the plan from happening. Mark Foster commented that he is also interested in considering the Division's and vendor's customer service performance, whether there are better technology solutions to improve the customer experience (such as electronic funds transfers instead of paper checks), and encouraged creation of a customer service focused policy. He is interested in considering customer service as part of overall value of the plan. Staff agreed that this is important to consider, and that the Division is working on internal improvements to improve communications and customer service. For example, they are ensuring there is a concierge service available to members.

The board decided to form a modernization committee. Members volunteered to serve on the committee: Joelle Hall, Cammy Taylor, Mark Foster. Chair Judy Salo approved formation of this committee and appointed the three members to the committee. Staff will share information and notices of meetings with all board members if they would like to participate as well.

The board has a general e-mail address for communications: alaskaRHPAB@alaska.gov. The staff member supporting the board (Vanessa Kitchen) has access and will route communications to the board as needed. Public comments have been received through this e-mail and will continue to be.

- **Motion** by Judy Salo to adjourn the meeting. **Second** by Cammy Taylor.
    - **Discussion**: None.
    - **Result**: No objection to adjournment. The meeting was adjourned at 4:00.