

**Retiree Health Plan Advisory Board  
Modernization Committee  
Meeting Agenda**

**Meeting:** Modernization Committee  
**Date:** August 10, 2018  
**Time:** 1:00pm-5:00pm  
**Location:** **Anchorage:** Atwood Building, 550 W 7<sup>th</sup>, 19<sup>th</sup> Floor Conf. Room  
**Juneau:** State Office Building, 10<sup>th</sup> Floor Conf. Room  
**Teleconference:** **1-855-244-8681 / Meeting Number 282 288 646 #**  
WebEx Link:  
<https://stateofalaska.webex.com/stateofalaska/j.php?MTID=m3a9704f00d7b6d66a1bb6b684cc89ae8>  
**Committee Members:** Mark Foster, Cammy Taylor and Joelle Hall

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August 10, 2018

<b>1:00pm</b>	<b>Call to Order – Mark Foster</b> <ul style="list-style-type: none"><li>• Approve the agenda</li><li>• Approve the previous meeting minutes (7/26/18)</li><li>• Introductions</li></ul>
<b>1:10pm</b>	<b>Public Comment</b> <ul style="list-style-type: none"><li>• Read the Oral Public Comment Script</li></ul>
<b>1:30pm</b>	<b>Continue to Discuss Analysis – DRB Presentations</b> <ul style="list-style-type: none"><li>• EGWP</li></ul>
<b>3:00pm</b>	<b>Break</b>
<b>3:15pm</b>	<b>Continue to Discuss Analysis – DRB Presentations</b> <ul style="list-style-type: none"><li>• Lifetime</li><li>• Preventative</li><li>• Travel Benefit</li></ul>
<b>4:15pm</b>	<b>Public Comment</b>
<b>4:45pm</b>	<b>Final thoughts</b> <b>Schedule next meeting</b>
<b>5:00pm</b>	<b>Adjourn</b>

# Meeting Minutes

## 7/26/18

## Retiree Health Plan Advisory Board

### Modernization Committee Meeting Minutes

Date: Thursday, July 26, 2018 1:00 to 4:00 p.m.

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

#### Meeting Attendance

Name of Attendee	Title of Attendee	
Retiree Health Plan Advisory Board (RHPAB) Members		
Mark Foster	Committee Chair	Present (phone)
Joelle Hall	Committee Member	Present
Cammy Taylor	Committee Member	Present
Judy Salo	Board Chair	Present
Mauri Long	Board Member	Present
State of Alaska, Department of Administration Staff		
Leslie Ridle	Commissioner, Alaska Department of Administration	
Ajay Desai	Director, Retirement + Benefits	
Emily Ricci	Health Care Policy Administrator, Retirement + Benefits	
Vanessa Kitchen	Administrative Assistant	
Michele Michaud	Deputy Director of Retirement + Benefits	
Andrea Mueca	Health Operations Manager, Retirement + Benefits	
Others Present + Members of the Public		
Richard Ward	Segal Consulting (actuary for AlaskaCare plans)	
Anna Brawley	Agnew::Beck Consulting (meeting support)	
Brenda Arney	Public	
Grant Callow	Public	
Sharon Clar	Public	
Carol Fleek	Public	
Susan Miller	Public	
John Northcott	Public	
Brad Owens	Public	
Stephanie Rhoades	Public	
Rose Scherer	Public	
Nancy Woolford	Public	

## Common Acronyms

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

- ACA = Affordable Care Act (formal name: Patient Protection and 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)
- HRA = Health Reimbursement Account, a mechanism for the employer to reimburse high-income Medicare enrollees for any premium charge for their Medicare plan (IRMAA)
- IRMAA = Income Related Monthly Adjustment Amount, a surcharge from CMS for a Medicare plan for individuals or households earning above certain thresholds
- MAGI = Modified Adjusted Gross Income, based on an individual or household's tax returns and used by CMS to determine what if any premium must be paid for a Medicare plan.
- 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 + Introductions

Committee Chair Mark Foster called the meeting to order at 1:00 p.m. The committee conducted roll call for members present.

Review of agenda: Mark Foster proposed shortening the afternoon break to 15 minutes (2:00 to 2:15) instead of 20 minutes. He also proposed scheduling a second committee meeting prior to the August 29 RHPAB board meeting. The committee will discuss scheduling later in the meeting.

Emily Ricci shared an update from staff: the State has contracted with Agnew::Beck Consulting to provide support for staff on a variety of projects, including documentation of RHPAB meetings while the Division is short-staffed. The contract was awarded in June after a competitive bid process. A::B project manager Anna Brawley attended the meeting and documented the minutes.

### Item 2. Public Comment (Part 1)

Mark Foster reminded those present in the meeting that public comments should be mindful of protected health information as protected under HIPAA, and that testimony in the meeting and in writing to the State is public information. By giving testimony on the public record and sharing any of this protected health information, a person waives their right to this protection; a person may not opt to waive another person's rights, including their spouse or family member.

#### Public Comment

- Carol Fleek (Juneau) shared that she would like to make a comment, but is not sure this is the appropriate meeting and will hold her comments until later in the meeting or another time.
- Nancy Woolford (Juneau) worked for the state for 21 years and has appreciated the benefits provided. She has a question regarding the policy for beneficiaries (spouses, etc.) for deceased public employees, and understanding the benefits available.
- Brenda Arney (Anchorage) retired from the state in 1999, and turned 65 in 2014. She sent an e-mail message to the board (RHPAB) but received a response from State (DRB) staff instead, she is concerned that a communication meant directly for the board was viewed by staff, and would like a direct line of communication to the board.

When she enrolled in Medicare and requested information about drug benefits from the State, she learned that the State's pharmacy benefits are robust, as good as Medicare benefits; and in most cases, the State's current drug program is better than what Medicare Part D provides. She feels that the State is neglecting its fiduciary duties for its own financial benefit by shifting Medicare eligible retirees to EGWP. She understands there are significant projected savings to the health trust and other state funds, and those savings can be utilized to offer additional benefits for members. However, as a Medicare enrolled retiree, she feels that this will be a diminishment as they will not be able to access other benefits. She is also concerned that this is potentially age discrimination. It is very difficult to find a doctor who accepts Medicare, so it is hard to find a provider. She feels that enrollment in Medicare was a diminishment of her previous benefits in the retiree plan. She is also concerned about the potential of the federal government to eliminate the Medicare Part D program, since it is not constitutionally protected the way that the state benefits are. She is

concerned that there would be no oversight by the State over this federal program, so it would be difficult to protect these benefits.

She also feels that the 5-step appeal process to CMS will be burdensome, and that the federal government will not sufficiently protect their benefits. She urges state employees to consider that they will be retirees someday, and these decisions will impact them as well in the future.

- Others present in the meeting opted to testify during the second public comment period.

### **Items 3 and 4. Findings on Priority Items in Modernization Project + Discussion of Findings**

*Materials: EGWP Analysis Memo in 7/26/18 meeting agenda packet*

*Note: These items were separate items on the agenda, but board members asked questions and made comments throughout the presentation on individual topics. This item will be continued at the next Modernization Committee meeting.*

Mark Foster invited staff to provide updates on the modernization project, and requested plenty of time and regular pauses to accommodate questions.

#### **Defining Actuarial Value**

Michele Michaud introduced Richard Ward, the state's actuary who works for Segal Consulting.

Richard Ward works with Segal Consulting, a national actuarial firm, and is a member of the Society of Actuaries. He specializes in public sector health plans and has been supporting public organizations throughout his career. He is on contract to the State to provide expertise on actuarial issues.

Richard presented the definition of actuarial value: in the context of a health plan, actuarial value is calculated in aggregate for all members, in the form of a percentage. For example, 90% actuarial value means that on average for all members utilizing the plan each year, the health plan provider (in this case, State of Alaska) covers 90% of the costs, and the member covers the other 10% through co-pays, deductibles, etc. This does not take into account the breadth of provider network, types of services covered or not, and other aspects of a plan. Actuarial value is a general measure for the financial value of the plan, but is not the only measure of financial impact. For example, introducing higher-quality or more doctors into a network than were previously available would have a financial impact on the plan and improve the overall quality of the plan for members, but not alter the plan's actuarial value.

When measuring actuarial value of a plan, actuaries look at cost sharing mechanisms, deductibles and out of pocket maximums. The actuarial value of a plan does not include premiums, for entry into the plan, this would also have a financial impact if changed, but does not change actuarial value.

- Judy Salo asked: from the member's perspective, how does actuarial value relate to the financial impacts of the plan for that member?
  - Richard responded that it would depend on the individual member or situation, but for example, if the plan has a \$4 co-pay and that does not change, the actuarial value stays the same. Another example: changing a vendor, or implementing a new program, may have a financial impact but does not change actuarial value.
  - Judy responded that as an individual member, she would be more interested in the overall financial impacts and not just actuarial value, but she is still working to

understand the meaning of “actuarial value” and how it applies to overall financial value and impacts of changes to plans.

Michele Michaud shared that staff have prepared a summary analysis of the proposed changes to the plan, using the template shared in the agenda packet that the State will use to summarize their analysis of impacts to the plan.

#### EGWP Impact Analysis Memo

The analysis conducted is categorized by benefit impacts, financial impacts, members who will be impacted, and any other relevant impacts. Staff will use these categories to consider various possible impacts for each proposed change.

Michele shared that overall, a change to EGWP will retain current coverage of prescription drugs that are covered in the current plan, and that it will not change the actuarial value of the plan because there will not be changes to co-pays or the types of medications covered. Staff also reviewed the experience of other states: over 90% of states who offer health benefits to their retirees have already implemented an EGWP and have realized cost savings.

The change to EGWP was discussed by the Alaska Retirement Management Board in 2017, and passed a resolution supporting this change to the plan. *The resolution is included in the meeting packet.*

If the federal EGWP is substantially changed or reduced, or is otherwise not meeting the needs of Alaska’s members, the State has authority to revise or unenroll from EGWP in the future. The State will monitor the performance of the plan and make changes as needed.

Approximately 48,889 members are estimated to be Medicare eligible, about 60% of retirees live in Alaska, and about 40% live outside of Alaska. There is a small number of people living outside the U.S., and another small number who are actively working, and not eligible for Medicare A premium free making them ineligible to be enrolled in EGWP. This small population will continue to receive benefits in the same manner as they do today, without the benefit of the federal subsidies to the health trust.

The State proposes using an enhanced EGWP, which uses a “wrap” and allows the State to cover additional medications, or covered at a different rate, in addition to what is covered by Medicare Part D. Staff are aware that the Medicare formulary alone (list of covered medications and at what levels) is not as comprehensive as what the State offers now. The State intends to cover other drugs as part of the wrap in the enhanced EGWP, and has communicated this need to potential pharmacy vendors as part of the procurement process, asking that they have an “open formulary” which allows for customization. This is how the State will ensure that pharmacy benefits will be equivalent to the current plan.

Commissioner Ridle commented that this is an administrative change to how the medications are paid for and reimbursed to the State, not a day to day change to the member.

- Joelle Hall asked for clarification: is this the same as the current plan, which already has federal subsidies, and it is just a change in the program?
  - Michele responded that the reimbursement mechanism is slightly different, the current plan (RDS) includes reimbursement after the fact. The new plan would include cost sharing at the point of sale (such as required manufacturer discounts), as well as subsidies that are reimbursement after the fact. The State will also receive a higher level

of reimbursement. Leslie added that the current program (RDS) and the new program (EGWP) are both “back end” administrative mechanisms.

- Mauri Long asked for clarification about the statement that a prescription drug that is covered today, and that it would still be covered under EGWP. She asked about how coverage is determined for a newly-FDA-approved medication today, and how that would change under this proposed plan?
  - Michele shared that CMS will update the EGWP formulary annually which will determine which drugs qualify for the federal subsidy and which will be covered under the wrap benefit.
  - Emily Ricci added that once a new medication is available, such as receiving FDA approval, it is included on a pricing sheet and plans can determine whether they want to cover the medication and at what level. There is typically a plan committee (the Pharmacy and Therapeutics Committee) who reviews this, and determines whether the plan will cover it. As a self-insured plan, the State would like to cover new drugs as they are available, rather than later after additional review like most commercial plans. The intent is to make the medications available to members as soon as is feasible. They have given direction to the PBM to cover new medications.
- Mauri Long asked how often the formulary is adjusted?
  - Emily Ricci responded that the formulary is reviewed and adjusted as needed twice a year. She is not sure how new drugs are included in the formulary, but the State has given direction to the PBM to cover new medications when they are available.
- Carol Fleek (member of the public) asked what if any changes the members will see, such as going to the local pharmacy?
  - Emily Ricci responded that there will be new ID cards, because of the change to a new pharmacy benefits manager vendor, and there may be impacts during the transition such as getting pre-authorization for medications, but the prescription medications and coverage levels will remain the same.
- Judy Salo asked staff to speak to the efforts underway to ensure little to no impact to members, and the work by staff to help make these changes a smooth transition.
  - Michele Michaud shared that the State has issued a notice of intent to award to the new pharmacy benefit manager vendor (PBM), and are currently in the protest period but will be able to share more information soon once the protest period closes and they begin contract negotiations. Changing vendors is significant, staff are working to manage the process and will work closely with the vendor to minimize impacts as much as possible, and where that isn't possible, to understand and inform members about the change and how to get set up in the new system.
  - Emily Ricci added that staff are continuing to conduct analysis and identify any issues to address in the process, and will continue to address this before the new contract in place takes effect on January 1, 2019. The State has high expectations for vendors, and staff have worked closely with the vendor to talk through all of the potential issues that may come up and how the vendor will address them. This process has been more deliberate and in-depth than it has been in the past, and will continue to be rigorous to ensure that members have minimal impacts and continue to have the same level of benefits. One of these analyses is a review of members' claims under the current



pharmacy plan and analyzing if and how it would be different under the EGWP program. This includes a review of where prescriptions were filled, whether there are other nearby pharmacy options, etc. This will begin after the award process concludes, and the State can begin coordination with the vendor to address all these issues.

- Judy Salo commented that she understands that these are large projects (transition of PBM vendor, EGWP) and has participated as a committee member in the procurement process, she appreciates the State's thoroughness. She understands that not all questions can be answered at this time, but there are still opportunities to get those questions answered during this process, particularly after the State can start working with the vendor.

Michele discussed that CMS requires the state to enroll the retirees in the Medication Therapy Management Program, a program that reviews for drug side effects and drug interactions. Members can unenroll at any time.

- Mauri Long asked if this program would result in a denial for filling a medication?
  - Michele clarified that no, this will not impact members' ability to fill a prescription. Commissioner Ridle added that she understands some members will not want these notifications, while others may want to know, for example, that they have two medications that will cause nausea and vomiting if taken together. Members meeting those criteria will be enrolled in the program automatically, but can opt out at any time without any impact to other benefits.
- Cammy Taylor asked if this is similar to Aetna's existing program notifying people about medications and potential medical issues or risks?
  - Michele answered that yes, most plan providers have an equivalent of this program, including notifying providers that their patients' medications may have negative interactions.

*The committee took a 15-minute break from 2:00 p.m. to 2:15 p.m.*

*Mark Foster had a technical issue and could not re-connect to the meeting. He asked the group via text communication with DRB staff to call the meeting back to order and resume without him. He continued to attempt to connect to the meeting, but was not able to connect again after the break.*

*Cammy Taylor assumed chair responsibility for the rest of the meeting.*

#### EGWP Impact Analysis Memo (Continued)

- Judy Salo asked for clarification about what is available for retirees living outside the U.S., if they are not eligible for Medicare?
  - Michele Michaud clarified that all retirees who are not eligible for Medicare for any reason, including living outside the U.S., they would remain on the current plan. This means that they will still have the same plan regardless, but the State will not receive subsidy for their prescription drug claims.

Plan coordination: For individuals or couples with multiple retirement plans, such as spouses who both have State retiree plans or a separate retiree plan, currently these individuals do not have a co-pay (\$0 co-pay). This will continue for those individuals.

For individuals who, for example, work at a different company and have a health plan through that company, there will continue to be the same type of plan coordination as there is today. The specifics for each case will depend on whether the State plan is the primary or secondary plan.

CMS does not allow the State to coordinate plans with the Veterans Administration, but individuals with VA care will continue to have service-related conditions and medications covered 100% by the VA if filled at VA locations. Although members cannot request reimbursement for co-pays of non-service related VA-covered medications under the current plan or the enhanced EGWP, under the current program the VA can seek reimbursement directly. This would no longer be the case with an EGWP and additional analysis must be done to understand this potential impact to members. Additionally, of the 1,400 members who fill prescriptions at VA pharmacies, there are approximately 100 members who do not have an EGWP pharmacy within 5 miles of their current VA pharmacy.

- Mauri Long asked for information about how many Alaska pharmacies are not in the network?
  - Michele shared that there are 19 pharmacies in the state not in the AlaskaCare network, but they plan to work with the new PBM vendor and these pharmacies to bring these pharmacies in the network if possible.
  - Richard Ward added that for out of network pharmacies, the member has to pay for the prescription upfront and is reimbursed afterwards, so there is a cost for the member at point of sale, but the cost is reimbursed later. This is not a change from the current plan.
  - Emily Ricci added that the State is building a relationship with the association of independent pharmacies in Alaska, and is working to negotiate with them to include them in the network and otherwise coordinate on the benefits of the AlaskaCare plan.

Michele Michaud shared that Medicare Part D covers the same benefits that the State plan, and historically staff have discouraged people from enrolling in this plan since it is redundant. Unlike an individual Medicare D plan, the EGWP is a group plan, so an individual does not need to self-enroll and pay a premium for the Medicare Part D plan separately. If they are already in an individual Part D program when the new plan goes into effect, they will be disenrolled in the individual plan and placed in this group plan. There may be people who retired with another organization that also offers a health plan with an, EGWP; these individuals would not be enrolled in the AlaskaCare EGWP, but could opt into it later if they disenroll in the first plan. Staff are working to identify any affected individuals in these situations.

High income premium: CMS requires that high income individuals (defined by their modified adjusted gross income from tax returns) pay a premium, scaled with their annual income level (currently, household income of \$85,000 for an individual and \$170,000 for a married couple). This is a feature of all Medicare plans and is known as an Income Related Monthly Adjustment Amount (IRMAA). For those receiving Social Security, this would be deducted from their social security payments; for those not receiving Social Security, CMS would bill the member directly.

As part of EGWP implementation, the State intends to cover the cost of any surcharge or premium assessed by CMS via reimbursement. The State is setting up a Health Reimbursement Account (HRA) in order to reimburse members. If they are having the premium deducted from social security the HRA can be used to reimburse them each month, with a net cost of \$0. If they are billed the premium, the HRA can be used to pay the premium directly.

For high income members who are charged the Medicare premium, the State will not have access to data about who is being charged and at what amount, so members will need to communicate with the State that they are being charged this premium and at what amount, to arrange reimbursement.

- Judy Salo asked how CMS has access to income data to determine any surcharges?
  - Michele Michaud was unsure, but believes that as a federal agency, CMS can access individuals' tax information from the IRS directly. The State does not have direct access to individual members' tax information, and will rely on members to share some of that information for purposes of providing an IRMAA reimbursement.
  - CMS uses two years' prior data to determine the surcharge for the following year: currently, they will use 2017 data to determine 2019 surcharges.
- Mauri Long asked whether the State currently reimburses members for the IRMAA premium if they enrolled in Medicare Part B?
  - Michele Michaud responded that the State does not cover surcharges for Medicare Part B if someone is enrolled in it. The reimbursement would be for EGWP specifically.

Administrative impacts: The EGWP plan is a group plan, and individual members will not need to enroll themselves. Members will receive new ID cards from the new PBM vendor, which will be a separate card from medical services. There will not be a separate card for EGWP, it is part of the pharmacy plan.

CMS has a 90-day grandfather period for medication that CMS requires a pre-authorization. Pre-authorization typically happens between a health care provider, the vendor and a pharmacy: physicians' offices often handle this for patients, and it can be done electronically. The State's current plan has some pre-authorization rules, such as limits on the number of units that can be filled. For example: attempting to fill a prescription with 300 days of opioids would typically not be allowed, but if considered medically necessary such as the patient having a severe chronic pain condition, a physician could work with the vendor to allow this. (For the record: the State does not anticipate it being medically necessary to have that large of a supply of opioids, this was an illustration).

There is no step therapy in the proposed plan: CMS does not require this, and the State does not intend to implement this in their plan. Step therapy is a policy requiring use of a lower-cost drug (generic, alternative medication, cheaper brand name) and failure of that medication before the insurer will authorize use of the drug. The State does not use step therapy in the AlaskaCare plan.

- Cammy Taylor asked about the pre-authorization to determine whether a drug is covered under EGWP or the wrap, i.e., whether it will receive the federal subsidy?
  - Michele answered that in most cases, it will be clear whether or not the drug is covered under Medicare Part D. However, for drugs that require preauthorization the determination would depend on the individual's case: for example, for some medications, Medicare Part D may cover the medication because of a type of condition or diagnosis, while it may not cover it for other diagnoses. In these cases, determination has to do with whether EGWP will reimburse for that medication, or if it is covered under the State's wrap.
  - Staff estimate there are approximately 1,500 prescriptions impacted by this, or about 0.14% of all prescriptions filled under the State plan.

- Joelle Hall asked how members and their health care providers will know whether they need to do pre-authorization?
  - Michele shared that in addition to the preliminary analysis they have conducted using prior claims, they will conduct a deeper analysis of the data to determine which medications will require a new pre-authorization. They will be providing information to members, who can also speak with their health care providers about pre-authorization. Physicians' offices are very familiar with pre-authorization and communicating with insurers.
- Joelle followed up with a hypothetical scenario: what if the physician did not complete the pre-authorization properly, or there is some other administrative problem that results in the member not being able to fill their prescription? What recourse will the member have to get their medication?
  - Michele shared that this is a problem for some members today, the first step is to contact the physician's office to correct the issue. The pharmacy benefits manager could also authorize a limited fill in the meantime while the issue is being sorted out, and once the issue is resolved the member can go to the pharmacy again to get the prescription filled. If the claim is still denied, the member can appeal to CMS for Medicare Part D covered drugs, or the wrap (State plan) would cover the cost, without CMS reimbursement. If the wrap does not cover the medication either for some reason, the next step would be an appeal.
  - Emily Ricci noted that the 5-step appeals process with CMS is very similar to the State's current appeals process, the primary difference is the federal versus state points of contact in each step, and culminating in an appeal through the federal or state court system depending on which plan.
- Commissioner Ridle asked: how long does pre-authorization last for medications?
  - Michele responded that for some medications such as opioids, the pre-authorization period is short, corresponding with short prescription fills. For longer-term maintenance medications or medications requiring long term follow-up, pre-authorization may last 6 months to a year, and is reassessed after a follow-up doctor's visit with the member.
- Cammy Taylor asked what happens if a drug is supposed to be covered under Medicare Part D formulary, but is denied during the preauthorization process? Is the next step to approach the State to be covered under the wrap? Or would this require an appeal?
  - Michele commented that it will depend on the situation. If the prescription is denied for a refill-too-soon, the member may need to wait to fill. If determined to be excluded from the EGWP formulary, and assuming it would otherwise be covered under the plan as medically necessary it would be covered under the wrap. If it goes to the wrap and is denied as not being medically necessary (which is required of any AlaskaCare health care benefit), then it would be subject to the State's appeal process.
  - Commissioner Ridle added that CMS does not have any jurisdiction over the State's formulary or wrap benefits, so they cannot tell the State not to cover the medication if it is part of the plan.
  - Joelle Hall commented that the appeals chart in the presentation is somewhat confusing, and suggests that there will be many situations requiring federal appeal. She recommends clarifying that in most cases where Medicare Part D does not cover a

medication, it will be covered by the State and therefore the member will not experience a disruption. The appeal process would not be the immediate next step following a denial in this situation.

- Mauri Long asked whether the State has any right to appeal to CMS, or if it is just the member? She is concerned that moving to this program will have a negative impact if CMS denies coverage of several medications that are supposed to be covered under the EGWP formulary, resulting in the need for more appeals to resolve cases for members.
  - Richard Ward responded that the most straightforward solution will be coverage of the medication in the wrap. There are limited situations where the State may wish to appeal, but this is uncommon. Appeals usually involve individuals directly on a case by case basis.
- Mauri Long asked about the frequency of reimbursements from CMS to the State under RDS (current) and EGWP (proposed)?
  - Leslie Ridle commented that in the current system, the State receives quarterly payments under the RDS program and works with the federal government to address coverage issues. It is possible that the State has been underpaid or overpaid a subsidy, this is worked out after each quarter's payments. The new plan would have similar administrative structure, but it will relate to coverage of specific drugs on the Medicare Part D formulary, versus coverage under the State plan. Additionally, the subsidy will often be done at point of sale: the federal portion of coverage will be subtracted, rather than requiring reimbursement later. This will not impact the price for the member, who will have a co-pay as usual but does not see the rest of the drug price.
- Judy Salo asked how communications will be handled with providers, to give them information to adjust to this change?
  - Michele commented that previously (through 2018), the medical plan and pharmacy plan have been handled by the same vendor. They are working to communicate these changes, and will be working with the new vendor to develop a provider communication plan.

Opt out: Michele shared that it is typical in other states with retiree pharmacy benefits under EGWP, members who are Medicare eligible and want to opt out of that pharmacy plan, are not offered alternative pharmacy benefits for that plan. The State proposes instead to provide an alternative for a member who opts out, by enrolling that member in a plan equivalent to the current DCR (Defined Contribution Retirement) health plan.

- Mauri Long asked for clarification about a couple or family who have multiple plans, one person is Medicare eligible and the other is not, and they choose not to enroll in the EGWP, how would this work?
  - Michele clarified that Medicare eligibility is determined on an individual basis, so it is possible that a non Medicare eligible retiree would be in the State plan and their Medicare eligible spouse would be enrolled in EGWP. However, if the Medicare eligible spouse opts out of EGWP, they would be placed in the equivalent-DCR plan.
  - Mauri followed up: the current plan allows for coordination of plans, that can result in a \$0 co-pay.

- Michele stated that because CMS does not allow the member to have more than one EGWP plan, the impact to the member is being solved by enrolling them into a single EGWP plan that mirrors the benefits that the two separate plans provide today. However, if the member opts-out of EGWP, they will not be provided two opt-out plans and therefore would see additional out-of-pocket cost. The non-Medicare eligible spouse would not be impacted.
- Emily Ricci proposed further exploration of this scenario of other examples to address this situation, it is somewhat more complicated and they would like to ensure that they are expressing it accurately.
- Judy Salo commented that this less-beneficial plan (the DCR health plan) seems like a significant disincentive for disenrolling in EGWP.
- Cammy Taylor asked for clarification: if a member is assessed the CMS premium surcharge (IRMAA) and refuses to pay, they would be disenrolled from EGWP as an opt out? And they would therefore be enrolled in the DCR-equivalent plan?
  - Michele confirmed this is accurate. Refusal to pay the IRMAA would make the member ineligible for EGWP, which in effect is opting-out of the plan. If this happens and the member wants to opt back into the plan, the member could re-enroll during Medicare open enrollment for next year.
  - This is a separate situation to a missed payment to CMS or another issue where the member intends to pay the IRMAA premium. There are ways to address late payments without automatically being removed from the plan.
  - Emily added that this is similar to how it works today for members who are enrolled in a Medicare Part B plan, they can also be disenrolled if they refuse to pay the IRMAA premium. The health plan continues to estimate the amount Medicare would have paid, before providing any benefit.
  - The state will work with the PBM to develop the opt-out process, including for lack of payment of IRMAA. The process will ensure that the member is informed about the implications of this choice if they do not pay the surcharge, so they are not disenrolled without having given their informed consent.
- Cammy Taylor asked what would happen if a physician does not help the patient complete pre-authorization and provide documentation for medical necessity?
  - Michele indicated that the PBM vendor can assist the member by contacting the provider, it is a common practice and PBM vendors are very experienced with communicating with doctors to ensure patients' prescriptions are filled in a timely way.
  - Emily added that many issues that the State sees with pre-authorization have to do with communication between a physician and the vendor. In those cases, the State may get involved if the member makes them aware of the issue, they can help resolve the issue with the physician and the vendor.

Michele Michaud continued: members in the EGWP will receive required communications from CMS, many of which may not be applicable to the State's plan. These communications will be sent by CMS regardless, but staff will prepare some guidance to help members understand these and which can be disregarded as not applying to this plan. Staff plans to review all required communications to understand which ones are relevant, and let members know which are relevant. Also member's with a

post office box for a mailing address may need to attest that they live in the United States and therefore eligible for Medicare.

Access impacts: The State is aware of 19 pharmacies who are not in the EGWP network, many of which are located near pharmacies that are within the EGWP network. There are specific communities (Dillingham, Bethel, Petersburg, Wrangell) who do not have an EGWP-network pharmacy, the State is focusing on addressing access for members in these communities first, and working with all 19 non-network pharmacies. Staff estimates that approximately 600 members in Alaska may not have access to an EGWP pharmacy, and they are working on expanding network pharmacies and otherwise improving access across the state.

- Joelle Hall commented that 600 members is a large number, and she is concerned about the impacts for those members. If the additional pharmacies cannot be included in the network, what is the contingency plan for those members? Will there be a grace period where members could still use their old pharmacy benefits?
  - Richard Ward noted that currently, for many members, there may not be a pharmacy in network in their community or anywhere nearby. For other members, they may not have an in-network pharmacy now, but will be included in an in-network pharmacy under EGWP. The focus is on troubleshooting access issues for people who may lose access, but others may gain access.
- Joelle requested information about the number of members who may be affected by not having a network pharmacy in their community. She commented that while mail order is an option, it is not necessary a good option for all medications, such as a time-sensitive prescription or a new prescription that must be taken immediately. Additionally, mail can be unreliable or infrequent in rural areas, and need additional time for medication to arrive, so mail order will not be sufficient replacement for having access to a pharmacy.
- Emily Ricci noted that it would also be helpful to know whether these are in-network pharmacies with the new PBM vendor's network now: there are Alaska communities today that do not have an in network pharmacy, or any pharmacy within convenient distance.
- Richard Ward also noted that some rural pharmacies have determined not to participate in pharmacy networks, have chosen not to as a business decision, and may not want to be included in any network regardless of the terms. So, there may still be areas where there is no in-network pharmacy because of those business decisions.
- Joelle Hall commented that she is aware of this situation of pharmacies choosing not to participate in networks. She would like to know, however, if this is a loss or a feature of the status quo, for purposes of taking action to address impacts specific to the PBM vendor change and EGWP.
- Commissioner Ridle added that the State continues to build relationships with independent pharmacies generally and include them in the State plan; staff will continue to do this.
- Judy Salo reiterated concerns about mail order prescriptions, and when these would not be good solutions for members needing medications immediately or very soon.

Actuarial Impact: Richard Ward presented that the State estimates a neutral actuarial impact in changing to EGWP, meaning that there is no change to the actuarial value of the plan. While there will

be changes in other ways for this plan, in actuarial terms there is no change, as co-pays and member cost sharing remain the same.

- Mauri Long asked whether a member opting out of the enhanced EGWP, which would represent a significant change to that individual's benefits, changes the actuarial value?
  - Richard Ward responded that actuarial value is measured by the plan that is offered, and a members choice not to participate in that plan does not impact actual value.

#### **Item 5. Modernization Project Next Steps**

The RHPAB Modernization Committee would like to schedule a second meeting prior to the next board meeting, and discussed meeting for 4 hours on Friday, August 10, 1:00 to 5:00 p.m. The purpose of the meeting will be to continue presentation of the material in this packet, have discussion as originally planned for this meeting, and identify any other items for follow-up before the August 29 meeting. Staff will follow up with committee members to finalize scheduling and post a public notice for the meeting.

#### **Item 6. Public Comment (Part 2)**

Cammy Taylor restated the required information about HIPAA, protected health information, and that providing public testimony means it will become part of the public record. Testifiers waive their right to protection of health information shared during their testimony if they share it in the meeting.

##### **Public Comment**

- John Northcott (Anchorage) asked about the State's efforts to bring a pharmacy into the network? When a pharmacy indicates they do not want to participate in the network, what rationale do they give? Is the State tracking these reasons for purposes of addressing issues? He has friends in the plan who live in areas without a participating pharmacy.
  - Michele Michaud responded that negotiations take place between the pharmacy benefit manager and the pharmacy directly, so the State is not privy to those discussions. However, if the PBM vendor reports that those negotiations were not successful, the State can follow up and attempt to find a solution.
  - Emily Ricci added that staff have been meeting regularly with the Alaska Association of Independent Pharmacists, sharing information with them about the State's plan, the modernization project, and others including proposed plan changes. They have built a good relationship with pharmacists and can resolve individual issues
- Rose Scherer (phone) submitted written comments to the board already. She listened to the committee meeting and has been trying to understand these changes, they are complicated and she is not clear of the need for these changes. She is concerned about age discrimination and feels that because this change is happening for Medicare eligible members, typically older individuals with varying levels of health, and that this is more problematic and complicated for older members than other plan members.
- Grant Callow (phone) commented that staff identified several items of analysis that need follow-up and more information, identified in this meeting and previous meetings. He requests that DRB staff provide a list of those items and the status of each.  
He also has a question: if the new PBM vendor is performing poorly, making many mistakes or



otherwise acting recklessly and creating problems for members to access health care, has the State considered compensation or remedy for members due to an irresponsible vendor?

- Emily Ricci responded that the State has not considered remedy in this situation.

Grant asked a follow-up, are there incentives built into the new PBM contract in order to protect members and incentivize the vendor to perform?

- Michele Michaud shared that they have not completed the contract because they are in the protest period for the new vendor, but there will be performance incentives in the contract. Commissioner Ridle added that the State cannot share any information about the contract until it is executed, when it will become public information.

Grant also asked, what is the protest period?

- Emily Ricci shared that the protest period is a standard feature of the State's procurement processes, bidders have opportunity to review any public information about the process (such as competitors' proposal, unless the proposer requested that the proposal remain confidential because it contains proprietary information) to inform their protest. That required protest period must close before contract negotiations can begin. If another bidder submits a protest, the State must resolve the protest.
- Susan Miller (Anchorage) commented on the information about the IRMAA premium, pages 9-11 in the agenda packet. She asked for clarification about this surcharge payment, how would a member be reimbursed each month? She commented that this seems burdensome, this will be a new expense for members each month, even if they receive reimbursement later.
  - Michele Michaud responded that staff need to work out the details of this process, but yes, the State would reimburse the member each month, provided that the member:
    - Informs the State that they are being charged this IRMAA surcharge, since the State will not have that information from CMS; and
    - Provides documentation each year demonstrating that the member has high enough income that they are being charged by CMS, so the State is providing accurate reimbursement.
  - Emily Ricci acknowledged that the State has not developed this process yet, but will work to find the process that is least burdensome on the retiree as far as what documents members need to share, and how reimbursement will happen. For example, they will need to determine if the reimbursement (HRA) can be done through electronic funds transfer.
  - Susan added that Medicare sends annual documentation to her, as a Medicare enrolled retiree, about what her IRMAA surcharge will be. This may be an appropriate document to request from members, rather than asking for tax information directly.
  - Michele agreed this is potentially a good option, the State will look into this.
- Brad Owens (Anchorage) shared that he has not had a chance to review the information in the packet yet, but he understands that the main motivation of the change is to save money in the health trust. He is concerned that the State's analysis is being conducted outside the boundaries of the requirements under the *Duncan vs. RPEA* case, and that there hasn't been sufficient analysis of this proposed change's impact as legally required. He noted that the court may need to determine whether sufficient analysis has been conducted. He recommends having an independent analysis, from a party other than the State who has an interest in the outcome of this decision, of whether this constitutes sufficient hardship.

He also commented that he would like to better understand the appeals process: currently, retirees have a right to appeal a denial under the process laid out for the State. In the new plan, as stated in the meeting today, the first step being covering the drug under the wrap, versus initiating a CMS appeal. He believes that apply the federal appeal process would be illegal under *Duncan*.

He also is concerned about the State choosing OptumRx as the new PBM vendor, he has found information online from AARP and others about problems with OptumRx as a vendor, denials and other complications. He fears that choosing OptumRx will not be good for retirees.

- Sharon Clar (Anchorage) asked for clarification: if the new PBM contract will be signed before August 10, what is the purpose of this meeting, if the EGWP decision has already been made?
  - Commissioner Ridle clarified that regardless of the EGWP decision, the pharmacy benefit manager vendor contract is a separate process and is being negotiated for a change in 2019. The State changing to an EGWP is separate from the vendor contract. The information presented today on EGWP is not related to the terms of the contract for the PBM vendor being discussed. The August 10 committee meeting is proposed by RHPAB members to continue the presentation and discussion, since there is no additional time today.

Sharon also commented that she is concerned about pre-authorization and medical necessity—she is concerned about the possibility of a doctor’s decision being overridden by the insurer. She is also concerned about situations where a necessary medication is not available.

- Michele Michaud responded that this situation can arise with any prescription or service, medical necessity must be demonstrated in order for an insurer to pay for it. There are standards for medical necessity that are applied by diagnosis and situation. If there is a denial based on medical necessity, a committee of medical providers will review the case and relevant medical history that apply to the case. The committee can also request additional information from the provider to support the case.
- Joelle Hall added that the issue of medical necessity is an ongoing issue and occurs now.
- Judy Salo commented that as a committee member for the evaluation of vendor proposals, she understands the concern about being caught in the middle between a physician and an insurer, and stated that this issue was brought up during review of the PBM proposals to understand how the vendor would handle those situations.
- Emily Ricci commented that review and appeals for medical necessity has multiple steps and can be complicated, and will depend on the case. She also shared that there are options in place for medical emergencies or time-sensitive medications, or can fill a smaller number of units of medication, as discussed earlier.
- Stephanie Rhoades (Anchorage) commented that she believes the Alaska Retirement Management Board’s resolution addresses financial benefits of the enhanced EGWP, as does the documentation of the analysis for this change. However, she feels that does not adequately address the required analysis under *Duncan*, including impacts to members such as delayed reimbursement. She has had issues with prior authorization under the current plan; she pointed out that unlike medical care where resolving a billing and coverage issue will wait to bill the member for that service, a pharmacy will require payment upfront and therefore the member cannot get resolution of the issue under an appeal. She is concerned that the administrative burden on retirees will be a larger problem than it is now; older members will have more

difficulties dealing with this administrative burden, and these should be considered. She requests that the State look beyond actuarial value when concluding that it has neutral impact.

- Carol Fleek commented that when she fills a prescription, she often is able to get a refill 7 to 10 days in advance, or longer, which would allow time for preauthorization if needed. There are also options for requesting the fill farther in advance if you will be traveling out of state or out of country.
- Susan Miller commented that in most situations she is familiar with, mail order prescriptions are not necessarily appropriate. For example, getting painkiller for an extracted tooth is more urgent than allowing for mailing upfront. Even a new long-term prescription often requires filling the first few doses in town.
- Grant Callow commented that a study was conducted about the appeals process. The study found that for individuals who conduct an appeal of a denial of a pharmacy benefit: the results of the appeals varied significantly, ranging from 39% to 59% of cases. The study did not measure the length of time the appeal took. The variation will depend on the individual cases, but he concluded that there are often appeals that are not successful, and that the number of appeals and reversal of decisions is significant. He will share this information with the board.

*Joelle Hall excused herself and left the meeting at 4:10 p.m.*

#### **Item 7. Meeting Adjournment**

Commissioner Ridle restated that staff will be posting information about the August 10 meeting online shortly, and ensure that all materials are available online. She encourages board members and members of the public to save their packets, as they will continue review of this information at the next meeting.

- **Motion** by Cammy Taylor to adjourn the meeting. **Second** by Judy Salo.
- **Result:** The meeting was adjourned at 4:25 p.m.

# Public Comment Guidelines

Public Comment	
<b>Purpose</b>	The public comment period allows individuals to inform and advise the Retiree Health Plan Advisory Board about policy-related issues, problems or concerns. It is not a hearing and cannot be used to address health benefit claim appeals. The protected health information of an identified individual will not be addressed during public comment.
<b>Protocol</b>	<p>Individuals are invited to speak for up to three minutes.</p> <ul style="list-style-type: none"> <li>• A speaker may be granted the latitude to speak longer than the 3-minute time limit only by the Chair or by a motion adopted by the Full Advisory Board.</li> <li>• Anyone providing comment should do so in a manner that is respectful of the Advisory Board and all meeting attendees.</li> </ul> <p>The Chair maintains the right to stop public comments that contains Private Health Information, inappropriate and/or inflammatory language or behavior.</p> <p><b><u>Members providing testimony will be reminded they are waiving their statutory right to keep confidential the contents of the retirement records about which they are testifying. See AS 40.25.151.</u></b></p>
Protected Health Information	
<p><b>Protected Health Information (PHI)</b> submitted to the Board in writing will be redacted to remove all identifying information, for example, name, address, date of birth, Social Security number, phone numbers, health insurance member numbers.</p> <p>If the Board requests records containing protected health information, the Division will redact all identifying information from the records before providing them to the Board.</p>	

Frequently Asked Questions	
<p><b>How can someone provide comments?</b></p>	<p><b>IN PERSON</b> - please sign up for public comment using the clipboard provided during the meeting.</p> <p><b>VIA TELECONFERENCE</b> – please call the meeting teleconference number on a telephone hard line. To prevent audio feedback, do not call on a speaker phone or cell phone. You may use the mute feature on your phone until you are called to speak, but do not put the call on hold because hold music disrupts the meeting. If this occurs, we will mute or disconnect your line.</p> <p><b>IN WRITING</b> – send comments to the address or fax number below or email AlaskaRHPAB@alaska.gov. For written comments to be distributed to the Advisory Board prior to a board meeting they must be received thirty days prior to the meeting to allow time for distribution and identifying information will be redacted (see “Protected Health Information”).</p> <p><b>PRIVATE HEALTH INFORMATION:</b> The state must comply with federal laws regarding Private Health Information. Written information submitted for public comment which contains identifying information will be redacted to ensure compliance with privacy laws.</p> <p><b>Address:</b> Department of Administration, Attn: RHPAB, 550 W 7<sup>th</sup> Avenue, Ste 1970, Anchorage, AK 99501 Fax: (907) 465-2135</p>
<p><b>Can I bring my questions or concerns about a claim or medical issue to the Board?</b></p>	<p>The Board does not have authority to decide health benefit claim appeals. Members should call Aetna at 1-855-784-8646 to address their question and/or concern. After contacting Aetna, members can also contact the Division of Retirement and Benefits at 1- 800-821-2251 or 907-465-8600 if in Juneau.</p>
<p><b>For additional information:</b></p>	<p>For additional information please call 907-269-6293 or email AlaskaRHPAB@alaska.gov if you have additional question.</p>

# EGWP

DRAFT – Summary of Responses to Proposed  
Plan Design

**Proposed change:** Enhanced Employer Group Waiver Program (EGWP)

**Plans affected:** DB Retiree Plan

**Reviewed by:** Retiree Health Plan Advisory Board, Alaska Retirement Management Board

**Proposed implementation date:** January 1, 2019

**Review Date:** July 26, 2018

*Table 1: Plan Design Changes*

	Member	Actuarial	DRB Ops	Financial	Clinical	TPA	Provider
No impact		X					
Minimal impact	X				X		X
High impact			X	X		X	
Need Info							

**Description of proposed change:**

The proposed change has a neutral actuarial impact and results in no changes to the drugs covered by the plan or member copays.<sup>1</sup>

An Employer Group Waiver Program (EGWP) is one method offered by the federal government to provide subsidies to the State of Alaska retiree health trusts for qualifying prescription drug costs while retaining existing retiree benefits. An EGWP, pronounced “egg whip”, is a *group* Medicare Part D prescription drug plan option. An enhanced EGWP is an EGWP plan offered with a supplemental prescription drug benefit (also known as a “wrap”) that provides additional coverage for drugs not covered under the Medicare Part D program.

More than 90% of states that provide drug benefits to Medicare retirees have already implemented EGWPs and have already begun to realize cost savings.<sup>2</sup> By implementing an enhanced EGWP it is estimated that additional federal subsidies will save the State of

<sup>1</sup> Attachment A: *Employer Group Waiver Program – Focus on Actuarial and Financial Impact*, Segal Consulting memo dated July 24, 2018.

<sup>2</sup> *State Retiree Health Plan Spending* by The Pew Charitable Trusts and MacArthur Foundation (May 2016), supplemented with research by Segal of publicly available documents.



Alaska retiree health trust \$19 million to \$25 million annually.<sup>3</sup> In addition, the future liabilities for Other Post-Employment Benefits (OPEB) will be reduced, which decreases the State assistance payment by an estimated \$40 million to \$60 million annually.<sup>4</sup>

The AlaskaCare EGWP would be available to all individuals who are: 1) eligible for Medicare; 2) enrolled in Part A or Part B; and 3) and are covered by the AlaskaCare retiree health plan. The AlaskaCare EGWP will provide prescription drug coverage in a way that preserves the benefits Medicare-eligible retirees enjoy today while also promoting cost savings for the health trusts. The additional savings will assist the State in keeping its promise to retirees to provide health benefits into the future. This will require some administrative changes that are anticipated to be minor as outlined below.

The Alaska Retirement Management Board passed a resolution on December 8, 2017 in support of the adoption and implementation of an EGWP effective January 1, 2019.<sup>5</sup>

If the Division of Retirement and Benefits (Division) later determines that the enhanced EGWP is not meeting the needs of our members or the State, the Division can disenroll from the program.

### **Member impact:**

#### **WHO IS IMPACTED-**

The AlaskaCare EGWP would be available to all individuals who are: 1) eligible for Medicare; 2) enrolled in Part A or Part B; and 3) and are covered by the AlaskaCare retiree health plan.

Based on 2017 reporting, this is estimated to be approximately 48,889 individual policies for Medicare eligible retirees covered under the health plan. In general, approximately 60% of all retirees reside in Alaska, and 40% reside outside of Alaska.

Retiree members who otherwise meet the EGWP criteria but who are in the following circumstances will not be enrolled:

- Retiree members living outside of the United States (estimated to be 175 individuals)

<sup>3</sup> Attachment A: *Employer Group Waiver Program – Focus on Actuarial and Financial Impact*, Segal Consulting memo dated July 24, 2018.

<sup>4</sup> Attachment B: *State of Alaska Estimated EGWP Savings Projections* Conduent January 24, 2018

<sup>5</sup> Attachment C: ARMB Res 2017-20 Employer Group Waiver Program

- Retiree members who are actively working and therefore do not qualify for Medicare Part A with no premium (estimated to be 125 individuals)

### BENEFIT IMPACT-

EGWP represents an administrative change, rather than a change in plan benefits. There is no anticipated impact to the benefits that members will receive. A minor change will be necessary to comply with industry-standard fill measures which would not impact the prescription strength or type of coverage, but the timing of prescription fills (described below). An AlaskaCare EGWP would be an enhanced EGWP, which is an EGWP provided with a “wrap,” or a supplemental benefit package. This “wrap” allows the plan to cover medications that would not typically be covered through a group Medicare Part D plan.

The EGWP is subject to Centers for Medicare and Medicaid Services (CMS) regulations. For example, CMS determines a formulary, or a list of prescription drugs, that qualify for a federal subsidy and are covered under the EGWP. Drugs that are not on the CMS formulary will be covered through the wrap benefit. This ensures that if a drug is covered in the AlaskaCare plan today, it will be covered under an AlaskaCare EGWP. The member will pay the same copay (\$8 brand, \$4 generic or \$0 for all mail order) as they do today.

The determination of prescription drugs covered under the EGWP and the wrap plan will occur through the Pharmacy Benefit Manager (PBM) point-of-sale claims adjudication software.<sup>6</sup> The pharmacist will run the prescription as they do today, and the software program will apply appropriate coding so that the plan receives a subsidy if eligible, or covers the full cost of the medication under the wrap if not eligible for a federal subsidy.

Fill Requirements- CMS restricts filling of medication to no more than a 90-day supply of the medication being filled at one time. The current plan allows “the greater of 90-day or 100 unit supply” and would need to be changed to remove the 100 unit option.<sup>7</sup>

In 2017 there were approximately 2,200 members who received prescription drug fill based on a 100 unit supply, that may be impacted. These included about 100 members who received a 100 unit box of unfilled syringes.

<sup>6</sup> A pharmacy benefits manager (PBM) is a vendor the Division of Retirement and Benefits hires to process and adjudicate pharmacy claims and to maintain a network of contracted pharmacies.

<sup>7</sup> Page 2 of the May 2003 Retiree Insurance Information Booklet, as amended.

<http://doa.alaska.gov/drb/pdf/ghlb/retiree/RetireeInsuranceBooklet2003with2018amendment.pdf>

Affected members can still access the same amount of medication, but the number of times they are required to fill may change. Depending on the “days’ supply” the 100 unit would typically cover, this could require an increase in some member copayments, but members can still access medications via the mail order program at \$0 copay.

The plan allows for vacation overrides and other exceptions as necessary; this would be preserved under an AlaskaCare EGWP.

## OTHER

CMS requires that retirees enrolled in an AlaskaCare EGWP that have multiple medical conditions or high drug utilization be enrolled in a Medication Therapy Management Program (MTMP).<sup>8</sup> This program helps the member and their doctor make sure the medications are working to improve the health of the member, and provides a comprehensive review if medications have side effects or might have interactions with other medications the member is taking. Members may opt out of this program at any time.

Additional analysis is needed to understand how many retirees meet the criteria for enrollment into the MTMP.

## FINANCIAL IMPACT-

- a. Copayments - There is no anticipated impact to member’s co-pay.

*Table 2: Comparison of Current to Proposed AlaskaCare EGWP (no change)*

	Mail Order Copay	Retail Generic Copay	Retail Brand Name Copay	Drugs Covered
Current	\$0	\$4	\$8	Open Formulary <sup>9</sup>
AlaskaCare EGWP	\$0	\$4	\$8	Open Formulary

- b. Coordination of Benefits - An AlaskaCare EGWP will continue to coordinate with other AlaskaCare plans the same way it does today, so if a member with

<sup>8</sup> Additional information specific to the conditions and definition of high drug utilization is underway.

<sup>9</sup> A formulary is a list of covered prescription drugs that will be paid under a health plan. An open formulary means there are no restrictions on which drugs will be covered as long as the drug meets the definition of “prescription drug”, i.e. a medical substance which must bear a label that states, “Caution: Federal law prohibits dispensing without a prescription” and is not otherwise excluded under the plan.

multiple coverages under the AlaskaCare plan does not pay copayments today for medications, they would not have to pay them under an AlaskaCare EGWP.

There are no restrictions on allowing an AlaskaCare EGWP to coordinate benefits with a plan that is not an EGWP or individual Medicare Part D plan with two exceptions:

- 1) CMS does not allow coordination of benefits with prescriptions filled at a Veterans Administration Pharmacy. This is not a change from how AlaskaCare benefits are coordinate with VA pharmacy claims today.
    - AlaskaCare does not currently cover pharmacy benefits related to a service connected medical condition, so this does not represent a change for military service-related prescriptions.
    - For non-service related conditions, the VA pharmacy charges a copay. The AlaskaCare does not currently cover this copay.
    - There are about 1,400 members utilizing VA pharmacies. Of these only about 100 members will not have an EGWP pharmacy option within 5 miles of the VA pharmacy currently being utilized.
  - 2) CMS does not permit a member to have more than one EGWP or individual Medicare part D plan.
    - Additional research is required to determine how many retirees may have outside EGWP plans.
- c. Premiums - CMS requires certain high-income retirees to pay an extra surcharge. This is the same requirement for members who are covered today under Medicare Part B. This surcharge is called the Income Related Monthly Adjustment Amount (IRMAA). Monthly Adjusted Gross Income (MAGI) is determined by the amount on the last line of the individual/couples IRS 1040 tax form (line 37 on form 1040, line 21 on form 1040A, or line 4 on form 1040EZ), **plus** any tax-exempt interest income (line 8b on form 1040). This information from two years prior is used to determine the IRMAA for the current premium year. For example, information from 2017 will determine the 2019 IRMAA. The below table shows the IRMAA for 2018, but this is subject to change.

Table 3: Overview of MAGI and Surcharge Categories

Individuals MAGI	Couples MAGI	Extra Monthly Surcharge Amount
Equal to or below \$85,000	Equal to or below \$170,000	\$0
\$85,001-\$107,000	\$170,001-\$214,000	\$13.00
\$107,001-\$133,500	\$214,001-\$267,000	\$33.60
\$133,501-\$160,000	\$267,001-\$320,000	\$54.20
Above \$160,000	Above \$320,000	\$74.80

**No member will be required to shoulder this additional cost for their pharmacy benefits.** The Division will fund a Health Reimbursement Arrangement (HRA) account to offset the full amount of IRMAA associated with the EGWP.<sup>10</sup>

The number of impacted members is unknown because the Division does not have access to member's household income, however based on Alaska pension information alone an estimated 650 retirees meet the minimum income threshold.<sup>11</sup> The Division will work to inform retirees of the income thresholds and encourage them to proactively contact the Division to: 1) understand if they will be impacted; and 2) to make arrangements for compensation.

Members paying a surcharge for Medicare Part B today can expect to be assessed a surcharge under EGWP.<sup>12</sup> The requirements are the same.

There are two methods the Division could use to compensate members subject to the surcharge. Both require the Division to establish and pre-fund an HRA for the impacted member.

- 1) If a retiree/member has the IRMAA deducted from their social security benefit, the HRA can reimburse the member on a monthly-basis.
- 2) If a retiree/member does not have social security and is invoiced by Medicare, the HRA can be set up to automatically pay Medicare directly each month so the member does not have to pay out-of-pocket.

<sup>10</sup> A Health Reimbursement Arrangement (HRA) account is an IRS-approved, employer funded, tax-advantaged account that can be used to reimburse for individual health insurance premiums.

<sup>11</sup> Based on 2016 pension data.

<sup>12</sup> Medicare premiums for high income beneficiaries. <https://www.ssa.gov/pubs/EN-05-10536.pdf>

Members will need to provide the Division with documentation to ensure the HRA is being funded accurately. The Division has yet to identify exactly what that documentation will entail but has an objective of only requiring essential documentation and limiting effort by the member. Examples of potential documentation include a statement with the surcharge, a copy of tax returns, etc.

As household income can fluctuate, members may need to contact the Division annually to provide updated information to ensure the HRA funding aligns with the surcharge.

- d. Other – There may be instances where a member could be fiscally impacted by the change in removing the 100 unit supply from the existing plan language which allows for fills “greater of 90-day or 100 unit, supply”. If the 100 unit supply is greater than the 90-day supply and would otherwise have needed to be filled less than 4 times a year, the change requires them to seek more frequent refills resulting in them being subject to an additional copayment. However, members can mitigate the impact of this by filling their prescription through mail order or, if applicable, the specialty drug program offered through the PBM, both of which feature \$0 copayments.

ADMINISTRATIVE IMPACT: There are several areas where member’s may experience administrative impact. These are listed below:

- a. Enrollment - The health plan will enroll Medicare eligible members into the AlaskaCare EGWP. Members do not have to apply individually, and the Division does not anticipate additional administrative impact to the member.
- b. ID Cards - Members will have an ID card specifically for pharmacy benefit claims, a separate card from their Medical plan. Historically member’s have had a single card for both medical and pharmacy claims, so this will be a new change and may require additional effort by the member to keep track of the cards and ensure they are submitting the correct card. The Division and the PBM will work to educate members to avoid confusion.
- c. Premiums – See description of IRMAA above. Impacted members would need to undertake actions similar to what they do today in terms of paying their Medicare Part B surcharge; however, they would need to submit and complete additional paperwork to establish and maintain the plan-funded HRA to cover the IRMAA related to the pharmacy benefit.
- d. Pre-authorization - CMS requires a new prior authorization on certain medications and requires prior authorizations on medication that previously did not require one. Prior authorization reviews will not only review the type of drug,

but the diagnosis it is being used to treat as that can impact if it is covered on the EGWP formulary or under Medicare Part B or excluded from the EGWP formulary.

**CMS does not require step therapy.** Step therapy is when a member is required to try a less expensive medication before the plan will cover a more expensive drug.

CMS requires prior authorization for the following:

1) Medicare Part B or Part D determination-

- This review focuses on identifying if a drug qualifies for subsidy under the prescription program or should be covered under Medicare Part B the medical plan.
- It is not anticipated to impact either the plan benefits or the member copayment. For example, if its determined that the drug is covered under Medicare Part B instead of the EGWP, the member will continue to receive the same drugs they are getting today for the same copay they are paying today.
- Additional analysis are underway, but the Division estimates approximately 4,000 prescriptions (.38% of overall prescription claims for Medicare eligible members) will be subject to this type of prior authorization.

2) EGWP formulary determination-

- This review focuses on determining if a drug is covered or excluded under the EGWP formulary.
- It is not anticipated to impact either the plan benefits or the member copayment. For example, if a drug is not covered through the EGWP formulary, it will be covered by the wrap. If its covered by EGWP, the plan benefits from the federal subsidy. If it is not covered under EGWP, the plan pays for the medication through the wrap benefits and the member can continue to receive the drugs they are getting today for the same copay they are paying today.
- Additional analysis are underway, but the Division estimates approximately 1,500 prescriptions (.14% of overall prescription claims for Medicare eligible members) will be subject to this type or prior authorization.

Prior to implementation of an AlaskaCare EGWP, members who are taking a medication that require prior authorization will be notified by the PBM and either the member, or their doctor, will have to complete and submit the required form. This will need to be completed even if the medication was already authorized under the existing plan. The Division will work with PBM to streamline this process and mitigate this administrative burden on the membership.

Following implementation, if a member is prescribed medication requiring prior authorization for the first time, they or their doctor will need to complete and submit the required form.

For most medications, once a prior authorization is established it is in effect for a year or longer; however, some medications may require more frequent reviews. These include opioids, specialty medications, etc.

- e. Appeals – To appeal a medication that is denied in the EGWP, and is not otherwise covered under the wrap, the member must use a federal appeal process. This mirrors what occurs today in the medical plan for members covered under Medicare Part A and B. **The vast majority of disputed claims will be subject to the existing appeal process and members will not have any change to the administrative requirements in place today.**

The Division is still working to identify a circumstance under which a member would not be subject to the existing appeals process, so far they have been unable to identify a specific example. It is important to note that the CMS appeals process mirrors the state substantively. A comparison is outlined in below.

*Table 4: Comparison of CMS appeals process and AlaskaCare appeals process*

	<b>AlaskaCare Wrap/ Current AlaskaCare Appeal Process<sup>13</sup></b>	<b>EGWP – Part D CMS 5-Step Appeal Process<sup>14</sup></b>
Step 1	Redetermination by PBM	Redetermination by PBM
Step 2 (clinical)	Independent Review Organization	Independent Review Organization
Step 3	Division of Retirement and Benefits	Federal Administrative Law Judge
Step 4	State Administrative Law Judge (OAH)	Medicare Appeals Council
Step 5	State Superior Court	Federal District Court

<sup>13</sup> January 1, 2018 amendment to the May 2003 Retiree Insurance Information Booklet, page i-xvi.

<http://doa.alaska.gov/drb/pdf/ghlb/retiree/RetireeInsuranceBooklet2003with2018amendment.pdf>

<sup>14</sup> Medicare Appeals, <https://www.medicare.gov/Pubs/pdf/11525-Medicare-Appeals.pdf>



- f. Opt-out - CMS requires the AlaskaCare plan to offer Medicare eligible retirees the option to Opt-Out of the EGWP. To disincentivize members from opting out of this program, many plans choose not to cover prescription drug benefits at all should members opt-out. The Division proposes instead enrolling members who opt-out into an alternative pharmacy benefit plan which mirrors the prescription drug benefits offered in the Defined Contribution Retirement health plan. A summary of the opt-out plan is shown below.

*Table 5: Opt-out plan based on current DCR health plan*

Prescription Tier	Coinsurance	Minimum Covered Person Payment	Maximum Covered Person Payment
Retail 30 Day at Network Pharmacy			
Generic prescription drug	80%	\$10	\$50
Preferred brand-name prescription drug	75%	\$25	\$75
Non-preferred brand-name prescription drug	65%	\$80	\$150
Mail Order 31-90 Day at Network Pharmacy			
Prescription Tier		Copayment	
Generic prescription drug		\$20	
Preferred brand-name prescription drug		\$50	
Non-preferred brand-name prescription drug		\$100	
Out-of-Network Pharmacy			
Coinsurance for all prescription drugs		60%	
Out-of-Pocket Limit			
Annual individual out-of-pocket limit		\$1,000	

This type of disincentive is already applied to the medical benefit as the plan assumes that individuals who are eligible for Medicare have enrolled and calculates the benefits assuming they are. If members have delayed or declined to enroll in Medicare, they bear the additional cost, the plan does not make up the difference.

A member who opts-out, can reenroll during the annual open enrollment for the next benefit year.

- g. Other - CMS has many mandatory communications that will be mailed to members. These communications will be provided to all members covered under the AlaskaCare EGWP. The Division can include cover letters and guidance but cannot suppress these communications.

CMS may require members with a mailing address that is a post-office box to attest that they are a resident of the United States. Additional research is ongoing to understand the number of retirees required to attest to residency.

ACCESS IMPACT: Members may experience some change in the network of pharmacies they can access, however any difference is anticipated to be minimal with the Division providing alternatives. This is not unlike what occurs under the existing plan when there is a change from one PBM to another.

CMS has established certain requirements for a pharmacy to participate in an EGWP network. In an initial analysis based on information obtained and evaluated in the PBM Request For Proposal (RFP), it appears that 19 pharmacies in Alaska are not in the EGWP network, however many of these are in areas where there are other network pharmacies members can access. As it has in past transitions or changes in networks, the incoming PBM, OptumRx, will work with non-participating pharmacies to bring them in the network prior to January 1, 2019.

At this point in time, Dillingham, Bethel, Petersburg and Wrangell have no pharmacies participating in the EGWP network.

If OptumRx is not able to bring them into the network, members can still utilize these pharmacies but will need to submit paper claims as is required for out-of-network pharmacies today. Members can also fill their prescriptions through mail order or the specialty mail services. Additional analysis will be conducted on pharmacies outside of Alaska. Additional analysis will be conducted to determine the number of members utilizing pharmacies not currently in the network. Currently this is estimated to be around 500 members.

#### **Actuarial impact<sup>15</sup>**

**Neutral** Enhancement / Diminishment

The implementation of an enhanced EGWP will provide the same cost share structure as members receive today (see *Table 2* above). For this reason, there is no change in the

<sup>15</sup> "Under the ACA, a health insurance plan's actuarial value indicates the average share of medical spending that is paid by the plan, as opposed to being paid out of pocket by the consumer."  
[https://www.actuary.org/files/Actuarial\\_value\\_basics\\_for\\_NAIC\\_040113.pdf](https://www.actuary.org/files/Actuarial_value_basics_for_NAIC_040113.pdf)

actuarial value of the plan.<sup>16</sup> Based on Attachment A developed by Segal Consulting,<sup>17</sup> implementation of the AlaskaCare EGWP does not impact the plan's overall actuarial value based on the following:

- a. The primary change associated with the transition to EGWP is the change in federal subsidies, which do not impact the actuarial value.
- b. As previously noted, there will be no change to copay structure, which will remain \$4 (generics), \$8 (brands) and \$0 (mail order).
- c. There will be no change to the members that have multiple coverages in the State Plan. For these members their net drug costs will remain \$0.
- d. Members' access to covered drugs and pharmacies will not be impacted by the EGWP transition.
- e. Implementing a 90-day supply limitation and discontinuing the 100 unit limitation will not impact actuarial value. Members can still access the same amount of medication, but the number of times they are required to fill it may change. Members can still access medications via the mail order program at \$0 copay.

There is no change in the value of the benefits associated with the EGWP implementation. Therefore, there will be no impact on the actuarial value of the Retiree Plan.

*Table 6: Actuarial Impact (none)*

	Actuarial Impact	Notes
Current	N/A	N/A
Proposed change	None	No changes in member cost share.

### **DRB operational impacts:**

The Division is responsible for procuring the services through a Pharmacy Third-Party Claims Administrator (PBM)). The Division will work with the vendor to auto enroll the eligible retirees and dependents through CMS into the group Medicare D plan. For those whose enrollment is denied by CMS (e.g. those living outside the United States, or currently working and not eligible for Medicare A), will be enrolled in the plan provided to non-Medicare eligible retirees and dependents.

<sup>16</sup>Attachment A: *Employer Group Waiver Program – Focus on Actuarial and Financial Impact*, Segal Consulting memo dated July 24, 2018

<sup>17</sup> Attachment A: *Employer Group Waiver Program – Focus on Actuarial and Financial Impact*, Segal Consulting memo dated July 24, 2018

The Division will be responsible for leading the transition to an AlaskaCare EGWP in conjunction with the PBM and all associated activities. This will require significant effort by staff.

The Division will need to make technical changes to its eligibility reporting system to support the transition to an AlaskaCare EGWP.

The Division will need to provide an attestation that existing retirees were covered under a pharmacy benefit that was at least as good as those offered under the EGWP (was Creditable Coverage).

The Division will need to design the pharmacy “wrap” benefit to ensure formulary and network gaps are covered by the plan in accordance with the *Retiree Insurance Information Booklet*. This will be completed with the assistance of the benefit consultants and the PBM.

The Division will need to establish processes and protocols for identifying members subject to IRMAA and necessary information to establish and maintain Health Reimbursement Arrangement (HRA) for those members.

The Division will need to establish process and protocols related to retroactive termination of coverage when untimely notified of the death of a member or a divorce as there are some CMS limitations that conflict with the existing process.

The Division will need to maintain existing support for the Retiree Drug Subsidy (RDS) program as an additional source of federal subsidies for those retirees who are not eligible for EGWP subsidies.

It was initially thought that the PBM would be the fiduciary for an EGWP, however **CMS does not require a change in fiduciary**<sup>18</sup>. This applies only to fully-insured plans and will have no impact on the AlaskaCare EGWP. The plan’s fiduciary status will remain as it is today.

**Financial impact to the plan:**

An AlaskaCare EGWP is estimated to provide substantial savings to the plan, outlined below. Several consultants have provided a range of estimated savings in various reports over the last three years. The savings estimated in table 7 are based on a review of those estimates from Conduent outlined in Attachment B<sup>19</sup>.

<sup>18</sup> Title 42, 423.501, 423.504 and 423.505

<sup>19</sup> Attachment B: *State of Alaska Estimated EGWP Savings Projections*, Conduent dated January 24, 2018.

Table 7: EGWP estimated savings

	Current RDS program	Proposed enhanced EGWP
CMS Subsidies	\$16M to \$23M annually	\$35M to \$44M annually (net of additional expenses)
OPEB Liability Impacts	None	\$300M to \$350M
Reduction of State Assistance	None	\$40M to \$50M in annual savings <sup>20</sup>
Summary of Public Comments	Pending	Pending

The current federal Retiree Drug Subsidy (RDS) are about 28% of qualified drug costs, which calculates to about \$19 million annually. However, RDS has limitations:

- No subsidies are received for the first \$405 in an individual retiree's drug spend
- No subsidies will be paid for prescription drug costs in excess of \$8,350
- The amount of the subsidies cannot be used in forecasting plan experience for purposes of Other Pension Employment Benefits (OPEB).

The EGWP offers 3 substantial subsidies estimated to total between \$35 million to \$44 million (\$16 million to \$23 million over the RDS) annually:

- A direct subsidy for each member per year, even if they have \$0 in drug spend
- A Coverage Gap Discount subsidy, which provides a 50% manufacturer discount on brand-name drugs when the member is in the coverage gap (\$3,750-\$7,508.75)
- Catastrophic coverage subsidy, where Medicare provides 80% reimbursement for highest utilizers (greater than \$7,508.75)

In addition, the EGWP subsidies can be used in forecasting plan experience for purposes of OPEB, which results in an estimated reduction of between \$40 million and \$60 million to the State assistance payments annually.<sup>21</sup>

The savings analysis looked at pharmacy claims data from 2016 and 2017. Assumptions were also made that claims cost through 2019 would increase at 6.0% annual based trend, and that member copays would vary due to fluctuation in drug utilization.<sup>22</sup> Projected EGWP subsidies were developed based on claims experience and average subsidies received by other similar groups. These savings were then reduced by the estimated increase in administrative fees, fees associated with the Patient Protection and

<sup>20</sup> Attachment B: *State of Alaska Estimated EGWP Savings Projections* Conduent dated January 24, 2018.

<sup>21</sup> Ibid.

<sup>22</sup> Attachment A: *Employer Group Waiver Program – Focus on Actuarial and Financial Impact*, Segal Consulting memo dated July 24, 2018.

Affordable Care Act (ACA), projected IRMAA reimbursements, changes in rebates and the estimated subsidies that would have been received under the Retiree Drug Subsidy program.

### **Clinical considerations:**

**There are no plans to implement “step therapy” or “fail first” provisions in the retiree plan, that would require additional information from clinicians.** “Step therapy” is when an insurance plan requires a member to try certain lower-cost medications first before covering a more expensive type of medication.

For a very limited number of drugs, the retiree health plan already requires prior authorization, and in a few cases where a drug is extraordinarily expensive and other alternative medications are available, the plan requires members try those medications first or have a medically necessary reason why those would not work. This is not a requirement of EGWP, this is part of the current plan administration. This is limited to a very small number of drugs and should not be impacted by an AlaskaCare EGWP.

### **Third Party Administrator (TPA) operational impacts:**

The impacts to the Medical, Dental and Long-Term Care Third Party Administrator will be minimal. The impact to the Pharmacy Benefit Manager (PBM) will be significant. There is a heavy back-end administrative burden that is performed by the PBM to minimize member impacts. This includes, but is not limited to:




- gaining approval from CMS to be an EGWP sponsor;
- creating and publishing a custom EGWP formulary that is compliant with Medicare Part D program requirements;
- administering the supplemental wrap benefits to ensure AlaskaCare benefits remain as they are today;
- enrolling Medicare eligible retirees under the EGWP;
- managing the CMS required Opt-out process;
- administering CMS required Medication Therapy Management Program;
- producing prescription drug events files, health plan management system reports, and other required CMS reporting;
- providing customer service support to retirees;
- mailing mandatory CMS communications;
- administering low income subsidies;
- administering the supplemental wrap benefits to ensure AlaskaCare benefits remain as they are today; and
- conducting CMS subsidy payment reporting.

**Provider considerations:**

Impacts to providers are anticipated to be minimal. However, the PBM will run detail analysis to verify what, if any, provider impacts will occur as a result of a transition to the enhanced EGWP.

The Division's current understanding is that participating pharmacies will not be required to do any more than they do today to fill a member's prescription. Members will have a single pharmacy card, and the claims adjudication system automatically attributes the claim to the AlaskaCare EGWP or the AlaskaCare wrap benefits without intervention by the member.

**Documents attached include:**

<u>Document Name</u>	<u>Attachment</u>	<u>Notes</u>
<b><i>Employer Group Waiver Program – Focus on Actuarial and Financial Impact, Segal Consulting dated July 24, 2018</i></b>	A	 Segal EGWP Memo
<b><i>State of Alaska Estimated EGWP Savings Projections, Conduent dated January 24, 2018.</i></b>	B	 Conduent
<b>ARMB Res 2017-20 Employer Group Waiver Program</b>	C	 ARMB Resolution
<b>Summary of public comment</b>	D	See Attached

# Attachment A



## MEMORANDUM

**To:** Ajay Desai, Director, Division of Retirement and Benefits

**From:** Richard Ward, FSA, FCA, MAAA

**Date:** July 24, 2018

**Re:** Employer Group Waiver Program – Focus on Actuarial and Financial Impact

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The AlaskaCare Retiree Plan currently participates in the Retiree Drug Subsidy (RDS), which is a federal program operated by the Centers for Medicare and Medicaid (CMS). This program provides federal subsidies to group plan sponsors to offset the cost of pharmacy benefits for Medicare retirees. To qualify, a plan must provide a minimum level of benefits, but otherwise a plan sponsor has latitude in the benefit structure and administration.

An Employer Group Waiver Program (EGWP) is an additional CMS program that provides a greater subsidy level than RDS. To qualify as an EGWP, the plan must comply with the CMS requirements and mandates for all Medicare Part D plans. An EGWP is a group plan, and the plan sponsor retains control of the design and administration provided the CMS mandates are met.

### Actuarial Value

The transition to an EGWP is largely a “behind-the-scenes” change. The implementation of the AlaskaCare EGWP will not impact member benefits or cost share (copays will be identical), and there will be a negligible impact on how members’ will receive their medications.

Therefore, the implementation of the AlaskaCare EGWP does not impact the Plan’s overall actuarial value:

- CMS mandates that all Medicare Part D prescription drug plans limit the maximum supply per script to a 90-day fill. The current AlaskaCare benefit covers a 100-unit supply if greater than the 90-day fill.

Under either provision, members can receive a full year's supply with four (4) fills, which are \$0 when the mail order benefit is utilized. Therefore, there is no impact on actuarial value.

- There will be no change to copay structure, which will remain \$4 for retail generic, \$8 for retail brand name and \$0 for mail order prescriptions.

	Mail Order Copay	Retail Generic Copay	Retail Brand Name Copay	Drugs Covered
<b>Current RDS</b>	\$0	\$4	\$8	Open Formulary <sup>1</sup>
<b>AlaskaCare EGWP</b>	\$0	\$4	\$8	Open Formulary

- There will be no change to the members that have multiple coverages in the State Plan. For these members their net drug costs will remain \$0.
- Members' access to covered drugs and pharmacies will not be impacted by the EGWP transition.
- Some high-income members will be subject to the Income Related Monthly Adjustment Amount (IRMAA), which will result in some retirees paying an additional surcharge. This is the same requirement for members who are covered today under Medicare Part B. This does not impact actuarial value. However, it is worth noting that the Division of Retirement and Benefits will reimburse any retiree that is impacted by the Part D IRMAA.

## Financial Impact

The current RDS program provides approximately \$16M-\$23M in annual subsidies, which is used to offset the annual claims cost of about \$250M-\$260M (Medicare and non-Medicare retirees). Annual projected EGWP subsidies are \$35M-\$44M, resulting in a net gain of \$19M-\$21M annually. These figures are net of additional administrative costs and projected IRMAA reimbursements.

This analysis is based on 2016 and 2017 pharmacy claims data, projected to 2019 at 6.0% annual trend. Projected RDS subsidies are based on recent subsidies received by the State. Projected EGWP subsidies were developed collaboratively with the State's current Pharmacy Benefit Manager (Aetna) and are based on claims experience and average subsidies received by other similar group plans.

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<sup>1</sup> A formulary is a list of covered prescription drugs that will be paid under a health plan. An open formulary means there are no restrictions on which drugs will be covered as long as the drug meets the definition of "prescription drug", i.e. a medical substance which must bear a label that states, "Caution: Federal law prohibits dispensing without a prescription" and is not otherwise excluded under the plan.

*Please note that the projections in this report are estimates of future costs and are based on information available to Segal at the time the projections were made. Segal Consulting has not audited the information provided. Projections are not a guarantee of future results. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, trend rates, and claims volatility. The accuracy and reliability of projections decrease as the projection period increases. Unless otherwise noted, these projections do not include any cost or savings impact resulting from The Patient Protection and Affordable Care Act (PPACA) or other recently passed state or federal regulations.*

cc: Michele Michaud, Division of Retirement and Benefits  
Emily Ricci, Division of Retirement and Benefits  
Linda Johnson, Segal  
Michael Macdissi, Segal  
Noel Cruse, Segal  
Dan Haar, Segal

# Attachment B

## State of Alaska

### Estimated EGWP Savings Projections

\$ in millions

	Segal Estimates		Aetna Estimates		
	Low Range	High Range	Existing Plan	Alternate Plan	Aetna Proposed
(1) Base Subsidy	\$9.0	\$10.0	\$9.0	\$9.0	\$9.0
(2) Coverage Gap Discount	22.0	25.0	25.2	24.9	23.4
(3) Catastrophic Reinsurance	<u>12.0</u>	<u>15.0</u>	<u>13.8</u>	<u>16.4</u>	<u>13.8</u>
(4) Total Subsidies (1) + (2) + (3)	\$43.0	\$50.0	\$48.0	\$50.3	\$46.2
(5) Change in Gross Claims	2.0	3.0	2.4	2.4	12.6
(6) Change in Member Costs	(0.1)	0.1	(0.2)	0.9	0.9
(7) Additional Admin Fees	(6.8)	(6.5)	(6.6)	(6.6)	(6.6)
(8) ACA Fees	(0.5)	(0.4)	(0.5)	(0.5)	(0.5)
(9) Rebate Change	<u>(2.5)</u>	<u>(1.5)</u>	<u>3.5</u>	<u>3.5</u>	<u>9.1</u>
(10) Net EGWP (4) + (5) + (6) + (7) + (8) + (9)	\$35.1	\$44.7	\$46.6	\$50.0	\$61.7
(11) RDS Subsidy	19.0	21.0	21.0	21.0	21.0
(12) Estimated Savings	\$16.1	\$23.7	\$25.6	\$29.0	\$40.7
(13) Percentage Savings Increase (10) / (11) - 1	85%	113%	122%	138%	194%

#### Important Notes:

- The Segal and Aetna estimates were provided to Conduent by the State of Alaska. The Segal estimates were in a presentation dated May 4, 2017 and the Aetna estimates were provided in a spreadsheet dated June 21, 2017.
- The RDS Subsidy used in the Aetna estimates was set equal to the high range from the Segal estimates. Aetna used an amount of \$28.8M in their estimates, but indicated that Segal would have the best estimate. For reference, the actual RDS received for the 2016 plan year was \$21.2M (as provided by State of Alaska).
- Additional details on the plan designs modeled by Aetna can be found in their analysis dated June 21, 2017.

#### Final FY19 Contribution Rates - State Assistance Contributions<sup>1</sup>

PERS	5.58%	5.58%	5.58%	5.58%	5.58%
TRS	16.34%	16.34%	16.34%	16.34%	16.34%
JRS	32.45%	32.45%	32.45%	32.45%	32.45%

#### FY19 Contribution Rates Reflecting EGWP Savings - State Assistance Contributions

PERS	4.18%	3.70%	3.57%	3.54%	3.43%
TRS	15.57%	15.53%	15.52%	15.48%	15.42%
JRS	32.45%	32.45%	32.45%	32.45%	32.45%

#### FY19 Projected Payroll<sup>1</sup>

PERS	\$2,423.3	\$2,423.3	\$2,423.3	\$2,423.3	\$2,423.3
TRS	784.4	784.4	784.4	784.4	784.4
JRS	15.1	15.1	15.1	15.1	15.1

#### FY19 Projected State Assistance Contributions Savings

PERS	\$33.9	\$45.6	\$48.7	\$49.4	\$52.1
TRS	6.0	6.4	6.4	6.7	7.2
JRS	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>
Total	\$39.9	\$52.0	\$55.1	\$56.1	\$59.3

#### Reduction in Normal Cost as of June 30, 2016<sup>2</sup>

PERS DB	\$3.2	\$4.3	\$4.6	\$5.2	\$7.4
PERS DCR	0.2	0.5	0.6	0.8	1.4
TRS DB	0.9	1.1	1.2	1.4	1.9
TRS DCR	0.0	0.1	0.1	0.2	0.3
JRS	<u>0.1</u>	<u>0.1</u>	<u>0.1</u>	<u>0.1</u>	<u>0.1</u>
Total	\$4.4	\$6.1	\$6.6	\$7.7	\$11.1

#### Reduction in APBO as of June 30, 2016<sup>2</sup>

PERS DB	\$375.1	\$498.8	\$538.5	\$609.1	\$856.4
PERS DCR	2.1	4.5	5.3	6.6	11.3
TRS DB	141.4	188.0	203.0	229.6	322.8
TRS DCR	0.6	1.4	1.6	2.1	3.6
JRS	<u>1.0</u>	<u>1.3</u>	<u>1.4</u>	<u>1.6</u>	<u>2.3</u>
Total	\$520.2	\$694.0	\$749.8	\$849.0	\$1,196.4

<sup>1</sup> Documented in letter dated September 15, 2017, providing Allocation of Additional State Contributions for FY19

<sup>2</sup> Reduction measured as of June 30, 2016, which is the basis for calculating the FY19 State Assistance Contributions

Except for the EGWP savings adjustments noted above, all of the data, assumptions, methods and plan provisions used in the above calculations are documented in the valuation reports for the 2017 fiscal year (valuation date of June 30, 2016).

# Attachment C

## ALASKA RETIREMENT MANAGEMENT BOARD

Subject: Employer Group Waiver Program ACTION: x

Date: December 8, 2017 INFORMATION

### Resolution 2017-20

WHEREAS, the Alaska Retirement Management Board (Board) was established by law to serve as trustee to the assets of the State's retirement systems; and

WHEREAS, under AS 37.10.210-220, the Board is to establish and determine the investment objectives and policy for each of the funds entrusted to it; and

WHEREAS, AS 37.10.071 and AS 37.10.210-220 require the Board to apply the prudent investor rule and exercise the fiduciary duty in the sole financial best interest of the funds entrusted to it and treat beneficiaries thereof with impartiality; and

WHEREAS, the retirement trust provides prescription drug coverage plans to eligible retirees and dependents, including Medicare-qualifying retirees and dependents; and

WHEREAS, the AlaskaCare retiree health plan pharmaceutical costs in the retiree health plan were \$218M in plan year 2016;

WHEREAS, the pharmaceutical costs account for approximately 42% of the plan expenditures in that year; and

WHEREAS, pharmaceutical expenditures have been one of the fastest growing trends in the AlaskaCare retiree plan averaging 11% annual increase between 2014 and 2016; and

WHEREAS, the AlaskaCare retiree health plan received \$21.2M in federal subsidies through the Medicare retiree drug subsidy program in plan year 2016; and

WHEREAS, the Employer Group Waiver Program is an alternative mechanism by which the AlaskaCare retiree health trust can receive an estimated \$43M to \$50M in federal subsidies for prescription drug benefits per plan year; and

WHEREAS, the Employer Group Waiver Program will also reduce the unfunded liability for the Other Post Employment Benefit liability; and

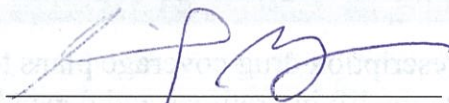
WHEREAS, the benefits provided to retirees and their eligible dependents can be preserved with minimal impact; and

NOW THEREFORE, BE IT RESOLVED BY THE ALASKA RETIREMENT MANAGEMENT BOARD, supports the AlaskaCare retiree health plan adoption and implementation an Employer Group Waiver Program to be effective January 1, 2019.

DATED at Anchorage, Alaska this 8<sup>th</sup> day of December 2017.

  
Chair

ATTEST:

  
Secretary



# Attachment D

-----Original Message-----

From: Janice Templin-Weller [REDACTED]

Sent: Wednesday, May 30, 2018 10:43 PM

To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>

Subject: Changes to Retiree Pharmacy Plan

My husband worked for a school district and retired after 30 years and I worked for the State of Alaska for 28 years. We retired with TERS and PERS with the constitutional commitment from the State of Alaska that our level of benefits could not be changed to disadvantage or decrease our benefits. We have already seen a decrease in benefits for chiropractic care and accupuncture. Now we are threatened with a decrease in benefits for our prescription coverage. This is not acceptable and not what we signed up for when we retired. This change is not constitutional and must not be implemented.

Janice Templin-Weller

-----Original Message-----

From: Sue Petersen <[REDACTED]>

Sent: Wednesday, May 30, 2018 11:02 PM

To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>

Subject: Change of pharmacy plan

To whom it may concern:

We earned the pharmacy benefits we have.

Alaska can't diminish our benefits!

There is a protocol you must follow. Do it right the first time. We will take you to court if we have to.!!!!

Sue Petersen

Sent from my iPhone

**From:** Sandra Lemke Nesvick [REDACTED]  
**Sent:** Thursday, May 31, 2018 2:03 PM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Subject:** Insurance changes

As a retiree of Alaska I object wholeheartedly to this new proposal regarding our medication benefits. Please rethink this proposal and restore our benefits to the level that allows us to live on our retirement without investing the services of a shopping cart for our possessions.

Sandra L Nesvick

**From:** Gary Miller [REDACTED]  
**Sent:** Thursday, May 31, 2018 1:59 PM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Subject:** Fwd: Pharmacy Coverage Change  
**Cc:** Dennis Sharon Early <[REDACTED]> Sam Kito <[representative.sam.kito@akleg.gov](mailto:representative.sam.kito@akleg.gov)>,  
Justin Parish <[representative.justin.parish@akleg.gov](mailto:representative.justin.parish@akleg.gov)>, Sharon Hoffbeck <[REDACTED]>

When I went to work for the State of Alaska in 1975, I was promised a retirement system that would cover my healthcare after I retired. There wasn't anything in the retiree hand book that said if I wanted those promises and benefits to be kept that I would have to fight for them. This new scheme to switch me to Medicare and reduce my prescription drug benefits is a violation of the Alaska Constitution and violates the Alaska Supreme Court decision protecting my retiree benefits.

I want you to oppose these changes. I worked for the State of Alaska for 26 years. I kept my part of the bargain by staying with the State of Alaska. The State of Alaska needs to keep its word and stick with the bargain that was promised me!!!!!!

Gary Miller

**From:** Deborah Hansen [REDACTED]  
**Sent:** Thursday, May 31, 2018 1:09 PM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** Sharon Hoffbeck [REDACTED]  
**Subject:** Changes in Pharmacy coverage - concerns regarding co-ordination of benefits

Hello-

I am concerned about your change in coverage and how it will affect my husband. His [REDACTED]  
[REDACTED]. Will this change in coverage since it is Federal then become  
his primary? I do know that we have had many problems with Medicare and coverage since [REDACTED]  
[REDACTED]

Currently, the pharmacy coverage is working very well and there are no problems. Given our problems with reconciling bills with Medicare and their constant denials, I anticipate the change in coverage not going well.

Deborah Hansen

**From:** crtsales [REDACTED] >  
**Sent:** Thursday, May 31, 2018 12:04 PM  
**To:** [AlaskaRHPAB@laska.gov](mailto:AlaskaRHPAB@laska.gov)  
**Cc:** [REDACTED]  
**Subject:** Rx drug change

Hello

I think that DOA changing to the proposed Part D plan would be a change not allowed by the court decision several years back.

This new plan seems far worse than our Tier 1 Alaska Care Rx plan now, as there are far more restrictions and requirements to comply with on proposed Part D Plan to get medication that our Dr's prescribe than on our Tier 1 Rx. Plan. I'm [REDACTED] and my [REDACTED] this is bad news for us as our Rx needs keep increasing with age. Why have you, DOA proposed to change my plan after retirement and if done it's not equal to what we have? You should look someplace else to make up for the budget shortfall, you already took ½ of our permeant fund checks.

I spent 27 years working for SOA with a guarantee of the Tier 1 health plan, back when I started in 1976 you couldn't get people in the Electronics Tech field to work for SOA as your wages didn't compare with Pipe line wages. The Tier 1 benefits package was promised and agreed to in union our contract. That is what kept lots us on board with SOA through the years also. I request DOA to not continue with this. I also request REPA to file court proceedings to stop this.

Thanks

Allen Sanders

**From:** Carol Thompson [REDACTED]  
**Sent:** Thursday, May 31, 2018 11:59 AM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>; Sharon Hoffbeck [REDACTED]  
**Subject:** Retirees' Pharmacy Plan

Dear Retiree Health Plan Advisory Board,

I strongly object to the implementation of any planned changes in the Retirees Pharmacy Plan that does not comply with the Alaska Supreme Court's RPEA v. Duncan. In particular, the changes must adhere to the following.

- A) The analysis must be based on reliable evidence, such as solid, statistical data drawn from actual experience—including accepted actuarial sources—rather than by unsupported hypothetical projections.
- B) Equivalent value must be proven by comparison of the actual benefits provided to those that are proposed in the changes.
- C) Where any individual shows that a proposed change results in a serious hardship that is not offset by comparable advantages, that affected individual must be allowed to retain existing coverage.

Please inform me when A) and B) have been completed and provide the results of those analyses.

Thank you,

Carol Thompson  
Retiree

--

**Carol C. Thompson**

[REDACTED]



**From:** Brad Parker [REDACTED]  
**Sent:** Thursday, May 31, 2018 11:39 AM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Subject:** FW: Proposed Change to Retiree over 65 prescription plan

I object to any changes in the pharmacy plan for those of us over 65 [REDACTED]  
[REDACTED] mostly paid for by my current employer's pharmacy plan and supplemented by the Alaska Care Plan. When I retire I plan to rely on the Alaska Care plan. I was hire by the State of Alaska in 1977 and retired from the State of Alaska in 2000. At both times I expected that my wife and I would one day receive the benefits as promised by the D.O.A and the state.

It certainly appears that it is the intention of the State to diminish those benefits this coming year. This is unfair and wrong. We do not want to participate in a plan which will force me to use drugs not prescribed by our doctors. This will also create a night mare with coordination with other insurers.

Bradford Parker

**From:** Brad Parker <[REDACTED]>  
**Sent:** Thursday, May 31, 2018 11:49 AM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** [REDACTED]  
**Subject:** Changes to Retiree Pharmacy plan

I have [REDACTED] It was coordinated with my other insurance .What will happen to that promised approval ?

This is terrible . What kind of trouble will we go through when this happens. It took us 6 months to get things worked out with our pharmacy and the insurance companies when Aetna took over. It was a very frustrating mess. Please do not change our prescription plan. It will be another mess even worse when we have to have our other insurance coordinate with this Part D plan or will it even be possible ??

If we drop our other insurance it will probably put a greater cost on the Alaska Care plan.

Bradford Parker

**From:** Jerrold Fields [REDACTED]  
**Sent:** Thursday, May 31, 2018 11:02 AM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Subject:**

So what is the point of constitutional law if the SOA and DOA try to bypass? I have medications that are life saving and expensive and that I have taken for awhile. How might this plan adversely affect my health? The only advantage to this proposed change I can see is the SOA will pay less money! Sounds like greed and corruption to me and we the people who paid their dues get screwed! I hope RPEA and the advisory board can stop this, it stinks! This is a set up for retirees. There is no doubt this is a less advantageous plan for retirees. It seems DOA is attempting to bypass the law to push this through, which is in itself a bad sign. I have 100% coverage on meds presently, will that continue under this new plan. In other words will [REDACTED] still meet my co-pay? What happens if the Feds decide to just discontinue this? The appeals processes sound horrible! The insurance deciding what meds I should take other than my doctors and I deciding is also horrible! Is this stoppable? What does RPEA think in more detail? Does RPEA/advisory board see any advantages for retirees?

Thanks,

Jerrold Fields

**From:** Robert F. Nesvick Jr. <[REDACTED]>  
**Sent:** Thursday, May 31, 2018 7:42 AM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Subject:** Chance in REITREE PHARMACY PLAN

RHPAB,

As a State of Alaska Retiree over the age of 65, I would like to file an objection to the proposed change in the Retiree Pharmacy Plan. We worked long and hard serving the citizens of the State for these benefits.

The Alaska Supreme Court in the past has ruled that the State of Alaska can not diminish our benefits, and this proposed change would do just that.

***Robert F. (Bob) Nesvick Jr.***  
***Retired Alaska State Trooper***  
[REDACTED]

To: Board chair, Judy Salo and Retiree Health Plan Advisory Board

As you are probably aware, beginning in approximately mid-November DOA will enroll all retirees who are 65 and older in a Medicare Part D pharmacy plan called an EGWP/wrap. It will be administered by a separate Pharmacy Benefits Manager (PBM). DOA is in the process of reviewing bids in response to the RFP (Request for Bids) that was put out earlier this year.

Our existing health plan benefits are protected under Article XII, Section 7 of the Alaska Constitution from diminishment or impairment, and cannot be changed to disadvantage or impair the current retiree benefits unless comparable new advantages are included to offset the proposed changes.

Additionally, because the EGWP is a federal program, it is not a Constitutionally protected benefit like the prescription drug program under our current health care plan, and could be modified, suspended or cancelled at any time by Medicare.

Before DOA can impose any proposed changes—including the EGWP plan--to the retiree health plan, it must follow the process specified by the Alaska Supreme Court in the case of *RPEA v. Duncan* by performing an equivalency analysis to establish whether the changes which disadvantage retirees as a group are offset by additional advantages of comparable value.

The law requires DOA to make these analyses before it imposes any proposed changes. We objects to these changes because DOA has not done the required equivalency analysis.

Kevin and Cristine O'Sullivan  
State of Alaska retirees

**From:** Debra Buzdor [REDACTED]  
**Sent:** Thursday, May 31, 2018 7:08 AM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Subject:** Fwd: [Rpea.sc.mat-su] [Rpea.sc] [Rpea.members] CHANGE IN REITREE PHARMACY PLAN

To the board:

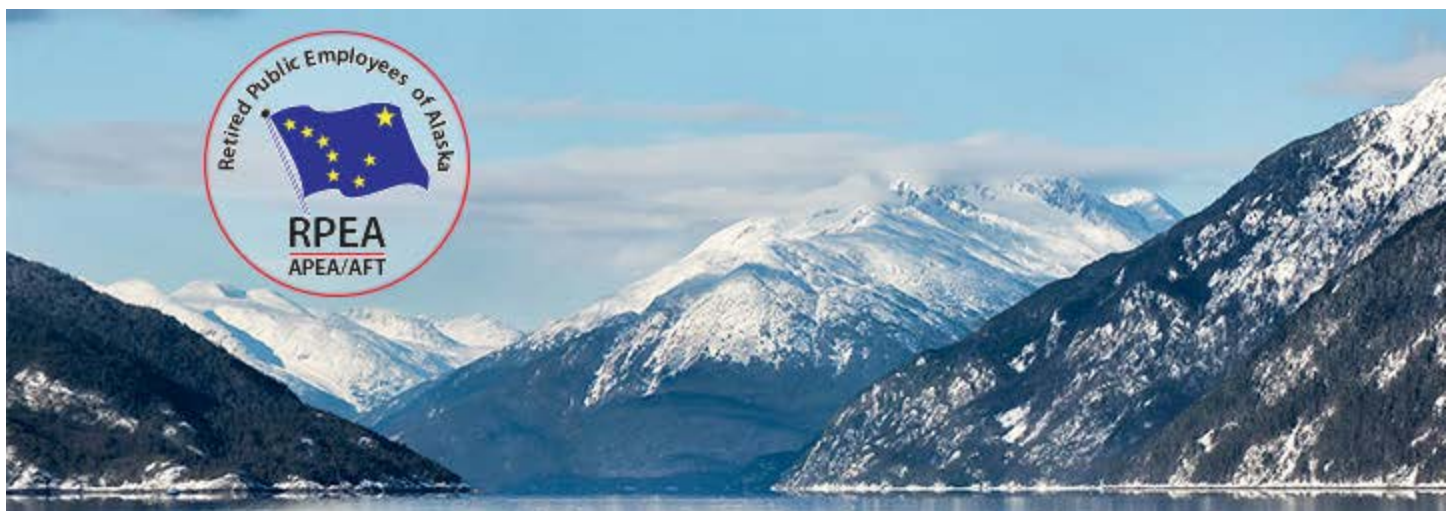
I am a retired Mat-Su Teacher. I was upset when I retired and learned that our insurance coverage which was promised for the 24 years I worked, was actually a scaled down package compared to our coverage as active teachers. NOW you are going to make it harder to get prescriptions, when we are all pushing into our 70's????

I HIGHLY DISAGREE WITH ITEM NUMBER AND 1 AND NUMBER 2. This is a violation of our agreement.

Please reconsider taking this action, (see below) and thank you for your participation and for your work.

----- Forwarded message -----

**From:** Sharon Hoffbeck <[REDACTED]>  
**Date:** Wed, May 30, 2018 at 9:05 PM  
**Subject:** [Rpea.sc.mat-su] [Rpea.sc] [Rpea.members] CHANGE IN REITREE PHARMACY PLAN  
**To:** RPEA Members--All <[REDACTED]>



## CHANGE IN RETIREE PHARMACY PLAN

We want to give you a heads-up about some changes the Department of Administration (DOA) is planning to make to the retiree pharmacy plan, **effective January 1, 2019**. This change is scheduled to begin implementation mid-November, 2018.

**These changes will only affect those 65 and over.** The Pharmacy plan for those 65 and under will remain the same.

According to a presentation by the Department of Administration (DOA) at the May 8<sup>th</sup> Retiree Health Plan Advisory Board meeting, beginning in approximately mid-November DOA will enroll all retirees who are 65 and older in a Medicare Part D pharmacy plan called an EGWP/wrap. It will be administered by a separate Pharmacy Benefits Manager (PBM). DOA is in the process of reviewing bids in response to the RFP (Request for Bids) that was put out earlier this year.

Medicare Part D is a commercial pharmacy plan, approved by Medicare but not managed by Medicare. What DOA is implementing is called an EGWP/wrap, which is a Medicare Part D pharmacy plan with a 'wrap' that is intended to supplement the Medicare Part D drug plan with the additional pharmacy benefits that the AlaskaCare retiree plan currently includes.

A few of the major changes are:

1. If a prescribed drug is denied, the denial must be appealed using a 5 step federal appeal process. Currently, if there is a denial, the Division of Retirement & Benefits can directly intervene with the Third Party Administrator (currently Aetna), assuring the retiree pharmacy plan is not diminished.
2. Step Therapy appears to be a part of the Medicare Part D/EGWP plan. This would be a significant change and diminishment from the current retiree pharmacy plan. Step Therapy requires that you may have to try other drugs that are less expensive and chosen by the PBM, other than the drugs your doctor prescribes, and if they do not work as needed you can then request the drug your doctor prescribed. This is a multi-step process that can potentially impact your course of care prescribed by your doctor. Under the current retiree plan, your course of care is a decision between you and your doctor.
3. The regular monthly Medicare Part D premium will be paid from the medical trust for all retirees.

For those in a 'high income' category set by the federal government (currently \$85,000 single or \$170,000 married),



there will be an additional monthly surcharge that currently ranges from approximately \$35.00--\$75.00. This surcharge must be paid by the retiree, and will be reimbursed by the state at a later date. The state will not be notified if you are in the high income category, and you must contact them to activate the reimbursement process. If the surcharge is not paid, you will be dropped from the Medicare Part D/EGWP plan, and enrolled in an alternate pharmacy plan designed by the state that will not have the same benefits as the current pharmacy plan. The details of this alternate pharmacy plan have not yet been disclosed by DOA.

4. Copays for some drugs may increase.

To see DOA's EGWP/wrap pharmacy plan presentation, please go to the RPEA website and you will find it posted under "Retiree

Health Plan Advisory Board", "EGWP/Wrap Pharmacy Plan". An acronym that you will see repeatedly in their report is "CMS" which

stands for Centers for Medicare & Medicaid Services.

RPEA Website Link:

<http://www.rpea.apea-aft.org/>

As you know, our existing health plan benefits are protected under Article XII, Section 7 of the Alaska Constitution from diminishment or impairment, and cannot be changed to disadvantage or impair the current retiree benefits unless comparable new advantages are included to offset the proposed changes.

However, because the EGWP is a federal program, it is not a Constitutionally protected benefit like the prescription drug program under our current health care plan, and could be modified, suspended or cancelled at any time by Medicare.

Before DOA can impose any proposed changes—including the EGWP plan--to the retiree health plan, it must follow the process specified by the Alaska Supreme Court in the case of *RPEA v. Duncan* by performing an equivalency analysis to establish whether the changes which disadvantage retirees as a group are offset by additional advantages of comparable value.

Furthermore –

1. The analysis must be based on reliable evidence, such as solid, statistical data drawn from actual experience—including accepted actuarial sources—rather than by unsupported hypothetical projections.
2. Equivalent value must be proven by comparison of the actual benefits provided to those that are proposed in the changes.
3. Where any individual shows that a proposed change results in a serious hardship that is not offset by comparable advantages, that affected individual must be allowed to retain existing coverage.

RPEA believes that the law requires DOA to make these analyses before it imposes any proposed changes. RPEA objects to these changes because DOA has not done the required equivalency analysis. RPEA's specific objections are included in the statement that Brad Owens, our Executive Vice President, made at the May 8<sup>th</sup> Retiree Health Plan Advisory Board meeting. This statement is posted on the RPEA website and can be located under "Retiree

Health Plan Advisory Board”, “2018/05/08 RPEA Statement to Advisory Board”.

RPEA Website Link:

<http://www.rpea.apea-aft.org/>

Comments concerning these changes should be made to the Retiree Health Plan Advisory Board at [AlaskaRHPAB@laska.gov](mailto:AlaskaRHPAB@laska.gov). This email address is managed by the Department of Administration, and emails are forwarded to the Board chair, Judy Salo. We ask that you also cc RPEA: [sharonhoffbeck@gmail.com](mailto:sharonhoffbeck@gmail.com).

As always, please feel free to contact me directly.

***Sharon Hoffbeck***

President

Retired Public Employees of Alaska

[REDACTED]

--

Deb Buzdor

**From:** dale skinner [REDACTED]  
**Sent:** Thursday, May 31, 2018 6:43 AM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** Sharon Hoffbeck [REDACTED]  
**Subject:** Proposed changes to the Pharmacy Plan

As a state retiree who is over the age of 65 I am totally and completely against this change being made to the existing pharmacy plan. I see these changes as increasing our cost for the drugs we need and will need as we get older. I am also opposed to this step therapy. I see this as being a significant change and greatly diminish from the current retiree pharmacy plan. To force a patient to first use a drug which their doctor has NOT recommended is not only foolish but could be very dangerous to the patient. In order for a patient to go from first trying a drug which your doctor has not prescribed to using a drug which the doctor knows is best for the patient, will this require one to go through this 5 step reveal process? Who is the one to determine if a lesser drug is working or not? Who is at the forefront of wanting to make this change? I see this as having the potential of increasing ones cost due to increased doctor visits and possible ER visits due to this lesser drug not working properly. How about the patient you dies because they were forced to take a lesser drug?

Dale Skinner

**From:** PATRICK STEVENS <[REDACTED]>  
**Sent:** Thursday, May 31, 2018 4:52 AM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Subject:** proposed changes to pharmacy benefits

Dear Sirs:

I have been informed that State of Alaska retirees over the age of 65 are about to become participants in the Medicare Part D program for pharmaceuticals. I object to this change.

From my understanding, other Medicare retirees are allowed, under the Medicare Part D program, to select from a wide variety of pharmacy programs when they enroll, and are able to change their program at the beginning of each benefit year. Therefore, they are able to adjust their program to fit their needs. The program you are enrolling us in will not give us that choice. In fact, it may be a pharmacy program that greatly reduces an individual enrollee's benefit and damage their health care irreparably.

I understand that Alaskacare is an expensive program, and that the State of Alaska has assumed a great burden by providing these benefits to retirees. But I also understand that these benefits were earned by myself and all other retirees as a part of our contract with the state during the time we worked. I expect the state to honor their contract, just as I honored mine.

Thank you,

Patrick A. Stevens

-----Original Message-----

From: [REDACTED]

Sent: Thursday, May 31, 2018 3:16 PM

To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>

Cc: [REDACTED]

Subject: EGWP

I have read through the proposed changes to our Alaska Retiree RX benefit plan as presented in your EGWP Presentation.

You can butter it any way you want but the end result is that the retiree will be the loser if this goes forward.

No where do you cover how the program will work for those of us (husband and wife) that are both Alaska Retirees. Currently any co-pay is covered by the other's plan. I'm sure you know how coordination of benefits (COB) works. How will it work under the proposed plan changes? Is it a benefit that we will lose?

If an individual is currently taking a medication that is covered under the current plan (no pre-authorization required) but now under the EGWP requires a pre-authorization and MEDICARE does not authorize this medication, what does the individual do??? Are they now required to jump through a bunch of hoops to appeal. If so, this is a diminishment to our current benefit package.

Any added administrative hoops that the EGWP requires of the retiree does in fact diminish the retirees benefit package.

Once this program falls under federal regulations the state will have lost control and the retiree will be at the mercy of MEDICARE. How does this fair with Article XII, Section 7 of the Alaska Constitution?

If I currently am receiving medication "XYG" and 5 years down the road MEDICARE states they are no longer going to let me have "XYG" because "XYG" is no longer in the MEDICARE formulary, how is this not considered a diminishment of our benefit package.

If our current RX benefit package is protected under Article XII, Section 7, of the Alaska Constitution then how can the state give up ownership of this program to MEDICARE. Once it is transferred to MEDICARE it will no longer be protected by the Alaska Constitution. What would the state be able to do if MEDICARE did away with Part D?

Stan and Debbie Palco

[REDACTED]

Henry M. Wiedle



Department of Retirement & Benefits:

Regarding the below change: if this occurs and they take away the medication that we are now on, a lawsuit will be filed. This is age discrimination plain and simple. We have worked all our life to have reliable health care and now our doctors cannot prescribe what is best for us and instead some pharmacy can do it. This is insane and won't be without a lawsuit. A strong letter will follow.

Henry & Margaret Wiedle  
Anchorage

**From:** Sharon Hoffbeck [REDACTED]  
**Sent:** Monday, June 04, 2018 9:28 AM  
**To:** 'Hank Wiedle'  
**Subject:** RE: [Rpea.sc.anchorage] [Rpea.sc] [Rpea.members] FW: CHANGE IN REITREE PHARMACY PLAN

Hi Hank—

You should send your comments to the Div. of Retirement & Benefits at [AlaskaRHPAB@alaska.gov](mailto:AlaskaRHPAB@alaska.gov).  
Please also cc me in your message to DRB.

I know this appears to be age discrimination, but we've asked the attorney representing RPEA and he said that the courts may not consider it such any more than the requirement to enroll in Medicare Part B at 65. But you never know what a court may decide.

I've attached the statement that RPEA made to the administration and Retiree Health Plan Advisory Board, as well as a document we have supplied them outlining the requirements that must be followed before changes can be made. DRB did none of them prior to making this decision.

***Sharon Hoffbeck***  
President  
Retired Public Employees of Alaska

[REDACTED]

I am referring to this letter we received, my comment is in RED.

H Wiedle

**From:** Hank Wiedle <[REDACTED]>  
**Sent:** Monday, June 4, 2018 9:09 AM  
**To:** 'Sharon Hoffbeck' <[REDACTED]>  
**Subject:** RE: [Rpea.sc.anchorage] [Rpea.sc] [Rpea.members] FW: CHANGE IN REITREE PHARMACY PLAN

Regarding the below change: if this occurs and they take away the medication that we are now on, a lawsuit will be filed. This is age discrimination plain and simple. We have worked all our life to have reliable health care and now our doctors cannot prescribe what is best for us and instead some pharmacy can do it. This is insane and won't be without a lawsuit.

Henry & Margaret Wiedle  
Anchorage

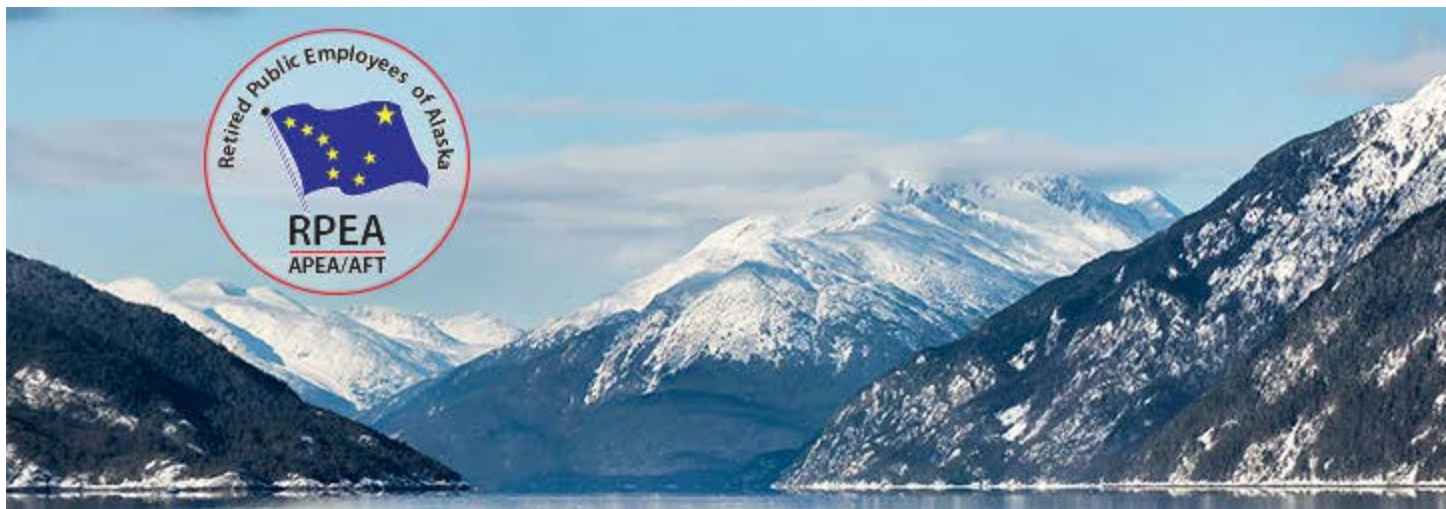
**From:** [REDACTED]  
[REDACTED] **On Behalf Of** Sharon Hoffbeck  
**Sent:** Wednesday, May 30, 2018 9:23 PM  
**To:** RPEA Members--All  
**Subject:** [Rpea.sc.anchorage] [Rpea.sc] [Rpea.members] FW: CHANGE IN REITREE PHARMACY PLAN

Email address correction—

The Retiree Health Plan Advisory Board email address is:  
[AlaskaRHPAB@alaska.gov](mailto:AlaskaRHPAB@alaska.gov).

**From:** Sharon Hoffbeck <[REDACTED]>  
**Sent:** Wednesday, May 30, 2018 9:05 PM  
**To:** RPEA Members--All <[REDACTED]>  
**Subject:** CHANGE IN REITREE PHARMACY PLAN





### **CHANGE IN RETIREE PHARMACY PLAN**

We want to give you a heads-up about some changes the Department of Administration (DOA) is planning to make to the retiree pharmacy plan, **effective January 1, 2019**. This change is scheduled to begin implementation mid-November, 2018.

**These changes will only affect those 65 and over.** The Pharmacy plan for those 65 and under will remain the same.

According to a presentation by the Department of Administration (DOA) at the May 8<sup>th</sup> Retiree Health Plan Advisory Board meeting, beginning in approximately mid-November DOA will enroll all retirees who are 65 and older in a Medicare Part D pharmacy plan called an EGWP/wrap. It will be administered by a separate Pharmacy Benefits Manager (PBM). DOA is in the process of reviewing bids in response to the RFP (Request for Bids) that was put out earlier this year.

Medicare Part D is a commercial pharmacy plan, approved by Medicare but not managed by Medicare. What DOA is implementing is called an EGWP/wrap, which is a Medicare Part D pharmacy plan with a 'wrap' that is intended to supplement the Medicare Part D drug plan with the additional pharmacy benefits that the AlaskaCare retiree plan currently includes.

A few of the major changes are:

1. If a prescribed drug is denied, the denial must be appealed using a 5 step federal appeal process. Currently, if there is a denial, the Division of Retirement & Benefits can directly intervene with the Third Party Administrator (currently Aetna), assuring the retiree pharmacy plan is not diminished.
2. Step Therapy appears to be a part of the Medicare Part D/EGWP plan. This would be a significant change and diminishment from the current retiree pharmacy plan. Step Therapy requires that you may have to try other drugs that are less expensive and chosen by the PBM, other than the drugs your doctor prescribes, and if they do not work as needed you can then request the drug your doctor prescribed. This is a multi-step process that can potentially impact your course of care prescribed by your doctor. Under the current retiree plan, your course of care is a decision between you and your doctor.

3. The regular monthly Medicare Part D premium will be paid from the medical trust for all retirees.

For those in a 'high income' category set by the federal government (currently \$85,000 single or \$170,000 married), there will be an additional monthly surcharge that currently ranges from approximately \$35.00--\$75.00. This surcharge must be paid by the retiree, and will be reimbursed by the state at a later date. The state will not be notified if you are in the high income category, and you must contact them to activate the reimbursement process. If the surcharge is not paid, you will be dropped from the Medicare Part D/EGWP plan, and enrolled in an alternate pharmacy plan designed by the state that will not have the same benefits as the current pharmacy plan. The details of this alternate pharmacy plan have not yet been disclosed by DOA.

4. Copays for some drugs may increase.

To see DOA's EGWP/wrap pharmacy plan presentation, please go to the RPEA website and you will find it posted under "Retiree Health Plan Advisory Board", "EGWP/Wrap Pharmacy Plan". An acronym that you will see repeatedly in their report is "CMS" which stands for Centers for Medicare & Medicaid Services.

RPEA Website Link:  
<http://www.rpea.apea-aft.org/>

As you know, our existing health plan benefits are protected under Article XII, Section 7 of the Alaska Constitution from diminishment or impairment, and cannot be changed to disadvantage or impair the current retiree benefits unless comparable new advantages are included to offset the proposed changes.

However, because the EGWP is a federal program, it is not a Constitutionally protected benefit like the prescription drug program under our current health care plan, and could be modified, suspended or cancelled at any time by Medicare.

Before DOA can impose any proposed changes—including the EGWP plan--to the retiree health plan, it must follow the process specified by the Alaska Supreme Court in the case of *RPEA v. Duncan* by performing an equivalency analysis to establish whether the changes which disadvantage retirees as a group are offset by additional advantages of comparable value.

Furthermore –

1. The analysis must be based on reliable evidence, such as solid, statistical data drawn from actual experience-including accepted actuarial sources—rather than by unsupported hypothetical projections.
2. Equivalent value must be proven by comparison of the actual benefits provided to those that are proposed in the changes.
3. Where any individual shows that a proposed change results in a serious hardship that is not offset by comparable advantages, that affected individual must be allowed to retain existing coverage.

RPEA believes that the law requires DOA to make these analyses before it imposes any proposed changes. RPEA objects to these changes because DOA has not done the required equivalency analysis. RPEA's specific objections are included in the statement that Brad Owens, our Executive Vice President, made at the May 8<sup>th</sup> Retiree Health Plan Advisory Board meeting. This statement is posted on the RPEA website and can be located under "Retiree Health Plan Advisory Board", "2018/05/08 RPEA Statement to Advisory Board".

RPEA Website Link:  
<http://www.rpea.apea-aft.org/>

Comments concerning these changes should be made to the Retiree Health Plan Advisory Board at [AlaskaRHPAB@alaska.gov](mailto:AlaskaRHPAB@alaska.gov). This email address is managed by the Department of Administration, and emails are forwarded to the Board chair, Judy Salo. We ask that you also cc RPEA: [sharonhoffbeck@gmail.com](mailto:sharonhoffbeck@gmail.com).

As always, please feel free to contact me directly.

***Sharon Hoffbeck***  
President  
Retired Public Employees of Alaska

  
RPEA STATEMENT  
TO ADVISORY BOAR

  
Duncan  
Template.pdf



## Retired Public Employees of Alaska, APEA/AFT

3310 Arctic Blvd., Suite 200, Anchorage, Alaska 99503

Phone: (907) 274-1703 or (800) 478-9992, Fax: (907) 277-4588

Email: [rpea@alaska.net](mailto:rpea@alaska.net)

Web site:

[www.rpea.apea-aft.org](http://www.rpea.apea-aft.org)

### PUBLIC COMMENTS BEFORE THE RETIREE HEALTH PLAN ADVISORY BOARD

May 8, 2018

Good morning. My name is Brad Owens and I am the Executive Vice President of the Retired Public Employees of Alaska. These comments today are offered on behalf of RPEA.

1. RPEA is a non-profit organization which was formed in 1996 and incorporated in 1998. Its members are mostly retired public employees and their dependents. Its purpose is to protect retiree benefits by educating, assisting and advocating on behalf of not only the members of RPEA but for all persons covered by PERS, TRS, JRS and other state retirement systems.
2. This Retiree Health Plan Advisory Board was recently created to provide an efficient and transparent way to facilitate regular engagement, communication and cooperation between the members of the state retirement systems and the Governor, the Department of Administration and the ARM Board (Alaska Retirement Management Board) about the administration and management of the state's retirement systems.
3. The principal responsibility of this Board is to make recommendations to DOA related to the health care plans provided under the state retirement systems.

I want to comment on three items today:

1. The EGWP program,
  2. The health plan modernization proposed by DOA, and
  3. DRB's regular denial of access to the OAH appeal process.
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4. The materials provided by DOA for this meeting indicate it has been developing changes to the retiree health care plans: The Employer Group Waiver Program or EGWP (pronounced "egg whip") and the "DB Retiree Health Plan Modernization."

5. The EGWP is a program offered by the federal government under Medicare as a group Medicare Part D prescription drug plan option. It is described by the DOA as the “most cost-effective way for the retirement system to provide retiree prescription drug coverage for Medicare eligible retirees and dependents.”
6. DOA recognizes that the existing health plan benefits are protected under Article XII, Sec. 7 of the Alaska Constitution from diminishment or impairment and, as such, cannot be modified to disadvantage or impair these current retiree benefits unless comparable new advantages are included to offset these proposed changes.
7. However, because the EGWP is a federal program, it is not a Constitutionally protected benefit like the prescription drug program under our current health care plan and could be modified, suspended or cancelled at any time by Medicare.
8. Despite this, it appears DOA proposes to change our current health care plan by implementing this EGWP plan in the very near future. In fact, the Financial Analysis provided at page 33 appears to be a forecast of savings in 2018.
9. The DOA also proposes a Retiree Health Plan Modernization through amendments to the current health care plan over the next two years. However, the timeline provided in the Plan Cycle, at page 4, appears to show implementation of the proposal in 2018.
10. This proposal is based on 12 areas DOA has focused on, described at page 9 of the materials, such as outdated pharmacy design, the safety and efficacy of drugs, reduced sensitivity to the price and increases in unnecessary services, confusion over rehabilitative services and dental implants, and use of a network for enhanced clinical review. It does not, however, indicate either the source of these concerns, nor the scope or impact of the concerns.
11. But before DOA can impose any of these proposed changes – either the EGWP or the proposed modernization -- it must follow the process specified by the Alaska Supreme Court in the case of *RPEA v. Duncan*: first, it must perform an equivalency analysis to establish the value between the changes which disadvantage retirees as a group and those that provide offsetting advantages; second, this analysis must be based on reliable evidence, such as solid, statistical data drawn from actual experience-including accepted actuarial sources-rather than by unsupported hypothetical projections; and third, equivalent value must be proven by a comparison of the actual benefits provided to those that are proposed in the changes.

12. In addition, where any individual shows that a proposed change results in a serious hardship that is not offset by comparable advantages, that affected individual should be allowed to retain existing coverage.
13. Similarly, changes that will predictably cause hardship to a significant number of beneficiaries who cannot at the time of the change be specifically identified, an option of providing an election to beneficiaries to retain existing coverage should be available, unless the state can show a compelling need for the change and the impracticability of providing for an election.
14. Likewise, major deletions in the types of coverage, such as coverage of a particular disease or condition, should not be allowed 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.
15. Lastly, changes that substantially reconfigure the mix of benefits to beneficiaries should be approved only upon a strong showing of justification and unusual gaps in coverage should be avoided.
16. DOA must perform an analysis of the impact of these proposed changes on the retirees and beneficiaries before it imposes the changes. It must do so because, as the administrator and fiduciary of these retirement benefits, it must ascertain the impacts of any changes that disadvantage retirees, what the nature and extent of the disadvantage might be, identify and provide prior notice to any retirees who might experience a substantial hardship as a result of the changes and provide them an opportunity to establish such hardship, and ensure that any diminishments or impairment caused by these changes are offset by adequate and comparable new advantages.
17. We believe the law requires DOA to make these analyses in an adequate and proper way before it imposes any proposed changes.
18. We hope that this Board, in fulfilling its responsibilities to the retirees and participants of these health care plans, will investigate these proposed changes and recommend whatever steps are appropriate to ensure DOA follows the proper procedure.

The other matter I wanted to bring to the attention of this Board is the concerted and ongoing effort by DRB to deny members their right to appeal claim denials to OAH.

#### DENIAL OF OAH APPEAL RIGHTS

DRB has regularly inserted itself into the appeal process and has settled specific claims that have been appealed but has done so in a way that precludes the retiree from obtaining a decision on whether he or she is entitled to rely on the settled claims as a determination of coverage for future claims of the same type.

This has occurred over the last year or more primarily in the area of rehabilitative care involving physical therapy, occupational therapy, massage therapy and chiropractic care. What DRB has done is settle the specific denied claims and directed payment of those claims but has also stated in each appeal that settlement of the past claims is not a determination as to coverage for any similar future claims.

In many cases the retiree has objected to this refusal by DRB to determine future coverage of similar claims under the terms of the plan and its refusal to submit this remaining coverage issue to OAH for a decision – a right to which they are entitled under the provisions of PERS and TRS.

DRB has repeatedly taken the position that payment of the specific denied claims renders any further appeal to OAH moot. In this manner, DRB has been able to avoid any decision on the merits of coverage for future similar claims. This regular course of conduct violates the statutory right to appeal to OAH and constitutes a breach of DRB's fiduciary duty.

RPEA requests this Board to investigate these refusals to submit appeals to OAH and to recommend appropriate action to DOA which allows retirees to exercise their statutory right to have their entire claim decided by OAH.

**From:** Mike Mitchell <[REDACTED]>  
**Sent:** Thursday, May 31, 2018 4:14 PM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** Sharon Hoffbeck <[REDACTED]>  
**Subject:** Medicare Part D wraparound

Dear Alaska RHPA Board Members,

The Federal 5 step appeal process is effectively a diminution of benefits because acts as a barrier and could lead a lower standard of care simply by the fact that Federal appeals are time consuming. Some of us may die while waiting for that decision. I belong to the >\$85,000/year club. I think it is wrong to allow the imposition a surcharge by Medicare which requires a request to DOA for reimbursement. The original plan has no hoops such as this to jump through. It appears to me that DOA wants me to pay more for less and perform acrobatics to gain what is now an undiminished benefit. If this gets implemented as described our pharmacy benefit which we earned will be diminished for sure. Please do what you can to stop this action before its hurts retirees.

I have to wonder if this move thought through. By moving us to Medicare part D, the State of Alaska is giving up its right to negotiate for lower prices with the drug companies. Our corrupt Congress has prohibited Medicare from negotiating lower drug prices. As a result, Medicare pays the highest possible amount for drugs. What a sweet deal for the pharmaceutical manufacturers! This move could very well cost the State of Alaska more than it currently does.

Sincerely,  
Mike Mitchell



-----Original Message-----

From: judy [REDACTED]

Sent: Thursday, May 31, 2018 6:12 PM

To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>

Subject: new pharmacy plan for retirees over 65

I am not at all in support of the purposed changes as outlined in the Medicare Part D EGWP/wrap. There is no way of knowing before approval of the PLAN's activation, what may or may not be an approved medication, for starters. No way of determining what additional costs may be. I absolutely agree with RPEA's objections and concerns as outlined!!!!

And I do not understand how this new pharmacy plan can be approved and put into motion without required due process of a constitutionally protected benefit. When I retired I signed documents agreeing to the benefits the State of Alaska promised I would receive. It did not state those benefits might change after I reached the age of 65!!! The DOA is not above the law. They need to be reminded of that fact. Sincerely, Judith A. Bassett, Retiree

**From:** Barbara Smith <[REDACTED]>  
**Sent:** Thursday, May 31, 2018 11:37 PM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** Hoffbeck Sharon <[REDACTED]>  
**Subject:** Changes in the Retirement Pharmacy Plan

[REDACTED] and will be affected by the recently proposed EGWP/Wrap Pharmacy Plan. I will also be affected by the “high income” monthly surcharge. To require retirees to pay for a Medicare part D coverage and then have to REQUEST a refund of the premiums, and threatening us by saying if it isn’t paid “you will be dropped from the Medicare Part D/EGWP and enrolled in an alternate pharmacy plan that will not have the same benefits is blackmail. Not giving us the alternative plan is unconscionable and sneaky way to cheat retirees out of benefits. The State of Alaska is trying to wiggle out of providing retirees pharmaceutical benefits protected by the Constitution.

The denial process, and Step Therapy is onerous, involving oppressively burdensome effort on behave of the “elderly” and their physicians. This is a disadvantage and impediment to both the retiree and their physician who have already established or are in the process of establishing, personal medication treatments. A Pharmacy Benefit Manager is going to decide! Who is this person? Do they know what is best for the retiree better than their own physician? I think not. This is another way to try to bring costs down, focusing on the economics of treatment instead of the health and wellbeing of the retiree. A 5 (five) step appeal process? That is definitely another very burdensome piece of this poorly thought out proposal.

Because the EGWP is a federal program you state adopting it as the State Retiree Drug provider is not Constitutionally protected by the State of Alaska and could be modified, suspended, or cancelled by Medicare. This fact by itself puts retiree pharmacy benefits in danger of loss, harm or failure and thus diminishes the benefits and security we currently have under our pharmacy plan. I would think this would make these proposals illegal. These are attempts to change and chip away at the retiree benefits that were promised and protected by the State of Alaska Constitution.

I oppose these latest attempts to change the Retiree Pharmacy Plan.

Sincerely;

Barbara Smith  
[REDACTED]

**From:** Stan Reed <[REDACTED]>  
**Sent:** Friday, June 01, 2018 2:11 AM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** [REDACTED]  
**Subject:** CHANGE IN RETIREE PHARMACY PLAN

To: DOA

This unacceptable and arbitrary proposed change to our retiree pharmacy plan has not followed correct protocol for such changes, and will create hardship for the recipients affected by the proposed change.

As people transition into a fixed income life, especially after 65, much of our financial planning is completed. We have planned and projected what we will need to continue to live our life out as we have planned it. The pharmaceutical agreement that the State of Alaska made with us is the agreement we have used to plan our future. The nebulous black hole of part D Medicare will create unnecessary hardship. My health decisions and the medications that I may need to have prescribed are between me and my doctor. I do not need to live with the fear that a required medication may be denied, leaving me to advocate and appeal through a maze of a five step process. All this while I am not having my health concerns addressed as I wait for you to decide whether or not my life is worth treating as my doctor and I see fit.

**As you know, our existing health plan benefits are protected under Article XII, Section 7 of the Alaska Constitution from diminishment or impairment, and cannot be changed to disadvantage or impair the current retiree benefits unless comparable new advantages are included to offset the proposed changes. Medicare part D is not Constitutionally protected.**

This plan is not acceptable.

Stan Reed  
Retired Anchorage Teacher

**Subject:** Medicare Part D pharmacy plan called an EGWP/wrap

Email: [AlaskaRHPAB@Alaska.gov](mailto:AlaskaRHPAB@Alaska.gov)

Subject: Retiree Pharmacy Program & Medicare Part D pharmacy plan called an EGWP/wrap

Dear Sir/ Madame:

and I am already

I understand the State of Alaska wishes to contain Health Care costs but at the same time the State of Alaska has a Constitutional Obligation to provide health benefits that are not diminished over time. Before DOA can impose any proposed changes—including the EGWP plan--to the retiree health plan, it must follow the process specified by the Alaska Supreme Court in the case of RPEA v. Duncan by performing an equivalency analysis to establish whether the changes which disadvantage retirees as a group are offset by additional advantages of comparable value.

My wife and I believe that the law requires DOA to make these analyses before it imposes any proposed changes. We object to these changes because DOA has not done the required equivalency analysis. In addition, we oppose these changes as we believe that they do diminish our benefits with no real benefit other than making the system that much more complicated for the Retirees.

I continue to emphasize the fact that many years ago the State made the pitch that they would provide great health benefits when we retired and as such was the reason that the State was going to pay us less at the time we were employed. It was supposed to be an investment in the future for our retirement. Sad to say no one remembers that promise!!

At every turn in the last 5 or so years, the State of Alaska has attempted to modify our health benefits to the detriment of the Retirees.. The system has consistently gotten more complicated and harder for Retirees to follow what is going on. As we age, we were hopeful that things would not be as complicated and easier to deal with; but the State has abrogated that option, making our benefits more complicated and harder to know when we are being taken to the cleaners. In my mind the State is purposely attempting to make it more complicated and harder for the Retirees to deal with so that no one will challenge them on it. It is time that the State leave our benefits alone and meet its Constitutionally required mandate to provide health care without it being reduced in any manner. If they State wanted to improve our benefits we would be all in favor of it but that has not been the case.

Sincerely,

Eric & Mary Marchegiani

PS: Remember some day; -- you too will be a Retiree – and you also will have to live with the benefits that you are reducing today.

**From:** Bill Burgess <[REDACTED]>  
**Sent:** Friday, June 01, 2018 8:29 AM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** Sharon Hoffbeck RPEA <[REDACTED]>  
**Subject:** Objection to Moving me out of State Benefits

I am a retiree from the State of Alaska. I am [REDACTED] years old and not in the best of health. I am emailing you to STRONGLY protest the move to diminish my retirement benefits. Also, making it EXTREMELY difficult to appeal a denial by adding a 5 government step process.

How dare you enroll me in a non-State of Alaska pharmacy insurance program. I am already experiencing a reduction in my dental benefits from MODA, next will be even more reductions in benefits from Aetna surely. How can the State DOA violate the Alaska State Constitution which states you cannot diminish benefits??

**From:** Becky Charlton <[REDACTED]>  
**Sent:** Friday, June 01, 2018 9:06 AM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Subject:** Medicare Part D

To Alaska RHPAB,

Thank you for putting out the information concerning the latest change to our retirement health care plan.

I strongly object to any change in our current health pharmacy plan.

I feel once again DOA is taking advantage by offering us Medicare Part D which is a nightmare to deal with according to any senior that is covered under it.

What the state has already taken from our health care coverage is bad enough but now to attack our strong pharmacy plan and give us Medicare Part D is not even comparable.

Thank you for being there for us and fighting for our health rights.

Sincerely,

Becky Charlton

**From:** julane martin <[REDACTED]>  
**Sent:** Friday, June 01, 2018 10:48 AM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Subject:** Changing our Retiree Pharmacy Plan

To whom it may concern.

In the first place you say you are implementing the new pharmacy plan in November. It's June today and that gives us only 3 months to understand why this is being done to Retirees over 65. Most of us are no longer working and are on a fixed income. I for one am not understanding this.

I have an Alaska Care Retiree Health Plan and it includes the pharmacy plan. How could this be changed without contacting any members unless you think 3 months is enough time. How can it go into effect on January 1st of 2019, when you plan on implementing it in November. You are taking the oldest most vulnerable of the retirees and raising costs, and giving us a difficult and problematic way of using the plan, but yet you still don't know who is going to run it.

I am angry and I need answers and this change needs to be spelled out to help folks understand it. I certainly don't. Please reply to me, as I phoned the Retiree and Benefits and they knew absolutely nothing about this plan except that they got the notice today. Who is representing us on this?. Thank you for your time. Please answer my reply. Thank you, Julane Martin [REDACTED]



**From:** [REDACTED] >  
**Sent:** Friday, June 01, 2018 12:26 PM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>;  
[REDACTED]  
**Subject:** CHANGE IN RETIREE PHARMACY PLAN

Retiree Health Plan Advisory Board

Re: Changes in the Retiree Pharmacy Plan

I'm writing to give you my feedback on the "Change in Retiree Pharmacy Plan" being considered (I hope it is still being considered and not already decided course of action).

My name is Walter White, and I'm currently a retiree.

My take on this:

The current plan is GREAT - I hope and pray you don't change it!

What is this bear scat about there could be up to 5 steps for any appeals? Sounds like more red tape, longer reply time, longer delays, more waiting for someone else to review and decide, etc, all the while the retiree is still without the prescriptions his or her doctor has prescribed. Sounds like you are making it more complex and eventually you are hoping the member just rolls-over and gives in/up before anything get resolved or "appealed". Why not devote your time and money to make it easier on the retiree not harder, without changing the plan?

Medicare Part D: Are you kidding! You are now going to have us subscribe to yet another federal government program and all the non-sense that goes with it. They can't balance a check book what makes you think they will handle our prescriptions processing any better. With using federal programs, it is always subject to budget cuts (the feds don't have the retiree best interest in mind, now do they) - then what happens? Sounds like to want to pass all responsibility to someone else and no longer be accountable for the state retirement plan. You should keep the plan under state control and administration - just like it is currently. Leave the doctoring to the doctors that have the best interest for the patience; not the best interest of the "company" (who's only interest is to save the company money). Stick with the administrating the pharmacy plan (dispensing of prescriptions) and let the doctors be doctors.

To recap:

**Plane and simple:- We have a great plan... Keep it and don't change it.**

Walter E White

[REDACTED]

[REDACTED]

[REDACTED]

**From:** Brad Owens <[REDACTED]>  
**Sent:** Friday, June 01, 2018 3:24 PM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Subject:** Duncan Principles and checklist

After the May 8 Board meeting, I thought about the question asked by a Board member: does DOA have a template for the rules established by the Duncan decision? Commissioner Ridle answered that it did not have one.

I thought it might be useful to send to the Board a more complete description of the comparative analysis principles announced by the Court in Duncan, as well as a proposed template for analyzing changes to the retiree health care plan.

I have attached below a more complete description of the analysis required by Duncan. I have also included in that review a proposed template for use by DOA when it reviews changes it proposing to the existing benefits and coverage under the retiree health care plan. I hope the Board members, and DOA, find this helpful.

**ATTACHMENT:**

***DUNCAN v. RPEA* COMPARATIVE ANALYSIS**

The retiree health care plan was first developed as part of the public retirement systems in 1975. It was specifically intended to encourage qualified individuals to enter into and remain in public employment. It provided extensive and valuable health care benefits and coverage for qualified public employees. The retiree health care plan, like other retirement benefits, created a type of “savings” plan for public employees – one they could rely upon to provide the promised coverage once they retired.

In the case of *Duncan v. RPEA*, the Supreme Court ruled that health care benefits, just like other retirement benefits, are protected from diminishment or impairment by the Alaska Constitution. However, that does not mean that retirement benefits cannot be changed. Benefits can be modified so long as the modifications are reasonable, and one condition of reasonableness is that disadvantageous changes must be offset by comparable new beneficial changes.

The Court in *Duncan* recognized that health care benefits must be allowed to change as health care evolves. Recognizing the economic realities of administering health care coverage, the Court reluctantly concluded that an equivalency analysis of any changes must be done from a group standpoint rather than on an individualized basis.

However, the Court reiterated that equivalent value must be proven by **reliable evidence**.

Under any group approach, just as with an individual comparative analysis, offsetting advantages and disadvantages should be established by solid, statistical data drawn from actual experience rather than by unsupported hypothetical projections.

Such statistical data can include accepted actuarial sources, but the Court did not say an actuarial analysis was the only, or even the best, data.

The Court reiterated that equivalent value must be proven by a comparison of the benefits **actually provided** – a mere comparison of old and new premium costs does not establish equivalency.

The Court warned that Duncan did not allow or approve any **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.

Where an individual can show that substantial detriments were not offset by comparable advantages and that this resulted in a **serious hardship**, the affected individual should be allowed to retain existing coverage.

Moreover, the Court stated that changes that will predictably cause hardship to a significant number of beneficiaries who cannot at the time of the change be specifically identified should be given the option of an election to retain existing coverage, unless the state can demonstrate a compelling need for the change and the impracticability of providing for an election.

Finally, the Court stated that changes that substantially reconfigure the mix of benefits to beneficiaries should be approved **only** upon a strong showing of justification; and any unusual gaps in coverage should be avoided.

A proposed **template** for the type of **equivalency analysis** might be as follows:

1. Is there an identified legitimate need to change the benefits provided?
2. What are the reasons for each proposed change?
3. What data exists that supports or bears on each proposed change?
4. Do the proposed changes substantially reconfigure the mix of current benefits?
5. Will the proposed changes result in any unusual gaps in the benefits or coverage currently provided?
6. Do the proposed changes involve the restriction, reduction or elimination of currently provided benefits?
7. If so, how many members will be impacted by each particular change?
8. Will the proposed changes predictably cause hardship to a significant number of members who cannot be specifically identified?
9. Have all members affected by the proposed changes been given adequate notice of the proposed changes?
10. Have the affected members been given adequate opportunity to question or obtain additional information about the proposed changes?
11. Have the affected members been given adequate opportunity to show any proposed changes may result in substantial hardship?
12. Is any substantial hardship offset by comparable advantages?
13. Do the proposed changes result in the diminishment or impairment of any current benefits?
14. Has there been an adequate and timely comparative analysis performed to determine if there is equivalent value between the offsetting advantages and disadvantages under the proposed changes?
15. What specific solid statistical data, drawn from actual experience, has been used in this comparative analysis?
16. Has the comparative analysis and the data upon which it is based been made available to all affected members sufficiently before the implementation of the proposed changes to allow their response and input?

-----Original Message-----

From: Tom Wardell [REDACTED] >

Sent: Saturday, June 02, 2018 10:06 PM

To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>

Subject: Proposed Change in Retiree Pharmacy Plan

While I am not a member of the RPEA, I am a retired State Employee and I adopt the position they have taken in reference to the proposed change.

Thomas M. Wardell

**From:** Pete Heddell <[REDACTED]>

**Sent:** Saturday, June 02, 2018 10:50 AM

**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>

**Subject:** The proposed changes to the prescription are unacceptable as the changes proposed violate the constitutional guarantees that tier 1 retirees are afforded under the state constitution.

Gordon P Heddell 1963 to 1987

**From:** Gary Williams <[REDACTED]>

**Sent:** Friday, June 01, 2018 3:51 PM

**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>

**Subject:** Medicare Plan D

Dear Board Members, I am a retired Teacher, age [REDACTED] yrs, and am very upset about the possible change to our medication benefits. If our benefits are currently protected by the Alaska constitution, how is it that we will lose that protection under the new federal pharmacy plan? Is this a done deal or just proposed? Do we retirees have any recourse to fight these changes? I worked for 10 yrs as a teacher with lower salaries because of the promise of guaranteed medical and pharmacy benefits at retirement. How can the DOA possibly change this guaranteed benefit? Please explain! Gary Williams



**From:** Jim Owens <[REDACTED]>

**Sent:** Sunday, June 03, 2018 4:04 AM

**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>

**Subject:** Prescription Benefits

I am writing regarding the changes to my/our prescription benefits in my retirement plan. I am aware that the plan can be changed. But I believe that it should not be changed until all of the studies have been completed. If that is not finished first I feel like I am being told 'Here it is. Take it or leave it.' Please consider following the proper channels.

Thank you.

Mavis Owens

**From:** Glenda Lindley <[REDACTED]>  
**Sent:** Sunday, June 03, 2018 12:33 PM  
**To:** Sharon Hoffbeck <[REDACTED]> Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Subject:** Retirement Plan fails to meet needs of Retirees

In regard to the New Pharmacy benefit talks:

Wow, Should I feel humble? grateful ? I'm feeling like the American Pie we all worked our career around, you know, "stay in school, go to College, get a good job, pay into retirement for our future (union or otherwise), retire and live...." was all for a pipe dream, a big fat promise (prediction); joke on me, I believed. Now, I'm worried and feel less confident with every expense.

This just adds another step to the otherwise cumbersome process called "The American Health Care System" . With every layer of infrastructure that already has too many layers, in my opinion, there is the possibility that the insurance won't get or be filed in the every changing length "timely manner" and then we get to pay for Rx ourselves, Pretty good deal for who?

In regard to general benefits:

I've never had so many medical bills! Denials and challenges aplenty. AETNA, BLUE CROSS, among other insurance companies over the years, are bigger, cost more and deliver less and less. Health Care Reform is multi-layered, multifaceted and with endless variables, Maybe I can't have grandfather rights but it sure would be nice to go to my doctor, be treated or /and get a Rx with out all the extra administration. Do You remember that slogan from years gone by that the school district used? "Do more with less and do it better"; admin and infrastructure less, insurance costs less. We are all aging and need to be considerate of using benefits to pay for new programs and more infrastructure, retirees are real people, with real people needs.

Thanks for your service,

Glenda

-----Original Message-----

From: Harky and Jackie Tew [REDACTED] >

Sent: Sunday, June 03, 2018 1:24 PM

To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>

Cc: [REDACTED]

Subject: EGWP/WRAP Medicare Part D Pharmacy

Your pending consideration of a change in the AK retirees pharmacy coverage is totally uncalled for! Shows age discrimination for those over 65? Additional fee based on annual income. Believe me if we have that much annual income didn't get it from the State of AK. Starting monthly salary was \$545 a month.

Nothing hourly and no overtime in those days.

Appears to be a violation of the States Constitution related to retiree benefits.

I am a retired Captain with the Alaska State Troopers. Born and raised in Ketchikan Alaska.

Also, served as Security for former Governor Jay Hammond.

Prior to my retirement from the Troopers I served In Anchorage, Bethel, Ketchikan, Petersburg, Sitka (twice) Glenallen (during the pipeline construction), Palmer and retired from Juneau as Captain.

Was stationed in Anchorage during the big Earthquake.

During my second assignment in Sitka was the onsite supervisor following the Alaska Airlines accident near Juneau that took over 100 lives.

Now after all my years and at the age of [REDACTED] this June you want to change the RX benefit for retirees over 65?

After all these years and a number of surgeries you want to change something that is working just fine. Is this like the Aetna medical administration of the Sate Med program that went forever without being signed?

Might I ask how long you have lived in the great state of Alaska?

How many times were you out in the night with temps of minus 60 or lower? How many nights were you away from your family due to your commitment to your job and the people of Alaska?

If nothing else grandfather us in.

Your reply will be when I see what you have decided.

Lastly, are there not more important and pressing issues needing your attention?

Many of us retirees need meds every month. Without the present program we may not be able to afford our meds. Fixed/limited income does not allow for increases. SS has not gone up in years.

State retirement increases harding will pay my phone bill.

Impatiently await your decision and getting on to more important issues.

Thank you

Harcourt A. Tew

**From:** Mary Kay and Peter <[REDACTED]>  
**Sent:** Monday, June 04, 2018 7:18 AM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** Sharon Hoffbeck <[REDACTED]>  
**Subject:** Re: proposed changes to AlaskaCare pharmacy plan

I would like to comment on the proposed changes to the AlaskaCare retiree pharmacy plan.

I understand that the option of the Employer Group Waiver Plan with wraparound may be a savings for the retiree pharmacy plan. However, this proposed change to implement the EGWP/wrap may result in diminshment or impairment of current retiree benefits which are protected under the Alaska Constitution. Has an equivalency analysis to determine if the proposed changes may result in a disadvantage to retirees been done? Making a change this large that would affect retirees over the age of 65 must be based on solid statistical evidence.

We are living in tumultuous times where benefits for so many Americans seem to be getting whittled away. Life as a senior citizen on a fixed income is a reality for my husband and myself. I have always felt peace with the assurance that AlaskaCare was protected by the Alaska Constitution. Now I am concerned about diminution of benefits, not only for myself but for all retirees that may be affected by this potential change.

I understand that DRB states that nothing will change with the possible implementation of an EGWP/wrap. However, EGWP is a federal program and would not be protected by the Alaska Constitution as the current pharmacy plan is. The fact that EGWP would require step therapy, may make it difficult for retirees to obtain certain medications they are currently using, impose a premium surcharge on those in a high income category and require a five-step federal appeal process are definitely obvious changes from our current plan.

I have always been very appreciative of our AlaskaCare program, and also of the fact that it is protected by the Alaska Constitution. This is a very serious proposed change. Please take the steps necessary to ensure that the retiree pharmacy plan is preserved intact in its current state.

Thank you,  
Mary Kay Whelan

**From:** Rosie & Pat <[REDACTED]>  
**Sent:** Monday, June 04, 2018 9:40 AM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** 'Sharon Hoffbeck' <[REDACTED]>  
**Subject:** Changes in Retiree Pharmacy Benefit Plan

June 3, 2018

To: Retiree Health Plan Advisory Board  
Re: Changes in Retiree Pharmacy Benefit Plan  
Cc: Sharon Hoffbeck

I am writing in strong opposition to the change in the Pharmacy Benefit Plan. As a Tier One retiree, I find it first of all highly discriminatory against those 65 years of age and older. In reading through your lengthy presentation of reasoning, what strikes me the most is the total non-concern for the impact your plan will have to the elderly (65 and over) who have been using and depending on the current plan and one which has helped to maintain our optimum health without the trauma of worrying about government bureaucracy. You speak of minimizing member impact and yet list all of the ways that we will be impacted negatively. We were promised and backed by law, the benefits we are receiving. You need to honor your commitment to us.

Here are some of the concerns but not all that I will share with you:

- 1) Under your plan you are not preserving overall benefit value for the group you are targeting and you certainly are not minimizing member impact. You state the majority of members will experience no change. To what members are you referring? Those under 65 years of age? So in essence you are penalizing those of us 65 and older to bail you out of what you see as a financial burden? Bailing you out by forcing us into an inferior medication drug plan other than the one we were lawfully promised?
- 2) According to the union, DRB had NOT done the required *Duncan* analysis to be sure benefits are not diminished. This must be done prior to changes and presented to all involved retirees before any action for change is initiated.
- 3) Under our present program, quality health care is insured by the physician/patient relationship and agreement to treatment options including medications. Most physicians and retirees use generic drugs thus saving cost as do the rest of our members under 65. Under the proposed plan, someone somewhere looks at a chart and makes a decision regarding our health and welfare. If a drug is denied, the 5 step process will be a real hardship to most retirees. This is bureaucracy at the highest level and one that is often found as inefficient. And again tell us how this will not diminish our care?
- 4) Most retirees have gone through the steps of finding the right drug to treat their particular illness. Most are stable on those medications. To have to go back and try drugs that may or may not have been tried before just because they are on the list of "approved drugs" is inhumane. This is particularly true when retirees and others are not 65 and can still work with their physicians for appropriate drug therapy. More importantly; it will have the potential to destabilize medical conditions that are being well managed. In this case, your cost of further medical care will increase thus negating what you are trying to achieve. Again we ask "is this not diminished care"?

- 5) At present, we have a dedicated team through Aetna. They are phenomenal. They help the recipients with refills, notifying the physician when there are no refills and are courteous and helpful. We can order on line, on the phone or with a real person. We will NEVER get this service from what you plan to offer. Instead we will get impersonal and inefficient service. Again we ask “is this not diminished care”?
- 6) Financial cost to retirees on fixed incomes will increase. This will be a hardship because as you well know the cost of living in Alaska is high. We, the retirees 65 and above, as well as those who will be in this category, have worked many years to provide quality service in many fields to the state and to its citizens. We were promised this care.

While I understand that Governor Walker On September 27, 2017, (less than one year ago) signed [Administrative Order 288](#) establishing a Retiree Health Plan Advisory Board, it appears he also made the appointments to this board. In his administrative order, he states that public meetings be held and feedback be given. I do not recall anyone being notified of these meetings. This appears to be greatly dictatorial rather than abiding by what we were promised under Article XII, Section 7 of the Alaska constitution regarding diminishment or impairment.

Governor Walker has already taken half of the permanent dividend fund from all of Alaska citizens and as I understand it—taken more from the primary source of the fund. I suggest that he look at many other areas of inefficiencies that occurs in this state.

The bottom line is that you are discriminating against this group and separating us from others recipients only to provide diminished services and increased trauma to an aging population.

We will support our representatives that are seeking fair and equal treatment under the law.

Rose M. shearer  
Alaska Senior Citizen Retiree

-----Original Message-----

From: RICHARD FRANCISCO <[REDACTED]>

Sent: Monday, June 04, 2018 10:43 AM

To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>

Cc: [REDACTED]

Subject: Adding Medicare Part D to retirement drug plan

Dear Alaska RHPAB,

I think the proposal to switch us to the Medicare Part D plan is unacceptable. This is not the drug plan that was promised in the retirement plan that was offered when I retired. Please do not make this change. Thank you.

Richard Kim Francisco

**From:** Cathy Anderegg <[REDACTED]>  
**Sent:** Tuesday, June 05, 2018 2:23 PM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** [REDACTED]  
**Subject:** Proposed changes to retirement pharmacy plan

As a retiree, I am greatly concerned by the proposed changes to the retirement pharmacy plan by the Department of Administration (DOA). The changes unequivocally disadvantage retirees; there is no offset of additional advantages reported by DOA.

Before the Department of Administration can impose any changes to the retirement pharmacy plan, it must follow the process specified by the Alaska Supreme Court in the case of RPEA v. Duncan by performing an equivalency analysis to establish whether the changes which disadvantage retirees as a group are offset by additional advantages of comparable value.

Has the Department of Administration performed an equivalency analysis to establish whether the changes which disadvantage retirees as a group are offset by additional advantages of comparable value? If so, how can we access that report to determine the offset of the disadvantages. If not, they are acting illegally and the proposed imposition of changes must be stopped.

I ask that you hold DOA responsible for following the processes set forth and that they be required to perform their due diligence prior to imposing these changes.

Sincerely,  
Cathy Anderegg



**From:** [REDACTED]  
**Sent:** Tuesday, June 05, 2018 1:36 PM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** [REDACTED]  
**Subject:** Proposal to move to Medicare Part D/EGWP for retirees over 65

These comments concerning and against the proposed change in pharmacy benefits in 2019 are submitted by Kimberly K. Geariety (PERS Tier I retiree) and Gerald P. Geariety (TRS Tier I retiree)

**UNACCEPTABLE PROPOSAL TO MOVE RETIREES 65 OR OLDER TO THE EMPLOYEE GROUP WAIVER PROGRAM FROM EXISTING PRESCRIPTION HEALTH BENEFIT**

Please do not move the 65-over retiree pharmacy benefit to Medicare Part D/EGWP and the federal government. To begin with, on a practical level, this change is very significant. I am a retired attorney (Tier I) and I have assisted a number of older clients, friends, and family (all over 65) with a variety of elder care matters, including filling out forms and filing appeals to the federal government regarding different federal programs. I have seen firsthand the difficulty most of these older individuals have reading the forms or directions, understanding what the federal program requires, and completing and filing a federal government form or appeal. Changing the information source, forms, and appeal process for a majority of retirees over 65 to the now proposed Medicare Part D/EGWP from the state of Alaska really will cause hardship and anguish that, in my opinion and experience, will implicitly constitute a diminishment and impairment of existing benefits.

The fact that they would be protected from such hardship and anguish was what motivated many of the retirees to stay with the state until retirement. Clearly the proposal changes are nothing like what the retirees thought they were guaranteed under the state Constitution when they retired from the state. DOA's repeated assurances that they will comply with the state constitutional requirement and not "diminish or impair" benefits are disingenuous given the assurances have one-by-one disappeared these past 3-4 years. The proposed change in pharmacy benefits for retirees over 65 in 2019 is yet another slap in the face by DOA and the employees who by the way are much younger and unaffected by this proposal.

On a legal level, the State of Alaska, Department of Administration, Division of Retirement and Benefits, decision to move all retirees 65 or older onto a Medicare Part D/EGWP pharmacy plan violates Article XII, Section 7 of the Alaska's constitution. DOA's primary motivation to move retirees over 65 to this plan is to improve financial "efficiency of retiree program" as stated in their presentation on May 8, 2018 (slide deck page 26). The presentation also goes on to focus on the cost savings of "\$16-24 million" over the current system (slide deck page 29).

Nothing in the presentation assures me or my fellow retirees that my pharmacy benefits will not be diminished or impaired by this proposed change. The DOA materials do not demonstrate by reliable evidence that this proposed change is of an equivalent value to what retirees over 65 were promised and now enjoy as required under *Duncan v. RPEA*.

DOA claims and wants retirees to believe that this proposed change will “preserve the overall benefit value” while “minimizing member impact.” However, DOA cannot assure any retiree that their benefits will be preserved and the individual impacts will be minimal. Relinquishing control and oversight of the retiree pharmacy benefit for those over 65 to the sole discretion of the Centers for Medicare and Medicaid Services (“CMS”) is a major impact and does not, by DOA’s own admission, preserve the overall benefit value, in at least the following ways.

1. The pre-authorization requirement constitutes a major change as none is required right now. What if they are not authorized? Then what? A retiree who now takes a drug that is not authorized by CMS has lost a benefit and, although there is an appeal process, there is no guarantee that CMS will authorize a drug that is currently allowable under the pharmacy program after the appeal process. What happens if that drug is critical to the retiree’s care and the retiree does not take it while on appeal because they now have to pay for it but they cannot afford it? It seems obvious to me, if not DOA, that this is a direct diminishment and impairment of benefits.
2. According to DOA, there may be co-pays increases under the CMS regulation. There is no indication in any of the material provided by DOA that the co-pay increases will be reimbursed by the state. This is a direct monetary loss to the retiree.
3. The CMS mandatory appeal process is unduly onerous (5-step federal appeal process). Most retirees will be confused, unsure of what to do, may need to hire an attorney, and might just give up and go without their drugs. This is a clear diminishment or impairment of benefits and an unacceptable, potential outcome of this proposed pharmacy change.

4. The Step Therapy aspect of the Medicare Part D/EGWP plan changes dramatically who gets to decide what drug is taken by the retiree – the federal government or their doctor. When I retired from the state I never expected that the federal government would be telling me what drugs I could take or set my course of care. Sure, I knew the State of Alaska would have a say, but never the federal government. Anything having to do with the federal government and Medicare or Medicaid is constantly in flux and unknown and at any time can change without recourse. Regulations are created by federal bureaucrats in Washington DC without any regard to the Alaska State Constitution and the promises made by the state to its retirees.

Finally, given that DOA will have no responsibility regarding these pharmacy benefits, the proposal unlawfully relieves the DOA of its fiduciary duties for all retirees over 65 given that DOA will have absolutely no control over the Medicare Part D/EGWP programs or the CMS regulation. Likewise, an appeal of any pharmacy-related matter ends with CMS. There will be no State of Alaska oversight or opportunity to ensure that the retiree's pharmacy benefits are not diminished or impaired by the federal government.

Please do not implement this change as proposed in 2019. And please quit trying to save money on the backs of retirees. As retired state employees who had opted out of social security, many retirees already suffer substantial reductions in their social security due to the Windfall Elimination provision. I understand that costs are going up and that the plan needs to be efficient, but please do not make us subjected or beholden to the CMS system and federal government more than we already are when we turn 65.

**From:** Judith Anderegg <[REDACTED]>  
**Sent:** Tuesday, June 05, 2018 12:38 PM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** Rep. Andy Josephson <[Rep.Andy.Josephson@akleg.gov](mailto:Rep.Andy.Josephson@akleg.gov)>; Sen. Berta Gardner <[Sen.Berta.Gardner@akleg.gov](mailto:Sen.Berta.Gardner@akleg.gov)>; RPEA <[REDACTED]>; Sharon Hoffbeck <[REDACTED]>  
**Subject:** Proposed Changes to Pharmaceutical Benefits in Alaska Retiree Health Plan

I have just received an email from RPEA (Retired Public Employees of Alaska) letting us know of changes proposed to happen in November to our pharmaceutical coverage as retirees. I am concerned about the possible diminishment of our pharmaceutical coverage. I am not satisfied by the materials I have read from RPEA or from the presentation made by DRB to the Retiree Health Plan Advisory Board, that DRB is taking care to ensure that our constitutionally protected benefits are going to be intact when (IF) the EGWP, the federal plan, goes into place.

It looks to me like the EGWP will save the state money, but it does not look like our benefits are intact.

Examples of unresolved issues:

1. if a retiree needs a particular medication, the EGWP requires a generic be tried first. If the generic does not work, it looks like a retiree could get mired down in a 5 step appeal process.
2. The step plan with its multi-step process looks like it could impact the timeliness of care.
3. The co-pays are going up.
4. "Higher income" folks will definitely be impacted by new processes.
5. The EGWP, as a federal program, is not constitutionally protected as our current plan is. The EGWP could be modified, suspended, or cancelled. I didn't see any statements addressing what would happen to state retirees then.
6. Several of the "frequently asked" questions with answers in the DRB presentation seemed to indicate diminishment in retiree benefits.
7. There has been no notification to the retirees by DRB on these changes. The only reason I know about the proposal is because of an email from RPEA .
8. It does not appear a thorough analysis has been done by the state to ensure there will be NO diminishment of benefits. There is no question that we have an incredibly good pharmaceutical plan. DRB is supposed to have done a thorough analysis to answer all questions about diminishment of benefits before making a decision to change to what definitely appears to be a plan with less benefits than we currently have.
9. As I went through the questions in the DRB presentation, a number of answers were phrased using the word ...."should" not shall or will. In other words, it does not sound like there is a guarantee this proposed plan is as good as our current plan.

How can you approve a plan that is not DEFINITELY the same as what we are guaranteed under the Alaska Constitution? How can you put in place a plan that is not guaranteed in any form under the Alaska Constitution?

Our health benefits as retirees are protected under Article XII, Section 7 of the Alaska Constitution from diminishment or impairment. If DRB make changes, they and you are supposed to analyze thoroughly any proposed plan changes to ensure the benefits are similar or if not, have a plan for how the State will make up the diminished benefits. I will be the first to admit I do not understand everything I have read,

but it looks like there are serious questions about whether the pharmaceutical benefits which we currently enjoy will be intact if and when the new EGWP plan is in place.

I am a retired state employee. I worked in the Governor's Office. I served as an aide in the State Senate. I am a retired teacher. I worked long hard hours, many over my contracted wages. I never received large wage increases. I did my job. I was gratified to work for my fellow Alaskans - first adults and later children as a public servant. And I knew that when I retired, I was guaranteed, under the Alaska State Constitution, a pension and health benefits. How can you be considering such a drastic change to guaranteed health benefits?

Thank you for this opportunity to comment. I hope my concerns have an impact on your decision making process.

Judith Anderegg



**From:** Randy Hambright [REDACTED] >  
**Sent:** Monday, June 04, 2018 11:05 PM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** Sharon Hoffbeck [REDACTED]; Randy Hambright [REDACTED]  
**Subject:** Changes to Pharmacy Benefits for Retirees

Please forward to Judy Salo, and the Retiree Health Plan Advisory Board

Dear Ms. Salo and Retiree Health Plan Advisory Board Members:

I am extremely concerned about changes proposed to the Teachers Retirement and Public Employees health plan pharmacy benefits. I am a caretaker for [REDACTED] who is a retired teacher in Fairbanks. He became [REDACTED]

[REDACTED]

I am not a nurse. This has all been very difficult, exhausting, and scary for me [REDACTED] but I have been relieved that he had good medical care, and hopeful that most of his expenses would be covered by Alaska Care (and Medicare once he turned 65 in March). There have been endless confusing invoices from the many doctors, radiologists, therapists, clinics, the hospital, and Denali Center. I have called to follow up with some providers on bills that are in process, and told not to pay because they are waiting on insurance, and the next month I get a letter threatening to send me to collections. I am telling you this so you know how difficult the life of a patient and caregiver is already, and so you can take that into consideration when you decide to make changes to the system that is in place.

Our doctors have prescribed the medications that, in their judgement, will be best for helping [REDACTED] to recover, or at least be comfortable as he tries to live with the aftermath of his devastating illness. The pharmacy benefit that is in place now has covered most of the cost of all of his medications, and this has been the least difficult part of this whole illness. The pharmacists know [REDACTED] and know that the medications that are prescribed for [REDACTED]

Changing this plan, and giving control to a "Pharmacy Benefits Manager" who does not know [REDACTED] history and current challenges, and who may or may not have the years of training and experience that our doctor has can not possibly be in his best interest. Adding a 5 step appeals process for him to get the medications that are going to be most effective for him is cruel, and time consuming for me and for his doctor, who will no doubt be called upon to justify the reasons for the medication that has been prescribed. This is a terrible thing to do to sick, vulnerable, and elderly retired people who were promised health care for life.

I hope you will think very hard about the decision to make life so much harder for people who gave their best years to the children of Alaska. These people should be treated with respect and kindness during their final years.

Sincerely,

Tamara Hambright

**From:** nancy long <[REDACTED]>  
**Sent:** Monday, June 04, 2018 12:58 PM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** [REDACTED]  
**Subject:** Comments on Proposed Changes to Retiree Health Care

Dear Board Chair, Judy Salo, and Members of the Retiree Health Plan Advisory Board,

I am greatly concerned about the proposed changes for the Retiree Health Care Plan.

Specifically, for the prescribed drug denial process that is being proposed; the adoption of a five-step federal appeal process will be overly burdensome. Elders would especially be affected due to the difficulty in tracking and managing such an arduous process. We should be making administrative issues for appealing claims easier not harder for everyone, especially the elderly. Clearly, DOA, insurance companies and the health industry will be the beneficiaries of this proposed change rather than retirees. Most retirees will not persevere with such a difficult process. This is *clearly* a plan that will undermine the patients ability to appeal. I am adamantly apposed to the proposed prescribed drug appeal program requiring a five-step appeal process. Please retain the current retiree pharmacy plan that allows DRB to directly intervene with the Third Party Administrator.

Additionally, the "Step Therapy" that is apparently part of the Medicare Part D/EGWP plan would result in a significantly diminished retiree pharmacy plan. When a patient and a doctor consult and decide on appropriate medication, this *should not* be undermined through a Step Therapy plan chosen by the PBM. The PBM will choose what is best for them financially not what is best for the health of the patient. The Step Therapy plan could result in grave impacts for the patient. The course of appropriate care and medication should be determined by a health care provider who takes the Hippocratic Oath or Nightingale Pledge to uphold ethical standards and practices on behalf of the patient. Again, what is the least expensive for the DOA, insurance company and health industry should not be the determining factor for prescribing medication and care. Please retain the current retiree pharmacy plan.

Finally, I concur with the "REPA Statement to the Advisory Board" provided on May 5, 2018 by Brad Owens, Executive Vice President of the Retired Public Employees of Alaska. His assertion that DOA cannot impose proposed changes without an equivalency analysis is supported in the Alaska Supreme Court case of *RPEA v. Duncan*, and must be upheld.

Sincerely,  
Nancy Long  
State of Alaska Retiree



**From:** [REDACTED]  
**Sent:** Tuesday, June 05, 2018 8:56 AM  
**To:** [AlaskaRHPAB@alaska.gov](mailto:AlaskaRHPAB@alaska.gov).  
**Subject:** pharrmacy changes

Sirs,

I worked for the State of Alaska for almost 30 years and when I retired I was promised a certain level of health coverage which is now gradually being eroded.

[REDACTED] which you now tell me I have to take medicine which is only covered because it is cheaper and may not help my condition and is not what my doctor wants me to take.

On top of that if I make too much money I may have to pay a monthly fee which may or may not be reimbursed by the state at a later date if they don't change their minds. When a person tries to take care of themselves they are punished for it.

Health care is very important to people and obviously you don't care to provide it.

Retiree,

Robert Banks

**From:** Joan Bohmann <[REDACTED]>  
**Sent:** Tuesday, June 05, 2018 4:23 PM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Subject:** Proposal to move to Medicare Part D/EGWP for retirees over 65

These comments concerning and against the proposed change in pharmacy benefits in 2019 are submitted by Joan C. Bohmann, Tier 1 Retiree

**UNACCEPTABLE PROPOSAL TO MOVE RETIREES 65 OR OLDER TO THE EMPLOYEE GROUP WAIVER PROGRAM FROM EXISTING PRESCRIPTION HEALTH BENEFIT**

As an employee of the Anchorage School District I spent years going above and beyond the requirements of my contract with the District. In fact, I was recognized by numerous awards for my service to my profession. I upheld my obligations to my employer.

When I retired from the district it was with the expectation that the State of Alaska would uphold its contract obligations to me as well.

Retirees plan for their future knowing they will be living on a fixed income and with the awareness that aging involves medical care. I placed my trust in the State of Alaska's Retirement Benefits knowing that as a public employee I not only could not pay into Social Security but would also be penalized by the Windfall Provisions should I be eligible for such benefits.

Given I turned 65 I am required to sign up for Medicare. The billing process has been a nightmare and I have spent hours and months trying to get this straightened out. I cannot imagine successfully navigating the morass that awaits when my cognitive capacity and physical stamina declines.

The new requirements and limitations do not appear to be consistent with Alaska's Constitutional obligations to Alaska's retirees.

I go on record opposed to these changes and plead with you not to implement such drastic changes.

Sincerely,

Joan Bohmann

**From:** [REDACTED]  
**Sent:** Tuesday, June 05, 2018 9:10 PM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** [REDACTED]  
**Subject:** Re: retiree prescription drug plan

It is beyond my comprehension why you would place the Retirees over age 65 on the Medicare Part D plan when it doesn't appear that you have studied the cost savings. To me this is a diminishment of benefits for the people on Medicare which I feel is grossly unfair when we didn't have input into the decision. I would encourage you to study and do much more research before this plan is implemented. I can't understand how you can choose this plan arbitrarily without retiree input. To me, this is discrimination towards the people age 65 and over. The appeals process alone is much too complicated compared to the current drug plan appeals process. Tell me why you would even think of implementing this plan? Also, this is not fair to the people having to pay dollars if you make an income over \$85,000. Please, I would encourage you to stop this process immediately toward Medicare D for retiree people over 65. Sincerely, Carolyn Graham/Retiree over 65.

**From:** Fred Lau <[REDACTED]>  
**Sent:** Wednesday, June 06, 2018 12:19 AM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Subject:** FW: Changes to the Employee Retiree Prescription Plan

## Retiree Health Plan Advisory Board

I have just read the presentation made to the Board by the Department of Administration (DOA) regarding the possible implementation of a Medicare Part D/EGWP Plan and I want to say I am opposed to a change in the present plan for the following reason:

1. It does not appear that DOA has not done the required equivalency analysis and this needs to be done before it imposes any proposed changes. It appears the DOA is not following the law and has already put out an RFP for a Pharmacy Benefit Manager to manage this new program even though it has not done the required study. The analysis must be based on reliable evidence, such as solid, statistical data drawn from actual experience—including accepted actuarial sources—rather than by unsupported hypothetical projections.
2. The new plan requires a lengthy appeal process if a drug is not approved, which would be very cumbersome for retirees and in some cases could be life threatening if the process takes an extended period of time.
3. The new plan would require an addition payment for those retirees who are in higher income tax brackets and while these funds would be reimbursed, the process of paying and then getting reimbursement again is cumbersome for retirees. If the surcharge is not paid, you will be dropped from the Medicare Part D/EGWP plan and enrolled in an alternate pharmacy plan designed by the state that will not have the same benefits as the current pharmacy plan and may be less than the current plan .
4. Step Therapy appears be a part of the Medicare Part D/EGWP plan. This would be a significant change and diminishment from the current retiree pharmacy plan.
5. EGWP is a federal program, it is not a Constitutionally protected benefit like the prescription drug program under our current health

care plan, and could be modified, suspended or cancelled at any time by Medicare.

6. The copay for some prescription drugs may increase.

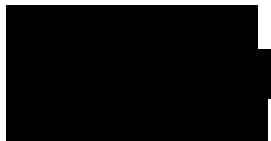
7. Not all pharmacies are on the approved provider listing and could cause a potential problem for some retirees.

While DOA indicates this new plan would save money for the State, it appears that over the long run it will increase costs to retirees. I worked for school districts in the State for 31 years and 14 years as the Director for Homer Seniors and I believe this new system will pose undue problems for retirees. As we get older, we hope that we will have less and less stress in our life. Even if this new plan is found to be equivalent to the present in terms of benefits, it will not be equivalent in that it will increase stress and paperwork for retirees. At present we have a system that seems to be working efficiently for retirees. Why put one in place on that appears to be cumbersome and inefficient?

I hope you as a Board will recommended that the present system not be changed.

Sincerely,

Fred Lau

A black rectangular redaction box covering the signature area.

-----Original Message-----

From: George Beck <[REDACTED]>

Sent: Wednesday, June 06, 2018 10:00 AM

To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>

Subject: Pharmacy plan change

Hello,

Thanks for giving us a heads up on this proposed change. I don't think it may be a good idea for us, what could we do to make sure we are not hurt by this change?

Thanks,

George Beck

-----Original Message-----

From: David Pelto [REDACTED] >

Sent: Wednesday, June 06, 2018 10:07 AM

To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>

Cc: [REDACTED]

Subject: Changes to Retiree health benefits

Members of the Board,

As an Alaskan and member of TRS I am disappointed in both the process and the results of the effort to reduce the cost of pharmaceutical delivery to Alaska state retirees.

It is patently unfair to retired members of PERS and TRS that the change to Medicare Part D is being made without giving reasonable time for notification and member response to the plan. Further notification and solicitation of comments should be made before any decision or agreement is made.

As I read the powerpoint material presented to the board, I could see numerous concerns with cost to the members (rise in copay), awkward reimbursement issues for those forced to pay the federal "high wage earner" penalty, and serious concerns over access to drugs when a member must go through a multi-step process to obtain non generic medications. Finally, the powerpoint made no mention of any other alternative considered. If this is the only choice and the federal government decides to make changes or eliminate the program, what will DROB do then for its members? I see no assurance that this new program will guarantee benefits that a guaranteed under our state constitution.

I hope the board will take due notice of these concerns and reconsider the adoption of the plan as currently presented.

Sincerely,

David Pelto, TRS member

[REDACTED]

**From:** [REDACTED]  
**Sent:** Wednesday, June 06, 2018 10:21 AM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** 'jer' <[REDACTED]>  
**Subject:** RE: Proposal to move to Medicare Part D/EGWP for retirees over 65

I was told that this information will not be provided to the Advisory Board until just before their meeting. It is important that they get this information in hand now, as well as any other comments by retirees, so that they understand and DOA understands that retirees in the know are against – strongly against – this proposed change.

Given the news this morning in the Seattle paper that Medicare funding is failing even more than was thought, movement to any Medicare program is irresponsible if worse at this time given the state of Alaska's Constitutional mandate that benefits not be diminished or impaired.

Please forward these comments and our earlier submission to the Board immediately.

Thank you. Kimberly and Jerry Gearity

**From:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) [<mailto:alaskarhpab@alaska.gov>]  
**Sent:** Tuesday, June 5, 2018 5:14 PM  
**To:** [REDACTED]; Alaska Retiree Health Plan Advisory Board (DOA sponsored)  
**Subject:** RE: Proposal to move to Medicare Part D/EGWP for retirees over 65

Thank you very much for sending this public comment to the RHPAB. Public comment will be provided to the board prior to their next meeting on August 29, 2018 meeting. Please send us any further thoughts and check <http://doa.alaska.gov/drb/alaskacare/retiree/advisory.html> or <https://aws.state.ak.us/OnlinePublicNotices/Notices/Search.aspx> for updates on meetings, agendas and materials for upcoming meetings.

Thank you,

Natasha Pineda, MPH  
Deputy Health Official  
Alaska Department of Administration  
550 W 7<sup>th</sup> Avenue  
Anchorage, AK 99501  
(907) 754-3511

This email, including attachments, is intended for the exclusive use of the person or entity to which it is addressed and may contain confidential or privileged information. If the reader of this email is not the intended recipient or his or her agent, the reader is notified that any dissemination, distribution or copying of this email is prohibited. If you think you have received this email in error, please advise the sender by reply email and delete this email immediately. Thank you.

**From:** [REDACTED]  
**Sent:** Tuesday, June 05, 2018 1:36 PM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>



Cc: [REDACTED]

**Subject:** Proposal to move to Medicare Part D/EGWP for retirees over 65

These comments concerning and against the proposed change in pharmacy benefits in 2019 are submitted by Kimberly K. Geariety (PERS Tier I retiree) and Gerald P. Geariety (TRS Tier I retiree)

**UNACCEPTABLE PROPOSAL TO MOVE RETIREES 65 OR OLDER TO THE EMPLOYEE GROUP WAIVER PROGRAM FROM EXISTING PRESCRIPTION HEALTH BENEFIT**

Please do not move the 65-over retiree pharmacy benefit to Medicare Part D/EGWP and the federal government. To begin with, on a practical level, this change is very significant. I am a retired attorney (Tier I) and I have assisted a number of older clients, friends, and family (all over 65) with a variety of elder care matters, including filling out forms and filing appeals to the federal government regarding different federal programs. I have seen firsthand the difficulty most of these older individuals have reading the forms or directions, understanding what the federal program requires, and completing and filing a federal government form or appeal. Changing the information source, forms, and appeal process for a majority of retirees over 65 to the now proposed Medicare Part D/EGWP from the state of Alaska really will cause hardship and anguish that, in my opinion and experience, will implicitly constitute a diminishment and impairment of existing benefits.

The fact that they would be protected from such hardship and anguish was what motivated many of the retirees to stay with the state until retirement. Clearly the proposal changes are nothing like what the retirees thought they were guaranteed under the state Constitution when they retired from the state. DOA's repeated assurances that they will comply with the state constitutional requirement and not "diminish or impair" benefits are disingenuous given the assurances have one-by-one disappeared these past 3-4 years. The proposed change in pharmacy benefits for retirees over 65 in 2019 is yet another slap in the face by DOA and the employees who by the way are much younger and unaffected by this proposal.

On a legal level, the State of Alaska, Department of Administration, Division of Retirement and Benefits, decision to move all retirees 65 or older onto a Medicare Part D/EGWP pharmacy plan violates Article XII, Section 7 of the Alaska's constitution. DOA's primary motivation to move retirees over 65 to this plan is to improve financial "efficiency of retiree program" as stated in their presentation on May 8, 2018 (slide deck page 26). The presentation also goes on to focus on the cost savings of "\$16-24 million" over the current system (slide deck page 29).

Nothing in the presentation assures me or my fellow retirees that my pharmacy benefits will not be diminished or impaired by this proposed change. The DOA materials do not demonstrate by reliable

evidence that this proposed change is of an equivalent value to what retirees over 65 were promised and now enjoy as required under *Duncan v. RPEA*.

DOA claims and wants retirees to believe that this proposed change will “preserve the overall benefit value” while “minimizing member impact.” However, DOA cannot assure any retiree that their benefits will be preserved and the individual impacts will be minimal. Relinquishing control and oversight of the retiree pharmacy benefit for those over 65 to the sole discretion of the Centers for Medicare and Medicaid Services (“CMS”) is a major impact and does not, by DOA’s own admission, preserve the overall benefit value, in at least the following ways.

1. The pre-authorization requirement constitutes a major change as none is required right now. What if they are not authorized? Then what? A retiree who now takes a drug that is not authorized by CMS has lost a benefit and, although there is an appeal process, there is no guarantee that CMS will authorize a drug that is currently allowable under the pharmacy program after the appeal process. What happens if that drug is critical to the retiree’s care and the retiree does not take it while on appeal because they now have to pay for it but they cannot afford it? It seems obvious to me, if not DOA, that this is a direct diminishment and impairment of benefits.
2. According to DOA, there may be co-pays increases under the CMS regulation. There is no indication in any of the material provided by DOA that the co-pay increases will be reimbursed by the state. This is a direct monetary loss to the retiree.
3. The CMS mandatory appeal process is unduly onerous (5-step federal appeal process). Most retirees will be confused, unsure of what to do, may need to hire an attorney, and might just give up and go without their drugs. This is a clear diminishment or impairment of benefits and an unacceptable, potential outcome of this proposed pharmacy change.
4. The Step Therapy aspect of the Medicare Part D/EGWP plan changes dramatically who gets to decide what drug is taken by the retiree – the federal government or their doctor. When I retired from the state I never expected that the federal government would be telling me what

drugs I could take or set my course of care. Sure, I knew the State of Alaska would have a say, but never the federal government. Anything having to do with the federal government and Medicare or Medicaid is constantly in flux and unknown and at any time can change without recourse. Regulations are created by federal bureaucrats in Washington DC without any regard to the Alaska State Constitution and the promises made by the state to its retirees.

Finally, given that DOA will have no responsibility regarding these pharmacy benefits, the proposal unlawfully relieves the DOA of its fiduciary duties for all retirees over 65 given that DOA will have absolutely no control over the Medicare Part D/EGWP programs or the CMS regulation. Likewise, an appeal of any pharmacy-related matter ends with CMS. There will be no State of Alaska oversight or opportunity to ensure that the retiree's pharmacy benefits are not diminished or impaired by the federal government.

Please do not implement this change as proposed in 2019. And please quit trying to save money on the backs of retirees. As retired state employees who had opted out of social security, many retirees already suffer substantial reductions in their social security due to the Windfall Elimination provision. I understand that costs are going up and that the plan needs to be efficient, but please do not make us subjected or beholden to the CMS system and federal government more than we already are when we turn 65.

**From:** Sharon Hoffbeck [REDACTED] >  
**Sent:** Wednesday, June 06, 2018 4:52 PM  
**To:** Pineda, Natasha M (DOA) <[natasha.pineda@alaska.gov](mailto:natasha.pineda@alaska.gov)>  
**Cc:** Brad Owens-Executive Vice President--RPEA <[REDACTED]>  
**Subject:** Advisory Board Email Address

Natasha—

I have had several retirees tell me that when they use the Advisory Board address the email is returned as undeliverable. I had the same problem yesterday, had to retry several times and finally it went through.

I just tried to forward the below email as requested by Mrs. Louk and it was returned twice.

Please forward Mrs. Louk's email to the Board upon receipt.

Thank you

***Sharon Hoffbeck***  
**President**  
**Retired Public Employees of Alaska**  
[REDACTED]

**From:** Bunnie Louk [REDACTED]  
**Sent:** Wednesday, June 6, 2018 2:36 PM  
**To:** Sharon Hoffbeck <[REDACTED]>  
**Subject:**

Dear Sharon, I cannot get this to go to the advisory board address Will you please forward it to them for us.  
Thank you.

Please do not force us into the Federal Medicare Part D. Our current plan is working very Well. We do not like these proposed changes for the following reasons:to:

1} Drug denial- we would have to use a five step federal appeal process. More complicated?

2}We want our Doctors to prescribe our medications, not a second party who is not familiar with our medical history, changes which may not work .

3} The procedure for "high income" surcharge is very complicated and will be an additional and unnecessary obligation for elderly patients.

4} It does not appear that changes to our pharmacy plan is in accordance with article XII, section 7 of the Alaska Constitution. Is this legal?

5} This federal plan is not constitutionally protected. The United States Congress can change the programs any time they want and we would be left out in the cold.

Please do not do this. My wife and I are both Alaska State retirees. We are [REDACTED] years of age now, we do not need more complication in our lives, we need more simplification.

Sincerely,  
Dale & Bernice Louk

cc;Judy Salo & Sharon [REDACTED]

**From:** carol downs [REDACTED] >

**Sent:** Thursday, June 07, 2018 9:40 PM

**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>

**Subject:** Re: Change in Retiree Pharmacy Plan

My husband and I would be greatly affected by the new plan. I am a group 1 Alaska State retiree, and my husband is a group 3 retiree. My health plan covers both myself and pays co-pay for my husband, and his health plan covers himself and co-pays for me. Therefore, after deductibles are met [REDACTED] In many cases

[REDACTED] In 2014 changes to our dental plan greatly affected us and we are still in hopes it will be reversed. We were out a lot dental expenses because of the changes made that year.

Thank you for your help in these matters. Carol Downs

**From:** Jim Morrison <[REDACTED]>  
**Sent:** Friday, June 08, 2018 3:06 AM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Subject:** Change in Retiree's medical plan

Dear Board Members;

My Name is James Morrison and I retired as the General Manager of Anchorage Telephone Utility in 1995. I first went to Alaska in the 80's, and stayed because of the promise of a paid retirement and medical plan. I have worked in Ketchikan, Fairbanks and Anchorage. In each of those communities, the Telephone Company delivered Millions of Dollars of profits to help all the residents of each city. There were almost a thousand employees that worked for the respective Telephone Companies, and each stayed in Alaska because of the promise by the city, state or union to provide undiminished retirement benefits.

With the Trump Administration refusal to enforce the provisions of the Affordable Care Act, there is no way to gauge what changes the White House may try to eliminate or modify Medicare and the drug program. I ask you to consider this scenario. My ex wife of 28 years, [REDACTED] is vested in the PERS system. She is [REDACTED]. If you force me into the Medicare program, and I die, [REDACTED] gets PERS medical coverage but cannot qualify for Medicare. What then. With Billions in the Permanent Fund, Tell the Legislature to man up and start funding the Retirees Pension Plan for the people who made Alaska what it is

**From:** Eric M <[REDACTED]>  
**Sent:** Friday, June 08, 2018 6:01 AM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** Eric(Desktop) <[REDACTED]>; [REDACTED]; Saddler, Dan (LEG) <[representative.dan.saddler@akleg.gov](mailto:representative.dan.saddler@akleg.gov)>; MacKinnon, Anna (LEG) <[senator.anna.mackinnon@akleg.gov](mailto:senator.anna.mackinnon@akleg.gov)>  
**Subject:** Proposed DB Retiree Health Plan Modernization

June 8, 2018

Eric & Mary Marchegiani

Email: [REDACTED]

Subject: Proposed DB Retiree Health Plan Modernization

Dear Sir/ Madame:

First off, whenever I hear that someone is ready to make modification to our Health Plan a red flag goes up because usually it means that our benefits are going to be reduced or made more complicated to obtain; -- to the detriment of the Retiree and to the benefit of the State of AK. That has been the case with the previous change in the health care provider Aetna and the modifications to our dental plan by going to Moda.

I would ask that any future change to our Health Plan consider two over riding concepts:

1. Any change needs to make the process and submittal process as simple as possible. As we retirees age, it becomes more and more difficult for us to handle our insurance benefits which means that complicated processes and submittal processes results in our inability to deal with them and as a result many of us will end up paying more out of a fixed income. That means our quality of life will diminish.
2. All of our benefits should be handled under one company / provider. The separation of the Medical Benefits from the Dental and Vision makes it more complicated to deal with. As I have indicated above in #1; the process needs to be straight forward and simple. As a result of this – I am recommending that the State of AK re-advertise for its benefits (medical, dental, vision etc) all under one provider. It has been over 4 years since the last advertisement and it is time for a change., Aetna has been terrible to deal with... in my opinion their first review is to deny benefits if there is anything that seems different vs actually looking at the claim... then it is incumbent upon the Retiree to fight it. We should not be put in that position. Our benefits were much easier to deal with prior to Aetna.



Unfortunately, I will not be able to attend the teleconferenced meeting and provide testimony at the meeting time. In lieu of that I am listing below my comments on the PP Presentation that was made available ahead of time. Obviously, there may be things that come up in the meeting which I will not be able to comment upon but that said, my comments below will hopefully provide some perspective on my and my wife's views.

**Comments:**

1. It seems a bit unusual for the modernization program in its discussion of the pharmacy benefits to have totally left out the most recent proposal to modify the Retiree pharmacy benefits as they become 65 and qualify for Medicare. It may be an entirely separate discussion but all of us will be 65 at some point and being a retiree.... Well that would seem like an obvious topic to include within the modernization of the health plan. I have recently sent comments on that recent proposal but it should be included within this overall package. Similar to any changes here... there needs to be an analysis that demonstrates that the benefits will not be diminished.
2. Under the Areas of Focus: positive improvements
  - a. I have wondered for a long time as to why the State of AK did not provide for preventative services... i.e. fix the issue before it becomes a bigger problem would seem to be a no brainer. I concur that adding preventative services would be a logical way to save costs.
  - b. Increasing or eliminating the Lifetime Limit obviously is a benefit to all retirees and I concur with any improvement in that area.
3. Item #3 Low Cost Share: -- I totally disagree with the concept that the Retiree's and not sensitive to the cost of services. Being on a fixed income raises one's awareness level on any expenses that are incurred. Increasing the deductible and out of pocket limits will severely impact Retiree's income as they age and I am adamantly against it.
4. Item #4 Increasing Cost of Pharmacy Benefits: --
  - a. I disagree that Retirees use a higher percentage of brand medication when there are less expensive alternatives available. [REDACTED] At the same time, there are some medications that the Doctor's prescribe as brand because the generic is not as reliable or as efficient [REDACTED] the Doctor's recommendation on those items.
  - b. Also the service provider at times interprets that there is an alternative medication that will do the same thing but in reality it is a completely different medication... and when that happens it is a burden on the Retiree to appeal the Service Provider's decision. Again, it becomes a contest of back and forth with the service provider trying to force something down the retiree's throat.

- c. If the State of AK wishes to decrease the pharmacy costs, then it should not look to the Retiree but rather to the pharmacy companies. Work with the Federal Government to rein in the overall cost of medications. Putting the burden on the Retiree is backwards. **Fix the cause not the recipient.**
5. Item #5 Outdate Pharmacy Design: -- I am unsure about this item and how it is handled. I don't have an issue with a 90 day fill. What I do have an issue with is the ability to have two or three refills in any prescription. If that is what is being attempted here then I am opposed to it. Retirees should be able to have a number of refills of 90 days with any prescription that the Doctor issues.
6. Item #8 Confusion Over Rehabilitative Services: -- Your slide is confusing in itself... you have 20 visit limit per benefit year and then you have a 45 visit limit for all chiropractic, PT/ OT/SPT. This is the kind of stuff that gives Retirees headaches and also provides avenues for the Service Provider (i.e. Aetna ) to deny benefits after 20 visits vs 45?? Thee item needs to be clear. I like the elimination of the requirement for continued significant improvement. As we age again... there likely is not going to be significant improvement. It really is a maintenance item to avoid surgery in many cases. [REDACTED]  
[REDACTED] The limit on Chiropractic adjustments has been an issue with [REDACTED].  
The State of AK as the Secondary provider has helped to date assuming the Chiropractor files for it. Providing benefits for continuing chronic conditions makes sense.
7. Item #9 Dental coverage: -- As I indicated in my opening statement... having a separate insurance company to process Dental claims is another complication and problem for all Retirees irrespective of whether or not it is Dental Implants or just routine cleaning, and cavity repairs. It needs to be all under one company.
8. Item # 10 High Use of Hi-Tech Imaging & Testing: -- I doubt seriously that there is any major safety concern to the Retirees... I believe the State is only concerned with the costs. Adopting an enhanced imaging review program means more complications for the Retiree before they get the analysis that is needed. As I stated previously; -- the State of AK needs to make things less complicated, not more complicated. If the Doctor recommends a particular analysis then it should be done without further complication.
9. Item 12 Confusing Plan Booklet: -- The Plan Book should be easy to read and understand and not drawn up by a lawyer. As I have stated multiple times in this and other submission, as the Retiree gets older it becomes harder and harder to understand what is covered given the complicated nature of the plan. It is time that the plan be written in lay language that the Retiree can understand and know what their benefits are. I am unsure as to why there is this continuing desire to implement amendments... the plan should be fairly static after the State's Modernization Plan... assuming that you do a good job of it. It should be good for 5-10 years or more. so no amendments .. no changes to confuse the Retiree.. In addition, one could post a full copy of the plan (in layman's terms) on line for the Retiree to be able to access... Most retirees (although not all) have

some technology skills to access a web link and an electronic version of the plan (especially if it has not been modified 15 times).

**Finally, as previously discussed any change to the legacy plan will require a substantive detailed analysis of the benefits and losses to the Retiree Legacy Plan before it is implemented. At no time shall the legacy plan be diminished in any manner.**

Respectfully,

Eric & Mary Marchegiani

**From:** Timothy Shine <[REDACTED]>  
**Sent:** Friday, June 08, 2018 9:19 AM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Subject:** FW: Pharmacy plan changes

Sent from [Mail](#) for Windows 10

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**From:** Timothy Shine  
**Sent:** Friday, June 8, 2018 9:10:04 AM  
**To:** [AlaskaRHPAB@laska.gov](mailto:AlaskaRHPAB@laska.gov)  
**Subject:** Pharmacy plan changes

Please register my objection to the proposed pharmacy plan changes for retirees 65 and older. The motive for the change is obviously to reduce costs. The 5 step Federal appeal process for denial sounds like an abomination, hovering over the heads of retirees like the sword of Damocles. Please push for thorough evaluation of the proposed reduction of benefits prior to implementation. Legal action seems more than warranted.

Respectfully,  
Timothy Shine

**From:** Kalmsea Johnson <[REDACTED]>  
**Sent:** Friday, June 08, 2018 10:05 AM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** Sharon Hoffbeck <[REDACTED]>  
**Subject:** Changes in Retiree Pharmacy Plan

Dear Sirs: [REDACTED]  
[REDACTED]

Retiree health plan, future coverage for prescribed medicines for those who also are eligible for medicare prescription service.

I am [REDACTED] years old, going on [REDACTED]. My wife is [REDACTED] years old and my youngest child is [REDACTED] years old. I do not think that medicare wants to pay for the [REDACTED]

Am I and my family going to be allowed to continue to use the old State of Alaska, prescription plan or will be caught, out in the cold, with no prescription drug coverage?

David A. Johnson,

**From:** Judy Jantz [REDACTED] >  
**Sent:** Friday, June 08, 2018 10:10 AM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** [REDACTED]  
**Subject:** Proposed Changes in Pharmacy Benefit Plan

To: Retiree Health Plan Advisory Board  
Date: June 8, 2018  
Re: Changes in Retiree Pharmacy Benefit Plan  
Cc: Sharon Hoffbeck

I am sending some of my concerns about the proposed changes in the Pharmacy Benefit Plan. I think you are not considering retirees as the most important factor.

According to the union, you have not conducted the required *Duncan* analysis to be sure benefits are not diminished. Please don't think you can pull the wool over our eyes just because we are over 65 years of age.

Maybe you are suggesting the most cost-effective way to maintain retirement drug benefits, but why are you thinking of cost instead of retirees. Retirees should be number one, not number two.

If a drug is denied and we have to go through the long, long, long process to file a claim, will you provide pre-paid envelopes to us? If you are suggesting that we file on-line, what happens to those people who do not have computers?

Why are you choosing people 65 and over. That is age discrimination to the fullest.

So why "mandatory mailings related to EGWP, **most of which will not apply to you.**" Dollars could be saved without those mailings.

Will everyone be subject to this plan (even the people orchestrating this procedure or will they be exempt)?

How can you think that the 5 step process to appeal a drug denial is something that all senior citizens can do?

Health care should be between the patient and their doctor. Someone who has no idea the health of a patient, should not make the decision as to which drug would best keep the cost down for the State of Alaska and, oh yes, just maybe help the patient.

I somehow cannot believe that there are no other areas in the State of Alaska Government to cut. Again, I ask why are you picking on Alaska Retirees. We have given many years of service (I have given 30 and many others have given more) to the State of Alaska and this is how you are thanking us? We were promised decent health care until death. You need to keep that promise.

Judilee Jantz  
Alaska Senior Citizen Retiree

**From:** Gary Miller <[REDACTED]>  
**Sent:** Saturday, June 09, 2018 11:03 AM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** Ricci, Emily K (DOA) <[emily.ricci@alaska.gov](mailto:emily.ricci@alaska.gov)>; Michaud, Michele M (DOA) <[michele.michaud@alaska.gov](mailto:michele.michaud@alaska.gov)>; Sharon Hoffbeck <[REDACTED]>  
**Subject:** Health Plan Modernization

I read the Proposed Modernization Plan and here are my comments.


It would be **very helpful** to have all of the amendments in one booklet **and** incorporate decisions made by the Office of Administrative Hearings, **including** those that have nondisclosure agreements. We retirees were promised health insurance at retirement if we stayed in our public service. I believe that we retirees have earned insurance documents that are clear and easy to understand. As the document states, "This would make it easier for members to understand and provide more transparent and specific direction as to how AlaskaCare claims should be adjudicated".

As medical costs continue to rise, people can reach the lifetime limit easier. A heart transplant could do that. As other medical procedures are developed, some of those are exorbitant. In addition, some of the newer drugs are so expensive that people without insurance can't afford treatment and are left to die. Therefore, I think the lifetime limit should be eliminated. It would be nice to know how many people each year reach the limit and are dropped from insurance coverage. Would it be morally right to let them die because they no longer have health insurance?

Preventive care can reduce medical costs by catching medical issues early where treatment is more likely to be successful and less expensive. Some examples are pap smears, mammograms, PSA tests, health fairs, etc. There must be studies that show which preventative services would save the program money and whether or not retirees would take advantage of them. If there are money saving preventative services, then consider implementing them.

Canadians pay about one-third to one-half the price for prescription drugs as Americans do. Someone needs to take the lead to allow the importation of prescription drugs from Canada. Since Congress passed the laws prohibiting it, Alaska's governor and legislature should be pushing senators Murkowski and Sullivan and representative Don Young to take the lead on this. Several years ago, about half of the cost of retiree healthcare was for prescription drugs. Do a study and find out if that has gone up. Governor Walker could make this an issue at the national governor's conferences. Alaska is not the only state facing this problem.

Having a travel concierge purchase airline tickets is an interesting concept. Bidding could be done with the different airlines to secure the best fares. I think this is a brilliant idea and bravo to the person who thought of it. What about airline miles. Who would get the credit, the insurance company or the traveler? If there is a medical emergency and a person has to be medevacked, would reimbursement be for the full amount or reduced because the concierge was not used?

I understand the idea of "...enhanced imaging review...". there should be some flexibility. For example, I recently injured [REDACTED]. The physician's assistant ordered [REDACTED] and declared that I had [REDACTED]. After more pain, I went back and saw the doctor. He ordered and [REDACTED] and said that I had [REDACTED] and would need surgery. Would my [REDACTED] be questioned? 

Changing the retirement statue defining "dependent child" would not be challenged if the age limit goes up but if it is lowered I think there would be grounds for a lawsuit if it applied to people who are currently retired. The constitutional protection would be violated. In addition, would some legislators want to make other changes and open up a can of worms?

Best of luck on this interesting and probably long over due project. Also, thanks to those of you serving on the Retiree Health Plan Advisory Board's. I appreciate your volunteering.

Gary Miller.

Gary Miller  
[REDACTED]



**From:** Terry or Freda McConnaughey [REDACTED]  
**Sent:** Sunday, June 10, 2018 9:10 AM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Subject:** Changes to retiree health insurance coverage

Board Members: I am against the most recent changes to our prescription drug coverage becoming part of the federal program Medicare. The job that Aetna is doing is working well and does not need to be discarded. Please forget about the plan to include the Medicare involvement in our State of Alaska Retiree Program. Thank you. John T McConnaughey

**From:** Jean Brown <[REDACTED]>  
**Sent:** Sunday, June 10, 2018 9:39 PM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** [REDACTED]  
**Subject:**

June 11, 2018

To: Retiree Health Plan Advisory Board (Senator Judy Salo, Cammy Taylor, Mark Foster, Gayle Harbo, Joelle Hall, Dallas Hargreaves, and Mauri Long)

**PLEASE SEND TO BOARD IMMEDIATELY**

Re: Changes in Retiree Pharmacy Benefit Plan

CC: Sharon Hoffbeck

My purpose in writing is to voice my opposition to the proposed change in the Pharmacy Benefit Plan. Being a retiree for 18 years, and over the age of 65 this change will most definitely affect my health care and that of many others. For the last 8 years, the only healthcare benefit I have received from my State of Alaska promised and backed by law plan has been the Pharmacy Benefit. The medical bills were reduced by Medicare and after all my Physician visits for the year very little was paid for by the State Insurance. The Pharmacy Benefit has provided me with the medication my Physicians have ordered for me. My physicians have used generic medications when possible. My care is managed by my physicians and me. Some types of medications have not been effective in keeping my symptoms in check and need to be changed quickly. Under the proposed plan, an unknown person will look at a report and decide what drug that I would be able to receive. They will not know my history, what drugs have been tried etc. Then if a drug is denied, the 5 step process will have to be done---in which time my physical condition will considerably deteriorate. I am not the only person this will affect many do not have the ability to work through these processes.

At the present time, we have a Central Pharmacy with our Aetna. Our refills are done by knowledgeable people quickly and professionally. Medications filled by a Specialty Pharmacy are chosen by our Physician NOT a list. The Specialty Pharmacist speaks directly to our physician to make sure required testing is done without interruption to the patient thus allowing great coordination between physician/pharmacist/patient.

I realize that Governor Walker signed Administration Order 288 establishing a Retiree Health Plan Advisory Board, but wasn't sure how the board was appointed. I would like to believe each was appointed to maintain our benefits not to diminish them. We were guaranteed under Article XII, Section 7 that we would have paid Health Benefits including medications to maintain our health.

While I understand Governor Walker is trying to decrease expenses in some areas, he is **discriminating** against the State retirees over age 65 and upcoming retirees on Tier I. The retirees have worked for the State of Alaska for many years providing services to its citizens.

I would request that the Retiree Health Plan Advisory Board recommend that the Pharmacy Benefit remain the same—since it is the only benefit those over 65 receive being forced on Medicare.

Thank You for your consideration,  
Jean L Brown  
Alaska Senior Citizen Retiree

**From:** Brad Parker <[REDACTED]>

**Sent:** Monday, June 11, 2018 6:02 AM

**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>

**Subject:** RE: Changes to Retiree Pharmacy plan

I am really concerned about the pharmacy program. I currently have everything coordinated with our primary insurance. It took 6 months to do this when Aetna took over.

In the mean time it was a terrible problem. Please leave it alone. Thank you.

Bradford Parker, Commerce and Economic Development, Law, Public Safety, 1977-2000

Modernization Committee members,

After the Committee meeting this afternoon, I thought it might be helpful to apply the template based on Duncan to the proposed modernization of the medical plan. I have included my thoughts on this proposal and what remains to do in order to comply with the Duncan decision. I offer my answers to these questions in the attached document.

Brad Owens

### Equivalency analysis questions:

1. *Is there an identified legitimate need to change the benefits provided?*

DOA describes three goals – a) provide value to members through incorporating common benefits not currently available while b) preserving the overall benefit of the plan and c) implementing common cost saving mechanisms

2. *What are the reasons for the proposed changes?*

DOA identifies a) to modernize an outdated legacy plan by amendments over next two years and b) improve the plan documentation by incorporating prior amendments into body of the plan

3. *What data exists that supports the proposed changes?*

DOA identifies 12 areas of focus: 1) limited preventive care services; 2) lifetime limit of \$2M; 3) low cost share; 4) increasing pharmacy costs; 5) outdated pharmacy design; 6) drug safety and efficacy; 7) limited travel benefits; 8) confusion about rehab services; 9) confusion about dental implants; 10) high use of hi-tech imaging and testing; 11) dependent coverage limits; and 12) confusing plan booklet. However, little data is provided that supports these proposed changes.

4. *Do the proposed changes substantially reconfigure the mix of current benefits?*

DOA doesn't discuss the extent to which the changes proposed in these areas of focus would reconfigure the mix of current benefits. However, the description of the particular 12 areas of focus provided by DOA shows potential enhanced benefits in only four of these (#1, 2, 7 & 12) while the remaining eight areas would diminish or reduce current benefits or coverage. Unfortunately, there is little information or specific data on each of these areas to allow an appropriate assessment of the degree of reconfiguration of current benefits.

5. *Will the proposed changes result in any unusual gaps in in the benefits or coverage currently provided?*

Without more detailed data, it is difficult to determine what gaps may occur, or the extent of any gaps, under these proposed changes. Presumably, the pharmacy and drug concerns (#4, 5 & 6) would be impacted by the EGWP program DOA proposes to implement in 2019. Based on the summary

information provided by DOA and without further specific data, it is unclear what impact the remaining areas will have that could result in unusual gaps in current benefits or coverage.

6. *Do the proposed changes involve the restriction, reduction or elimination of currently provided benefits?*

Based on the summary description of each area provided by DOA, it appears clear that the majority of the changes involve a restriction or reduction of current benefits such as #3, 4, 6, 8, 9 & 10. Without greater specific benefit usage data provided by DOA, it is difficult to determine the extent of restriction or reduction of benefits resulting from the proposed changes.

7. *If so, how many members will be impacted by each particular change?*

DOA and Aetna would have specific data gathered over the last four and one-half years to show the actual usage by members and dependents of the benefits in each of these areas and what likely impact each of these proposed changes would cause, both individually and as a group.

8. *Will the proposed changes predictably cause hardship to a significant number of members who cannot be specifically identified?*

Since the proposed increase in the deductible and out-of-pocket maximum expenses would apply to every member or dependent who utilizes plan benefits, each of them would be impacted. Consequently, it is possible there would be hardship caused by this change to a significant number of members whose monthly pension is limited. The increased cost of pharmacy benefits is another change where hardship to a significant number of members could occur, particularly in the proposed formulary change under EGWP in addition to its substantially more difficult and time-consuming appeal procedures. The change to limiting hi-tech imaging and testing through in-network clinical review could predictably cause hardship to a significant number of members as well. But without additional specific data showing the number of members affected by these changes, based on actual experience, hardship to a significant number of members seems predictable but unclear.

9. Have all members affected by the proposed changes been given adequate notice of the proposed changes?

DOA has provided general public notice of the intended change of the current retiree drug program to the EGWP but has not provided sufficient direct individual notice of the change and possible impacts to members 65 and older. Nor has it provided adequate notice of the proposed changes to modernize the medical plan. Providing adequate prior notice to all affected members and dependents of these proposed changes to the medical plan is both critical and essential.

10. Have the affected members been given adequate opportunity to question or obtain additional information about the proposed changes?

It is essential that DOA not only give general notice of the intended changes under this modernization plan but that it also give specific opportunities to all affected members to obtain more specific information about each proposed change, what options will be available and how it could impact each of them specifically. DOA must provide adequate and appropriate opportunities for the impacted members to ask questions in public meetings and describe the hardship any changes might cause them individually. DOA must make every reasonable effort to avoid the confusion and uncertainty that resulted from the 2014 amendments imposed without adequate notice and information to members.

11. Have the affected members been given adequate opportunity to show the proposed changes may result in substantial hardship?

Once DOA has provided adequate notice, information and meetings with members to educate about the changes, it must then provide an adequate opportunity for individual members to show these proposed changes will result in substantial hardship to them.

12. Is any substantial hardship offset by comparable advantages?

DOA recognizes that the disadvantages caused by changes to the plan must be offset by new advantages. Of the 12 areas of focus, three (#1, 2 and arguably 7)

appear to offer new advantages. However, no specific reliable data based on actual experience has been provided by DOA to substantiate these new advantages are comparable or adequate. DOA must now review actual experience and utilization data to develop the ability to perform an appropriate evaluation of equivalent value.

13. *Do the proposed changes result in the diminishment or impairment of any current benefits?*

As discussed above, it appears there will be a diminishment or impairment of the current benefits and/or coverage provided under the retiree health plan but the actual experience-based data that would show whether or not that is true has not been provided yet by DOA.

14. *Has there been an adequate and timely comparative analysis performed to determine if there is equivalent value between the offsetting advantages and disadvantages under this proposed change?*

DOA has not performed a comparative analysis to determine if there is equivalent value under the proposed changes at this point. Once it has produced reliable data this analysis can be completed.

15. *What specific solid statistical data, drawn from actual experience, has been used in this comparative analysis?*

Presumably, the analysis performed will be made public and the data utilized and relied upon by DOA in performing the analysis will be made available to all affected members.

16. *Has the comparative analysis and the data upon which it is based been made available to all affected members sufficiently before the implementation of the proposed changes to allow their response and input?*

Not presently.



-----Original Message-----

From: Diane Bachen <[REDACTED]>

Sent: Thursday, June 14, 2018 6:59 AM

To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>

Cc: Sharon Hoffbeck <[REDACTED]>

Subject: EGWP

Dear Board Members;

I am very disturbed about the proposed change to the prescription benefit program for Alaska retirees from Aetna to the EGWP with Medicare. This sounds like it is already a “done deal” and I believe has not gone through the necessary stringent analysis to see if the benefits will be the same as our current program. We need reliable, concrete evidence that the retirees will be receiving the same services and benefits. While I certainly understand the need to look at cost savings, it needs to be done in a systematic and structured way, not done on hypothetical analysis. Please take the time to do this before committing to this program

Diane Bachen

**From:** Helen Josephs (Adams) <[REDACTED]>  
**Sent:** Friday, June 15, 2018 12:04 PM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** Sharon Hoffbeck [REDACTED]; Helen Josephs (Adams) [REDACTED]  
**Subject:** Changes to Retiree Pharmacy Plan

Retiree Health Plan Advisory Board,  
Ladies and Gentlemen:

The proposed changes by the Department Of Administration (DOA) to the drug plan, are not acceptable.

I work as an RN in Utilization Review, regularly dealing with payers for health care claims.

This proposal will hinder the ability of health care providers, complicate filing for claim reimbursement and downgrades the quality care.

With increased control and restrictions on care comes an increase in administrative cost to providers. The likely result will be still fewer providers accepting Medicare patients.

The payer/insurance mandated controls will fail for patients. The likelihood that healthcare costs will increase due to complications in primary care will increase visits to Urgent Care, hospital and emergency room.

Still most important is that the doctor: patient relationship is personal and private, and based on trust. This proposal denigrates the importance of this bond and thus affects direct primary physical and supportive emotional care.

This is a BAD idea that should never be a plan.

Submitted by  
Helen Josephs Adams  
Retired as of November 2012  
[REDACTED]

**From:** Dona Hermon <[REDACTED]>  
**Sent:** Friday, June 15, 2018 3:38 PM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Subject:** Changes to Retiree Pharmacy plan

1. If we are protected by the Alaska Constitution, how can the Department of Administration go ahead with these changes?
2. Why aren't all retirees treated equally? Those under 65 could still be working after retirement and supplementing their income and able to cover any extra expenses.
3. What guarantee do we have that the premium will be paid by Medicare. Congress is continually trying to cut our Medicare benefits.

Thank you for your had work.

George and Dona Hermon

**From:** [REDACTED]  
**Sent:** Monday, June 18, 2018 10:45 PM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** [REDACTED]  
**Subject:** Retiree health insurance

Dear Natasha, Thank you for your attention to this disastrous change in retiree pharmacy care. Having to go through a step process for meds is subverting a doctor's ability to do their job. Insurance companies have no business dictating what meds are tried for a condition. The doctor should be able to prescribe the medication that they feel will be most effective, and sometimes that is a non-generic medication. Also increasing the difficulty of the appeal process which is already challenging for some retirees is a very bad step. Please do not allow this to go through. Thank you, Pat Kehoe

**From:** Bruce Baker <[REDACTED]>  
**Sent:** Tuesday, June 19, 2018 1:25 AM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** [REDACTED]  
**Subject:** Proposed Change in Retiree Pharmacy Plan

ATTENTION: Natasha Pineda, MPH  
Deputy Health Official  
Alaska Department of Administration  
550 W 7<sup>th</sup> Ave.  
Anchorage, AK 99501

I am an Alaska state retiree and I oppose the intent of the Department of Administration to enroll all retirees 65 or older in a Medicare Part D pharmacy plan referred to as “EGWP/wrap.”

One of the more egregious provisions of this change is that the proposal interferes with my doctor-patient relationship by requiring that I may have to try other drugs that are less expensive and chosen by a separate Pharmacy Benefits Manager (PBM) instead of drugs that my doctor prescribes. It is not enough to say that if such alternate drugs do not work, I can then request the drug my doctor prescribes. Under the current retiree plan, my course of care is a decision between me and my doctor.

Your proposed multi-step process could endanger my health by wasting precious time in embarking on the best possible medical treatment that needs to be implemented as soon and as expeditiously as possible if it is to have the greatest probability of success and possibly prevent permanent physical impairment or perhaps even premature death. I choose my doctors carefully, they are the most knowledgeable of my medical needs, and they know a lot better than some faceless PBM employee buried in the bowels of a distant bureaucracy about what medication is likely to be most effective and most immediate in achieving its purpose.

I understand that under your proposed change, if a prescribed drug is denied, the denial must be appealed using a 5-step federal appeal process. Currently, if there is a denial, the Division of Retirement & Benefits can directly intervene with the Third-Party Administrator (currently Aetna), assuring the retiree pharmacy plan is not diminished. This 5-step bureaucratic process would delay my being able to

begin taking a medication that my doctor considers the most effective alternative. Again, this delay could result in permanent physical impairment or possibly even premature death.

I urge you to cancel your plan to impose a Medical Part D pharmacy plan known as “EGWP/wrap” and to protect the current health benefits program for State of Alaska employees.

Sincerely,

/s/ *Bruce Baker*

Bruce Baker

A large black rectangular redaction box covering the signature area, with a smaller rectangular redaction box extending from the bottom right corner of the main box.

**From:** Robert Hutton <[REDACTED]>  
**Sent:** Tuesday, June 19, 2018 7:48 AM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Subject:** Proposed Medicare Plan

To Whom It May Concern:

The two of us are retired Alaska teachers who are over the age of 65. We have read recently that the State of Alaska Department of Administration intends to enroll us in Medicare Part D as of January 1, 2019. We are categorically opposed to such a change, as it will result in higher costs for us and a more ponderous system than the current Aetna plan. We therefore regard this as a change that does not adhere to what we understand to be the Alaska constitutional guarantee that retirement benefits "shall not be diminished or impaired." None of the proposed changes appears to improve our health care plan, and our biggest concern is the surcharge.

As is the case with many Alaskan retirees, our income is over the \$170,000 limit for married filing jointly. The surcharge that we will be subjected to is an unwarranted and unfair financial burden that was not placed on us at the time of our retirement as under Tier I. In addition, the program for reimbursement of the surcharge sounds unnecessarily and ridiculously complicated. We understood (beginning with our initial employment in Alaska back in the 1970's) that any changes to our health coverage in retirement would not result in increased out-of-pocket costs, and clearly this would not be the case under the proposed Medicare Part D system.

Once again, as retired teachers, we vigorously oppose the proposed transition to Medicare Part D.

Robert Hutton  
Glenda Hutton

-----Original Message-----

From: Steve B [REDACTED]

Sent: Tuesday, June 19, 2018 8:18 AM

To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>

Cc: "\"President Hoffbeck\" [REDACTED]

Subject: changes to alaska state retiree prescription drug coverage

To Whom It May Concern,

I strongly disagree with the State's proposal to move retirees over the age of 64 into the Medicare Part D program.

This change will add several layers of federal bureaucracy to our RX process. It is bad enough dealing with the Aetna and State bureaucracy when RX orders encounter difficulty and it will be ten times worse at the federal level.

One such instance is the vacation override process. I have done this several times with Aetna and each time they seem to balk or have difficulty getting the order processed. I don't even know if the Part D program allows vacation overrides which is a problem for retirees that may travel for several months at a time with no fixed address for receiving mail orders.

It appears to me that the state is trying to diminish our constitutional protected retiree RX drug program. I STRONGLY discourage the state from making this change.

Stephen M Bennett

[REDACTED]



**From:** Mark Miller <[REDACTED]>  
**Sent:** Tuesday, June 19, 2018 8:41 AM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** Sharon Hoffbeck [REDACTED]  
**Subject:** Enrolling State of Alaska retirees, age 65 and over, into Medicare Part D

Dear members of the Retirement Health Plan Advisory Board:

I am strongly opposed the plan for the State of Alaska to enroll all retirees who are 65 and older in a Medicare Part D pharmacy plan called EGWP/wrap.

For nearly 20 years the Federal Government has made huge concessions to pharmaceutical companies to dramatically increase prices/profits on prescription drugs. These include blocking prescription sales to Americans from Canadian pharmacies and prohibiting Medicare from competitively negotiating prescription drug prices. Clearly the Federal Government promotes pharmaceutical profits over the best interests of American's health. Shifting to the EGWP/wrap plan will only promote increase costs and diminish prescription benefits to Alaskan retirees.

The EGWP/wrap plan will greatly complicate denial appeals with a five step federal appeal process compared to direct intervention by Division of Retirement & Benefits, currently available to retirees.

The EGWP/wrap plan may reduce pharmaceutical options, threatening retirees health while increasing retirees cost.

EGWP/wrap has not been adequately debated in the legislature with public input opportunities. It does not live up to the State's obligations and promised benefits to employees who invested their careers with the State of Alaska. It appears to be a very diminished plan that I will oppose as much as possible.

I appreciate your consideration of my views.

Sincerely, Mark Miller

**From:** Colleen Ingman <[REDACTED]>  
**Sent:** Tuesday, June 19, 2018 11:23 AM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** Sharon Hoffbeck <[REDACTED]>  
**Subject:** Fw: Change in Retiree Pharmacy Plan

**Sent:** Tuesday, June 19, 2018 10:59:23 AM AKDT  
**Subject:** Change in Retiree Pharmacy Plan

Dear Natasha Pineda, MPH  
Deputy Health Official  
Alaska Department of Administration

I'm writing in opposition to the proposed plan called an EGWP/wrap for retirees who are 65 years of age or older. I oppose it for the following reasons:

It requires a federal appeal process, which will be cumbersome and lengthy; diminishing the current ability where Department of Retirement and Benefits can directly intervene and work with Aetna.

Step Therapy becomes a multi-step process impacting the course of care, that is currently between the doctor and the retiree.

The fact that you will not be notified what category you are in under the Medicare Part D surcharge purposes, and if the surcharge is not paid, that you will be dropped from the Medicare Part D and enrolled in another plan that will not have equal benefits.

There is a strong potential for copays to increase, which will be difficult for those of us on a limited retirement income.

Thank you for allowing me to share my concerns.

*Colleen Ingman*  
**Retiree**

**From:** Martha Bless <[REDACTED]>  
**Sent:** Tuesday, June 19, 2018 11:31 AM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** [REDACTED]  
**Subject:** Change in Retiree Pharmacy Plan

To the Retiree Health Plan Advisory Board,

I am writing to voice my concerns about the change in the Retiree Pharmacy Plan. I ask your board to repeal this change. The idea that an agency can overrule a physician's course of care is inconceivable as well as frightening. This change seriously impacts the health care of the most fragile segment of our society. Elderly and senior citizens are the most in need of a doctor's specialized training and knowledge. Many senior citizens have developed a relationship with their doctors over many years and this includes their physicians' knowledge of the complexities of their medical histories and medications. To override this important doctor-patient bond is insupportable.

I am of the understanding that before DOA can impose any proposed changes, including the EGWP to the retiree health plan, it must follow the process specified by the Alaska Supreme Court in the case of *RPEA v. Duncan* by performing an equivalency analysis to establish whether the changes which disadvantage retirees as a group are offset by additional advantages of comparable value. The analysis must be based on reliable evidence, such as solid, statistical data drawn from actual experience, including accepted actuarial sources rather than by unsupported hypothetical projections. Equivalent value must be proven by comparison of the actual benefits provided to those that are proposed in the changes and where any individual shows that a proposed change results in a serious hardship that is not offset by comparable advantages, that affected individual must be allowed to retain existing coverage.

On a personal basis, the specific medications, of which I am prescribed, took years of trial and error with many medications to determine efficacy. If they were changed or denied to me it would produce a setback of years of treatment by my physician, a professional with more than twelve years of specific training and many decades of experience in this area of medicine.

Again, I respectfully ask your board to repeal this change and preserve the retiree health plans that retirees rely on and for which they have worked many, many years to receive.

Sincerely,  
Martha O. Bless

**From:** Karen Paulick [REDACTED]  
**Sent:** Tuesday, June 19, 2018 1:11 PM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** [REDACTED]  
**Subject:** Medicare Part D-EGWP plan

Natasha Pineda, MPH, Deputy Health Official, Alaska Department of Administration:  
I would like to formally protest the decision to enroll State of Alaska retirees over age 65 into Medicare Part D.

This proposed program is convoluted and complicated (particularly the appeals process) and is going to require more paperwork, tracking and oversight by retirees. If someone is quite ill this is really an unfair additional burden on the patient and family.

Additionally the new program interferes with the doctor/patient relationship by requiring patients to try drugs proposed by someone not even involved in their treatment - perhaps leading to a worsening of their condition or serious reactions that could have been prevented if the original prescription had been used.

The program will likely increase costs for medications - and can add monthly "surcharges" for some retirees.

Basically this proposed program denies retirees of the level of benefits they paid for and were guaranteed by the State of Alaska.

Please reconsider this decision to change our pharmacy plan to Medicare Part D.

Regards,

Karen Paulick  
[REDACTED]

**From:** Judith Kearns-Steffen <[REDACTED]>  
**Sent:** Tuesday, June 19, 2018 5:24 PM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>; Jonathan Kreiss-Tomkins <[REDACTED]>; Rep. Jonathan Kreiss-Tomkins <[REDACTED]>; Sharon Hoffbeck <[REDACTED]>; [rpea@alaska.net](mailto:rpea@alaska.net)  
**Subject:** EGWP

ATTENTION:  
Natasha Pineda  
Deputy Health Official  
Alaska, Department of Administration

With utmost **outrage**, I oppose and DO NOT SUPPORT the Medicare Part D pharmacy plan called EGWP.

**I do not support** that if a prescribed drug is denied, the denial must be appealed using a 5-step federal appeal process. Currently, if there is a denial, the Division of Retirement & Benefits can directly intervene with the Third-Party Administrator (currently Aetna), assuring the retiree pharmacy plan is not diminished.

**I do not support** Step Therapy that appears to be a part of the Medicare Part D/EGWP plan. This would be a significant change and diminishment from the current retiree pharmacy plan. Step Therapy requires that a person may have to try other drugs that are less expensive and chosen by the PBM, other than the drugs your doctor prescribes, and if they do not work as needed you can then request the drug your doctor prescribed. This is a multi-step process that can potentially impact your course of care prescribed by your doctor. Under the current retiree plan, your course of care is a decision between you and your doctor.

**I do not support:** The regular monthly Medicare Part D premium will be paid from the medical trust for all retirees. For those in a 'high income' category set by the federal government (currently \$85,000 single or \$170,000 married), there will be an additional monthly surcharge that currently ranges from approximately \$35.00--\$75.00. This surcharge must be paid by the retiree and will be reimbursed by the state at a later date. The state will not be notified if you are in the high-income category, and you must contact them to activate the reimbursement process. If the surcharge is not paid, you will be dropped from the Medicare Part D/EGWP plan and enrolled in an alternate pharmacy plan designed by the state that will not have the same benefits as the current pharmacy plan. The details of this alternate pharmacy plan have not yet been disclosed by DOA.

**THE LACK OF TRANSPARENCY AND UNDERHANDEDNESS TO THOSE OF US WHO HAVE SPENT MOST OF OUR ADULTHOOD INSTRUCTING THE YOUNG PEOPLE IN ALASKA IS HORRENDOUS. YOU SHOULD BE ASHAMED.**

Judith A. Kearns-Steffen  
[REDACTED]

**From:** Ed Hays <[REDACTED]>  
**Sent:** Wednesday, June 20, 2018 7:24 AM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Subject:** Protesting change in retiree pharmacy plan

To: Natasha Pineda, MPH

I am a retiree in the Alaska Teacher Retirement Program, writing to protest the proposed changes in the retiree pharmacy plan. There are several things that appear to cut back on the benefits offered, among which are the following.

1. If a prescribed drug is denied, the denial must be appealed using a 5-step federal appeal process. This process will make the process more cumbersome and increase the burden on retirees.
2. Step Therapy appears to be a part of the Medicare Part D/EGWP plan. This would be a significant change and diminishment from the current retiree pharmacy plan. Under the current retiree plan, the course of care is a decision between the participating member and their doctor.
3. Copays for some drugs may be increasing.

I urge you to not allow these changes to progress.

Thank you for your consideration.

Sincerely,

Edward Hays  
[REDACTED]

-----Original Message-----

From: Linda Deal <[REDACTED]>

Sent: Wednesday, June 20, 2018 11:14 AM

To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>

Subject: Rx

PLEASE, PLEASE do not change our prescription program. It works great and does not need to be replaced. As a recent participant of Medicare, I find it very disjointed and extremely difficult to use. Our current plan is NOT broken! Linda Deal


**From:** Val Horner [REDACTED] >  
**Sent:** Tuesday, June 19, 2018 3:15 PM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** [REDACTED]  
**Subject:** Proposed Medicare Part D changes to Retiree's benefits

It seems like the State is trying to whittle down benefits that we retiree's have earned. In good faith, we stayed our 30 years or more with reassurance that our health needs would be met.

Currently it is a battle to get Aetna to pay for medical that is or should be covered by our plan. Last year it took 12 months and intervention from Juneau legislators to get my chiropractor bills paid – not just mine but all of the chiropractor's retiree patients! Services once covered suddenly were removed from coverage. For example, my husband's [REDACTED], was covered and 6 months later the exact same treatment for the exact same [REDACTED] was denied for a friend. This treatment for [REDACTED] is 99% successful. A lawsuit settled out of court reimbursed them. But see my point?? Cancer treatments, including drugs, and treatments for all illnesses should be decisions of the patient and doctor, not third parties bent on saving the money or who may be biased or have no real knowledge of the condition and new treatment options.

It seems like the appeal process was broken and now with the help of the retiree's association and some legislators it is nearly back on track. Now the prescription coverage is to be changed, or I should say "under attack", and we will have a worse appeal process of 5 layers! And nothing with Social Security appeals moves quickly.

The current level of coverage has been such a relief and "safety net" compared to our friends and family who have Part D coverage and/or coverage from employers other than the State. (We use the mail-order service. The convenience and lower cost are important to us.) I hear complaints from friends/family about the confusion of what is covered and what isn't through Part D, the stress of trying to fill the gap, and the need for a spouse to go to one pharmacy for drugs while the other needs to go to a different pharmacy for their prescriptions. The stress and the inability to go through the Medicare red tape is more and more difficult as my friends and family age and struggle to understand the process. I have come to believe that the insurance companies count on us being too old or too ill to understand or have patience to fight or appeal their decisions.

Some of us retirees, including me, have spouses that have benefits from their unions or might even continue to work full or part time. That doesn't make us rich. It makes us comfortable in our  retirement. It also caused our Medicare premiums to spike. Ours personally is now at \$800 per month, plus our vision & dental. That is a big chunk that puts us in a Catch-22. My husband has to keep working to pay the Medicare premium and the premium is high because he continues to work plus has his union retirement. He is almost 70 years old!

It is a cheap and lousy way for the State to save money. The appeal process is ridiculous – the patient might be dead by the time someone makes a decision on the 5<sup>th</sup> appeal to allow the drug purchase. And it is likely the drug purchase decision will be based on the cost not the need or effectiveness, especially on new drugs for chronic or terminal illnesses. (I worked in Public Assistance for 30+ years. Some of my clients did die while waiting for SSA to make a decision on a disability!) It is more likely that a senior, especially one with major health issues, will not understand or cope with the stress to 1) make an appeal



and 2) submit to the State a request for reimbursement of Part D premiums. Either a relative will intervene for them (not an easy thing to ask of a relative) or the retiree/patient simply won't bother.

I trusted that the State would be there for me as promised when I first was employed in 1972. I feel cheated and feel that we are paying the penalty for the State, and by extension the legislature's, failure to deal with the State's budget woes. I am angry about this proposal and feel that the State is punishing the seniors and going back on promises made. I strongly oppose this change to our drug coverage.

Valerie A Horner, State of Alaska Retiree  
Juneau, Alaska

Sent from [Mail](#) for Windows 10

**From:** Karl Koch [REDACTED]  
**Sent:** Wednesday, June 20, 2018 8:31 PM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Subject:** prescription drug benefit reduction

Besides the legal ramifications of making these reductions to retiree drug benefits, there are also moral ramifications as well. What is being proposed is not only bypassing a court ruling that spells out procedure, but it is also morally and ethically corrupt. How board members can even consider this is beyond me, especially since most of the board members will be affected at some point if this plan is adopted. My wife has [REDACTED] and is in pain pretty much 24 hours a day. The thought of possibly not being able to get needed medication because it may or may not be on a list is beyond inhumane. My wife will be the one who won't be able to sleep and endure unimaginable pain if she has to go through a five step appeal. I worked for SOA for 22 years, which included holidays, shift work, weekends and being on call without pay. I put my job before my family, believing that at some point the state would live up to their retiree commitment and that retirees would receive the medical, dental and pharmacy benefits that they were promised. Please consider all the hard working and dedicated employees that have given their all and the families that also endured the sacrifice with them. I ask the board members to try and imagine the unimaginable..... being retired from SOA, living on a fixed income, Failing health and pain coupled with eroding benefits and more bureaucratic red tape and hoops to jump through.

Sincerely  
Karl Koch

**From:** Barbara Rook <[REDACTED]>  
**Sent:** Wednesday, June 20, 2018 9:49 PM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** [REDACTED]  
**Subject:** Change in Retiree Pharmacy Plan

I strongly protest the change in retiree pharmacy plan effective January 1 2019 in which you plan to enroll anyone age 65 or over in Medicare Part D. This is an example of another diminishment of benefits for Alaska Retirees. I strongly oppose after reading all the information provided. Please let me know this can be remedied by continuing the current coverage.

Barbara Bucsko  
[REDACTED]

Mailing:  
[REDACTED]  
[REDACTED]

**From:** Jonnie lazarus <[REDACTED]>  
**Sent:** Thursday, June 21, 2018 6:12 AM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** Sharon Hoffbeck <[REDACTED]>  
**Subject:** changes in retiree health benefits

Thank you for providing me, via RPEA, of planned upcoming changes to retiree health benefits. Many seem to be a great improvement, however I do have concerns regarding the following:

3 Tier pharmacy plan- At the very least, no one should be made to revert to old Rx's that proved inadequate for treatment. In addition, my husband and I both feel strongly that it is our doctors who are best informed as to what medications would serve us best for our issues. I hate to think that elders would be forced to continue to suffer with drugs a health care plan thinks would serve them rather than what our doctors believe are best for our health care issues. We stand opposed to this change.

Pharmacy 90 day refill- some months have 31 days and this will not cover a 3 month span. Also- a question- will there still be the possibility of "Vacation Over ride" ? We are traveling quite a bit while we are able to and often are gone for more than 3 months. In the past we were able to get a 1 year over ride which was great. Now we are able to get 6 month over rides. This is adequate but not great. If we are not able to mail order our medications for at least 6 months at a time, the burden of refilling Rx's at what ever pharmacy is near by will greatly impact us financially.

In addition- I wonder what impact these new changes will have on our coverage while traveling outside of the US. The current plan coverage is good, although we have had to fight with Aetna tooth and nail for reimbursement and rates of exchange. If this coverage is discontinued, I am sure it will be a great impediment for many retirees who plan to travel in their early retirement years. This coverage is what makes travel out side the US possible for many of us.

I look forward to your response to my questions. Thanks so much

Jonnie Lazarus

**From:** Bill Burgess <[REDACTED]>

**Sent:** Thursday, June 21, 2018 7:40 AM

**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>

**Cc:** Sharon Hoffbeck RPEA [REDACTED]>

**Subject:** Attempt to reduce retirement benefits

I am [REDACTED] State of Alaska retiree. I am in constant fear of my retirement benefits being reduced or setup to be reduced in the future. I have read a little about this scheme to quietly reduce my retirement benefits and increase my costs. I live on a very small Alaska retirement check and some Social Security. In the last 10 years my Social Security "cost of living" increase has been next to nothing, ie 0.01%. My groceries, utilities, housing etc etc is constantly going up. Now it looks like your proposals to increase the deductibles and out-of-pocket limits are significantly be raised. Also moving the coverage to a non State of Alaska control is outrageous. I depend on my prescription coverage greatly, my medical secondary to Medicare and my dental coverage. PLEASE DO NOT DO THIS "MODIFICATION" (AKA reduction in coverage and increase costs). I have been told for over 30 years my benefits were protected by the State of Alaska Constitution. So how did your slick rich lawyers come up with this scheme? A guess we live in a time of shady dealings, dishonest promises, get out of contractual agreements. I am glad I am on my way out. Things are really getting rotten. So, bottom line, DONT DO THIS "MODIFICATION. WILLIAM BURGESS

**From:** Phil Bennett <[REDACTED]>  
**Sent:** Thursday, June 21, 2018 8:41 AM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** Sharon Hoffbeck <[REDACTED]>  
**Subject:** Rx Portion of Retiree Health Plan

No! No! No! Our plan continues to be chipped away at. Having a health care plan in retirement that was NOT Medicare was guaranteed and was a factor when committing to public service career. Now we have to pay for Medicare Part B - based on State statute. Enough, leave the Rx Plan as it is.

Philiciann (Phil) Bennett  
[REDACTED]

**From:** Wayne/Barbara Kinunen [REDACTED]  
**Sent:** Thursday, June 21, 2018 11:46 AM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Subject:** retiree pharmacy plan

As an Alaskan retired teacher, I am writing to protest the changes proposed to the **RPEA CHANGES IN the RETIREE PHARMACY PLAN.**

One of the benefits that we looked forward to in retirement and worked hard for, was the health plan we were promised at retirement. Please do not change it and sell us short. It appears that is what is proposed to take place this fall. This would be a significant change and diminishment from the current retiree pharmacy plan. We do NOT need this added stress as we try to enjoy our remaining lives during our senior years.

Please hear our concerns and do not make these changes to our plan.

Thank you,

Barbara Kinunen

[REDACTED]

**From:** Dot Wilson [REDACTED]  
**Sent:** Thursday, June 21, 2018 2:49 PM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** Sharon Hoffbeck [REDACTED]  
**Subject:** re Retiree Changes

Thank you for the opportunity to express my thoughts on the upcoming proposed changes in the Alaska Public Retiree's coverage in medical and pharmacy benefits. I am asking that you do not approve proposed changes to the current health benefit plan that will result in diminished Alaska retired employees insurance coverage. I am a Tier I employee and our health coverage is supposed to be 100%. Original contract said nothing about our medical and pharmaceutical coverage being allowed to change as years passed. I am [REDACTED] years old and our health insurance coverage is more important then ever.

With the current proposed changes to the plan including the possibility of having to be approved by Medicare Part D, or go through a 5 step appeal level before a prescription will be filled. There conceivably may be serious delay and perhaps untimely death while some government or health insurance paper analyst makes a health decision for us. If the doctor who knows the patient prescribes a certain drug, how can a person, who who does not know the patient and only has paperwork to review, make a decision to deny a Tier I employee coverage. A 5 step appeal process by its nature causes many delays. and should not be a part of our benefits package.

Also, we already pay for Medicare Part A & B. I do not believe we should be charged by a Third Party Health Administrator to pay for Medicare Part D. The Tier I employees were never told that health benefits would be transferred to the Federal Government. Even if the Federal Government decides we are in a "high income" level. that should have no effect on the Tier I coverage. I am requesting that you not require Medicare Part D coverage and that, if you do enable the TPA to use Medicare Part D, DRB pay for any costs directly rather than wait for elderly retirees to request reimbursement for a "surcharge." Surcharge was not in the original Tier I contract and many elderly may not understand the reimbursement process. If the State is going to pay a surcharge, do it up front.

Can you please reverse any changes you have made or will make to the original Tier I plan including optional dental and visual coverage.. Many of us who worked in the 70's are no longer physically able to return to work, which is the traditional way of paying for increases in living expenses, medical bills, and retirement. Most of us planned our retirement with assurances that health needs would not make us squander our savings. To diminish the Tier I benefits at this stage in our lives can be a significant loss of income or a significant loss of time required to receive proper medication.

We have already seen significant changes in our health coverage in the last several years. If you need to change the benefits for people that are currently not retired, and if they agree to them during negotiations, that is different than taking benefits away from Retired elderly employees.

Because my husband and I travel occasionally and illness doesn't always strike when we are in Alaska, it is important that my medical and diminished coverage not be diminished nor delayed because we are not in Juneau at the time we need care.

Sincerely,



Dorothy S. Wilson

-----Original Message-----

From: peter stern <[REDACTED]>

Sent: Thursday, June 21, 2018 4:26 PM

To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>

Cc: [REDACTED]

Subject: retiree medical and pharmacy "modernization"

Hello:

I have read over the proposed DB Retiree Health Modernization Plan Presentation dated May 2018. It reads more like the title should have been DB Retiree Health Diminishment Plan. The way the "Concerns" are laid out seem to be more issues the State has in administering the plan. If language needed to be clarified that could have easily been done rather than make big changes to coverage.

Forcing retirees into the EGWP program is DIMINISHMENT of coverage.

Medicare Part D may or may not be sustainable in the future based on projected fund amounts. The statement that it will be up to me to contact the state to request reimbursement for IRMAA Medicare part D adjusted higher premiums is ambiguous. It also likely will mean the reimbursement will be taxable and there will be no guarantee the state will honor that process in the future.

There is an attitude expressed that generic drugs are the answer to lowering drug costs. I'm not opposed to trying generic drugs but I have first hand experience with generic drug problems. Generic drugs in my experience sometimes work okay but often times don't work well. Generics are not tested by the FDA for efficacy. The binders used in the drugs can effect how well they work or don't work and that can vary based upon who made the drug. When a pharmacy changes suppliers problems can begin, I have first hand experience with that.

There seems to be a drive to force retirees into using in network pharmacies or to fill drugs via mail order. Penalizing retirees with higher sliding scale copays for brand named drugs is a diminished benefit issue. The higher copay for filling a brand name prescription locally versus by mail is discriminatory. DIMINISHMENT!.

The 5 step appeal process for waiving generic drug or non formulary drugs process is a BIG problem that can delay prescription changes.

Decisions about drugs belong between myself and my doctor. I don't want a pharmacy benefits manager in the middle of my medical decisions. This appeal process is designed to drag out filling prescriptions with the right drugs. It takes a full page of text to describe what my provider and I have to work through in using this process. ABSURD!!!!  
DIMINISHMENT!!!!

<https://www.medicare.gov/claims-and-appeals/file-an-appeal/prescription-plan/prescription-drug-coverage-appeals.html>

I support local pharmacies. I do not want to be forced into using mail order pharmacies. I want to be able to use safeway, fred meyer, walgreens, and costco. When I travel having access to national chains is important. I do not want drugs to be ordered and then subjected to freezing during winter delivery in my mail box. I have also had enough misdelivery problems with the USPS to be very concerned. USPS will show the parcel as delivered in tracking but in fact it was delivered to the wrong mail box.

The state is proposing increasing my out of pocket costs by raising the medical deductible. I'm already paying higher medicare premiums due to IRMAA and now prescription drug premiums will also be subject to IRMAA (with an ambiguous reimbursement system) and copays are being raised especially for those of us that need brand name drugs. It sounds like further limitations are being looked at to limit where and how prescriptions can be filled.

At this point in time there is no way to view the proposed formulary list to see what affect that may have. How the Part D "doughnut whole situation" will effect retirees is left to guessing.

These changes to the medical and drug plans are being "fast tracked" at the expense of the effect they will have on retirees. The state has done terrible job allowing for comment on these changes. The communication to retirees is just that change is coming, regardless of its' effect on us. Shame!

peter stern

**From:** DENNIS WATSON <[REDACTED]>  
**Sent:** Friday, June 22, 2018 12:43 PM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** [REDACTED]  
**Subject:** Change in benefits

My wife and I recently retired are in disagreement with the change in prescription benefits. As you have acknowledged publicly you agree the plan cannot be changed if there is a reduction in value. How you can possibly justify your mathematical calculations for equal value when a retiree must go back to their doctor, have them write a letter making a case for a brand name pharmaceutical does not impact the plan negatively.

Why would you think an out of network doctor will not increase the charges assessed the plan and potentially the retiree? What will the state do if the new changes increase beyond what you are currently paying on our behalf? Will you then reverse the plan? I suspect that has not been considered by DOA.

Since many of our legislators are over 65 and also covered by state insurance I will be contacting them as well. Please respond to the two questions I posed in the previous paragraph.

Sincerely,

Dennis Watson



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**From:** Sherilyn Johns <[REDACTED]>  
**Sent:** Saturday, June 23, 2018 3:49 AM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>;  
[REDACTED]  
**Subject:** Medical changes

One of the reasons we can survive on our limited retirement income is because of the wonderful medical benefits we were promised and have thus far received. Doubling the pharmacy out of pocket costs, doubling the deductible is going to be crippling. We try very hard to take care of ourselves and do not abuse the system in anyway. Outrageous medical costs are fueled by insurance companies willing to pay them and just charging their members more and more each year. Our incomes are not doubling. Please keep our promised benefits in tact and take the medical and pharmacy profession to task.

thank you  
sherilyn johns

**From:** Jerrold Fields [REDACTED]  
**Sent:** Saturday, June 23, 2018 3:19 PM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>; Sharon Hoffbeck <[REDACTED]>  
**Subject:** proposed changes to the retiree healthcare plan

SO WHAT CONTINGENCIES ARE BEING DISCUSSED TO PROTECT RETIREES IF DOA GOES TO THE MEDICARE PART D WRAP AND THEN THE FEDERAL GOVERNMENT MODIFIES, SUSPENDS, OR CANCELS THE PLAN? I FEAR THIS IS A DIMINISHMENT IN STAGES WHEREBY THERE WILL BE ONGOING ATTRITION OF OUR HEALTHCARE PLAN UNTIL OVERTIME IT WILL BE A SHELL OF WHAT IT WAS AND WHAT RETIREES WERE ASSURED BY THE SOA AND THE ALASKA CONSTITUTION. I THINK THE BENEFIT IMPROVEMENTS ARE FAR LESS BENEFICIAL THAN WHAT WILL BE DIMINISHED! ULTIMATELY, IT WILL COST MORE MONEY FOR RETIREES ESPECIALLY FOR PRESCRIPTIONS, WILL BE FAR MORE INTRUSIVE, AND CUMBERSOME IN APPEALING WHAT SEEMS A PLAN WROUGHT WITH PITFALLS THAT WILL REQUIRE APPEALS. IT WILL BE SEEMINGLY TOO FRUSTRATING WITH THE OUTCOME BEING A COMPROMISE IN HEALTHCARE INCLUDING AND ESPECIALLY PHARMACEUTICALS. PERSONALLY, I HAVE [REDACTED]. I TAKE A LOT OF LIFE SAVING MEDICATIONS AND HAVE FOR YEARS. THE THOUGHT THAT SOME THIRD PARTY NON-MEDICAL PERSON WILL INTERFERE WITH MY TREATMENT PLAN, WHICH HAS BEEN SUCCESSFUL FOR YEARS SCARES ME IMMENSELY. AS A RETIREE I LIVE ON A FIXED INCOME AND HAVE MEDICATIONS THAT COST A LOT EACH YEAR. I CANNOT AFFORD THESE EXPENSES. NOR CAN MY HEALTH AFFORD TO BE PUT IN A POSITION OF CHOOSING MEDICATIONS OR FOOD. THE PROPOSED CHANGES WREAK OF THIS POTENTIAL.

THANKS FOR HEARING MY CONCERNS.

JERROLD FIELDS

**From:** Brian Lynch <[REDACTED]>  
**Sent:** Sunday, June 24, 2018 9:39 AM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** [REDACTED]  
**Subject:**

As a retired State of Alaska (SOA) employee with 30 years service with the Department of Fish and Game I have serious concerns about the Division of Retirement and Benefits (DRB) recent proposals to change our retiree healthcare benefits.

It has come to my attention that beginning in approximately mid-November the Department of Administration will enroll all retirees who are 65 and older in a Medicare Part D pharmacy plan called an EGWP/wrap. It will be administered by a separate Pharmacy Benefits Manager (PBM). From my reading of this proposed change from the current AlaskaCare retiree plan, I consider these changes to be a diminishment of benefits prohibited under Article XII, Sect. 7 of the Alaska Constitution. The Alaska Supreme Court has already ruled specifically that retirees medical insurance benefits are part of the benefits protected by the Alaska Constitution and may not be diminished or impaired.

There are three points where I believe the proposed changes may constitute a diminishment of benefits:

1. I have significant concerns about the pre-authorization provisions. If a prescribed drug is denied, the denial must be appealed using a 5-step federal appeal process. This process appears to be significantly more cumbersome than our current process and take more unnecessary time to navigate. I'm also concerned that this process could result in the disruption of necessary medication therapy.
2. Step Therapy appears be a part of the Medicare Part D/EGWP plan. This would be a significant change and likely could be a diminishment from the current retiree pharmacy plan. Step Therapy requires that we may have to try other drugs that are less expensive and chosen by the PBM, other than the drugs our doctor prescribes, and if they do not work as needed you can then request the drug your doctor prescribed. This is a multi-step process that can potentially impact our course of care prescribed by our doctor. In my [REDACTED] has had side effects from drugs our doctor has prescribed. If she is taken off of existing medication it could very negatively impact her health. Under the current retiree plan, our health care is a decision between us and our doctors.
3. Co-pays for some drugs will increase.

In addition, I have significant concerns about that Medicare benefits may be cut via Congressional actions. If that were to be the case, we would likely lose benefits. How would this impact our benefits and has the State even considered this possibility?

While the DRB is required to undertake an equivalency analysis to establish the value between the changes which disadvantage retirees as a group and those that provide comparable offsetting advantages, I have serious concerns about the biases that may be inherent in such analyses. The proposed changes are obviously being considered in an attempt to cut costs. Therefore, if the analysis is predicated on cost savings, the analysis may be biased toward that end and minimize potential diminishments of current benefits. The bias may be unintentional, but present nonetheless. Any such analysis should be conducted by an independent entity with no potential for economic gain from any proposed changes.

In conclusion, the DRB's proposed changes appear to constitute a diminishment of benefits and, as such, may prompt another lawsuit. Given the track record on these sorts of suits, DRB needs to be extremely careful that these changes do not diminish our retirees health benefits.

Sincerely,

[Redacted Signature]



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-----Original Message-----

From: Larry Edwards [REDACTED] >

Sent: Sunday, June 24, 2018 8:22 PM

To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>

Cc: Sharon Hoffbeck <[REDACTED]>

Subject: Please oppose Medicare Part D forced-enrollment

Hello,

I am a State of Alaska retiree, [REDACTED] years old. I am writing to protest the plan by Department of Administration to force-enroll retirees over 65 years old in Medicare Part D.

Please do everything in your power to prevent this from happening.

Hoping for your support,

-- Larry

Larry Edwards

**From:** Lynda Giguere <[REDACTED]>  
**Sent:** Monday, June 25, 2018 8:49 AM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Subject:** Oppose proposed changes to retiree prescription drug plan

To whom it may concern,

I am writing to state my opposition and concern with the Alaska Division of Retirement and Benefits' proposal to change the retiree health care prescription drugs plan.

A few of the major changes are:

1. If a prescribed drug is denied, the denial must be appealed using a 5-step federal appeal process. This is ridiculous and will cause undue stress and time to rectify. Currently, if there is a denial, the Division of Retirement & Benefits can directly intervene with the Third-Party Administrator (currently Aetna), assuring the retiree pharmacy plan is not diminished.
2. My rates may go up with a surcharge and if the surcharge is not paid, I will be dropped from the Medicare Part D/EGWP plan and enrolled in an alternate pharmacy plan designed by the state pharmacy plan.
3. Co-pays for some drugs may increase.
4. My current benefits plan will be diminished.

It seems as though the state is constantly looking for ways to diminish our benefits, after retirement, which makes our futures uncertain.

Sincerely,  
Lynda Giguere  
Retiree

**From:** Priscilla Morse [REDACTED] >  
**Sent:** Monday, June 25, 2018 1:08 PM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Subject:** Re: Medicare Part D

I am an Alaska State Retiree and in the last 18 months I have had my first several medical crises of my lifetime. I would like to make three points for you to consider from my experience:

- 1) With all the prescriptions I have had filled, almost all (if not all) have been the generic equivalent, which I think is just fine. I feel strongly, however, that if a generic is not available, our insurance should pay for what the doctor prescribes. No one needs to go through bureaucratic struggles when they are ill, and when you are considering drugs for which there are no generic equivalents, chances are the illness is a severe one.
- 2) If co-pays go up it will seriously impact many of us. They put a dent in my budget every quarter as it is.
- 3) Once we all turn 65, we are forced to go on Medicare, and become 2nd class citizens because of the limitations on what Medicare will pay for services. Some doctors won't even take Medicare patients! And our insurance only has to pay the 20% of that limited allowance, thus saving money on seniors. Now they want to whittle down the pharmacy side of things? That was the part of the coverage I thought most beneficial.

Respectfully,  
Priscilla Morse

**From:** Barry Bracken [REDACTED]  
**Sent:** Monday, June 25, 2018 12:40 PM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** [REDACTED]  
**Subject:** Retiree pharmacy plan

## MEMORANDUM

**TO:** Retirement Health Plan Advisory Board  
**DATE:** June 25, 2018  
**FROM:** Barry and Kathleen Bracken  
[REDACTED]  
**Re:** Pharmacy coverage

We are Tier I retirees who are both Medicare eligible. It has come to our attention that the Department of Administration is planning to implement a change to the Retiree Health Plan pharmaceutical coverage, specifically converting our current TPA coverage to an EGWP/Wrap through a Pharmacy Benefits Manager. There has been no communication to retirees from the State regarding this proposed change. What we have seen of the proposed plan definitely represents a diminishment of benefits. We understand that this is illegal under the State of Alaska constitution, Article XII, Section 7, which states that retirement benefits "shall not be diminished or impaired".

These are among the specific reasons we are concerned that our pharmacy benefits would be diminished:

1. The five-step appeal process would be very burdensome, particularly for elderly retirees.
2. The step therapy provision in the proposed plan could be harmful if the correct medication is not administered as needed. The decision to prescribe the correct medication for a patient should lie with the patient's doctor who is aware of other medication taken and the specific condition being treated, not with a committee.
3. The additional co-pay is a diminishment of benefits to those retirees in higher income brackets even if there is a provision for reimbursement. That is because of the unequal treatment of retirees and the burden the reimbursement process would impose.
4. Copays for some drugs may increase, which constitutes a diminishment of coverage.

Again, we strongly oppose this proposal. Our current plan seems to be working just fine and it appears to us that the proposed plan would be burdensome at best and potentially dangerous to retirees at its worst.

Thank you for your consideration.

Sent from my iPad

Done

alaska.pages



This email is concerning the RETIREE HEALTH PAN CHANGES proposed by DRB.

I am a retiree, Kenneth E. Wooten, and my wife is also a retiree, Donna J. Wooten.

Since we are now on a fixed income, it would be a hardship for us to come up with double the amount for the **out-of-pocket of \$1600.00** of the deductible. Why double that? That amount seems way too high. We have paid into the program our entire working careers and now to have to be penalized when we need the health care benefits, seems discouraging and a hardship if we both have health issues. This could be devastating as our retirement income doesn't go up.

Also, **to limit the pharmacy to 90 day refill**, and exclude over the counter equivalent is NOT helpful. The over the counter equivalent is less expensive and should be covered. To limit to 90 day refill, DOES NOT meet the doctor's prescription of meds taken for a year for high blood pressure, or other meds that a person may be on for more than 90 days. This will also cause a hardship to those of us on meds for a year or more, not to mention affect our health.

These are our concerns concerning the proposed changes to the Retiree Medical Plan. We hope you will NOT make more of a hardship and consider not making these changes.

Thank you,

Kenneth E. Wooten  
Donna J. Wooten

(emailed to AlaskaRHPAB@ [alaska.gov](mailto:alaska.gov). July 3, 2018)

Auto Reply's began Monday 6/25 at 9:27pm.  
Format of retiree's e- mail is different. VRK

Please accept the attached comments protesting the proposed EGWP/wrap.

Joe Mehrkens

[REDACTED]

[REDACTED]

June 25, 2018

Joseph R. Mehrkens

[REDACTED]

Correspondence sent via Email

[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)

Natasha Pineda, MPH  
Deputy Health Official  
Alaska Department of Administration  
550 W 7<sup>th</sup> Ave.  
Anchorage, AK 99501

Dear Ms. Pineda,

As a retiree over 65 years of age, I'm contacting you to protest your plan to enroll us in a Medicare Part D pharmacy plan called an EGWP/wrap. I can assume you are striving to reduce health care costs – but I see significant losses in benefits which in-turn warrant an equivalency value analysis.

Most retirees are aware that their health benefits are protected by our State's Constitution. Moreover, a State Supreme Court ruling requires that proposed changes that may diminish or impair our existing benefits require a rigorous statistical analysis and public disclosure of the findings.

Consistent with the Constitutional protections and the Court's ruling, the Division of Retirement and Benefits needs to conduct an equivalency value analysis to establish the net value between the disadvantages to retirees as a whole and any offsetting new advantages. More important, the equivalency analysis is to be rigorous, statistically sound and based on real life experiences. This is not a trivial task and certainly applies to the proposed EGWP/wrap.

I understand the EGWP/wrap is a Medicare Part D pharmacy plan with additional pharmacy benefits (the wrap) which we are currently entitled to under AlaskaCare. However, several of these proposed changes are not explicit, transparent or clearly suggest diminished or impaired benefits. For example, the substitute federal benefits are not guaranteed to the same degree as in our State's Constitution and could be reduced through simple federal legislation. Also, there are no offsets to the opportunity costs due to delayed health care or the required use of ineffective drugs.

More specially, should a drug prescribed by my doctor but be denied under the proposed plan, my only recourse is to appeal through the 5-step federal process. In contrast, under the existing benefits the Division of Retirement & Benefits can directly intervene to assure that my pharmacy plan is not delayed/diminished. For equivalency value purposes, what is the real evidence that postponing a doctor prescribed drug over the average time to successfully complete the 5-step federal appeal process will not create greater health risks and/or increase the subsequent health care costs?

Likewise, the new Medicare Part D/EGWP plan requires step therapy. This means that I may have to try less expensive "alternative" drugs rather than take what is prescribed by my physician. If these "alternative" drugs do not work, or are less effective, my only recourse is to request the original drug after the damage is already done. Again, what is the statistical, actuarial evidence that a multi-step process will not impair the health of retirees as a group and lead to more costly future healthcare for all of us? And, what about the inevitable gray areas where the alternative drug is only partially effective (an imperfect substitute?)

Lastly, I'm financially positioned to incur the required monthly surcharges for the Medicare Part D premiums. However, if I do not pay, I understand I will be dropped from the Medicare Part D/EGWP plan and supposedly will be enrolled in an unspecified State pharmacy plan. Given the great uncertainty over this alternate plan and the potential for diminished benefits and/or increased costs (including co-pays), an equivalency value analysis is in order before any changes are implemented.

Thanks for the opportunity to comment on this vital element of my health and well-being. I look forward to the equivalency value analysis and further public disclosure.

Sincerely,

Joe Mehrkens  
Kathy Bracken

[REDACTED]

Helen Mehrkens

[REDACTED]



June 22, 2018

To: Retiree Health Plan Advisory Board

From: Jennifer Gleason Schmidt, RN

I am writing to express some serious concerns about the proposed change in the retiree pharmacy plan, which would enroll retirees who are 65 and over in a Medicare Part D plan. I understand the importance of controlling costs of drugs, but do not believe that this major change in the retirees' health care coverage is right, nor do I think it will benefit the health of the retirees. My comments are written from two perspectives; as a nurse for 45 years in Alaska, 27 years in public health, and as a patient with [REDACTED] which was diagnosed in 2017.

Any changes should simplify, not complicate, the prescription process for patients, providers, and pharmacies. Having made thousands of home visits to families and patients, I have seen piles of medical bills, EOBs and letters that rarely clarify the status of the patient's coverage on kitchen counters or bedside tables. This adds tremendous stress to people dealing with trauma or a chronic disease.

It is important to remember that this is a health plan for Retirees.....for older people. Perhaps half of our members are cognitively able to deal with these ongoing changes, but applications, appeals, and requests for reimbursement may be overlooked as the member's health status deteriorates. The additional monthly surcharge required from retirees in the "high income" category, was not in our contract, and could cause financial difficulty for some retirees. The fact that the coverage will be dropped if the retiree misses a surcharge payment could leave some of our most vulnerable members without coverage, and with surprise bills. Others may not apply for reimbursement of the surcharge, thereby paying more for their coverage.

In February of 2017, [REDACTED]. Fortunately, my health care provider and I were able to choose the most [REDACTED] and I have had the best possible outcome at each step of my treatment. Knowing how [REDACTED], I can't imagine what it would be like to have to go through step therapy (to see if something cheaper will work first) before actually getting the treatment that has been shown through studies to be the most effective. Also, imagine how long a five step federal appeal process might take, only to be decided by a judge who has never attended medical school.

The rate at which new pharmacological agents are being developed is really astounding. Since I entered treatment 15 months ago three studies have been published that have altered [REDACTED]. One reduced the time I needed to take a [REDACTED] from 12 to 4 months (a cost savings), and one approved the addition of another [REDACTED] for a year to reduce recurrence ([REDACTED] is also a cost savings). Specialized Oncologists have a hard time keeping up with the research, and national guidelines are revised every 6 months. The same could be said for cardiac medications, or psychiatric medications. What is a patient supposed to do if their physician's recommended treatment is not on Medicare or the EGWP/wrap list?

It seems that this is a HUGE change to Alaska's Retiree Pharmacy Plan, with too many unanswered questions that need to be answered before implementation. I would like the Department of Administration and the Retiree Health Plan Advisory board to see if other states have implemented a similar change and examine how well it has worked for retirees. It will be a real mess to implement this plan without an analysis of how it has worked elsewhere.

Also, Consumer Reports recently published a general cost comparison of the major pharmacy chains and local pharmacies, and there is a huge range of costs. I believe that members, given enough advanced notice, might better understand and adjust to a clearly outlined preferred provider pharmacy or pharmacies, as a first step in reducing costs.

Alaska's retirees didn't work all those years to retire and sit at home sorting through medical bills, filing appeals, or requesting reimbursement of money we will now need to pay up front to maintain

RECEIVED

JUN 11 2018

Div. of Ret. & Benefits

June 8, 2018

Bruce McKenna

[REDACTED]

Retiree Health Plan Advisory Board

Division of Retirement and Benefits

P.O. Box 110203, Attn: RHPAB

Juneau Alaska, 99814-02031

Dear Board Members;

I will make this as concise as possible. Upon retirement I was told that Medicare part D was not needed because the State insurance, secondary to Medicare, would cover our needs. I recently discovered that a gap exists in our coverage through the State of Alaska for Shingles shots. Please make an effort to close the gaps in coverage for this, other immunization shots, and whatever other gap exist between our coverage and Medicare part D.

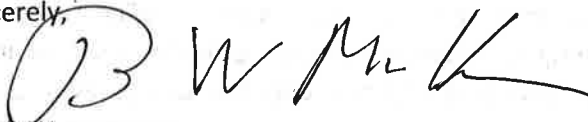
A proper plan would mimic part D Medicare coverage in all aspects not currently covered by the plan retirees are already paying for. To the credit of the State of Alaska, most needs are currently covered.

Another matter that requires attention is the Dental Plan. Time and tide, Inflation and soaring dental costs, have made our insurance all but obsolete save for the most minor of procedures.

I believe that the membership should be petitioned to see if we would be amenable to paying a higher monthly insurance rate for better coverage. I think canvassing for interest in a petition could be easily initiated through an article in the existing publication "Health Matters, Alaska Care".

Meanwhile...Welcome new board members. Keep us aging fossils going. I know you will do your best.

Sincerely,



Bruce W. McKenna

[REDACTED]

Cc: Ajay Desai,  
Michele Michaud

June 26, 2018

Sharon Hunter

Correspondence sent via Email

[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)

Natasha Pineda, MPH  
Deputy Health Official  
Alaska Department of Administration  
550 W 7<sup>th</sup> Ave.  
Anchorage, AK 99501

Dear Ms. Pineda,

I am contacting you to register in writing my protest to your plan to enroll Alaska state retirees in a Medicare Part D pharmacy plan called an EGWP/wrap. From the meager information I have seen this change will result in a significant loss in service level to us and has not been well examined or thought through. This plan lacks due diligence performed beforehand to meet the standard that our benefits may not be decreased without a change in our state constitution.

It greatly concerns me that my doctor's decision on the best therapy for me will be subjected to revisions requiring therapy meet a step approach and which would require a 5 step process to resolve ineffective treatment. I fail to see how that is arguably equal to our current level of service and have concern that the negative effects such delays can cause will negatively impact our health.

As a retired nurse I know how Medicare D plans do not work in our remote setting. I watched my patients treatments suffer from the delays caused by our local pharmacy being unable to fill prescriptions because in the real world there is no way they can have contracts with all the part D suppliers thus making patients deal with mail order pharmacies which incurs delays and also takes away support of our local economy.

Your plan to alter our current pharmacy benefit is not supported by the needed rigorous studies to ensure the services remain equal to what is currently offered and should not be implemented.

Sincerely,

Sharon Hunter

Cc Sharon Hoffbeck

Cc Representative Jonathon Kreiss-Tomkins  
Cc Senator Bert Stedman

June 26, 2018

My wife and I are covered by the retiree medical plan with Tier 1 benefits by virtue of her having initially taught in the Anchorage School District in 1970-1971 and then upon our return in 1975 until 2002. We both are covered by Medicare and over the years have had our difficulties with Aetna.

When my wife sustained a [REDACTED] it took me nearly six months to obtain a written commitment to coordinate benefits – with Alaska Cares becoming primary when the then Medicare physical therapy limit was reached. The surgeon called for a year of physical therapy, but when Medicare stopped paying, the therapist refused to deal with Aetna and terminated treatment despite the written undertaking.

We only recently became aware of the range of change which the State of Alaska is about to impose in our medical coverage and have not been informed by the State concerning the actual extent of changes, although it appears clear that the State has failed to follow the procedure mandated by the Supreme Court of the State of Alaska. Doing so would have provided an information base which would have afforded us means of evaluating the changes.

We are affected:

- A. As direct beneficiaries of the prescription drug plan; and
- B. As consumers of medical services through coordination of benefits and, where Medicare fails to provide coverage, by direct coverage under the State plan.

We fully appreciate the complexity of medical and prescription coverage, unlike some politicians, and have not had the time to fully develop an appreciation of the impending changes or the impact thereof. Information is difficult to obtain and explanations and justifications even scarcer.

It appears that the prescription co-pay is to double, which is a burden to us. This appears to be proposed despite the fact that if a Medicare Part D plan variant is imposed, there is a 50% reduction to the plan in the cost of brand name drugs. There is a clear detriment to us and a benefit to the Plan.

There also appears to be a requirement that a procedure of testing the efficacy of progressively more expensive drugs is imposed on members of the plan. My wife has a [REDACTED] for which she has already been through trials of different drugs before finding one which, while expensive, is effective for her. She should not be required to go through this again. It is stressful; and having been done, unnecessary.

The limitation to prescriptions for 90 days seems arbitrary and a burden on both plan members and physicians. Additionally, given the potential for significant seismic events, the condition of the Anchorage Port, and inability of emergency services to provide assistance for a minimum of a week according to the emergency plan of the Greater Anchorage Borough – which is probably unduly optimistic given FEMA's recent performance when operating outside CONUS – the limitation on stocking medication which is crucial to plan beneficiaries' lives is a very serious matter.

The speed with which the State has proceeded, with the RFP issued in January, 2018 and contract award during the third calendar quarter as per the state's posted timeline, given the failure to follow the Court's guidelines can only be greeted with suspicion. The State clearly cannot be trusted to comply with the guidelines and act in a transparent manner. The recent meeting of the Advisory Board and total absence of plan details simply reinforces this.

We have seen that the State appears to be willing to increase the benefit cap or to do away with the current \$1million cap entirely. This is likely to benefit a very small number of participants, if any.

Without an unbiased evaluation of the history of claims, projections of the number and ages of retirees with their benefit tiers, the change in the cap is an ephemeral benefit given the Medicare program in which we are required to enroll at age 65. It sounds good, but is unlikely to be a significant benefit and truly offset increased participant costs.

There is another aspect of this which causes concern. If the State intends to adopt a Plan D Employer Group Waiver Plan Wraparound, that plan must meet Federal requirements over which the State of Alaska has no control. The oversight of the Alaska Supreme Court will become far less effective because Federal changes may violate our rights under the State Constitution. The choice may be between chaos or continuation of a plan which violates our constitutional rights. This is not an idle concern; given the state of politics and constant attacks on the Affordable Care Act it is a risk that is probably greater than a great quake in the short run.

Every time a portion of our coverage is put out to bid, it is awarded to an entity which promises to save the State money. It has consistently meant a deterioration in service to the plan participants and increased cost in time or money, or both. This appears to be the most significant change we have experienced. We are far from optimistic, particularly due to the way this matter is being handled.

Peter J. Crosby  
With  
Carolyn J. Crosby

Areas of focus DRB/DOA identified for consideration:

A. Limited preventive care services: Add some preventive services.

Additional preventive services hopefully would be balanced by increased savings down the road, and we support this provision although exact information has not been provided. Flu shots are a good example.

B. Lifetime Limit of \$2M: remove or increase limit.

No limit would reduce the amounts available to benefit retirees as a whole while benefiting a few. Oppose.

C. Increase deductible and out-of-pocket maximums:

A deductible of \$300 per person could restrict someone from obtaining needed care. A low copay per medical visit would be more fair.

The \$1,600 out-of-pocket limit is too high.

Do not increased costs for medications necessary to control medical conditions.

D. Implement 3-tier pharmacy benefit, change out-of-network benefits:

The 3-tier pharmacy benefit is scary. More information needed.

E. , F., Limit pharmacy to 90 day refill, etc.: No comments

G. Enhance travel benefits: More information needed; probably beneficial for all.

H. Implement yearly service limits for various therapies: Agree reasonable limitations needed.

I. Exclude some dental implants: Disagree. Removing the implant provision from medical coverage would reduce retiree benefits and be unavailable to some retirees without dental coverage or funds to allow for this procedure to maintain their health. The dental plan probably does not have sufficient funds without raising rates.

J. High use of hi-tech imaging and testing: Review of prescribed imaging could be cumbersome and restrictive and hard to evaluate without more information.

K. Update retiree plan book: Absolutely.

#### OTHER:

The EGWP/WRAP proposal needs a lot more information including what the acronym stands for.

Dependent care. Do not extend dependent coverage to age 26 from the current 23 while enrolled in college. Another example of reducing retiree benefits where the funds are finite.

#### Lack of adequate notice on changes to AlaskaCare

On April 18, 2018 [REDACTED] was discharged from the Post Falls, Idaho hospital following [REDACTED] of the most painful surgeries, the day before. Post Falls is over 100 miles from our home in Montana. On the drive home we stopped in Sandpoint, Idaho to pick up a prescription for [REDACTED]. The pharmacy would fill his prescription for a ten day supply, but Aetna would not approve because approval had not been requested before the surgery. A new provision had been added to AlaskaCare on January 1, 2018 without notice to retirees except for an insert on the website. We receive and read Health Matters from AlaskaCare and PERS Newsbreak, but no mention was made there. Phoned complaints to Alaska R&B and Aetna provided no resolution other than to drive back to Post Falls, have the doctor submit a request to Aetna, if approved a new prescription could be written and taken back to Sandpoint. Obviously this was not possible. Eventually Aetna did send a letter by mail approving prescriptions for April 20 – May 20, too late to benefit [REDACTED], and refused reimbursement for the prescription filled on April 18.

Many retirees do not have access to the internet or use it frequently to see if benefits have changed without notice.

We look forward to receiving further information on the proposed AlaskaCare revisions.

(Jack & Elaine Vander Sande)

Prior to making changes to the retiree health plan, including the EGWP plan, please perform the required equivalency analysis to establish whether the changes which disadvantage retirees as a group are offset by additional advantages of comparable value.

sincerely,  
Greg Huebschen

Sent using [Zoho Mail](#)



Dear Advisory Board, Michele Michaud, and Leslie Ridle,

I have reviewed the proposed changes to the pharmacy benefits of the AlaskaCare Retiree Health Plan. I am concerned about the following:

#### **Concerning OTC.**

1. When you have been on a drug covered by your health plan at \$4 - 8 dollars and then it becomes OTC it is rare that the cost is lower. I am thinking specifically of some of the anti ulcer drugs. This proposed solution will affect thousands who rely on these OTC to treat their symptoms successfully, thus not costing the Plan more in medical dollars.

2. What happens if you are on a drug that changes to OTC but you need it in at a mg. higher than you can get OTC?

3. What happens in the case of “pharmacist” dispensed medications i.e. Plan B or morning after pill? Those not needing a physician’s prescription but pharmacists dispense.

#### **Concerning use of diagnostic and testing services**

1. Improvement in non invasive methods to diagnose and treat medical conditions is a natural progress of technology and should be embraced not limited and scrutinized, because the harm to the person is much less than invasive forms. If there is a need to minimize the frivolous use of the technology then address and define those conditions specifically and not in generalities open for interpretation.

2. There should be a tiered approach to in and out of network providers as you provide in other areas with reasonable and affordable levels of coverage. The Retiree should never be left without coverage in an area as vital and growing as diagnostic testing and imaging. This area is the core of a lot of treatment courses, and to abandon the Retiree because they go to a expert that might be “out of network” is counter to what the Health Advisory Board should be doing which is protecting and promoting a healthy retiree population.

3. **This point is a non-starter:** To require all Retirees to pay for a Medicare part D coverage is basically removing all retirees age 65 and older from the pool of “covered”. In order for the Retiree’s State Health Insurance to be secondary they have to sign up and pay for Medicare parts A & B. Then and only then will the State Health Benefits be able to be billed. But if the Federal and State pharmacy coverage are the same entity, where is the secondary coverage?

#### **Concerning Medicare Part D and Wrap Proposal**

I am over 65 and will be affected by the recently proposed EGWP/Wrap Pharmacy Plan. I will also be affected by the “high income” monthly surcharge. To require retirees to pay for a Medicare part D coverage and then have to REQUEST a refund of the premiums, and threatening us by saying if it isn’t paid “you will be dropped from the Medicare Part D/EGWP and enrolled in an alternate pharmacy plan that will not have the same benefits is blackmail. Not giving us the alternative plan is unconscionable and sneaky way to cheat retirees out of benefits. The State of Alaska is trying to wiggle out of providing retirees pharmaceutical benefits protected by the Constitution.

#### **Concerning Denial Process**

The denial process and Step Therapy is onerous, involving oppressively burdensome effort on behalf of the "elderly" and their physicians. This is a disadvantage and impediment to both the retiree and their physician who have already established or are in the process of establishing, personal medication treatments. A Pharmacy Benefit Manager is going to decide! Who is this person? Do they know what is best for the retiree better than their own physician? I think not. This is another way to try to bring costs down, focusing on the economics of treatment instead of the health and wellbeing of the retiree. A 5 (five) step appeal process? That is definitely another very burdensome piece of this poorly thought out proposal.

### **Concerning other Areas**

Because the EGWP is a federal program you state adopting it as the State Retiree Drug provider is not Constitutionally protected by the State of Alaska and could be modified, suspended, or cancelled by Medicare. This fact by itself puts retiree pharmacy benefits in danger of loss, harm or failure and thus diminishes the benefits and security we currently have under our pharmacy plan. I would think this would make these proposals illegal. These are attempts to change and chip away at the retiree benefits that were promised and protected by the State of Alaska Constitution.

I would also like to see the Health Advisory Board address adult immunizations. This is such a simple and cost effective PREVENTIVE measure which it has not addressed for the retiree and which could save millions of dollars. The only time a retiree can get a free flu or, pneumonia vaccine is at the few Health Fairs staged at large population centers, They are not available throughout the state at Public Health Centers which would be easier for many to go to. All prevention should be covered and there should be no pre-existing limitations or limitations on life time benefits.

I hope you take these items under serious consideration. Please always put a person's life and health before dollars. What coverage would you want?

Barbara Smith

June 27, 2018

TO: Retirement Health Plan Advisory Board

FROM: E.L. Young

Re: Pharmacy coverage

I am a Tier 1 retiree in Petersburg, AK. I understand the Department of Administration is planning to implement a unilateral change to the Retiree Health Plan pharmaceutical coverage that would convert the current TPA coverage to an EGWP/Wrap through a Pharmacy Benefits Manager. Retirees have not been notified by the State of Alaska regarding a proposed change.

The change represents a diminishment of benefits which are increasingly important to me as my wife and I get older. Under the State of Alaska Constitution, Article XII, Section 7, it states that retirement benefits "shall not be diminished or impaired".

Here are some specific reasons for my concern:

1. The five-step appeal process would be burdensome, particularly for elderly retirees.
2. The therapy provision in the proposed plan could allow an incorrect medication to be administered. The patient's doctor should have the final decision in all medication decisions. This is vital to the welfare of retirees. In many cases a substitute drug can have side-effects not experienced from the one prescribed by our doctor. In many cases a doctor has arrived at the drug prescribed through interaction with the patient and observing his/her reaction to a long-term use of a medication, i.e., blood pressure medications, heart medications. A committee cannot safely make changes to existing drug regimes.
3. The additional co-pay reduces benefits for those of us who are not lower-income, although there is a provision for reimbursement. Unequal treatment of retirees through the reimbursement process would be a burden. As I age, the filling out of forms becomes more difficult and frustrating.
4. Any increase in co-pay amounts would be a reduction in my coverage and one more cost of living increase that reduces my ability to survive on my fixed income.
5. Putting us under a Federal program increases our burden of contacting and dealing with agencies that are far removed from Alaska with a diminished understanding of what it means to live in remote communities with limited resources.
6. The change would tie us to changes in Federal regulations which are increasingly concerned with budgets rather than people. Our agreement was with Alaska, not the Federal government.

The proposed plan would be potentially burdensome, if not dangerous to the health needs and safety of retirees.

Thank you,

E.L. Young

[REDACTED]

[REDACTED]

Cc: Kreiss-Tompkins, Stedman, Governor Miller

To the R&B Board

I've carefully reviewed the changes to prescription medications you propose. If enacted, these changes may cause serious injury to my wife.

My wife suffers from [REDACTED], which presents symptoms similar to [REDACTED] and serious joint pain. She used the drug [REDACTED], successfully, for many years, until it began to affect her vision. She then tried three other biologics, none of which worked, and is now using [REDACTED], which is effective. [REDACTED] costs \$3,700.00 per month, \$44,400.00 per year; it keeps her active and mobile.

Your proposed changes could result in her being denied the drug she needs while she must try to find a cheaper alternative- been there, done that. The lengthy appeal process outlined could cause her to lead a vastly diminished lifestyle, for years, in order for the state to save money.

I signed a contract with the State of Alaska when I joined the Troopers. The state is now trying to deny my contractual rights and benefits, which the courts have already denied. The state cannot plead poverty, again according to the courts, since the state has the right to tax to meet its obligations...

I respectfully request that the state honor the contracts we agreed to, and spare my wife the suffering she WILL experience if these changes are implemented.

Respectfully

Jeffrey J. Hall  
Alaska State Troopers (ret.)

I just received notice of the proposed Plan Booklet for September, 2018. I have a concern though that is not addressed in the new proposed Plan Booklet. The card received in the mail stated **"Retirees should not have to look in more than one place to find what the plan covers"**.

**In reviewing the Retired Public Employees of Alaska (RPEA) website I noted a proposed change that I had not been made aware of through the State - The Employee Group Waiver Program (EGWP) proposed for January, 2019.** I am hoping that this has been set aside as a proposal by the State. **Based on the statement above this in fact would be a secondary place to find what the plan covers.**

**The DOA Retiree Health Plan Advisory Board EGWP presentation in May, 2018 stated the Program objectives were to improve financial efficiency of retiree program while preserving overall benefit value and minimizing member impact.** I have always felt blessed at the simplicity of the cost for generic versus brand for drugs. Currently, if you signed up for Medicare part D you could not go back to the State plan. **However, the EGWP is sponsored by Medicare part D and the State is prepared to waiver from the current policy for "payments of federal subsidies to Alaska Care".** "The savings from the EGWP can be reflected in the current year liability . . . , helping the State fulfill its promise to provide benefits to our AlaskaCare retirees".

**This is a plan to put the burden of the drug and other medical costs on the backs of those 65 and older.** You go to bed one day at 64 and the next day you wake up at 65 and find out that the drug you took the day before and for many years is no longer covered. **This is blatant age discrimination** putting those 65 and older in a sub group under the Alaska Care.

The Centers of Medicaid and Medicare Services (CMS) would have a list of drugs that require pre-authorization. **"You may have to get a pre-authorization for drugs where it was not previously required, or drugs that have already been pre-authorized through Aetna.** You can start the pre-authorization in process in December or the first time you fill a prescription in 2019". Since this list is not available it is impossible to check to see if a drug you are taking would be involved. "If a prescription drug is denied, CMS has a mandatory 5-level appeal process that must be followed". **What are you supposed to take during the 5-level appeal process especially on a previously approved drug.** Not all drugs work the same, example my [REDACTED]. The generic brand has an adhesive that does not [REDACTED] and thereby stays with the brand. What good is the drug if it does not stay on - truly a waste of money.

**"CMS requires that you be given the opportunity to opt-out of EGWP. However, retirees that opt-out of EGWP will be placed in a prescription drug program that is much different than the plan prescription drug benefits offered today.** This alternative plan **may result in increased out-of-pocket expenses** for you or your eligible dependents". **I did not appreciate the threatening language that if you don't do as we say you will have something less than you have today. This would be a obvious reduction in benefits as a sub group.**

May I hear from you concerning my issues and statements presented above at your earliest possible opportunity?

Thank You,

Beverly Marquart

I have been reviewing information that the State of Alaska Division of Retirement and Benefits planned changes to my health and pharmaceutical plan and at this point am unable to determine if these changes will create a hardship for me or my husband. I do know that in the decision on the Duncan case that the State is required to do a comparison of the planned changes to benefits vs. what we currently receive. It appears to me that this comparison has not been done therefore I don't see how any change can be implemented until completed and retirees have the opportunity to see these results side by side. Please let me know when you plan to conduct this comparison and where retirees will be able to access the information.

Thank you.

Margaret Duggan

Sent from my iPad

I have been advised of potential changes to the pharmacy benefits for retired state employees. I have a condition that requires [REDACTED] that would not be covered by pharmacy if this benefit had to be covered through Medicare part D. As a result I would then have to obtain this medication through infusions which would swing it into the medical benefits category. I would then have to travel 2 hours to an [REDACTED] center.

As you know these are benefits that were paid for and should not be restricted or infringed upon. I strongly urge the decision be made to leave the benefits as they are without further restriction. Dental and vision have been changed already, during a process that came after many claims were not fully honored and settlements were brought to bear. Such meddling in paid for entitlements will only continue in court cases to stop the depletion of paid for benefits.

Dale & Lynn Stone, retired 2010



**From:** Michaud, Michele M (DOA)  
**Sent:** Thursday, June 28, 2018 7:31 AM  
**To:** Kitchen, Vanessa R (DOA) <[vanessa.kitchen@alaska.gov](mailto:vanessa.kitchen@alaska.gov)>  
**Cc:** Ricci, Emily K (DOA) <[emily.ricci@alaska.gov](mailto:emily.ricci@alaska.gov)>  
**Subject:** FW: diminishment of retiree benefits

FYI

**From:** Ronald Johnson <[REDACTED]>  
**Sent:** Wednesday, June 27, 2018 5:34 PM  
**To:** Michaud, Michele M (DOA) <[michele.michaud@alaska.gov](mailto:michele.michaud@alaska.gov)>; Ridle, Leslie D (DOA) <[leslie.ridle@alaska.gov](mailto:leslie.ridle@alaska.gov)>  
**Cc:** Sharon Hoffbeck <[REDACTED]>; Carol Johnson <[REDACTED]>; Monte Lynn Jordan <[REDACTED]>; brothers <[REDACTED]>; Rep. Scott Kawasaki <[Rep.Scott.Kawasaki@akleg.gov](mailto:Rep.Scott.Kawasaki@akleg.gov)>; Rep. Adam Wool <[rep.adam.wool@akleg.gov](mailto:rep.adam.wool@akleg.gov)>; Sen. Pete Kelly <[Sen.Pete.Kelly@akleg.gov](mailto:Sen.Pete.Kelly@akleg.gov)>; Bishop, Click (LEG) <[senator.click.bishop@akleg.gov](mailto:senator.click.bishop@akleg.gov)>  
**Subject:** diminishment of retiree benefits

**I'm so disappointed that you are attempting to reduce retiree health benefits. What are you thinking?**

**The Alaska Constitution (Art. XII, Section 7) expressly protects the earned and vested retirement benefits of Alaska public employees from being diminished or impaired.**

One of my medications, for example comes as [REDACTED] per month. I surely hope you are not going to penalize me for not having it mail ordered [REDACTED].

The process now works very well. Are you now trying to increase paperwork for both you and the retirees by forcing us to enroll in medicare part D plans?

Now there will be money and time going towards litigation on your and our parts instead of keeping it simple.

I urge you to not adopt these proposed changes.

--

Ron Johnson  
Professor Emeritus

[REDACTED]

[REDACTED]



Virus-free. [www.avast.com](http://www.avast.com)

I am very concerned about the proposal to reduce the benefits of PERS retirees' Medical Benefits by enrolling retirees in Medicare Part D. Our medical benefits are supposed to be guaranteed by the Alaska Constitution to not diminish and there are several issues with Medicare Part D in regards to pharmacy distribution. I also do not trust Medicare to continue their services as the system is increasingly overloaded.

Please reconsider this notion and continue to serve your retirees as promised.

Thank you,

Barbara Sandberg

Natasha Pineda, MPH  
Deputy Health Official  
Alaska Department of Administration  
Anchorage, Alaska

June 30, 2018

Dear Ms. Pineda,

I am writing concerning the major change in pharmacy coverage for those of us who are AlaskaCare retirees over 65. The proposed changes to the pharmacy benefit are a significant and detrimental change to our current coverage. Particularly, the federal appeal process is a cumbersome, time consuming and potentially dangerous reduction in coverage. As a registered nurse, I understand that this is a change that can be detrimental to efficient and high quality health care.

Our level of benefit is constitutionally protected. I urge you to avoid a costly court battle over this issue, and maintain our current plan.

Sincerely,

Marlene Cushing

Both I and my husband, Gary Mowry, are State of Alaska retirees, and are concerned about the proposed changes to the pharmacy plan. Trying to make any coverage more efficient and less expensive is understandable and desired. That said, we are concerned that the EGWP/wrap will not be an improvement for us. Especially with the current president's administration wanting to dismantle Medicare benefits. This new federal program would not be protected as is the current plan.

We agree with the points made by Brad Owens in his May 8, 2018 mailing.

\_ We are especially concerned with "5 step federal appeal process." This would be bureaucracy to the nth degree! The bigger problem is that the delay this would involve might prove literally lethal to the person who is having difficulty getting the correct medication.

In addition, if the person/patient difficulty performing administrative tasks (sight, hearing, dementia, language) it would require a guardian assigned to assist.

If there is a problem with certain medical providers inappropriately prescribing medications, why not have a group of doctors review and agree on a medication. The patient should not have to change drugs or administer any appeal while this is going on.

- We are also concerned with the monthly surcharge PROCESS. (Not a monthly surcharge for high income retirees.) Even though we don't fall into that financial category now, the potential for loss of coverage for basically not knowing what's happening is ridiculous.

- Any changes to our coverage should be thoroughly researched and determined to be fair, equal, and of no diminishment to our current coverage.

Dorothy "Diane" Mowry

[REDACTED]

and

Gary L. Mowry

To whom it may concern,

I appreciate the opportunity to submit the following responses to the proposed changes to the Retiree Pharmacy Plan.

Step Therapy:

I have no concern when a generic version of my prescribed medication is issued to me as done under all of our prior insurance carriers. However, I am very concerned when my insurance company would replace my prescribed medication just because it is less expensive. Too many times you hear of replacement drugs issued simply because “Big Pharma” wants to push their product. How is it possible that Medicare Part D’s provider can possibly consider every individual’s issues better than a patient’s own doctor. Additionally, if the replacement drug does not work, how can it be determined that it does not work and after how long to even know? Then what – use the 5-step Federal appeal process as noted below? After all that, what additional and potentially deadly health issues can arise as a result?

5-step Federal appeal process:

I have experienced the 5-step AETNA appeal process concerning a blood test that was previously covered under the health coverage prior to AETNA. This was a nightmare that took well over a year and ended with no reversal of denial. I do not hold out any hope that the Federal process will be any better. In fact, it will most likely be considerably worse due to their volume.

Additional monthly surcharge:

How does Medicare Part D determined “high income”? How would the insured individual know that they owe the additional monthly surcharge?

If owed, would it automatically be deducted from Social Security as is done with Medicare?

Additional overall concern:

How secure is Medicare when everyday you hear of the program being decimated by the Federal Government?

Sincerely,

Linda Deakins

As a [REDACTED] year old SOA Retiree, I must strongly protest the planned illegal diminishment of our retiree medical benefits, specifically the proposed change in the pharmacy plan. Our medical benefits are protected under the Alaska Constitution. This attempt to erode our benefits is illegal, and it would seriously harm those of us who gave years and years of service to the State of Alaska. Many of us are now facing serious health issues as we age. In my case, I have [REDACTED] and related health issues. I depend on the health benefits I am entitled to by the Constitution of Alaska.

Rebecca Eames

I am very concerned that the proposed drug coverage by Medicare part D may significantly decrease retiree coverage. Specifically the so called donut hole under Medicare could drastically increase drug expenses for retirees who require large amounts of drugs or expensive specific drugs for treatment. Replacing the very efficient present drug coverage with Medicare looks to be a significant decrease in coverage.

I encourage you to rethink this proposed change.

Lawrence Johnson

RPEA member

Sent from my iPhone

The plan to move the over-65 retiree pharmacy benefit to Medicare Part D will have a direct impact on my husband and myself. As the plan currently exists the pharmacy benefit is very easy to use and straightforward. It is a plan administered by the state of Alaska and does not involve the complications of an additional layer of bureaucracy. Further, if the changes are made the plan will be in the hands of the federal government and who knows what that will mean in the future. The paperwork is easy and effortless with the current benefit and it will surely become much more complex and difficult to understand with the proposed changes. Right now we can call Aetna directly if we have changes and a person is always available to take care of my concerns. There is no guarantee, and in fact is is most uncertain, that this will continue under federal administration. This is particularly concerning with all the budget cuts already in place and proposed across the board in the federal government.

Finally, there is no guarantee that the specific medications we need will be approved under Medicare Part D. Those are decisions that must be made between our physician and ourselves. We do not want our prescription drug decisions made by an anonymous third party with no knowledge of our situation and only with some formulaic procedure to determine the lowest cost option.

There is most definitely a serious impact to each retiree under the proposed changes. It can be measured in quality of care, time and actual costs. We have some level of control and input to our benefit at this time and that will be gone forever with the proposed changes. To hand over this benefit to the ever changing whims of a federal bureaucracy is irresponsible. Keep the benefit in its current form.

Sincerely,  
Jeanne Camille Gordinier  
Alaska Retiree



Dear Retiree Health Plan Advisory Board,

I strongly object to the implementation of any planned changes in the Retirees Pharmacy Plan that does not comply with the Alaska Supreme Court's RPEA v. Duncan. In particular, the changes must adhere to the following.

- A) The analysis must be based on reliable evidence, such as solid, statistical data drawn from actual experience-including accepted actuarial sources—rather than by unsupported hypothetical projections.
- B) Equivalent value must be proven by comparison of the actual benefits provided to those that are proposed in the changes.
- C) Where any individual shows that a proposed change results in a serious hardship that is not offset by comparable advantages, that affected individual must be allowed to retain existing coverage.

Please inform me when A) and B) have been completed and provide the results of those analyses.

I am particularly concerned about provisions that clearly reduce current benefits:

- 1) Restrictions on pharmacy compounding. This will affect my spouse, as the only medication addressing her medical condition is [REDACTED] and the only alternative is expensive and risky surgery.
- 2) Pharmacy substitution of doctor judgment on prescriptions, requiring lower cost medications (which may or may not be as effective) to be used prior to medications recommended by physicians. This could affect me directly, as lower-cost medications were not effective in addressing my medical condition.

I believe that there are no provisions in the proposed Retiree Pharmacy Plan that prove that new actual benefits are equivalent to the current actual benefits.

Thank you,

Brian Rogers

*Dr. Rosie Roberts*



TO: Retiree Health Plan Advisory Board

FROM: Rosie Roberts  
Member, AlaskaCare Retiree Health Plan

**SUBJECT: IRREPRABLE HARM UNDER PROPOSED PHARMACY BENEFITS**

DATE: July 4, 2018

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I am writing to you today to strenuously object to the proposed changes to the pharmacy benefits proposed by the Alaska Division of Retirement and Benefits. As I am covered by 2 health/pharmacy insurance policies, I believe my past pharmacy experience places me in a unique position to charge that irreparable harm will be suffered by Alaska retirees if a Medicare D program is adopted by the State. Let me explain.

My primary health care/prescription plan is with AETNA. My secondary health care/pharmacy plan is [REDACTED], which changed to a Medicare D plan several years ago. Under Medicare regulations, if a person is covered by 2 pharmacy plans, the Medicare D plan takes precedence over a non-Medicare D plan. Therefore, for pharmacy benefits, I am required to use the Medicare D plan as my primary pharmacy plan, followed by AETNA.

Since being switched to a Medicare D pharmacy plan I have on several occasions been refused medications prescribed by my primary care physician. In all cases, the medications that I have been utilizing for years were abruptly changed under the Medicare D plan to medications that proved ineffective, as well as one Medicare D over-ride of my primary care physician caused a serious regression in my health. I did utilize the appeals process in the aforementioned situation, which was a multi-step process where numerous bureaucrats decided my medical fate rather than my own primary care physician. My doctor was overruled by a number of non-medical administrators.

If the State of Alaska chooses to convert to a Medicare D pharmacy plan, I will suffer irreparable harm as I already have at the hands of unskilled, untrained, unlicensed bureaucrats who choose to ignore the medical plans of my skilled, trained, licensed primary care physician who has evidence as to what I need to maintain my health.

Under law, I know that AlaskaCare benefits cannot be diminished. I also know the Alaska Supreme Court ruled that the Division of Retirement and Benefits may make changes in the Plan benefits for retirees if no Plan beneficiaries will suffer any serious hardship or harm as a result of a loss of a particular benefit, and as long as new benefits are added that fairly compensate for any benefit that is reduced or eliminated. **Please clearly understand that I have lived under a Medicare D plan for enough years to know that there are no new**

**benefits that can be added for such a plan change that will fairly compensate Alaska retirees who will be thrust under a pharmacy plan that has already proven to be harmful to my personal health.** In this case, an injury to one will be an injury to all.

Changing the AlaskaCare pharmacy plan to Medicare D will not, in my mind, meet the requirements of the Supreme Court decision as I have heard of no “new benefits” that are being proposed to compensate AlaskaCare retirees for the replacement of our own doctors. I strenuous argue against this proposed change.

Retiree Health Plan Advisory Board,

I am a former State employee who gave 23 years of his working career to the State of Alaska instead of working for better pay in Industry. I accepted the pay decrease because my monthly state compensation package included retirement benefits which were to provide me and my family with health care in our retirement years. Although, at the time, there were many mis-conceptions about what we would actually receive as retirees; like thinking we would get continued state health care or a plan that was close. Instead, we got Medicare being primary and the state health care picking up 20% of what was left after Medicare paid its negotiated rate ( $\$100 \times 0.8$  doctor write off =  $\$20 \times 0.8 = \$16$  (medicare payment) leaving \$4 for the state to pay ....peanuts) (20%) We actually believed that the retiree health care was something we earn and was guaranteed. Instead, the retirees are faced with another attempt by the state or their third part administrator to degrade the quality of medical care at a time when many need it most.

Now, the state is considering defaulting prescription care to Medicare Part D. If that was considered an acceptable option by retirees, many would have already taken it or be using it as a supplement. Instead we were told we did not need to sign up for Part D and our retiree plan was much better and gave us good prescription care. How can the state think that Part D, with its restrictions on what prescriptions a person can get irregardless of the fact that their doctor prescribed that medicine for a specific reason, is acceptable. I have had to fight with Aetna several times over what prescription medicines I needed, why I didn't want a generic or why their delivery service would not meet my needs and I required an extra 1 month prescription to make sure I had my BP meds. Now you want to force us to go with a prescription service that may want us to give up the meds that are working well for us and have for several years. This is wrong!

As a retired state employee and former Union chapter chair I have seen benefit creep before. It is unfair to offer your employees something in their compensation package and then change it later. If our leaders were held financially liable for the lies and deceit they made in negotiating past contracts with their employees, none of this would happen. Remember, things taken away from current retirees are just the beginning of losses for current state employees in the future. Do unto others as you would want to have happen to you when you retire and are living on a fixed income.

( Gerald & Cathy (Guay?) )

July 9, 2018

Commissioner Leslie Ridle  
Department of Administration  
550 W. 7<sup>th</sup> Ave., Ste 1900  
Anchorage, AK 99501

and

Judy Salo, Board Chair  
Retiree Health Plan Advisory Board  
c/o Division of Retirement and Benefits  
AlaskaRHPAB@alaska.gov

**Request for Analysis of the EGWP under *Duncan* prior to beginning retiree enrollment and implementation.**

Dear Commissioner Ridle and Advisory Board Members:

Based on the materials and information presented by DOA during the RHPAP meeting on May 8, RPEA understands the State proposes to implement an Employer Group Waiver Program (EGWP) as a new method to provide subsidies to the State of Alaska retiree health trusts for qualifying prescription drug costs. It proposes to change the current RDS program for the EGWP beginning in November when it will start to enroll retirees receiving or eligible to receive Medicare.

RPEA understands the State is motivated to make this change because it believes an EGWP will generate approximately \$20 million per year in savings to the health plan through additional federal subsidies, which would be reflected in the annual liability calculation for Other Post-Employment Benefits (OPEB). This change would reduce the State's need to use General Funds to make up its unfunded liability to fulfill its promise to provide health benefits to AlaskaCare retirees. Beyond this, however, the information provided by DOA for implementation of the EGWP plan fails to provide sufficient information about how this proposed change will actually impact and affect the retirees. Information provided thus far by DOA offers primarily unsupported claims, little reliable data and no analysis of any potential adverse effects.

In the slide presentation, DRB claims that an EGWP would have "minimal impact" on the members and little change to the benefits under the existing plan. The State has confirmed it is on course to begin the move to an EGWP plan in November, just a few short months from today, yet the State has not conducted or disclosed any appropriate analysis of the changes under the EGWP as required by the *Duncan* decision.

Because DOA has informed several retirees that some erroneous and confusing information has been provided about the EGWP, RPEA requests that DOA provide as

much specific information about this proposed change as possible, in order to clarify and better inform retirees about what actual impacts are expected and all data upon which DOA relies to claim these changes are not a detriment.

RPEA recognizes the *Duncan* decision allows the State to modify the AlaskaCare retiree health care plan. However, if any proposed changes involve the restriction, reduction or elimination of currently provided benefits, *Duncan* requires offsetting advantages of equivalent value. The only way to determine whether proposed changes to the current plan meet this legal standard is to conduct the appropriate analysis utilizing reliable, experience-based data. The mere assertion that changing to the EGWP would have only a “minimal impact” is putting the cart before the horse. It is impossible to know what impact EGWP will have without conducting this analysis. Even a minimal impact—if it restricts, reduces or eliminates current benefits—must be measured against offsetting advantages. That is the constitutional requirement defined by the Alaska Supreme Court.

RPEA believes *Duncan* requires the State to not only perform an appropriate analysis of the detrimental impact resulting from the changes and offsetting advantages, that decision requires adequate prior notice and explanation of these changes by the DOA to retirees and beneficiaries before any implementation. Retirees must be given sufficient prior notice and the opportunity to obtain accurate specific information about the changes in order to determine if any proposed changes will result in hardship so that they can notify DOA and have an adequate opportunity to claim substantial hardship.

The State’s materials and public comments about an EGWP demonstrate more than “minimal” changes in several areas. To change to an EGWP plan, AlaskaCare, through a vendor, would have to contract with the Centers for Medicaid and Medicare Services (CMS) to serve as a Medicare Part D Plan Sponsor and manage compliance with CMS regulations. That signals several major changes to the current plan.

The demographics of the membership of the AlaskaCare retiree plan are paramount to keep in mind. Many members are elderly, living on limited income, and some have limited education or disabilities. First, AlaskaCare retiree members eligible for Medicare would be enrolled into the EGWP prescription drug benefits by DOA beginning in November. The plan would then be subject to CMS regulations, resulting in retirees receiving a number of mandatory EGWP mailings, which may be inapplicable and often very confusing to them. Second, CMS has a list of drugs that require pre-authorization of new and reauthorization of anything already authorized under the current plan, none of which is required by the AlaskaCare plan. This is restrictive as it requires providers to respond to these authorization requests, over which members have no control. Third, and, most notably, if a prescription drug is denied, CMS has a mandatory 5-level appeal process. This includes redetermination from the plan, a review by an Independent Review Organization, a hearing before an Administrative Law Judge, a review by the Medicare Appeals Council, and a Judicial review by a federal district court. This imposes a far more confusing, complex, lengthy and onerous process, especially for medications. Medications are generally needed immediately. Pharmacies do not advance medication pending appeal in the same way that medical services are often advanced to the patient with the medical provider bearing the cost of awaiting the appeal determination. Fourth, this new appeal process denies retirees

their statutory and Constitutionally protected right under Alaska law to appeal any determination with which they disagree to OAH and then to the Alaska Superior Court. Fifth, certain high-income retirees will have to pay an extra surcharge. Although DOA claims these payments will be reimbursed, a retiree still must have the amount in their account to pay up front and the inability to do so results in automatic opt-out of the EGWP. This is a change that amounts to a significant reduction to the current plan. Finally, EGWP requires a change in the formulary and imposes step-therapy, as well as requires use of generic drugs even when a physician has prescribed a different drug based on medical necessity.

Once again, if RPEA's understanding of EGWP as described above is incorrect, it requests DOA to provide as much specific information as possible to help clarify any misunderstanding and to allow retirees to better understand the program. RPEA also requests all of the data DOA has that shows the actual impact a change to EGWP will have on retirees and their dependents.

These changes highlighted above are not exhaustive but are descriptive of the apparent detrimental impacts under EGWP. At a minimum, they show the legacy retiree plan would in fact change if the State imposes the EGWP. In that instance, despite any internal assessment of the degree of change by DOA, the impact of any change must be measured through an appropriate *Duncan* equivalency analysis.

Consequently, the Retired Public Employees of Alaska is requesting, formally and unequivocally, that the State complete an appropriate analysis under *Duncan* prior to enrolling any retiree in an EGWP plan.

RPEA requests DOA to respond in writing to this request by **not later than July 23, 2018**. Given the known changes to the AlaskaCare Plan that moving to an EGWP plan poses, the State should agree to perform an appropriate *Duncan* analysis and withhold any enrollments or implementation until that analysis is completed and the results, including disclosure of all the data utilized for the analysis, is provided to all retirees. DOA is also responsible to hold informational meetings throughout Alaska to clarify and answer any questions retirees or beneficiaries have about the proposed changes and/or the analysis. This will allow any retiree who believes he/she will be adversely impacted by any of the changes an adequate opportunity to claim and establish serious hardship under the *Duncan* case. All of this must be completed prior to the implementation of the EGWP.

RPEA will consider any failure by DOA to respond by July 23, 2018, as a denial of this request and will act accordingly.

Sincerely,

*Brad Owens*

Bradley D. Owens  
Exec. V. President

To Whom it May Concern:

I am truly concerned about the change in Pharmacy Benefits being proposed for retirees.

I retired in 2015 from teaching. I also turned [REDACTED] and went on medicare that year. Just retiring and going on medicare I have seen my medical benefits change for the worst. My doctor of 20 years does not accept medicare (I don't blame her when I see what they pay) and therefore have had to pay out of pocket to continue having her as my doctor. Fortunately at this time I am healthy and can continue seeing her for my annual visits.

Back to the pharmacy benefits. I have taken two [REDACTED] drugs since 1998. From what I have read about Part D in Medicare, they would not cover the [REDACTED] drugs until I had experimented with all the generic drugs considered similar to what I am currently using. Then they could deem whether they are medically necessary or not for me. The idea of Medicare having more say over the drug I take than the doctor that is prescribing it is troubling in the least. I already have to deal with Aetna every 3 months when I get the prescriptions renewed as they don't want to pay for them either. None of this was an issue until I retired.

I am healthy and cost the plan very little. I pay more in monthly premiums and medicare than I incur in medical costs. After years of having such good medical coverage, it is sad to retire, be on a fixed income, and have to pay more for medical even when you are healthy.

Sincerely,

Patricia Gallego



Dear Retiree Health Plan Advisory Board and others concerned:

I am a State of Alaska retiree and have been for over 20 years. Since I took early retirement, I went through the transition that transferred my primary coverage to Medicare at age 65+. That transition was not easy, and...I was a lot younger! The thought of having to adjust to yet another transition to the medicare system for prescription drugs is not a pleasant one.

There will be more paperwork and often the need to pay some costs up front and then fight through up to five levels of appeal, to get the benefits to which I am entitled. I am still of sound mind and capable of dealing with the additional administrative burden, but many retirees are not! However, despite my being able to cope with the additional administrative burdens, there will be a cost to me in terms of time expended and in explaining the new system to pharmacies. I see no provision for reimbursing me for that time. Some retirees will have to pay others to do that work for them. Therefore, those costs should be computed in your balancing of new benefits vs reductions in current services.

We are, after all, retirees. While the State may save some funds in pursuing this new approach, there will be costs in making a transition to it. Meanwhile, we retirees will be dying off, which will also save the State money. I wonder if a proper analysis has been done as to whether the transition costs might be higher than predicted?

I'm sure the Division of Retirement and Benefits has not done a proper study of the costs to each retiree in coping with the proposed system. When my spouse (also an Alaska State retiree) transferred to Medicare, I estimate that we spent a minimum of 40 hours of time with various providers sorting out that she had to change her primary coverage provider for medical services, requesting re-billing, etc., etc.

The State needs to do a much more thorough analysis of this proposed plan for prescription drugs before proceeding with implementation. I urge you to postpone such a momentous decision until a proper analysis has been done.

Sincerely,

Charles Northrip  
Retiree: University of Alaska and State of Alaska

I am a retired educator currently receiving benefits under the Alaska Care Retiree Plan (Aetna) I continue to be concerned about the changes that are proposed in our plan. Specifically, I am concerned about the Medicare Part D pharmacy plan called an EGWP/wrap. First, if my medication is denied, I would be required to use a 5-step federal appeal process. The health-care process in place is already difficult, complicated, and confusing. We do not need more confusion. If you are asking the elderly, who may be chronically or terminally ill, to comply with such processes, they highly likely will not be able to comply. Second, Step Therapy would require the person go through a period of time, perhaps with no medication, until they sort out what medication they will even be able to use under their benefits. Doctors need to know this up front, so they can advise their patients competently. This could be devastating, even resulting in either more medical needs or even death of the patient. Third, additional monthly surcharges for premiums for higher income retirees, while you say you will reimburse them if they contact the state, will, again, make the process for those retirees more cumbersome and difficult; they may be unable to follow-through due to illness or brain deficits. Depending upon their health-care needs, they may or may not have immediate access to the money needed. These proposals are hardly elderly friendly; and may be discriminatory. In addition, excluding dental implants from the medical plan and covering it under the dental plan exclusively will seriously negatively impact our dental plan, which is already at a maximum of \$2000/year. My request would be for the State to host a series of meetings and invite the retirees to attend, so they can not only understand completely what you are proposing and why but also give you input regarding how we may be individually and collectively impacted specifically, so you are able to make meaningful and informed decisions. While I appreciate costs are increasing and your need to address the issue, the answer is not to penalize our elderly but, instead, to look at health-care systematically and create a better system that works for everyone. Barbara Pastorino

to: Alaska RHPAB

Dear Sirs and Madams,

I am writing to oppose any changes to the Pharmacy coverage from AETNA to MEDICARE PART D for enrollees in Alaska state retirement health coverage.

I am diagnosed with [REDACTED]. I have three different [REDACTED] for my condition. They said that I would be on this medication for the rest of my life.

I recently refilled this medication. It cost [REDACTED] for a ninety-day prescription. I cannot afford any changes to my current coverage! A financial crisis and hardship would occur for me, as well as my long-term prognosis for my condition and for my life.

**Do NOT make changes to my coverage!**

AETNA Mail Order has been a reliable and friendly supplier for my medical needs. Stay the course, no changes!

***ALASKAN RETIREES DESERVE BETTER!!!***

Sincerely,

Richard P. Greene

FW TEC III (RETIRED)

Ketchikan, Alaska

On May 30, we received notification that the Department of Administration is planning major changes to the Retiree Pharmacy plan and that effective January 1, 2019, retirees will be enrolled in a Medicare Part D Pharmacy Plan.

HOW IRONIC THAT JUST DAYS LATER THE FOLLOWING ARTICLE APPEARS IN THE NEWSPAPER:

**Trustees report Medicare will become insolvent in 2026**

Medicare's financial problems have gotten worse, and Social Security's can't be ignored forever, the Government said Tuesday in an annual assessment that amounts to a sobering checkup on programs vital to the middle class.

The report from program trustees says Medicare will become insolvent in 2026 - three years earlier than previously forecast. Its giant trust fund for inpatient care won't be able to cover projected medical bills starting at that point.

Guess my question is? "Where would that put Alaska Retirees enrolled in Medicare Part D?????"

Martin and Sandra Nusbaum

**To The Retiree Health Plan Advisory Board:**

**This message is in regard to the proposed changes for medical and pharmacy plan coverage for Alaska Retiree health benefits. I have been a lifetime member of RPEA since 2001 and have lived and worked in Alaska (in PERS) from 1973-1991. I have based my retirement, investment and financial planning (which includes staying in Alaska as I age IF I CAN AFFORD IT) based on the constitutionally guaranteed health insurance benefits I was promised as a Tier I employee and now a retiree. Alaska is an expensive place to live and health care options are limited, often requiring travel outside, compared to the Lower 48. Even though I "retired" in 2001 I continue to work full time in the private sector so that I can afford to live in Juneau and perhaps fully retire one day. To have health care benefits diminished, in any way, severely effects my quality of life, the ability to EVER retire and/or live out my days in Alaska. I am particularly concerned about the Medicare Part D pharmacy plan (Employer Group Waiver Plans/wrap) in addition to other plans which will reduce our current benefits. This is not right. After doing my research here's what I now know:**

Beginning in approximately mid-November Department of Administration will enroll all retirees who are 65 and older in a Medicare Part D pharmacy plan called an EGWP/wrap. It will be administered by a separate Pharmacy Benefits Manager (PBM). DOA is in the process of reviewing bids in response to the Request for Bids that was put out earlier this year.

Medicare Part D is a commercial pharmacy plan, approved by Medicare but not managed by Medicare. What DOA is implementing is called an EGWP/wrap, which is a Medicare Part D pharmacy plan with a 'wrap' that is intended to supplement the Medicare Part D drug plan with the additional pharmacy benefits that the AlaskaCare retiree plan currently includes.

A few of the major changes are:

1. If a prescribed drug is denied, the denial must be appealed using a 5-step federal appeal process. Currently, if there is a denial, the Division of Retirement & Benefits can directly intervene with the Third-Party Administrator (currently Aetna), assuring the retiree pharmacy plan is not diminished.
2. Step Therapy appears be a part of the Medicare Part D/EGWP plan. This would be a significant change and diminishment from the current retiree pharmacy plan. Step Therapy requires that you may have to try other drugs that are less expensive and chosen by the PBM, other than the drugs your doctor prescribes, and if they do not work as needed you can then request the drug your doctor prescribed. This is a multi-step process that can potentially impact your course of care prescribed by your doctor. Under the current retiree plan, your course of care is a decision between you and your doctor.

3. The regular monthly Medicare Part D premium will be paid from the medical trust for all retirees. For those in a ‘high income’ category set by the federal government (currently \$85,000 single or \$170,000 married), there will be an additional monthly surcharge that currently ranges from approximately \$35.00--\$75.00. This surcharge must be paid by the retiree and will be reimbursed by the state at a later date. The state will not be notified if you are in the high-income category, and you must contact them to activate the reimbursement process. If the surcharge is not paid, you will be dropped from the Medicare Part D/EGWP plan and enrolled in an alternate pharmacy plan designed by the state that will not have the same benefits as the current pharmacy plan. The details of this alternate pharmacy plan have not yet been disclosed by DOA.

On May 9, 2018, **RPEA filed a lawsuit a second lawsuit against the State of Alaska Department of Administration, Division of Retirement & Benefits (DRB), alleging that it has illegally diminished major medical insurance benefits as well as benefits available under the optional Dental/Vision/Audio (DVA) insurance that is available at the time of retirement.** This lawsuit asserts that DRB has diminished and impaired those benefits in violation of the express promise made in Article XII, Section 7 of the Alaska Constitution that retirement benefits “shall not be diminished or impaired”.

This lawsuit primarily concerns the changes that DRB imposed in recent years to our medical benefits. RPEA contends in part that DRB improperly delegated its duties as Plan Administrator to Aetna and Moda Health, the companies that the state hired in 2014 to be the third-party administrators (TPAs) to manage the retiree health plans.

In making those changes, DRB has allowed Aetna and Moda Health to impose their own internal clinical and payment policies in place of the policies and plan coverage that had been regularly applied under the retiree health plans prior to 2014. As many of you know, the result has been that benefits have been significantly diminished and impaired in violation of the Alaska Constitution.

**There has NOT been enough analysis or time given to truly and fairly gather appropriate, clear and adequate information to consider making these changes. I fully support these law suits brought by RPEA and plan to contribute more money to help with the legal battle on behalf of State of Alaska retiree health benefits. I have devoted hours pouring through information and sharing with my friends and family members, near and far, who will be affected by these changes. PLEASE TAKE A STEP BACK AND GIVE THOSE AFFECTED TIME TO RESPOND.**

**Sincerely,**

**Mary L. DeSmet**



My name is Michael C. Childs and my wife's name is Diann Ericson. We each worked for eight years for the Northwest Arctic Borough School District—1990—1998. A big incentive to remain at jobs so far from our home in Montana was the promise of a superior health care plan included in our retirement package. Now we've read of the proposed changes to the plan we were promised and we are not happy with those changes. Here's why.

1. We do not wish to spend our last years filling out federal forms and filling appeals to the federal government. Our present system, thankfully, lacks all the red tape and delay incumbent with the federal rules and regulations.
2. The Alaska State Constitution guarantees that our health care plan cannot be reduced or impaired, but by turning us over to a different health care system (Medicare Part D/EGWP), a system that may reduce our benefits, our health care may be diminished. This seems unfair. This seems like 'bait and switch' and a far cry from the treatment we expect after devoting many of our working years to the benefit of Alaska children in a harsh and challenging environment.
3. The clinic we now go to here in Missoula Montana routinely prescribes generic alternatives to the drugs we need. The clinic's name is [REDACTED] and you are welcome to check their policies. We do not take advantage of our present healthcare plan. We live eighty miles from the clinic and do not run to town with every runny nose. We exercise regularly, take our vitamins, and avoid risky activities like rock climbing, motocross, or ski racing. In other words we are sensible people.
4. My wife and I have already been hampered by the Windfall Elimination provision that has reduced our social security. We do not need additional reductions to our retirements benefits.
5. We feel discriminated against because of our age (we are now both over 70) and no one else under 65 is having their health care plan tinkered with.
6. Since the federal government and Medicare or Medicaid is always changing and can alter at any time without recourse, the promises made under the Alaska State Constitution to Alaska retirees can be ignored in a heartbeat.
7. I want my doctor to decide my course of care and any drugs required to keep me healthy. I do not trust the federal government to do it for him.
8. I do not think you can prove the proposed changed to our health care plan will not diminish our health care and that is a violation the Alaska Constitution. Are you factoring the potential costs of litigation into your proposed savings gained by cutting our benefits?

Please do not implement this change as proposed in 2019. We are on a fixed income now and believe me, we are sensitive to rising costs. We conserve energy. We hunt for bargains at the grocery store, the clothing store, and the hardware store. We harvest deer and elk to supplement our protein source. And, as I said before, we exercise for hours each day to keep healthcare costs down. If we can be more efficient in our fight against inflation, I hope you can too. But please to not saddle us with more health care costs and dealing with the federal government. For ourselves and our fellow retirees—we deserve better.

Sincerely,

Michael C. Childs and Diann Ericson (please count this letter as two letters of protest since we are both in agreement on this issue. Thanks.)



i just received a card from AlaskaCare i re to the draft for the new benefit booklet. I went to the pharmacy benefit section in the 2018 booklet and it is the same a always. no where does it say that at age 65 you get moved to a medicare type plan. the card from AlaskaCare says this draft does not add, remove or change any plan benefits.

i am quite concerned how you can treat seniors this way. You cannot guarantee what the copays would be. I have seen when checking out this new plan that some copays re as much as 25%. Can you guarantee that will not happen to us?

most of us are on fixed income and calculate our budget which takes in to consideration drug costs, etc.

To me, this new proposal is a discrimination again st seniors. Please reconsider this and leave the health benefits alone.

Excuse any typing error as I have [REDACTED].

Thank you

Evelyn Korhonen

Natasha Pineda, MPH,

This email is being sent to protest the changes in the Retiree Pharmacy Plan.

The five step federal appeal process is unacceptable for a prescribed drug denial.

An increase in copay for drugs is unacceptable.

I am concerned that the Medicare Part D administration will follow the changes allowed by DRB to Aetna and Moda Health in imposing their own internal clinical and payment policies instead of retaining our current benefits.

This would cause undue hardship for retirees requiring medications to maintain their health.

Limiting pharmacy to 90 day refill is a problem. I have served missions out of the country and in the past been able to take my thyroid medication to cover the entire length of my mission.

I am also concerned with the Retiree Health Plan Changes Proposed by DRB specifically the increase in deductible and out-of-pocket maximums.

As a retiree I am on a fixed income and I grow older my need for care unfortunately increases and this increase would cause a hardship financially.

Limiting chiropractic, physical therapy and massage therapy or hired specialized vendor is also unacceptable. These treatments are used by retirees in place of pain medication to give them pain relief without drugs.

Changes to our retiree medical coverage should not be made without input from the retirees covered by the plan.

Sincerely,.

Mary Ann Arseneau

cc: Sharon Hoffbeck

Dear colleagues,

I am writing to express my concerns over the AlaskaCare retiree plan moving to an EGWP. Specifically, it has been a rude awakening as I approach my 65<sup>th</sup> trip around the sun to learn that I have to pay an extra premium to Medicare because I continue to be employed and am considered by Medicare to be a “high-income” beneficiary. Under EGWP, I will be similarly penalized for a benefit for which I now experience no premium. I am the single breadwinner in my household; my husband is retired from federal service, and his pension is modest, certainly not enough for us to live on should I eventually elect to retire. Instead, I remain fully- employed and engaged in my career, now in the non-profit sector. I am far from “high income” by Alaska standards.

I realize that the EGWP has the potential to save AlaskaCare money, money that could potentially be directed toward other benefits, but at the same time I wonder how many other AlaskaCare retirees are in the same position as I, being penalized for continuing to be engaged and employed, as are a great many people of our generation. Please do the math on how many members would be so adversely impacted before making this decision.

Thank you for your consideration,

Mitzi C Barker, FAICP  
Director, Planning & Construction Division  
Rural Alaska Community Action Program



Do not remove or diminish a single benefit we get for prescriptions. If it's not broken, don't mess with it.

-----  
Paula Cadiente

Attached please find the comments of my husband David Pelto and myself. We are retired teachers who have lived in Alaska almost all of our lives. We are very disappointed not only in the proposal for modernization of our retiree health care plan but also in the lack of information provided for us to use in making educated and informed comments on the proposal.

Judith Anderegg and David Pelto



RHPAB final 716  
pdf.pdf

TO: Alaska Retiree Health Plan Advisory Board

**NOTE ON EMAIL RECEIVED TODAY ON ALASKACARE:** *We have just received our first email from DOA/DRB about the healthcare plan. It had a lot of information. This should have been happening all along - not now right before DOA/DRB decides to modernize the plan. That being said we are sending comments written earlier today before receipt of the email, which did NOT allay our concerns.*

We are concerned about the approach being taken by DOA/DRB in revising/modernizing our health care plan including but not limited to:

1. the lack of transparency both by the department and in the documents produced by DOA/DRB
2. the lack of sharing information related to - cost savings versus added expenses of additions and deletions to our plans
3. confusion of putting through major changes to the pharmaceutical plan in June/July and then on top of those, as yet adopted changes proposing additional changes in the pharmaceutical portion of the modernization plan as a whole
4. The lack of contact, outreach, and education to retirees about what all these changes mean

There is a clear lack of transparency, not just in the department moving forward with the modernization effort but also with the document laying out proposed changes. On some items, we actually do not understand what DOA is giving or taking away from the plan. In addition, we are commenting on changes without full knowledge of all the facts. DOA can not diminish retiree benefits without adding benefits, but without costs of each item - it is difficult to comment on what is an equitable or fair exchange. Retirees were informed by RPEA - **NOT** DOA/DRB, last month of changes being proposed to the pharmaceutical section of the retiree health plan. This modernization effort, which retirees also heard about through RPEA includes yet more changes to the pharmaceutical plan. It is very difficult to comment on changes to a section of the plan which is in a state of flux at the present time. Our last comment relates to the lack of adequate outreach to retirees on a constitutionally protected benefit by DOA/DRB. We object to such shoddy treatment by the State of Alaska which we served for many years.

Let us repeat the beginning of Judith's letter last month regarding changes to movement to an EGWP for pharmaceutical benefits. We are STILL not satisfied by the materials from DOA/DRB or from the presentation made by DRB to the Retiree Health Plan Advisory Board, on the EGWP and change to a federal plan. DOA/DRB has not made a convincing case that it is taking care to ensure that our constitutionally protected benefits are going to be intact when (IF.....) the EGWP, the federal plan, is adopted and then at some future dates is diminished, shut down or reduced.

Now we will comment on the 12 items that were listed in the Modernization presentation done for the Retiree Health Advisory Board.

1. Limited preventive care services. - we do favor additional preventive services  
Without added cost, it is difficult to rank the importance of this item.
2. Lifetime limit - we favor removing or increasing the limits of cost of lifetime coverage.  
Again, without added cost, it is difficult to rank the importance of this item.
3. Low cost share reduces sensitivity to price and increases unnecessary services - we agree with this in theory to help retirees take responsibility for services which they use.  
Again, without cost savings it is difficult to rank the importance of this item.

4. Increasing costs of pharmacy benefits

5. Outdated pharmacy design

6. Safety and efficacy of drugs

Because DOA/DRB has proposed a set of changes to pharmaceutical system that is not yet in place, it is difficult, if not impossible, to comment on yet more changes to pharmaceutical system.

Again, without cost savings it is difficult to rank the importance of this item

7. Limited Travel Benefits - This one is difficult to understand and should be dealt with in parts.

Non-emergency procedures taken out of state should have travel covered by retiree, but perhaps some of the other parts of this benefit change should be looked at for emergency/life saving versus non-emergency. .

Again, without cost savings it is difficult to rank the importance of this item.

8. Confusion over Rehabilitative Services - This one should be rewritten. It is not clear in what it is proposing to diminish.

20 visits per year - is that 20 all told for all therapies or 20 per therapy?

Limitation of 45 visits - Is that lifetime? Is that for all therapies or 45 per therapy?

An example of confusion - What about physical therapy for different needs - knee versus back?

Is that 20 each or 20 for both?

In addition to clarification of what is meant - there is the issue of cost savings by this proposed diminishment.

Again, without cost savings it is difficult to rank the importance of this item.

9. Confusion of Dental Implants. In theory, we agree with this one in terms of delineating what is in the medical plan and what is in the dental plan.

Again, without cost savings it is difficult to rank the importance of this item.

10. High use of high-tech imaging and testing. While we agree in theory on this diminishment or realignment of our health care benefits, we would need more specifics on this one - particularly:

Bullet 1 - what is the additional level? Who is going to do the scrutinizing as to what is and is not acceptable?

Bullet 3 - Does this solution mean as secondary payer the plan will or won't cover retiree's expenses not met by primary (ie Medicare?)

Again, without cost savings it is difficult to rank the importance of this item.

11. Dependent Coverage Limits This sounds like something that is simply a statutory change that is not so much up to whether we as retirees think this should or should not happen.

Again, without cost savings, it is difficult to rank the importance of this item.

12. Confusing plan booklet Not only does DOA/DRB need to do a better job of clarifying where the booklet is and how to find information it should do the job - of informing retirees **IN A TIMELY MANNER**.

**CORRECTION NOTE:** This afternoon (7/16/18) we received our **FIRST** email from DOA/DRB about any of these proposed changes.

Looking at the comments on each of the 12 delineated concerns up for change, all but 3 look to be diminishment of service rather than enhancements. We assume that is because of cost savings versus actual cost of changes. If the costs of each item are not shared and DOA/DRB is not transparent, then how can comment be made in an educated fashion as to what changes are appropriate?

As retirees, we are very disappointed to be treated this shabbily by our home state of more than 50 years. Retiree health care is constitutionally covered. We should be kept in the loop as to any and all changes.

Judith Anderegg and David Pelto

Don't change our pharmaceutical benefits for those of us over 65 !! Please !!

I am not seeing the benefits to our retirees over 65 on new changes to our pharmaceutical benefits.

(Sharon Merrick – added VRK)

(Two separate e-mails came in back to back – put on one sheet. VRK)



but you may notice some small administrative changes like the list of **medications requiring preauthorization may change**

What is this? I have never had to get preauthorization for any medications. I received a letter from your offices stating there were no such restrictions after Aetna tried to stop paying for [REDACTED].

I would really like the payment of vaccinations especially for Shingles to be approved. Preventive medicine is always cheaper than paying for treatment of the disease.

Thank you for the opportunity to share my concerns.  
Janet Downing

Greetings,

ref your below email, the list of changes below are excellent. It's been very frustrating to receive notices from our administrator and others, regarding how valid and important preventive care is, and yet have our plan reject that coverage. It's also frustrating to see nationally recognized priorities rejected as not applicable to our plan, i.e. life time limits.

With the high cost of health care it has often seemed like the primary solution has been to limit coverage, and the default position is seems frequently to declare service is not medically necessary.

I was very nervous to see an email regarding changes to our help plan, however, the list below is encouraging, and I completely agree the list reflects important priorities.

I also appreciate the health fairs our plan participates in each Fall, and I make every effort to take advantages of those services.

Thank you for you work on these issues.

Sincerely,

Greg Tanner

It's a scam!!! I need [REDACTED] that I know Medicare will not cover. I will have to appeal losing months of good health. At this age who knows if I will recover without a costly hospital visit or surgery. I have taken the [REDACTED] that Medicare pays for. They no longer work. What am I do do? Just suffer with the bureaucracy I guess. You don't care about my health. You are bean counters.

In addition, I will have to pay additional premiums for the pharmacy benefit. I pay \$625/3 months for Medicare which means I make too much \$\$\$\$. Why? Because I have saved and invested. I sold property in 2017 which was reflected on my 2018 taxes. My income for that year is exceptionally high because of this sale. Now you want to base my pharmacy coverage on 2018 tax return. So I will have to pay more. Unfair!!! And against the constitution.

You have no legal right to make all these changes. No input was made by us. The employee retirement group has repeatedly asked for comparisons which you refuse to provide. You want to balance the state budget on our backs. The legislative branch needs to fund our pension benefits.

We have given 20+yrs of our lives for Alaskan children. And now you repay us with terrible benefits. You can't fool me. You are heartless. You only care about budgets. Disgusting.

Sent from my iPhone  
(Carol Boquard)

The following thoughts are offered after reading the July 2018 AlaskaCare Retiree Health Plan newsletter and after efforts to understand information provided regarding DOA's efforts to "modernize" the retiree health benefits. I appreciate getting information and being asked for input.

It seems as though the decision for a new vendor to manage pharmacy benefits and the decision to transition Medicare-eligible retirees to EGWP are final. I have worked for many years with multiple medical doctors to identify a diagnosis and medications that allow me to function "normally" on a daily basis. I have watched with dismay since 2014 when the State/insurance administrator has tried to bar insurance coverage for certain prescriptions. I can't help but wonder if, even though the prescriptions are currently covered, they will be denied with a new vendor or in the EGWP. I will be hoping that the mentioned "small administrative changes" will not disrupt the medical well-being I have finally achieved. I am Medicare eligible and, as stated in the newsletter, will be enrolled in the EGWP. The newsletter states "the benefits for all AlaskaCare retirees, . . . will remain the same with very few exceptions." Again, I hope the unnamed exceptions aren't going to surprise me with a denial of coverage. Should that happen, I would feel like my daily well-being was overlooked or sacrificed to save state dollars or to provide "enhanced benefits" for someone else.

The newsletter also informs that making the stated changes to the pharmacy benefit gives AlaskaCare more resources to consider offering important benefits such as travel benefits and removing some lifetime maximums. Without the benefit of any data, one could say that both of these "enhanced benefits" might actually benefit a small number of retirees. Many retirees don't have to travel for healthcare and maybe only 10% or less of insured retirees reach the cap each year. Many retirees will not actually receive any benefit from these changes.

The newsletter didn't mention that the Division is also considering changes to two other features of the current retiree medical and pharmacy benefits. In stark contrast to possibly increasing some benefits that will impact a small portion of retirees, the proposal to increase deductibles for both the medical

and pharmacy coverage and changes to prescription benefits and charges will most likely take money from the pockets of all but the most healthy retirees.

Again, without any data, we know increased deductibles will impact all retirees that have any medical or pharmacy costs throughout the benefit year. Although some retirees may not need any prescriptions, it is quite likely, considering the group's demographics, that a majority of retirees will have prescription needs and will be impacted by increased prescription costs. It's also likely that retirees that have established medications will want to continue with the same. Based on past experience, I am one of the retirees on established medication routines that will very likely be impacted by efforts to only provide coverage for the "lower cost" or "safer" alternatives instead of medications the doctor and retiree have found to be effective without harmful side effects.

If DOA is asking the majority to take a hit to help the few who might have expensive needs at some time, it should say so. However, former state employees worked for and paid for a known insurance plan. As retirees we have not been given any guidance on what might be required to meet the "substantial harm" standard. The state seems to be relying on one's inability to meet the standard and hoping to prevail with its version of "modernizing" the insurance plan, without the majority of retirees seeing where the scales are weighing greater benefit-to the State or to retirees. I acknowledge the Division's responsibility to address fiscal issues. However, moving Medicare eligible employees to EGWP may provide sufficient savings without additional program changes. Retirees have not been given an opportunity to comment on whether they would prefer foregoing "modernization" or enhanced benefits with the associated costs identified. Nor have retirees been provided with data that could inform such a decision. Maybe DOA doesn't have, and therefore cannot provide, specific costs and data that support its proposals.

Has the DOA considered keeping current retirees insured as outlined for 2019 and crafting its modernized health plan for future retirees, similar to the tiered employee system? If that route was taken, current retirees would have the health plan they thought they were getting and future retirees would know in advance what health insurance they would be receiving.

Thanks for taking the time to consider the above.

Ann Wilde  
Retired July 2017

I feel strongly negative to the proposed increases in the deductible and out of pocket limit.

It appears that the proposed increases in the deductible and out of pocket limit reflect the perspective of people whose current wages greatly exceed the income of the older retirees whose retirement income is based on wages back in 1970's and 80's. The requirement that retirees carry Medicare part B already saddles us with about \$1200 per year premiums, so the combination of Medicare premiums plus AlaskaCare deductible, out of pocket and copays add up to a sizeable proportion of our retirement income.

The proposed additional assessment placed on all retirees essentially penalizes all retirees in order to help defray the high medical costs of the more costly retirees. In many respects, it appears comparable to assessing an insurance premium on our medical benefits.

Thankyou for your consideration,

David Burbank

July 18, 2018

Division of Retirement and Benefits  
And  
Retiree Health Plan Advisory Board  
PO Box 110203, Juneau, AK  
99811-0203.  
[AlaskaRHPAB@alaska.gov](mailto:AlaskaRHPAB@alaska.gov).

Dear Administrators and RHPAB Board Members:

I recently became aware of changes being proposed to my State of Alaska (SOA) Retiree prescription drug benefit by enrolling me in a Medicare Part D plan called an Employer Group Waiver Plan (EGWP). I have the following comments on this proposal.

In general, I am skeptical about Medicare Part D and would prefer not to have anything to do with it. The current State of Alaska prescription drug plan for retirees works well for me. Transferring to a Medicare Part D plan further subjects my health care to the political turmoil involved in health care at the federal level. This is particularly concerning, because the current CMS administrator has demonstrated repeatedly that she wants to shift costs from Medicare and Medicaid onto the individuals covered by these plans.

I have reviewed the presentation included in the packet dated May 5, 2018 and it does not answer all my questions. In particular, regarding reimbursements to high earners, it provides no details on how this reimbursement is to be accomplished. To get more information, I called the Division of Retirement and Benefits. I was told that, at the present time, the intention is to establish a Health Reimbursement Arrangement (HRA) and deposit funds into it that are equal to the extra premiums that high earners have to pay under EGWP. In my case, I am unlikely to be able to use the amounts deposited in my HRA, and I do not believe that I will be able to recover unused funds. This means that my premiums for prescription drugs will be increased under the EGWP and I will be offered a benefit I cannot use in full measure to the extra premium cost to me. This imposes a cost to me that I currently do not have to pay. I am opposed to this option.



However, a direct monthly reimbursement to me in the amount of the extra premiums that I am assessed under EGWP would be acceptable. I understand there may be a federal tax liability to doing this. If there is a way to provide direct reimbursement without incurring this new tax penalty, I would much prefer this. Regardless, I am requesting that direct reimbursement for high earner premiums be added as another option. This way, if people would benefit from a HRA, they may choose that option. Alternatively, those that prefer a direct dollar for dollar reimbursement would be provided that option.

In closing, I want to emphasize that this proposed change is momentous and I do not believe that the materials provided to beneficiaries like myself have been adequate to answer all the questions this change poses. Therefore, I think more information needs to be provided on the impacts, because clearly there are going to be impacts, despite the assurances in your document that the impacts will be minimal. In addition to printed materials, I believe that before a change of this magnitude is undertaken, public hearings should be held across the state. At these meetings, public officials will be expected to make presentations and answer questions from those in attendance. This will enable those affected to better assess if this change is in their interest.

Thank you.

Sincerely,

Geron Bruce

Medicare offers a number of preventative services. R&B could piggy back on these so that Medicare covers the bulk of the costs.

(Gary Miller – added by Vanessa)

I have written a letter and mailed to you via USPS. Please read it and DO SOMETHING.  
PLEASE.

I have been a member for several years and have paid my dues and have not asked for anything until now. Stop this legalize reduction in my retirement benefits that I was promised when I left my career in California to provide my much needed services in Alaska government (Dept of Natural Resources, Dept of Administration). William Burgess



Email 7-19-18.pdf

William L. Burgess




July 19, 2018

Ref:Where Are You On Benefits Changes

Alaska AFSCME Retiree Chapter 52  
2601 Denali Street  
Anchorage, AK 99503

Dear Sir/Madam,

I have been a member of AFSCME for several years . I have never asked for anything yet pay my dues.

Where is AFSCME now?? The State of Alaska is "Modernzing" my Medical Benefits.

RPEA is the only one that is protecting retirees. JOIN IN THE FIGHT.

They are removing benefits that probably 90% of the retirees use and replacing benefits that maybe only 10% retiree use and call this 'NOT DIMINISHING BENEFITS.

This is a sneaky lawyer gimmick.

**WHERE ARE YOU ON STOPPING THIS FROM HAPPENING????**

PLEASE PLEASE PLEASE DO SOMETHING.

Sincerely,



William Burgess

cc: Alaska Department of Administration  
ATTN: Commissioner Retirement and Benefits  
P.O. Box 11020  
Juneau, AK 99811-0200

Email: RPEA

Sharon Hoffbeck, President

Email: [retchapter@afscmelocal52.org](mailto:retchapter@afscmelocal52.org)

I strongly support the changes/suggestions mentioned in your recent newsletter. I would like to add re: the vaccines, I would hope the Shingles vaccine be included. Currently it is strongly recommended seniors receive it, but at over \$200 it's prohibitive for many of us. Also, when I was an active employee, Acupressure and Acupuncture were covered. They are not under the retiree insurance. Both have been proven to be successful in decreasing/stopping RA pain, among other conditions. It would be beneficial AND cost effective if those disciplines were to be covered again. RA medicines, especially Biologics, are extremely expensive and in some cases, they could be stopped or decreased if those two disciplines were covered.

I would also encourage the board to work with AARP in reducing prescription costs overall. They are prohibitive to many seniors, including those state employees who are coming along, age wise. I know the insurance coverage is not as generous as we enjoy and believe me, we greatly appreciate it! Having talked with friends who are retired whose insurance coverage is not nearly as good as ours, I'm so grateful for what the state did for those of us who are in Tier 1 and 2. Were it not for that, I would not be able to afford the medications or medical care that provide me with medical support now.

Thank you for continuing to work with the retiree population to provide the best possible medical care and prescription coverage.

Sincerely,

Russell L. Music  
Alaska State Retiree, Tier 2

You can leave my persecution program alone. I have not seen any kind of actuarial study that supports any of your proposals. I see a distinct probability that this will end up before the courts, once again.

George Boatright



We have read with concern the proposed changes to our AlaskaCare retiree health and medical benefits.

My husband, Edwin Obie, and I have depended on these benefits since we retired from the Department of Education and PERS. We are currently in our mid to later 70s

We know that maintaining our health now can extend our lives in good health and reduce costs as we age.

We fear that erosion of pharmacy benefits will make it more difficult for us to receive prescription medications we need.

We depend on dental services such as periodontal care, implants and procedures, and prophylactic care to prevent oral diseases.

We have relied on vision services for vision correction and, at times surgical procedures to maintain reasonable vision.

We have been told by medical professionals that we may need hearing aids in the near future

We also need full vaccination benefits, including those needed for older Americans, and ask for inclusion of Shingles vaccinations overwhelmingly recommended by medical professionals for older adults.

We don't need increased travel benefits, since we're able to be served locally.

At this time, it is unclear what benefits will be maintained and what will be removed. We have been grateful for the medical/dental/vision and hearing benefits we receive and have earned after 30+years each, of service to Alaska.

We ask that you maintain our current benefits, and add important maintenance such as Shingles vaccines.

Please contact me with any questions or comments via email or text to [REDACTED]  
We ask you to keep older retirees in mind as you re-examine AlaskaCare.

Sincerely,  
Naomi Obie  
Ed Obie

[REDACTED]



I am writing to express some of my concerns about a couple of the changes planned for the retiree health plan. The changes are so numerous that it is hard for the lay person to evaluate them all. It appears to me that there are substantial reductions in benefits in this plan and I am especially concerned with changes that will come with the transfer to a medicare part D pharmacy plan. I support efforts to reduce costs to the State of Alaska as long as it does not diminish the quality of care to retirees.

I do not have a problem with trying the least expensive drug first, however, I am [REDACTED]. With this plan will I have to go back and prove again that the cheaper drugs do not work?

My husband and I are both on [REDACTED]. We both started on the least expensive drug. (I do not remember the name of the drug now) We both developed a [REDACTED]. We are now on [REDACTED] with no more problems at all.

I was on [REDACTED] for several years and had [REDACTED] the entire time I took it.

I also tried at least [REDACTED]. All of these gave problems with [REDACTED] which can be very dangerous. As one becomes older they can become less sensitive to [REDACTED]. I am now on a more expensive drug, [REDACTED] and it is working extremely well. It is controlling my [REDACTED] well and I have not had a low in the four months that I have been taking it.

The appeals process appears to be especially lengthy and onerous. Does one have to be on inadequate medication during this process??

Perhaps one possible solution to the medication issue is to have current retirees grandfathered in to use of their current medications.

Thank you for the opportunity to review this proposed action.

Floy Ann MacPhee

[REDACTED]

Dear Advisory Board Members:

Thank you for serving on the Board and for your efforts to improve our plan while keeping costs as low as possible. It can't be an easy task. As a retiree since 2004, I do have some comments and suggestions.

Some proposed improvements, such as increasing travel benefits and preventive services could help reduce costs in the long run and I'm happy to see them on the list.

Another way that costs might be reduced is by implementing more proactive strategies for good health rather than surgery..... trying physical therapy or yoga before back or knee surgery, for example. Also, improved and less invasive treatments for many types of cancer are now available and these are less expensive at the time and less expensive for patients to recover from. I see these as ways our health plan can evolve, allowing expanded coverage without adding costs or cuts to the retirees.

Regarding the move to the Medicare Part D EGWP/wrap plan, there are three areas of concern and probable hardship to me.

1. When I enrolled in Medicare, AlaskaCare sent information to explain options and it stated clearly that the pharmacy plan we had was recommended and the Part D offering was inferior in several ways. I'm concerned about that.
2. The 5 step appeal process for denials might be too complicated and cumbersome as I age. People may end up losing a benefit they qualify for simply because they can't endure the lengthy appeal process.
3. The step therapy provision is particularly concerning because people may have to try inferior or less efficient medications at the risk of their health. I do take a specific drug rather than a popular generic because of decisions made by my doctor over a period of time and switching drugs would likely have impacts on my [REDACTED] system. That seems risky and perhaps expensive in the long run. I believe it is critically important to keep the provision that medication decisions be made by the doctor and patient.

As the board studies options for the retiree programs it is important to keep in mind that the lack of funding was a deliberate decision made by a governor and a few legislators. When funds were widely available, retirees made calls and wrote letters urging full funding, and for reasons that are obscure, funding was denied. It is no wonder some suggestions for cuts and draw backs are met with a bit of hostility.

I thank you for your efforts to provide fair and complete coverage, as promised.

Sincerely,  
Jo Clark

Sent from my iPad

Thank you for your consideration regarding the proposed changes Ak Care Retiree Health Plan.

1) I would like our Pharmacy benefits to remain intact as much as possible. Yes to RDS if that is what we have had since 2004. I have had problems in the past with reactions to some of the rapidly changing approved ingredients and dispensing bottles in some of the generic drugs. I do not buy the cheapest dishwasher because it does not work as well. Similarly over the counter equivalents may not be effective.

Putting an insurance company in power to override the doctors decision can cause problems...If necessary I am happy to pay more but would seriously not like to be forced to try a pharmacy product just because it is less expensive and be unable to have some control over best choice. I would like us to avoid going over to Medicare D and EGWP.

2) I feel that Alaska Care is dividing up our medical coverage into increasingly smaller and therefore underrepresented groups. Together we are stronger . I am the same employee that worked 28 years in TRS and yet my benefits are being traded depending on whether I am one of the few teachers that did not have quite enough credits to qualify for Social Security. Medicare is now charging me more than if I had SS backing my Medicare B benefits.

I worry that my interests are being bartered away with special exceptions just because I do not live in Alaska. Please do not penalize those of us in the smaller groups....such as: “out of network”, or “different out of pocket” expenses and whether it will have a different amount to go to “maximum payment reached”.

I appreciated The Alaska Care card “We Have Heard You” I hope you do not add, remove or change plan benefits. Please do not start bartering benefits which will cause serious hardship and diminished benefits for some and long court battles.

Keep current basic coverage that benefits the many.

J.A. Williams TRS employee 28 years

**From:** Gail Tilton [REDACTED]  
**Sent:** Thursday, July 19, 2018 12:04 PM  
**To:** Benefits (DOA sponsored) <[doa.drb.benefits@alaska.gov](mailto:doa.drb.benefits@alaska.gov)>  
**Subject:** Changes in benefits

The current plans to change our benefits without having done a comparison study of the proposed changes is wrong. Our benefits are guaranteed in the state constitution and are protected from diminishment there as well.

I am very concerned you are jumping into the abyss and taking our retiree prescription benefits with you with no proof our benefit will not be diminished.

The new plan would require retirees to get preauthorization for existing prescriptions and probably push supposed generic equivalents over brand name drugs. I have experience with both and in some cases they are not equivalent. I didn't see compounded medications addressed either.

Both my husband and I take several prescriptions daily. To go through preauthorization for our medications and probable changes by the new administrator is most definitely a diminishment our benefits. We have already done that in the current system and have balanced our medications for our maximum benefit. I resent a new management group stepping between me and my doctors' prescriptions.

The DOA is forging ahead with these changes without the necessary ground work and research. The losers in this rush to change are the retirees over 65.

I spent 26 years as a PERS employee and am counting on my benefits remaining as they are.

Sincerely,  
Gail Tilton

One has to wonder what will happen once CVS/Aetna corners the medicare RX market. Aetna is already supplying most of the supplemental insurance policies that are needed for retirees on medicare. This is a monopoly in the making!

I cannot believe this merger is for our benefit. Every time our benefits are changed we lose. Please do not tie us to medicare in this way. I am concerned that Alaska Care will become just another Medicare supplemental insurance and that was never the intent for this benefit.

Very concerned,  
Barbara J Daniels

Sent from my iPad

To Whom It May Concern:

We are making the following comments on the proposed pharmacy plan change.

We are both well over 65 and feel that changing our pharmacy plan, to a much more complicated plan, without fulfilling the required equivalency analysis, as required by the Supreme Court, is illegal. We also feel that DOA will be discriminating against us simply because we are ■■■ (or older) and on Medicare. Also, being required to go through a 5 step process appeal, may be beyond some of our abilities. Another large concern is that our Doctor's prescribed medication can be over ridden by third party administrator who knows nothing of our symptoms and illnesses.

We urge you to abandon this project and leave well enough alone.

Respectfully submitted  
Ruby N. Hotchkiss  
Fremont L. Hotchkiss

As a Tier 1 over 65 retiree, I would like to adamantly object to the implementation of the planned changes to the retiree pharmacy plan.

After a rough start, Aetna mail order is finally working well for me. Our prescription needs increase as we age and diminished benefits would only create serious financial hardships for those of us 65 and on a fixed income

The medications I take are life saving and denials and a lengthy appeal process to fight for these medications would certainly create a hardship and health complications.

These changes are not acceptable and not what was promised upon retirement.

Patricia Clark  
Retired APD Employee over 65

CC: Sharon Hoffbeck

Sent via the Samsung Galaxy S8+, an AT&T 4G LTE smartphone



I am requesting that you share my objection to the Department of Administration (DOA) regarding enrolling me into the Medicare Part D EGWP/wrap plan.

In 2014 upon turning 65 I was aware that the Alaska State Statute required me to sign up for Medicare. However, the DOA informed me that it was not necessary to sign up for Medicare Part D because the prescription drug coverage offered by AlaskaCare Defined Benefit Retiree Health Plan is considered Creditable Coverage. In fact, they continued to state that in at least one of their health newsletters yearly, even going as far as to say in 2016, that "AlaskaCare members have prescription drug coverage which is as good as, and in most cases, better than Part D".

Therefore, it is my opinion that by enrolling me in Medicare Part D EGWP/wrap:

1. They are neglecting their fiduciary duty by selling me off to benefit themselves. Per DOA's answer when asked why AlaskaCare is switching to the enhanced EGWP, they stated that "the retiree health trust would receive significantly higher subsidies than we do today, saving the trust up to \$20 million annually and providing \$40-\$60 million each year in additional state savings through a reduction in the unfunded liability.
2. From the savings created by the switch, DOA is placing me in a program that diminishes *my* benefits to improve the health benefits of those retirees who have not yet reached the age of 65; as stated in their answer to the same above questions: "These savings are critical if we are to consider making important changes to our plan that will benefit our members, such as wellness and preventive care, more travel benefits, and changing the lifetime maximum spending limits for care." Any improvement in the health plan will not benefit those in the Medicare Health plan.
3. DOA is creating an age tier by providing a better drug program for those under age 65. This may or may not fall under age discrimination, however, just like Medicare Part A and B diminished my health benefits, so will Part D.
4. DOA is placing my health in jeopardy since my AlaskaCare pharmacy plan is protected under the Alaska Constitution but Medicare Part D EGWP will not be protected. Should our Federal Government decide to eliminate Medicare Part D, it will be a burden on me to have to purchase a drug program without adequate funds to do so, which could possibly place me in a diminished capacity.

Furthermore:

1. As required under Duncan v. RPEA, the DOA has not demonstrated with reliable evidence that this proposed change is of an equivalent value to what retirees over 65 were promised and now enjoy.

2. The pre-authorization requirement constitutes a major change and CMS takes control instead of the retiree and their doctor.

3. The 5-step appeal process is unacceptable. It is sure to add confusion and frustration to the point of causing stress and diminishing the retiree's health. There will be no State of Alaska oversight or opportunity to ensure that the retiree's pharmacy benefits are not diminished or impaired by the federal government.

4. Additional premium for higher income levels is a diminished benefit.

DOA cannot assure me that my pharmacy benefits will be preserved, and the impacts will be minimal. Giving up control of the retiree's pharmacy program (for us over 65) for CMS to control will have a major impact and will diminish our benefits. Our federal government and Medicare are in a constant state of flux. The bureaucrats in Washington DC could care less what they do to Medicare because they have an excellent healthcare retirement plan that they will make sure never diminishes their benefits.

It is my hope that the DOA remind themselves, that they too may someday be a part of AlaskaCare Retiree Health Plan and recognize that the Medicare Part D EGWP plan is not beneficial and diminishes our current pharmacy benefits. Please DO NOT implement these changes into the Medicare Part D Enhanced EGWP/wrap program.

Sincerely,  
Brenda Arney

Sent from [Mail](#) for Windows 10

Dear Chair Salo,

This is a follow-up to the RHPAB meeting yesterday.

I would be grateful if you would please circulate this to the other members of your committee.

Attached is a copy of the GAO report I referenced yesterday about the high number of health insurance claim denials that are reversed on appeal.

For your convenience, I have highlighted certain parts of the report, and there is a useful summary on the second page.

The data for the GAO study came mostly from four states whose insurance regulators required such reporting. However, the GAO report cites a similar study done by an insurance industry trade group that reported similar results. Presumably, that was because the insurance trade group had more data it obtained from its members who no doubt keep records of the rates of reversals of denials of coverage.

The GAO study points out that it has no data on what percentage of claims that are denied are actually appealed. It's obvious that that's important, of course. Although there certainly are claims that are correctly denied, the more important issue is the percentage of claims that are wrongfully denied but are not appealed.

We can all think of reasons why someone might not appeal a wrongful denial of a medical coverage claim.

Some of the more obvious reasons include:

1. They might simply trust the insurer, believing they are "In Good Hands" and that the insurer will behave "Like a Good Neighbor," not realizing that part of insurers' business model is to pay as little as it can on any particular claim.

2. They might not be able to decipher the codes and technical language in the EOBs.

3. They might not want to spend the time and effort needed to appeal a relatively small claim they believe was wrongfully denied. The work required to appeal a small claim is often as much as appealing a large claim-- writing letters; collecting, organizing and sending off copies of medical records; asking health care providers for help.

Although a wrongful denial might cost the insured a few hundred dollars, when wrongful denials of relatively small claims are part of a pattern or practice and go unappealed, over the months and years those hundreds of dollars that should have been paid quickly add up to millions of dollars.

4. Probably the most common factor discouraging people from appealing denials of claims the intimidation factor-- that is, the huge psychological hurdle that must be overcome by individuals who are unfamiliar with the law and procedure and who know they will be going up against the power and resources of experienced insurance professionals. Add to that the reluctance of people to ask their doctors for help, and the fact

that some doctors don't want to be bothered to help, and the result is that many insurance claims that are wrongfully denied, in whole and in part, are not appealed.

And as the GAO report indicates, there are a lot of wrongful denials of medical claims.

Therefore, there needs to be a relatively simple, quick, an inexpensive process for appealing denials of claims under the AlaskaCare Retiree Health Plan. There also need to be incentives and/or disincentives to adjusters and claim managers to help minimize wrongful denials.

The existing AlaskaCare appeals process, being subject to supervision by the DRB and, ultimately, by the courts of Alaska, ensures that at least there will be some state accountability. It also leaves open the ability of the state system to improve itself - including improvement to better ensure that state benefits are provided to Alaska' retired public employees in accordance with state law and that the constitutional promises and guarantees.

Turning over to the federal government the appeal process for coverage denials of prescription drugs would put an end to effective supervision by DRB and the courts of Alaska. It would also put an end to the State's ability to adjust and improve the means of providing prescription medication benefits to Alaska's retirees.

For over a century, Alaska has fought-- and to this day continues to fight-- against the repeated and incessant efforts of the federal government to exert control over our state.

Ceding control to the federal government of a key part of the system set up to ensure that the retired public employees of Alaska receive the prescription medical benefits they have been promised would be contrary to that public policy and heritage.

It would not only diminish some benefits (as the DRB folks seemed to acknowledge yesterday), but it would certainly impair the ability of retirees to receive those benefits in cases where there is a wrongful denial. It would do so by making appeals more complicated

and

more time-consuming

.

It would also do so b

y turning over the decision-making process to

various

federal bodies that are completely detached and unaccountable to any branch of Alaska state government

t

and, most important, to the retirees who would be turning to them for relief. That

would

be unconstitutional, an injustice and just plain unfair.

For these reasons and the others expressed by people who spoke at yesterday's meeting, I respectfully urge you and your colleagues on the RHPAB to recommend strongly against the proposed EGWP.

My thanks to you and the other members of your committee for all your time and effort to help ensure that Alaska's promises to it retired employees are fulfilled.

Best regards,

Grant Callow

(42 page document from Grant Callow)



GAO report re  
appeals of denials c

(Board members have been forwarded this e-mail, include the pdf?)

I am extremely concerned about the potential change of Alaska Care Drug Plan to Medicare part D, and how it is supposed to be completely transparent with no noticeable differences. Apparently you believe Medicare part D to be a simple transition, but there are many plans that give very different levels of drug coverage.

This may be an issue especially for [REDACTED], I asked my Pharmacy, (Carrs Safeway) about Medicare part D and they say there are so many possibilities of plans which depend on different types of hoops to jump through. They told me it would be very difficult to determine whether the [REDACTED] medication would be available or covered under Medicare part D, such as:

[REDACTED] for a 90 day supply, also [REDACTED] is also expensive. Other normal drugs that are inexpensive such as [REDACTED] tends to have reaction issues with the [REDACTED], which makes you take [REDACTED] for 90 days, instead of inexpensive alternatives.

If this program of switching from State retirement drug plan to Medicare part D is supposed to be totally transparent,

I have had no issues with getting my [REDACTED] for the [REDACTED], my [REDACTED] was in [REDACTED]. This change in plans will be catastrophic, if the medications listed above are not available on Medicare Part D, or are restricted with various bureaucratic hoops.

Also, I ran into an issue last week when [REDACTED]. It would have been nice to have had a heads up about needing pre-authorization for [REDACTED]. Aetna acted as though this was a normal process, but the pharmacy said Aetna is a pain in the neck with this policy, and it started Jan 1, 2018.

I would prefer to stay on the existing medication program. Also, there may be another issue. When [REDACTED] occurs, [REDACTED], medicare is offered as an option to pay for procedure, and required medication for [REDACTED]. It was explained to me, at the event where the [REDACTED], if you reject the medicare plan, and opt for the state plan, you are ineligible for any further coverage for medication under medicare. At the time, and after careful evaluation of the circumstances, the State medicine plan was more beneficial. Therefore, we choose to opt out of medicare until age 65.

This may be another problem, unless Medicare changes their previous stance.

Thanks, Frank Berlen, retired since 2014 May, and [REDACTED] next July. This could become a life and death situation depending on the outcome of this evaluation, and I am positive the State has not even thought of this particular circumstance, and only money is their motivation for drop



To whomever:

After reviewing the proposed "Employee Group Waiver Program (EGWP)" presentation I have a few questions that I surly hope you will answer during your presentation.

- I'd like to know exactly what it is a retiree needs to do to maintain my pharmacy prescription coverage (the more detailed the better, please don't assume the retiree knows all of the in's and out's of what you all have expertise in).
- How much it will cost the retiree?
- What will be different from what is currently being done with the prescriptions?
- Will there still be a mail-order, with 90 supplies?
- What happens if something isn't done in time.
- Will the retiree be required to enroll into "Medicare Part D"?
- Under the "retiree impact" of your presentation, it looks like retiree can opt out of Medicare D and will be enrolled in an alternative prescription drug plan, can you please explain what and how this works?
- Please explain what it is that "must follow a Medicare Part D approved formulary" is?
- For those drugs not covered under the "Medicare Part D formulary" but covered under the "wrap supplemental drug benefit, what is that cost/limitations/factors (waiting period, try other drugs, etc)?
- Is there a cost to be covered under the "Enhanced wrap supplement drug benefit"?
- Will the retiree need to sign up for Medicare Part D?
- What are the CMS Regulations that the EGWP will be subject to and how will that impact the retiree?
- Explain CMS pre-authorization requirements – what is that?
- What is the DMS required communications?"
- Seems the retiree is losing the "out of Country" coverage?



## Retiree Health Plan Advisory Board (RHPAB)

After reviewing the proposed "Employee Group Waiver Program (EGWP)" presentation I have a few questions that I surly hope you will answer during your presentation.

First and for most, I sure wish there was a way to ask questions for anyone that can't personally attend one of the upcoming RPEA Benefits Meetings, but thank you for providing at least a "listen only" option.

Can I request that you please keep your answers to questions simple. Understand most folks are not well versed in the different acronyms used by your profession and expertise. We do understand what we need and how much it is costing us.

- Need to know what the retiree needs to do, as I'm sure this is a done deal?
- Will the retiree need to enroll in Medicare Part D?
- Is there a cost for Medicare Part D and who will pay that cost?
- Does the retiree need to enroll in the EGWP?
- What are the associated costs with enrolling into the EGWP, and who will pay those costx?
- Will the retiree need to enroll in the "Enhanced" EGWP?
- What are the associated costs with enrolling in the "Enhanced" EGWP and who will pay those costs?
- What are the CMS regulations, please explain:
  - Required communications
  - What are the pre-authorization requirements (currently there are none) - (is this another change from the current plan)??
- Seems that another benefit being lost is the one for retirees living outside of the US (another change from the current plan)?
- See where the retiree can opt-out of Medicare Part D
  - What is the ramification for this?
  - Enrolled in alternative prescription drug plan, who pays for it and how does it compare to what is the current plan?
- Please explain what the Medicare Plan D drug formulary is and how this will affect the retirees prescriptions?
- I'm eligible for Medicare and I'm enrolled in Medicare Part A and B, what happens to my prescriptions with Aenta will I need to go to yet another place for my prescriptions?



During the Subcommittee meeting on July 26, DRB provided additional information about the proposed EGWP. In particular, the information provided about the appeal procedure was unclear to me and, as a consequence, I wanted to submit more specific questions to address my concerns that the appeal procedure under EGWP clearly impairs the Constitutionally protected statutory rights of all retirees and beneficiaries to appeal a denial of coverage or benefits under the AlaskaCare Plan to the OAH and then to the Alaska Superior Court.

The table 4 in the materials provided by DRB on July 26 shows two separate appeal procedures that might apply to a denial of some drug or medication by the PBM. It appears to show that some denials fall under the federal appeal procedure while others--under the EGWP "wrap"--are handled under the current appeal process. It is unclear to me when and how the determination is made, and by whom, to apply one or the other. It seems to imply that any denial by the PBM under EGWP might then "shift" under the "wrap" part of the plan to determine if coverage exists there. If that too is denied, then an appeal might proceed under the current appeal procedure because the last denial occurred under the EGWP "wrap"..

If that is the case, it would be helpful to have it clearly stated. I am skeptical whether CMS would permit a "shift" of a denial under EGWP from the federal appeal procedure to the state appeal procedure in such cases, but perhaps DRB has information which explains that is permitted.

If that is how the procedure is intended to work, then it seems unlikely there would ever be a circumstance where any denial by the PBM would ever proceed under the federal appeal procedure. It seems to be a disservice to retirees for DRB to withhold this information, if it has information that answers these questions. Hopefully, if it does, it will provide that information before or at the August 10 meeting.

Brad Owens

I will be on the road in the Yukon August 27, thus unable to attend the meeting in Juneau or even call in to listen to the discussion on using Part D drug coverage for retirees, aka EGWP.

The proposal is such a convoluted mess, in my opinion, that it is difficult to analyze what is going on and how it will impact my family. (I made my living with the State successfully analyzing complex proposed and existing federal Medicaid, TANF, and Food Stamp regulations for impacts to Alaska! I was often the rep for the State in discussion with federal agencies and with other states. I was a pro at deciphering and analyzing complex jargon. And most of the stuff in the drug proposal confused me!) I have been following the proposed changes and they continue to be in a state of flux. For something that was supposed to be effective November, a lot of analysis on the impact to retirees has yet to be done. So far, all I read is the impact to the State's coffers.

I object to the term "modernizing" that the State is using. They are tweaking things that aren't broken to save money not modernize. If they were to modernize, then they would include alternative medicine coverage that would save on drug costs and for some, save on physical therapies and doctor visits. I know from personal experience that the Chiropractor and Acupuncturist have saved the state money and saved me from [REDACTED]. (By the way, insurance covering mammograms is a federal law that passed years ago, and I think so is the coverage for pap smear and PSA test, so don't take credit as modernization.)

Back to the drug plan, that appears to be the only discussion on the table and this meeting.

1)if I am having trouble figuring this out, then the less educated, elderly, and infirm will be totally lost understanding this in order to comment, not to mention actually using the proposed drug plan. They will give up rather than work through the red tape to get the drug, get their refund from the state, or appeal a denial. (I know this is fact, having worked in Public Assistance for over 30 years – for elderly and disabled red tape that they didn't understand caused them to not bother applying. But then, perhaps that is the goal with the new changes.)

2) the State severely underestimates the impact of Part D because many of us are filing "married" and our spouse's retirement and/or wages and investments are included in the determination of how much our part D premium will be. Right now going back 2 years when my [REDACTED] and working in construction is hitting us hard...\$400 each per month for Part B. (Maybe I should divorce him.) We have less than half of that income now that he is retired and it is a serious impact to our monthly income of retirement plus social security. I have just enough social security payment to cover my B premium, as I paid into it before the state opted out. Now let's add Part D to it based on his earnings of 2 years ago and I'll owe a Medicare Part D payment from my pocket as my social security check won't cover it.

3) I might opt out of "egg whip" to opt out of the hassle. At this time our drug needs are fairly simple. Might be cheaper for us.

4) I have [REDACTED] [REDACTED] who fought with the current drug program for coverage. Putting on a Part D layer is going to make it worse for them. Two already told me that they checked the list of covered drugs and their needs are not on the Part D list. What about them? And, while I never have had a Rx for more than 90 tablets, why is 10 tablets more such a big issue? It could be a big issue for one of my friends who takes more than one tablet a day to manage her illness. I don't see a cost saving to the State over 10 tablets.

5) Network providers. What a pain in the butt already for doctors, chiropractors, dentists, and eye care. In Juneau we have limited pharmacies, as do other SE communities. My doctor and Chiropractor have trouble getting Medicare and Aetna reimbursements and go through reams of red tape over and over again to get payment. I predict when the State goes to Part D that the increase in problems for the pharmacy will cause some to say “forget it”. (My doctor and chiropractor do not take new patients who are Medicare.) It has been in the news for years that Anchorage Medicare and Medicaid recipients have difficulty finding doctors to take their coverage. Let’s now add pharmacies to the problem. Currently I and [REDACTED] have run into the problem because our doctors or chiropractors aren’t “in the network”. We have enough to have a network in Juneau? (As well as reasonable and customary charges based on “where”? The person on the other end of the phone scrambles for some type of answer but usually ends up telling me Anchorage or the lower 48.) Now a drug program that is working needs to be broken under the guise of modernization and the use of network pharmacies.

6) Everyone who has appealed with Medicare knows that the appeal process can take a long time. I appealed denial of fixing [REDACTED]...they paid for the diagnosis of the [REDACTED], but not the [REDACTED]. My appeal was also denied. What the heck? Let’s pay to find out if a [REDACTED]...Yep. So sorry.

Will they be providing expensive drug coverage for a major illness or disease while you go through all the layers of appeals and try to explain to someone in the lower 48 that we have limited medical services and can’t just go find another pharmacy when you only have 1 or 2 or even 4 in town? Or that you have a potentially terminal or chronic illness and this is a new FDA approved but expensive drug that is needed but not yet on their list? When I worked for Public Assistance I had [REDACTED] before their appeal process with Social Security finished.. [REDACTED], but a little too late for the client/patient.

7) The argument that other state retirement programs have moved to EGWP – so WHAT??? They see cost savings but you don’t report how it impacts the patients in those states. Just because they have it in the lower 48 doesn’t mean it is good for Alaskans or that we want it. My friends who retired from other states (Washington, Idaho, N Dakota, New Hampshire, New York, and the federal government to name a few) tell me how lucky I am to have our drug program (I totally agree) because theirs stinks as retirees.

Bottom line, I see that this has less benefit to the retiree and not anything to do with modernization. It is all about cost saving without serious regard to the impact on retirees. The State is going back on their promise. Many of us stayed working for more than 30 years, even when wages weren’t competitive anymore and we were on a [REDACTED] so we hadn’t even seen a performance pay raise in over a decade.

The comparison charts do not show any plus for the retiree’s drug coverage, but cost savings to the state and a bunch of red tape if you are brave enough to appeal it. I don’t see that the proposal meets the test that we don’t have less and don’t suffer from the change. Plus, we get another form to fill out regularly to get reimbursement from the State for Part D premiums, not to mention sharing my family’s personal income data that isn’t really the state’s business. Don’t call it modernization. It is going back on a promise in order to save money, without regard to the negative impact to retirees. A true analysis would show pros and cons for the retirees. This proposal is one sided. Is it good for the State budget? Yes. Is it good for the retiree? NO.

Valerie Horner, Tier I retiree



Sent from [Mail](#) for Windows 10

Having read the information you have put on your website about the EGWP program, I still don't understand what changes are being made.

I take a relatively new medication for [REDACTED]. I am very concerned about what it's going to cost me with the EGWP. It's a very expensive drug.

Can the Department of Retirement and Benefits do this to us? It seems like they are going against contract the union signed with them. I know they will be saving money but at whose expense?

The information the DRB has put out is very confusing. I hope you can provide us with better information.

Connie Olson  
RPEA member

Sent from my iPad

Some brief feedback:

Dear Division:

Thank you for the update. Let me provide some observations. Every time you change pharmacy vendors, it throws into chaos our relationship with our local pharmacy. AETNA was the best system by far in the past years. Especially in coordinating benefits for couples. Why change a service that was working well? The cost savings are one criterion but service is equally important. I predict you will find the cheaper alternative fraught with problems.

Second, you could be much clearer and say “all you retirees on Medicare are about to be changed from AETNA to EGGWHIP.” OptumRX is NOT for you. What EGGWHIP is exactly is not clear.

This communication is clear as mud. Be honest. You can’t save \$60-80 million and only add benefits. Be honest about what we will face—more disapprovals of medications, more approval hoops to try to navigate, and what does Federal Reimbursement to us as individuals mean?

So we have no voice, no vote, but must accept this change as we are subjected to the decisions of a group of political appointees whose primary goal is to save the State money. I hope the RPEA can hold you accountable in court if necessary to fully disclose the likely trade-offs included in these changes.

Yours, Pat

Patricia A. Book, Ph.D.  
Consultant, Writer

Inaugural Leadership Fellow  
Western Interstate Commission for Higher Education Cooperative for Educational Technologies (WCET)  
Past-President, University Professional and Continuing Education Association Medical anthropologist,  
continuing and distance educator, University academic administrator

A large black rectangular redaction box covering the signature area, with a small vertical line to its right.



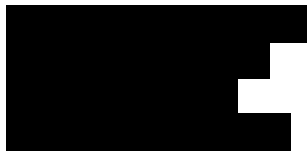
Explain to Medicare Retirees that you are basically NOT providing us with a new pharmacy vendor but you are putting us in a special Medicare Part D program that has flawed reimbursement methodology as if everyone is on an HMO when most of us are in a PPO. See below!

[https://www.ahip.org/wp-content/uploads/2017/03/MA\\_EGWPs\\_FINAL\\_324.pdf](https://www.ahip.org/wp-content/uploads/2017/03/MA_EGWPs_FINAL_324.pdf)

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Patricia A. Book, Ph.D.  
Consultant, Writer

Inaugural Leadership Fellow  
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Past-President, University Professional and Continuing Education Association  
Medical anthropologist, continuing and distance educator, University academic administrator



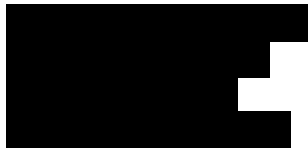
1. Will we be able to get 90 day supply of medications in the new drug plan without enormous hassle? I travel for months at a time domestically and internationally.
2. As I have [REDACTED], can I still get brand name [REDACTED]?
3. I pay Medicare deductibles as does my spouse. What deductibles will we expect with Medicare Part D? Are we being being fairly treated with respect to deductibles?
4. What type of card will we receive for pharmacy— Medicare Part D?
5. EGWHIP is subject to changes and has been shown to use flawed methodology in reimbursement calculations so won't we now we subject to the whims and changes of CMS annually?

You should provide a chart comparing AETNA and Medicare Part D item by item so we can see the changes.

Pat

Patricia A. Book, Ph.D.  
Consultant, Writer

Inaugural Leadership Fellow  
Western Interstate Commission for Higher Education  
Cooperative for Educational Technologies (WCET)  
Past-President, University Professional and Continuing Education Association  
Medical anthropologist, continuing and distance educator, University academic administrator



If you change to Medicare Part D I will suffer. I take [REDACTED] without generics. One has prevented me from having costly surgery. Is the change worth the thousands for more tests and surgery?

Here is the complicated Medicare appeal. Have you really understand that thousands of us could end up in the ER or hospital suffering for months with appeals? You have diminished our coverage. What is the approved list of medication? I can't find it anywhere.

#### Medicare drugs

##### Page 28

If you use a drug not on your plan's drug list, you'll have to pay full price, instead of a copayment or coinsurance, unless you qualify for a formulary exception. All Medicare drug plans have negotiated to get lower prices for the drugs on their drug lists, so using those drugs will generally save you money. Also, using generics instead of brand-name drugs may save you money.

##### Generic drugs

The FDA says generic drugs are copies of brand-name drugs and are the same as those brand-name drugs in dosage form, safety, strength, route of administration, quality, performance characteristics, and intended use. Generic drugs use the same active ingredients as brand-name drugs. Generic drug makers must prove to the FDA that their product works the same way as the brand-name prescription drug. In some cases, there may not be a generic drug the same as the brand-name drug you take, but there may be a generic drug that will work as well for you. Talk to your doctor or other prescriber.

##### Tiers

To lower costs, many plans place drugs into different "tiers" on their formularies (drug lists). Each tier costs a different amount. A drug in a lower tier will cost you less than a drug in a higher tier. Each plan can divide its tiers in different ways.

Example of a drug plan's tiers:

- Tier 1—Generic drugs. Tier 1 drugs cost the least.
- Tier 2—Preferred brand-name drugs. Tier 2 drugs cost more than Tier 1 drugs.
- Tier 3—Non-preferred brand-name drugs. Tier 3 drugs cost the most.

Your plan's drug list might not include a drug you take. However, in most cases, you can get a similar drug that's just as effective.

##### Prior authorization

You may need drugs that require prior authorization. This means before the plan will cover a particular drug, you must show the plan you meet certain criteria for you to have that particular drug. Plans also do this to be sure these drugs are used correctly. Contact your plan about its prior authorization requirements, and talk with your prescriber.

Please reconsider the impact on us.

Carol Boquard – name added

# Lifetime Limits

**Proposed change:** Increasing or removing the lifetime maximum

**Plans affected:** DB Retiree Plan

**Reviewed by:** Retiree Health Plan Advisory Board

**Proposed implementation date:** January 1, 2019

**Review Date:** July 26, 2018

*Table 1: Plan Design Changes*

	Member	Actuarial	DRB Ops	Financial	Clinical	TPA	Provider
No impact							
Minimal impact		X	X	X		X	X
High impact	X				X		
Need Info							

**Description of proposed change:** The AlaskaCare retiree defined benefit health plan currently contains a \$2 million lifetime maximum described below and found on page 14 of the 2003 booklet:

“The maximum lifetime benefit for each person for all covered medical expenses is \$2,000,000.

At the end of each benefit year, up to \$5,000 of medical benefits used is automatically restored regardless of your physical condition. If you have received more than \$5,000 of covered medical benefits, your full annual spent maximum may be restored when you submit proof of good health satisfactory to the claims administrator within the following year. This provision will not provide benefits for covered expenses incurred before the date the maximum is restored.”<sup>1</sup>

The proposed change would remove this language entirely and eliminate the lifetime maximum limit.<sup>2</sup> This will:

- 1) Ensure members will retain access to health insurance during a catastrophic health event;
- 2) Prospectively reinstate full coverage for all members who have hit the lifetime maximum;

<sup>1</sup> <http://doa.alaska.gov/drb/pdf/ghlb/retiree/RetireeInsuranceBooklet2003with2018amendment.pdf>

<sup>2</sup> The lifetime maximum does not apply to costs associated with claims under the pharmacy plan, but it would apply to any injections or other medications covered by the medical plan.

- 3) Increase the overall actuarial value of the health plan by 0.40%; and
- 4) Increase annual plan expenditures by an estimated \$2,700,000.<sup>3</sup>

While the number of individuals impacted by the existing lifetime maximum is small (see member impact below); those who are impacted find themselves without an avenue for affordable health insurance at an extremely vulnerable time. Without a change to this plan provision, it is likely that an increasing number of individuals will reach the lifetime maximum given the growing cost of health care and new technologic innovations.

The specific consequences are described further in the member section below, but this is a priority item for Division staff who see the devastating impacts on members reaching their lifetime maximum.

### **Background:**

The \$2 million provision currently in the plan represents an increase from initial plan provision which set the limit at \$250,000. In 1985, the \$250,000 lifetime max was increased to \$1 million, and in 1999 it was increased again to the present limit.

Relatively recently, the Patient Protection and Affordable Care Act (ACA) required most health plans to remove any lifetime maximum, and as a result these provisions are becoming increasingly uncommon in health plans.<sup>4</sup> At the same time, the cost of health care has grown significantly over the past decade due to a variety of factors including access to new technological advancements.

### **Member impact:**

#### **WHO IS IMPACTED-**

A lifetime maximum provision of \$2 million may have seemed sufficient and typical 18 years ago, however it is now causing serious hardship for a small, but growing number of members.

It is unknown exactly how many members have reached this maximum limit as the records for individuals who have “termed,” or who are no longer covered by the plan, are not retained in perpetuity. Table 1 shows the number of current members who have met or who are approaching this limit.<sup>5</sup>

<sup>3</sup> Attachment A: *Removal of the Retiree Plan Lifetime Maximum*, Segal Consulting memo dated July 25, 2018.

<sup>4</sup> As a retiree plan, the AlaskaCare retiree plan is exempt from this ACA provision.

<sup>5</sup> A member could be termed for several reasons including death, loss of coverage due to lack of premium payment if they are not eligible for premium-free health benefits, or loss of coverage through divorce or other special circumstances.

Table 2: Overview of current member lifetime accumulators – 2018<sup>6</sup>

# Members	Lifetime Accumulator
5	> \$2 million or more
3	> \$1,700,000
11	> \$1,500,000
25	> \$1,000,000
181	> \$500,000

There are currently 5 members who have reached the lifetime limit; and are receiving an annual \$5,000 reinstatement.

Non-Medicare- Members who are not eligible for Medicare and facing extraordinarily high health care costs are disproportionately impacted by the lifetime maximum as they do not have guaranteed access to other health insurance the way Medicare-eligible members do.

Options for members who are not eligible for Medicare are limited to the following:

- 1) Medicaid- for those who meet certain eligibility or income thresholds.<sup>7</sup>
- 2) Federally Facilitated Marketplace (e.g. “Individual market”)- members may qualify for participating in the special enrollment period; but the regulations are unclear in this specific circumstance and the \$5,000 reinstatement creates complexity for members requiring special approval and/or review.
- 3) Alaska Comprehensive Health Insurance Association<sup>8</sup> – this has been a resource for some members who have reached their lifetime maximum, but premiums range depending on age with an individual who is 60 years of age paying \$3,089 per month for a plan with \$1,000 deductible to \$1,153 per month for a plan with a \$15,000 deductible.<sup>9</sup>

Other impacts: Even members who have not reached their lifetime maximum may be impacted by this provision. The Division is aware of at least one circumstance where providers have withheld care or delayed treatment until the member comes

<sup>6</sup> Summarized from an Aetna report from June 29, 2018.

<sup>7</sup> Alaska Department of Health and Social Services [DHSS], Division of Public Assistance, Medicaid Eligibility Standards: [http://dpaweb.hss.state.ak.us/POLICY/PDF/Medicaid\\_standards.pdf](http://dpaweb.hss.state.ak.us/POLICY/PDF/Medicaid_standards.pdf)

<sup>8</sup> Alaska Comprehensive Health Insurance Association [ACHIA]: <http://www.achia.com/premiums.asp>

<sup>9</sup> ACHIA 2018 Monthly Individual Premiums Rates: <http://www.achia.com/docs/PPO%20ACHIA%202018%20Premium%20Rates%20rev11.10.2017.pdf>



up with sufficient monetary deposit because they are concerned the recommended treatment course will exceed the remainder of their plan benefit despite having over \$1 million left.

Another individual has indicated he must delay a necessary procedure for 2 years, until he reaches Medicare eligibility, because his remaining plan benefits are not sufficient to cover the service.

An unintended consequence of the \$5,000 annual reinsurance provision is that even after a member reaches their lifetime maximum, they are considered by other plans to have insurance which meets minimum essential coverage provisions limiting their ability to qualify for other forms of insurance.

Often, members are not necessarily aware of the lifetime maximum plan provision and retire confident that they have health insurance for themselves and their dependents for the remainder of their lives. When they do reach the maximum, they are generally extraordinarily sick and highly vulnerable.

### **Actuarial impact**

Neutral / **Enhancement** / Diminishment

*Table 2: Actuarial Impact*

	Actuarial Impact
Current	N/A
Proposed w/removal of lifetime max	0.4% increase <sup>10</sup>

Note: The claims data was not a credible source for the analysis, given the relatively small number of occurrences. For this reason, Segal used the Apex Actuarial Rate Modeling System<sup>11</sup>, calibrated to account for the current membership demographics, geography and overall cost structure to determine the impact of removing the lifetime maximum.

### **DRB operational impacts:**

Impacts to the Division will be minimal. The work associated with this will occur up front. The Division will need to notice the membership, amend the plan booklet, communicate the change, direct the Third-Party Administrator to implement the change,

<sup>10</sup> Attachment A: *Removal of the Retiree Plan Lifetime Maximum*, Segal Consulting memo dated July 25, 2018.

<sup>11</sup> The Apex Actuarial Rate Modeling System provides comprehensive plan design and rate modeling capabilities, and is widely utilized throughout the industry by consulting actuaries.

and ensure members are reinstated. Once these activities are complete the Division does not anticipate any additional work on this issue.

**Financial impact to the plan:**

Based on a preliminary retiree claims projection of \$680,000,000 for 2019, the anticipated fiscal impact is estimated to be approximately \$2,700,000 or 0.4% in additional annual costs.<sup>12</sup>

**Clinical considerations:**

Removal of the lifetime maximum will remove existing impediments to care that members experience potentially improving their clinical outcomes; however, it is likely that most members exceeding this cost threshold have very serious, critical health issues.


**Third Party Administrator (TPA) operational impacts:**

Removing this provision will bring the retiree health plan in-line with other, mainstream, health plan provisions and will require less effort for the TPA once the initial change is completed. The TPA will need to assist in identifying and informing members who would benefit from having their plan benefits reinstated and will need to update their programming to remove the lifetime accumulators. These activities will be a one-time effort that should not require significant work by the TPA.

**Provider considerations:**

Any impacts to health plan providers are estimated to be both minimal and positive as this removes a potential barrier to care for their patients.

**Documents attached include:**

<u>Document Name</u>	<u>Attachment</u>	<u>Notes</u>
<b><i>Removal of the Retiree Plan Lifetime Maximum, Segal Consulting memo dated July 25, 2018.</i></b>	A	 Segal Lifetime Max Memo
Summary of Public Comment	B	See Attached

<sup>12</sup> Appendix A: *Removal of the Retiree Plan Lifetime Maximum*, Segal Consulting memo dated July 25, 2018.

# Attachment A

## MEMORANDUM

**To:** Ajay Desai, Director, Division of Retirement and Benefits

**From:** Richard Ward, FSA, FCA, MAAA

**Date:** July 25, 2018

**Re:** Removal of the Retiree Plan Lifetime Maximum

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The State currently provides retiree coverage up to a lifetime maximum of \$2,000,000, with an annual \$5,000 reinstatement once the limit is reached.

We reviewed 2014-2017 claims data provided by Aetna for retirees over and under 65 and identified: 181 claimants from January, 2014 to December, 2018 that have exceeded claims of \$500,000; 25 claimants with claims totaling over \$1 million; and eleven (11) with accumulated claims over \$1.5 million. Additionally, Aetna provided detailed data, as of April 2, 2018, on eight (8) claimants that have claims in excess of \$1,700,000 over their lifetime, with five (5) of these members over the \$2,000,000 maximum and receiving the \$5,000 annual restatement.

New specialized treatments and medications continue to be developed and put into practice. As treatments and medications become more specialized, they tend to have an increase in cost associated with them. As a result, it is anticipated that the cost of care for higher cost claimants will increase as they utilize these new treatments and medications. The Alaskan marketplace also contributes to the dynamic of escalating cost, as the cost of care in Alaska is markedly higher than in the rest of the country.

Additionally, the majority of new retirees will not yet be eligible for Medicare at retirement. Retirees without Medicare generally have costs 200%-300% of those for retirees with Medicare. It is also anticipated that retirees will require these emerging treatments and medications at an ever-increasing rate.

We reviewed recent claims detail to identify the highest costs associated with the high cost claimants. Given both the escalating costs in the marketplace and the non-Medicare status of new

retirees, we have determined there may be a higher (than typical) probability that these claimants will reach the \$2,000,000 maximum.

Predicting future claims activity for individuals can be challenging given the limited information on health risks and current treatment plans for each individual. The true value of this benefit enhancement will likely vary and fluctuate annually, potentially to a substantial degree. Even with over 60,000 members, the claims data are not a credible source for the analysis, given the relatively small number of occurrences.

Therefore, we utilized the Apex Actuarial Rate Modeling System<sup>1</sup> to determine the impact of removing the lifetime maximum. Apex indicates that removing the maximum will increase the Plan's actuarial value by 0.40%. The model was calibrated to account for the current membership's demographics, geography and overall cost structure. Our results are representative of the average anticipated increase for a typical year under typical circumstances.

Based on a preliminary retiree claims projection of \$680,000,000 for 2019, this equates to approximately \$2,700,000 in additional annual costs.

*Please note that the projections in this report are estimates of future costs and are based on information available to Segal at the time the projections were made. Segal Consulting has not audited the information provided. Projections are not a guarantee of future results. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, trend rates, and claims volatility. The accuracy and reliability of projections decrease as the projection period increases. Unless otherwise noted, these projections do not include any cost or savings impact resulting from The Patient Protection and Affordable Care Act (PPACA) or other recently passed state or federal regulations.*

cc: Michele Michaud, Division of Retirement and Benefits  
Emily Ricci, Division of Retirement and Benefits  
Linda Johnson, Segal  
Michael Macdissi, Segal  
Noel Cruse, Segal  
Dan Haar, Segal

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<sup>1</sup> The Apex Actuarial Rate Modeling System provides comprehensive plan design and rate modeling capabilities, and is widely utilized throughout the industry by insurance carriers and consulting actuaries. Segal holds an annual license to utilize this model.

# Attachment B

**From:** Gary Miller [REDACTED]  
**Sent:** Saturday, June 09, 2018 11:03 AM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** Ricci, Emily K (DOA) <[emily.ricci@alaska.gov](mailto:emily.ricci@alaska.gov)>; Michaud, Michele M (DOA) <[michele.michaud@alaska.gov](mailto:michele.michaud@alaska.gov)>; Sharon Hoffbeck <[REDACTED]>  
**Subject:** Health Plan Modernization

I read the Proposed Modernization Plan and here are my comments.

It would be **very helpful** to have all of the amendments in one booklet **and** incorporate decisions made by the Office of Administrative Hearings, **including** those that have nondisclosure agreements. We retirees were promised health insurance at retirement if we stayed in our public service. I believe that we retirees have earned insurance documents that are clear and easy to understand. As the document states, "This would make it easier for members to understand and provide more transparent and specific direction as to how AlaskaCare claims should be adjudicated".

As medical costs continue to rise, people can reach the lifetime limit easier. A heart transplant could do that. As other medical procedures are developed, some of those are exorbitant. In addition, some of the newer drugs are so expensive that people without insurance can't afford treatment and are left to die. Therefore, I think the lifetime limit should be eliminated. It would be nice to know how many people each year reach the limit and are dropped from insurance coverage. Would it be morally right to let them die because they no longer have health insurance?

Preventive care can reduce medical costs by catching medical issues early where treatment is more likely to be successful and less expensive. Some examples are pap smears, mammograms, PSA tests, health fairs, etc. There must be studies that show which preventative services would save the program money and whether or not retirees would take advantage of them. If there are money saving preventative services, then consider implementing them.

Canadians pay about one-third to one-half the price for prescription drugs as Americans do. Someone needs to take the lead to allow the importation of prescription drugs from Canada. Since Congress passed the laws prohibiting it, Alaska's governor and legislature should be pushing senators Murkowski and Sullivan and representative Don Young to take the lead on this. Several years ago, about half of the cost of retiree healthcare was for prescription drugs. Do a study and find out if that has gone up. Governor Walker could make this an issue at the national governor's conferences. Alaska is not the only state facing this problem.

Having a travel concierge purchase airline tickets is an interesting concept. Bidding could be done with the different airlines to secure the best fares. I think this is a brilliant idea and bravo to the person who thought of it. What about airline miles. Who would get the credit, the insurance company or the traveler? If there is a medical emergency and a person has to be medevacked, would reimbursement be for the full amount or reduced because the concierge was not used?

I understand the idea of "...enhanced imaging review...". there should be some flexibility. For example, I recently injured [REDACTED]. The physician's assistant ordered [REDACTED] and declared that I had [REDACTED]. After more pain, I went back and saw the doctor. He ordered and [REDACTED] and said that I had [REDACTED] and would need surgery. Would my [REDACTED] be questioned?



Changing the retirement statute defining "dependent child" would not be challenged if the age limit goes up but if it is lowered I think there would be grounds for a lawsuit if it applied to people who are currently retired. The constitutional protection would be violated. In addition, would some legislators want to make other changes and open up a can of worms?

Best of luck on this interesting and probably long over due project. Also, thanks to those of you serving on the Retiree Health Plan Advisory Board's. I appreciate your volunteering.

Gary Miller.

Gary Miller  
[REDACTED]



**From:** [REDACTED]  
**Sent:** Saturday, June 09, 2018 3:12 PM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** sharonhoffbeck <[REDACTED]>  
**Subject:** Fwd: [Rpea.outside] [Rpea.members] DRB Retiree Health Plan Modernization

Thank you for the opportunity to comment on the DRB Modernization Presentation. I live out of Alaska so I appreciate RPEA notifying me of the Retiree Health Plan Advisory Board's retiree plan modernization committee meeting on 12 June.

I appreciate the fact that I have Tier I health insurance coverage. I guess one could say I worked at the right time and the right place. Very fortunate indeed. Overall I am happy with the coverage we have been afforded to date.

I wish there were more preventative coverages for the main reason it is "preventative". Why wait until one is seriously ill to have coverage kick in. In a dollar and cents theory it seems it would be a great deal cheaper to catch something or prevent something through a "preventive" process. In this vain I agree with the solution to add full preventive services to the plan. Also as an older adult my physician has indicated I do not need a pap smear every year but an annual wellness visit with associated blood work is a valuable assesment. So why do we need to have an annual pap smear covered~~~why not just a wellness exam and associated blood work to see how well one is.

I thought the following line was very confusing.....what are the services referenced here: **\*\*Preventive services are defined as those that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.** I think it is critical to list those services so we all know what is being included!

I consider the following to be inequitable and unfair:

**o Members using an out-of-network provider would be paid at a reduced coinsurance (60%) and their portion of the cost would not count towards the annual out-of-pocket limit.**

Is that even constitutional? Why would you penalize people who live in an area where there are no network providers?

For the same reasons I feel the following is unfair as well.

Concern: Pharmacy costs are increasing and using out-of-network providers is more expensive. Possible Solution: Change coverage for prescriptions filled at an out-of-network pharmacy. o Prescriptions filled at an out-of-network pharmacy: • Plan pays 60% coinsurance, • Member pays 40% until annual \$1,000 out-of-pocket maximum is reached

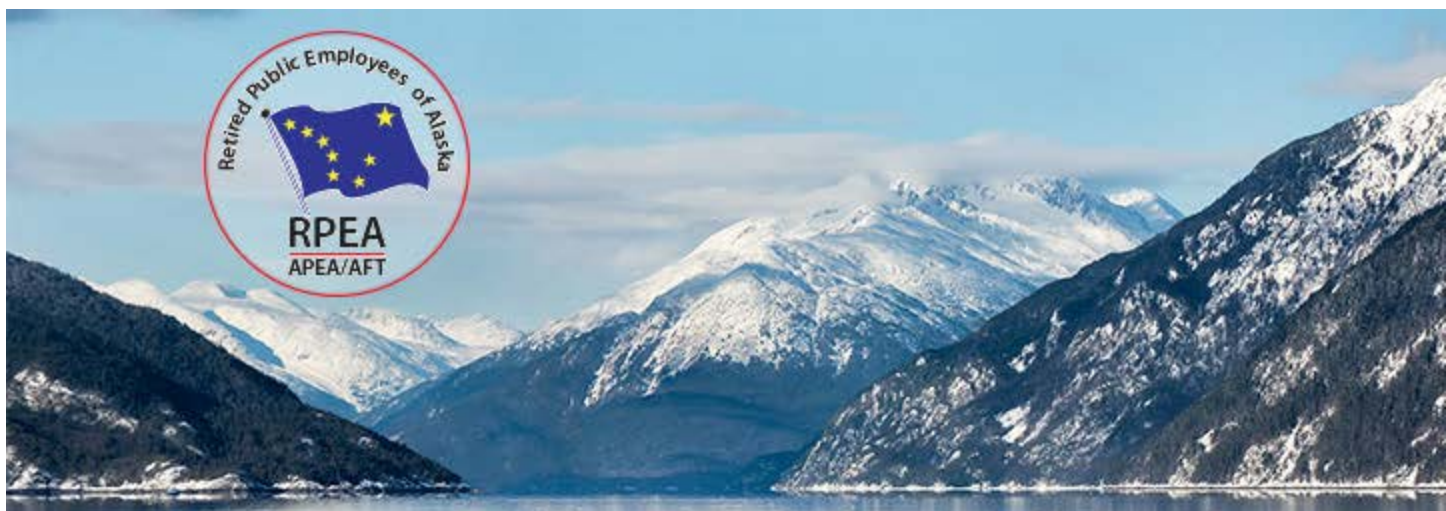
There should be NO LIFETIME limits!!!

And lastly I feel it is time defiantly time to prepare a new handbook/manual. With all of the amendments over time it is very cumbersome and difficult to understand and read. Prepare a new version that is updated in its entirety.

Thank you again for the opporutnity to share my thoughts. Deborah S. Boyd, [REDACTED]

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**From:** "sharonhoffbeck" <[REDACTED]>  
**To:** "RPEA Members--All" <[rpea.members@mailman.apea-aft.org](mailto:rpea.members@mailman.apea-aft.org)>  
**Sent:** Thursday, June 7, 2018 7:57:19 PM  
**Subject:** [Rpea.outside] [Rpea.members] DRB Retiree Health Plan Modernization



Dear RPEA Members,  
The Retiree Health Plan Advisory Board's retiree plan modernization committee will meet June 12, 2018 from 1:00-4:00p.m. Alaska time.

Teleconference is available for anyone wishing to attend:

**Teleconference number:** [\(907\) 269-3000](tel:9072693000) / Session No: [804 901 371](tel:804901371) /  
Attendee No: # [808 521 878](tel:808521878)

Attached is the DRB modernization presentation. Those who cannot open the attached document can also view it at the RPEA website after June 10<sup>th</sup> under the 'Retiree Health Plan Advisory Board' link: <http://www.rpea.apoa-aft.org/>.

The retiree health care plan was first developed as part of the public retirement systems in 1975. It was specifically intended to encourage qualified individuals to enter into and remain in public employment. It provided extensive and valuable health care benefits and coverage for qualified public employees. The retiree health care plan, like other retirement benefits, created a type of "savings" plan for public employees – one they could rely upon to provide the promised coverage once they retired.

In the case of *Duncan v. RPEA*, the Supreme Court ruled that health care benefits, just like other retirement benefits, are protected from

diminishment or impairment by the Alaska Constitution. However, that does not mean that retirement benefits cannot be changed. Benefits can be modified so long as the modifications are reasonable, and one condition of reasonableness is that disadvantageous changes must be offset by comparable new beneficial changes.

RPEA will closely monitor all actions taken by the Division of Retirement & Benefits to assure that any changes to the plan comply with the *Duncan* court ruling.

It is important that retirees attend meetings via teleconference when possible, and send comments and concerns to the Retiree Health Plan Advisory Board at [AlaskaRHPAB@alaska.gov](mailto:AlaskaRHPAB@alaska.gov). Please cc RPEA as we are keeping track of issues that are important to retirees:

[REDACTED]

Please let me know if you have questions.

***Sharon Hoffbeck***  
President  
Retired Public Employees of Alaska

[REDACTED]



Virus-free. [www.avast.com](http://www.avast.com)

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Rpea.members mailing list  
[Rpea.members@mailman.apea-aft.org](mailto:Rpea.members@mailman.apea-aft.org)  
<http://mailman.apea-aft.org/cgi-bin/mailman/listinfo/rpea.members>

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Rpea.outside mailing list  
[Rpea.outside@mailman.apea-aft.org](mailto:Rpea.outside@mailman.apea-aft.org)  
<http://mailman.apea-aft.org/cgi-bin/mailman/listinfo/rpea.outside>

**From:** dale skinner <[REDACTED]>  
**Sent:** Thursday, June 21, 2018 5:31 AM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
[REDACTED]  
**Subject:** Comments on Medical Changes

- A. Limited preventive care services: Add some preventive services.

(Note: Currently, the retiree medical plan includes preventive services for PAP test and associated exam, PSA test and associated exam and mammograms. It was not disclosed what additionally is being considered.)

This would be wonderful to add some preventive services to our current health plan.

- B. Lifetime Limit of \$2M: remove or increase limit.

I am all in favor of an increasing the limit. I would never want to see this limit removed or decrease.

- C. Increase deductible and out-of-pocket maximums: per DRB, low cost share reduces sensitivity to price & increases unnecessary services.

(Note: A previous DRB proposal was:

- a. Raise the yearly deductible from \$150/person with a max of \$450/family to \$300/person with a max of \$600/family.

This would be terrible to allow the yearly deductible to be increased. I am totally against this.

- a. Currently the plan pays claims at 80% with a 20% copay until a yearly out-of-pocket of \$800 is reached, and then the plan pays at 100%. DRB's proposal is to raise the yearly out-of-pocket before the plan pays at 100% to \$1,600.

Again, a terrible idea to make this kind of an increase and place this added burden on the backs of retirees.

- a. Double the pharmacy copay for drugs on the pharmacy benefit manager's formulary. Charge a \$25 copay for drugs not on the pharmacy benefit manager's formulary.

Again, terrible plan. As we age, how many drugs we need and the cost of those drugs goes up more and more every year. We should stay with our current plan and not have this kind or any kind of an increase.

These kinds of choices, the cost of our medical, should be made by retirees for retirees, not by anyone not yet retired.

**From:** [REDACTED]  
**Sent:** Thursday, June 21, 2018 9:10 AM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** [REDACTED]  
**Subject:** Comments on Proposed Changes to Retiree Health Benefits

Dear Retiree Health Plan Advisory Board:

This email represents my comments on proposed changes to the health benefits for retirees. I oppose any changes that could be construed as reducing my benefits. I could have made much more working for the federal government or private industry, but I chose to make a career with the State of Alaska because of its retirement benefits.

- A. Limited preventive care services: Add some preventive services.

I support adding annual physicals. This should save money in the long run by finding serious medical problems early when it will cost less to address them

- B. Lifetime Limit of \$2M:

I support removing or increasing the limit.

- C. Increase deductible and out-of-pocket maximums: per DRB, low cost share reduces sensitivity to price & increases unnecessary services.

This increase seems like a diminishment of benefits.

- D. Implement 3-tier pharmacy benefit, change out-of-network benefits

I strongly oppose this change. I have [REDACTED] and throughout time medicines become ineffective. It is extremely important to me (and to lower costs for the State) to get the most effective medicine. About a year ago, my [REDACTED], but returned to an acceptable range with new medicine. I'm afraid the step approach might have resulted in [REDACTED] that I could not recover from



- E. Limit pharmacy to 90 day refill, and exclude over the counter equivalent

If this is done, it should only be for non-chronic conditions. With conditions such as [REDACTED], a one-year refill will save time and money because my doctor only requires one visit per year when [REDACTED] remain acceptable. If you increase this to 4 times per year, the State will incur more costs.



F. Limit compound medication coverage for non-FDA approved drugs

Any limit should not cover people who have exhausted other medications.

G. Enhance travel benefits

Keep the same benefits unless an increase can be done without reducing other benefits. Alaskan's have lots of miles that could be used if they need more travel. For chronic conditions, people often ask for mileage donations – I have donated miles a number of times.

H. Implement yearly service limits for chiropractic, physical therapy and massage therapy, or hire a specialized vendor to manage the current benefit.

No comment

I. Exclude some dental implants from the medical plan and cover under dental plan exclusively.

Need more information on this proposed change before I have an opinion,

No comment.

J. High use of hi-tech imaging and testing: implement in-network enhanced clinical review.

Not sure what high use means. Rather than eliminating this benefit, perhaps increase the justification for its use by doctors.

K. Update retiree plan book to include regulations, amendments & benefit clarifications.

I agree with this proposal. Unless I don't have a current version, the current book hasn't been updated in a long time.



Glenn Gray  
Retiree

Auto Reply's began Monday 6/25 at 9:27pm.  
Format of retiree's e- mail is different. VRK

Areas of focus DRB/DOA identified for consideration:

A. Limited preventive care services: Add some preventive services.

Additional preventive services hopefully would be balanced by increased savings down the road, and we support this provision although exact information has not been provided. Flu shots are a good example.

B. Lifetime Limit of \$2M: remove or increase limit.

No limit would reduce the amounts available to benefit retirees as a whole while benefiting a few. Oppose.

C. Increase deductible and out-of-pocket maximums:

A deductible of \$300 per person could restrict someone from obtaining needed care. A low copay per medical visit would be more fair.

The \$1,600 out-of-pocket limit is too high.

Do not increased costs for medications necessary to control medical conditions.

D. Implement 3-tier pharmacy benefit, change out-of-network benefits:

The 3-tier pharmacy benefit is scary. More information needed.

E. , F., Limit pharmacy to 90 day refill, etc.: No comments

G. Enhance travel benefits: More information needed; probably beneficial for all.

H. Implement yearly service limits for various therapies: Agree reasonable limitations needed.

I. Exclude some dental implants: Disagree. Removing the implant provision from medical coverage would reduce retiree benefits and be unavailable to some retirees without dental coverage or funds to allow for this procedure to maintain their health. The dental plan probably does not have sufficient funds without raising rates.

J. High use of hi-tech imaging and testing: Review of prescribed imaging could be cumbersome and restrictive and hard to evaluate without more information.

K. Update retiree plan book: Absolutely.

#### OTHER:

The EGWP/WRAP proposal needs a lot more information including what the acronym stands for.

Dependent care. Do not extend dependent coverage to age 26 from the current 23 while enrolled in college. Another example of reducing retiree benefits where the funds are finite.

#### Lack of adequate notice on changes to AlaskaCare

On April 18, 2018 [REDACTED] was discharged from the Post Falls, Idaho hospital following [REDACTED] one of the most painful surgeries, the day before. [REDACTED] is over 100 miles from our home in Montana. On the drive home we stopped in [REDACTED], Idaho to pick up a [REDACTED]. The pharmacy would fill his prescription for a ten day supply, but Aetna would not approve because approval had not been requested before the surgery. A new provision had been added to AlaskaCare on January 1, 2018 without notice to retirees except for an insert on the website. We receive and read Health Matters from AlaskaCare and PERS Newsbreak, but no mention was made there. Phoned complaints to Alaska R&B and Aetna provided no resolution other than to drive back to [REDACTED], have the doctor submit a request to Aetna, if approved a new prescription could be written and taken back to [REDACTED]. Obviously this was not possible. Eventually Aetna did send a letter by mail approving prescriptions for April 20 – May 20, too late to benefit [REDACTED], and refused reimbursement for the prescription filled on April 18.

Many retirees do not have access to the internet or use it frequently to see if benefits have changed without notice.

We look forward to receiving further information on the proposed AlaskaCare revisions.

(Jack & Elaine Vander Sande)

## Retiree Health Plan Advisory Board:

Please see the comments below on proposed changes to the health benefits for retirees. I oppose any changes that could be construed as reducing my benefits! I could have made much more money in my career working in the private sector, but I chose to make a 30 year career with the State of Alaska because of its retirement benefits.

- B. Limited preventive care services: Add some preventive services.  
I support adding annual physicals. This should save money in the long run by finding serious medical problems early when it will cost less to address them
- C. Lifetime Limit of \$2M:  
I support removing or increasing the limit.
- D. Increase deductible and out-of-pocket maximums: per DRB, low cost share reduces sensitivity to price & increases unnecessary services.  
This increase seems like a diminishment of benefits.
- E. Implement 3-tier pharmacy benefit, change out-of-network benefits  
I strongly oppose this change. I have [REDACTED] and throughout time medicines become ineffective. It is extremely important to me (and to lower costs for the State) to get the most effective medicine. About a year ago, [REDACTED], but returned to an acceptable range with new medicine. I'm afraid the step approach might have resulted in [REDACTED] that I could not recover from
- F. Limit pharmacy to 90 day refill, and exclude over the counter equivalent  
If this is done, it should only be for non-chronic conditions. With conditions such as [REDACTED], a one-year refill will save time and money because my doctor only requires one visit per year when my [REDACTED] remain acceptable. If you increase this to 4 times per year, the State will incur more costs.
- G. Limit compound medication coverage for non-FDA approved drugs

Any limit should not cover people who have exhausted other medications.

H. Enhance travel benefits

Keep the same benefits unless an increase can be done without reducing other benefits. Alaskan's have lots of miles that could be used if they need more travel. For chronic conditions, people often ask for mileage donations – I have donated miles a number of times.

I. Implement yearly service limits for chiropractic, physical therapy and massage therapy, or hire a specialized vendor to manage the current benefit.

No comment

J. Exclude some dental implants from the medical plan and cover under dental plan exclusively.

Need more information on this proposed change before I have an opinion,

No comment.

K. High use of hi-tech imaging and testing: implement in-network enhanced clinical review.

Not sure what high use means. Rather than eliminating this benefit, perhaps increase the justification for its use by doctors.

L. Update retiree plan book to include regulations, amendments & benefit clarifications.

I agree with this proposal. Unless I don't have a current version, the current book hasn't been updated in a long time.

Please take these comments into consideration.

Russell Carey  
State of Alaska Retiree

Thank you for agreeing to serve on the retirement committee.

Thank you for the opportunity to comment on the medical and dental coverage for PERS retirees.

The plans must be more comprehensive to meet our family's needs!

The lifetime limit on coverage is disconcerting. That amount could be wiped out in a very short time if the God-forbid should happen. But, we could be left with no medical care at all with such a low limit. I may have another 40 years of life, and so that limit does not allow for much at all if annualized.

I would hope that traveling to another location, outside Alaska, is something that is supported by the plan. The cost of care in Alaska, whether Wasilla or Anchorage, is very prohibitive. I can't help but believe that even with airfare, per diem for housing and meals, ground transportation, care would be much less expensive elsewhere in the USA, even if on the East Coast or Florida. It would make that lifetime limit go farther.

Chiropractic care is proving very beneficial [REDACTED] and I wish that this care was covered better under my retirement and benefits. I'd rather do this than have surgery or injections.

If we need surgery, I think going Outside would be the right thing to do. Because of cost of care as well as quality of care.

Recently a provider in the Valley said he would not be a preferred provider because he is the only one in his specialty in the MatSu. I decided to not see him, and forego care in lieu of going to Anchorage as it was not that critical at the moment. I am getting okay care at a GP.

Warm Regards, Anna Weiss

I'd like to comment on a few things.

Taking away the 2mil lifetime benefit would be a detriment to those who've paid in to this account knowing there'd be the money there for insurance and passed down to living spouses. I don't necessarily support increasing it, but keeping the 2 mil for already retired should stay the same. Change it for those just joining the State of Alaska. Don't penalize the retired.

Also, travel benefits should include people traveling from Fairbanks and outlying areas to go to anchorage to receive treatment. Fairbanks does not have adequate or good care. I had [REDACTED] in Anchorage and my travel benefits were denied because there is a surgeon who replaces knees here— yet, he's one of the worst, and surgeons outside of Fairbanks have had to fix his problem knee replacements. Overall, there would be a great savings to the state— aetna— by having surgeries done right the first time.

Thank you,  
Christie Neff



The plan changes asked for and apparently being considered per the AlaskaCare Retiree News | July 2018 are:

- Adding coverage for preventive services (including vaccines)
- Increasing or removing the \$2 million lifetime maximum
- Adding an enhanced travel benefit to provide airfare, lodging, and per diem for a member and a companion to a center of excellence for certain surgeries
- Improving coverage for rehabilitative services including physical and occupational therapy and chiropractic care
- Implementing an Enhanced Employer Group Waiver Program (EGWP) (see below)

The first item is most important and should save money. It seems like it should have been done years if not decades ago. The travel benefit should also save money given the exceedingly high cost of care in Alaska vs alternatives.

The critical question is how much will be taken from the plan to cover the costs of increasing the maximum and improved coverage?

Hopefully reasonable negotiations will be successful in balancing the changes.

Sincerely

Lawrence A. Semmens

Hello,

I'm writing regarding the potential changes the Retiree Health Plan Advisory Board is considering, see below.

I wholehearted support the addition of coverage for preventative services and/or annual wellness care/exams. I am really glad to see this is being considered, it just makes sense to me to operate from a position of wellness/maintaining wellness.

Regarding the increasing or removing the \$2 million lifetime maximum - I don't have an opinion on this at the moment but was curious about the rationale for increasing or removing. Also, statistics showing how often people max out on this would be helpful. My concern is if someone reached the maximum and wouldn't have healthcare.

Thank you for your time and for providing an opportunity for input on the health plan.

Best,  
Nancy Winford

The Division is working with the newly-created Retiree Health Plan Advisory Board to improve and modernize the AlaskaCare retiree plan. We need your help to protect, sustain, and improve the plan. Please let us know what you think is working, and what you would like to see improved. You can send comments to [alaskaRHPAB@alaska.gov](mailto:alaskaRHPAB@alaska.gov).

The Division and the Board have formed a working group to prioritize implementation of some potential changes you've already asked for. These include:

- Adding coverage for preventive services (including vaccines)
- Increasing or removing the \$2 million lifetime maximum
- Adding an enhanced travel benefit to provide airfare, lodging, and per diem for a member and a companion to a center of excellence for certain surgeries
- Improving coverage for rehabilitative services including physical and occupational therapy and chiropractic care
- Implementing an Enhanced Employer Group Waiver Program (EGWP) (see below)

The next working group meeting is scheduled for **Thursday, July 26th, from 1 p.m. to 4 p.m.** with locations in Juneau and Anchorage and teleconference provided. The full board will meet **Wednesday, August 29th, from 9 a.m. to 4 p.m.** You are welcome to attend or listen in.

For more information, including teleconference information and meeting materials, please visit [AlaskaCare.gov/retiree/advisory.html](http://AlaskaCare.gov/retiree/advisory.html).

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Sent from my iPad

The lifetime maximum should include actual monies paid out by the plan for the retiree's medical expense and not for the total cost of the medical visit and associated costs of medical care. Please check to see if that is the way it is being recorded by Aetna. I assume it is but do not know that it is being recorded as actual monies paid by the supplemental retiree plan.

Sent from [Outlook](#)

(Greg S – added by Vanessa)

## Alaska Retiree Health Plan Advisory Board

### RE: DB Retiree Health Plan Modernization

I am an Alaska State retiree covered by the Alaska Retiree Health Plan. I have reviewed the modernization solutions to the plan described in your proposal. My comments on several of the proposed Areas of Focus solutions are below.

#2 – I agree that a lifetime maximum is an out of date concept and the current maximum should be eliminated.

#3 – Low Cost Share: I've always thought that all participants should pay a share of costs. This is particularly applicable to the family deductible, where the problem isn't as much a low cost share per participant, but a lack of participation by every person in each covered household. I believe the deductible should be paid by every participant, whether there are 2 or 10 in the family.

The current amount of the deductible is quite reasonable, but if it needs to be raised, it should be in a phased approach and not exceed \$250.

The out of pocket suggestion at \$1,600 is too high at double the current amount, and if increased, it should only go to \$1,000. But again, the problem isn't the actual amount, but the lack of participation by every person in the household. The out of pocket should be paid by every participant in the plan, including all dependents.

#4 – If a specific non-preferred pharmaceutical brand is required to meet a medical necessity, it should be treated the same as a Tier 2 drug, as it is now. It shouldn't have a higher co-pay than the current level.

#5 – The plan design is outdated in the requirement that meds be supplied for only 100 days. I would like to see an allowance, with a justification from my provider, for a 180 day supply for lifetime meds.

Over the counter meds requirements need to consider allergies and the unavailability of allergy free OTCs.

#6 – I support the following: "Medical exceptions will be allowed to avoid allergies or provide dosages or mixtures that are not available commercially". Compounded meds should be covered at the same copay as in the current pharmacy benefit.

#7 – I support expansion of travel benefits.

Please feel free to contact me if you have any questions.

Regards,

Alison L. Smith



Hello-

I appreciate your wanting to improve our healthcare!

I strongly agree that AlaskaCare needs to improve:

preventative care - by adding more common illnesses

increase the \$ 2 million max - health prices have increased dramatically when that figure was decided upon

improve the rehabilitative services...

██████████ for my ██████████  
██████████, but was denied more



even tho my problem was not resolved, and when I asked what they would recommend & cover - silence.

PLEASE SIMPLIFY THE ALASKACARE BOOK! Make it user friendly, not attorney friendly.

Thank you for your time.

Karen Koester  
retiree

Hi there,

I would love to see the following improvements to the Retiree Plan:

- Adding coverage for preventive services (including vaccines) – Shingles shots would be great
- Increasing or removing the \$2 million lifetime maximum
- Adding preventative

I have issues when my health care provider writes just about every appointment up as “Well Care” or “Well Woman.” It makes it sound as though it’s a physical or something similar. As an example, [REDACTED] was written that way. My appointment was [REDACTED] and they insisted on calling it Well Woman. Aetna would not pay for a Well Woman exam. We’re still battling this one. Maybe if our plan allowed for “names” like that, it would avoid this kind of issue.

I also don’t understand why preventative (like a physical) aren’t covered. “An ounce of prevention...?”

Thank you,

Mary Josefa LaFurney

[REDACTED]

# Preventive Care



**Proposed change:** Expanded preventive services subject to network steerage.

**Plans affected:** DB Retiree Plan

**Reviewed by:** Retiree Health Plan Advisory Board

**Proposed implementation date:** January 1, 2019

**Review Date:** July 26, 2018

*Table 1: Plan Design Changes*

	Member	Actuarial	DRB Ops	Financial	Clinical	TPA	Provider
No impact							
Minimal impact			X			X	
High impact	X	X		X	X		X
Need Info							

**Description of proposed change:**

Expanding preventive services will add value to the plan for most retirees and will increase the overall actuarial value of the plan. Expanding preventive will have a positive clinical and provider impact. However, expanding benefits will increase claims cost and have a negative financial impact to the plan. The Division and the Medical and Pharmacy Third Party Administrators will be minimally impacted by the changed.

The plan was first developed in 1975 and provides extensive and valuable benefits for retirees and their dependents necessary for *the diagnosis and treatment* of an injury or disease. The plan was not established as a preventive or ‘wellness’ plan. Preventive services that are used to screen individuals prior to symptoms being exhibited are limited to mammograms, Pap smears and Prostate Specific Antigen tests (to detect prostate cancer in males).

One of the main reoccurring complaints the Division of Retirement and Benefits (Division) receives is related to the retiree plan’s lack of preventive care coverage. This is a complex topic since the plan serves two very distinct populations: those retirees and their dependents who are eligible for Medicare, and the retirees under the age of 65 (U65) who do not yet qualify for Medicare coverage. As Medicare already offers many preventive services at no cost to the beneficiary, adding preventive coverage is not as high a priority for those eligible for Medicare benefits.

Around 2010, in conjunction with certain requirements in the Patient Protection and Affordable Care Act (ACA), insurance coverage for age-specific guidelines indicating

the utilization of screening and preventive services for older adults grew increasingly common. Despite these industry changes, the omission of most preventive benefits in the plan may cause retirees to forego getting recommended age-specific vaccinations, screenings, and other preventive services. The goal of preventive services is to increase early detection and treatment of health conditions in order to improve clinical outcomes, arrest disease at an earlier stage when it is easier and more effectively treated, and to promote health-conscious behavior.

Simply adding preventive screening does not necessarily save a plan money as articulated by the Robert Wood Johnson Foundation in their 2009 study.<sup>1</sup> They found high-risk groups often stay away from screenings,<sup>2</sup> and health-conscious members may use the screenings in excess. The result is higher procedure volume and total costs without the net savings associated with early detection or treatment.

“It is unlikely that substantial cost savings can be achieved by increasing the level of investment in clinical preventive care measures. On the other hand, research suggests that many preventive measures deliver substantial health benefits given their costs.

Moreover, while the achievement of cost savings is beneficial, it is important to keep in mind that the goal of prevention, like that of other health initiatives, is to improve health. Even those interventions that cost more than they save can still be desirable. Because health care resources are finite, however, it is useful to identify those interventions that deliver the greatest health benefits relative to their incremental costs.”<sup>3</sup>

The objective in adding preventive care to the AlaskaCare defined benefit retiree health plan is not to save money, but to save lives, and to support the members in maintaining their health. Preventive services are both mainstream and greatly desired by the membership, particularly those who are not Medicare-eligible and do not have any coverage for these services.

The Division proposes adding the full suite of evidence based preventive services to the plan that mirror those provided in most employee plans in accordance with the Affordable Care Act. These expanded services include those with an “A” or “B” rating

<sup>1</sup> Goodell, S., Cohen, J., & Neumann, P. (2009, Sep 1). Cost Savings and Cost-Effectiveness of Clinical Preventive Care. Retrieved from <https://www.rwjf.org/en/library/research/2009/09/cost-savings-and-cost-effectiveness-of-clinical-preventive-care.html>

<sup>2</sup> Benson WF and Aldrich N, CDC Focuses on Need for Older Adults to Receive Clinical Preventive Services, Critical Issue Brief, Centers for Disease Control and Prevention, 2012, <http://www.chronicdisease.org/nacdd-initiatives/healthy-aging/meeting-records>

<sup>3</sup> Ibid.

by the United States Preventive Task Force.<sup>4</sup> The specific services will change as the USPTF updates their recommendations to reflect the most current research and evidence.

The Division proposes that preventive services would be subject to normal cost-share provisions (annual deductibles, coinsurance, copay and annual maximum out-of-pocket limits, etc.), with the exception that the coinsurance paid by the plan will be reduced by 20% when the preventive care services are provided by an out-of-network provider. Further, those out-of-network expenses will not count towards the annual out-of-pocket maximum.

*Table 2: Comparison of Current to Proposed Change*

Benefit	Current	Proposed in-network	Proposed out-of-network
<b>Coinsurance</b>	<ul style="list-style-type: none"> <li>80% after deductible. (100% after annual out-of-pocket reached.)</li> </ul>	<ul style="list-style-type: none"> <li>80% coinsurance after deductible. (100% after annual out-of-pocket reached.)</li> </ul>	<ul style="list-style-type: none"> <li>60% coinsurance after deductible. (Does not apply if no network access)</li> </ul> <p>Not subject to the individual out-of-pocket maximum (exception if no network access)</p>
<b>Mammograms</b>	<ul style="list-style-type: none"> <li>One baseline between age 35-40.</li> <li>One every two years between age 40-50.</li> <li>Annually at age 50 and above and for those with a personal or family history of breast cancer.</li> </ul>	<ul style="list-style-type: none"> <li>Biennial screening between age 50-74</li> <li>Earlier or additional screenings for those at high risk</li> </ul>	
<b>Pap Smear</b>	One per year for women 18 years of age and older. Also includes limited office visit to collect the pap smear.	One every 3 years for women age 21 to 65, or every 5 years with a combination of cytology and HPV testing.	

<sup>4</sup> A current list of A and B services is available at:

<https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/>

<b>Prostate specific antigen (PSA)</b>	<ul style="list-style-type: none"> <li>• One annual screening test for men between ages 35 and 50 with a personal or family history of prostate cancer,</li> <li>• One annual screening test for men 50 years and older.</li> </ul>	Not covered
<b>Vaccines</b>	Not Covered	Coverage for those recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
<b>Annual Routine Physical</b>	Not Covered	Covered
<b>Well Woman Preventive Visit</b>	Not Covered (exception of limited exam to collect the pap smear)	Subject to any age, family history and frequency guidelines that are evidence-based items or services that have in effect a rating of A or B in the recommendation so the United States Preventive Services Task Force and Evidence informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration
<b>Routine Cancer Screening</b>	Not Covered (except as covered under Mammograms, PSA and Pap Smear above)	Subject to any age, family history and frequency guidelines that are evidence-based items or services that have in effect a rating of A or B in the recommendation so the United States Preventive Services Task Force and Evidence informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration

### **Member impact:**

Studies suggest that increase in coverage for prevention may increase the use of preventive services. This will be an added benefit for all members, providing access to preventive care previously excluded under the retiree health plan.

As an example, one of the more expensive preventive services is a screening colonoscopy. The USPSTF guidelines recommend screening colonoscopies once every 10 years for non-high-risk adults starting at age 50. The AlaskaCare retiree plan has approximately 20,000 retiree adults between the ages of 50-64. Colonoscopy is a covered benefit under Medicare for whom most retirees age 65 and above are eligible.

Medicare eligible members will have access to preventive care not covered under Medicare, such as vaccination against shingles and an annual full physical examination.

The Division regularly receives complaints about the lack of preventive coverage in the plan, and the addition of these services is something the Division believes members will find both valuable and desirable.

### **Actuarial impact**

Neutral Enhancement Diminishment

*Table 3: Actuarial Impact*

	Actuarial Impact	Notes
Current	N/A	N/A
Expanded preventive	0.75% increase <sup>5</sup>	80% coinsurance in network/60% out-of-network

### **DRB operational impacts:**

The Division anticipates the expansion of preventive benefits in the retiree health plan will reduce calls, complaints and appeals to the Division related to lack of preventive coverage.

The retiree health plan is an antiquated plan design and is unusual in its lack of coverage for most preventive services. For this reason, there is a substantial communication and education need for the Division to notice members regarding the lack of preventive services. That need would no longer exist if the benefits were expanded.

<sup>5</sup> Attachment A: *Preventive Care Benefits – Focus on Actuarial and Financial Impact for the Retiree Plan*, Segal Consulting memo dated July 25, 2018

### **Financial impact to the plan:**

Based on a Segal Consulting's preliminary retiree claims projection of \$680,000,000 for 2019, the anticipated fiscal impact is estimated to be approximately \$5,000,000 in additional annual costs.<sup>6</sup>

Segal's analysis looked at 2016 and 2017 medical and pharmacy claims data, and projected to 2019 at 3.0% and 6.0% annual trends respectively. For Medicare member, Medicare covers many of these services, including colonoscopies, at 100%. For these member, no change in utilization is assumed and the impact on the Plan is anticipated to be negligible. The analysis for non-Medicare members focused on the approximate 20,000 members between age 50 and 65.<sup>7</sup>

### **Clinical considerations:**

It is largely agreed that the recommended preventive services can help detect disease, delay their onset, or identify them early on when the disease is most easy to manage or treat. Adding these services could have a positive clinical impact.

An example is colonoscopies. Excluding skin cancers, colorectal cancer is the third most common cancer diagnosed in both men and women. Screening can prevent colorectal cancer by finding and removing precancerous polyps before they develop into cancer. The cost of treatment is often lowest, and the survivor rates are better, when the tumor is found in the earlier stages.

### **Third Party Administrator (TPA) operational impacts:**

Using the industry standard set by the Affordable Care Act to determine what services are covered, the impact to the TPA is minimal. This is often an "yes/no" indicator switch in a TPA's claims adjudication system. The change would simplify the administration of the AlaskaCare retiree health plan, which currently requires customization to provide the limited preventive services covered by the plan today.

Similarly, it is industry standard to have a separate network/out-of-network coinsurance for preventive services and therefore will not require any customization.

Last, offering the full suite of preventive services allows greater flexibility in disease management and broader communication options when there is not a concern about recommending a service not covered under the health plan.

<sup>6</sup> *Preventive Care Benefits – Focus on Actuarial and Financial Impact for the Retiree Plan*, Segal Consulting memo dated July 25, 2018.


<sup>7</sup> *Ibid.*

**Provider considerations:**

The Division expects that expanding preventive coverage will have a positive impact on providers. They may gain customers in members who previously would have forgone the non-covered services, and they should see ease in administration in that they will not need to bill the member directly for the non-covered services.

The coinsurance differential may incentivize some doctors to join the network, as many members may look for a network provider to maximize their health plan benefits.

**Documents attached include:**

<u>Document Name</u>	<u>Attachment</u>	<u>Notes</u>
<i>Preventive Care Benefits – Focus on Actuarial and Financial Impact for the Retiree Plan</i> , Segal Consulting memo dated July 25, 2018	A	 Segal Preventive Memo
Summary of Public Comment	B	See Attached

# Attachment A



## MEMORANDUM

**To:** Ajay Desai, Director, Division of Retirement and Benefits  
**From:** Richard Ward, FSA, FCA, MAAA  
**Date:** July 25, 2018  
**Re:** Preventive Care Benefits – Focus on Actuarial and Financial Impact for the Retiree Plan

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The AlaskaCare Retiree Plan currently provides coverage for some select preventive benefits. Currently, the Plan provides coverage for the following routine lab tests:

- One pap smear per year for all women age 18 or older. Charges for a limited office visit to collect the pap smear are also covered.
- Prostate specific antigen (PSA) tests as follows:
  - One annual screening PSA test for men between ages 35 and 50 with a personal or family history of prostate cancer, and
  - One annual screening PSA test for men 50 years and older
- Mammograms as follows:
  - One baseline mammogram between age 35 and 40
  - One mammogram every two years between ages 40 and 50, and
  - One annual mammogram at age 50 years and above, and for those with a personal or family history of breast cancer.

Coverage is provided in the same manner that other medical treatments and services are covered. The Plan applies the general plan provisions, such as deductible, coinsurance and out-of-pocket limitations, to determine any portion of the costs that are the member's responsibility. If the

member has additional coverage, such as Medicare or other employer provided coverage, any portion of the costs covered by that plan is also considered.

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

Deductibles			
Annual individual / family unit deductible		\$150 / up to 3x per family	
Coinsurance			
Most medical expenses		80%	
Most medical expenses after out-of-pocket limit is satisfied		100%	
Second surgical opinions, Preoperative testing, Outpatient testing/surgery		100%	
• No deductible applies			
Out-of-Pocket Limit			
Annual individual out-of-pocket limit		\$800	
• Applies after the deductible is satisfied			
• Expenses paid at a coinsurance rate other than 80% do not apply against the out-of-pocket limit			
Benefit Maximums			
Individual lifetime maximum		\$2,000,000	
• Prescription drug expenses do not apply against the lifetime maximum			
Individual limit per benefit year on substance abuse treatment without precertification. Subject to change every three years		\$12,715	
Individual lifetime maximum on substance abuse treatment without precertification. Subject to change every three years		\$25,430	
Prescription Drugs		Up to 90 Day or 100 Unit Supply	
		Generic	Brand Name
Network pharmacy copayment		\$4	\$8
Mail order copayment		\$0	\$0

A change to the benefits under consideration would align the scope of benefits with those required of non-Grandfathered plans under the Affordable Care Act (ACA). Note that retiree plans, such as the AlaskaCare Retiree Plan, are not subject to the same provisions under the ACA that apply to the AlaskaCare Employee Plan. Preventive benefits will continue to be subject to deductibles, coinsurance and other plan provisions that apply in 2018.

## Actuarial Value

Our analysis determines the impact of expanding the scope of covered services to align the scope of benefits with those required of non-Grandfathered plans under the ACA would be an increase of 0.75% in actuarial value.

## Financial Impact

Based on a preliminary retiree claims projection of \$680,000,000 for 2019, this equates to approximately \$5,000,000 in additional annual costs to the Plan.

This analysis is based on 2016 and 2017 medical and pharmacy claims data, projected to 2019 at 3.0% and 6.0% annual trends, respectively. The data was reviewed, but not audited, and found to be sufficient and credible for this analysis.

With over 60,000 members and a high incidence rate of preventive care, the data is considered credible for this analysis. For Medicare members, many of these services, including colonoscopies, are currently covered at 100% by Medicare. For these members, no change in utilization is assumed and the impact on the Plan is anticipated to be negligible. For non-Medicare members, our analysis focused those between ages 50 and 65. There are approximately 20,000 such members.

*Please note that the projections in this report are estimates of future costs and are based on information available to Segal at the time the projections were made. Segal Consulting has not audited the information provided. Projections are not a guarantee of future results. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, trend rates, and claims volatility. The accuracy and reliability of projections decrease as the projection period increases. Unless otherwise noted, these projections do not include any cost or savings impact resulting from The Patient Protection and Affordable Care Act (PPACA) or other recently passed state or federal regulations.*

cc: Michele Michaud, Division of Retirement and Benefits  
Emily Ricci, Division of Retirement and Benefits  
Linda Johnson, Segal  
Michael Macdissi, Segal  
Noel Cruse, Segal  
Dan Haar, Segal

# Attachment B

**From:** Eric M <[REDACTED]>  
**Sent:** Friday, June 08, 2018 6:01 AM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** Eric(Desktop) <[REDACTED]>; [REDACTED]; Saddler, Dan (LEG) <[representative.dan.saddler@akleg.gov](mailto:representative.dan.saddler@akleg.gov)>; MacKinnon, Anna (LEG) <[senator.anna.mackinnon@akleg.gov](mailto:senator.anna.mackinnon@akleg.gov)>  
**Subject:** Proposed DB Retiree Health Plan Modernization

June 8, 2018

Eric & Mary Marchegiani  
[REDACTED]

Subject: Proposed DB Retiree Health Plan Modernization

Dear Sir/ Madame:

First off, whenever I hear that someone is ready to make modification to our Health Plan a red flag goes up because usually it means that our benefits are going to be reduced or made more complicated to obtain; -- to the detriment of the Retiree and to the benefit of the State of AK. That has been the case with the previous change in the health care provider Aetna and the modifications to our dental plan by going to Moda.

I would ask that any future change to our Health Plan consider two over riding concepts:

1. Any change needs to make the process and submittal process as simple as possible. As we retirees age, it becomes more and more difficult for us to handle our insurance benefits which means that complicated processes and submittal processes results in our inability to deal with them and as a result many of us will end up paying more out of a fixed income. That means our quality of life will diminish.
2. All of our benefits should be handled under one company / provider. The separation of the Medical Benefits from the Dental and Vision makes it more complicated to deal with. As I have indicated above in #1; the process needs to be straight forward and simple. As a result of this – I am recommending that the State of AK re-advertise for its benefits (medical, dental, vision etc) all under one provider. It has been over 4 years since the last advertisement and it is time for a change., Aetna has been terrible to deal with... in my opinion their first review is to deny benefits if there is anything that seems different vs actually looking at the claim... then it is incumbent upon the Retiree to fight it. We should not be put in that position. Our benefits were much easier to deal with prior to Aetna.

Unfortunately, I will not be able to attend the teleconferenced meeting and provide testimony at the meeting time. In lieu of that I am listing below my comments on the PP Presentation that was made available ahead of time. Obviously, there may be things that come up in the meeting which I will not be able to comment upon but that said, my comments below will hopefully provide some perspective on my and my wife's views.

**Comments:**

1. It seems a bit unusual for the modernization program in its discussion of the pharmacy benefits to have totally left out the most recent proposal to modify the Retiree pharmacy benefits as they become 65 and qualify for Medicare. It may be an entirely separate discussion but all of us will be 65 at some point and being a retiree.... Well that would seem like an obvious topic to include within the modernization of the health plan. I have recently sent comments on that recent proposal but it should be included within this overall package. Similar to any changes here... there needs to be an analysis that demonstrates that the benefits will not be diminished.
2. Under the Areas of Focus: positive improvements
  - a. I have wondered for a long time as to why the State of AK did not provide for preventative services... i.e. fix the issue before it becomes a bigger problem would seem to be a no brainer. I concur that adding preventative services would be a logical way to save costs.
  - b. Increasing or eliminating the Lifetime Limit obviously is a benefit to all retirees and I concur with any improvement in that area.
3. Item #3 Low Cost Share: -- I totally disagree with the concept that the Retiree's and not sensitive to the cost of services. Being on a fixed income raises one's awareness level on any expenses that are incurred. Increasing the deductible and out of pocket limits will severely impact Retiree's income as they age and I am adamantly against it.
4. Item #4 Increasing Cost of Pharmacy Benefits: --
  - a. I disagree that Retirees use a higher percentage of brand medication when there are less expensive alternatives available. [REDACTED] At the same time, there are some medications that the Doctor's prescribe as brand because the generic is not as reliable or as efficient [REDACTED] the Doctor's recommendation on those items.
  - b. Also the service provider at times interprets that there is an alternative medication that will do the same thing but in reality it is a completely different medication... and when that happens it is a burden on the Retiree to appeal the Service Provider's decision. Again, it becomes a contest of back and forth with the service provider trying to force something down the retiree's throat.

- c. If the State of AK wishes to decrease the pharmacy costs, then it should not look to the Retiree but rather to the pharmacy companies. Work with the Federal Government to rein in the overall cost of medications. Putting the burden on the Retiree is backwards. **Fix the cause not the recipient.**
5. Item #5 Outdate Pharmacy Design: -- I am unsure about this item and how it is handled. I don't have an issue with a 90 day fill. What I do have an issue with is the ability to have two or three refills in any prescription. If that is what is being attempted here then I am opposed to it. Retirees should be able to have a number of refills of 90 days with any prescription that the Doctor issues.
6. Item #8 Confusion Over Rehabilitative Services: -- Your slide is confusing in itself... you have 20 visit limit per benefit year and then you have a 45 visit limit for all chiropractic, PT/ OT/SPT. This is the kind of stuff that gives Retirees headaches and also provides avenues for the Service Provider (i.e. Aetna ) to deny benefits after 20 visits vs 45?? Thee item needs to be clear. I like the elimination of the requirement for continued significant improvement. As we age again... there likely is not going to be significant improvement. It really is a maintenance item to avoid surgery in many cases. [REDACTED]  
[REDACTED] The limit on Chiropractic adjustments has been an issue with [REDACTED].  
The State of AK as the Secondary provider has helped to date assuming the Chiropractor files for it. Providing benefits for continuing chronic conditions makes sense.
7. Item #9 Dental coverage: -- As I indicated in my opening statement... having a separate insurance company to process Dental claims is another complication and problem for all Retirees irrespective of whether or not it is Dental Implants or just routine cleaning, and cavity repairs. It needs to be all under one company.
8. Item # 10 High Use of Hi-Tech Imaging & Testing: -- I doubt seriously that there is any major safety concern to the Retirees... I believe the State is only concerned with the costs. Adopting an enhanced imaging review program means more complications for the Retiree before they get the analysis that is needed. As I stated previously; -- the State of AK needs to make things less complicated, not more complicated. If the Doctor recommends a particular analysis then it should be done without further complication.
9. Item 12 Confusing Plan Booklet: -- The Plan Book should be easy to read and understand and not drawn up by a lawyer. As I have stated multiple times in this and other submission, as the Retiree gets older it becomes harder and harder to understand what is covered given the complicated nature of the plan. It is time that the plan be written in lay language that the Retiree can understand and know what their benefits are. I am unsure as to why there is this continuing desire to implement amendments... the plan should be fairly static after the State's Modernization Plan... assuming that you do a good job of it. It should be good for 5-10 years or more. so no amendments .. no changes to confuse the Retiree.. In addition, one could post a full copy of the plan (in layman's terms) on line for the Retiree to be able to access... Most retirees (although not all) have

some technology skills to access a web link and an electronic version of the plan (especially if it has not been modified 15 times).

**Finally, as previously discussed any change to the legacy plan will require a substantive detailed analysis of the benefits and losses to the Retiree Legacy Plan before it is implemented. At no time shall the legacy plan be diminished in any manner.**

Respectfully,

Eric & Mary Marchegiani



**From:** Barbara Smith [REDACTED]  
**Sent:** Friday, June 08, 2018 10:46 AM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** Hoffbeck Sharon <[REDACTED]>  
**Subject:** Retiree Health Plan

Dear Advisory Board,

I just reviewed the slides for the up coming teleconference and I would like you to addresses the following issues:

**Slide 15 concerning OTC.**

1. When you have been on a drug covered by your health plan at \$4 - 8 dollars and then it becomes OTC it is rare that the cost is lower. I am thinking specifically of some of the anti ulcer drugs. This proposed solution will affect thousands who rely on these OTC to treat their symptoms successfully, thus not costing the Plan more in medical dollars.
2. What happens if you are on a drug that changes to OTC but you need it in at a mg. higher than you can get OTC?
3. What happens in the case of "pharmacist" dispensed medications i.e. Plan B? Those not needing a physician's prescription.

**Slide 20 concerning use of diagnostic and testing services**

1. Improvement in non invasive methods to diagnose and treat medical conditions is a natural progress of technology and should be embraced not limited and scrutinized, because the harm to the person is much less than invasive forms. If there is a need to minimize the frivolous use of the technology then address the conditions in which you find that and list those conditions.
2. There should be a tiered approach to in and out of network providers as you provide in other areas. The Retiree should never be left without coverage in an area as vital and growing as diagnostic testing and imaging. This area is the cord of a lot of treatment courses and to abandon the Retiree because goes to a expert that might be "out of network" is a counter to what the Health Advisory Board should be doing..protecting the health and promoting a healthy retiree population.
3. **This point is a non-starter.** It is basically removing all retirees age 65 and older from the pool of "covered", since the Retiree's State Health Insurance is secondary to Medicare and Retirees are required to have Medicare parts A & B in order for the State Health Benefit to be a secondary payor.

I would also like to see the Health Advisory Board address adult immunizations. This is such a simple and cost effective PREVENTIVE measure which it has not addressed for the retiree and which could save millions of dollars. The only time a retiree can get a free flu or, pneumonia vaccine is at the few Health Fairs staged at large population centers, They are not available throughout the state at Public Health Centers which would be easier for many to go to.

I hope you take these items under serious consideration. Thank-you for the work you are doing on our behalf. Please always put a person's life and health before dollars.

Barbara Smith

**From:** Gary Miller <[REDACTED]>  
**Sent:** Saturday, June 09, 2018 11:03 AM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** Ricci, Emily K (DOA) <[emily.ricci@alaska.gov](mailto:emily.ricci@alaska.gov)>; Michaud, Michele M (DOA) <[michele.michaud@alaska.gov](mailto:michele.michaud@alaska.gov)>; Sharon Hoffbeck <[REDACTED]>  
**Subject:** Health Plan Modernization

I read the Proposed Modernization Plan and here are my comments.

It would be **very helpful** to have all of the amendments in one booklet **and** incorporate decisions made by the Office of Administrative Hearings, **including** those that have nondisclosure agreements. We retirees were promised health insurance at retirement if we stayed in our public service. I believe that we retirees have earned insurance documents that are clear and easy to understand. As the document states, "This would make it easier for members to understand and provide more transparent and specific direction as to how AlaskaCare claims should be adjudicated".

As medical costs continue to rise, people can reach the lifetime limit easier. A heart transplant could do that. As other medical procedures are developed, some of those are exorbitant. In addition, some of the newer drugs are so expensive that people without insurance can't afford treatment and are left to die. Therefore, I think the lifetime limit should be eliminated. It would be nice to know how many people each year reach the limit and are dropped from insurance coverage. Would it be morally right to let them die because they no longer have health insurance?

Preventive care can reduce medical costs by catching medical issues early where treatment is more likely to be successful and less expensive. Some examples are pap smears, mammograms, PSA tests, health fairs, etc. There must be studies that show which preventative services would save the program money and whether or not retirees would take advantage of them. If there are money saving preventative services, then consider implementing them.

Canadians pay about one-third to one-half the price for prescription drugs as Americans do. Someone needs to take the lead to allow the importation of prescription drugs from Canada. Since Congress passed the laws prohibiting it, Alaska's governor and legislature should be pushing senators Murkowski and Sullivan and representative Don Young to take the lead on this. Several years ago, about half of the cost of retiree healthcare was for prescription drugs. Do a study and find out if that has gone up. Governor Walker could make this an issue at the national governor's conferences. Alaska is not the only state facing this problem.

Having a travel concierge purchase airline tickets is an interesting concept. Bidding could be done with the different airlines to secure the best fares. I think this is a brilliant idea and bravo to the person who thought of it. What about airline miles. Who would get the credit, the insurance company or the traveler? If there is a medical emergency and a person has to be medevacked, would reimbursement be for the full amount or reduced because the concierge was not used?

I understand the idea of "...enhanced imaging review...". there should be some flexibility. For example, I recently injured [REDACTED]. The physician's assistant ordered [REDACTED] and declared that I had [REDACTED]. After more pain, I went back and saw the doctor. He ordered and [REDACTED] and said that I had [REDACTED] and would need surgery. Would my [REDACTED] be questioned?



Changing the retirement statute defining "dependent child" would not be challenged if the age limit goes up but if it is lowered I think there would be grounds for a lawsuit if it applied to people who are currently retired. The constitutional protection would be violated. In addition, would some legislators want to make other changes and open up a can of worms?

Best of luck on this interesting and probably long over due project. Also, thanks to those of you serving on the Retiree Health Plan Advisory Board's. I appreciate your volunteering.

Gary Miller.

Gary Miller  
[REDACTED]

**From:** Chris Milles <[REDACTED]>  
**Sent:** Saturday, June 09, 2018 1:36 PM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** [REDACTED]  
**Subject:** Retiree Health Plan Modernization

Modernization of the Retiree Health Care Plan should include in-network preventative health care coverage. As someone who retired after 33 years of state service at [REDACTED] and is actively retired, we have found that the plan is for medical necessity and does not include preventative medical procedures or doctor visits or vaccines.

Things that can be done to prevent or detect problems early are not covered as they were as a state employee. The retiree is only covered after the medical issue is discovered and potentially after it has progressed.

Examples of vaccines that are not covered are the flu vaccine, approximately \$30, and the new shingles vaccine, which is a two shot vaccine at \$169 per shot).

Preventative doctor visits for routine annual physicals with EKG and lab work is in excess of \$1500.

The in-network doctor is not allowed to charge me a lower cash price for the visit and tests because they would be in violation of the network agreement.

I would strongly support modernization to include preventative medical procedures.

I have brought this to RPEA on previous occasions but was reminded that in order to get preventative items, something must be given up.

While this may have been correct, providing in-network preventative care would likely be less expensive in the long run with early detection and prevention. One would not expect the in-network costs to not be that high given what other negotiated payments are.

Thank you for your time.

Chris Milles  
[REDACTED]

**From:** travis durnford <[REDACTED]>  
**Sent:** Saturday, June 09, 2018 2:55 PM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>; RPEA [REDACTED]>  
**Subject:** AlaskaCare proposals

Hi,

I recently read over the proposals concerning our AlaskaCare plan and I have some concerns with it. My husband and I are extremely healthy and mostly see a physican for our annual Medicare visit. This year, we did have to have a physical for our [REDACTED], which is a one-time expense paid for by Medicare.

[REDACTED] exercise daily. We are not in a high risk group. Therefore, I am not in favor of raising our deductible to \$300. I feel it would penalize us for not needing more medical care. We are very sensitive to the cost of health care and do not use unnecessary services. If anything, we under-use them.

I am also opposed to the proposal to not cover dental implants as part of our medical plan. Two years ago, I needed [REDACTED] to negligence on the part of my periodontist. [REDACTED] the bone and tooth. With a maximum of \$2,000 in dental coverage, that would not have covered much of the procedure.

I've been concerned over the years that AlaskaCare's insurance philosophy is not based on prevention. A physical exam has never been covered. We're very lucky to have local health fairs for blood work and immunizations and now Medicare physicals. I would like to see a preventative approach. Also, maybe reward people who work hard to maintain good health. How about a lower deductible for those who don't smoke, exercise regularly and who maintain a healthy weight. That might give people incentive to get healthy and be more sensitive to rising health care costs.

I look forward to hearing from you.

Sincerely,

Elizabeth Durnford

**From:** [REDACTED]  
**Sent:** Saturday, June 09, 2018 3:12 PM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** sharonhoffbeck <[REDACTED]>  
**Subject:** Fwd: [Rpea.outside] [Rpea.members] DRB Retiree Health Plan Modernization

Thank you for the opportunity to comment on the DRB Modernization Presentation. I live out of Alaska so I appreciate RPEA notifying me of the Retiree Health Plan Advisory Board's retiree plan modernization committee meeting on 12 June.

I appreciate the fact that I have Tier I health insurance coverage. I guess one could say I worked at the right time and the right place. Very fortunate indeed. Overall I am happy with the coverage we have been afforded to date.

I wish there were more preventative coverages for the main reason it is "preventative". Why wait until one is seriously ill to have coverage kick in. In a dollar and cents theory it seems it would be a great deal cheaper to catch something or prevent something through a "preventive" process. In this vain I agree with the solution to add full preventive services to the plan. Also as an older adult my physician has indicated I do not need a [REDACTED] every year but an annual wellness visit with associated blood work is a valuable assesment. So why do we need to have an [REDACTED] covered~~~why not just a wellness exam and associated blood work to see how well one is.

I thought the following line was very confusing.....what are the services referenced here: **\*\*Preventive services are defined as those that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.** I think it is critical to list those services so we all know what is being included!

I consider the following to be inequitable and unfair:

**o Members using an out-of-network provider would be paid at a reduced coinsurance (60%) and their portion of the cost would not count towards the annual out-of-pocket limit.**

Is that even constitutional? Why would you penalize people who live in an area where there are no network providers?

For the same reasons I feel the following is unfair as well.

Concern: Pharmacy costs are increasing and using out-of-network providers is more expensive. Possible Solution: Change coverage for prescriptions filled at an out-of-network pharmacy. o Prescriptions filled at an out-of-network pharmacy: • Plan pays 60% coinsurance, • Member pays 40% until annual \$1,000 out-of-pocket maximum is reached

There should be NO LIFETIME limits!!!

And lastly I feel it is time defiantly time to prepare a new handbook/manual. With all of the amendments over time it is very cumbersome and difficult to understand and read. Prepare a new version that is updated in its entirety.

Thank you again for the opporutnity to share my thoughts. Deborah S. Boyd, [REDACTED]

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**From:** "sharonhoffbeck" [REDACTED]  
**To:** "RPEA Members--All" <[rpea.members@mailman.apea-aft.org](mailto:rpea.members@mailman.apea-aft.org)>  
**Sent:** Thursday, June 7, 2018 7:57:19 PM  
**Subject:** [Rpea.outside] [Rpea.members] DRB Retiree Health Plan Modernization



**From:** Kathleen Vander Zwaag <[REDACTED]>  
**Sent:** Monday, June 11, 2018 2:36 PM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Subject:** Shingrix Vaccine

The new Shingrix 2-dose vaccine for Shingles has shown significantly improved efficacy over the previous Zostavax Shingles vaccination. Please add it as a covered benefit for AlaskaCare retired members.

Since the Zostavax was covered and this new vaccine provides much better protection, it seems reasonable that Shingrix should also be covered. Perhaps it is so new that the plan simply needs to add it as a covered benefit. Please do.

Thanks,

Kathleen Vander Zwaag  
[REDACTED]

**From:** Kathleen Vander Zwaag <[REDACTED]>  
**Sent:** Thursday, June 14, 2018 4:24 PM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Subject:** Re: Shingrix Vaccine

Thanks you for your response. On the same topic (Shingrix as covered vaccination) please see attachment from the July Issue of the Cleveland Clinic *Men's Health Advisor* regarding the fact that "many private insurers cover the new vaccine."

Thanks,

Kathleen Vander Zwaag

On Thu, Jun 14, 2018 at 3:11 PM, Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)> wrote:

Thank you very much for sending this public comment to the RHPAB. Public comment will be provided to the board prior to their next meeting on August 29, 2018 meeting. Please send us any further thoughts and check <http://doa.alaska.gov/drb/alaskacare/retiree/advisory.html> or <https://aws.state.ak.us/OnlinePublicNotices/Notices/Search.aspx> for updates on meetings, agendas and materials for upcoming meetings.

Thank you,

Natasha Pineda, MPH

Deputy Health Official

Alaska Department of Administration

[550 W 7<sup>th</sup>](#) Avenue

Anchorage, AK 99501

(907) 754-3511

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**From:** Kathleen Vander Zwaag <[REDACTED]>  
**Sent:** Monday, June 11, 2018 2:36 PM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Subject:** Shingrix Vaccine

The new Shingrix 2-dose vaccine for Shingles has shown significantly improved efficacy over the previous Zostavax Shingles vaccination. Please add it as a covered benefit for AlaskaCare retired members.

Since the Zostavax was covered and this new vaccine provides much better protection, it seems reasonable that Shingrix should also be covered. Perhaps it is so new that the plan simply needs to add it as a covered benefit. Please do.

Thanks,

Kathleen Vander Zwaag

[REDACTED]

[REDACTED]



Shingrix covered by  
many private insurere

SHINGLES... *continued from 3*

Shingrix may cause more injection-site pain than Zostavax, Pallotta notes, as well as other side effects—namely, fatigue, headache, shivering, nausea, and muscle pain—which usually resolve within a few days.

Perhaps the main downside to the new vaccine is that it requires two injections, spaced out two to six weeks apart, compared with a single injection of Zostavax. Also, the two-dose Shingrix vaccine costs about \$336, compared with about \$267 for its older counterpart, Pallotta says. Medicare Part D and many private insurers cover the new vaccine.

Regardless of the cost or convenience, Pallotta and other experts emphasize the need to get both doses of the new vaccine to gain a stronger, more durable shield against shingles.

“Just getting one dose does not afford you the really good efficacy, so it’s very important to get the second dose so you have that strong immune response,” she adds. “We encourage physicians and pharmacists to schedule patients for the second immunization as soon as they get the first one, so they have an appointment on the schedule.” ■

## WHAT YOU SHOULD KNOW

## About the shingles vaccine...

- **Shingrix is now the preferred shingles vaccine** and is recommended for all healthy adults age 50 and older, even if you’ve already had shingles or aren’t sure if you’ve had chickenpox.
- **If you’ve received Zostavax you should still get Shingrix;** wait at least eight weeks after Zostavax vaccination.
- **Shingrix is administered in two doses,** given two to six months apart. Schedule an appointment for your second dose when you receive the first injection.
- **Zostavax remains a viable option** for healthy adults age 60 and older who are allergic to Shingrix.
- **Medicare Part D and many private insurers cover the cost of Shingrix.** Check with your insurance provider.

# A Multi-Pronged Attack Against Prostate Cancer

*Radiation might be needed to keep your cancer from recurring after surgery. Know when it’s required and what to expect.*

**Y**ou’ve undergone surgery for prostate cancer, so now you might think your treatment needs have been met. You return home, confident that your cancer has been cured.

However, if the pathology specimen reveals an increased risk that your cancer could recur, or if your physician suspects that some cancer cells remain after surgery, chances are you might need adjuvant external-beam radiation therapy (EBRT) to reduce your risk of recurrence and metastasis.

Recent research from Cleveland Clinic investigators suggests that administering EBRT shortly after surgery, rather than delaying the treatment, reduces the risk of recurrence, metastasis, and death from prostate cancer. And, a new molecular test, Decipher®, may better identify which men need follow-up EBRT after surgery.

“If the pathology shows aggressive features that increase the risk for recurrence, talk to your doctor about whether adjuvant radiation is appropriate,” says Eric Klein, MD, Chairman of Cleveland Clinic’s Glickman Urological & Kidney Institute. “Up until recently, those triggers for adjuvant radiation were all based on pathology, and now we have this other tool, Decipher, in the precision-medicine era that allows us to better risk-stratify who is likely to benefit from adjuvant radiation.”

## Adjuvant vs. Salvage Radiation

According to some estimates, 25 to 30 percent of prostate cancer patients who undergo surgical removal of the prostate (radical prostatectomy) will experience biochemical recurrence



©J-Elgaard | Getty Images

**Follow-up external-beam radiotherapy may be necessary if the pathology from your surgery and/or results of genomic testing suggest that your prostate cancer is likely to recur.**

after surgery, traditionally defined as a rise in prostate-specific antigen (PSA) levels of at least 0.2 nanograms per milliliter (ng/ml) that suggests cancer. Some physicians follow an observation strategy and administer post-prostatectomy EBRT only after a man’s PSA rises to this threshold.

Guidelines from the American Urological Association and American Society for Radiation Oncology suggest a more proactive and preventive approach, adjuvant radiation therapy, which is given in the months after surgery before any signs of recurrence appear. The organizations recommend that adjuvant radiation be offered to prostate cancer patients with adverse pathological findings at the time of surgery, such as cancer that has spread outside the prostate or to the seminal vesicles or cancer found on the outer edge of the prostate specimen (positive surgical margins).



-----Original Message-----

From: Barbara Christian <[REDACTED]>

Sent: Wednesday, June 20, 2018 10:31 AM

To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>

Subject: Retiree health benefit for rolfing

Dear Ms. Salo and Board Members:

I am writing in support of revising the retiree health plan to cover certified rolfer services. I believe such coverage will save AlaskaCare a significant portion of the money now expended for surgeries and physical therapy.

I have suffered over 40 years from [REDACTED]. It has precipitated 3 very costly surgeries and literally years of physical therapy. The surgeries left as many problems as they solved. Physical therapy has helped more, but it is very expensive, and AlaskaCare has picked up where the Medicare coverage has left off. I recently came under the care of [REDACTED], a professional rolfer in the Kenai/Soldotna area who is respected (and even used) by local physicians and surgeons. [REDACTED] on the advice of numerous people who have found pain relief through his practice. I can honestly say that I improved as much from the first session (\$300 for over 1.5 hours) as I did from my entire physical therapy program last year, which lasted 4 months and cost Medicare and AlaskaCare thousands of dollars.

I wish to continue under [REDACTED] care, and I sincerely hope the Retiree Health Plan Advisory Board will add coverage for rolfing services. I would be happy to provide more details.

Barbara Christian

[REDACTED]

**From:** sharon whytal [REDACTED]  
**Sent:** Wednesday, June 20, 2018 8:09 PM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Subject:** proposed retiree medical plan changes

Dear Advisory Board,

Thank you so much for paying close attention and reporting back to us after that snafu on the teleconferencing in. I am so grateful for your presence there!

As both a retired Public Health Nurse and a consumer, I am writing to discourage the implementation of "H. yearly service limits for chiropractic and physical therapy services....."

Having worked in the field of prevention for over 26 years, I see the value in non-drug interventions, and the amount it saves in medical/surgical/drug interventions later. I utilize these disciplines myself first, both for prevention and the earliest treatment of problems, because I find them to support my body's functioning and often eliminate the need for a doctor's visit at all. Please do look at the "experience-based usage data" before making recommendations back to them about these changes, with a comparison to both costs and health outcomes (which also impact future costs) without these services for the same problems, vs. strictly medical/surgical interventions. There are both cost saving and quality of life issues here, so I really hate to see this particular direction.....

As with our current nationwide and statewide opioid dilemma, if we continue to focus on drug-based interventions, we miss the ability to both protect quality of life and save money. We need MORE non-drug interventions for pain of all kinds, NOT fewer.

Respectfully,  
Sharon Whytal

**From:** dale skinner <[REDACTED]>  
**Sent:** Thursday, June 21, 2018 5:31 AM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** [REDACTED]  
**Subject:** Comments on Medical Changes

- A. Limited preventive care services: Add some preventive services.

(Note: Currently, the retiree medical plan includes preventive services for PAP test and associated exam, PSA test and associated exam and mammograms. It was not disclosed what additionally is being considered.)

This would be wonderful to add some preventive services to our current health plan.

- B. Lifetime Limit of \$2M: remove or increase limit.

I am all in favor of an increasing the limit. I would never want to see this limit removed or decrease.

- C. Increase deductible and out-of-pocket maximums: per DRB, low cost share reduces sensitivity to price & increases unnecessary services.

(Note: A previous DRB proposal was:

- a. Raise the yearly deductible from \$150/person with a max of \$450/family to \$300/person with a max of \$600/family.

This would be terrible to allow the yearly deductible to be increased. I am totally against this.

- a. Currently the plan pays claims at 80% with a 20% copay until a yearly out-of-pocket of \$800 is reached, and then the plan pays at 100%. DRB's proposal is to raise the yearly out-of-pocket before the plan pays at 100% to \$1,600.

Again, a terrible idea to make this kind of an increase and place this added burden on the backs of retirees.

- a. Double the pharmacy copay for drugs on the pharmacy benefit manager's formulary. Charge a \$25 copay for drugs not on the pharmacy benefit manager's formulary.

Again, terrible plan. As we age, how many drugs we need and the cost of those drugs goes up more and more every year. We should stay with our current plan and not have this kind or any kind of an increase.

These kinds of choices, the cost of our medical, should be made by retirees for retirees, not by anyone not yet retired.



-----Original Message-----

From: Nina Daley, Philip Cowan <[REDACTED]>

Sent: Thursday, June 21, 2018 5:39 AM

To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>

Subject: Proposed Changes

Unfortunately due to my ongoing health issue the proposed changes to out of pocket and pharmacy will cost me approximately \$920 more a year. This could possibly be offset by increased coverage of preventive services.

**From:** Douglas Lottridge <[REDACTED]>  
**Sent:** Thursday, June 21, 2018 7:48 AM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** Sharon Hoffbeck <[REDACTED]>  
**Subject:** proposed changes to benefits

Despite having gone to the various websites I have found it difficult to find any details regarding proposed changes. I can tell you what changes would impact me and/or my wife adversely.

Any increase in deductibles or increase in out-of-pocket would cost us more money on a very limited retiree income.  
Limitations on preventive measures would hurt. PSA tests and mammograms come to mind.

We are not interested in any help with travel benefits since we have never applied for any travel benefits.

I understand there was a supreme court ruling that benefits could be reduced if there is a corresponding increase, however, so far the changes that have been made overall have hurt us more than helping us.

Douglas Lottridge

**From:** [REDACTED]  
**Sent:** Thursday, June 21, 2018 9:10 AM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** [REDACTED]  
**Subject:** Comments on Proposed Changes to Retiree Health Benefits

Dear Retiree Health Plan Advisory Board:

This email represents my comments on proposed changes to the health benefits for retirees. I oppose any changes that could be construed as reducing my benefits. I could have made much more working for the federal government or private industry, but I chose to make a career with the State of Alaska because of its retirement benefits.

- A. Limited preventive care services: Add some preventive services.

I support adding annual physicals. This should save money in the long run by finding serious medical problems early when it will cost less to address them

- B. Lifetime Limit of \$2M:

I support removing or increasing the limit.

- C. Increase deductible and out-of-pocket maximums: per DRB, low cost share reduces sensitivity to price & increases unnecessary services.

This increase seems like a diminishment of benefits.

- D. Implement 3-tier pharmacy benefit, change out-of-network benefits

I strongly oppose this change. I have [REDACTED] and throughout time medicines become ineffective. It is extremely important to me (and to lower costs for the State) to get the most effective medicine. About a year ago, my [REDACTED], but returned to an acceptable range with new medicine. I'm afraid the step approach might have resulted in [REDACTED] that I could not recover from



- E. Limit pharmacy to 90 day refill, and exclude over the counter equivalent

If this is done, it should only be for non-chronic conditions. With conditions such as [REDACTED], a one-year refill will save time and money because my doctor only requires one visit per year when my [REDACTED] remain acceptable. If you increase this to 4 times per year, the State will incur more costs.



F. Limit compound medication coverage for non-FDA approved drugs

Any limit should not cover people who have exhausted other medications.

G. Enhance travel benefits

Keep the same benefits unless an increase can be done without reducing other benefits. Alaskan's have lots of miles that could be used if they need more travel. For chronic conditions, people often ask for mileage donations – I have donated miles a number of times.

H. Implement yearly service limits for chiropractic, physical therapy and massage therapy, or hire a specialized vendor to manage the current benefit.

No comment

I. Exclude some dental implants from the medical plan and cover under dental plan exclusively.

Need more information on this proposed change before I have an opinion,

No comment.

J. High use of hi-tech imaging and testing: implement in-network enhanced clinical review.

Not sure what high use means. Rather than eliminating this benefit, perhaps increase the justification for its use by doctors.

K. Update retiree plan book to include regulations, amendments & benefit clarifications.

I agree with this proposal. Unless I don't have a current version, the current book hasn't been updated in a long time.

Glenn Gray  
Retiree

Auto Reply's began Monday 6/25 at 9:27pm.  
Format of retiree's e- mail is different. VRK

Following are comments about DB health plan modernization plan.

Adding the full suite of preventive services is needed, even if deductibles need to be modestly increased. Also needed is full update of plan booklet.

One particularly troubling topic is focus on hi-tech imaging and testing and the proposed solution of “in-network enhanced clinical review.”

“Enhanced clinical review” should be clarified. “Enhanced review” must not simply mean fewer ICD-10 diagnosis codes will be covered. AlaskaCare medical necessary determinations for imaging and testing should use up-to-date and broadly accepted clinical guidelines. Most important, clinical policy should follow current recommendations of professional medical organizations such as the American Cancer Society. I find that Aetna clinical policy bulletins generally do this. Access to medically necessary hi-tech imaging and testing is important.

He did not sign his name – I added it. VRK

Jeff Graham

**From:** Judith Salo [REDACTED] >  
**Sent:** Friday, June 22, 2018 3:40 PM  
**To:** Michael Christian <[REDACTED]>  
**Cc:** Ricci, Emily K (DOA) <[emily.ricci@alaska.gov](mailto:emily.ricci@alaska.gov)>; Michaud, Michele M (DOA) <[michele.michaud@alaska.gov](mailto:michele.michaud@alaska.gov)>  
**Subject:** Re: Retiree Health Plan Advisory Board

Thank you, Mike.. We have had several letters supporting the addition of Rolfig to the retiree plan. I know how much [REDACTED] was helped through Rolfig. We will include your letter for consideration when we discuss the "Modernization" of the plan in the months to come. Adding services will not be easy, however, and would likely require giving up something of similar financial impact to the plan. Thanks again for your letter, say Hi to Barb.

Sent from my iPad

On Jun 22, 2018, at 2:45 PM, Michael Christian [REDACTED] wrote:

I to your email from [REDACTED] and I hope you don't mind my contacting you on a recommendation for the Retiree Health Plan Advisory Board. I was pleased to learn you are chairing the board and that AlaskaCare is interested in retired employees' input. I sent an email to the board through the contact on the website, but I wanted personally to let you know my thoughts, as well.

I've been pleased with our coverage in general, but as more of us experience the discomforts of aging, I would like the board to consider covering professional rolfig. Currently, the practice is covered for employees but not retirees. I sincerely believe adding it to the retirees' health plan would save AlaskaCare a significant portion of the money now expended for surgeries and physical therapy. Also, it could improve the quality of life for many pain sufferers.

I have suffered over 40 years from [REDACTED]. It has precipitated 3 very costly surgeries and literally years of physical therapy. The surgeries left as many problems as they solved. Physical therapy has helped more, but it is very expensive. Fortunately for me, AlaskaCare covers it for retirees and has picked up when the Medicare coverage has been depleted.

I recently came under the care of [REDACTED], a professional rolfer in the Kenai/Soldotna area who is respected (and even used) by local physicians and surgeons. [REDACTED] on the advice of numerous people who have found pain relief through his practice. I can honestly say that I improved as much from the first session (\$300 for 1.5 hours) as I did from my entire 2017 physical therapy series, which lasted 4 months and cost Medicare and AlaskaCare thousands of dollars.



I wish to continue under [REDACTED] care despite the expense, but I sincerely hope the Retiree Health Plan Advisory Board will recommend the addition of coverage for rolfig services.

I hope your summer is going well.

Cheers,  
Barb Christian



Areas of focus DRB/DOA identified for consideration:

A. Limited preventive care services: Add some preventive services.

Additional preventive services hopefully would be balanced by increased savings down the road, and we support this provision although exact information has not been provided. Flu shots are a good example.

B. Lifetime Limit of \$2M: remove or increase limit.

No limit would reduce the amounts available to benefit retirees as a whole while benefiting a few. Oppose.

C. Increase deductible and out-of-pocket maximums:

A deductible of \$300 per person could restrict someone from obtaining needed care. A low copay per medical visit would be more fair.

The \$1,600 out-of-pocket limit is too high.

Do not increased costs for medications necessary to control medical conditions.

D. Implement 3-tier pharmacy benefit, change out-of-network benefits:

The 3-tier pharmacy benefit is scary. More information needed.

E. , F., Limit pharmacy to 90 day refill, etc.: No comments

G. Enhance travel benefits: More information needed; probably beneficial for all.

H. Implement yearly service limits for various therapies: Agree reasonable limitations needed.

I. Exclude some dental implants: Disagree. Removing the implant provision from medical coverage would reduce retiree benefits and be unavailable to some retirees without dental coverage or funds to allow for this procedure to maintain their health. The dental plan probably does not have sufficient funds without raising rates.

J. High use of hi-tech imaging and testing: Review of prescribed imaging could be cumbersome and restrictive and hard to evaluate without more information.

K. Update retiree plan book: Absolutely.

OTHER:

The EGWP/WRAP proposal needs a lot more information including what the acronym stands for.

Dependent care. Do not extend dependent coverage to age 26 from the current 23 while enrolled in college. Another example of reducing retiree benefits where the funds are finite.

#### Lack of adequate notice on changes to AlaskaCare

On April 18, 2018 [REDACTED] was discharged from the Post Falls, Idaho hospital following [REDACTED] one of the most painful surgeries, the day before. [REDACTED] is over 100 miles from our home in Montana. On the drive home we stopped in [REDACTED], Idaho to pick up a prescription for [REDACTED]. The pharmacy would fill his prescription for a ten day supply, but Aetna would not approve because approval had not been requested before the surgery. A new provision had been added to AlaskaCare on January 1, 2018 without notice to retirees except for an insert on the website. We receive and read Health Matters from AlaskaCare and PERS Newsbreak, but no mention was made there. Phoned complaints to Alaska R&B and Aetna provided no resolution other than to drive back to [REDACTED], have the doctor submit a request to Aetna, if approved a new prescription could be written and taken back to [REDACTED]. Obviously this was not possible. Eventually Aetna did send a letter by mail approving prescriptions for April 20 – May 20, too late to benefit [REDACTED], and refused reimbursement for the prescription filled on April 18.

Many retirees do not have access to the internet or use it frequently to see if benefits have changed without notice.

We look forward to receiving further information on the proposed AlaskaCare revisions.

(Jack & Elaine Vander Sande)

## Retiree Health Plan Advisory Board:

Please see the comments below on proposed changes to the health benefits for retirees. I oppose any changes that could be construed as reducing my benefits! I could have made much more money in my career working in the private sector, but I chose to make a 30 year career with the State of Alaska because of its retirement benefits.

- B. Limited preventive care services: Add some preventive services.  
I support adding annual physicals. This should save money in the long run by finding serious medical problems early when it will cost less to address them
- C. Lifetime Limit of \$2M:  
I support removing or increasing the limit.
- D. Increase deductible and out-of-pocket maximums: per DRB, low cost share reduces sensitivity to price & increases unnecessary services.  
This increase seems like a diminishment of benefits.
- E. Implement 3-tier pharmacy benefit, change out-of-network benefits  
I strongly oppose this change. I have [REDACTED] and throughout time medicines become ineffective. It is extremely important to me (and to lower costs for the State) to get the most effective medicine. About a year ago, [REDACTED], but returned to an acceptable range with new medicine. I'm afraid the step approach might have resulted in [REDACTED] that I could not recover from
- F. Limit pharmacy to 90 day refill, and exclude over the counter equivalent  
If this is done, it should only be for non-chronic conditions. With conditions such as [REDACTED] a one-year refill will save time and money because my doctor only requires one visit per year when my [REDACTED] remain acceptable. If you increase this to 4 times per year, the State will incur more costs.
- G. Limit compound medication coverage for non-FDA approved drugs

Any limit should not cover people who have exhausted other medications.

H. Enhance travel benefits

Keep the same benefits unless an increase can be done without reducing other benefits. Alaskan's have lots of miles that could be used if they need more travel. For chronic conditions, people often ask for mileage donations – I have donated miles a number of times.

I. Implement yearly service limits for chiropractic, physical therapy and massage therapy, or hire a specialized vendor to manage the current benefit.

No comment

J. Exclude some dental implants from the medical plan and cover under dental plan exclusively.

Need more information on this proposed change before I have an opinion,

No comment.

K. High use of hi-tech imaging and testing: implement in-network enhanced clinical review.

Not sure what high use means. Rather than eliminating this benefit, perhaps increase the justification for its use by doctors.

L. Update retiree plan book to include regulations, amendments & benefit clarifications.

I agree with this proposal. Unless I don't have a current version, the current book hasn't been updated in a long time.

Please take these comments into consideration.

Russell Carey  
State of Alaska Retiree

To modernize the retiree health benefit plan preventative care (mammograms, cancer checks, etc) should be covered. I joke that the reason preventative care is not covered is that a retiree is no longer useful and the sooner they die the better. However, that does not describe the forward thinking policy of most modern health plans that encourage primary and preventative care.

Also, retiree dependents should be covered to 26 just like employees.

Tamra Matlock

I would love to see vaccines included. I would also like to see as little change as possible. When we changed from blue cross to Aetna, it was problematic for us in the retiree system.

Rebecca P Bunde

[REDACTED]

Sent from my iPhone

I certainly hope the changes to the health plan will include preventive vaccines and other screenings. In the long run, it seems to me that it would save money. Paying for a shingles vaccine cost a huge amount less than covering the healthcare for someone who is sickened by shingles or other diseases. Colonoscopies are also much more cost effective than paying for treatment for colon cancer.

Also, I believe that paying for travel for medical care —when it can be obtained at a higher quality and a less expensive cost also seems to make sense. As a person who had [REDACTED] many years ago, I learned that there are huge differences in cost depending on the state and facility.

I don't know what role you have in this, but I believe it is important for you to advocate that all health providers—be it doctors, clinics or hospitals—provide an easily understandable list of the cost of each procedure that is given to patients beforehand so that they can make an educated decision about whether or not to proceed with the recommended procedures. The high cost of health care in our country is unconscionable and all of us should work towards making it more affordable and equitable.

Thank you,  
Sharon Resnick

[REDACTED]

Thank you for agreeing to serve on the retirement committee.

Thank you for the opportunity to comment on the medical and dental coverage for PERS retirees.

The plans must be more comprehensive to meet our family's needs!

The lifetime limit on coverage is disconcerting. That amount could be wiped out in a very short time if the God-forbid should happen. But, we could be left with no medical care at all with such a low limit. I may have another 40 years of life, and so that limit does not allow for much at all if annualized.

I would hope that traveling to another location, outside Alaska, is something that is supported by the plan. The cost of care in Alaska, whether Wasilla or Anchorage, is very prohibitive. I can't help but believe that even with airfare, per diem for housing and meals, ground transportation, care would be much less expensive elsewhere in the USA, even if on the East Coast or Florida. It would make that lifetime limit go farther.

Chiropractic care is proving very beneficial to me, and I wish that this care was covered better under my retirement and benefits. I'd rather do this than have surgery or injections.

If we need surgery, I think going Outside would be the right thing to do. Because of cost of care as well as quality of care.

Recently a provider in the Valley said he would not be a preferred provider because he is the only one in his specialty in the MatSu. I decided to not see him, and forego care in lieu of going to Anchorage as it was not that critical at the moment. I am getting okay care at a GP.

Warm Regards, Anna Weiss



I would like retiree benefits to include monthly fees for gym memberships such as the YMCA and Lifetime Fitness.

(Barbara Knoll – I included VRK)

Please, please add a silver sneakers benefit to the plan. It would have been so wonderful to have this prevention as part of the retirees health plan. Thank you.

*"I am spiritually fulfilled when my unique gifts are dedicated to the service of others"*

*Rev. Kathleen Flynn*



No issues with move to new prescription provider, since I seldom yet need such.

I do like the prospect of more preventive/wellness emphasis. I think much more emphasis should be placed on education of why a malady starts with the needed nutrition so it does not manifest. I also think Naturopathic Doctors who get the same years of medical school training as an MD should be allowed to prescribe prescription drugs at least to the extent of properly weening patients off them as their patients become healthier. This will also mean lower costs for the plan, including having to deal with additional prescriptions for prescription side effects. Based on the many millions paid out by the vaccine injury court I deeply want vaccines to remain voluntary and not required for acceptance by a doctor to treat.

What about paying doctors a retainer fee for checkups/health counseling and bonus for wellness? And make sure doctors do not get a kickback for particular or quantity of prescriptions written.

(Larry Colp – added VK)

The present plan is inadequate in preventative measures that would improve health.

- 1) The plan should cover a thorough annual physical that includes blood tests and other important screenings.
2. It should cover vaccines like shingles.
3. Should encourage active living by offering programs like silver sneakers as daily exercise is the single most effective remedy for many health issues: obesity, diabetes, blood pressure, etc.

Sent from my iPhone

(No name, E-mail: [dcmattio](#) [REDACTED])

Cover annual physical exams and also cover vaccinations. This is a no-brainer.

John A Mayer

Hello,

I'm writing regarding the potential changes the Retiree Health Plan Advisory Board is considering, see below.

I wholehearted support the addition of coverage for preventative services and/or annual wellness care/exams. I am really glad to see this is being considered, it just makes sense to me to operate from a position of wellness/maintaining wellness.

Regarding the increasing or removing the \$2 million lifetime maximum - I don't have an opinion on this at the moment but was curious about the rationale for increasing or removing. Also, statistics showing how often people max out on this would be helpful. My concern is if someone reached the maximum and wouldn't have healthcare.

Thank you for your time and for providing an opportunity for input on the health plan.

Best,  
Nancy Winford

The Division is working with the newly-created Retiree Health Plan Advisory Board to improve and modernize the AlaskaCare retiree plan. We need your help to protect, sustain, and improve the plan. Please let us know what you think is working, and what you would like to see improved. You can send comments to [alaskaRHPAB@alaska.gov](mailto:alaskaRHPAB@alaska.gov).

The Division and the Board have formed a working group to prioritize implementation of some potential changes you've already asked for. These include:

- Adding coverage for preventive services (including vaccines)
- Increasing or removing the \$2 million lifetime maximum
- Adding an enhanced travel benefit to provide airfare, lodging, and per diem for a member and a companion to a center of excellence for certain surgeries
- Improving coverage for rehabilitative services including physical and occupational therapy and chiropractic care
- Implementing an Enhanced Employer Group Waiver Program (EGWP) (see below)

The next working group meeting is scheduled for **Thursday, July 26th, from 1 p.m. to 4 p.m.** with locations in Juneau and Anchorage and teleconference provided. The full board will meet **Wednesday, August 29th, from 9 a.m. to 4 p.m.** You are welcome to attend or listen in.

For more information, including teleconference information and meeting materials, please visit [AlaskaCare.gov/retiree/advisory.html](http://AlaskaCare.gov/retiree/advisory.html).

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Sent from my iPad

First of all, thanks for asking for our input. I don't recall that ever happening before. A benefit I would love to see improved is in the preventive care realm. Currently there are limited (or no?) benefits for exercise program coverage outside of Alaska. In my region (SW Washington State), many retirees and Medicare beneficiaries are enrolled in a program called Silver Sneakers through their health insurance. These benefits can be used at several venues (such as community recreational facilities, retirement homes, etc.) which encourage folks to exercise frequently at convenient nearby locations. When I study the Alaska Care website I do not see any benefits for exercise for retirees living outside the state. Please consider providing exercise benefits for us!

Thanks,

Deborah Murphy

but you may notice some small administrative changes like the list of **medications requiring preauthorization may change**

What is this? I have never had to get preauthorization for any medications. I received a letter from your offices stating there were no such restrictions after Aetna tried to stop paying for [REDACTED].

I would really like the payment of vaccinations especially for Shingles to be approved. Preventive medicine is always cheaper than paying for treatment of the disease.

Thank you for the opportunity to share my concerns.  
Janet Downing



Greetings,

Thank you for the opportunity to give some input.

I think the board, or any appropriate person or group, should look into paying for acupuncture services.

I personally had [REDACTED] for years. Then when I was living overseas, I went to a Chinese acupuncturist. The [REDACTED] was GONE totally in two or three appointments. I do believe this is a much less costly method of dealing with what is chronic pain in so many people.

Medicine is advancing and I believe it is to your advantage financially to look at this as a viable option for pain relief of all kinds.

Thanks for your consideration of my comments.

Linda Layfield

Hello,

I would like to suggest that AlaskaCare add:

1. Preventative medical for doctors visits and/or other medical items.
2. Vaccinations: such as flu, shingles, etc

These two items are currently missing from our coverage and are very important for our continued health.

Thank you,  
Daniel Brown



Sent from my iPad

Retiree Health Plan Advisory Board: As an AlaskaCare retiree, I urge you to include the vaccine Shingrex as a covered benefit under the Retiree Health Plan. Shingrex significantly reduces the risk of occurrence or reoccurrence of shingles infection, an extremely painful and now preventable condition. When a person contracts shingles, the Plan may incur the expense of anti-viral medication and the doctor's visit for the needed prescription.

Once contracted, shingles may recur multiple times. Each recurrence may cost the Plan money for retiree office visits and prescription medication. Adding the Shingrex vaccine as a covered benefit will avoid these expenses, saving the Plan money otherwise spent treating this preventable condition.

Medicare A and B do not cover the cost of the Shingrex vaccine. The Medicare D prescription benefit does cover Shingrex, but AlaskaCare retirees may not pay the extra Medicare D premium because they receive their prescription benefits through the Retiree Health Plan.

The Shingrex vaccine takes two injections to become effective. Each injection may cost the retiree \$160 USD - for a total of \$320 USD. This is a significant expense. Even though the Shingrex vaccine will reduce their risk of contracting shingles, retirees may decide not to spend their money to receive it.

Please help AlaskaCare retirees reduce their risk of contracting shingles by adding the Shingrex vaccine as a covered benefit under the Retiree Health Plan. This one-time expense will save the Plan money otherwise spent treating this painful and preventable condition. Thank you!  
Charles Knittel, SOA retiree

Dear Board Members,

If the genuine intent of the health care program is to reduce pain (as stated in the current booklet), I would like to suggest consideration of acupuncture. I have personal experience of total pain elimination for [REDACTED]. In light of all the problems with addiction to pain medications acupuncture does not use drugs. If this helps, when [REDACTED] was working for the State of Washington, we had acupuncture coverage. I happily paid about \$17 a session. This was several years ago and I have no idea what the cost for an acupuncture session was then or is now, but would appreciate your consideration of this option. Also, I had significant pain reduction in [REDACTED] with the help of a massage therapist. This was not due to an injury and was paid by State of Washington Insurance-and was another fantastic alternative to drugs. I believe there are added health benefits to both of these health care options because these providers will work on other problem areas at the same time. I cannot help but think this reduces overall health care costs.

Thank you for your consideration! My husband and I really appreciate your efforts on behalf of all retirees.

Sincerely,

Patricia G. Sele  
[REDACTED]  
[REDACTED]

Thank you! In my opinion, preventative services are one of the most important services we could have, and it has been very difficult to ensure that we remain healthy when such services have been excluded. Thank you so much for considering adding these services to our plan. I have no doubt but that it will be a cost effective move, also! Kathleen Humphrey, Retiree

Hello-

I appreciate your wanting to improve our healthcare!

I strongly agree that AlaskaCare needs to improve:

- preventative care - by adding more common illnesses

- increase the \$ 2 million max - health prices have increased dramatically when that figure was decided upon

- improve the rehabilitative services... I used chiropractic care for my [REDACTED] issue, but was denied more

- even tho my problem was not resolved, and when I asked what they would recommend & cover - silence.

PLEASE SIMPLIFY THE ALASKACARE BOOK! Make it user friendly, not attorney friendly.

Thank you for your time.

Karen Koester  
retiree

I strongly support the changes/suggestions mentioned in your recent newsletter. I would like to add re: the vaccines, I would hope the Shingles vaccine be included. Currently it is strongly recommended seniors receive it, but at over \$200 it's prohibitive for many of us. Also, when I was an active employee, Acupressure and Acupuncture were covered. They are not under the retiree insurance. Both have been proven to be successful in decreasing/stopping [REDACTED] pain, among other conditions. It would be beneficial AND cost effective if those disciplines were to be covered again. [REDACTED] medicines, especially [REDACTED], are extremely expensive and in some cases, they could be stopped or decreased if those two disciplines were covered.

I would also encourage the board to work with AARP in reducing prescription costs overall. They are prohibitive to many seniors, including those state employees who are coming along, age wise. I know the insurance coverage is not as generous as we enjoy and believe me, we greatly appreciate it! Having talked with friends who are retired whose insurance coverage is not nearly as good as ours, I'm so grateful for what the state did for those of us who are in Tier 1 and 2. Were it not for that, I would not be able to afford the medications or medical care that provide me with medical support now.

Thank you for continuing to work with the retiree population to provide the best possible medical care and prescription coverage.

Sincerely,

Russell L. Music  
Alaska State Retiree, Tier 2

Hello, my name is Jim Kenshalo, I am retired and I live in [REDACTED].



I want to add my voice to the chorus of people that supports the idea of paying for immunizations.

If for no other reason, the more people are inoculated, the more will be healthy. Which has to play a role in lowering health care costs.

Thank you for allowing me to be part of this discussion.

Your pal, Jim



Hi there,

I would love to see the following improvements to the Retiree Plan:

- Adding coverage for preventive services (including vaccines) – Shingles shots would be great
- Increasing or removing the \$2 million lifetime maximum
- Adding preventative

I have issues when my health care provider writes just about every appointment up as “Well Care” or “Well Woman.” It makes it sound as though it’s a physical or something similar. As an example, my recent [REDACTED] was written that way. My appointment was ONLY a [REDACTED] and they insisted on calling it Well Woman. Aetna would not pay for a Well Woman exam. We’re still battling this one. Maybe if our plan allowed for “names” like that, it would avoid this kind of issue.

I also don’t understand why preventative (like a physical) aren’t covered. “An ounce of prevention...?”

Thank you,

Mary Josefa LaFurney

[REDACTED]

We have read with concern the proposed changes to our AlaskaCare retiree health and medical benefits.

My husband, [REDACTED], and I have depended on these benefits since we retired from the Department of Education and PERS. We are currently in our mid to later 70s

We know that maintaining our health now can extend our lives in good health and reduce costs as we age.

We fear that erosion of pharmacy benefits will make it more difficult for us to receive prescription medications we need.

We depend on dental services such as periodontal care, implants and procedures, and prophylactic care to prevent oral diseases.

We have relied on vision services for vision correction and, at times surgical procedures to maintain reasonable vision.

We have been told by medical professionals that we may need hearing aids in the near future

We also need full vaccination benefits, including those needed for older Americans, and ask for inclusion of Shingles vaccinations overwhelmingly recommended by medical professionals for older adults.

We don't need increased travel benefits, since we're able to be served locally.

At this time, it is unclear what benefits will be maintained and what will be removed. We have been grateful for the medical/dental/vision and hearing benefits we receive and have earned after 30+years each, of service to Alaska.

We ask that you maintain our current benefits, and add important maintenance such as Shingles vaccines.

Please contact me with any questions or comments via email or text to [REDACTED]  
We ask you to keep older retirees in mind as you re-examine AlaskaCare.

Sincerely,  
Naomi Obie  
Ed Obie

[REDACTED]

Dear Advisory Board Members:

Thank you for serving on the Board and for your efforts to improve our plan while keeping costs as low as possible. It can't be an easy task. As a retiree since 2004, I do have some comments and suggestions.

Some proposed improvements, such as increasing travel benefits and preventive services could help reduce costs in the long run and I'm happy to see them on the list.

Another way that costs might be reduced is by implementing more proactive strategies for good health rather than surgery..... trying physical therapy or yoga before back or knee surgery, for example. Also, improved and less invasive treatments for many types of cancer are now available and these are less expensive at the time and less expensive for patients to recover from. I see these as ways our health plan can evolve, allowing expanded coverage without adding costs or cuts to the retirees.

Regarding the move to the Medicare Part D EGWP/wrap plan, there are three areas of concern and probable hardship to me.

1. When I enrolled in Medicare, AlaskaCare sent information to explain options and it stated clearly that the pharmacy plan we had was recommended and the Part D offering was inferior in several ways. I'm concerned about that.
2. The 5 step appeal process for denials might be too complicated and cumbersome as I age. People may end up losing a benefit they qualify for simply because they can't endure the lengthy appeal process.
3. The step therapy provision is particularly concerning because people may have to try inferior or less efficient medications at the risk of their health. I do take a specific drug rather than a popular generic because of decisions made by my doctor over a period of time and switching drugs would likely have impacts on my glandular system. That seems risky and perhaps expensive in the long run. I believe it is critically important to keep the provision that medication decisions be made by the doctor and patient.

As the board studies options for the retiree programs it is important to keep in mind that the lack of funding was a deliberate decision made by a governor and a few legislators. When funds were widely available, retirees made calls and wrote letters urging full funding, and for reasons that are obscure, funding was denied. It is no wonder some suggestions for cuts and draw backs are met with a bit of hostility.

I thank you for your efforts to provide fair and complete coverage, as promised.

Sincerely,  
Jo Clark

Sent from my iPad

It's difficult to comment on this because there is no discussion in the presentation as to what the trade-offs are. If there was a chart to list the potential costs associated with the option it would be more informative. I realize it would get more complicated to list the costs if multiple additions were added.

Personally, my biggest concern is preventative. I support adding preventative and in doing so it would be able to fall under the current cost structure for in network providers and not raise the overall cost for out of pocket, lifetime limits, and deductibles. For out of network providers there could be higher costs or a differ percentage paid as the provider costs have not been negotiated.

I am not too concerned about travel given my location but I can see where AK retirees might be interested but some of that is a personal choice as to where to obtain service and those costs should be born by the insured. Most service are now available in Alaska for joint replacement and some cardiac, maybe not so for some of the more complex medical situations.

My preference is to add preventative as it helps my long term health and well-being and keep the deductible and out of pocket as it is now.

Chris Milles



As an Alaskan retiree, I received the Health Matters Alaska Care newsletter about the new Advisory Board members. I also see there is an upcoming meeting. I would like to request a particular subject be discussed.

Specifically...the fact that our retiree medical insurance does NOT cover preventative treatment. Yes, I realize this is a legislative decision of long-ago. However, in this era of outrageous high medical costs, this simply does not make sense. While I cannot quote any financial study showing the expenditure of money on preventative measures would reduce the total expense of retiree treatments, it only makes sense.

However, I strongly urge that the Board commission a study to see if a savings to the State would occur and report the findings to the retirees. If a savings could be effected, retirees and the Board could lobby the legislature for a change to benefit all. The longer this is delayed, the more money is potentially wasted by the State and the more retirees needlessly suffer. If a study shows otherwise, reporting this to retirees would also be appreciated and at least clarify the issue.

Thank you for your consideration.

*Jacqui Austin*

----- Forwarded message -----

From: **Naomi Obie** <[REDACTED]>

Date: Sun, Jul 22, 2018, 12:52 PM

Subject: Changes in AlaskaCare for retirees

We are resubmitting this important request to remove our request for the inclusion of shingles vaccines.

We have read with concern the proposed changes to our AlaskaCare retiree health and medical benefits.

My husband, [REDACTED], and I have depended on these benefits since we retired from the Department of Education and PERS. We are currently in our mid to later 70s

We know that maintaining our health now can extend our lives in good health and reduce costs as we age.

We fear that erosion of pharmacy benefits will make it more difficult for us to receive prescription medications we need.

We depend on dental services such as periodontal care, implants and procedures, and prophylactic care to prevent oral diseases.

We have relied on vision services for vision correction and, at times surgical procedures to maintain reasonable vision.

We have been told by medical professionals that we may need hearing aids in the near future

We also need full vaccination benefits, including those needed for older Americans, and ask for inclusion of Shingles vaccinations overwhelmingly recommended by medical professionals for older adults.

We don't need increased travel benefits, since we're able to be served locally.

At this time, it is unclear what benefits will be maintained and what will be removed. We have been grateful for the medical/dental/vision and hearing benefits we receive and have earned after 30+years each, of service to Alaska.

We ask that you maintain our current benefits, and add important maintenance such as Shingles vaccines.

Please contact me with any questions or comments via email or text [REDACTED]  
We ask you to keep older retirees in mind as you re-examine AlaskaCare.



Sincerely,  
Naomi Obie  
Ed Obie

[REDACTED]

One has to wonder what will happen once CVS/Aetna corners the medicare RX market. Aetna is already supplying most of the supplemental insurance policies that are needed for retirees on medicare. This is a monopoly in the making!

I cannot believe this merger is for our benefit. Every time our benefits are changed we lose. Please do not tie us to medicare in this way. I am concerned that Alaska Care will become just another Medicare supplemental insurance and that was never the intent for this benefit.

Very concerned,  
Barbara J Daniels

Sent from my iPad

Please consider adding rolfig benefits to our health benefits program.

Thank you

Mari Auxier  
Sent from my iPhone



Good day,

I just retired from state service. For the past several years I have gone in for an annual physical. This annual event had made me aware of some health issues. I only became aware of these medical issues because of the annual physical. This benefit was covered under my insurance as an employee.

Now as a retiree, I have been advised by AETNA that an annual physical is not covered. I would hope this medical plan would want to take preventive measures for its retirees. Why as a retiree should I have fewer benefits? What can be done that this is a covered procedure?

Thank you,

Sincerely,

Robert M. Redlinger

# Travel Benefit

**Proposed change:** Enhancing the travel benefits to include SurgeryPlus benefits

**Plans affected:** DB Retiree Plan

**Reviewed by:** Retiree Health Plan Advisory Board

**Proposed implementation date:** January 1, 2019

**Review Date:** July 26, 2018

*Table 1: Plan Design Changes*

	Member	Actuarial	DRB Ops	Financial	Clinical	TPA	Provider
No impact							
Minimal impact		X	X	X			
High impact	X				X	X	X
Need Info							

**Description of proposed change:**

Amend the plan booklet to add the SurgeryPlus travel program to the retiree plan which arranges and coordinates travel for a member and their companion to a network of surgeons and facilities that meet rigorous quality metrics for deeply discounted prices.

The fiscal impact to the plan is estimated to be \$2.8 million a year in savings associated with the SurgeryPlus travel program. There is no anticipated actuarial impact to the plan<sup>1</sup>.

The increase in covered travel costs will be fiscally beneficial to the membership and will increase their options for treatment. The addition of the SurgeryPlus network will provide members with access to surgeons who demonstrate they meet and maintain a combination of objective and subjective quality metrics.<sup>2</sup>

These changes will require additional administrative work by the Third-Party Administrator(s) and the Division.

The expansion of travel benefits to include the SurgeryPlus program, could create additional competition in the Alaska medical marketplace as providers compete with those offering the same services outside of their community. This could result in reduced costs and better services as providers work to remain competitive. Alternatively, as

<sup>1</sup> See attachment A; Segal Consulting Memorandum, July 25, 2018.

<sup>2</sup> See attachment B for a list of SurgeryPlus provider metrics.

members in small communities seek care elsewhere, fixed cost for providing those services could be spread across a smaller number of patients increasing costs for those who receive care at home.

### **Background:**

The AlaskaCare retiree defined benefit health plan currently provides reimbursement for certain travel expenses in the following circumstances:

- 1) In emergency situations<sup>3</sup>
- 2) For a minor (under 18 years of age) with a parent/legal guardian<sup>4</sup>
- 3) For certain transplant services at an Aetna Institute of Excellence (IOE) with a companion and lodging<sup>5</sup>
- 4) Second surgical opinions<sup>6</sup>
- 5) Treatment not available locally<sup>7</sup>
- 6) Surgery in other location if provided less expensively<sup>8</sup>

All travel, excluding emergency travel and surgery less expensive in other locations, require pre-authorization. If travel is not-preauthorized members are not eligible for reimbursement. The plan does not pay for travel costs up front, the member is required to front those costs and submit them for reimbursement following completion of the trip.

Table 1, below, outlines the proposed changes.

<b>Circumstance</b>	<b>Current</b>	<b>Proposed</b>
Emergency travel <sup>9</sup>	Transportation to nearest hospital by professional ambulance	No change
Transplant via Aetna IOE <sup>10</sup>	-Member and companion -Overnight stay: -\$50 per person/night -\$100/night maximum -Companion expense: -\$31/night	No change
Travel for minor	-Minor and companion	No change

<sup>3</sup> Page 42, AlaskaCare Retiree Health Insurance Information Booklet, 2003:

<http://doa.alaska.gov/drb/pdf/ghlb/retiree/RetireeInsuranceBooklet2003with2018amendment.pdf>

<sup>4</sup> Page 41, Ibid.

<sup>5</sup> Page xxxvii-xl. Ibid.

<sup>6</sup> Page 43, Ibid.

<sup>7</sup> Page 42, Ibid.

<sup>8</sup> Page 44, Ibid.

<sup>9</sup> Page 42, Ibid.

<sup>10</sup> Page xxxvii, Ibid.

	-Transportation covered <sup>11</sup>	
Second surgical opinion	-Transportation covered for member only	No change
Treatment not available locally	-Transportation, lodging and per diem covered for member only. -Limited to treatment only -Limited to the following visit per benefit year: -1 treatment for condition -1 for follow-up -1 pre- or post-natal care -1 for maternity delivery -1 pre- or post-surgery -1 per surgical procedure -1 per allergic condition	No change
Surgery in other locations less expensive	-Only applicable for surgery. -Transportation covered for member only. -Total cost may not exceed the recognized charge for same expenses received locally. -Total cost must include: -surgery -hospital room and board -travel to another location	No change
SurgeryPlus Program	-Not currently available to retiree members	-All travel includes member and companion -Travel costs arranged for and covered up front by SurgeryPlus. -Hotels arranged and paid for by plan. -\$31 per diem for member/\$62 with companion -Members receive pre-loaded debit card in advance of trip.

<sup>11</sup> This includes either airfare or round-trip transportation and associated costs (including \$80/day for lodging) if distance exceeds 100 miles one-way.

**SURGERYPLUS BACKGROUND:** The Division competitively bid travel coordination and administrative services in the first half of 2018. The selected bidder was SurgeryPlus. Extensive details are available in Attachment B, but a high-level overview of SurgeryPlus services follow:

- SurgeryPlus develops a network of providers across the United States that meet certain quality criteria, both objective and subjective..
- SurgeryPlus negotiates discounted, case rates for services.
- SurgeryPlus advocates serve as a single point of contact for members.
- When members seek an elective surgery, they can contact Surgery Plus to see if the procedure they are seeking is offered through the SurgeryPlus network and to be provided a list of three surgeons who are best suited to perform the surgery.
- If the member selects a physician, SurgeryPlus arranges for a transfer of the member's medical records to the selected physician who will review the case.
- Upon review, if the surgeon accepts the case SurgeryPlus will begin arrangements for the members' travel.
- When the member is ready to travel they will receive a copy of their itinerary in advance in a format of their preference.
- At admission (or check in) they will present their SurgeryPlus card.
- Their lodging will be covered for a duration necessary as determined by the surgeon.
- Following discharge, a SurgeryPlus advocate will follow up telephonically with the member.
- After the member travels home, follow up care can be provided through their primary care physician combined with telehealth services.
- If necessary, the member can travel back to the surgeon for necessarily follow up care.

SurgeryPlus will also provide travel administration services for members who are Medicare-eligible and are not using the SurgeryPlus network along with members seeking care in other circumstances (e.g. treatment not available locally or surgery less expensive elsewhere).

Members who do not want to use the SurgeryPlus travel administration services to book travel can also use the current method and submit receipts for reimbursement to the Third-Party Administrator.

It is not anticipated that the deductible or cost share would be waived under any of these scenarios.

### **Member impact:**

Members would benefit from this change, as it would provide additional financial assistance in covering the cost of travel for themselves and a companion. It may facilitate increased access for members requiring care from specialists that are not available locally and the overall number of members seeking care outside of their community. It may also result in better outcomes through reduced complication rates based on the provider quality of the SurgeryPlus network.

### **WHO IS IMPACTED:**

Members traveling now for care: Approximately 1,200 AlaskaCare retiree members received reimbursement for covered travel in 2017. This number should be viewed with caution in predicting member utilization for several reasons:

- 1) Members may not have realized pre-authorization is required and be denied coverage as a result;
- 2) Members may have traveled and not realize they were eligible for services and therefore did not apply for reimbursement;
- 3) Administrative challenges may have resulted in member's claims not processing correctly.

Given this, the Division estimates utilization of a travel benefits under the proposal will be higher than is experienced today; however, it is difficult to predict with certainty what actual usage will be.

In reviewing claims data, SurgeryPlus estimates utilization at around 400 procedures per year in the retiree plan. This represents about 20% of eligible procedures.<sup>12</sup>

Members who are Medicare-eligible: Medicare-eligible members will not fully benefit from the provider network offered through the SurgeryPlus travel program, which is preempted by Medicare's own provider network. However, they will be able to utilize SurgeryPlus for travel arrangement.

Members who are not Medicare-eligible: Members who are not Medicare-eligible will benefit both fiscally and through anticipated positive outcomes associated with high quality care from the SurgeryPlus network of providers and the travel arrangement and coordination offered.

<sup>12</sup> See attachment A; Segal Consulting Memorandum, July 25, 2018

Members will be required to pay their deductible and co-insurance to SurgeryPlus prior to receiving care; which may pose a financial burden to some as these bills are generally received following surgery.

**Actuarial impact:**

Neutral / Enhancement / Diminishment

*Table 2: Actuarial Impact*

Actuarial Impact	
Current	N/A
Proposed	No actuarial impact <sup>13</sup>

**DRB operational impacts:**

The Division anticipates minimal operational impacts as follows:

- Staff will need to manage an additional vendor and the routine work associated with that including quality control, reporting, billing, responding to member issues, eligibility questions, and communications.
- Staff will need to review and distribute communications to educate and increase awareness of the new plan benefit.
- A plan amendment will need to be developed, put forward for public comment, and published before the benefit takes effect.
- Staff will need to coordinate and oversee implementation including plan education and cultural training for the SurgeryPlus team, ensuring coordination between SurgeryPlus and the Third-Party Administrator are working smoothly, coordinating eligibility, and responding to member questions and/or concerns.

Division staff have already been working with SurgeryPlus on implementing this program beginning August 1, 2018 for the AlaskaCare employee plan, so many of these items are already being worked through. The addition of the retiree plan will require some additional work to ensure the program is being properly administered, but the majority of coordination has already occurred.

**Financial impact to the plan:**

The overall financial impact to the plan is estimated to be savings of \$2.8 million annually. This is based on members using the SurgeryPlus network for 400 procedures

<sup>13</sup> See Attachment A



per year. The total savings is net of the administrative costs for SurgeryPlus and the estimated cost per member per trip of \$3,000.<sup>14</sup>

### **Clinical considerations:**

These changes are anticipated to result in overall better quality of care for members.

Access to SurgeryPlus program- Provider quality is a distinguishing feature of the SurgeryPlus network which reports complication rates of 0.82% among members using their network<sup>15</sup> compared to the 14.1% average for AlaskaCare retirees living in Alaska but seeking care outside of the state in 2017 (13.8% for professional services, 17.1% for outpatient care and 27.6% for inpatient care).<sup>16</sup>

### **Third Party Administrator (TPA) operational impacts:**

The impact to the TPA is anticipated to be high for several reasons:

- The TPA will need to coordinate with an external vendor (SurgeryPlus) including sharing prior-authorizations; member accumulator data, eligibility, and claims data.
- The TPA will need to retain the ability to pre-authorize travel even if an external vendor is coordinating that travel on behalf of the member.
- The TPA will provide eligibility to the external vendor.
- The TPA will need to maintain its existing process for travel claims administration in parallel with the additional services provided by the external vendor.
- The TPA will need to ensure its staff are trained and knowledgeable about the new benefits to accurately answer members travel-related questions and appropriately transfer members to the external vendors.

The Division is already working with the Third-Party Administrator and the external vendor to implement this benefit for the AlaskaCare employee plan effective August 1, 2018, so many of these items will have been worked through and resolved prior to any retiree health plan implementation.

### **Provider considerations:**

The expansion of travel benefits to include the SurgeryPlus program, could create additional competition in the Alaska medical marketplace as providers compete with



<sup>14</sup> See Attachment A: Segal Memorandum; July 25, 2018

<sup>15</sup> 2016 average for SurgeryPlus's book of business.

<sup>16</sup> Based off of 2017 claims experience. It should be noted that while SurgeryPlus's overall book of business saw a 0.82% complication rate in 2016, the AlaskaCare retiree population is older, and so higher rates ought to be anticipated to some extent.

those offering the same services outside of their community. This could result in reduced costs and better services as providers work to remain competitive. Alternatively, as members in small communities seek care elsewhere, fixed costs for providing those services could be spread across a smaller number of patients increasing costs for those who receive care at home.

**Documents attached include:**

<u>Document Name</u>	<u>Attachment</u>	<u>Notes</u>
Segal Memorandum; July 25, 2018	A	 Segal Travel Memo
SurgeryPlus Overview	B	 State of Alaska SurgeryPlus.pdf
Public Comments	C	See Attached

# Attachment A

## MEMORANDUM

**To:** Ajay Desai, Director, Division of Retirement and Benefits

**From:** Richard Ward, FSA, FCA, MAAA

**Date:** July 25, 2018

**Re:** Travel Benefits – Focus on Actuarial and Financial Impact for the Retiree Plan

---

The AlaskaCare Retiree Plan currently reimburses for coach airfare associated with select services and treatments. Precertification is required and travel is restricted to the treatment facility. The Plan does not reimburse members if airline miles are used to purchase tickets, nor does it reimburse for the cost of food, lodging, or local ground transportation such as airport shuttles, cabs or rental cars.

The Plan applies the general benefit provisions, such as deductible, coinsurance and out-of-pocket limits, to determine any portion of the costs that are the member's responsibility. If the member has additional coverage, such as Medicare or other employer provided coverage, any portion of the costs covered by that plan is also considered. Below is a table outlining the current benefits offered under the Plan:

<b>Deductibles</b>	
Annual individual / family unit deductible	\$150 / up to 3x per family
<b>Coinsurance</b>	
Most medical expenses	80%
Most medical expenses after out-of-pocket limit is satisfied	100%
Second surgical opinions, Preoperative testing, Outpatient testing/surgery	100%
• No deductible applies	
<b>Out-of-Pocket Limit</b>	
Annual individual out-of-pocket limit	\$800
• Applies after the deductible is satisfied	

• Expenses paid at a coinsurance rate other than 80% do not apply against the out-of-pocket limit	
<b>Benefit Maximums</b>	
Individual lifetime maximum • Prescription drug expenses do not apply against the lifetime maximum	\$2,000,000
Individual limit per benefit year on substance abuse treatment without precertification. Subject to change every three years	\$12,715
Individual lifetime maximum on substance abuse treatment without precertification. Subject to change every three years	\$25,430
<b>Prescription Drugs</b>	Up to 90 Day or 100 Unit Supply
	Generic      Brand Name
Network pharmacy copayment	\$4      \$8
Mail order copayment	\$0      \$0

## Actuarial Value

The Department of Administration is contracting with SurgeryPlus to provide enhanced travel benefits, which include a per diem for lodging and meals, companion airfare, and concierge-level member services to coordinate travel arrangements with medical care. The scope of covered services and procedures eligible for travel benefits will also be expanded.

While these enhancements are favorable for the member, there will be no impact on actuarial value. These changes promote efficient utilization of medical services, which helps manage program costs. However, there are no changes to how the cost share is determined and therefore, the enhanced travel benefits do not affect the actuarial value of the program.

Additional incentives that affect cost sharing (such as waiving deductibles and/or coinsurance) would likely result in an increase to actuarial value.

## Financial Impact

While there is no impact on the Plan's actuarial value, there would be a financial impact.

Based on the experience with their book of business, SurgeryPlus estimates that 20% of eligible procedures will result in about 400 procedures annually, resulting in savings due to the utilization of lower cost providers and fewer associated complications. Offset by contractual administrative expenses and assuming \$3,000 per procedure in travel costs, it is estimated there will be approximately \$2,800,000 in annual savings to the Plan.

This analysis is based on medical claims data from December 2016 through November 2017, which was summarized specifically to analyze the opportunity for an enhanced travel benefit. The data was reviewed, but not audited, and found to be sufficient and credible for this analysis.

Segal reviewed the assumptions used by SurgeryPlus and consider them to reasonable. For budgeting purposes, in order to be conservative in projecting the impact of a new program, Segal's analysis utilizes a 20% margin.

*Please note that the projections in this report are estimates of future costs and are based on information available to Segal at the time the projections were made. Segal Consulting has not audited the information provided. Projections are not a guarantee of future results. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, trend rates, and claims volatility. The accuracy and reliability of projections decrease as the projection period increases. Unless otherwise noted, these projections do not include any cost or savings impact resulting from The Patient Protection and Affordable Care Act (PPACA) or other recently passed state or federal regulations.*

cc: Michele Michaud, Division of Retirement and Benefits  
Emily Ricci, Division of Retirement and Benefits  
Linda Johnson, Segal  
Michael Macdissi, Segal  
Noel Cruse, Segal  
Dan Haar, Segal

# Attachment B

# SurgeryPlus for



A supplemental benefit for non-emergent surgeries that provides top-quality care, a better experience and lower costs



# Our Differentiators

## Surgeons of EXCELLENCE

Rigorous Screening &  
Reduced Complications

## Employee SATISFACTION

Better User Experience  
We Handle It All

## Hard-Dollar ROI SAVINGS

Pre-Negotiated Bundled Rates  
Reduced Employer & Employee Costs

# Surgeons of Excellence Credentialing

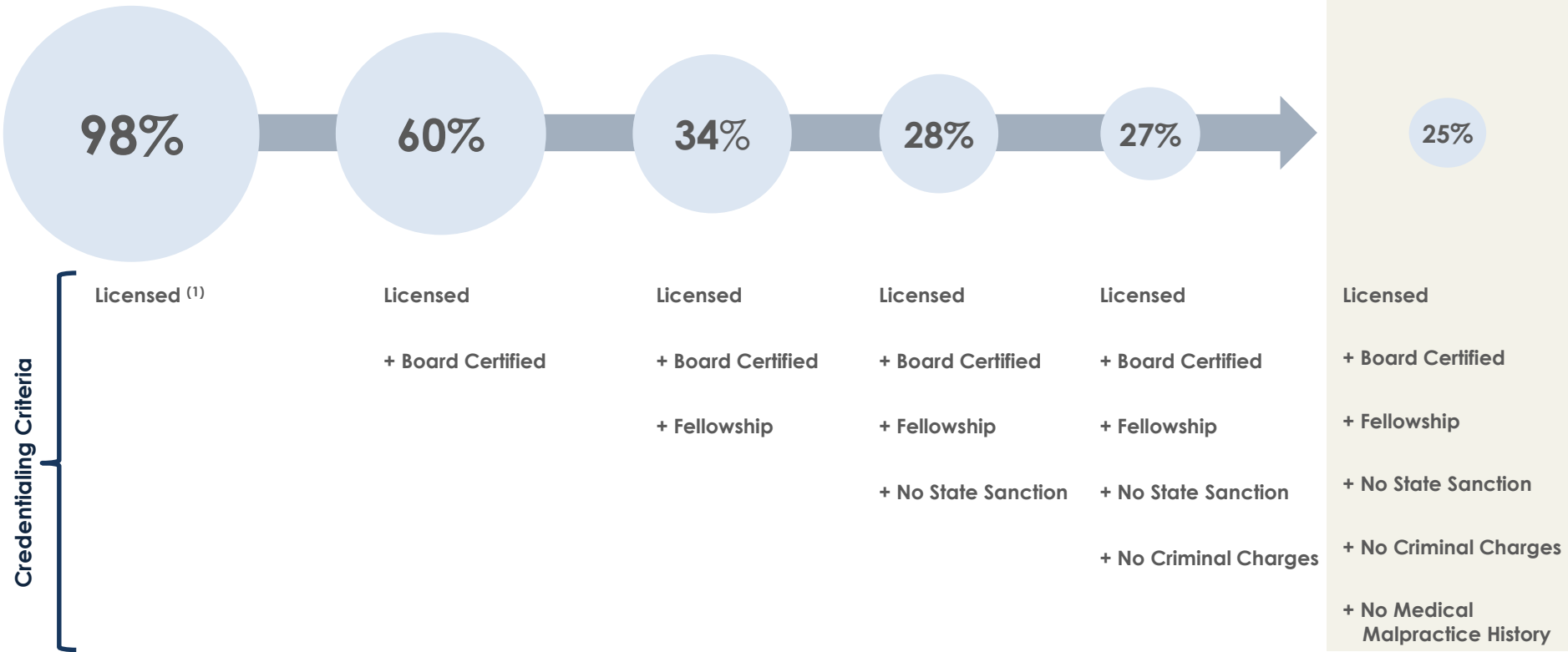
## More Comprehensive Evaluation Process

	Other Network	 By  EmployerDirect Healthcare	
Board Certification	Optional	Mandatory	Unlike some of our peers, our quality starts with the physician; a poor doctor will lead to a poor result even in the best facility
Specialty Training Requirements	Optional	Mandatory	
Procedure Volume Requirements		✓	
State Sanctions Check		✓	SurgeryPlus had an overall <b>complication rate of ~1%</b> in 2017 and is under 1.50% life to date
Medical Malpractice Claims Review		✓	
Criminal Background Checks		✓	
CMS Quality Requirements (Hospital Only)		✓	Our surgeons are committed to patient optimization; not risk selection
Monthly Network Management		✓	
ASC Steerage		✓	

# Provider Preliminary Credentialing Case Study

## Examining our Rigorous Credentialing Process

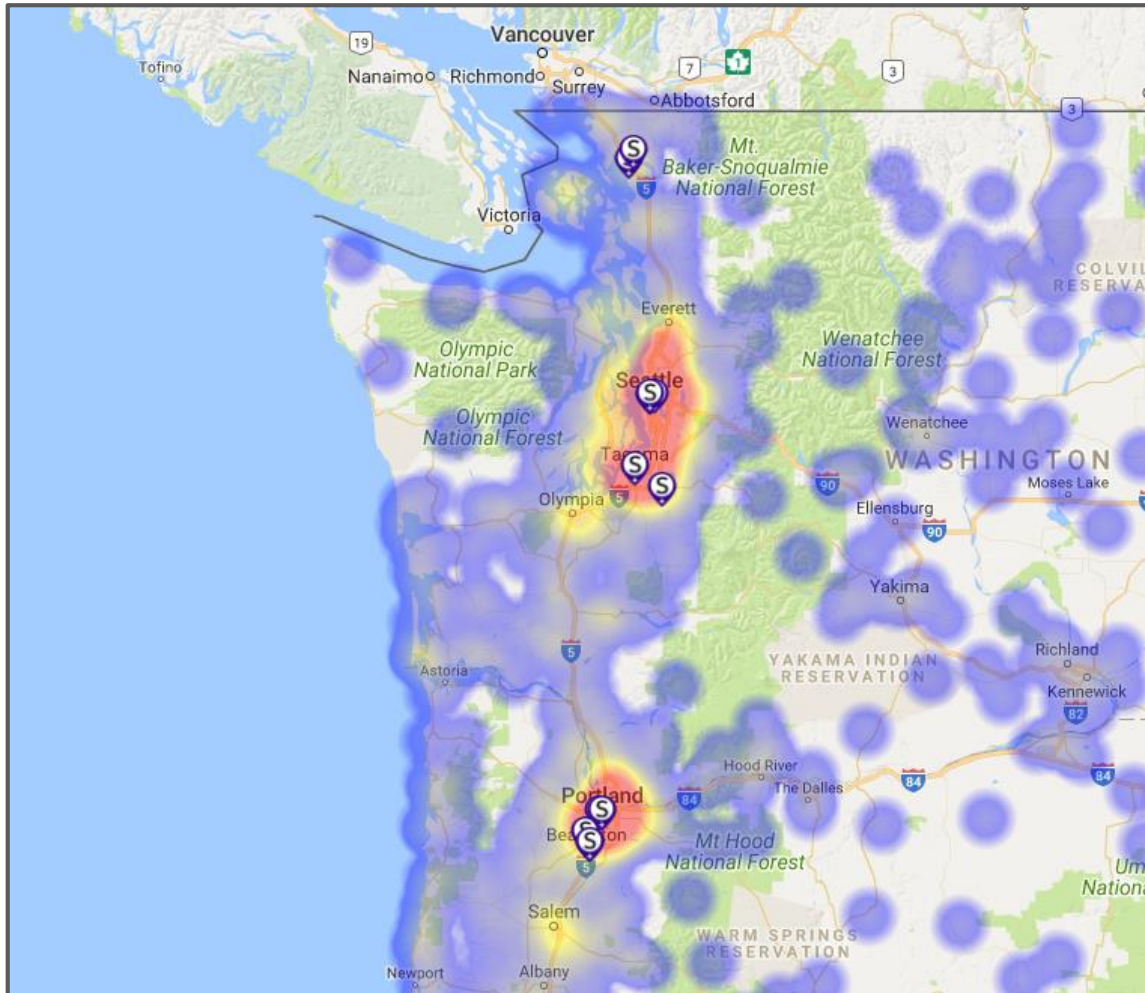
- Reflects 122 Orthopedic surgeons in the Tampa, FL MSA with the following network affiliations: BlueCross BlueShield: 116 surgeons; Aetna: 99 surgeons; UnitedHealth: 82 surgeons; Cigna: 55 surgeons
- The percentages in each bubble (from left to right) represents the total percent of orthopedic surgeons who meet the SurgeryPlus credentialing requirements listed respectively below
- This does not include our interviews, site visits or reviews of standards and volumes



(1) Two doctors remain on the carrier's portal but have retired, licensing is a standard requirement.



# SurgeryPlus Provider Network

## Seattle / Portland



**Legend:**  SurgeryPlus Provider

Source: SurgeryPlus Provider Network as of July 23, 2018.

Seattle, WA		
Category	Covered?	S+ Facilities
Orthopedics	✓	 Virginia Mason
Spine	✓	
Bariatrics	✓	
General	✓	
GYN	✓	 THE POLYCLINIC Where you come first.
Thyroid	✓	
GI	✓	
ENT	✗ *	
Cardiac	✓	

\*In Discussions

### Provider Spotlight

  
Virginia Mason

#### Virginia Mason

- Performed over 15,000 surgical procedures in 2016
- COE for Walmart, Boeing, FedEx
- Recognized 5 consecutive years by US News & World as a national high performer in Orthopedics

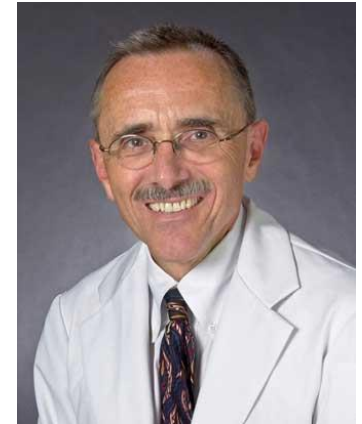
# Michael E. Morris, M.D.

## Orthopedics

### Physician Information

**Facility:** Virginia Mason Medical Center

1100 9<sup>th</sup> Ave.  
Seattle, WA 98101  
(888) 862-2737



### Education



### Fellowship & Residency



Residency



Fellowship

### Select Professional Societies



The American Board of  
Orthopaedic Surgery

### Notable Leadership

- Dr. Morris is the head orthopedic team physician for the Seattle Sounders (Major League Soccer)
- Voted on of Seattle's top doctors by both Seattle Metropolitan and Seattle Magazine in 2009
- Voted on of Seattle's top doctors by Seattle Met magazine in 2010



# SurgeryPlus vs. Average Carrier

## State of Alaska Member Experience

### Provider Overview

Carrier	
Juneau, AK	Seattle, WA
40 – 60% above SurgeryPlus	\$24,000 – \$26,000



### Member Overview

Deductible Amount	\$600	\$600	Member saves \$2,250
OOPM	\$2,850	Waived	
Airline/Car Travel (~\$550)	✗	S+ covers travel costs	
Per Diem Cost (\$25 per person, per day)	✗	S+ covers travel costs	

# SurgeryPlus Can Save Members Thousands

Know What Your Procedure Costs Ahead of Time

## State of Alaska **WAIVES** coinsurance

SurgeryPlus collects what is left on member's primary deductible

---

## No medical bills in the mail

SurgeryPlus handles all bills following your procedure

---

## Zero risk of out-of-network charges


Never worry any part of the procedure falls out of network

**\$0 coinsurance**


Note: SurgeryPlus does not coordinate with current benefits in place by State of Alaska

# SurgeryPlus Member ID Card

## Unlocking Access to your SurgeryPlus Benefit



John Doe  
2100 Ross Ave, Suite 3200  
Dallas, TX 75201



**ACTIVATE YOUR  
ONLINE PORTAL EXPERIENCE**

1. Visit [Alaska.SurgeryPlus.com](http://Alaska.SurgeryPlus.com)
2. Click **Register Now**
3. Access Code: **surgeryplus**
4. Complete profile and explore

The State of Alaska has partnered with **SurgeryPlus** to provide a supplemental surgical benefit for AlaskaCare Employee Health Plan members and their families.

**SurgeryPlus** offers quality surgeons that are all board certified, concierge service, and ways to lower costs for hundreds of non-emergent procedures. With this benefit, your coinsurance is waived. **SurgeryPlus' concierge service** can help you understand your benefits, choose a surgeon, book appointments, facilitate medical record transfer, coordinate travel and anything else you need for a great experience. Members have access to an **online portal** where they can search surgeons and providers for certain procedures, read success stories and learn more about the benefit.


*This new travel benefit available through SurgeryPlus, is only available through our Employee Plan member's primary AlaskaCare health plan; it does not coordinate with additional AlaskaCare or other health plans. Services provided are subject to your annual plan deductible.*

To learn more, call a Care Advocate at (855) 715-1680, or register online at [Alaska.SurgeryPlus.com](http://Alaska.SurgeryPlus.com) with the information provided above.

**The SurgeryPlus Difference**

HIGH QUALITY	GREAT EXPERIENCE	LOW COST
High-performance surgeons are 100% board-certified and rigorously screened.	A dedicated Care Advocate manages the entire procedure process for you.	SurgeryPlus waives coinsurance reducing post-procedure bills and financial burden.

Remove and keep the ID card below for you and your dependants as a reference when needing a surgery or to present at any scheduled SurgeryPlus consultation or procedure.




**MEMBER NAME:**  
John Doe  
Includes member's covered spouse and dependants  
**(855) 715-1680**  
[Alaska.SurgeryPlus.com](http://Alaska.SurgeryPlus.com)  
Member portal registration access code: surgeryplus



**MEMBER ID:** XXXXXXXX  
**GROUP NUMBER:** XXXXXXXX

**SURGERYPLUS BENEFIT**  
DEDUCTIBLE COINSURANCE WAIVED



**MEMBER NAME:**  
John Doe  
Includes member's covered spouse and dependants  
**(855) 715-1680**  
[Alaska.SurgeryPlus.com](http://Alaska.SurgeryPlus.com)  
Member portal registration access code: surgeryplus

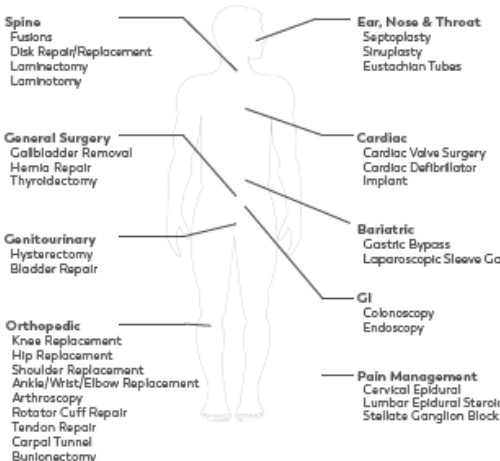


**MEMBER ID:** XXXXXXXX  
**GROUP NUMBER:** XXXXXXXX

**SURGERYPLUS BENEFIT**  
DEDUCTIBLE COINSURANCE WAIVED

Contact a Care Advocate if you would like additional cards for dependants on your plan

**SURGERYPLUS COVERS HUNDREDS OF NON-EMERGENT SURGERIES, INCLUDING:**



Not all procedures are listed. If you don't see a procedure listed, speak to a Care Advocate or explore the member portal **(855) 715-1680 | Alaska.SurgeryPlus.com**

**Provider Instructions:**

1. Employer Direct | SurgeryPlus is the only payer for this consultation/procedure.
2. Send medical claim to the below location(s) after discharge to receive payment.
3. Contact the number below immediately for any questions in providing quality care to the SurgeryPlus member.
4. Please only use the patient's traditional insurance for the following items outside of the episode of care: diagnostic studies, imaging, physical therapy, durable medical equipment, prescriptions, lab work, non-spine-related pain procedures, pre-operative labs and any other medical tests.

**Send Medical Claims To:**  
Employer Direct Healthcare  
2100 Ross Ave. #3200  
Dallas, TX 75201  
Electronic Payer ID: 48888

**Member Service:** 1-855-715-1680  
**Provider Inquiry:** 1-855-300-3038  
**Billing Inquiry:** 1-855-200-6689  
Hours: 8:00am-5:00pm M-F  
Monday - Friday  
[www.edhc.com](http://www.edhc.com)

**Provider Instructions:**

1. Employer Direct | SurgeryPlus is the only payer for this consultation/procedure.
2. Send medical claim to the below location(s) after discharge to receive payment.
3. Contact the number below immediately for any questions in providing quality care to the SurgeryPlus member.
4. Please only use the patient's traditional insurance for the following items outside of the episode of care: diagnostic studies, imaging, physical therapy, durable medical equipment, prescriptions, lab work, non-spine-related pain procedures, pre-operative labs and any other medical tests.

**Send Medical Claims To:**  
Employer Direct Healthcare  
2100 Ross Ave. #3200  
Dallas, TX 75201  
Electronic Payer ID: 48888

**Member Service:** 1-855-715-1680  
**Provider Inquiry:** 1-855-300-3038  
**Billing Inquiry:** 1-855-200-6689  
Hours: 8:00am-5:00pm M-F  
Monday - Friday  
[www.edhc.com](http://www.edhc.com)



# Care Advocates Handle It All

Full-Concierge Service Creates a Better Member Experience



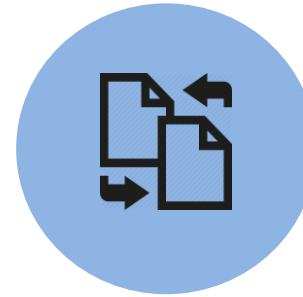
## Locate

Find best fitting Surgeon of Excellence



## Schedule

Book timely appointments & manage logistics



## Coordinate

Bundle service providers & transfer records



## Follow Up

Ensure complete member satisfaction

Managed by the Metrics for Scalability

Wait Time

~5 seconds

First-Time Call Length

~4 minutes

Time to Consult

~21 days

% of Calls to Cases

~52.4%

% of Cases to Procedures

~50.7%

Time to Procedure

~35 days

# Most Common Covered Procedures

## Commonly Covered Procedures by Category

### **Knee:**

- Knee Replacement
- Knee Replacement Revision
- Knee Arthroscopy
- ACL/MCL/PCL Repair

### **Hip:**

- Hip Replacement
- Hip Replacement Revision
- Hip Arthroscopy

### **Shoulder:**

- Shoulder Replacement
- Shoulder Arthroscopy
- Rotator Cuff Repair
- Bicep Tendon Repair

### **Foot & Ankle:**

- Ankle Replacement
- Bunionectomy
- Hammer Toe Repair
- Ankle Fusion
- Ankle Arthroscopy

### **Spine:**

- Laminectomy / Laminotomy
- Anterior Lumbar Interbody Fusion (ALIF)
- Posterior Lumbar Interbody Fusion (PLIF)
- Anterior Cervical Disk Fusion (ACDF)
- 360 Spinal Fusion
- Artificial Disk

### **Wrist & Elbow:**

- Elbow Replacement
- Elbow Fusion
- Wrist Fusion
- Wrist Replacement
- Carpal Tunnel Release

### **General Surgery:**

- Gallbladder Removal
- Hernia Repair (inguinal, ventral, umbilical, and hiatal)
- Thyroidectomy

### **GI:**

- Diagnostic Colonoscopy
- Endoscopy

### **GYN:**

- Hysterectomy
- Bladder Repair (Anterior or Posterior)
- Hysteroscopy

### **Bariatric:**

- Gastric Bypass
- Laparoscopic Gastric Bypass
- Laparoscopic Sleeve Gastrectomy

### **Cardiac:**

- Defibrillator Implant
- Permanent Pacemaker Implant
- Pacemaker Device Replacement
- Valve Surgery
- Cardiac Ablation

### **ENT:**

- Ear Tube Insertion (Ear Infection)
- Septoplasty
- Sinuplasty

# Attachment C

**From:** Gary Miller [REDACTED]  
**Sent:** Saturday, June 09, 2018 11:03 AM  
**To:** Alaska Retiree Health Plan Advisory Board (DOA sponsored) <[alaskarhpab@alaska.gov](mailto:alaskarhpab@alaska.gov)>  
**Cc:** Ricci, Emily K (DOA) <[emily.ricci@alaska.gov](mailto:emily.ricci@alaska.gov)>; Michaud, Michele M (DOA) <[michele.michaud@alaska.gov](mailto:michele.michaud@alaska.gov)>; Sharon Hoffbeck <[REDACTED]>  
**Subject:** Health Plan Modernization

I read the Proposed Modernization Plan and here are my comments.

It would be **very helpful** to have all of the amendments in one booklet **and** incorporate decisions made by the Office of Administrative Hearings, **including** those that have nondisclosure agreements. We retirees were promised health insurance at retirement if we stayed in our public service. I believe that we retirees have earned insurance documents that are clear and easy to understand. As the document states, "This would make it easier for members to understand and provide more transparent and specific direction as to how AlaskaCare claims should be adjudicated".

As medical costs continue to rise, people can reach the lifetime limit easier. A heart transplant could do that. As other medical procedures are developed, some of those are exorbitant. In addition, some of the newer drugs are so expensive that people without insurance can't afford treatment and are left to die. Therefore, I think the lifetime limit should be eliminated. It would be nice to know how many people each year reach the limit and are dropped from insurance coverage. Would it be morally right to let them die because they no longer have health insurance?

Preventive care can reduce medical costs by catching medical issues early where treatment is more likely to be successful and less expensive. Some examples are pap smears, mammograms, PSA tests, health fairs, etc. There must be studies that show which preventative services would save the program money and whether or not retirees would take advantage of them. If there are money saving preventative services, then consider implementing them.

Canadians pay about one-third to one-half the price for prescription drugs as Americans do. Someone needs to take the lead to allow the importation of prescription drugs from Canada. Since Congress passed the laws prohibiting it, Alaska's governor and legislature should be pushing senators Murkowski and Sullivan and representative Don Young to take the lead on this. Several years ago, about half of the cost of retiree healthcare was for prescription drugs. Do a study and find out if that has gone up. Governor Walker could make this an issue at the national governor's conferences. Alaska is not the only state facing this problem.

Having a travel concierge purchase airline tickets is an interesting concept. Bidding could be done with the different airlines to secure the best fares. I think this is a brilliant idea and bravo to the person who thought of it. What about airline miles. Who would get the credit, the insurance company or the traveler? If there is a medical emergency and a person has to be medevacked, would reimbursement be for the full amount or reduced because the concierge was not used?

I understand the idea of "...enhanced imaging review...". there should be some flexibility. For example, I recently injured [REDACTED]. The physician's assistant ordered [REDACTED] and declared that I had [REDACTED]. After more pain, I went back and saw the doctor. He ordered and [REDACTED] and said that I had [REDACTED] and would need surgery. Would my [REDACTED] be questioned?



Changing the retirement statute defining "dependent child" would not be challenged if the age limit goes up but if it is lowered I think there would be grounds for a lawsuit if it applied to people who are currently retired. The constitutional protection would be violated. In addition, would some legislators want to make other changes and open up a can of worms?

Best of luck on this interesting and probably long over due project. Also, thanks to those of you serving on the Retiree Health Plan Advisory Board's. I appreciate your volunteering.

Gary Miller.

Gary Miller



Auto Reply's began Monday 6/25 at 9:27pm.  
Format of retiree's e- mail is different. VRK

Areas of focus DRB/DOA identified for consideration:

A. Limited preventive care services: Add some preventive services.

Additional preventive services hopefully would be balanced by increased savings down the road, and we support this provision although exact information has not been provided. Flu shots are a good example.

B. Lifetime Limit of \$2M: remove or increase limit.

No limit would reduce the amounts available to benefit retirees as a whole while benefiting a few. Oppose.

C. Increase deductible and out-of-pocket maximums:

A deductible of \$300 per person could restrict someone from obtaining needed care. A low copay per medical visit would be more fair.

The \$1,600 out-of-pocket limit is too high.

Do not increased costs for medications necessary to control medical conditions.

D. Implement 3-tier pharmacy benefit, change out-of-network benefits:

The 3-tier pharmacy benefit is scary. More information needed.

E. , F., Limit pharmacy to 90 day refill, etc.: No comments

G. Enhance travel benefits: More information needed; probably beneficial for all.

H. Implement yearly service limits for various therapies: Agree reasonable limitations needed.

I. Exclude some dental implants: Disagree. Removing the implant provision from medical coverage would reduce retiree benefits and be unavailable to some retirees without dental coverage or funds to allow for this procedure to maintain their health. The dental plan probably does not have sufficient funds without raising rates.

J. High use of hi-tech imaging and testing: Review of prescribed imaging could be cumbersome and restrictive and hard to evaluate without more information.

K. Update retiree plan book: Absolutely.

#### OTHER:

The EGWP/WRAP proposal needs a lot more information including what the acronym stands for.

Dependent care. Do not extend dependent coverage to age 26 from the current 23 while enrolled in college. Another example of reducing retiree benefits where the funds are finite.

#### Lack of adequate notice on changes to AlaskaCare

On April 18, 2018 [REDACTED] was discharged from the Post Falls, Idaho hospital following [REDACTED] [REDACTED] one of the most painful surgeries, the day before. [REDACTED] is over 100 miles from our home in Montana. On the drive home we stopped in [REDACTED] Idaho to pick up a prescription for [REDACTED]. The pharmacy would fill his prescription for a ten day supply, but Aetna would not approve because approval had not been requested before the surgery. A new provision had been added to AlaskaCare on January 1, 2018 without notice to retirees except for an insert on the website. We receive and read Health Matters from AlaskaCare and PERS Newsbreak, but no mention was made there. Phoned complaints to Alaska R&B and Aetna provided no resolution other than to drive back to [REDACTED] have the doctor submit a request to Aetna, if approved a new prescription could be written and taken back to [REDACTED]. Obviously this was not possible. Eventually Aetna did send a letter by mail approving prescriptions for April 20 – May 20, too late to benefit [REDACTED], and refused reimbursement for the prescription filled on April 18.

Many retirees do not have access to the internet or use it frequently to see if benefits have changed without notice.

We look forward to receiving further information on the proposed AlaskaCare revisions.

(Jack & Elaine Vander Sande)



I was reviewing the proposed changes to the retiree medical plan. The one that I'd like to comment on is this;

## ○ Provide travel concierge to purchase airline tickets for member.

I live in [REDACTED] which is a small village about 250 miles west of Anchorage. At this stage of our lives all of our medical care is obtained in Anchorage. The most cost effective and efficient way to get from here to there is with a couple of mom & pop air taxi services. Neither of them have a regular schedule service, but fly whenever they have enough passengers to make a load. We've used them for year and know how to make it all work, but I think it might be difficult for a travel concierge, who doesn't know these particular ins and outs, to make this work for us. So possibly have the option of the travel concierge book the flights, but allow those of us who want to book their own flights retain that option as well. Allow both options.



Thanks,  
Susan Hubbard  
[REDACTED]

So, some of my benefits that probably 90% of retirees use will be eliminated so something like travel where maybe 10% of retirees use will take its place. NICE. So much for not eliminating benefits but replacing something of value (yea 10% of retiree benefit and 90% get a reduction. The politicians think we are stupid. Maybe just too many retiree complacent. William Burgess

I certainly hope the changes to the health plan will include preventive vaccines and other screenings. In the long run, it seems to me that it would save money. Paying for a shingles vaccine cost a huge amount less than covering the healthcare for someone who is sickened by shingles or other diseases. Colonoscopies are also much more cost effective than paying for treatment for colon cancer.

Also, I believe that paying for travel for medical care —when it can be obtained at a higher quality and a less expensive cost also seems to make sense. As a person who had knee replacement surgery many years ago, I learned that there are huge differences in cost depending on the state and facility.

I don't know what role you have in this, but I believe it is important for you to advocate that all health providers—be it doctors, clinics or hospitals—provide an easily understandable list of the cost of each procedure that is given to patients beforehand so that they can make an educated decision about whether or not to proceed with the recommended procedures. The high cost of health care in our country is unconscionable and all of us should work towards making it more affordable and equitable.

Thank you,

 [m](#)

Thank you for agreeing to serve on the retirement committee.

Thank you for the opportunity to comment on the medical and dental coverage for PERS retirees.

The plans must be more comprehensive to meet our family's needs!

The lifetime limit on coverage is disconcerting. That amount could be wiped out in a very short time if the God-forbid should happen. But, we could be left with no medical care at all with such a low limit. I may have another 40 years of life, and so that limit does not allow for much at all if annualized.

I would hope that traveling to another location, outside Alaska, is something that is supported by the plan. The cost of care in Alaska, whether Wasilla or Anchorage, is very prohibitive. I can't help but believe that even with airfare, per diem for housing and meals, ground transportation, care would be much less expensive elsewhere in the USA, even if on the East Coast or Florida. It would make that lifetime limit go farther.

Chiropractic care is proving very beneficial to me, and I wish that this care was covered better under my retirement and benefits. I'd rather do this than have surgery or injections.

If we need surgery, I think going Outside would be the right thing to do. Because of cost of care as well as quality of care.

Recently a provider in the Valley said he would not be a preferred provider because he is the only one in his specialty in the MatSu. I decided to not see him, and forego care in lieu of going to Anchorage as it was not that critical at the moment. I am getting okay care at a GP.

Warm Regards, Anna Weiss

I'd like to comment on a few things.

Taking away the 2mil lifetime benefit would be a detriment to those who've paid in to this account knowing there'd be the money there for insurance and passed down to living spouses. I don't necessarily support increasing it, but keeping the 2 mil for already retired should stay the same. Change it for those just joining the State of Alaska. Don't penalize the retired.

Also, travel benefits should include people traveling from Fairbanks and outlying areas to go to anchorage to receive treatment. Fairbanks does not have adequate or good care. I had my [REDACTED] in Anchorage and my travel benefits were denied because there is a surgeon who replaces knees here— yet, he's one of the worst, and surgeons outside of Fairbanks have had to fix his problem knee replacements. Overall, there would be a great savings to the state— aetna— by having surgeries done right the first time.

Thank you,  
Christie Neff

The plan changes asked for and apparently being considered per the AlaskaCare Retiree News | July 2018 are:

- Adding coverage for preventive services (including vaccines)
- Increasing or removing the \$2 million lifetime maximum
- Adding an enhanced travel benefit to provide airfare, lodging, and per diem for a member and a companion to a center of excellence for certain surgeries
- Improving coverage for rehabilitative services including physical and occupational therapy and chiropractic care
- Implementing an Enhanced Employer Group Waiver Program (EGWP) (see below)

The first item is most important and should save money. It seems like it should have been done years if not decades ago. The travel benefit should also save money given the exceedingly high cost of care in Alaska vs alternatives.

The critical question is how much will be taken from the plan to cover the costs of increasing the maximum and improved coverage?

Hopefully reasonable negotiations will be successful in balancing the changes.

Sincerely

Lawrence A. Semmens

## Alaska Retiree Health Plan Advisory Board

### RE: DB Retiree Health Plan Modernization

I am an Alaska State retiree covered by the Alaska Retiree Health Plan. I have reviewed the modernization solutions to the plan described in your proposal. My comments on several of the proposed Areas of Focus solutions are below.

#2 – I agree that a lifetime maximum is an out of date concept and the current maximum should be eliminated.

#3 – Low Cost Share: I've always thought that all participants should pay a share of costs. This is particularly applicable to the family deductible, where the problem isn't as much a low cost share per participant, but a lack of participation by every person in each covered household. I believe the deductible should be paid by every participant, whether there are 2 or 10 in the family.

The current amount of the deductible is quite reasonable, but if it needs to be raised, it should be in a phased approach and not exceed \$250.

The out of pocket suggestion at \$1,600 is too high at double the current amount, and if increased, it should only go to \$1,000. But again, the problem isn't the actual amount, but the lack of participation by every person in the household. The out of pocket should be paid by every participant in the plan, including all dependents.

#4 – If a specific non-preferred pharmaceutical brand is required to meet a medical necessity, it should be treated the same as a Tier 2 drug, as it is now. It shouldn't have a higher co-pay than the current level.

#5 – The plan design is outdated in the requirement that meds be supplied for only 100 days. I would like to see an allowance, with a justification from my provider, for a 180 day supply for lifetime meds.

Over the counter meds requirements need to consider allergies and the unavailability of allergy free OTCs.

#6 – I support the following: "Medical exceptions will be allowed to avoid allergies or provide dosages or mixtures that are not available commercially". Compounded meds should be covered at the same copay as in the current pharmacy benefit.

#7 – I support expansion of travel benefits.

Please feel free to contact me if you have any questions.

Regards,

Alison L. Smith





It's difficult to comment on this because there is no discussion in the presentation as to what the trade-offs are. If there was a chart to list the potential costs associated with the option it would be more informative. I realize it would get more complicated to list the costs if multiple additions were added.

Personally, my biggest concern is preventative. I support adding preventative and in doing so it would be able to fall under the current cost structure for in network providers and not raise the overall cost for out of pocket, lifetime limits, and deductibles. For out of network providers there could be higher costs or a differ percentage paid as the provider costs have not been negotiated.

I am not too concerned about travel given my location but I can see where AK retirees might be interested but some of that is a personal choice as to where to obtain service and those costs should be born by the insured. Most service are now available in Alaska for joint replacement and some cardiac, maybe not so for some of the more complex medical situations.

My preference is to add preventative as it helps my long term health and well-being and keep the deductible and out of pocket as it is now.

Chris Milles



Dear Advisory Board Members:

Thank you for serving on the Board and for your efforts to improve our plan while keeping costs as low as possible. It can't be an easy task. As a retiree since 2004, I do have some comments and suggestions.

Some proposed improvements, such as increasing travel benefits and preventive services could help reduce costs in the long run and I'm happy to see them on the list.

Another way that costs might be reduced is by implementing more proactive strategies for good health rather than surgery..... trying physical therapy or yoga before back or knee surgery, for example. Also, improved and less invasive treatments for many types of cancer are now available and these are less expensive at the time and less expensive for patients to recover from. I see these as ways our health plan can evolve, allowing expanded coverage without adding costs or cuts to the retirees.

Regarding the move to the Medicare Part D EGWP/wrap plan, there are three areas of concern and probable hardship to me.

1. When I enrolled in Medicare, AlaskaCare sent information to explain options and it stated clearly that the pharmacy plan we had was recommended and the Part D offering was inferior in several ways. I'm concerned about that.
2. The 5 step appeal process for denials might be too complicated and cumbersome as I age. People may end up losing a benefit they qualify for simply because they can't endure the lengthy appeal process.
3. The step therapy provision is particularly concerning because people may have to try inferior or less efficient medications at the risk of their health. I do take [REDACTED] rather than a popular generic because of decisions made by my doctor over a period of time and switching drugs would likely have impacts on my glandular system. That seems risky and perhaps expensive in the long run. I believe it is critically important to keep the provision that medication decisions be made by the doctor and patient.

As the board studies options for the retiree programs it is important to keep in mind that the lack of funding was a deliberate decision made by a governor and a few legislators. When funds were widely available, retirees made calls and wrote letters urging full funding, and for reasons that are obscure, funding was denied. It is no wonder some suggestions for cuts and draw backs are met with a bit of hostility.

I thank you for your efforts to provide fair and complete coverage, as promised.

Sincerely,  
Jo Clark

Sent from my iPad