

Redacted Public Comment

5/9/18 – 8/22/18

From: [REDACTED]
Sent: Monday, May 14, 2018 8:07 AM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <alaskarhpab@alaska.gov>
Subject: Aetna and Moda

Dear Advisory Board Members,

I am writing you this letter for two reasons MODA (Dental Delta) and Aetna.

First, I disagree with MODA's policy of contracting with dentists. I just appealed to them and I will send you a copy of my appeal. It explains my position very well. [REDACTED] [REDACTED]

"I am officially appealing this under payment of my [REDACTED] (charges [REDACTED])
I pay for my dental insurance and I have \$2000 at my disposal for dental care. I dispute Colorado Delta Dental taking the LOWEST amount dentist charges for this procedure and applying it to my insurance.

I do not agree with your system of making deals with dentists and then limiting my charges at your discretion because my dentist does not belong to your membership. This is wrong!!! I already pay for my insurance and I paid my \$50 deductible. I have \$2000 for my dental care.

Colorado Delta Dental has NO right to take the LOWEST amount that any dentist in Colorado charges for this procedure and apply it to me. I Appeal this amount and want the rest of my charges applied to my dental account and paid for this service."

My second comments are about Aetna. Aetna has an impossible Appeal system. When one writes an Appeal they do NOT address the issues the member raises in their return letter. There is NO ONE to speak to about it, because the number they give you to call, when you call it they say, that is NOT our department. Then when you write your second appeal they do not address the issues you raise either. It gets worse from there. They are an impossible organization. They have upset me so much and they do not care. At one point they lost my appeal so I went without medical care and was in pain for four months waiting for the appeal to be processed. They did apologize for losing the appeal. This is just an example of how wrong they have been to me. In addition, they have been in the news for their poor appeals practices, but the State of Alaska still supports this horrible business. I have been complaining for years and no one listens.

Please do not support MODA stealing our dental insurance away from us and horrible Aetna for their inadequate appeals process and provide the retirement community with real insurance.

Please feel free to contact me for more information.

Thank you so much,
[REDACTED]
[REDACTED]
[REDACTED]



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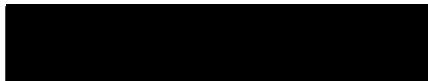
An old persons mouth
shrinks like the rest of their
bodies. This Moda Ins. is
B.S. Shame on you for allowing
this type of dental ins

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DIXIE BOYER



Your board needs to review this plan Introducing your new Retiree Health Plan Advisory Board!

We are pleased to introduce you to your new Retiree Health Plan Advisory Board (RHPAB) board! This board was created by the Governor under Administrative Order 288 to give retirees in the Public Employees, Teachers, and Judicial Retirement Systems (PERS/TRS/JRS) a voice in the administration of the retiree health care plans. The board members are:

✦ **Mauri Long**

Retired Public Employee Association (RPEA); PERS retiree

✦ **Cammy Taylor**

RPEA; PERS retiree; Board Vice-Chair

✦ **Gayle Harbo**

Alaska Retirement Board; TRS retiree

✦ **Senator Judy Salo**

National Education Association; TRS retiree; Board Chair

✦ **Dallas Hargreaves**

Human Resources Director, City and Borough of Juneau

✦ **Mark Foster**

PERS beneficiary

✦ **Joelle Hall**

Public member; AFL-CIO

Seven years is too long!

The board will meet quarterly, with the next meeting scheduled for May 8, 2018. Additional information, including how you can attend and participate in these public board meetings, is available online at alaska.gov/drb/alaskacare/retiree/advisory.html.

If you do not have access to a computer, you can request information through the Division of Retirement and Benefits toll-free at (800) 821-2251, or in Juneau at (907) 465-4460.

*You need to get
a better dental
ins. due to a 2yr. wait*

ALASKA CARE

Retiree Health Plan



for dentures

*It was 2yr
before?*

B

Ms Dixie Boyer

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MAY 25 2018

Div. of Ret. & Benefits

Alasha Care
P.O. Box 110203
Juneau, Ak.
99811-0203

99811-020303



From: William Updegrove [REDACTED]
Sent: Wednesday, May 30, 2018 10:06 PM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <alaskarhpab@alaska.gov>
Subject: Fwd: Changes to Retiree Pharmacy coverage

Please justify to me your reasoning for planning to involve both Medicare and a private company in administering the Alaska retiree pharmacy benefits for those of us over 65. The Aetna home delivery system has worked very smoothly for me - what benefit is it to me or the state to add additional layers of costly bureaucracy?

William Updegrove

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

From: Dave Musgrave <[REDACTED]>

Sent: Wednesday, May 30, 2018 10:09 PM

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

Subject: Planned changes in 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,

David L Musgrave

[REDACTED]

-----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>

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 acupuncture. 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>

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>
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>
Subject: Fwd: Pharmacy Coverage Change
Cc: Dennis Sharon Early <[REDACTED]> Sam Kito <representative.sam.kito@akleg.gov>, Justin Parish <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
[REDACTED]

From: Deborah Hansen [REDACTED]
Sent: Thursday, May 31, 2018 1:09 PM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <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
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

From: [REDACTED]
Sent: Thursday, May 31, 2018 12:04 PM
To: 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
[REDACTED]

From: Carol Thompson [REDACTED]
Sent: Thursday, May 31, 2018 11:59 AM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <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>
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>
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>

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: Don & Marge Dewoody [REDACTED]
Sent: Thursday, May 31, 2018 8:42 AM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <alaskarhpab@alaska.gov>
Cc: [REDACTED]
Subject: Changes to Pharmacy Plan

After reading your email regarding above, I feel that there is discrimination against people over 65 and Tier 1 employees. Since I am a Tier 1, retired 1994, I was under the impression that we were protected (State of Alaska Constitution) from such changes. What happened? Aetna has not seemed to have regard for the rights of retired employees. They haven't been able to handle their job as it is. Why add another department to add to the already present problem?

I thank the board for their work on our behalf.

Respectfully submitted,

Donnell C. DeWoody

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>
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]

From: Kevin O'Sullivan [REDACTED]
Sent: Thursday, May 31, 2018 7:25 AM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <alaskarhpab@alaska.gov>
Subject: CHANGE IN RETIREE PHARMACY PLAN

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>
Subject: Fwd: [Rpea.sc.mat-su] [Rpea.sc] [Rpea.members] CHANGE IN REITREE PHARMACY PLAN

To the board:

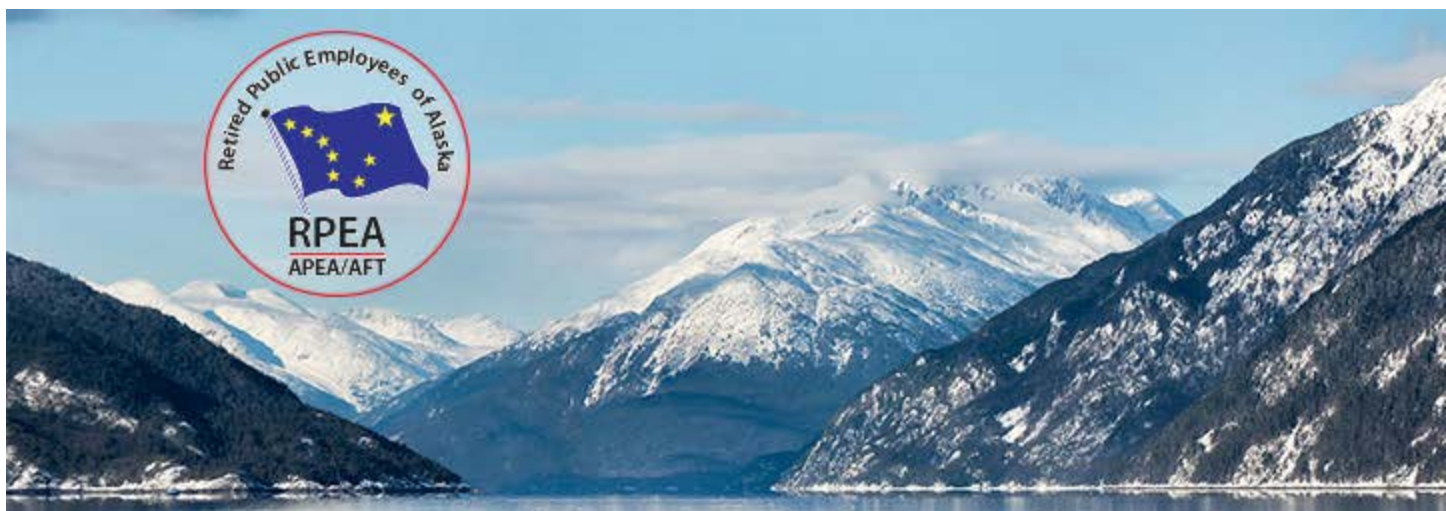
I am a retired Mat-Su Teacher. I was upset when I retired and learned that our insurance coverage which was promised for the 24 years I worked, was actually a scaled down package compared to our coverage as active teachers. NOW you are going to make it harder to get prescriptions, when we are all pushing 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 8th 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 8th 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. 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.

As always, please feel free to contact me directly.

Sharon Hoffbeck

President

Retired Public Employees of Alaska

[REDACTED]

--

Deb Buzdor

[REDACTED]

From: dale skinner [REDACTED]
Sent: Thursday, May 31, 2018 6:43 AM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <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: Ullmayer [REDACTED]
Sent: Thursday, May 31, 2018 5:48 AM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <alaskarhpab@alaska.gov>
Subject: Fw: [Rpea.se.juneau] [rpea.se] [Rpea.members] FW: CHANGE IN REITREE PHARMACY PLAN

Sometimes I wonder if, financially, it would not be better for some of us to just divorce and live together than to stay married. For those retirees whose spouses are on their insurance that is not an option. Please consider reimbursement by the State of Alaska in the form of a health savings account that would be nontaxable. Is that possible?

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

From: Carol Thomson [REDACTED]

Sent: Thursday, May 31, 2018 5:27 AM

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

Subject: Thank you

Thank you for the updated mail address... and thank you for the important information you send to Alaska retirees.

Sent from my iPad

From: PATRICK STEVENS [REDACTED]
Sent: Thursday, May 31, 2018 4:52 AM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <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

[REDACTED]

[REDACTED]

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

From: [REDACTED]
Sent: Thursday, May 31, 2018 3:16 PM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <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.
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.

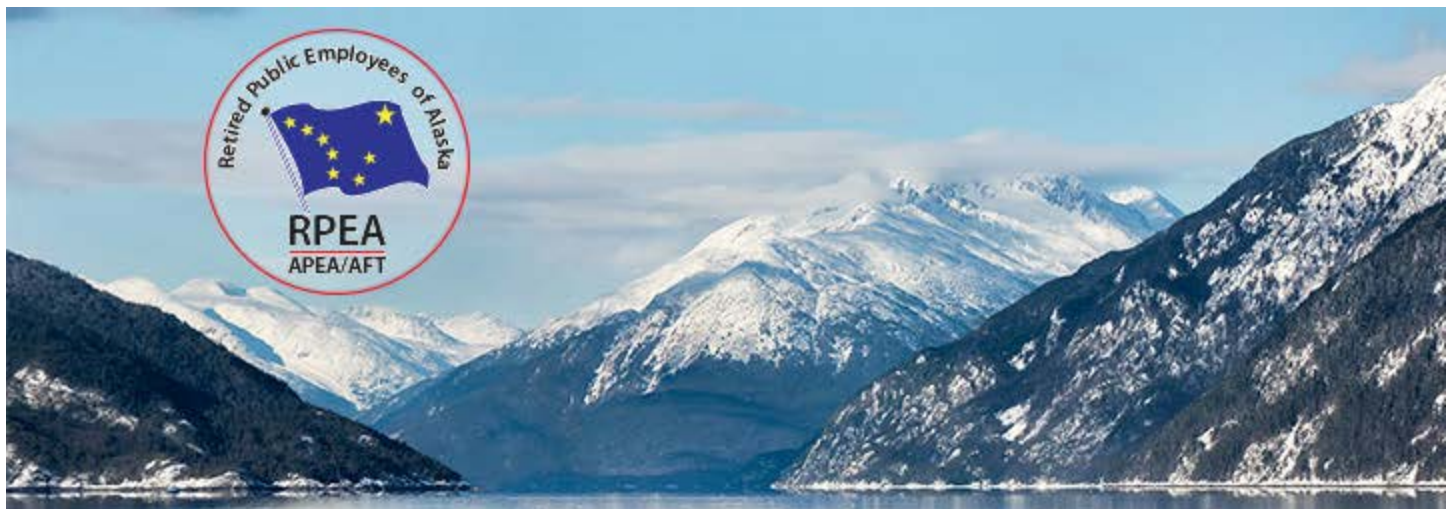
Henry & Margaret Wiedle
Anchorage

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.

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 8th 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 8th 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. 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.

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

Web site:

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.
-
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.



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

Web site: www.rpea.apea-aft.org

***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.

Proposed *Duncan* Equivalency Analysis Template

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 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?

From: Mike Mitchell [REDACTED]
Sent: Thursday, May 31, 2018 4:14 PM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <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>

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

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

From: Julie Morgan [REDACTED]

Sent: Thursday, May 31, 2018 6:25 PM

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

Subject: Retiree benefits

As a retiree and life long Alaskan I trusted the state upon my retirement that they would honor a commitment to me to uphold my benefits. That has not proven to be true.

The state has an obligation to its employees to at the very least to ask our opinions when they decide to change our agreed upon benefits. I am very disappointed at being treated as a non entity when deciding my health care! What's next, death panels!!

I strongly object to how the state is treating its former loyal employees regarding our health care. We are active and have brains. How dare you!

Julie Huber Morgan

Julie Huber Morgan

From your friend or family member, Julie Morgan

From: Barbara Smith [REDACTED]
Sent: Thursday, May 31, 2018 11:37 PM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <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>
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 [REDACTED] Teacher

From: Gene Dodd [REDACTED]
Sent: Friday, June 01, 2018 6:43 AM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <alaskarhpab@alaska.gov>
Subject: Retiree Health Insurance When Traveling out of USA

Good Morning:

My wife and I are retired Alaska school teachers now living in Southern AZ. We travel outside the USA several times a year and always run into the problem of health insurance when doing so. While I can understand the difficulty of having our insurance accepted as in the USA when traveling to Russia, it seems to me that we could work something with the Canadian provinces so that our Alaska Care is accepted in Canada just as it is in the USA. Since coming to Alaska in 1976, we have traveled in and through Canada dozens of times and I'm sure many other retirees do also. Thank you.

Howard and Karen Dodd

From: Eric M [REDACTED]
Sent: Friday, June 01, 2018 7:35 AM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <alaskarhpab@alaska.gov>
Cc: Eric(Desktop) [REDACTED]
Subject: Medicare Part D pharmacy plan called an EGWP/wrap

June 1, 2018
Eric & Mary Marchegiani

[REDACTED]
[REDACTED]
[REDACTED]
Email:

Retiree Health Plan Advisory Board
Email: AlaskaRHPAB@Alaska.gov

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

Dear Sir/ Madame:

It is my understanding that effective January 1, 2018 that the Retiree Pharmacy Plan will be changed to Medicare Part D pharmacy plan called an EGWP/wrap for all those Retirees over 65. My wife will turn [REDACTED] [REDACTED] and I am already [REDACTED]

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>
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>
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>
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>;
[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>
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>

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
[REDACTED]

From: Pete Heddell [REDACTED]
Sent: Saturday, June 02, 2018 10:50 AM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <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>
Subject: Medicare Plan D

Dear Board Members, I am a retired Teacher, age 68 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>

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>
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>

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
[REDACTED]

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>
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: Joe Mason [REDACTED]
Sent: Monday, June 04, 2018 8:54 AM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <alaskarhpab@alaska.gov>
Cc: [REDACTED]
Subject: Change in Retiree Pharmacy Plan

I just learned of the proposed Change in the Retiree Pharmacy Plan that the state is proposing. I am concerned that it will reduce the benefits I currently receive from my retirement plan.

I am currently retired from both PERS and TRS. As a result, I have double medical coverage, with the PERS acting as secondary to Social Security and the TRS acting as tertiary. Thus, my medication copays are normally covered. Also, if I have a medical emergency outside the country requiring medications, PERS would become the primary insurance and TRS the secondary since Social Security benefits aren't available out of the country.

I didn't see this issue addressed in the State's proposed changes to the Retiree Pharmacy Plan. Thank you for looking into this.

Gordon J Mason

Anchorage, Alaska

From: Rosie & Pat [REDACTED]
Sent: Monday, June 04, 2018 9:40 AM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <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>

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>
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>
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>
Cc: Rep. Andy Josephson <Rep.Andy.Josephson@akleg.gov>; Sen. Berta Gardner <Sen.Berta.Gardner@akleg.gov>; RPEA <rpea@alaska.net>; 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>
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]

[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]
[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

[REDACTED]

From: nancy long [REDACTED]
Sent: Monday, June 04, 2018 12:58 PM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <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.
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>
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>
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>
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 additional 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 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.
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.

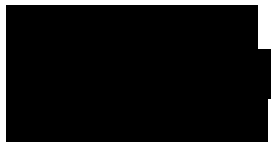
7. Not all pharmacies are on the approved provider listing and could cause a potential problem for some retirees.

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



-----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>

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>
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>
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 Geariety

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/dr/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 7th 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>

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: [REDACTED]
Sent: Wednesday, June 06, 2018 2:32 PM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <alaskarhpab@alaska.gov>; Sharon Hoffbeck [REDACTED]
Subject: Change in Retiree Pharmacy Plan

Please see attached comments.

Thank you,

John Middaugh

RPEA member

John Middaugh
[REDACTED]

Sharon Hoffbeck
President
[REDACTED]

Dear President Hoffbeck,

I am writing in response to your email of May 31 re: Change in Retiree Pharmacy Plan. Thank you for providing this important update and information. I totally support your vigorous efforts to challenge the actions of the Department of Administration to make these proposed changes. It is difficult to see how the Department of Administration can argue that the proposed changes are not a significant reduction in the current retiree benefits or that the proposed changes provide comparable new advantages.

Please let me know if there are any actions I can take to support the RPEA in this effort.

Yours truly,

John Middaugh
[REDACTED]

From: Sharon Hoffbeck [REDACTED]
Sent: Wednesday, June 06, 2018 4:52 PM
To: Pineda, Natasha M (DOA) <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: Sharon Hoffbeck [REDACTED]
Sent: Thursday, June 07, 2018 8:22 AM
To: Pineda, Natasha M (DOA) <natasha.pineda@alaska.gov>
Cc: Brad Owens-Executive Vice President--RPEA [REDACTED]
Subject: Advisory Board Email
Importance: High

Natasha—I sent the below email two days ago with a ‘read’ request, and did not receive notice that it was read so am not sure what the status is. Please forward this email to Judy Salo, and notify me when that has taken place. Thank you

From: Sharon Hoffbeck [REDACTED]
Sent: Tuesday, June 5, 2018 4:35 PM
To: 'AlaskaRHPAB@alaska.gov' <AlaskaRHPAB@alaska.gov>
Cc: Brad Owens-Executive Vice President--RPEA [REDACTED]
Subject: RPEA Equivalency Analysis--EGWP/Wrap
Importance: High

Natasha—please forward this email to Judy Salo upon receipt.


Judy—
Brad Owens recently sent you a *Duncan* template that he wrote for the Board’s consideration. Attached is that template applied to the EGWP pharmacy plan change that DOA intends to implement.

RPEA has also recently received copies of email that retirees have sent to the Board in the past few days concerning the EGWP plan change, which I hope you have received in a timely manner.

Please let me know if we can be of further assistance.

Respectfully,

Sharon Hoffbeck
President
Retired Public Employees of Alaska
[REDACTED]


Equivalency
Analysis--EGWP.pdf

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



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

Web site: www.rpea.apea-aft.org

June 6, 2018

Equivalency Analysis: EGWP/Wrap

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

Two reasons are given by DOA – a) improve financial efficiency of retiree program while b) preserving overall benefit value and minimizing member impact.

2. What are the reasons for the proposed change?

DOA identifies a) cost savings by switching from RDS to EGWP and b) help reduce OPEB liabilities associated with retiree health benefits.

3. What data exists that supports the proposed change?

DOA does not provide data but does claim that RDS subsidies are approximately \$19M -- \$21M annually and EGWP is estimated to be \$35 -- \$44M in savings annually which results in an immediate reduction to the OPEB liability. However, no data is provided that supports these assertions.

4. Does the proposed change substantially reconfigure the mix of current benefits?

DOA states that the vast majority of members will experience no change in benefits. However, the summary comparison of particular benefits or coverage provided by DOA shows generally several areas that change, such as network, benefits, pre-authorization, formulary, clinical programs, out-of-country coverage and plan fiduciary. Unfortunately, there is little information or specific data to allow an appropriate assessment of the degree of reconfiguration of current benefits.

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

Without more detailed data, it is difficult to discern what gaps may occur under the EGWP program, such as benefits, pre-authorization, formulary and clinical programs. Based on the summary information provided by DOA, the most obvious gap created by switching to the EGWP is the appeal process. Under the current RDS program, members are entitled to utilize a statutory three-step appeal process that allows a final review by Alaska courts, while the EGWP requires a member to utilize a cumbersome five-step appeal process under federal regulations with final review in federal court. In addition, EGWP is a federal program that could be modified, suspended or terminated at any time.

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

As noted above, EGWP requires members to follow federal regulations rather than current plan language, eliminates the plan statutory appeal process and changes the plan fiduciary from DOA to the PBM. Without greater specific benefit usage data provided by DOA, it is difficult to determine what other benefits under the current plan are restricted, reduced or eliminated. Again, as a federal program EGWP could be suspended, modified or terminated at any time.

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

EGWP would apply to all members 65 and over. The changes to federal regulations, the new appeal process and plan fiduciary would impact all those members. How many members would be affected by changes in benefits provided, pre-authorization, formulary, the clinical programs, or out-of-country availability is unclear without further specific data.

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

Given the age of the impacted members, it seems likely that many will have a difficult time understanding the changed program and new federal procedures that apply under EGWP. Without additional specific data covering 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 change been given adequate notice of the proposed change?*

It appears 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.

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

It is essential that DOA not only give general notice of the intended change to EGWP but that it give specific opportunities to affected members to obtain more specific information about the program, what options will be available and how it will 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 inflict on 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 change may result in substantial hardship?*

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

12. *Is any substantial hardship offset by comparable advantages?*

DOA claims that the vast majority of members will experience no change with implementation of the EGWP. This is based on claims that overall benefit levels can be maintained by such devices as a supplemental “wrap” program or enrollment in an “alternative prescription drug program.” However, little specific reliable data based on actual experience has been provided by DOA to substantiate these claims.

13. Does the proposed change result in the diminishment or impairment of any current benefits?

As discussed above, it appears there will be a diminishment or impairment of the benefits and/or coverage under the current retiree drug program 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?

If DOA has performed a comparative analysis to determine if there is equivalent value under the change to the EGWP program, that analysis has not been made public yet.

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

Once the analysis has been performed and made public, the data utilized and relied upon by DOA in performing the analysis should 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.

From: DCL [REDACTED]
Sent: Thursday, June 07, 2018 9:22 PM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <alaskarhpab@alaska.gov>
Cc: [REDACTED]
Subject: RE: Healthcare Modernization

We are actually pleased to see many of the updated items in the presentation that we have read on this version of the Healthcare Modernization Plan. Our biggest concern is the increase in the maximum out of pocket cost. As we age, more things will be eating away at our retirement money, and while we may be able to overcome the increased deductible, the out of pocket increase to \$1600.00 will more than likely be more than we could overcome, especially for two of us.

This is an area we think requires further review and discussion, due to the fact that our retirement income will not increase to overcome the additional amount. The justification used, as we read it, is that retirees overuse the benefits and this will make them realize the value of the benefit package, which we think is more like a punishment for using the benefits we worked for when we need them in our older age, with no hope of working more to recoup the monetary loss.

Sincerely,

Dale & Carole Long

State of Alaska Retiree

From: carol downs [REDACTED]

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

To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <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]

[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

To: Retiree Health Plan Advisory Board Members
Copy: Sharon Hoffbeck, President, Retired Public Employees of Alaska

Please consider these comments as you review proposals for changing our Alaska Retiree Health Plan.

My spouse and I are both Tier I defined benefit beneficiaries of the Plan. My spouse was an Administrative Assistant for the Alaska State Troopers; I was a city manager for Petersburg and Soldotna. Our AlaskaCare coverage has been secondary to Medicare for medical benefits for many years now. We are both most sincerely grateful for the retirement benefit - especially when we note how our medical coverage has been so much better than persons who've worked for other employers in and out of Alaska.

The dental coverage, however, is another story.

[REDACTED]

[REDACTED]

Please contemplate these suggestions for changes to the dental plan . . .

1. To mitigate confusion about coverage for implants under the medical or dental plan, assign all implant claims to just one TPA, including implants required because of accident or nondental disease.
2. Cover implant services at 80% of reasonable and customary charges [including sinus lift biological materials to aid in tissue regeneration (CDT code D4265); guided tissue regeneration (CDT code D4266); and radiographic/surgical services (CDT code D6190).
3. Cover implant related crown and bridge services at 50% of reasonable and customary charges subject to the annual deductible.
4. Increase the patient maximum dental benefit from \$2,000 to \$3,000 per year.

Attached find recent EOB's from AETNA and MODA/DELTA DENTAL for illustration to accompany this comment. Thanks for your consideration.

Richard Underkofler

[REDACTED]

ATTACHMENT HEAVILY REDACTED DU TO INCLUSION OF PHI.

[REDACTED]

[REDACTED]

[REDACTED]

Complaint and Appeal:

If you have a dental claim for a service that was covered prior to 2014, but has been denied by MODA, we urge you to file an appeal if you still can.¹ Appeal instructions can be found on the RPEA website: rpea.apea-aft.org. Either way, please send RPEA information about the denied claim [mail: RPEA@Alaska.Net] with a copy to Sharon Hoffbeck, President, Retired Public Employees of Alaska [mail: sharonhoffbeck@gmail.com].

Prior to 2014, [REDACTED]

[REDACTED]

Chronological Log Regarding these Claims

[REDACTED]

[REDACTED]

¹ RPEA Reporter, June 2017

[REDACTED]

[REDACTED]

(2) Your plan provides benefits for covered expenses at the prevailing charge level made for the service in the geographical area where it is provided. In determining the amount of a charge that is covered we may consider other factors including the prevailing charge in other areas. If there is additional information that should be brought to our attention, please contact us. [374]

[REDACTED]

² State of Alaska, AlaskaCare Employee Health Plan, January 1, 2014, Page 19 -26

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

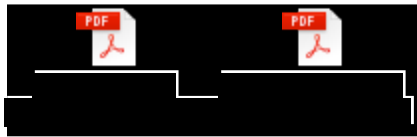
[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]



From: Jim Morrison [REDACTED]
Sent: Friday, June 08, 2018 3:06 AM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <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>
Cc: Eric(Desktop) [REDACTED] Saddler, Dan (LEG)
[REDACTED] MacKinnon, Anna (LEG)
Subject: Proposed DB Retiree Health Plan Modernization

June 8, 2018

Eric & Mary Marchegiani
[REDACTED]
[REDACTED]
[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: Marilyn Underkofler <[REDACTED]>
Sent: Friday, June 08, 2018 6:15 AM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <alaskarhpab@alaska.gov>
Cc: [REDACTED]
Subject: DRGB Retiree Health Plan Modernization

[REDACTED] sent you an email earlier and I would like to add my comments to his email.

Since we pay a premium for Audio, Vision, and Dental, I feel we should have the option of selecting the provider and plan. The way it is now, we are informed of what the State of Alaska has determined what plan we are enrolled and the price we are expected to pay. NOT ACCEPTABLE! If we desire to select another provider or plan, even if it means an increase in the premium, we should have the right to make that decision.

We have recently had an increase in our premium without the right to be involved in the selection of the provider or plan.

Thank you for your attention to this matter.

Sincerely,

Marilyn L. Underkofler

[REDACTED]

[REDACTED]

[REDACTED]

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

Sent from [Mail](#) for Windows 10

From: Timothy Shine
Sent: Friday, June 8, 2018 9:10:04 AM
To: AlaskaRHPAB@alaska.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>
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, [REDACTED]

From: Judy Jantz [REDACTED]
Sent: Friday, June 08, 2018 10:10 AM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <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: Barbara Smith [REDACTED]
Sent: Friday, June 08, 2018 10:46 AM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <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
[REDACTED]

From: Meg Hayes [REDACTED]
Sent: Friday, June 08, 2018 1:51 PM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <alaskarhpab@alaska.gov>
Subject: changes to Alaska Public Employee Retirement System Benefits

Dear Sirs or Mesdames,

My family relies on PERS retirement promises made in 1975 at the time my state employment began. Changes may only be made when hard data indicates that the proposal materially benefits the enrollees and the strengthens the system itself. These data must be available to its beneficiaries to evaluate for themselves and to comply with the Alaska public access to information acts. Our rights as beneficiaries include the expectation that disputes would be resolved quickly and equitably by people familiar with Alaska and the people who live in this great state.

Thank you for taking these issues into consideration when contemplating changes to PERS.

Meg Hayes

From: Paulette [REDACTED]
Sent: Friday, June 08, 2018 6:50 AM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <alaskarhpab@alaska.gov>
Cc: Sharon Hoffbeck [REDACTED]
Subject: Medical Plan Modernization

Re: Section 9 Confusion Over Dental Implants

If this will be covered, can those who elected another dental plan be allowed to enroll now that confusion about implants will be clarified?

Thank you,
Paulette Shannon
[REDACTED]

From: Gary Miller [REDACTED]
Sent: Saturday, June 09, 2018 11:03 AM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <alaskarhpab@alaska.gov>
Cc: Ricci, Emily K (DOA) <emily.ricci@alaska.gov>; Michaud, Michele M (DOA) <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 [REDACTED] and said that I had [REDACTED] and would need surgery. Would my [REDACTED] 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]

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

From: Jim Shook <[REDACTED]>

Sent: Saturday, June 09, 2018 12:37 PM

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

Subject: Retirement health care plan

As I was an employee starting in 1968 I always considered my relationship With the State of Alaska to be a binding partnership. The State was going to help and protect me and I would in turn give my all to the point of gladly risking my life for the people of Alaska. I as well as thousands of now retired Alaska State employees have worked thousands of uncompensated hours. Most specifically the Alaska State Troopers. There were years we averaged .25 cents to .50 cents an hour but again we did it gladly. 20 and 35 hour continuous shifts were common and the risks were sometimes great but we persevered. All the time I remember the State of Alaska would take care of me and my family. Now in my late seventies I find the State of Alaska has become my adversary and I have no trouble telling you in my naive way that I feel a sense of betrayal. Perhaps the younger generation's lack of respect for those who came before is seeping into the Governments philosophy but it is NOT right.! My thanks go to those like Duncan Fowler, Sharon Hoffbeck, Joe DeTemple and others who are watching out for us but they should not be necessary.

To the State of Alaska, Dpt. of Retirement and Benefits. If you screw us be prepared for a fight, you have our lives in your hands, literally! If the State messes with our heart meds. or breathing meds. It could end us by the time the State's henchmen come around. We are watching.

From: Chris Milles <[REDACTED]>
Sent: Saturday, June 09, 2018 1:36 PM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <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 56, 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>; 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 [REDACTED]. This year, we did have to have a [REDACTED], which is a one-time expense paid for by Medicare.

We don't take medications, we don't smoke, we're not over weight and we 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]. He failed to diagnose [REDACTED]. 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>
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 [REDACTED] is a valuable assesment. So why do we need to have an [REDACTED] covered~~~why not just [REDACTED] 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.

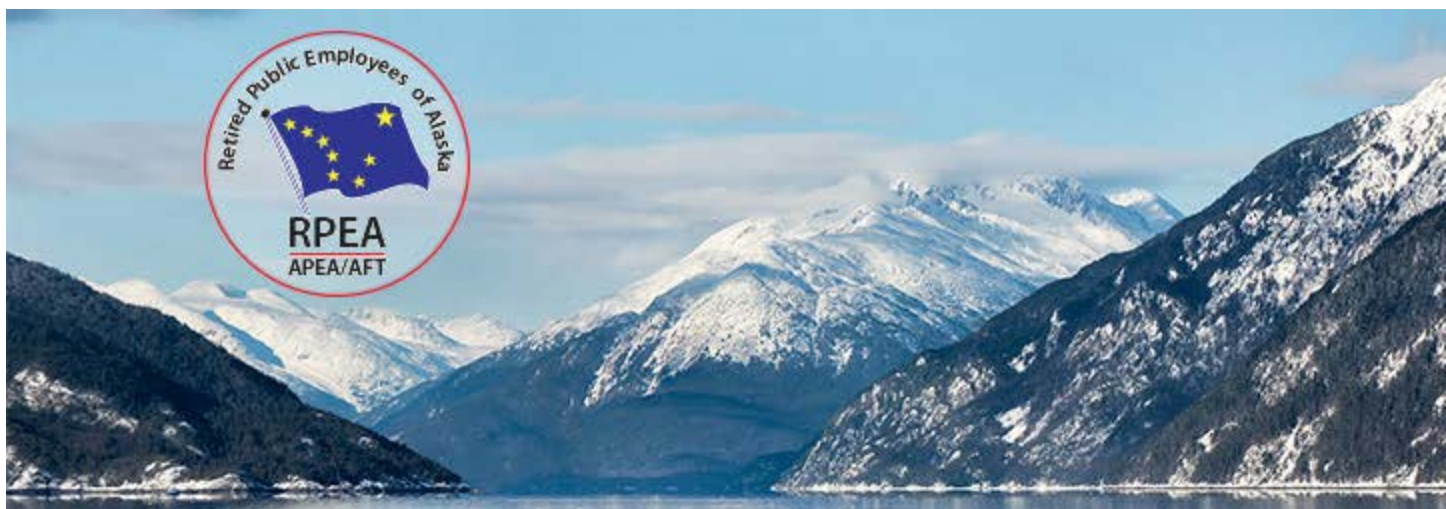
Concern: Pharmacy costs are increasing and using out-of-network providers is more expensive. Possible Solution: Change coverage for prescriptions filled at an out-of-network pharmacy. o Prescriptions filled at an out-of-network pharmacy: • Plan pays 60% coinsurance, • Member pays 40% until annual \$1,000 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]

From: "sharonhoffbeck" [REDACTED]
To: "RPEA Members--All" <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 10th 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.

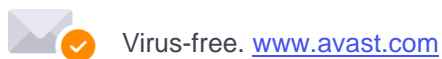
It is important that retirees attend meetings via teleconference when possible, and send comments and concerns to the Retiree Health Plan Advisory Board at AlaskaRHPAB@alaska.gov. Please cc RPEA as we are keeping track of issues that are important to retirees:

[REDACTED]

Please let me know if you have questions.

Sharon Hoffbeck
President
Retired Public Employees of Alaska

[REDACTED]



Rpea.members mailing list
Rpea.members@mailman.apea-aft.org
<http://mailman.apea-aft.org/cgi-bin/mailman/listinfo/rpea.members>

Rpea.outside mailing list
Rpea.outside@mailman.apea-aft.org
<http://mailman.apea-aft.org/cgi-bin/mailman/listinfo/rpea.outside>

From: Juanita Young [REDACTED]
Sent: Sunday, June 10, 2018 12:19 AM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <alaskarhpab@alaska.gov>
Subject: FW: [Rpea.sc] [Rpea.members] DRB Retiree Health Plan Modernization

Please read my comment in red ink below...Nita & Dan Young

From: Sharon Hoffbeck [REDACTED]
Sent: Saturday, June 09, 2018 7:39 AM
To: 'Juanita Young'
Subject: RE: [Rpea.sc] [Rpea.members] DRB Retiree Health Plan Modernization

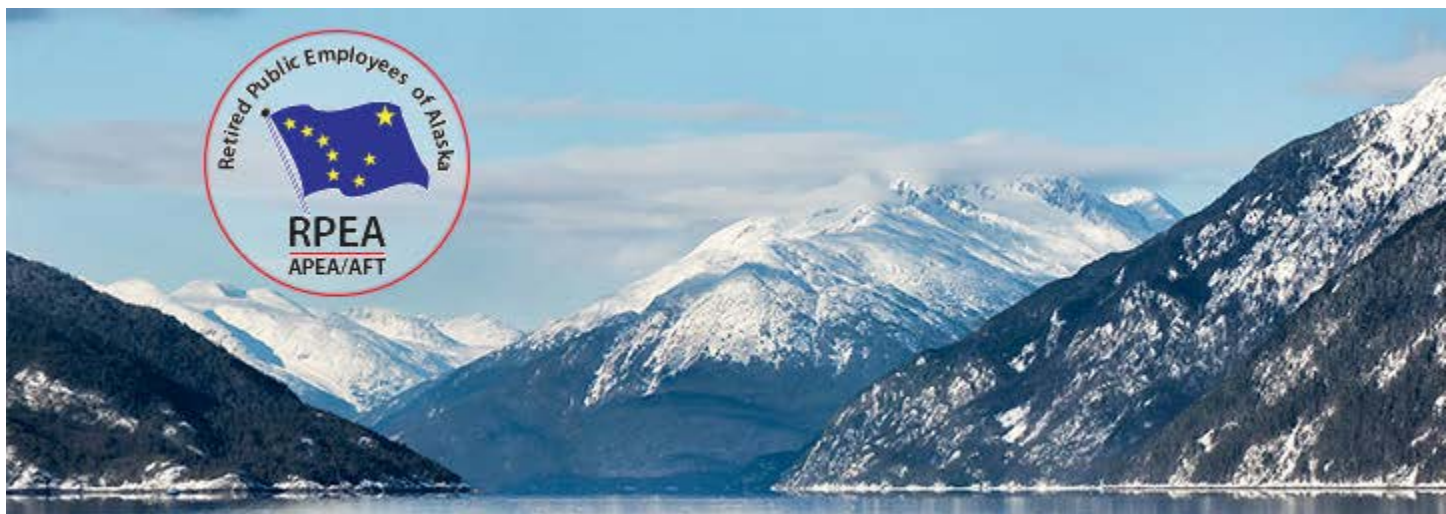
I agree. You should send your comments to the Retiree Health Plan Advisory Board. They will be meeting on Tuesday to discuss all of these changes.

AlaskaRHPAB@alaska.gov

From: Juanita Young [REDACTED]
Sent: Friday, June 8, 2018 10:19 PM
To: 'Sharon Hoffbeck' [REDACTED]
Subject: RE: [Rpea.sc] [Rpea.members] DRB Retiree Health Plan Modernization

Sharon for our part...I do not think this is a good thing...I think things need to be left alone...I just do not see this being an improvement or benefit to ANYONE.....Nita Young (Dan Young)

From: rpea.sc-bounces@mailman.apea-aft.org [<mailto:rpea.sc-bounces@mailman.apea-aft.org>] **On**
Behalf Of Sharon Hoffbeck
Sent: Thursday, June 07, 2018 6:57 PM
To: RPEA Members--All
Subject: [Rpea.sc] [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 10th under the 'Retiree Health Plan Advisory Board' link: <http://www.rpea.apea-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. Please cc RPEA as we are keeping track of issues that are important to retirees: sharonhoffbeck@gmail.com.

Please let me know if you have questions.

Sharon Hoffbeck

President

Retired Public Employees of Alaska



Virus-free. www.avast.com

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>
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>
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>
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

From: Forrest Blau [REDACTED]
Sent: Monday, June 11, 2018 11:28 AM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <alaskarhpab@alaska.gov>
Subject: Reducing State of Alaska Retiree Benefits

I worked for the State of Alaska for 23 years. Any reduction in retiree health or pension plans by the State of Alaska is not fair to all retirees since they worked under those health and pension plans for years.

Please going forward keep the retiree health and pension plans in tact.

Thank you,

S. Forrest Blau

[REDACTED]

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>
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]

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

From: bowens [REDACTED]
Sent: Tuesday, June 12, 2018 5:55 PM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <alaskarhpab@alaska.gov>
Cc: Sharon Hoffbeck [REDACTED]; Ridle, Leslie D (DOA) <leslie.ridle@alaska.gov>;
Stephanie Rhoades--MIC Director <[REDACTED]>
Subject: Modernization proposal Duncan questions

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>

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: Kathleen Vander Zwaag [REDACTED]
Sent: Thursday, June 14, 2018 4:24 PM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <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> 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 7th](#) 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: Kathleen Vander Zwaag <[REDACTED]>
Sent: Monday, June 11, 2018 2:36 PM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <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 insurers

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.

You’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).

From: Kari Mohn [REDACTED]
Sent: Friday, June 15, 2018 11:51 AM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <alaskarhpab@alaska.gov>
Cc: [REDACTED]
Subject: Retiree Pharmacy Plan

Greetings Retiree Health Plan Advisory Board Members,

I am concerned about the proposed change to the Retiree Pharmacy Plan. Please make sure that an equivalency analysis is done to establish whether the changes would disadvantage retirees. Please make sure that any new plan does not diminish or impair the current plan.

Thank you for looking after retirees' interests.

Karen M. Mohn
[REDACTED]

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>
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>
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: Stephen McMains [REDACTED]
Sent: Saturday, June 16, 2018 4:47 AM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <alaskarhpab@alaska.gov>;
[REDACTED]
Subject: Retirement Pharmacy Plan for Retirees

There is only one thing to do for current retirees, GRANDFATHER them and keep current plan in place for the current retirees and start this program for the new retirees. They will have the time to adjust to this plan if passed by the courts. That's all that needs to be done.

If money is the problem, let government generate a sales tax or start a state income tax to balance the budget not the backs of retirees though. Alaska had a income tax for a year or two and a additional effort to save money years ago they cut the union workweek from 40 hr to 37.5 hr . Make sure you tax all north slope workers living out of state. I saw in another email where someone said the federal government couldn't balance a check book, Alaska state government can't either. A retired TRS and PERS.

Thanks
Stephen McMains

From: Sandi Trumbower [REDACTED]
Sent: Saturday, June 16, 2018 7:41 PM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <alaskarhpab@alaska.gov>
Subject: Alaska Care

I am writing to discourage the Retiree Health Plan Advisory Board from advancing the plans to modify the retiree Pharmacy Plan.

I am strongly opposed to the denial/appeal process that would not only be more cumbersome than our current plan, involving 5 appeals rather than the current 3. It appears that it would also put the entire process in the hands of a third party, NOT AlaskaCare – the agency that I am in, what I consider to be, a contract with. I have fulfilled my end of the contract and expect the State of Alaska to fulfill theirs – as it was written.

The “high income” category is another unacceptable deviation from the contract that I have met and expect the state to meet. As a double retiree (TRS and PERS) I am 100% covered. When I reached the age of 65 I was required to sign up for Medicare at an additional cost of \$130 a month. Now it would appear this new plan would require me to pay more – above the \$1,500 a year that I feel should be picked up by the state, but is not. The additional threat of being dropped if the surcharge is not paid is an additional concern for those of us facing memory loss as we age.

The most upsetting thing I have so far heard about this proposed plan is the “Step Therapy”! I am a [REDACTED] and am well aware that if [REDACTED] I could be dead by the time I have used all the potential less expensive drugs that someone, other than my doctor, thinks may work. This part of the plan is TOTALLY unacceptable.

I worked for the state, for many years, forgoing Social Security and thereby saving the state from paying its share of my Social Security payments. In so doing I have reduced my retirement income. I do not appreciate the state’s efforts to further reduce the benefits that I have worked to acquire.

Please consider this a reminder that the state is obligated by RPEA vs Duncan to perform an equivalency analysis, comparing the changes disadvantages to benefits for the retirees based on actuarial sources rather than projections.

I would also point out that the state has for many years now failed to put the contract for administering our plan out to bid, as required, and just entering into a contract with Aetna. Please take action to make sure that it is put out to bid!

Thank you for your time and attention.

From: [REDACTED]
Sent: Monday, June 18, 2018 10:45 PM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <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>
Cc: [REDACTED]
Subject: Proposed Change in Retiree Pharmacy Plan

ATTENTION: Natasha Pineda, MPH
Deputy Health Official
Alaska Department of Administration
550 W 7th 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 its bottom right corner.

From: Patricia O'Brien <[REDACTED]>
Sent: Tuesday, June 19, 2018 7:02 AM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <alaskarhpab@alaska.gov>
Cc: [REDACTED]
Subject: Protest to the change in Alaska's retiree pharmacy plan.

I strongly disagree with my doctor being second guessed by an unknown person who does not know me selecting a cheaper drug than the one prescribed by my outstanding physician. She has provided my medical care for more than 20 years. She understands how my body may react to medications and should never be second guessed by a distant stranger in order to save a buck.

Shame of the State of Alaska and shame on Governor Walker for scaring State of Alaska retirees in this way.

Copy provided to Governor Walker on line at his "contact the governor" site.

Patricia OBrien

Patricia OBrien
[REDACTED]

From: Robert Hutton <[REDACTED]>
Sent: Tuesday, June 19, 2018 7:48 AM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <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
[REDACTED]

-----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>

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]

Side Note:

6/19/19 From Vanessa: When I replied to Stephen, the below came back as undeliverable. I sent him another e-mail with another reply saying there was a problem with Sharon's e-mail, but I wanted to ensure he received a reply.

--- The following addresses had delivery problems ---

<"\"President Hoffbeck\" sharonhoffbeck\" [REDACTED] > (5.1.2 The recipient address <"President Hoffbeck\" [REDACTED] [\[5.1.2\]](#) is not a valid RFC-5321 address. p8-v6si70904pfh.249 - smtp)

From: Mark Miller [REDACTED]
Sent: Tuesday, June 19, 2018 8:41 AM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <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>
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>
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>
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>; Jonathan Kreiss-Tomkins [REDACTED]; Rep. Jonathan Kreiss-Tomkins <Rep.Jonathan.Kreiss-Tomkins@akleg.gov>; Sharon Hoffbeck <[REDACTED]>; 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>
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: Barbara Christian [REDACTED]
Sent: Wednesday, June 20, 2018 10:31 AM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <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 [REDACTED]. The [REDACTED] left as many problems as they solved. [REDACTED] 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 [REDACTED] in the Kenai/Soldotna area who is respected (and even used) by local physicians and surgeons. I went to him 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 [REDACTED] 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 [REDACTED]. I would be happy to provide more details.

Barbara Christian
[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>

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>
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 [REDACTED] bills paid – not just mine but all of the [REDACTED] retiree patients! Services once covered suddenly were removed from coverage. For example, my husband's [REDACTED] treatment, a unique form of [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] 99% successful. A lawsuit settled out of court reimbursed them. But see my point?? [REDACTED], 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 [REDACTED] 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 5th 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: Robert Covarrubias <[REDACTED]>
Sent: Wednesday, June 20, 2018 7:28 PM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <alaskarhpab@alaska.gov>
Subject: Medical plan changes.

Please send me the information, let see. It always changes for the worst, right? I guess that why we support politicians. They do not care for the citizens, just themselves. Send me the data, thanks.

From: sharon whytal [REDACTED]
Sent: Wednesday, June 20, 2018 8:09 PM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <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: Karl Koch [REDACTED]
Sent: Wednesday, June 20, 2018 8:31 PM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <alaskarhpab@alaska.gov>
Cc: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <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 [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>

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]
[REDACTED]

Mailing:
[REDACTED]
[REDACTED]
[REDACTED]

From: dale skinner <[REDACTED]>
Sent: Thursday, June 21, 2018 5:31 AM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <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>

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.

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

From: PAM CHRIS [REDACTED] >

Sent: Thursday, June 21, 2018 5:42 AM

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

Subject: Change to healthcare retirement plan

To whom it may concern,

As an Alaska retiree on a fixed income I find the proposed increases in yearly deductibles from \$150 to \$300, out of pocket from \$800 to \$1600 and doubling the copay disturbing. The state of Alaska made a promise to tier 1 retirees and are now considering modification of that promise. My wife and I would be negatively impacted by these changes and are opposed to them. Chris Scranton

From: Jonnie lazarus [REDACTED]
Sent: Thursday, June 21, 2018 6:12 AM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <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>

Cc: Sharon Hoffbeck RPEA <[REDACTED]>

Subject: Attempt to reduce retirement benefits

I am a 76 years old 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: Jerry Weaver [REDACTED] >
Sent: Thursday, June 21, 2018 7:45 AM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <alaskarhpab@alaska.gov>
Subject: : Changes to Pharmacy Plan

Can the Board meet the test in calculating the financial impacts as required by State law in that the changes do not materially reduce the benefits of the retiree?

I object to the proposed changes for those over 65.

Jerry Weaver

From: Douglas Lottridge <[REDACTED]>
Sent: Thursday, June 21, 2018 7:48 AM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <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

[REDACTED]

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

From: Allan & Judy Morotti [REDACTED]

Sent: Thursday, June 21, 2018 8:25 AM

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

Subject: DRB Proposal

The proposed changes to cost to each patient is going to be a financial burden to me. I earn a small retirement and because of state laws I am not eligible for Social Security (one of only four states which deny benefits to workers) and because of other laws, I cannot even qualify for my husband's Social Security.

We are hit each and every way by punitive state laws against public sector employees. If you want quality teachers in the state to stay in teaching and public work, the state must stop punishing employees.

Sincerely,

Judith Morotti, M.Ed.

From: Phil Bennett <[REDACTED]>
Sent: Thursday, June 21, 2018 8:41 AM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <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: [REDACTED]
Sent: Thursday, June 21, 2018 9:10 AM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <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 diabetes, 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

From: Douglas Ruberg [REDACTED] >
Sent: Thursday, June 21, 2018 11:17 AM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <alaskarhpab@alaska.gov>
Subject: Health and pharmacy benefit changes

The changes for the Health Plan deductible will greatly impact me and my husband financially. The prospect of paying \$600 deductible annually will put a financial burden on our retirement set income which will diminish the quality of our lives. Please do not impose this. Also, the pharmacy proposed increase on co-pay adds to the financial burden this will place upon us.

Sherry Spray Ruberg

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>
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>
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>

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>
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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-----Original Message-----

From: Bill [REDACTED] >

Sent: Friday, June 22, 2018 12:54 PM

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

Subject: Retiree insurance.

Since medicare covers 80 percent. How about eliminating any deductible. We pay it for medicare. That is if we can find a doctor that will take medicare. I've struck out here in Kenai. Can see a nurse only.

Sent from my iPad

From: Sherilyn Johns [REDACTED]
Sent: Saturday, June 23, 2018 3:49 AM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <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>; 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>
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 to 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 wife's case, she 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>

Cc: Sharon Hoffbeck <[REDACTED]>

Subject: Please oppose Medicare Part D forced-enrollment

Hello,

I am a State of Alaska retiree, 69 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
[REDACTED]

From: Lynda Giguere [REDACTED]
Sent: Monday, June 25, 2018 8:49 AM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <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

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

From: [REDACTED]

Sent: Monday, June 25, 2018 9:32 AM

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

Cc: [REDACTED]

Subject: DRB Proposed Retiree Medical Plan Changes

As usual the ones that can least afford to have their benefits reduced are the ones that are targeted for benefit reductions. What is happening to the medical benefits that we were promised? They are slowly being eroded. Yes, DRB would have us believe that the increases will offset those benefits that are being reduced. I worked in the budget and finance field over 35 years and believe me when I say that DRB can make the numbers reflect any outcome they require.

I find it interesting that DRB would provide a briefing on changes to the Retiree Health Benefit Plan identifying a few possible increases but being very general in detail on the reductions.

Has any outside study been done that will reflect what impact DRB's unidentified proposed changes will have on the various retiree groups? If so, what were the findings?

Are those retirees projected to be impacted by DRB's unidentified changes going to be given a chance to comment once they have been identified?

When changes are proposed/made in secret the outcome for those being affected are never good!

Stan and Debbie Palco

[REDACTED]

From: Priscilla Morse [REDACTED] >
Sent: Monday, June 25, 2018 1:08 PM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <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

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

From: Judith Andereggs [REDACTED]

Sent: Saturday, June 23, 2018 9:24 PM

To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <alaskarhpab@alaska.gov>; Sen. Berta Gardner <Sen.Berta.Gardner@akleg.gov>; Rep. Andy Josephson <Rep.Andy.Josephson@akleg.gov>

Cc: RPEA [REDACTED]

Subject: Concerns about proposed changes to retiree healthcare plan

I have major concerns about DOA/DRB's current efforts to change the retiree health care plan and their lack of communication with retirees.

I have learned through RPEA that DOA/DRB is proposing major changes to the retiree constitutionally mandated health care plan - specifically first a major pharmaceutical change and second, a thorough "modernization" of the plan. We are not receiving information directly from DOA/DRB. I have been told that DOA posts any information about changes on their website. They seem to think that is enough communication with retirees. It is NOT. I was a public participation officer for a program in the Governor's office. I would never have been able to just post information on the web site and have that considered adequate public notification. If a retiree does not spend time on the computer reading the State websites, how would one know that anything was going on?

The proposal for the pharmaceutical plan is to move it outside state coverage to a federal program. Automatically it will no longer be constitutionally covered. If the federal plan goes belly up or reduces coverage, we retired state employees have NO recourse - because if what DOA is proposed goes through, our pharmaceutical coverage will no longer be a state plan. And we will be out of luck. We deserve time to understand the changes and to comment.

The "modernization" effort is a huge proposal with lots of items that are difficult to understand. It is my understanding that DOA/DRB can reduce a portion of our coverage in one area if they increase it the same amount it is reduced somewhere else in the plan. For the average retiree, that makes proposed changes even more difficult to understand. Further, in addition to the fact that DOA/DRB does not appear to be making an effort to reach out to retirees it also appears to be on a shortened, fast track timeline.

As I have talked to my retired friends, I am amazed how few know that this is occurring. They all assume that their health coverage is a protected right.

What I would like from Governor Walker, Lt. Gov. Mallott, and my Legislative Delegation - Senator Gardner and Rep. Josephson

1. I would like DOA/DRB to be required to reach out to retirees and keep us posted on major efforts such as changes to our health care so that we can comment. That is our right.
2. I would like DOA/DRB to slow down their efforts to amend the plan and do one thing at a time. If pharmaceutical is the first topic, so be it. But do not try to cram through a modernization of entire plan at the same time. These two topics are extremely complex. The changes in pharmaceutical by itself will

affect modernization of plan as a whole. If the pharmaceutical changes are in flux, it makes commenting on modernization more complicated.

3. Changes are bound to occur. The retiree health care plan has been around for a long time. But DOA/DRB should be required to be transparent about changes and keep retirees apprised.

I hope you will take time to look at these issues yourself and not simply forward it to the Commissioner of Department of Administration. I sent it to you and Lt. Gov. Mallott because DOA is operating under your leadership. I want you to know what is happening to your retired constituency in regards to healthcare. I sent it to my legislators because I want them to be aware of what is going on with the retiree health care plan. I sent it to the retiree healthcare advisory board because they advise the department. I assume that when it goes to the retiree healthcare advisory board that DOA/DRB will keep a copy of it for their own information and perhaps they will look at my concerns as well.

Cc:

Senator Berta Gardner

Rep. Andy Josephson

Retired Health Care Advisory Board

RPEA

From: Barry Bracken [REDACTED]
Sent: Monday, June 25, 2018 12:40 PM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <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

Auto Reply's began with this e-mail Joseph Mehrkens 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]

[REDACTED] via Email

alaskarhpab@alaska.gov

Natasha Pineda, MPH
Deputy Health Official
Alaska Department of Administration
550 W 7th 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?

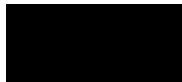
Likewise, the new Medicare Part D/EGWP plan requires step therapy. This means that I may have to try less expensive "alternative" drugs rather than take what is prescribed by my physician. If these "alternative" drugs do not work, or are less effective, my only recourse is to request the original drug 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



Cc Sharon Hoffbeck



Kathy Bracken



Helen Mehrkens



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

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

I have read the Change Proposals and numerous well-worded responses of others equally disturbed about the likely results if implemented. I plead for fair treatment and compliance with promises and benefits due us. I served the State of Alaska for 31+ years full time. Now, at ■■■ years old I am very disappointed and angry to be threatened by these proposed changes and reduced benefits!

Read again – Alaska Supreme Court decision RPEA v. Duncan

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.

And Article XII, Section 7 of the Alaska Constitution

This matter requires the concentrated attention and support of us all !

Respectively Submitted,

Bonnie M. Johnson
Retired Court of Appeals Judicial Secretary

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] 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 pharmacy coverage we have already earned. Please look for other options to provide the health care that we planned on in a manner that is efficient, and is respectful of the patient, and the providers.

Thank you for considering my concerns,

Jennifer Gleason Schmidt, RN

[REDACTED]

RECEIVED

JUN 11 2018

Div. of Ret. & Benefits

June 8, 2018

Bruce McKenna

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.

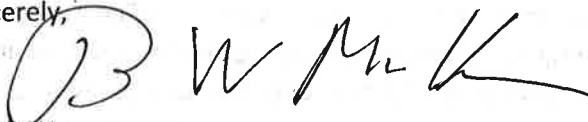
A proper plan would mimic part D Medicare coverage in all aspects not currently covered by the plan retirees are already paying for. To the credit of the State of Alaska, most needs are currently covered.

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 address block]

Cc: Ajay Desai,
Michele Michaud

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>; Michaud, Michele M (DOA) <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 [REDACTED]. 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 [REDACTED] in the Kenai/Soldotna area who is respected (and even used) by local physicians and surgeons. I went to him 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 [REDACTED], which lasted 4 months and cost Medicare and AlaskaCare thousands of dollars.


I wish to continue under [REDACTED] 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

June 26, 2018

Sharon Hunter



Correspondence sent via Email

alaskarhpab@alaska.gov

Natasha Pineda, MPH
Deputy Health Official
Alaska Department of Administration
550 W 7th 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 [REDACTED] limit was reached. The [REDACTED] called for a year of [REDACTED], 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

Dear Sir/Madam,

I was dismayed to read your recent proposals to change our retiree health care plan. It seems that Plan benefits dwindle each year and the benefits we actually receive are based on a complicated set of rules that we must continuously struggle through to get any benefits at all.

I could cite the problems each of your proposed changes would have on our lives as retirees, but I'm sure you're aware of the impact these proposed changes will cause. I will say this: when I accepted a position with the State of Alaska and worked for the Department of Commerce for many years, it was with the understanding that I would receive the full and complete health care benefits included in the 2003 benefit booklet when I retired.

I could have taken a higher-paying management job in the private sector, but I viewed my employment with State of Alaska as a package that included outstanding, lifetime health care benefits. In other words, I relied on the State's promise of future health care. Now it seems that this promise is eroding.

When people plan their retirement, they evaluate future living costs to determine whether they have sufficient funds over the years. My husband and I based our retirement decision in part, on future health care costs that would be offset by the retiree health care plan. We made our decisions with the understanding that our health care benefits would always be there for us. Now we find ourselves struggling to understand these "tradeoff" changes you are proposing. They do not seem fair and I believe they will complicate an already complicated process with AETNA, the health plan manager the State has elected to administer our benefit program.

I urge you to reconsider the impact your proposals will have on individual retirees. If you look at any one Explanation of Benefits the problems are clear. You will first see denials by AETNA for various reasons and then deductions from benefits for various reasons: exceeding reasonable and customary charges, ineligible items, etc. All of this on top of the annual deductible and copays which we accept as part of the plan. Do we really need to worry about losing more benefits?

As we age, we need to simplify our lives, not spend hours on the phone with AETNA struggling to understand why our benefits are not being applied as stated in our retiree plan. For those retirees with high medical costs, it seems that the problems will be even more extreme. Walk in our shoes as you consider these changes, or maybe you will when you become retirees yourselves. I urge you to honor the commitment made by State of Alaska during our employment years.

Sincerely,

Patricia Woodell

Sirs:

I write this with great concern on possible changes that will impact medical coverage for retired AK employees. I've only been retired 7 years after working 32 years for the state. In that 7 years I've watched health/drug plan changes closely because I have a very expensive preexisting condition that has no cure and can only get worse as I age.

Currently my drugs monthly cost is twice what I collect as my retirement pay. I am totally dependent on the co-pay from my health insurance to cover the costs of my drugs. Possible changes to the co-pay provisions or restrictions will impact my life severely, going as far as jeopardizing my long term health.

At the same time my visits to my doctor to monitor and help control my condition continue to increase, therefore increasing the cost of my health care. While I try to limit the number of visits per year the future is bleak. Each change to deductions, a cap on life time expenditures or a cap on yearly expenditures again jeopardize my health as I age.

Growing old is hard enough without having to balance health care costs over the cost of day to day living.

I hope you will use some compassion and logic as you look at changes to the AK Retirement Health Care. You are holding so many senior citizens lives in your hands you must weigh changes carefully.

Thank you.

Anna Walker



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 [REDACTED] 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)

From: Karen Donaldson [REDACTED] >
Sent: Wednesday, June 27, 2018 8:06 AM
To: Michaud, Michele M (DOA) <michele.michaud@alaska.gov>
Subject: Pharmacy

I need full coverage for Pharmacy for myself and my husband we are both retired and the medications I have to take are expensive.

Sent from my Windows Phone

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](#)

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] 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

I would like to share an experience we had in our family. My husband was suffering from a [REDACTED] [REDACTED] We attempted to find a doctor in Alaska to diagnose his problem. After months with no relief we need to go outside Alaska. We went to different specialist in [REDACTED] and then [REDACTED] Maryland and finally [REDACTED] to the [REDACTED] Institute before the diagnosis was reached. It was a long recovery for us all. We paid all the travel and housing expenses as we were rejected as they were not preferred provider. It wiped us out financially but thankfully we found relief with a diagnosis. One must consider the limitations we already endure being in Alaska with our limited resources without cutting back with proposed changes to our plan. Sincerely Sandra Csaszar-Swanson.

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 [REDACTED], 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

From: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored)
Sent: Tuesday, June 26, 2018 4:52 PM
To: 'Timothy Shine' <[REDACTED]>
Cc: Ricci, Emily K (DOA) (emily.ricci@alaska.gov) <emily.ricci@alaska.gov>; Michaud, Michele M (DOA) <michele.michaud@alaska.gov>
Subject: RE: Draft of plan

Mr. Shine,

Thank you for taking the time to speak with us today. As a follow up from our meeting I am sending you Emily and I's contact information. In addition, I have included a link to the Retiree Health Plan Advisory Board webpage. This page has information provided to the board, as well as recordings of prior meetings if you are interested. The next meeting of the board is scheduled for July 26th so watch for additional information to be posted in advance of that meeting.

Michele Michaud, michele.michaud@alaska.gov 907-465-3225.
Emily Ricci, emily.ricci@alaska.gov 907-465-8245.

<http://doa.alaska.gov/drb/alaskacare/retiree/advisory.html>

I hope you have a wonderful evening!

Michele

From: Timothy Shine <[REDACTED]>
Sent: Sunday, June 24, 2018 1:04 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Draft of plan

The draft of the retiree health plan is so confusing and time consuming that it was useless for me (a retiree over 65). I could find no guide or directory at the front end that would put me quickly in the areas of my concern. I could not help but wonder why money would be spent for a September 2018 update of the booklet, when DOA is proposing major revisions to the Retiree Plan for 2019? The proposed changes, especially to pharmacy benefits for retirees over 65, as I have heard them, are most disturbing to me. They seem to be casting older retirees to the wolves in the interest of cost savings. This diminishment of benefits is a betrayal that I predict will be resisted by each and every retiree, like myself, that settled for lower than market wages on the promise that the State of Alaska would provide top notch health care in retirement. I will be watching closely for explanations and justifications by the DOA that violate the spirit of the contract Alaska has with it's retirees, and will take part enthusiastically in any legal effort to retain undiminished health benefits.

Timothy Shine
[REDACTED]

Alaska has a huge unfunded benefit mandate. Instead of putting money in the budget every year to cover it they just ignore it. Maybe if the mandate was followed, the State would not resort to reneging on its contract with retired employees who chose to stay working for the state based upon the promise of retirement benefits instead of going into private sector where they could make more money.

Social Security already docks retirees who also earned Social Security retirement (as many older retirees did) and also docks their surviving spouse benefits — now the State of Alaska feels entitled to ignore the employment contracts made with their employees and turn its retirees over to a federal program that historically denies claims or requires burdensome verification of need for life-saving drugs?

The retiree health plan advisory board is a shameful example of Alaskan politics.

(Diane Dawley)

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 husband has a medication that is administered through the skin with a patch. The generic brand has an adhesive that does not stick (my husband tried it) 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

Alaska has a huge unfunded benefit mandate. Instead of putting money in the budget every year to cover it they just ignore it. Maybe if the mandate was followed, the State would not resort to reneging on its contract with retired employees who chose to stay working for the state based upon the promise of retirement benefits instead of going into private sector where they could make more money.

Social Security already docks retirees who also earned Social Security retirement (as many older retirees did) and also docks their surviving spouse benefits — now the State of Alaska feels entitled to ignore the employment contracts made with their employees and turn its retirees over to a federal program that historically denies claims or requires burdensome verification of need for life-saving drugs?

The retiree health plan advisory board is a shameful example of Alaskan politics.

Social Security is reportedly on shaky ground. It appears retiree benefits are destined for elimination as well. Please do a better job for Alaska retirees and honor the benefits promised them.

Bonnie Harms

Unfortunately, I've had some difficulty reviewing the actual proposed changes, but I've reviewed the summarized proposed changes and have these comments as to probable impact for me personally:

C. Increase deductible and out of pocket maximums: I am currently living on a minimal salary (approximately \$2,000/month). Raising the deductible and/or raising the pharmacy co-pay for drugs on the pharmacy benefit manager's formulary would represent a significant hardship for me. Currently I am having to take several different medications for [REDACTED] and the medications are expensive. It would become an issue of buying meds or buying groceries. Same issue with seeking medical treatment if co-pays were raised. I'm already having to choose not to seek medical care because I don't have sufficient funds to do so....and as has been evidenced numerous times, going to a primary care physician for care is much more cost effective than waiting till the condition is worse and then having to see a specialist.

D. Change Out of Network Benefits and implement 3-tier pharmacy benefit - I am unsure what these changes would entail, but somehow am pretty sure they would not be positive changes for me. I am currently traveling for approximately 2 years, living in an RV, and trying to keep our costs to a bare minimum. I have a [REDACTED] that requires frequent follow up, so have been doing so through a combination of telemed (provided gratis because the insurance won't pay for it) and Urgent Care visits. It would be impossible for me to adhere to "in network" providers. I don't know what the 3-tier pharmacy benefit would entail.

E. Limit pharmacy to 90 day refill - I hope that would not preclude the one time/year option of a 6 month RX through mail order pharmacy - that has been an invaluable service for me as I'm traveling.

H. Yearly Service Limits for chiropractic, physical therapy, and massage therapy or hire specialized vendor to manage- I was under the impression that these services already have yearly service limits - I would hope these are not being proposed to be reduced! I'm currently receiving chiropractic and massage therapy and now the services are being audited so I've had to greatly reduce my therapy in mid-process as I don't know the outcome of the audit. This is counter-productive to stop a service mid-course. I am already being negatively impacted by such a policy and can only surmise that any reduction in services would be even more of a hardship. Ironically, these services are much cheaper than traditional medical services and have been proven to be effective and to reduce the usage of more expensive services.

I. Implement in-network enhanced clinical review for hi-tech imaging services - I can only hope that the "enhanced clinical review" would be expedited and would not slow down or delay needed care.

Thank you for the opportunity to provide feedback on these proposed changes. Please let me know if there is anyone else I should forward this response to.

Margaret Susan Mason-Bouterse
[REDACTED]

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 7:32 AM
To: Kitchen, Vanessa R (DOA) <vanessa.kitchen@alaska.gov>; Ricci, Emily K (DOA) <emily.ricci@alaska.gov>
Subject: FW: RED UCTION IN RETIREMENT BENIFITS

FYI

From: Leonard Revet <[REDACTED]>
Sent: Wednesday, June 27, 2018 8:14 PM
To: michele.michaud@alaska.gov; Sharon Hoffbeck <[REDACTED]>; Ridle, Leslie D (DOA) <leslie.ridle@alaska.gov>
Subject: RED UCTION IN RETIREMENT BENIFITS

Hello Ms Michaud & Ms Ridle: As we Alaska retirees over [REDACTED] have been advised, we are faced with a proposal to reduce our medical benefits. We live in a World where the cost of living continues in a rapid pace, while our retirement income does not, at least not at anywhere near the same pace. What this means is that as we age we become poorer. The same is true of SSA of course but we have little or no way to have any input into that program.. As an Alaskan State resident for 57 years and 73 years, both State of Alaska retirees we believe that is unjust and wrong.

Sincerely, Leonard & Margaret Revet

From: Michaud, Michele M (DOA)
Sent: Thursday, June 28, 2018 7:31 AM
To: Kitchen, Vanessa R (DOA) <vanessa.kitchen@alaska.gov>
Cc: Ricci, Emily K (DOA) <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>; Ridle, Leslie D (DOA) <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>; Rep. Adam Wool <rep.adam.wool@akleg.gov>; Sen. Pete Kelly <Sen.Pete.Kelly@akleg.gov>; Bishop, Click (LEG) <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] 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

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

[REDACTED]

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

[REDACTED]

[REDACTED]

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

[REDACTED]

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?

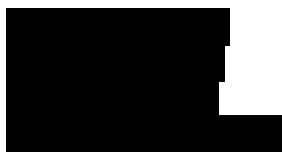
If owed, would it automatically be deducted from Social Security as is done with Medicare?

Additional overall concern:

How secure is Medicare when everyday you hear of the program being decimated by the Federal Government?

Sincerely,

Linda Deakins



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. July 3, 2018)

As a 67 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

Brian Rogers
[REDACTED]

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

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.

To Alaska RHPAB Members,

I am writing you this message to request that you not only maintain the current benefits for physical therapy and all rehabilitation services, but that you improve them and make them more liberal.

As one gets older there are so many problems with the muscular skeletal system that can be alleviated without surgery and more expensive methods.

For example, I was told by an orthopedic surgeon that I required [REDACTED] [REDACTED] Through many hours of manual therapy by a physical therapist that specializes in this type of therapy and an exercise program I am pain free in both [REDACTED]

I can give you so many examples of how beneficial rehabilitation services are. They should be maintained at the least and advanced at the best.

I also know that it would be beneficial to reimburse us at 100% on all rehabilitation services that Medicare does not cover. In the long run you would save money from surgeries and other health issues that would arise from a lack of therapy.

Thank you for the opportunity to express my views.

If you have any questions please feel free to contact me.

Lorraine Inez Lil

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

or email me

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 paypeanuts) (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 [REDACTED] 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?))



EGWP Duncan
demand.pdf

To: Judy Salo, Board Chair
Re: Attached letter to Com. Ridle

The letter attached to this email was delivered to Commissioner Ridle through AG Kate Demarest.
Please us know if you or other Board members have any questions.

Brad Owens
Exec. VP RPEA

(7-9-18)

July 9, 2018

Commissioner Leslie Ridle
Department of Administration
550 W. 7th 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.

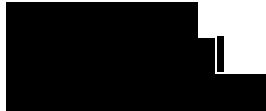
I retired in 2015 from teaching. I also turned 65 and went on medicare that year. Just retiring and going on medicare I have seen my medical benefits change for the worst. My doctor of 20 years does not accept medicare (I don't blame her when I see what they pay) and therefore have had to pay out of 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 compounded drugs since 1998. From what I have read about Part D in Medicare, they would not cover the compounded 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

A black rectangular redaction box covering the signature area.

Well here is a good example of Big Brother (DOA) thinking they know what's best. Forget how it will negatively impact anyone as long as it satisfies their needs.

We have to this date not received anything from the DOA that advises us of a pending change to our benefits, how these pending changes will impact us, when they will take effect, why they are being proposed, etc...

How we found out that DOA was proposing changes to our RX program was by email from RPEA. I know DOA will have an answer that they did all that was required by publishing info about these pending changes on their web site, but how many retirees review their web site on a regular basis? I'm sure it's a very low number, so there you have it, this is why they use this method of notification.

We have responded to DOA, in writing, on our concerns to these proposed changes and to this date have not received any response as to our concerns.

In the end Big Brother (DOA) will do what they want regardless of its impact on the retiree. They say there is a \$20 million savings and that there will be no impact on the retiree. We would like to know how one could take \$20 million away from somewhere and it not having an impact!!!!
As we have said before you can make the numbers say whatever you want them to say.

I would hope that DOA does the right thing and completes the appropriate analysis as required. If not I fully support that which is necessary to see that this review is accomplished.

Stan and Debbie Palco



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)

, 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

Alaska Retiree Health Plan Advisory Board,

At the suggestion of the Deputy Director Michele Michaud, I am writing you to offer my opinion of the retiree's medical benefits.

I'm writing this letter in order to ask for my medical benefits to not be decreased. I spent 21 years in Law Enforcement in Southeast Alaska doing my best to keep the community I was living in safe. I joined the force in 1979 and during my years on duty I was injured multiple times. The worst was in 1981 when I was [REDACTED] while I was on duty. I was told I would have [REDACTED] after that accident. It took me several years but I not only [REDACTED] but was able to get back to full active duty.

When I retired in 2000 I appreciated the fact that I had health insurance through my retirement. Now I can't imagine being without it – or even with reduced benefits. I have [REDACTED] in multiple joints, in addition I have [REDACTED] which causes me great pain. Because of the insurance I'm on a medication that is very expensive – but I'm able to continue to live a productive life and be a contributing member of society.

I would hope the State of Alaska would keep their promise and not reduce my medical benefits.

Scott Eddy

Retired Public [REDACTED]
[REDACTED]
[REDACTED]

[REDACTED] RPEA

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 [REDACTED] 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 [REDACTED]. 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 [REDACTED] 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 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], AK, 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], Ak

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 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] and have vision problems.

Thank you

Evelyn Korhonen

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

My husband and I both are state retirees receiving our own individual medical and dental insurance from the state. Once we are on this new pharmacy plan, will we still be double covered? Thus far, we've not usually had any copay whatsoever because we each are covered on one another's plans. Will this remain the same?

Thank you,
Cheri Murphy
Kevin Murphy

PS...is there a way to find out now if an ongoing drug that I take (and will continue to take) be covered without preauthorization on the new plan? Currently that drug is prescribed every 30 days. Will that prescription need to be switched to every 90 days under new plan? (no matter the drug?)

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 65th 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



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

To Whom it may concern,

I'm a PERS retiree living in [REDACTED], Thailand and my suggestion is to set up a direct account processing method with the major hospital and/or approved provider. Right now, the choices are to pay out of pocket here and apply for reimbursement with Alaska Care, or to send all the paperwork and wait for approval. The health care is excellent here at several main hospitals and much less expensive for everything, including medications. So far, I haven't actually used my Alaska Care coverage here in Thailand but I have asked about the payment methods from Alaska Care.

Thank you,
Raymond W. Cannon

I recently had a knee operation. I ended having to pay for two prescriptions for [REDACTED] and [REDACTED]. Done with both of them now as 11 weeks out but not sure why Aetna refused to pay for them even though doctor ordered. Know there is a lot of opioid rules now but how did Aetna end up being the gatekeeper. I took much less then prescribed so the small window they allowed was closed. I am a tier one retiree and anyone who has had a knee operation knows you don't want to sit there in pain while hassling with a insurance company on a benefit you have. I live in Oregon and again just paid for two of the prescriptions rather then argue with Aetna. Thank you Ed Beck

Sent from my iPad

Do not remove or diminish a single benefit we get for prescriptions. If it's not broken, don't mess with it.

Paula Cadiente

I read your message with interest and have some comments.

I'm sure I am not the only Alaska retiree living in Northern Nevada. A continuing problem I run into at some doctor's offices, clinics, and hospital system is that they do not like, and try to refuse medical services to me or my wife when they see the Aetna Card. Medical facilities in this part of the country do not like Aetna. We repeat to them that AlaskaCare is the State of Alaska's medical program for State retirees, they don't care. They see Aetna and have refused to go any farther. At one time, after complaining to your department, I obtained a contact name for the Renown Hospital system here in Reno and your department sent a letter to that person in finance explaining what I just printed. Aetna is a problem.

We had no such problems with any previous contract administrators of AlaskaCare. My wife is a school teacher and until she retires is under a different primary medical insurance plan. That has not been a difficulty.

I was an Alaska State employee from January 1975 until I retired August 1997 and I believe I was in what was called a Tier One classification. I saw no reference to that in your newsletter.

I don't wish to be a pain in rear but that Aetna problem was encountered head on when I moved to [REDACTED] in 1997 and persists to this day.

Cordially,

Everett A. Long

Author: "Cobras Over the Tundra"

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,
Sharon Resnick



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

Due to the vendor itemizing the charge for [REDACTED], instead of just listing the total cost; Aetna refused to pay for both the (A)(plastic, variable asperity lens, single vision),

and the (B)(.12 TO 2.00D cylinder, per lens spherocylinder, single vision, plano to plus or minus 4.00D sphere)

We appealed. They then agreed to pay for (B) Above only.

We were advised by the vendor and Aetna agents on the telephone; that if the vendor had just submitted the total charge without itemizing; Aetna would have paid the full 80%!

Thank You!

John McKimmey

I think the coverage is fine that way it is. The plan is diminished from what we had as a employees, but it's still adequate and good coverage. We CANNOT have any decrease in coverage, or it would be financially detrimental to many of us, as we age.

PLEASE stay the course, and follow the rule of law, that says insurance coverage must be maintained at this level, at a minimum.

PLEASE don't try or allow "trade off's" wherein, some aspect is enhanced and another is decreased. DON'T change the fine print without board approval or approval by all the members.

ALSO in the light of discussions that come from our Federal Government lately, DO NOT allow any decrease in pre-existing coverage for employees who have been enrolled prior to retiring.

Thank you in advance,
Debra Buzdor
Retired Mat-Su Teacher
[REDACTED], Ak

I would like retiree benefits to include monthly fees for gym memberships such as the YMCA and Lifetime Fitness.

(Barbara Knoll – I included VRK)

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

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

[REDACTED]

[REDACTED]



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

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



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)

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: [dcmattiol](#) [REDACTED])

I am certain you are familiar with the statistics... our senior citizens struggle with mental health issues. Please make certain that these benefits are strong and easy to secure. Also make certain services are delivered by highly competent and trained individuals. I do not believe a 6 week benefit is long enough

cheryl lee

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 wholeheartedly 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.

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.

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Sent from my iPad
Judy, Cammy, Mark, Joelle, Gayle, Dallas, and Mauri:

Thank you for serving on the advisory board. It is a proactive way of addressing serious topics in the ever-changing health care system.

I recognize that it takes time and commitment to represent retirees. It is comforting to know that we are represented by such an impressive group.

Thanks!

--

Gary Whiteley



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,

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

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)

Hello,

Thank you for soliciting suggestions from users on how to improve the Alaska Care Health Plan. I have been enrolled in the Alaska Care system for ten years now. Every time DRB changes to a new health care administrator it seems that the reporting of claims and benefits by the new administrator becomes more convoluted and difficult to track and understand than it was before. Aetna's reporting is especially hard to follow. They do not report key information, such as how claims were coded by a physician, so that the retiree cannot make sense from the paperwork why some claims are rejected and others are not. My wife and I are both beneficiaries covered under Alaska Care. Providers always submit a claim under both of our policies on the same day, every time we see a provider. Yet these claims are processed separately and are reported back to us at wildly different times and are buried within other claims in paperwork that we receive. It is nearly impossible to keep track of what has been addressed under each of our policies and what has not. If Aetna cannot do a better job of communicating to beneficiaries please make this a priority in your choice of a future plan administrator. Older people need things to be straightforward and easy to understand. You are going to be older one day and then you will really appreciate what I am saying- particularly if you become a beneficiary of Alaska Care. Thank you for soliciting and registering my comments.

Theo Lexmond



It's a scam!!! I need several formulary drugs without genetics 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 approved drugs that Medicare pays for. They no longer work. What am I to 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)

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

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

We are just absolutely appalled to learn the fact that Optum RX was awarded the contract for our pharmacy benefits. This company has the worst rating and reviews of just about any pharmacy manager out there.

Did the Department even look at the reviews of this company from other people that have been forced to use them. We never even imagined that the state would go with a company with such bad reviews from the people they serve. It does not matter how much money you plan on saving with them, the way they save money is by losing prescriptions, and using inferior people to be the front end helpers for there customer service.

It is endless the horrors they put people through when getting prescriptions, prior authorizations ect...

We can only hope that when the time comes that the people who put this company in charge of our pharmacy benefits get a first hand dose of how awful they truly take care of there clients.

DCL

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

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



I hope you can route this as appropriate, at the bottom of the newsletter I did not see an email contact listed.

- 1) **You will continue to receive a printed newsletter in the mail. If you prefer not to receive the email update, you can unsubscribe at any time**
 - a. I would like to unsubscribe from printed newsletter and keep email newsletter. Reason: Printed newsletters cost me additional money to have delivered outside the United States (up to \$15.00 in fees), and the delivery time delay can be up to 6 weeks.
- 2) Could a process for re-imbursement for expenses (medical, dental, or vision) be introduced where the re-imbursement could be direct deposited? Reason: Living outside the U.S. a printed check can take as long as 6 weeks to arrive. Once it arrives it either has to be endorsed and sent back to the U.S. for deposit, or deposited into a Foreign Country bank account, where it becomes effected by FBAR reporting. And of course 3 weeks before funds become available when deposited in my local bank.
- 3) Living in a foreign country is a choice. With that choice comes certain trade-offs and I have to be responsible for my choices. The realities of life for me is that I am a minority U.S. citizen in Panama. Panama has a cash economy similar to the 1950's in the U.S.. The postal system does not have home delivery, in fact home addresses are not formalized, but conversational (very much like before E911 was implemented in the U.S.). Each item physically sent to Panama has to go through a customs process, (inspected for controlled substances, categorized for import tariff). Cell telephones out number landlines 4:1 and the cell telephone number has an extra digit so it cannot be entered in many computer forms (as an example my cell number is (507) 6904-0814. Hospitals and Doctors are far less expensive and require payment (large expensive items may be negotiated as bill the insurance company). When I am in the Hospital and I need an [REDACTED], I have to pay the cashier before the procedure. Each **DAY** I must pay for my hospital room (yes, this means a trip to the cashier with my credit card each day). My last room charge was \$55/night which is a substantial savings to my health insurance, however I carry the charges until I can file a claim and be reimbursed. A doctor visit in the Hospital \$0.50, in a private office \$8.00, but a visit to my [REDACTED] doctor \$60, all cash outlays, A visit to the private dentist to [REDACTED] was \$60. I pay then file for re-imbursement. (MY RESPONSIBILITY) I have yet to try to get reimbursed for my Pharmacy expenses, as most purchase (other than narcotics) do not require a prescription, so things like reoccurring mediation (blood pressure, thyroid etc.) do not have prescriptions. I order and pay for my own Lab work and submit the reports to the doctor.

I say all of this only because, I wish this to be considered (you could not know, unless you lived outside the U.S.), I am a retiree, I could travel to the U.S. and spend a significantly larger amount using U.S. doctors and facilities, but by living here in Panama it is a cost benefit to the insurance costs if I can use the less expensive services available here in Panama.

NEW MAILING ADDRESS

[REDACTED]

[REDACTED]

Skype:

e-mail:

[REDACTED]

While I am in favor of most of the changes you are working on, I would like to share a couple concerns I have.

1) I'm not happy with the possibility of raising our deductible by doubling it. That is a big hit to take each year. It means I will probably not meet the deductible each year as I only visit the doctor once. Being healthy shouldn't penalize me by making my deductible higher.

2) I have been very unhappy with the choice of dental administer that was picked the last go round. I thought by now it would be time for you to go out for bid again for a new vendor. Moda Dental has been the worst administrator you've had. Their U&C is way lower than what we've had in the past. I end up paying way more every trip. You would think just a check up and cleaning would all be covered as they are both preventative services. Since my dentist is not in their network, I no longer get those items free. Since we pay for our own dental/vision coverage, it would be nice to have a plan that covered more of the preventative services.

Thank you,
Jenn Burchfield

I hope you can route this as appropriate, at the bottom of the newsletter I did not see an email contact listed.

Additional consideration

Medicare and Medicaid do not cover outside the U.S., therefor our retirement system is the primary for retirees that live outside the U.S.. By making it easy to take advantage of lower cost services, it saves for the State of Alaska.

NEW MAILING ADDRESS

Colin 'Soup' Campbell

[REDACTED]

United States

Skype:

e-mail:

[REDACTED]

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

Please forward me a copy of the cost study showing cost equivalency/betterment of the retiree health plan resultant from the changes being proposed currently. This e-mail is fine, or a hardcopy can be mailed to me at [REDACTED].

Thank you.....Dan Motley

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 my husband 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 my [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 wish you luck with your task to improve the health care plan. Please indulge me and allow me to tell you my story.

I worked for over 20 years for the state at Fairbanks International Airport Field Maintenance Foreman. A job I loved. On the down side I missed many holidays and family events because of snow events I can't get back. I worked hard and sacrificed for my retirement. I retired in 2006. When I retired I asked Retirement and Benefits if I retired to a foreign country where my retirement would go further if I would be covered. I was told yes. I would have to prepay and put in a claim for reimbursement. I retired to The country of Panama. All was good and had very little problems getting reimbursement until Aetna too over. I now have medical and prescription claims not paid back to 2014. They find any reason to not pay. Including claiming they have lost years of claims. Or just ignore with no communication. Resubmission dose no good. I have contacted the State for help but I just get referred back to Aetna who stonewalls, stalls and dose not help.

So in my opinion getting rid of Aetna would be the first step in improving the plan. Second seeing all those who have served the state for years are looked after.

Thank you for allowing me to tell you my story and voice my thoughts.

Regards

John Linse

July 18, 2018

Division of Retirement and Benefits
And
Retiree Health Plan Advisory Board
PO Box 110203, Juneau, AK
99811-0203.
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)

You asked for comments so here is mine!

A couple years back we had a toothpaste on the drug formulary that was entitled [REDACTED]. Somehow it was removed from our drug formulary. Now we can only get the [REDACTED]. They both have 1.15% Sodium Fluoride, but **only** the enamel protect has **5% potassium nitrate**. Potassium nitrate helps with sensitive teeth...more common in adults as they age.

In essence, our benefits were cut!

I did appeal this, but my appeal was denied. Imagine that.

So, it seems sensible and fair to restore that benefit by allowing a prescription toothpaste with both the fluoride and potassium nitrate. It certainly is preventive care to encourage and support good dental health/hygiene. To the best of my knowledge the cost is the same for both toothpastes; thus it seems like an easy fix to me.

Thank you.

Sincerely, Cathy McCorquodale

Please fix these coverages.

It's wrong to say they will pay 80% then when you get the service, submit bill it comes back way lower, never even close to 80%!! The 80% is of their customary fee. This sucks They say they will purchase a pair of glasses or get contacts each year, it will pay for glasses but will not purchase enough contacts for a year. This makes no sense!!

Sent from my iPhone

(Michele Juba - 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 (Membership ). 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



Dear Working Group;

One thing that really needs to be revised is to have an open enrollment for the retirees dental and vision parts of our health plan. I got married when I was in Japan and had no idea that I needed to go through the steps to get my spouse on those two portions of my retiree insurance within a certain number of days. It was not even a concern until we obtained a green card for my Japanese spouse and came back to Alaska. Then, it became a necessity, but it was impossible because I did not request to have my spouse in the program within 90 days of our marriage.

The vision and dental portions of our health plan are portions that we pay a considerable amount every month to be enrolled in, so there is no good reason for NOT allowing a spouse to be enrolled in those parts of our retiree health plan. At this time there is no open enrollment option for those parts of the insurance program - my spouse seems to be locked out of them forever! In our opinions this is ridiculous and needs to be addressed in future changes to the plans.

Thank you very much for reading our concerns.

Sincerely,
Daniel H. Wiczorek

[me](#)
[Our Publications](#)
[Our Homepage](#)

[Site Map of Our Website](#)

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]

- [REDACTED] 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 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



Hello, my name is Jim Kenshalo, I am retired and I live in [REDACTED], Alaska.

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]

Hi there,

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- Adding coverage for preventive services (including vaccines) – Shingles shots would be great
- Increasing or removing the \$2 million lifetime maximum
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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, 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 on two drugs that are more expensive....and have already tried the less expensive drugs which had bad side effects. 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] medication. We both started on the least expensive drug. (I do not remember the name of the drug now) We both developed a chronic dry cough. We are now on [REDACTED] with no more problems at all.

I was on [REDACTED] for several years and had chronic diarrhea the entire time I took it.

I also tried at least 2 separate pills at mealtime as well as [REDACTED] control. All of these gave problems with [REDACTED] which can be very dangerous. As one becomes older they can become less sensitive to lows, therefor less quick to take corrective action. 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]

Concern: Limits on Therapy Benefits.

To address possible confusion on short-term rehabilitation therapy the first option to establish a 20 visit per year limit and is too restrictive. Example: [REDACTED] had a total shoulder replacement this spring. Both the doctor and the physical therapist have commented that [REDACTED] heals more quickly than most people. Because he is conscientiously performing the exercises at home, the therapist has allowed him to come in only once a week rather than twice a week for most patients, yet he will just barely come within the proposed 20 visit limit. Additionally, what would be his options if he should have an injury later in the year?

The second possible solution is a 45 visit limit for all therapy services. Is that a lifetime limit? No time frame is mentioned. That would be unreasonable.

While a vendor specializing in medical management could be a reasonable option, an appeal process would be needed.

Concern: Dependent Coverage Limits

Changing the State retirement statute definition of dependent child to the PPACA definition, especially if it omits that the “child” must be a full-time student, unmarried and dependent on the retiree is excessive and detrimental to the retiree plan solvency.

Booklet Revision

Obviously badly needed especially to coordinate amendments. Hopefully retirees will be notified, and not just on-line, of any future amendments or policy changes so they will not be caught unaware as we were on [REDACTED] prescription denial.

(Jack & Elaine Vander Sande)

I may not be 65 yet, but what I've read and heard of this new program it sucks. Who in the hell wants to appeal a denial in 5 steps get real. The procedure probably will not be user friendly. You can look at it as a discrimination against people over 65 and or the company is selling us out by saving money lots of money!!!!

I would appreciate it very much if we can keep our same benefits as they are now.

Thank You,

Debbie Redmond

Michele and Judy,
On 7/17/18 and 7/19/18 [REDACTED] contacted the Aetna Internet Response Team about a reported recall of the FDA drug with the active ingredient Valsartan, a drug that she takes and purchases through the Aetna Rx Home Delivery Pharmacy. This recall is due to an impurity, N-nitrosodimethylamine (NDMA), which was found in the recalled products. NDMA is classified as a probable human carcinogen which is a substance that could cause cancer.

She was told by the Aetna Internet Response Team that they were aware of the recall—please see attachment #1.

However, Aetna explained that not all products containing Valsartan are being recalled and went on to instruct [REDACTED] to go to the FDA website to see if the drug that she purchased from Aetna's Rx Home Delivery pharmacy was involved in the recall. She followed Aetna's directions and learned that the drug she is taking is on the recall list.

Aetna further instructed her that until she had a replacement product, she should not discontinue taking this medication. In other words, even if her medication is contaminated, she should continue to take it even though it is potentially harmful.

Aetna goes on to state that they are not accepting returns of the recalled product and will not be mailing out any replacement of a contaminated drug that they sold. All Aetna is willing to do is request a refund for the copayment. Please see attachment #2.

It is DRB's responsibility, as the Plan administrator, to make sure the drugs provided by Aetna under the Plan are healthy and do not include any known contaminants that are known to be potentially dangerous. It is also both DRB's and Aetna's responsibility, as soon as they became aware of this recall, to identify plan members who were sold the contaminated drugs and immediately notify them, replacing the recalled drug with one that is safe to consume.

Aetna acknowledges that not all batches of this medication are contaminated. The responsible solution is for the Aetna Rx Home Delivery Program to immediately send a new 90 day prescription of a safe and healthy alternative for Susan and all other similarly impacted retirees, **at no additional cost to [REDACTED], any other affected retiree or the trust.**

The harm experienced by [REDACTED] and other AlaskaCare retirees who have taken the contaminated drug can never truly be remedied. However, that harm can and should be minimized by ensuring that all the affected members are promptly notified of the dangers, are provided with uncontaminated medication as quickly as possible and are told how to properly dispose of the contaminated medication.

The cost of doing that—costs in terms of time, effort and money—should not be shifted to retirees and the other Plan members who trusted Aetna to provide them with high-quality prescription medication. Aetna violated that trust. Basic fairness dictates that Aetna should accept responsibility and do all it can, as quickly as possible, to minimize the resulting harm, and at its own expense. Then, if Aetna chooses to do so, it can look to the persons responsible for manufacturing and selling the contaminated medication for reimbursement.

Please review the attached, and notify RPEA as soon as possible how DRB plans to handle this unacceptable situation facing all retirees who have purchased this medication through the Aetna Rx Home Delivery Pharmacy. It is also critical that DRB provide all essential information to all affected retirees who are in the same predicament as [REDACTED] as soon as possible.

Respectfully,

Sharon Hoffbeck

President

Retired Public Employees of Alaska

[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

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

July 24, 2018

Susan Hubbard
[REDACTED]

Attn: URGENT! Reported prescription drug contamination – Request for immediate help and notice to other affected Alaska retirees

Dear Michele Michaud, DRB CHO & Aetna,

I am a retired public employee of Alaska who is covered by the AlaskaCare Retiree Health Plan. I suffer from [REDACTED]. My condition is treated by a prescription drug called Valsartan. It was prescribed by my physician and I have been taking it take it once a day, as prescribed since 2015. On July 13, 2018 I learned that the FDA has ordered a recall of certain batches or lots of Valsartan that have been contaminated with a known human carcinogen. Even though I have been getting my Valtarsan prescription by mail from the Aetna Rx Home Delivery Pharmacy, I did not learn of the recall from Aetna or from DRB. Instead, learned about the recall from Newsweek magazine. Thank you Newsweek.

I immediately contacted my doctor and Aetna. The doctor explained that though he writes the prescription for the brand and the dosage, he couldn't really comment on the recall because he didn't know the manufacture or the lot # I'd been sent. He instructed me to make contact with the Aetna Rx Home Delivery Pharmacy, the dispensing pharmacy, because they would know which specific medications were recalled and would have a plan as to what the next steps would be.

I emailed Aetna immediately and the gist of their July 17, 2018 response was (See attachment #1), "Please accept our apology for any inconvenience you have been caused. The FDA has issued a voluntary recall of several drugs containing the active ingredient Valsartan. This recall is due to an impurity, N-nitrosodimethylamine (NDMA), which was found in the recalled products. However, not all products containing Valsartan are being recalled. NDMA is classified as a probable human carcinogen (a substance that could cause cancer) based on results from laboratory tests. To determine whether a specific product has been recalled, please look at the drug name and company name on the label of your prescription bottle. If you are taking one of the recalled medicines listed, please follow the recall instructions provided by the specific company. This information will be posted to the FDA's website, www.fda.gov

I found this a response shockingly inadequate for a number of reasons.

First, Aetna as my pharmacist has all the key information about what prescription medication they sent me, including the name of the manufacturer and the lot and the batch numbers. When the FDA recall occurred, Aetna should have checked its records and notified me and other people who were or might have been affected of the recall and us given clear instructions about what to do, including how to dispose of the contaminated drug. It did not do so.

Second, Aetna should also have immediately sent replacement medication by express mail to all affected people. Aetna did not do that, either. Instead, it simply told me to figure it out for myself.

Third, Aetna's "figure-it-out-for-yourself" response puts an especially unfair and unreasonable burden on older retirees like my mother who, because of advanced age or lack of tech skills, would not be able to accomplish this on their own.

Fortunately for me, I'm a relatively young retiree who has internet and who is fairly tech savvy. I also know that I need to be proactive when it comes to my health. I was able to look up the information on the internet.

It turns out my prescription, which I've been taking on a daily basis for over 3 years, and possibly giving myself cancer with in the process, **is in fact on the recall list.**



As soon as I discovered that, I promptly wrote Aetna back so they would know and take appropriate action.

Aetna responded to me on July 19, 2018 with (see attachment #2), "Aetna is not accepting returns of recalled products and will not be mailing out replacement Valsartan for prescriptions that have already been dispensed. You do not need to return your medication to us, just destroy it. However, we can request a refund for your copayment. Because Valsartan is used in medicines to treat serious medical conditions, the FDA recommends that members should not stop their medicine until they receive replacement product or a different medicine to treat their condition."

This was another shockingly inadequate response. Not mailing a replacement of a prescription medication that Aetna acknowledges is used to cause "serious medical conditions?" Telling me to "destroy" the medication without stating how? Telling me that Aetna "can request a refund" of my co-pay instead of, "We will see to it that your co-pay is promptly refunded or applied to the replacement medication we will be sending you?"

Ms. Michaud, please tell me if you think these responses from Aetna were appropriate and consistent with what you and DRB expect from Aetna. If not, please tell me what you will do to make sure this will not happen again. Human lives are potentially at stake.

I live in a very remote Alaska location 250 miles from the nearest road & doctor. Although I have internet, I don't have a phone and it is 55 river miles to the post office.

Here I am, forced now to take a daily medication that my doctor tells me that I need to take and that Aetna told me in their July 19 letter that, according to the FDA, I should not stop taking, but is a medication Aetna and I know is contaminated with a known carcinogen.

I hope you understand why I'm very worried and concerned for myself and other people who are covered by and rely on AlaskaCare for their medical treatments.

Ms. Michaud, I am writing to you because it is *YOUR* responsibility, as the administrator of the AlaskaCare Plan, to make sure the drugs provided under the Plan through Aetna are healthy and not contaminated, much less carcinogenic.

When something like this occurs, it is fair and reasonable to expect you to direct Aetna to immediately notify all the people covered by AlaskaCare who may have taken, and may still be taking the contaminated drug, of the recall and to make sure they get uncontaminated medication as soon as possible.

The proper and responsible solution is to direct Aetna to provide a new 90-day prescription of a safe and healthy replacement. As the FDA said, it is not all Valsartan that has been recalled. Taking it is still an option for me. I just need that medication from an uncontaminated batch or lot or, better yet, a different manufacturer. It is that simple.

Please, both Ms. Michaud for DRB and Aetna for itself, respond in writing by Wednesday, August 3, 2018 -- both in an email and a letter, sending the letter to me by certified mail.

Every day that passes is another day of increasing worry and concern on my part.

Attachment #1

From: Member Services

Dear Susan Hubbard:

Thank you for using the Contact Us form to reach Aetna Medicare Member Services. Please continue to use this form to ask questions. Our Message Center provides better security than standard e-mail to help protect your confidential information.

Please accept our apology for any inconvenience you have been caused. The FDA has issued a voluntary recall of several drugs containing the active ingredient Valsartan. This recall is due to an impurity, N-nitrosodimethylamine (NDMA), which was found in the recalled products. However, not all products containing Valsartan are being recalled. NDMA is classified as a probable human carcinogen (a substance that could cause cancer) based on results from laboratory tests. To determine whether a specific product has been recalled, please look at the drug name and company name on the label of your prescription bottle. If you are taking one of the recalled medicines listed, please follow the recall instructions provided by the specific company. This information will be posted to the FDA's website, www.fda.gov.

Because Valsartan is used in medicines to treat serious medical conditions, you should continue taking your medicine until you have a replacement product. If you are taking one of the recalled medicines, you should also contact your health care professional to discuss your treatment, which may include another Valsartan product not affected by this recall or an alternative treatment option.

Aetna Rx Home Delivery® pharmacy has pharmacists available to assist with your questions. Due to the clinical nature of your inquiry, please contact us at the number on your member ID card so that we may better assist you.

We're available:

Monday through Friday, 7:00 a.m. – 9:00 p.m. ET

Saturday, 8:00 a.m. – 4:30 p.m. ET

Sunday, Closed

We apologize for any inconvenience this may cause.

Always check with your health care provider before stopping or starting any drug. They know your health history and are responsible for your health care. And can best advise you whether the drug should be used or continued.

If you have additional questions, send us a 'Contact Us' message or call the toll-free number on your member ID card.

Health benefits are offered, underwritten or administered by Aetna Health Inc., Aetna Health of California, Aetna Health of Illinois, and/or Aetna Life Insurance Company.

Sincerely,
Shaunay C.
Internet Response Team
Aetna
37916721

NOTICE TO RECIPIENT(S) OF INFORMATION:

To view Aetna's privacy practices, please edit, copy and paste this website into your browser:
<https://www.aetna.com/legal-notices/privacy.html>

Aetna Rx HD - Other - Commercial

Original Message Excluded:

07/17/2018

Attachment #2

From: Member Services

Dear Susan Hubbard:

Thank you for contacting Aetna. We look forward to helping you get the most out of your benefits.

We apologize for any inconvenience or delay. We know that your medication is vital.

Aetna is not accepting returns of recalled products and will not be mailing out replacement Valsartan for prescriptions that have already been dispensed. You do not need to return your medication to us, just destroy it. However, we can request a refund for your copayment.

Because Valsartan is used in medicines to treat serious medical conditions, the FDA recommends that members should not stop their medicine until they receive replacement product or a different medicine to treat their condition.

Aetna is working to get additional supplies of medicines that are not affected by this recall to meet the needs of our members going forward.

Because Valsartan is used in medicines to treat serious medical conditions, you should continue taking your medicine until you have a replacement product. If you are taking one of the recalled medicines, you should also contact your health care professional to discuss your treatment, which may include another Valsartan product not affected by this recall or an alternative treatment option.

Aetna has Clinical Care Technicians available to assist with your medication questions. If you have any other questions, please contact Member Services at 1-888-792-3862 and ask to speak with a pharmacist

regarding your medication.

Our technicians are available:

Monday through Friday, 7:00 a.m. – 9:00 p.m. ET

Saturday, 8:00 a.m. – 4:30 p.m. ET

Sunday, Closed

Always check with your health care provider before stopping or starting any drug. They know your health history and are responsible for your health care. And can best advise you whether the drug should be used or continued.

If you have more questions, contact Member Services. Log on to www.aetna.com or www.aetn navigator.com. Select the "Contact Us" feature. You may also call the toll-free number on your member ID card, (TTY: 711) if applicable.

Sincerely,
Angelique R.
Internet Response Team

37926119

NOTICE TO RECIPIENT(S) OF INFORMATION:

To view Aetna's privacy practices, please edit, copy and paste this website into your browser:
<https://www.aetna.com/legal-notices/privacy.html>

APM - General – Commercial

07-19-18

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

From: Gail Tilton <[REDACTED]>
Sent: Thursday, July 19, 2018 12:04 PM
To: Benefits (DOA sponsored) <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

----- 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, 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]

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 65 (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

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

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's 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
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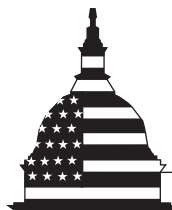
United States Government Accountability Office

Report to the Secretary of Health and
Human Services and the Secretary of
Labor

March 2011

PRIVATE HEALTH INSURANCE

Data on Application and Coverage Denials



G A O

Accountability * Integrity * Reliability

Highlights of [GAO-11-268](#), a report to the Secretary of Health and Human Services and the Secretary of Labor

Why GAO Did This Study

The large percentage of Americans that rely on private health insurance for health care coverage could expand with enactment of the Patient Protection and Affordable Care Act (PPACA) of 2010. Until PPACA is fully implemented, some consumers seeking coverage can have their applications for enrollment denied, and those enrolled may face denials of coverage for specific medical services. PPACA required GAO to study the rates of such application and coverage denials. GAO reviewed the data available on denials of (1) applications for enrollment and (2) coverage for medical services.

GAO reviewed newly available nationwide data collected by the Department of Health and Human Services (HHS) from 459 insurers operating in the individual market on application denials from January through March 2010. GAO also reviewed a year or more of the available data from six states on the rates of application and coverage denials and the rates and outcomes of appeals related to coverage denials. The six states included all states identified by experts and in the literature as collecting data on the rates of application or coverage denials and together represented over 20 percent of private health insurance enrollment nationally. GAO conducted a literature review to identify studies related to application and coverage denials and reviewed data from selected studies. GAO interviewed HHS and state officials and researchers about factors to consider when interpreting the data.

View [GAO-11-268](#) or key components. For more information, contact John E. Dicken at (202) 512-7114 or dickenj@gao.gov.

March 2011

PRIVATE HEALTH INSURANCE

Data on Application and Coverage Denials

What GAO Found

The available data indicated variation in application denial rates, and there are several issues to consider in interpreting those rates. Nationwide data collected by HHS from insurers showed that the aggregate application denial rate for the first quarter of 2010 was 19 percent, but that denial rates varied significantly across insurers. For example, just over a quarter of insurers had application denial rates from 0 percent to 15 percent while another quarter of insurers had rates of 40 percent or higher. Data reported by Maryland—the only of the six states in GAO's review identified as collecting data on the incidence of application denials—indicated that variation in application denial rates across insurers has occurred for several years, with rates ranging from about 6 percent to over 30 percent in each of 3 years. The available data provided little information on the reasons that applications were denied. There are also several issues to consider when interpreting application denial rates. For example, the rates may not provide a clear estimate of the number of individuals that were ultimately able to secure coverage, as individuals can apply to multiple insurers, and the rates do not reflect applicants that have been offered coverage with a premium that is higher than the standard rate.

The available data from the six states in GAO's review and others indicated that the rates of coverage denials, including rates of denials of preauthorizations and claims, also varied significantly. The state data indicated that coverage denial rates varied significantly across states, with aggregate rates of claim denials ranging from 11 percent to 24 percent across the three states that collected such data. In addition, rates varied significantly across insurers, with data from one state indicating a range in claim denial rates from 6 percent to 40 percent across six large insurers operating in the state. There are several factors that may have contributed to the variation in rates across states and insurers, such as states varying in the types of denials they require insurers to report. The data also indicated that coverage denials occurred for a variety of reasons, frequently for billing errors, such as duplicate claims or missing information on the claim, and eligibility issues, such as services being provided before coverage was initiated, and less often for judgments about the appropriateness of a service. Further, the data GAO reviewed indicated that coverage denials, if appealed, were frequently reversed in the consumer's favor. For example, data from four of the six states on the outcomes of appeals filed with insurers indicated that 39 percent to 59 percent of appeals resulted in the insurer reversing its original coverage denial. Data from a national study conducted by a trade association for insurance companies on the outcomes of appeals filed with states for an independent, external review indicated that coverage denials were reversed about 40 percent of the time.

GAO provided a draft of the report to HHS and the Department of Labor (DOL). HHS agreed with GAO's findings, noting the need to improve the quality and scope of existing data, and suggested clarifications, which were incorporated. HHS and DOL also provided technical comments, which were incorporated as appropriate.

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Abbreviations	
AHIP	America’s Health Insurance Plans
AMA	American Medical Association
DOL	Department of Labor
ERISA	Employee Retirement Income Security Act of 1974
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMO	health maintenance organization
HRP	high-risk health insurance pool
NAIC	National Association of Insurance Commissioners
PPACA	Patient Protection and Affordable Care Act
PPO	preferred provider organization

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United States Government Accountability Office
Washington, DC 20548

March 16, 2011

The Honorable Kathleen Sebelius
Secretary of Health and Human Services

The Honorable Hilda L. Solis
Secretary of Labor

A large majority of Americans—nearly 64 percent as of 2009—rely on private insurance for health care coverage, most through employer-sponsored group health coverage.¹ With the enactment of the Patient Protection and Affordable Care Act (PPACA) in March 2010,² enrollment in private health insurance could expand significantly, particularly for individuals and families that do not have access to group coverage through their employer. While there are certain federal requirements protecting against the denial of applications for enrollment for individuals eligible for group coverage, until PPACA is fully implemented, these protections do not apply to some consumers seeking individual coverage from private health insurers.³ In addition, once consumers are enrolled in either group or individual coverage, coverage can be denied for specific medical services, either through a denial of authorization of a service before it has been provided or payment for a service that has been delivered.⁴ There are some national data on the extent to which applications for enrollment are being denied; however, there is not yet any comprehensive, national information on the extent to which coverage for medical services is being denied when consumers seek health care. The federal government plans to

¹Private health insurance includes all forms of health insurance that are not funded by the government and may be purchased on an individual or group basis.

²Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010).

³Throughout this report, the term “insurer” refers to commercial, state-licensed issuers of health insurance coverage and entities such as health maintenance organizations (HMO). Insurers can offer coverage in the group market, individual market, or both. In this report, the term “insurer” does not include self-funded group health plans where instead of purchasing health insurance from an insurance company an employer sets aside its own funds to pay for at least some of its employees’ health care.

⁴Throughout this report, we refer to denials of authorization for services not yet provided as “preauthorization denials” and denials of payment for services rendered as “claim denials.”

collect additional information on the extent of denials of applications for enrollment and coverage for medical services and the reasons for those denials, with the intent to make it easier for consumers to shop for coverage. According to experts, those data may also help with government oversight of private health insurance.

Oversight of private health insurance has been a responsibility of state departments of insurance, and states vary in what they require of insurers and the degree to which they track insurers' activities, including the extent to which insurers are denying applications and coverage. The federal government's role in the oversight of private health insurance has included, for example, the establishment of certain consumer protections for states to enforce. It also includes oversight of employer-based coverage performed by the Department of Labor (DOL). However, the federal government's role has expanded with the enactment of PPACA. PPACA required the Department of Health and Human Services (HHS) to begin collecting, monitoring, and publishing information on health insurance products. HHS began publishing data from insurers on denials of applications for enrollment in October 2010 and intends to collect data in the future on denials of coverage for medical services.

PPACA directed us to study denials of applications for enrollment and coverage for medical services by considering samples of data related to such denials, including the reasons for the denials and favorably resolved disputes resulting from the denials.⁵ Specifically, we reviewed (1) the data available on denials of applications for enrollment and (2) the data available on denials of coverage for medical services.

To describe the data available on denials of applications for enrollment—referred to as application denials in this report—we reviewed federal, state, and other data including data on the rates of and reasons for such denials. First, we reviewed data recently collected by HHS from 459 insurers operating in the individual market in all 50 states and the District of Columbia.⁶ The data included application denial rates by insurer for a 3-month period—January through March—in 2010.⁷ To supplement the

⁵PPACA also directed that we submit our report to the Secretaries of HHS and DOL. Pub. L. No. 111-148, § 10107, 124 Stat. 911-2.

⁶The data were reported by state-licensed health insurers offering coverage in the individual market.

⁷This is the only quarter of data that HHS had collected as of December 2010.

single calendar quarter of HHS data, we contacted insurance department officials in six states regarding data on application and coverage denials.⁸ The six states include all the states identified by experts and in the literature as states that collect data from insurers on the incidence of application denials, coverage denials, or both. Because we did not survey all states to determine whether they collect data on the incidence of application or coverage denials, or both, there may be other states that collect such data that were not known to experts or discussed in the literature.⁹ Of the six states, we identified one, Maryland, that collected data on application denials. We reviewed data from Maryland for 2008, 2009, and the first half of 2010 on the rate of application denials by insurers operating in the individual market in that state. (See app. I for more information about our methodology for selecting states and the state data we reviewed.) We also conducted a structured literature review to identify studies related to application and coverage denials.¹⁰ We determined that a study was directly relevant to our objective on application denial data if it included empirical analyses of the frequency of application denials. Through our review, we identified four studies that met our criteria. Two of these four studies, produced by America's Health Insurance Plans (AHIP), included data on application denial rates in 2006 and 2008, and we reviewed those data. (See app. II for a description of the literature review methodology and the list of studies identified through the review.) Finally, we interviewed officials from HHS, Maryland, and AHIP about factors to consider when interpreting the data. We also interviewed officials from three large insurance companies about the data they collect on application denials.¹¹

⁸The six states we selected to contact were California, Connecticut, Florida, Maryland, New York, and Ohio.

⁹For example, through the course of our work, we found that Texas requires certain insurers to report on the number of requests for preauthorization of coverage for proposed services that insurers declined.

¹⁰To conduct this review, we searched a number of reference databases, such as EconLit and Social SciSearch, for peer-reviewed, industry, or government studies published from January 2000 through July 2010. In addition, we checked the bibliographies of the studies and interviewed a number of experts regarding the research done on private health insurance denials to identify other relevant studies.

¹¹The insurance companies we contacted offered coverage in both the individual and group markets and, according to AHIP, were among the 10 largest by enrollment, together accounting for nearly 26 million enrollees.

To describe the data available on denials of coverage for medical services—referred to as coverage denials in this report—we reviewed state and other data, including data on the rates of and reasons for denials and the outcomes of appeals related to denials, such as disputes resolved in favor of consumers. First, of the same six states we contacted regarding application denial data, we reviewed the most recent year of data available on the rate of coverage denials from the four that reported collecting such data.¹² Second, we reviewed data on the outcomes of appeals related to coverage denials from all of the six states for the most recent year available. We also interviewed officials from departments of insurance and other departments involved in overseeing insurance or responding to appeals in the six states about considerations for interpreting the data. To supplement the information from selected states, we reviewed data reported by 49 states and the District of Columbia to the National Association of Insurance Commissioners (NAIC) on the number of complaints related to coverage denials resolved in 2009 and the reasons for and outcomes of those complaints.¹³ We also reviewed information on the outcomes of complaints and appeals submitted by 35 states and the District of Columbia to HHS in applications for Consumer Assistance Program grants.¹⁴ As part of our literature review, we identified studies that included empirical analyses of the frequency of coverage denials, the reasons for such denials, the frequency of appeals of coverage denials, or the outcomes of such appeals. Through the review, we identified annual studies produced by the American Medical Association (AMA) in 2008, 2009, and 2010 that included data on the incidence and reasons for claim

¹²The data obtained from states on the incidence of coverage denials were not broken out by the types of medical services being denied.

¹³State regulators established NAIC to help promote effective insurance regulation, to encourage uniformity in approaches to regulation, and to help coordinate states' activities. Among other activities, NAIC collects data from state regulators on insurers, including complaints about insurer practices filed by consumers with states. We requested NAIC to provide us with data on the number of complaints reported by states that were related to coverage denials. The complaint data did not include information on the type of service for which coverage was denied.

¹⁴Under PPACA, \$30 million was appropriated to the Secretary of HHS for the award of federal grants to states to establish, expand, or provide support for offices of health insurance consumer assistance or health insurance ombudsmen programs. Pub. L. No. 111-148, § 1002, 124 Stat. 138. To receive these grants, called Consumer Assistance Program grants, states must ensure that their programs assist consumers with such tasks as enrolling in health coverage and filing complaints and appeals. In the applications for the grants, HHS directed states to report on complaints and appeals. States varied in the data they included in their application and the time frames for those data.

denials. We reviewed data from the 2010 study and interviewed AMA officials about factors to consider when interpreting the data. Finally, we reviewed data from DOL on complaints related to coverage denials for those with employer-sponsored coverage from fiscal year 2010, including the number and value of financial recoveries made by the department on behalf of consumers as a result of complaints.

To assess the reliability of the data we reviewed on the incidence of application and coverage denials, the reasons for such denials, and the outcomes of appeals and complaints related to those denials, we interviewed federal, state, and other officials about their efforts to ensure the quality of the data. This included discussing whether they required insurers to certify the accuracy of data reported on the incidence of application or coverage denials and what steps were taken to ensure the quality of data tracked by states and DOL on the outcomes of appeals and complaints related to denials. We also asked officials about the limitations of the data and reviewed any statements about data limitations in published reports of the data. We determined the data to be sufficiently reliable for the purposes of describing the (1) denial rates, (2) reasons for denials, and (3) outcomes of appeals related to denials indicated by the data; where relevant we stated the limitations of the data in the findings.

We conducted our performance audit from September 2010 through January 2011 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

In 2009, approximately 156 million nonelderly individuals obtained health insurance through their employer and another 16.7 million purchased health insurance in the individual market. Of those with employer-sponsored group health plans, in 2009, 43 percent were covered under a fully insured plan where the employer pays a per-employee premium to an insurance company.¹⁵ The remaining 57 percent were covered under self-

¹⁵Throughout this report, the term “group health plan” refers to employer-sponsored health plans, including both fully insured and self-funded plans.

funded plans where instead of purchasing health insurance from an insurance company the employer sets aside its own funds to pay for at least some of its employees' health care.¹⁶

Application Denials

Application denials result when an insurer determines that it will not offer coverage to an applicant either because the applicant does not meet eligibility requirements or because the insurer determines that the applicant is too high of a risk to insure. Underwriting is a process conducted by insurers to assess an applicant's health status and other risk factors to determine whether and on what terms to offer coverage to an applicant.

Many consumers are protected from having their application for enrollment denied. Consumers who obtain health coverage through their employment by enrolling in a group health plan sponsored by their employer have certain protections against application denials. For example, under federal law, individuals enrolling in group health plan coverage are protected from being denied enrollment because of their health status.¹⁷ Under federal law, insurers also generally are prohibited from denying applications for individual health coverage for certain

¹⁶As of 2009, 85 percent of small employers, those with 3 to 199 employees, that offered health benefits were fully insured while 88 percent of large employers, those with 5,000 or more employees, offered self-funded plans. See The Kaiser Family Foundation and Health Research & Educational Trust, *Employer Health Benefits: 2009 Annual Survey* (2009).

¹⁷Group health plans and health insurance issuers offering group coverage are prohibited from implementing eligibility rules based on health-status-related factors defined as health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability. See, for example, 42 U.S.C. § 300gg-1 (2006). PPACA extends this prohibition to health insurance issuers offering coverage in the individual market for plan years beginning on or after January 1, 2014. Pub. L. No. 111-148, § 1201(4), 124 Stat. 156.

Health insurance issuers that offer coverage in the small group market in a state generally are required to accept every small employer that applies for health coverage in that state. In addition, issuers cannot deny an application for enrollment by individuals employed by such employers due to health-status-related factors if the individuals apply when they are first eligible. See 42 U.S.C. § 300gg-11 (2006). For plan years beginning on or after January 1, 2014, PPACA requires health insurance issuers offering group or individual coverage in a state to accept every employer and individual that applies for coverage in that state, subject to certain requirements. Pub. L. No. 111-148, § 1201(4), 124 Stat. 156.

individuals leaving group health plan coverage and applying for coverage in the individual market.¹⁸

Currently, some consumers who apply for private health insurance through the individual market can have their applications denied for eligibility reasons or as a result of underwriting. For example, applications filed by some consumers with preexisting health conditions can be denied, unless prohibited by state or federal law.¹⁹ Additionally, insurers may accept the application but offer coverage at a premium level that is higher than the standard rate or that excludes coverage for certain benefits. The options for appealing application denials in the individual market can be limited to filing a complaint with the state department of insurance. However, in 35 states, individuals who—due to a preexisting health condition—have been denied enrollment or charged higher premiums in the individual market are typically eligible for coverage through high-risk health insurance pools (HRP).²⁰ Additionally, as required under PPACA, individuals who have preexisting health conditions and have been

¹⁸Health insurance issuers offering individual coverage are prohibited from denying coverage for individuals who (1) have had at least 18 months of prior creditable coverage with no break of more than 63 days; (2) have exhausted any available continuation of coverage; (3) are uninsured and are not eligible for other group coverage, Medicare, or Medicaid; and (4) did not lose group coverage because of the nonpayment of premiums or fraud. See 42 U.S.C. § 300gg-41 (2006). As referenced above, PPACA requires health insurance issuers to guarantee coverage to all individuals seeking coverage in that state for plan years beginning on or after January 1, 2014, subject to certain requirements.

¹⁹According to data from the Kaiser Family Foundation, as of January 2010, six states have guaranteed issue requirements that prohibit any insurer from denying coverage to an individual based on their current medical conditions or risk of poor health. Another seven states have guaranteed issue requirements that only apply to certain insurance plans or during limited times during the year.

As referenced above, in certain circumstances, federal law also protects consumers seeking individual coverage from application denials. For example, health insurance issuers cannot deny applications for eligible consumers who had prior group or other coverage.

²⁰See GAO, *Health Insurance: Enrollment, Benefits, Funding, and Other Characteristics of State High-Risk Health Insurance Pools*, [GAO-09-730R](#) (Washington, D.C.: July 22, 2009).

uninsured for 6 months are eligible for enrollment in a temporary national HRP program.²¹

Coverage Denials

Coverage for medical services can be denied before or after the service has been provided, either through denial of preauthorization requests or denial of claims for payment. As a condition for coverage of some services, providers or consumers are required to request authorization prior to providing or receiving the service. Preauthorization denials occur when a determination is made that (1) the consumer is not eligible to receive the requested service, for example, because the service is not covered under the individual's policy, or (2) the service is not appropriate, meaning that it is not medically necessary or is experimental or investigational. Denials of claims occur for various reasons. Claims may be denied for billing reasons, such as the provider failing to include a piece of required information on the claim, such as documentation that the provider received preauthorization for a service, or submitting a duplicate claim. Claims may also be denied because of eligibility issues. For example, a claim may be submitted for a service provided before an individual's coverage began or after it was terminated, or a claim may be submitted for a service that has been excluded from coverage under an individual's policy. Another reason for denials reported by some insurers is that the individual has not met the cost-sharing requirements of his or her policy, such as the required deductible. Finally, claim denials can occur when a determination is made that the service provided was not appropriate, specifically that the service was not medically necessary or was experimental or investigational. Depending on the reason for a claim denial, either the provider or the consumer may bear the financial responsibility for the denied coverage amount. Claims that are denied because of such billing errors as the provider not providing a required piece of information can be resubmitted and ultimately paid.

²¹The temporary national HRP program will terminate in 2014. Pub. L. No. 111-148, § 1101, 124 Stat. 141. As referenced above, for plan years beginning on or after January 1, 2014, PPACA prohibits health insurance issuers offering individual coverage from implementing eligibility rules based on health status-related factors and requires health insurance issuers offering individual coverage to accept every individual in the state who applies for coverage, subject to certain requirements. In addition, PPACA prohibits group health plans and insurers offering group and individual coverage from excluding coverage for pre-existing health conditions. This prohibition is generally effective for plan years beginning on or after January 1, 2014 for adults and plan years beginning on or after September 23, 2010 for individuals under age 19. Pub. L. No. 111-148, § 1201(2), 10103(e), (f), 124 Stat. 154, 895.

For claim denials, the full claim may be denied or, if the claim contained multiple lines, such as a surgery with charges for multiple procedures and supplies, only certain lines of the claim may be denied. How insurers and self-funded group health plans track claim denials and the reasons for denials may vary. For example, AMA officials noted that there is no guidebook for how reason codes should be assigned to claim denials. Officials noted that denials are often assigned the code for the most general reason even though the denial may be for a more specific reason.

Consumers have several avenues available to dispute coverage denials. First, consumers can file an appeal of a denial with the insurer or self-funded group health plan for review, referred to as an internal appeal. Internal appeals can result in the denial being upheld or reversed. In addition, consumers in most states can have their appeal reviewed by an external party, such as an independent medical review panel established by the state.²² These appeals, referred to as external appeals, can also result in denials being reversed and in states recovering funds for consumers for the cost of the denied service. State external appeal options may only be available once the consumer has exhausted the internal appeal process or for consumers with certain types of coverage. Historically, those with self-funded group health plans generally did not have access to an external appeal process, but consumers could file suit against a health plan in court to challenge a denial. PPACA, however, required that group health plans, including self-funded plans, provide access to an external appeal process that meets federal standards for plan years beginning on or after September 2010.²³ Finally, consumers may file complaints regarding coverage denials with the state, generally the department of insurance, or, for those with group health plans, with DOL.

²²According to research completed by AHIP, as of January 2006, 44 states and the District of Columbia operated external review programs. Such programs are generally available to consumers purchasing coverage from insurers regulated by states.

²³Under PPACA and implementing regulations, group health plans and health insurance issuers offering group or individual coverage, subject to certain exceptions, must comply with a state external review process that, at a minimum, includes consumer protections identified in the NAIC Uniform External Review Model Act. If a state external review process does not incorporate these consumer protections or a self-insured group health plan is not required to comply with the state external review process, then the health plan must follow a federal external review process. Pub. L. No. 111-148, §§ 1001(5), 10101(g), 124 Stat. 137, 887; *Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes under PPACA*, 75 Fed. Reg. 43,330 (July 23, 2010).

Filing a complaint can be a less formal mechanism for disputing a coverage denial than filing an appeal; however, complaints can result in reversals of denials and in financial recoveries for consumers.

State and Federal Oversight of Private Health Insurance

States have responsibility for regulating private health insurance, including insurers operating in the individual market and the fully insured group market. In overseeing insurer activity, states vary in the data they require insurers to submit on denials and internal appeals of denials. According to NAIC officials, few states require insurers to report data regularly on the frequency of denials and internal appeals, and NAIC has not issued any model laws or regulations that include requirements for insurers to report such data. States also may use data on complaints and external appeals to identify trends in the practices of insurers and target examinations of specific insurers' practices. Nearly all states and the District of Columbia regularly report complaint data, which includes information on the numbers of, reasons for, and outcomes of complaints, to NAIC.

Historically, the federal government's role in oversight of private health insurance has included establishing requirements for states to enforce. For example, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) established consumer protections on access, portability, and renewability of coverage.²⁴ In addition, with respect to group health plans, the federal government enforces disclosure, reporting, fiduciary, and claims-filing requirements under the Employee Retirement Income

²⁴For example, with respect to those leaving group coverage and applying for coverage in the individual market, HIPAA prohibited health insurance issuers from denying coverage for individuals who (1) have had at least 18 months of prior creditable coverage with no break of more than 63 days; (2) have exhausted any available continuation of coverage; (3) are uninsured and are not eligible for other group coverage, Medicare, or Medicaid; and (4) did not lose group coverage because of the nonpayment of premiums or fraud. See 42 U.S.C. § 300gg-41 (2006).

Security Act of 1974 (ERISA).²⁵ DOL conducts a number of efforts to enforce the ERISA requirements. For example, the department conducts civil investigations that can result in corrective actions, such as monetary recoveries for consumers who are enrolled in employment-based plans. In addition to these formal methods, DOL also works to resolve complaints filed with the department. These efforts are considered informal resolutions, although complaints can also serve as a trigger for formal enforcement actions.

PPACA expanded the federal oversight role by requiring HHS to begin collecting, monitoring, and publishing data from certain insurers. Specifically, PPACA required the establishment of an internet Web site through which individuals can identify affordable health insurance coverage options in their state.²⁶ To implement this requirement, in May 2010, HHS issued an interim final rule requiring insurers in the individual and small group markets to submit data to HHS on their products, including data on the number of enrollees, geographic availability of the products, and customer service contact information, by May 21, 2010, and annually after that.²⁷ In July 2010, HHS began publishing these data on the new Web site, which is designed for individuals and small businesses to obtain information on coverage options available in their state. In October 2010, HHS began posting additional data collected from insurers, including data on the percentage of applications denied for each product offered in the individual market. The interim final rule also required insurers to submit other data, such as data on the percentage of claims denied in the individual and small group markets, and the number and outcomes of

²⁵ERISA established certain federal requirements that apply when employers offer their employees, retirees, and dependents employee benefit plans that include health coverage, retirement plans such as pensions, and other benefits such as life insurance. See Pub. L. No. 93-406, 88 Stat. 829 (1974). ERISA requirements generally apply regardless of the size of the business, although some requirements are streamlined for smaller employers. ERISA imposes certain reporting and disclosure requirements, fiduciary obligations, and requirements for claims-filing procedures. ERISA is enforced through DOL's Employee Benefits Security Administration. PPACA expands upon ERISA's requirements for claims-filing procedures by applying new standards for internal claims appeals and for external claims review processes, as referenced above. Pub. L. No. 111-148, §§ 1001(5), 10101(g), 137, 887.

²⁶Pub. L. No. 111-148, §§ 1103, 10102(b), 124 Stat. 146, 892. The Web site is www.healthcare.gov.

²⁷Health Care Reform Insurance Web Portal Requirements, 75 Fed. Reg. 24,470 (May, 5, 2010).

appeals of denials to insure, pay claims, and provide preauthorization, in accordance with guidance to be issued by HHS. As of December 2010, HHS had not issued any guidance on reporting these additional data.

Federal, State, and Other Data Indicated Variation in Application Denial Rates and Provided Little Information on the Reasons for Denials

Nationwide data from HHS showed variation in application denial rates across insurers operating in the individual market. Specifically, data collected by HHS from 459 state-licensed insurers on the number of applications received and denied from January through March 2010 indicated that, while the aggregate rate of application denials was 19 percent nationally, the rate varied significantly across insurers. For example, just over a quarter of insurers had application denial rates from 0 percent to 15 percent while another quarter of insurers had rates of 40 percent or higher.²⁸ However, the insurers with rates of 40 percent or higher reported fewer applications. See table 1 for additional information on the range in application denial rates across insurers.

Table 1: Range of Application Denial Rates among State-Licensed Insurers, Based on HHS Data, January-March 2010

Application denial rates (percentage of applications denied)	Number of insurers reporting rates in range ^a	Number of applications received ^b
0 to 15	132	499,239
16 to 23	102	471,878
24 to 39	113	230,846
40 or higher	112 ^c	57,923

Source: GAO analysis of HHS data.

^aData were reported to HHS by 459 state-licensed insurers operating in 50 states and the District of Columbia. Data on insurers operating in states with guaranteed issue requirements that prohibit any insurer from denying coverage to an individual based on his or her current medical conditions or risk of poor health were included in the analysis.

^bInsurers were instructed to report the number of applications received for products offering comprehensive medical coverage. HHS officials told us that they identified instances where insurers included data on applications for more limited products, such as one that covers only hospital services. The application data may also include applications for products being sold for only a portion of the 3-month period.

^cThe data indicated that two insurers had denial rates of 100 percent and each of these insurers reported receiving one application in the 3-month reporting period.

²⁸The data indicated that two insurers had denial rates of 100 percent and each of these insurers reported receiving one application in the 3-month reporting period.

HHS officials noted that the data the department collected on application denials, which represent a single calendar quarter of applications, are only a starting point. They told us that as insurers report additional quarters of data, the value and usefulness of the data will increase. In addition, officials said that they have taken steps to ensure the accuracy of the data and noted that the accuracy of these data is critical to HHS, because no other source of information on private health insurance has a complete catalog of insurers operating in the individual market and what products those insurers are selling.

Data reported by Maryland—the only state we identified as collecting data on the incidence of application denials—indicated that variation in application denial rates across insurers operating in the state’s individual market has occurred in that state for several years. Maryland data showed that the range of application denial rates across insurers was 26 percentage points or more in each of three reporting periods, 2008, 2009, and the first half of 2010. (See table 2 for the range in denial rates in the data reported by Maryland.)

Table 2: Range in Application Denial Rates across Insurers Licensed in Maryland, 2008-2010

Data year	Range in application denial rates (percentage of applications denied)	Number of insurers represented in the data	Number of applications received	Aggregate application denial rate (percentage)
2008	6 to 34	11	98,612	14
2009	7 to 33	11	107,617	14
2010 (first half)	6 to 45	11	47,791	16

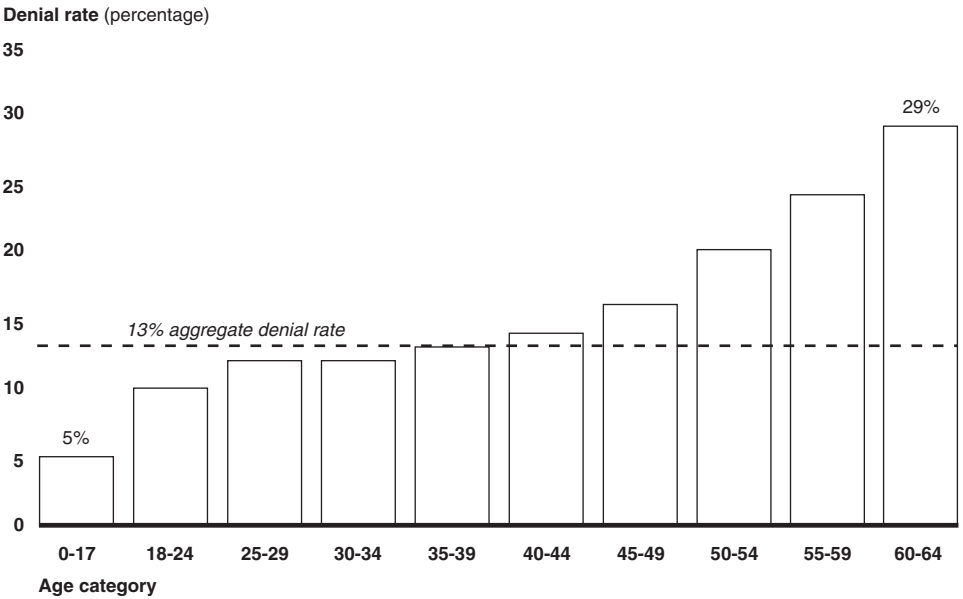
Source: GAO analysis of data from Maryland.

Note: Data are from 2008, 2009, and the first two quarters of calendar year 2010 and reported by insurers to Maryland.

Data reported in studies by AHIP also showed variation in application denial rates. The AHIP data illustrated that application denial rates varied across age groups, with denial rates increasing as the age of the primary applicant increased. In 2008, when AHIP data showed that 13 percent of all

medically underwritten applications were denied,²⁹ in general the denial rate progressively increased as the applicant's age increased, from a low of 5 percent for applicants under 18 years of age to a high of 29 percent for applicants from 60 to 64 years of age.³⁰ Similar variation in AHIP application denial rates was seen in data from 2006.³¹ (See fig. 1.)

Figure 1: Application Denial Rates by Age Group for 2008, as Reported by AHIP



Source: GAO analysis of data reported by AHIP.

Note: Data are from AHIP, *Individual Health Insurance 2009: A Comprehensive Survey of Premiums, Availability, and Benefits* (Washington, D.C.: 2009).

²⁹In 2008, according to AHIP data, 84 percent of applications were medically underwritten and 16 percent were not medically underwritten. Just over 1 percent of applications were denied before going through medical underwriting, and those denials were unrelated to the applicant's health status.

³⁰America's Health Insurance Plans, *Individual Health Insurance 2009: A Comprehensive Survey of Premiums, Availability, and Benefits* (Washington, D.C.: 2009). (See app. II for references to the AHIP study and other studies with information on application denial rates identified through our literature review.)

³¹America's Health Insurance Plans, *Individual Health Insurance 2006–2007: A Comprehensive Survey of Premiums, Availability, and Benefits* (Washington, D.C.: 2007).

The available data on application denial rates provided little information on the reasons that applications were denied. For instance, the HHS and Maryland data did not include any information on the reasons for application denials. The AHIP data, however, provided limited information. Specifically, AHIP's data showed that a higher percentage of applications were denied because of the applicant's health status than for nonmedical reasons, such as the plan not being offered in the applicant's geographic area. AHIP data showed that in 2008, of the 1.8 million applications for enrollment that insurers either denied or made offers of coverage, 1 percent were denied for nonmedical reasons and 12 percent were denied after underwriting when the applicant's health status and other risk factors were assessed. According to an AHIP official, applications that were denied after underwriting were presumably denied because the applicant's medical questionnaire responses were beyond the insurer's threshold for issuing a policy.

There are several issues to consider when interpreting application denial rates. First, application denial rates may not provide a clear estimate of the number of individuals that were ultimately able to secure health coverage, because individuals may submit applications with more than one insurer and be denied by one insurer but offered enrollment by another. Second, denial rates also do not reflect applications that have been withdrawn. For example, AHIP data for 2008 indicated that 8 percent of applicants withdrew their applications before underwriting occurred. Experts also noted that some individuals may not submit applications for health coverage because they believe or have been advised, for example by an insurance agent, that their application would likely be denied. Third, an insurer's denial rates may be affected by requirements of the states in which the insurer operates. For example, officials from one insurance company explained that for applicants in the state for which they are the insurer of last resort, state law prohibits them from denying applications for enrollment based on the health status of the applicant.³² Officials told us that a denial can occur only for nonmedical eligibility reasons, which the AHIP data indicate are far less frequent.

³²According to data from the Kaiser Family Foundation, as of January 2010, four states—Michigan, Pennsylvania, Rhode Island, and Virginia—and the District of Columbia have insurers of last resort, which are insurers that typically accept consumers with health conditions that prevent those consumers from obtaining coverage in the individual market.

Another consideration when interpreting application denial rates is that the rates do not reflect applications that have been accepted by an insurer but for coverage with a premium that is higher than the standard rate or with exclusions for coverage of specified services. Data from HHS, Maryland, and AHIP all indicated that some portion of applicants received offers at a premium that was higher than the standard rate. For example, the HHS data demonstrated that from January through March of 2010, about 20 percent of individual market applicants were offered coverage with premiums higher than the standard rate. Maryland data also indicated that for the first half of 2010, 8 percent of applicants were offered either coverage with premiums higher than the standard rate or coverage that excluded specified health conditions. Finally, AHIP data from 2008 showed that 34 percent of offers for coverage were for coverage at a higher premium rate. The AHIP data also showed that 6 percent of offers for coverage were for coverage that excluded specified health conditions.

State and Other Data Indicated That Coverage Denial Rates and the Reasons for Denials Vary and That Denials, If Appealed, Are Often Reversed

Data from selected states and others indicated that the rates of coverage denials, including denials for preauthorizations and claims, varied significantly, and a number of factors may have contributed to that variation. The data also indicated that coverage denials occurred for a variety of reasons, frequently for billing errors and eligibility issues and less often for judgments about the appropriateness of a service. Further, the data we reviewed indicated that coverage denials, if appealed, were frequently reversed in the consumer's favor and that appeals and complaints related to coverage denials sometimes resulted in financial recoveries for consumers.

State and Other Data Indicated Wide-Ranging Coverage Denial Rates, and a Number of Factors May Have Contributed to This Variation

State data that we reviewed showed that rates of coverage denials by insurers operating in the group and individual markets varied significantly across states. Specifically, aggregate claim denial rates for the three states that we identified as collecting such data ranged from 11 percent in Ohio in 2009 to 24 percent in California in the same year.³³ Data reported by the remaining state, Maryland, indicated a claim denial rate of 16 percent in 2007.³⁴ A fourth state, Connecticut, collected data on a different measure, preauthorization denials, and these data indicated a denial rate of 14 percent in 2009.³⁵ In addition, claim denial rates indicated by AMA data—3 percent during 2 months of 2010—varied from coverage denial rates in the four states.³⁶

Several factors may have contributed to the variation in rates across the four states and the AMA data. For example, Ohio and AMA data were based on denials of electronic claims.³⁷ AMA officials told us that providers with electronic billing systems and insurers that accept electronic claims are more sophisticated in terms of billing management,

³³The Ohio data included the number of electronically submitted claims paid and denied in the first and third quarters of calendar year 2009 and represented all insurers licensed in Ohio. The California data included the number of claims received and denied by six of the largest managed care insurers licensed in the state, each with enrollment in 2009 of over 400,000. We obtained these data from the Department of Managed Health Care's Web site from June through September 2010 (www.wpsso.dmhcc.ca.gov/fe/search).

³⁴The Maryland data were obtained from the Maryland Insurance Administration's *Report on Semi-Annual Claims Data Filing for Calendar Years 2005-2007* and represented data for calendar year 2007 from 41 insurers licensed in the state.

³⁵The Connecticut data were obtained from the Connecticut Insurance Department's *Consumer Report Card on Health Insurance Carriers in Connecticut* and represented data for calendar year 2009 from 21 managed care insurers licensed in the state.

³⁶The data were reported to GAO by AMA and represented claims from February 1, 2010, through March 31, 2010. The data indicated the total number of claim lines—charges for specific services included in the claim—that were denied. AMA defines a denial as a claim line where the amount allowed and the amount billed were equal, but the amount paid was \$0. Though not included in the claim denial rate, AMA also reported data indicating that 5 percent of claim lines were edited, that is, the claim lines were automatically reduced to a payment of \$0 by the insurer's payment system. According to AMA officials, both claim-line denials and claim-line edits result in no payment for the service, and therefore are denials from the perspective of the provider. The data on claim lines denied and edited were used as the basis for rates reported in AMA's *2010 National Health Insurer Report Card*. See citations to the 2010 report card and previous AMA report cards as well as other studies related to coverage denials in app. II.

³⁷Providers can submit paper or electronic claims. According to Ohio and AMA officials, electronic claims represented roughly 70 to 80 percent of their total claims activity.

and therefore the denial rates calculated by AMA may be lower than rates of denials for all claims, including both electronic and paper-based. In another example, Maryland's rate was calculated using data for categories of denials that accounted for about 90 percent of all claims denied. In contrast, according to California officials, California's data represented all claim denials.³⁸ Differences in the time frames for the data may have also contributed to the variation. AMA officials noted that their data were from a 2-month period of the year (February through March) when there was less contractual activity, such as open enrollment periods, and when denials related to meeting deductible requirements—which according to officials from one insurance company can be significant—have already been resolved. In contrast, data from the four states, except Ohio, covered a full year and therefore reflect all denials for the year, including those related to enrollment and deductible issues. See table 3 for the rates of coverage denials indicated by state data and a description of the characteristics of the data, some of which may have contributed to the variation in rates.

³⁸ California officials told us they currently require plans to report on their full “inventory” of denials but the state is revising its claim denial reporting instructions to clarify the denials that should be included and excluded from the numbers reported.

Table 3: Rates of Claim or Preauthorization Denials across States in GAO’s Review and Characteristics of the State Data

State	Rate of claim or preauthorization denials	Data year ^a	Characteristics of the data
Ohio	11 percent across all insurers licensed in the state	2009	Data limited to denials of electronic claims in the first and third quarters of the fiscal year ^b
Connecticut	14 percent across 21 managed care organizations licensed in the state	2009	Data were limited to denials of preauthorization for services and did not include data on denials of claims ^c
Maryland	16 percent across 41 insurers licensed in the state	2007	Data were limited to 16 categories of denials of claims, representing 90 percent of total claim denials ^d
California	24 percent across six of the largest managed care organizations licensed in the state	2009	Data were limited to denials of claims and reflected each insurer’s inventory of denials, which means that some insurers may have reported denials for government-sponsored health coverage, such as Medicaid ^e

Source: GAO analysis of data reported by insurers to states.

^aThe data years cited represent calendar years and the data reflect the most recent complete year of data available.

^bData were reported to GAO by the Ohio Department of Insurance.

^cData were obtained from Connecticut’s *Consumer Report Card on Health Insurance Carriers in Connecticut* (Hartford, Conn.: 2010).

^dData were obtained from the Maryland Insurance Administration’s *Report on Semi-Annual Claims Data Filing for Calendar Years 2005-2007* (Baltimore, Md.: 2009).

^eData were obtained from the Department of Managed Health Care’s Web site from June through September 2010 (www.wpsa.dmhc.ca.gov/fe/search).

In addition to variation across states in aggregated rates, state and other data also indicated that coverage denial rates varied significantly across insurers. For example, the California data indicated that in 2009 claim denial rates ranged from 6 percent to 40 percent across six of the largest managed care organizations operating in the state. Similarly, preauthorization denial rates in Connecticut varied across 21 insurers, with rates among the seven largest insurers ranging from 4 percent to 29 percent in 2009. Somewhat narrower variation across insurers was also evident in the AMA data, with claim denial rates in 2010 that ranged from

less than 1 percent to over 4 percent across the seven insurers represented in those data.³⁹

State and other officials told us about several factors that may have contributed to the variation across insurers and make it difficult to compare data across insurers. First, California officials told us that insurers may interpret a state's reporting requirements differently and noted that some insurers may count certain claims transactions as denials that the state would not consider a denial. This was evidenced by discussions with one insurer who told us that if asked to report the number of claims denied, some insurers might include claims where the service was approved but the insurer paid nothing because the member was liable for the charge, which California officials would not characterize as a denial. Officials from the insurer said that their current overall denial rate is 27 percent, but it would be 18 percent if member liability denials were excluded. Officials from California and AMA also indicated that circumstances unique to an insurer may affect their denial rate. For example, California officials told us one insurer's denials rose sharply in a month because providers were submitting claims to the insurer's HMO when they should have gone to the preferred provider organization (PPO). Rather than transferring the claims, the HMO denied all of them, and then the PPO paid the claims shortly after that.

**State and Other Data
Indicated That Coverage
Denials Occurred for
Various Reasons and
That Denials, If Appealed,
Were Frequently Reversed**

According to state and other data, coverage denials occurred for various reasons. For example:

- Claim denials were often made for billing errors such as duplicate claims and missing information on the claim. For example, data from Maryland showed that the most prevalent reason for claim denials in 2007 was duplicate claim submissions, accounting for 32 percent of all denials.⁴⁰ Among six of the largest managed care organizations in California, the four that reported on the most prevalent reasons for claim denials in 2009 all reported duplicate claims as one of those reasons. With regard to claims missing required information, the 2010 AMA data indicated that five of the seven insurers represented in the data made 15 percent or more of

³⁹ According to officials, the AMA claim data included data for insured products offered by the companies represented and self-insured products administered by the companies.

⁴⁰ The calendar year 2007 data were obtained from the Maryland Insurance Administration's *Report on Semi-Annual Claims Data Filing for Calendar Years 2005-2007*.

denials on the basis that the claim was missing information, such as documentation of preauthorization. Data from Maryland showed that 74 percent of denied claims did not meet the state's criteria for "clean" claims, those claims that include all of the required information needed for processing.⁴¹

- Denials of claims also frequently resulted from eligibility issues. For example, for six of the seven insurers in the 2010 AMA data, over 20 percent of claim denials occurred as a result of eligibility issues such as services being provided before coverage was initiated or after coverage was terminated.
- Insurers also denied preauthorizations and claims as a result of judgments about the appropriateness of the service, such as that the service was not medically necessary or was experimental or investigational, although less frequently than for billing errors and eligibility issues. Data from Maryland showed that in 2007 insurers denied nearly 40,000 preauthorizations or claims because they determined the services were not medically necessary.⁴² This was a relatively small number compared to the 6.3 million claim denials reported in the same year.⁴³ The 2010 AMA data showed that only one of the seven insurers denied claims on the basis that services were not appropriate, specifically that the service was experimental or investigational, with about 9 percent of denials made for that reason.⁴⁴ NAIC data on complaints filed with states in 2009 also provided some information on coverage denials related to the appropriateness of services. Specifically, the data showed that of the

⁴¹Maryland reports the total claim denial rate, as well as a denial rate for "clean claims"—those health care claims submitted by a health care provider on one of two widely used industry standard billing forms and that also include all of the essential information needed by a plan for processing—in their Semi-Annual Claims Data Filing Reports.

⁴²The data were obtained from The Maryland Insurance Administration's *2007 Report on the Health Care Appeals & Grievances Law*.

⁴³The data were obtained from the Maryland Insurance Administration's *Report on Semi-Annual Claims Data Filing for Calendar Years 2005-2007*.

⁴⁴The data on the reasons for claim denials reflect the reasons assigned by the insurer that denied the claim. According to AMA officials, there is no requirement that insurers assign the most specific reason for the claim denial, and they sometimes assign more general reasons. For example, although a denial may have occurred because the insurer determined a service was not medically necessary, the insurer may document that the claim was denied because the service was not covered, which could be for reasons other than that the service was not medically necessary.

approximately 14,000 complaints related to coverage denials, at least 8 percent were related to the insurer's determination that the service was not medically necessary and 2 percent were related to the determination that the service was experimental.

State and other data indicated that coverage denials, if appealed, were frequently reversed in the consumer's favor.⁴⁵ The data from the four states that we identified as collecting data on the outcomes of internal appeals filed with insurers indicated that at least 39 percent of internal appeals resulted in the insurer reversing its original coverage denial. Officials from two insurance companies explained that denials are frequently reversed because the consumer or provider submits additional information, such as the consumer's medical records. Officials from one of these insurance companies also explained that because insurers receive additional information through the appeals process, reversals of denials are expected even when the company is using accepted medical criteria to make the initial assessment of the appropriateness of the service; and regulators are sometimes concerned when few appeals result in reversals of denials. See table 4 for a summary of the outcomes of internal appeals reported by insurers to Connecticut, Maryland, New York, and Ohio.

⁴⁵Reversals of coverage denials were limited to denials for which an appeal was initiated. The data we reviewed did not allow for a systematic calculation of an "appeal rate"—the number of coverage denials for which an appeal was initiated—for several reasons, including different data sources or data years for denials and appeals data. Data from Ohio did provide limited information; specifically, for the first quarter of calendar year 2010, Ohio data indicated that 0.5 percent of claim denials were internally appealed.

Table 4: Number and Outcomes of Internal Appeals Filed with Insurers across States in GAO’s Review

State	Type of insurer reporting ^a	Data year ^b	Number of internal appeals	Percentage of internal appeals where initial determination was reversed
Connecticut ^c	HMOs	2009	1,932	53
	Indemnity managed care organizations	2009	1,797	59
Maryland ^d	HMOs, nonprofit health service plans, and commercial insurers	2009	4,844	50
New York ^e	HMOs	2009	5,968	39
	Commercial insurers	2009	71,787	47
	Nonprofit indemnity insurers	2009	8,946	48
Ohio ^f	All insurers	2010 (1 st quarter)	6,434	48

Source: GAO analysis of data reported by insurers to states.

^aThe types of insurers reported in this column are the categories used by each state and may not be comparable across states.

^bThe data years cited represent calendar years and reflect the most recent complete year of data available, unless indicated otherwise.

^cData were obtained from Connecticut’s *Consumer Report Card on Health Insurance Carriers in Connecticut* (Hartford, Conn.: 2010). The reversal rates represent the aggregate reversal rates for 6 HMOs and 15 indemnity managed care organizations.

^dData were obtained from the Maryland Insurance Administration’s *2009 Report on the Health Care Appeals & Grievances Law* (Baltimore, Md.: 2010).

^eData were obtained from the *2010 New York Consumer Guide to Health Insurers* (Albany, N.Y.: 2010). The reversal rates represent the aggregate reversal rates for 12 HMOs, 28 commercial insurers, and 5 nonprofit indemnity insurers.

^fData were reported to GAO by Ohio and represent internal appeals filed by all insurers licensed in Ohio.

Data on the results of appeals filed with states for external review also indicated that denials were frequently reversed. A study conducted by AHIP on 37 states’ external appeal programs showed that for 2003 and 2004, about 40 percent of external appeals resulted in denials being reversed.⁴⁶ More recent data from the six states we contacted indicated

⁴⁶America’s Health Insurance Plans, *Update on State External Review* (Washington, D.C.: 2006).

similar rates of denials being reversed upon external appeal. See table 5 for a summary of the outcomes of external appeals indicated by state data.

Table 5: Number and Outcomes of Appeals Submitted for External Review across States in GAO’s Review

State	Types of insurers for which denials were appealed ^a	Data year ^b	Number of external appeals resolved	Percentage of appeals where insurer determination was reversed or revised
California ^c	Managed care organizations with enrollment over 400,000	2009	1,606	54
Connecticut ^d	Managed care organizations	2009	184	40
Florida ^e	Managed care organizations	State fiscal year 2010	186	49
Maryland ^f	HMOs, nonprofit health service plans, and commercial insurers	2009	915	54
New York ^g	HMOs	2009	570	38
	Commercial insurers	2009	812	42
	Nonprofit indemnity insurers	2009	395	41
Ohio ^h	Traditional health insurers, PPOs, HMOs, and Public Employee Health Benefit Plans	2008	311	23

Source: GAO analysis of data reported by states.

^aThe types of insurers reported in this column are the categories used by each state and may not be comparable across states.

^bThe data years cited represent calendar years unless indicated otherwise, and the data reflect the most recent complete year of data available.

^cData were obtained from the California Department of Managed Health Care’s *2009 Independent Medical Review and Complaint Results* report.

^dData were reported to GAO by the Connecticut Insurance Department.

^eData were reported to GAO by the Florida Agency for Health Care Administration.

^fData were obtained from the Maryland Insurance Administration’s *2009 Report on the Health Care Appeals & Grievances Law* (Baltimore, Md: 2010).

^gData were obtained from the *2010 New York Consumer Guide to Health Insurers* (Albany, N.Y.: 2010). The reversal rates represent the aggregate reversal rates across 12 HMOs, 28 commercial insurers, and 5 nonprofit indemnity insurers.

⁴⁶Data were obtained from the Ohio Department of Insurance's *Patient Protection Act Report for the Year 2008* (Columbus, Ohio: 2009). The data represent external reviews for denials because the service was not appropriate and denials for contractual reasons, which were less frequently reversed than denials because the service was not appropriate.

The data on the outcomes of external appeals also indicated that the rate at which denials are reversed, if appealed, may vary depending on the reason for the denial and the type of service denied. For example, one study identified through our literature review looked at 740 external appeal decisions in California in 2001 and 2002. The study showed that appeals resulted in denials being reversed in 42 percent of cases where the denial resulted from the determination that services were not medically necessary and 20 percent of cases where services were determined to be experimental and investigational.⁴⁷ Further, the study showed that reversals of denials were more likely for certain services, such as gastric bypass surgery, stem cell transplants, and breast reduction surgery, than for other services, such as residential behavioral health care. Data from Florida also indicated variation in outcomes of external appeals based on the reason for the denial and the type of service denied. For example, for state fiscal year 2010, denials were reversed in 49 percent of cases where the denial resulted from the determination that services were not medically necessary and in 60 percent of cases where the service was deemed experimental or investigational, although there were fewer appeals of coverage denials for this reason.⁴⁸ Further, the data showed that appeals were more likely to result in a denial being reversed when the denial was for diagnostic testing and pharmaceuticals than for other services, such as cosmetic surgery and durable medical equipment.

Finally, federal and state data indicated that appeals and complaints related to coverage denials sometimes resulted in financial recoveries for consumers. According to data from DOL, more than 9,600 complaints related to coverage denials by group health plans resulted in about 500 recoveries of payments totaling nearly \$7 million in fiscal year 2010. Data

⁴⁷C. R. Gresenz and D. M. Studdert, "External Review of Coverage Denials by Managed Care Organizations in California" (RAND Institute for Civil Justice, Santa Monica, Calif.: 2005). See app. II for the list of studies that included external appeal data by the reason for the denial being appealed and the type of service being denied.

⁴⁸Data were reported to GAO by the Florida Agency for Health Care Administration. Maryland's data, obtained from the Maryland Insurance Administration's *2009 Report on the Health Care Appeals & Grievances Law*, also included some information on external appeals by the type of service being denied.

reported by states to HHS in applications for the Consumer Assistance Program grants also documented that complaints and appeals resulted in recoveries.⁴⁹ Specifically, 21 of the 35 states submitting applications reported financial recoveries. For example, Maryland reported recovering more than \$1.4 million for consumers in fiscal year 2009 as a result of internal appeals. NAIC data on complaints filed with states also gave some indication of recoveries. For example, NAIC's 2009 data indicated that of the approximately 14,000 complaints related to coverage denials, over 4 percent resulted in an outcome where money or benefits were returned to the consumer and about 7 percent resulted in the insurer paying more of a claim than was initially paid.

Agency Comments and Our Evaluation

HHS provided us with written comments on a draft version of this report. These comments are reprinted in appendix III. HHS agreed with our findings, noting in particular the need to improve the quality and scope of existing data, and suggested clarifications, which we incorporated. HHS and DOL also provided technical comments to the draft report, which we incorporated as appropriate.

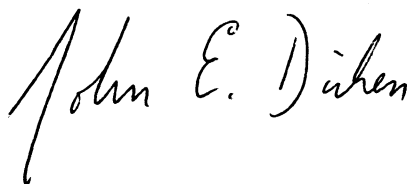
In its written comments, HHS emphasized the importance—for policymakers, regulators, and consumers—of data on health insurance application and coverage denials. HHS noted that data on application and coverage denials can help increase transparency in the private health insurance market and that these data can also provide an important baseline measure for evaluating the impact of changes resulting from PPACA. In its comments, HHS also noted that data collection on application and coverage denials has been uneven across insurers, plans, and states and that very little information is available to help analysts understand the causes or sources of variation in the data that are available. According to HHS, more effort is needed to improve the quality and scope of existing data collection to give policymakers and regulators better and richer data to evaluate health insurance plan practices and market changes and to produce measures that may be useful to consumers when they are shopping for insurance.

⁴⁹In October 2010, HHS awarded nearly \$30 million in Consumer Assistance Program grants to 35 states and the District of Columbia. States receiving the grants are required to begin reporting data 6 months after the award notice on the number of inquiries filed with the state about health coverage, the reasons for the inquiries, and the outcomes of the inquiries.

In its written comments, HHS also identified a limitation to our data that needed some clarification. Specifically, HHS pointed out—correctly—that while our draft report provided information on the percentage of claims that were denied, as well as data on the outcomes of internal appeals and external reviews of denied claims, our draft report did not provide data on the frequency with which claim denials are appealed by consumers. These data were not included in the report because the data we reviewed did not allow for a systematic calculation of an “appeal rate”—the number of coverage denials for which an appeal was initiated—for several reasons, including different sources or years of denials and appeals data we reviewed. In response to HHS’ comments, we added language to the report clarifying this limitation. For context, we also added information on the appeal rate from one quarter for one state—the only information we identified on internal claims appeal rates. HHS also noted that the statement in our draft report that “denials are frequently reversed” upon appeal may be confusing, because readers may assume a large number of claim denials are ultimately overturned. We revised the language in our draft report to prevent this misinterpretation of our data, by stating that coverage denials, if appealed, were frequently reversed in the consumer’s favor.

We are sending copies of this report to the Secretaries of HHS and DOL, the congressional committees of jurisdiction, and other interested parties. In addition, the report is available at no charge on the GAO Web site at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or dickenj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix IV.

A handwritten signature in black ink that reads "John E. Dicken". The signature is written in a cursive, flowing style.

John E. Dicken
Director, Health Care

Appendix I: Methodology for Selecting States and State Data Reviewed by GAO

In order to describe the data on denials of applications for enrollment and coverage of medical services, we contacted six states to interview officials and to obtain data the states collect and track on denials and appeals related to denials. The six states we selected included states identified in the literature, through searches of state insurance department Web sites, or in interviews with experts as a state collecting data on the incidence of application or coverage denials.¹ These also included states that collect or track data on appeals related to coverage denials reviewed by insurers (internal appeals) or reviewed by external parties (external appeals). The six states accounted for at least 20 percent of national enrollment in private health insurance.

Once we selected the states, we asked officials from each state whether they collected the following types of data: (1) incidence of application denials; (2) incidence of coverage denials, including incidence of denials of preauthorizations and claims; (3) incidence and outcomes of appeals reviewed by insurers (that is, internal appeals); and (4) incidence and outcomes of appeals reviewed by external parties (that is, external appeals). If state officials reported collecting the data, we reviewed at least the most recent year of data available. We reviewed data from one state on the incidence of application denials, from four states on the incidence of coverage denials, from four states on the number and outcomes of internal appeals, and from all six states on the number and outcomes of external appeals. (See table 6.)

¹Because we did not survey all states to determine whether they collect data on the incidence of application or coverage denials, there may be other states that collect such data that were not known to experts or discussed in the literature. For example, through the course of our work, we found that Texas requires certain insurers to report on the number of requests for verification of coverage for proposed services that insurers declined.

Table 6: Information on Denial Data Collected by and Private Health Insurance Enrollment for States in GAO's Review

State	Reported collecting data on the incidence of application denials	Reported collecting data on the incidence of coverage denials	Reported collecting data on internal appeals, including outcomes	Reported collecting data on external appeals, including outcomes	Total number of people enrolled in private health insurance in 2008 (in thousands)	Percentage of national enrollment
California		✓		✓	22,848	11.4
Connecticut		✓	✓	✓	2,575	1.3
Florida				✓	11,129	5.5
Maryland	✓	✓	✓	✓	4,171	2.1
New York			✓	✓	12,567	6.3
Ohio		✓	✓	✓	8,109	4.0

Source: GAO summary of state and U.S. Census Bureau data.

Note: Table includes data that officials from selected states reported collecting. U.S. Census Bureau data are from the bureau's Current Population Survey, 2009 Annual Social and Economic Supplement.

Appendix II: Methodology for and Studies Identified by Structured Literature Review

To identify research that examined private health insurance denials, including the incidence of denials of applications for enrollment and of coverage for medical services (i.e., “coverage denials”) and the incidence and outcomes of appeal related to coverage denials, we conducted a structured literature review. This review resulted in 24 studies that we determined to be relevant to our objectives. To conduct this review, we searched 23 reference databases for articles or studies published from January 2000 through July 2010,¹ using a combination of search terms, such as “denial” and “insurer.”² We determined that a study was directly relevant to our objectives if it: (1) included empirical analysis related to the incidence of application denials, the incidence of coverage denials, or the incidence and outcomes of appeals related to such denials; and (2) analyzed, at minimum, denial or appeal data from an entire state or two or more insurers. In addition to searching the reference databases, we checked the bibliographies of the relevant studies to identify other potentially relevant research and interviewed several private health insurance experts about research done on denials.

We identified 24 studies in the literature that included empirical analyses examining (1) the frequency of denials of applications for enrollment or (2) the frequency of or reasons for denials of coverage for medical services and outcomes of appeals related to such denials. Table 7 identifies the number of studies that address these topics, with some studies addressing more than one topic.

¹The 23 databases were BIOSIS Previews, NTIS: National Technical Information Service, Social SciSearch, ABI/INFORM, Gale Group PROMT, SciSearch: a Cited Reference Science Database, Pharmaceutical News Index, EMCare, Elsevier BIOBASE, EMBASE, Gale Group Business A.R.T.S., General Science Abstracts, Wilson Applied Science & Technology Abstracts, EconLit, Readers' Guide Abstracts, Wilson Social Sciences Abstracts, Gale Group Trade & Industry Database, Gale Group Legal Resource Index, MEDLINE, CANCERLIT, EMBASE Alert, Periodical Abstracts PlusText, and Wilson Business Abstracts.

²We searched the reference databases for the terms “denial” or “refusal” and “health plan,” “insurer,” “carrier,” or “issuer” with all of the following combinations of terms: (1) “application” or “enrollment;” (2) “coverage,” “claim,” or “preauthorization;” and (3) “complaint,” “appeal,” or “dispute” and “coverage,” “claim,” “service,” or “preauthorization.”

Table 7: Index of Studies Examining Private Health Insurance Denials, by Topic

Topic	Study numbers	Total number of studies
Frequency of denials of applications for enrollment	2, 3, 11, 20	4
Frequency of denials of coverage for medical services	5, 6, 7, 10, 16, 17, 19, 22, 24	9
Reasons for denials of coverage	5, 6, 7, 17, 19	5
Outcomes of appeals related to denials of coverage	1, 4, 8, 9, 12, 13, 14, 15, 18, 21, 23, 24	12
By reason for denial being appealed	9, 12, 13, 23	4
By type of service being denied	9, 13, 23	3

Source: GAO.

The 24 studies that GAO identified in the literature are as follows:

1. American Association of Health Plans. *Independent Medical Review of Health Plan Coverage Decisions: Empowering Consumers with Solutions*. Washington, D.C., 2001.
2. America's Health Insurance Plans. *Individual Health Insurance 2009: A Comprehensive Survey of Premiums, Availability, and Benefits*. Washington, D.C., 2009.
3. ———. *Individual Health Insurance 2006–2007: A Comprehensive Survey of Premiums, Availability, and Benefits*. Washington, D.C., 2007.
4. ———. *Update on State External Review Programs*. Washington, D.C., 2006.
5. American Medical Association. *2010 National Health Insurer Report Card*. Chicago, Ill., 2010.
6. ———. *2009 National Health Insurer Report Card*. Chicago, Ill., 2009.
7. ———. *2008 National Health Insurer Report Card*. Chicago, Ill., 2008.
8. California Healthcare Foundation. *Independent Medical Review Experiences in California, Phase I: Cases of Investigational/Experimental Treatments*. Prepared by the Institute for Medical Quality for the California Healthcare Foundation, Oakland, Calif., 2002.

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9. Chuang, K. H., W. M. Aubry, and R. A. Dudley. "Independent Medical Review of Health Plan Coverage Denials: Early Trends." *Health Affairs*, vol. 23, no. 6 (November/December 2004), 163-169.
 10. Collins, S. R., J. L. Kriss, M. M. Doty, and S. D. Rustgi. *Losing Ground: How the Loss of Adequate Health Insurance is Burdening Working Families: Findings from the Commonwealth Fund Biennial Health Insurance Surveys, 2001–2007*. New York, N.Y., 2008.
 11. Doty, M. M., S. R. Collins, J. L. Nicholson, and S. D. Rustgi. *Failure to Protect: Why the Individual Insurance Market is not a Viable Option for Most U.S. Families. Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2007*. New York, N.Y., 2009.
 12. Foote, S. B., B. A. Virnig, L. Bockstedt, and Z. Lomax. "External Review of Health Plan Denials of Mental Health Services: Lessons from Minnesota." *Administration and Policy in Mental Health and Mental Health Services Research*, vol. 34 (2007), 38-44.
 13. Gresenz, C. R., and D. M. Studdert. *External Review of Coverage Denials by Managed Care Organizations in California*. Working Paper No. WR-264-ICJ, RAND Institute for Civil Justice, Santa Monica, Calif., 2005.
 14. Gresenz, C. R., D. M. Studdert, N. Campbell, and D. R. Hensler. "Patients In Conflict With Managed Care: A Profile of Appeals in Two HMOs." *Health Affairs*, vol. 21, no. 4 (July/August 2002), 189-196.
 15. Gresenz, C. R., and D. M. Studdert. "Disputes over Coverage of Emergency Department Services: A Study of Two Health Maintenance Organizations." *Annals of Emergency Medicine*, vol. 43, no. 2 (February 2004), 155-162.
 16. Kaiser Family Foundation / Harvard School of Public Health. *National Survey on Consumer Experiences With and Attitudes Toward Health Plans: Key Findings*. Washington, D.C., 2001.
 17. Kapur, K., C. R. Gresenz, and D. M. Studdert. "Managed Care: Utilization Review in Action at Two Capitated Medical Groups." *Health Affairs*, Web exclusive (2003), W3-275-282.
 18. Karp, N., and E. Wood. *Understanding Health Plan Dispute Resolution Practices*. Washington, D.C., 2000.

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19. Pearson, S. D. "Patient Reports of Coverage Denial: Association with Ratings of Health Plan Quality and Trust in Physician." *The American Journal of Managed Care* (March 2003), 238-244.
 20. Pollitz, K., R. Sorian, and K. Thomas. *How Accessible is Individual Health Insurance for consumers in less-than-perfect health?* Prepared for the Henry J. Kaiser Family Foundation, Menlo Park, Calif., 2001.
 21. Pollitz, K., J. Crowley, K. Lucia, and E. Bangit. *Assessing State External Review Programs and the Effects of Pending Federal Patients' Rights Legislation*. Prepared for the Henry J. Kaiser Family Foundation, Menlo Park, Calif., 2002.
 22. Schauffler, H. H., S. McMenamin, J. Cubanski, and H. S. Hanley. "Differences in the Kinds of Problems Consumers Report in Staff/Group Health Maintenance Organizations, Independent Practice Association/Network Health Maintenance Organizations, and Preferred Provider Organizations in California." *Medical Care*, vol. 39, no. 1 (2001), 15-25.
 23. Studdert, D. M., and C. R. Gresenz. "Enrollee Appeals of Preservice Coverage Denials at 2 Health Maintenance Organizations." *The Journal of the American Medical Association*, vol. 289, no. 7 (Feb. 19, 2003), 864-870.
 24. Young, G. P., J. Ellis, J. Becher, C. Yeh, J. Kovar, and M. A. Levitt. "Managed Care Gatekeeping, Emergency Medicine Coding, and Insurance Reimbursement Outcomes for 980 Emergency Department Visits from Four States Nationwide." *Annals of Emergency Medicine*, vol. 39, no. 1 (January 2002), 24-30.

Appendix III: Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

FEB 16 2011

John E. Dicken
Director, Health Care
U.S. Government Accountability Office
441 G Street N.W.
Washington, DC 20548

Dear Mr. Dicken:

Attached are comments on the U.S. Government Accountability Office's (GAO) draft report entitled, "PRIVATE HEALTH INSURANCE: Data on Application and Coverage Denials" (GAO 11-268).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

A handwritten signature in cursive script, reading "Jim R. Esquea", is positioned above the typed name.

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "PRIVATE HEALTH INSURANCE: DATA ON APPLICATION AND COVERAGE DENIALS" (GAO-11-268)

The Department appreciates the opportunity to review and comment on this draft report.

The Affordable Care Act (ACA) of 2010 required GAO to study the rates of such application and coverage denials. GAO reviewed the data available on denials of the applications of enrollment and coverage for medical services.

We would like to emphasize the importance—for policy makers, regulators and consumers—of the data presented in your report, and make note of Center for Consumer Information and Insurance Oversight's (CCIIO) role in improving and expanding data collection on application and coverage denials to help bring about increased transparency in private health insurance.

We would like to also bring your attention to an important piece of data not included in your analysis. Although GAO's draft report provides information on the percentage of claims that are denied by private health insurance plans, as well as data on the outcomes of internal appeals and external review of denied claims, it does not provide data on the frequency with which claims denials are appealed by consumers. This letter offers views on why the gap matters and what might be done to close that data gap. It also highlights HHS' role, together with our Federal partners in the Departments of Labor (DoL) and Treasury, in crafting federal regulations to both create more uniform federal protections for internal appeals and external review and enforce notice requirements so that consumers are aware of their appeal rights, as required by the ACA.

Why the Data on Application and Coverage Denials Matter

Data on application and coverage denials help increase transparency in private health insurance. However, more effort is needed to improve the quality and scope of existing data collections to give policymakers and regulators better and richer data to evaluate health insurance plan practices and market changes, and to produce measures that may be useful to consumers when they are shopping for insurance.

The GAO's draft report makes it abundantly clear that data collection on application and coverage denials have been uneven across insurers and plans and across states. The report also reveals that very little information is available to help analysts understand the causes or sources of variation in the data that are available. For example, the GAO analyzed data—collected by CCIIO and displayed in the individual market plan finder on HealthCare.gov—on applications denials by plans in the individual health insurance market. The data perform an important function—alerting consumers to the uncertainty that goes along with applying for private coverage in the current market. The data also provide an important baseline measure for evaluating the impact of the ACA. We should, for example, expect to see a sharp reduction in these application denials over time, since denials for pre-existing conditions will be a thing of the past after 2014.

Similarly, the GAO's analysis of claims denials primarily serves to illustrate that there is variation across issuers. Unfortunately, not much more can be said about these data. Although the data illustrate wide variation in the reported rate of claims denial, the GAO was unable to describe the sources or significance of that variation. Further, it is possible that the states that do

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "PRIVATE HEALTH INSURANCE: DATA ON APPLICATION AND COVERAGE DENIALS" (GAO-11-268)

provide data are also the states with stronger appeals protections such that the reported rates are not representative of the national picture.

The GAO report also reveals that the scope of existing data collection needs to be expanded to assure transparency across the health insurance market.

How Often Do Consumers Appeal Claims Denials and What Obstacles Do They Face?

Together with our Federal partners in DOL and Treasury, HHS has crafted Federal regulations to create more uniform Federal protections for internal appeals and external review and to implement improved notice requirements for consumers. In order for the Departments to provide oversight for those new protections, data on the rate at which claims denials are appealed (and the outcomes of those internal appeals and external reviews) are needed.

ACA directed the GAO to study data on denials including denials where a "health plan later approves such coverage." Unfortunately, due to the limitations of existing data collections, the GAO, with one small exception, was not able to report data on the frequency with which claims denials are appealed in any segment of the market. Consequently, the GAO risks confusion when it states that "denials are frequently reversed." Readers may reasonably assume that a large percentage of claim denials are ultimately overturned (with a consumer receiving a previously denied benefit payment). It is unclear that this is the case, especially in the pre-ACA patchwork of appeals protections. For example, in its own discussion, the GAO seems to suggest that reversals and recoveries for consumers may be rare, citing a favorable outcome for a plan enrollee in 5.2 percent of reported cases (i.e., the GAO reports that recoveries were made in 500 cases out of 9,600 complaints about benefit denials received by the DOL from enrollees in self-funded plans).

Systematic, standardized and richer data collection on claims denials and appeals is needed across market segments—in both the commercially insured market and in self-funded group plans—to provide transparency for consumers and meaningful information for policymakers.

Appendix IV: GAO Contact and Staff Acknowledgments

GAO Contact

John E. Dicken, (202) 512-7114 or dickenj@gao.gov

Staff Acknowledgments

In addition to the contact named above, Kristi Peterson, Assistant Director; Susan Barnidge; Krister Friday; Jawaria Gilani; Teresa Tam; and Hemi Tewarson made key contributions to this report.

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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] patients, 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] would be available or covered under Medicare part D, such as:

Medication requirements: The [REDACTED] costs approximately \$4-5000 for a 90 day supply, also [REDACTED] is also expensive. Other normal drugs that are inexpensive such as [REDACTED] to have reaction issues with the [REDACTED], which makes you take [REDACTED] approx \$1600 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, [REDACTED] patients may become ineligible for [REDACTED].

I have had no issues with getting my [REDACTED] medicine for the past six years, my [REDACTED] was in October 2012. 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 my Dr issued a [REDACTED] medicine for [REDACTED] problems associated to side effects from other required meds. It would have been nice to have had a heads up about needing pre-authorization for pain meds. 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, requiring [REDACTED] medicare is offered as an option to pay for procedure, and required medication for [REDACTED] medication. 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 I will turn 65 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?

([wwhite](#) [REDACTED])

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?

([wwhite](#) [REDACTED])

I will be on the road in the [REDACTED] 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 addiction to opioids. (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 husband was not retired 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 3 close friends with chronic diseases and/or genetic conditions 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 some of my Juneau friends 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 a [REDACTED]...they paid for the diagnosis of the [REDACTED], but not the treatment to stop [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 clients die before their appeal process with Social Security finished...death proved that they were ill, 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 step (me!) for 10 years 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 my [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.

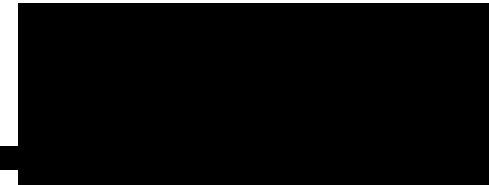
This communication is clear as mud. Be honest. You can’t save \$60-80 million and only add benefits. Be honest about what we will face—more disapprovals of medications, more approval hoops to try to navigate, and what does Federal Reimbursement to us as individuals mean?

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



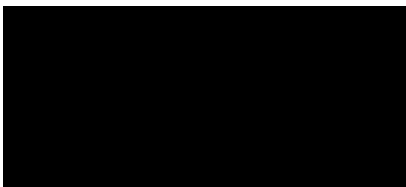
Explain to Medicare Retirees that you are basically NOT providing us with a new pharmacy vendor but you are putting us in a special Medicare Part D program that has flawed reimbursement methodology as if everyone is on an HMO when most of us are in a PPO. See below!

https://www.ahip.org/wp-content/uploads/2017/03/MA_EGWPs_FINAL_324.pdf

Shared via the [Google app](#)

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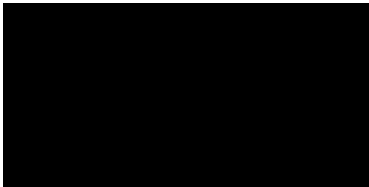
1. Will we be able to get 90 day supply of medications in the new drug plan without enormous hassle? I travel for months at a time domestically and internationally.
2. As I have [REDACTED] with [REDACTED], can I still get brand name [REDACTED]
3. I pay Medicare deductibles as does my spouse. What deductibles 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

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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.

What if I wanted to be in Optum RX and not Medicare Part D. Can we have that option?

Pat

Patricia A. Book, Ph.D.
Consultant, Writer

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continuing and distance educator, University academic administrator



We want you people to leave our ins alone! we want no part of your prescription planwe want things just left alone....nothing absolutely NOTHING in your new plan is of any benefit to retirees and their spouses...

You are using double talk to confuse the issues...leave them alone...we saw what you did under the table to our dental plan a few yrs ago....just leave our ins alone....you are only concerned about YOUR pocketbook...not the retirees who struggle from payday to payday....

Dan & Nita Young...

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

From: William Ennis <[REDACTED]>

Sent: Tuesday, August 07, 2018 3:56 PM

To: Member Svcs Contact Center Queue, DOA DRB (DOA sponsored) <doa.drb.MSCC@alaska.gov>

Subject: Health Benefit Comments

Dear Sir or Madame,

I taught in the Anchorage School District for 26 years, for the great portion of that time at East Anchorage High School. During those years, I was the first recipient of the BP Teacher of the Year and the 1999 Milken National Teacher Award. It is both my right and responsibility to respond to the proposed changes in the new "handbook".

As you are aware, Article 12, Section 7 of our Alaskan Constitution clearly states that, "Accrued benefits of these systems shall not be diminished or impaired."

As a member of RPEA, I am concerned with the unilateral use of the TPA's (Aetna, in this case) definitions. I will be [REDACTED] at week's end and after a career spent teaching Anchorage's students, the DRB has decided to reduce my benefits without negotiation and in complete disregard of an Alaskan-Constitutionally-protected contractual relationship between the state and the retired employees. Several three-letter acronyms came to mind when I learned of your actions, but in the interests of civility I shall refrain.

I stand firmly with my association's statement on this unwarranted diminution of our mandated retirement care. I am unsure whether the decision to move ahead with this by the DRB assumed that we were asleep or that we didn't care if our health care is decreased, but can assure you that neither is correct.

It should be your job to ensure that the system is adequately administered, and not to squeeze every penny from a contractual obligation between the State of Alaska and the retired public employees. It certainly seems that DRB is slowly reducing our health care by picking away at definitions and the like in the hopes that it goes unnoticed. If that's not the case, we would all appreciate a more clearly stated rationale.

Regards,

William Ennis
[REDACTED]

"A casual stroll through the lunatic asylum shows that faith does not prove anything."
Friedrich Nietzsche

Please share copies with each member of the board'
Thanks
Dunc

Duncan Fowler



8-9-18.pdf

Duncan C. Fowler

August 9, 2018

Senator Judy Salo, Chair
Alaska Retiree Health Plan Advisory Board
6th Floor State Office Building,
PO Box 110203,
Juneau, AK 99811-0203

RE: Proposed changes in the retiree medical plan

Dear Senator Salo,

It is my understanding that the State is considering significant changes to the retiree health plan. I am also aware that the benefits that retirees have earned by their service are guaranteed by the Alaska Constitution to not be diminished.

I worked for the state starting in April of 1968 to June of 1994. (I worked for the City and Borough of Juneau for 19 months during that time but remained a member of the State Retirement System.) My family had many "Alaska experiences" both good and challenging over the years, as did many of us who came to the state in the late 50's-60's. In retrospect I learned a lot and had great opportunities to help hundreds of people in my jobs as a Probation-Parole Officer, Regional supervisor and manager, Criminal Justice Planner in the Governor's office and finally as Alaska's Ombudsman appointed by the Legislature.

Since my retirement from Alaska I have tried to stay involved with the Ombudsman profession as well as Alaska. I have volunteered to help the Retired Public Employees of Alaska (RPEA) in their efforts to keep our retirees informed of their health benefits and provide help to some who needed help appealing denials of their benefits. These are things I enjoyed doing but never thought I would personally need.

Well, last September I received a [REDACTED] as I was getting short of breath. After the surgery I anticipated that I would just bounce back. I was put in a [REDACTED] program and the staff noticed that I was still [REDACTED] harder than I should and that my [REDACTED] content was low. They had me evaluated by a [REDACTED] I sought a second opinion at the University of Minnesota's Center for Lung Science and Health. It is nationally known as an excellent center for [REDACTED]

My doctor at the U added that not only did I have [REDACTED] he also believed I had a touch of [REDACTED]. He immediately placed me on a drug called [REDACTED]. It is only one of the two drugs that have been cleared by the FDA for treating [REDACTED]. And neither of these drugs can cure [REDACTED]. They only slow the advancement of further [REDACTED]. Medical books I have read rather consistently note that after an [REDACTED] I am optimistic that I can do better than that as my doctor indicated that I appeared to be a slow developing case.

I have been following research efforts. Some sound promising even to the point of dissolving the [REDACTED]. But, based on that, I would need to become a mouse 🐭 I am very hopeful that someday a real cure for [REDACTED] will be found. If and when that happens I would want access to that drug as soon as it is approved by the FDA. I don't want future changes to my health benefits which are guaranteed to not diminish. Understanding all that above I am concerned in what I have read in the "Modernization" proposal – the introduction of step therapy for drugs.

EACH DAY COUNTS for me!

It is my understanding that the State of Alaska is not required to participate in EGWP and that it is voluntary on the state's part. As such it must be very cautious in any reduction of benefits or extra funds retiree's must pay for their benefits. If the state allowed that to happen I see more litigation again and more charges to the Health Trust.

I am also aware that step therapy is not a requirement of EGWP, but research shows that it is built into Medicare Part D plans in their attempt to pay as little as possible. DRB claims that step therapy will not be a part of the EGWP/wrap plan, but there is serious concern that DRB may not be allowed to change the design of the Medicare Part D plan it chooses to enroll retirees in resulting in step therapy being implemented in the retiree pharmacy plan.

I am aware that "Step Therapy" is being considered as a way to save funds for the Trust and it appears that DRB is attempting to implement it not directly, but through the Medicare Part D plan where it will not be transparent to retirees.

I object to any consideration of Step Therapy either as part of the EGWP/wrap pharmacy plan or as part of DRB's 'modernization'

Understanding all of this, I think it must also be understandable that I don't want to be put on any sort of "Step Therapy" or have my doctors need to argue with drug plan managers over what is the right medication I should be receiving. I am feeling now like each day is a gift. And being an optimist, I am also watching and following various research on curing [REDACTED]. If a new promising drug is approved and my doctors feel it might work for me, I certainly don't want to wait while drug plan managers think about it.

Again, I am fully aware of the contractual guarantee that the Alaska Constitution made to all retirees about not diminishing earned benefits. And I am also knowledgeable about the fact that legislators over the years have granted retirement benefits to groups of employees and not provided adequate funding to cover those benefits. It is not the responsibility of those who are retired to cover those shortfalls. It remains the State's obligation just as implied in our Constitution.

Sincerely



Duncan C. Fowler

CC:

Members of the Health Plan Advisory Board

Cammy Taylor -Board Vice Chair – PERS Retiree

Mark Foster – PERS Retiree

Joelle Hall Public - AFL/CIO – Public Member

Gayle Harbo -Alaska Retirement Management Board – TRS Retiree

Dallas Hargreaves - CBJ Personnel -Human Resources Official

Mauri Long – PERS Retiree

Michele Michaud, Chief Health Official, Alaska DRB

Sharon Hoffbeck, President, RPEA

Good afternoon. My name is Sheila M. Short and I am a State of Alaska Retiree residing in Oregon.

I retired from the State of Alaska on August 31, 2015 as a tenured Tier I employee. My husband and I now reside in [REDACTED], Oregon.

We are extremely grateful to have our wonderful insurance through Aetna. We see many people where we now reside without adequate insurance.

I was dismayed to find out how old this retiree plan is. It is my understanding the Board is conducting meetings and considering updates.

I am requesting that the Board seriously consider the following updates which affect my household as well as other retirees; they are as follows: Preventative health care as well all immunizations as well as accupuncture. I will provide an important example for you that affected me last year. Every year for all of my adult life I have had [REDACTED]

[REDACTED] When I went to my doctor here in Oregon last year I did not know these types of tests are not covered for retirees and that [REDACTED] me over \$400 out of pocket!

It would be wonderful to see these routine tests added to the plan, its cost prohibitive to my household.

Also, immunizations are not covered, not even flu shots which we always have every year. I also had checked into Pneumonia Vaccine Shots which are critical for my husband as he has [REDACTED], and for my health as well-Even at Costco they are over \$200.

I had also checked into accupuncture and was advised that for retirees it is not covered.

Please take steps at your earliest convenience to update this plan to include all medical tests and immunizations and accupuncture for retirees.

I thank you all for your valuable time and sincerely hope that you will hear my concerns. I hope to receive a response if possible. Thank you again.

Sheila and Randy Short

[REDACTED]

hello:

I have the following comments on the revisions for the EGWP drug program and the "changes in the draft medical booklet."

Dental coverage billing for out of network, in state, under Moda has diminished. Network dentists are paid at 100% of the covered expense, 100% of the accepted filed fee, 100% of the billed charge.

The out of network dentist is subject to being discounted 2 times which is blatantly unfair and a diminished benefit. The 80th percentile of the prevailing rate charge as determined by Delta Dental in accordance with its' reimbursement policies, whatever those are. The second discount is then 75% of that.

If Delta insists on penalizing retirees who use out of network dentists the discounted reimbursement should only be based on Delta's known "network dentist" rate.

The SurgeryPlus network for the Seattle area only lists Virginia Mason. Swedish and University of Washington are not listed. This is not a good situation. Each of those hospitals have their own areas of expertise and resources.

The IRMAA aspect of the EGWP program is opening a pandora's box. It will add to the administrative burden of the retiree as well as the Alaska DRB.

The state admits it has no idea how many people will be affected by the IRMAA requirement. The state has no access to employee tax information and hasn't figured out what IRMAA documentation will be required.

Medicare has been changing the income limits for the various tiers subject to IRMAA. More people are being moved into the higher cost tiers. DRB is going to have to stay on top of these types of changes.

Publishing the IRMAA table as an explanation of impact, subject to change is a terrible way to address this issue. IRMAA is anything but simple. I have first hand experience with how much trouble can be created with this and how difficult it is to correct. This table changes annually so should not be published in the pamphlet but instead referred to the medicare web site.

I hope DRB has staff educated about how IRMAA works. CMS is worthless for information regarding Medicare Premiums and adjustments, they only deal with Medicare Benefits. They hand premium questions to local Social Security offices. I have first hand experience how much difficulty SSA staff has trying to figure out how IRMAA is handled.

There is no clear picture how IRMAA adjustments will be made for EGWP.

Will the Part D IRMAA be separate from the Medicare IRMAA? If Social Security rolls into a single amount charge, which seems to be indicated by the Medicare pamphlet for higher income individuals, good luck with sorting that out.

How is enrollment going to work? Retirees must enroll in Medicare parts A & B at age 65 1/2. Will they be directed to a state web site to enroll in the EGWP or will anyone medicare eligible be automatically enrolled by DRB?

Will the State of Alaska provide separate 1095 B or C forms to cover enrollment in the EGWP?

IMPORTANT ISSUE:

The only communication Social Security provides in regard to Medicare premiums is an annual letter issued in Nov that estimates the amounts for the coming year, acknowledging that the final amount may differ.

Information is provided for IRMAA the adjustments. There are no emails or monthly statements issued by Social Security when benefits are paid. If you have established an my social security account you only have 30 days to retrieve that month's break down of benefits and deductions. After that month, that information cannot be expanded.

This also gets more complicated if a retiree with Medicare is not drawing social security but chooses to work beyond normal retirement age. They are set up with a quarterly payment plan to CMS. The CMS accounting system is a complete mess that befuddles Social Security employees trying to research it.

The situation gets worse when a retiree actually retires and starts drawing social security. Already paid quarterly prepayments to CMS aren't factored in when starting social security so Medicare adjusted IRMAA premiums get double charged. Lots of "fun" to sort out.

The IRMAA amount is based on data from adjusted gross income (MAGI) 2 years previous. A new retiree, should have a lower income but unless they file a life changing appeal with Social Security they will be charged the higher IRMAA based on their 2 year old adjusted gross income.

The state has not made it clear where the money will be coming from to fund the IRMAA reimbursement amounts. Will this be subject to legislative approval in a manner that might not be funded?

If the state has to set up individual HRA accounts for every retiree subject to IRMAA, again a big administrative burden for both the state and the retiree to administer it. Having an HRA pay CMS directly automatically is a VERY bad idea given how poor the CMS accounting system is and how difficult it is to get meaningful explanations of payments/credits from CMS. Again, retirees have NO access to examine Medicare premium credits.

If CMS isn't paid directly, how will the state handle reimbursements? Will retirees have to apply for payment? This REALLY needs to be carefully thought out and explained. As it stands now, 1099R tracks the gross amount and the smaller gross amount that discounts the prepaid tax value. Will there be any changes to how that is handled for reimbursements?

Will the monthly statements for retirement benefits start using the adjustment column to document IRMAA adjustment credits?

Given the fact that the IRMAA adjusted premiums will change from year to year and the state is trying to throw the burden of providing IRMAA information on the retiree, I see an administrative nightmare ahead.

This statement from the DRM 7/26 board packet shows how incomplete the thinking really is on this complicated important issue and how additional burdens are going to be placed on retirees.

"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."

Data security: The requirement retirees might have to provide their tax returns so DRB can handle IRMAA reimbursements is a very BIG privacy issue. The state has demonstrated being unable to protect retiree data due to theft of that data. Why should I provide tax return data to a system that has security problems.

I believe the state is under estimating how many people have post office boxes for addresses. Residency determination is going to be a difficult requirement.

Retirees living in the bush where there are no network pharmacies will be subject to paperwork issues having to file for reimbursements if the PBM can't bring those pharmacies into "their network". The PBM will not likely understand the cost of doing business in bush alaska.

The PBM should provide a list of which pharmacies are considered currently in network for the rest of the state.

If a retiree travels overseas, what will happen to drug coverage? Medicare Part D doesn't apply, if the PBM doesn't see an approved Part D claim will they deny the claim and force the retiree into an appeal process?

For a retiree who lives out of the US, they will be forced into the Opt-out plan to continue at least some sort of coverage?

The appeal process for denied drugs as outlined in the 7/26 packet is terrible. Removing the state from the process is not good for retirees.

Characterizing the changes being outlined as minor is anything but true.

peter stern

Thanks for forwarding the report from Legislative Research. We certainly understand the whole EGWP better because of that report. We think most of our questions related strictly to the EGWP have been answered. However, at the present time DRB/DOA is also conducting an effort to modernize the healthcare plan. It looks like it contains yet more changes to pharmaceutical benefits on top of the proposed implementation of the EGWP. Since we are just beginning to understand the EGWP, we are concerned about DRB/DOA proposing changes to a plan not yet in place.

The EGWP and the Public Process

We noticed in the report there was a comment that DRB felt that there was a lot of misunderstanding of the EGWP. The EGWP is a very complicated issue especially for us as retirees. We think that if DRB/DOA was more proactive, more transparent and improved their communication with retirees it would go a long way towards taking care of misunderstandings. It does not appear to us that DRB/DOA actively informs retirees of actions of any kind that they take regarding our healthcare or other issues either for that matter. It is our understanding that DRB/DOA puts info on the website and assumes that retirees will see it. The only reason we became aware of not only the EGWP but also the modernization of the whole retiree health care plan is because RPEA has informed us. Most of our understanding of retiree issues has come from RPEA not from DRB/DOA.

The EGWP and the Modernization of Retiree Health Care Plan

We do have a concern that is not addressed by this report from Legislative Research regarding the EGWP. As we stated above, DRB/DOA is not only proposing to set up the EGWP but also in a separate effort to modernize the entire retiree health care plan including yet more changes to the pharmaceutical section of our plan. It appears the additional changes to pharmaceutical are on top of the EGWP which is not yet in place. This is extremely difficult to understand.

We recognize that Legislative Research was tasked with reviewing only the EGWP proposal. But this additional effort by DRB/DOA to modernize the entire health care plan including the new pharmaceutical section which isn't even in place is extremely confusing. It would have been helpful if Legislative Research had had an opportunity to look at the modernization effort of the entire health care plan as well.

Regarding the Modernization

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 - the EGWP and then on top of those, as yet to be adopted changes proposing additional changes to the pharmaceutical portion in the modernization plan as a whole
4. The lack of contact, outreach, and education to retirees about what all these changes mean

SUMMARY

While we understand the EGWP better because of Legislative Research report we continue to be concerned about the fact that the EGWP is not in place, but the proposed modernization of the entire retiree health care plan contains even more changes to the pharmaceutical portion of our plan.

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.

We would like to thank Representative Josephson for his attempt to help us understand what is happening and RPEA for their efforts to keep us informed as to changes in our benefits.

Judith Anderegg and David Pelto
[REDACTED]

On Aug 6, 2018, at 2:52 PM, Megan Holland <Megan.Holland@akleg.gov> wrote:

Hello Judith and David,

Attached is the report we recently received from Legislative Research regarding the effects of implementing EGWP in the state of Alaska. Tom will be on vacation for the next few months, and he has instructed me to take over his work on this issue. Feel free to reach out with any additional comments or concerns. I will be in touch moving forward.

Thank you,

Megan Holland

Office of Representative Andy Josephson

1500 West Benson Avenue, Suite 403

Anchorage, AK 99503

907-269-0265

megan.holland@akleg.gov

Attached are my specific comments on the proposed changes to the Retirees' health care plan. I did not review any of the old proposed changes that have not implemented and were stricken. I looked only for the new text and stricken text from the current 2003 Plan.

I did not find any text referring to the use of Medicare Part D. If this proposal is still on the table, please advise me of the section in the Plan that details how this will work.

Valerie Horner
Tier 1 Retiree

Sent from [Mail](#) for Windows 10
August 8, 2018

My analysis of the proposed changes to the retirees' health care plan is as follows:

- 1) In general, the document puts total control into AETNA's hands regarding what is and what isn't covered.
- 2) What happens if our next provider isn't AETNA?
- 3) A few typos but only commented on one that didn't make sense in the sentence.
- 4) The penalty of \$400 in some places says "may" be applied and others say it "will" be applied. Perhaps the circumstances differ so judgement is needed, but sections should be double checked to determine if they should be consistently applied.

In section 1.1: Travel benefits: limits to lodging at \$80. The listing is inconsistent with other language in the Plan that details the \$80 and \$31. I was confused as to exactly what the allowance is intended to cover. It implies in this section that it is a "per diem" to be used for lodging, food, etc., but in following sections, if you look for it, it implies that it is not for lodging, etc.

If it is for lodging, then it is unrealistic. From Juneau, emergency travel will be to Seattle or Anchorage. You might find lodging for \$80 at a substandard hotel during the winter, but definitely can't in the summer. Plus, locking it in to \$80 now does not allow for inflation in 5 years or 10 years, creating a need to go back and modify the health plan again. Another part of this is \$31...same applies. The language has been taken out describing what the allowance is expected to cover so now it lumps land travel costs, food, etc. into the \$31. If you are out in the edges of Anchorage or Seattle to find a room at \$80 you will likely pay more than \$31 just for the taxi to get you back to the airport.

Or, there should be a chapter reference to get more details on what you expect the allowance to cover.

I had a [REDACTED] in October 2015. I was [REDACTED] from Juneau to Seattle. My stay at the hospital was 2 nights (Wednesday and Thursday). [REDACTED]. The surgeon released me on Friday morning (saving hospital fees) but required me to stay one night at a nearby lodging before flying home to Juneau, "...just in case there is a problem with the [REDACTED]." I stayed at an old hotel in a very tiny room where clearly the bathroom was an addition after indoor plumbing was invented. The room was \$125 a night. The only reimbursement approved was for my flight home (thank you, Alaska Airlines for finding me some discounts!). It took me over an hour to walk from Virginia Mason Hospital to the metro station so I could catch the monorail back to the airport. My hotel room was not reimbursed

nor was my transportation to the airport. Yes, I did appeal trying to get the hotel room and the metro fare reimbursed but the denial was firm.

In section 1.2: no mention of out of network pharmacy. How much do we pay if it is out of network pharmacy? If there isn't a difference, then the word network should be removed.

In section 3.1.4: Giving authority to AETNA as "...in accordance to AETNA reimbursement policies..." allows AETNA to call all the shots. I see this as a decrease in our level of benefits, especially if AETNA is determining this based on costs of care that might not any relationship to where the medical service is provided. This is totally a judgement call for the personal processing the claim. An appeal is likely to do no good to the patient as this section gives AETNA full authority to make the decision.

Personally, I have had AETNA deny or greatly reduce a payment based on "reasonable and customary". When I called and asked where was the "reasonable and customary", one person told me it was "Alaska" and another said "Southeast Alaska" another said the zip code at my address. At the time, only two urologists practiced in Southeast (2010), one in Juneau and one in Ketchikan. We were in [REDACTED]. The response simply did not make sense. I never did find out why or where they figured out the reasonable and customary amount.

Also in this section the term "geographic area where the service is furnished as determined by AETNA." My service is in [REDACTED] Alaska. Is my geographic area "as determined by AETNA" Alaska as they search for a cheaper rate or is my area Southeast Alaska, or is my area in my zip code, or the provider's zip code? This is too vague a statement, and even in an appeal it is likely the patient will lose because the language leaves it up to AETNA to determine. The original language provided for judgement on services and specifically uses Juneau and Southeast as an example is sufficient. The language now makes it less specific and left up to AETNA. I see this as a decrease in the level of benefits. Nothing is wrong with the original language.

Again, throughout this section we give total authority to AETNA to determine "reimbursement policies". The State of Alaska and the Retirees are customers, and AETNA should be dictated to, not dictating to the Retirees and DOA. Supposedly AETNA is following Medicare's policies, but Medicare is subject to federal changes that might actually reduce the level of services and benefits - I understand the Duncan lawsuit prohibits reduction of benefits. Acceptance of this language does indeed allow reduction of benefits if the federal Medicare program reduces coverage. In this political environment, it is certainly possible.

Personally, in 2017 I had a [REDACTED] that could not be treated in [REDACTED]. Medicare paid for the diagnosis and denied the treatment! I did appeal it with Medicare and they returned with the decision that it was "a service not covered". AETNA paid, as it was intended, what Medicare failed to cover.

Changes must preserve our level of benefits under our State/Tier 1 medical coverage and this section would fail to do that if it is something Medicare doesn't cover. By allowing AETNA to call the shots based on Medicare, this section will decrease the level of benefits to retirees.

In section 3.2.1 that describes Precertification Procedures, if a call is made does AETNA provide a Precertification number so that there is a "trail" that it actually was approved? It dictates that written instructions will be provided, but where is the proof of the required phone call and approval?

In section 3.2.2 there is a list of services requiring precertification. “Transportation” covers non emergency air and ground travel. Then there is “Travel” listed...this section is too vague. Isn’t it covered by the sections called “Transportation”?

In this same section, this statement “Those furnished only because the person is in the hospital on a day when the person could safely and adequately be diagnosed or treated while not in the hospital; or...” seemed reasonable and why I was released from the hospital on Friday after my [REDACTED] but required to stay in a nearby (rundown) hotel to ensure I was close to the hospital if I suffered a problem with the [REDACTED]. However, the \$125 hotel cost was denied. Maybe I should have twisted the doc’s arm to justify another day in ICU! See my comments in section 1.1.

In section 3.3.6, you change the penalty amount for failure to precertify from \$200 to \$400...how is this NOT a “diminishment” in the coverage?? This change is obviously a negative change to the existing coverage.

In section 3.3.7 discussion of the \$400 penalty, unlike other sections, says the penalty “may” apply and the word “will” is specifically stricken out. This should be consistent with other sections applying the penalty, and who makes the judgement call on “may”. It gives permission to someone to decide to apply it or not. Same in section 3.3.5. If it is intended to be a judgement call, then more guidelines need to be defined.

In section 3.3.8 and 3.3.9, see the note in 3.3.6.

In section 3.3.10, this statement needs to be removed “However, to avoid duplication, the attending physician is encouraged to share...” as the word ‘encouraged’ adds nothing. You can “encourage” all you want but is it enforceable? It is left open to a very big judgement call. Should whoever processes the claim make the judgement that the original x-ray on an antique machine should be “shared” vs. a state of the art new machine used by the specialist running a new test? The physicians should be deciding whether another or current test or x-ray or whatever should be used, not whomever processes the billing. It has been my experience that the physician/specialist does want records, test results, etc., that have been done by another physician. Frankly, equipment in many Alaskan communities is not replaced often enough to keep up with better technology. Specialists and urban hospitals are more likely to have better technology.

In section 3.3.18, see comments in 1.1 and 3.2.2 regarding travel costs limited to \$80 and to \$31. The second bullet is confusing when read with 1.1 and 3.2.2, and how does this connect to the paragraph in 3.3.18 that follows the second bullet? The text seems to contradict itself. In the other sections, it reads to me (maybe I read it wrong) that the \$80 and \$31 is intended to cover lodging, food, taxi, etc., but the text after the second bullet now says it doesn’t cover those items. So what exactly is it supposed to cover?

Section 3.3.18 also contains text that the penalty for failing to get precertification is \$400. This increases the penalty and that is a negative change to the current penalty.

In section 3.4.4, how do these bullets apply to hospital administered drugs? • Any drug entirely consumed at the time and place it is prescribed. • The administration or injection of any drug. Also in

this section, is that a typo in bullet six using the word “signal”? If you substitute the word single, it still isn’t clear what is meant. Being specific about “smoking cessation” drugs means any new treatment on the mark but more effective or less side effects will not be covered unless we go through another revision of the booklet. This needs rewriting to mean what is intended.

In section 3.5.1, the new paragraph that starts out “however ...” to rewrite it “These exclusions do not apply to...” The word however is unnecessary and using “do not apply” takes out any judgement calls. Also in this section, the bullet “Aetna determines, based on at least two documents of medical and scientific evidence, that you would likely benefit from the treatment”, who produces the documentation? Can the attending physician/specialist produce acceptable documentation? This seems like a hole, especially in new treatments for cancer and other chronic or terminal illnesses that AETNA may not recognize. This will cause appeals or unnecessarily denied benefits.

Also in 3.5.1, “There is an ongoing clinical trial. You are enrolled in a clinical trial that meets these criteria: “

The requirement to meet ALL criteria is excessive. For example, a treatment at MD Anderson Cancer Center that is still in clinical trials, is proving effective, and yet not met every listed criteria would be disqualified. It is a cancer research hospital. It seems probable that a clinical trial would meet most but not all of the requirements.

Section 7.1.5, the first paragraph is incomplete. Contained in what?

Section 8.14.4...just saying this never happens. No specific details in the denial. Number codes used that are generic “service not covered”. No specific references to our health care plan. No description of what is missing that is preventing payment.

When I looked at joining the Alaska State Troopers in January 1973, the pay wasn't much compared to the wages I was making at the time. However, I looked at the benefits during employment and after I retired. I gave the State 26 years and did my best to fulfill my contract or obligations I was committed too.

Now, it seems all the benefits pertaining to our health from dental to vision is being reduced or completely removed. That was not I signed on for and have expectation of retaining what was in writing at the time I retired and not be removed or traded off.

(Bradley)

To whom it may concern:

I do not think that the new 2018 Draft Plan Booklet makes understanding the benefits any easier.

For example: I am trying to understand if my [REDACTED] are covered. He's had [REDACTED] [REDACTED] for many years, had several surgeries and ongoing treatments. When he had [REDACTED] done in 2013, the procedure was covered by Aetna (Medical Plan). He now has had two more [REDACTED] done and coverage was denied by Moda Health. Reading through the various plans it is my understanding that the [REDACTED] should be covered but I don't know how to go about getting them covered.

Perhaps someone could comment on this.

Thank you,

Christel Petty

To: Retiree Health Plan Advisory Board

I disagree with DOA / DRB's statement that the drafted revisions of the Defined Benefit Retiree Insurance Information Handbook is NOT adding, removing, or changing plan benefits.

As DOA have been made aware, Article XII, § 7 of Alaska's Constitution provides that membership in a state employee retirement system constitutes a contractual relationship and the accrued benefits of these systems "shall not be diminished or impaired." The Alaska Supreme Court has held specifically that medical benefits available to retirees are part of the benefits protected by the Alaska Constitution, and that health insurance coverage therefore may not be diminished or impaired. Changes are permitted, but only to the extent that any disadvantages are offset by comparable advantages.

When Commissioner Curtis Thayer selected Aetna as the third-party claims administrator of the retiree medical, visual and audio health plan (Plan) in January of 2014, retirees' coverage and benefits were depreciated. This change permitted Aetna, without oversight by DRB, to use its own clinical policies and discretion in determining coverage and benefits under the Plan resulting in substantial diminished benefits and wrongful denials of claims often leaving retirees little recourse due to a very convoluted and flawed appeals process. Aetna's reduced coverage for chiropractic care plus physical and massage therapy services, restrictions in the provision of medical travel benefits, new pre-certification requirements on medical treatment, and denial of coverage for certain prescriptive drugs and medicines previously covered and paid by the Plan before January of 2014 are examples of this impairment to our medical benefits.

Without seeking the input of the Alaska Care DVA beneficiaries, DOA also repealed the provisions of the retiree dental insurance plan that had been in effect through 2013, and hastily implemented the Moda Delta network, effective January 1, 2014. The Moda plan significantly reduced the excellent dental benefits and coverage available to retirees who had initially opted into the Alaska Care DVA plan. It negatively affected both preventive and restorative dental care for retirees and also penalized Alaskan resident patients who use services from a provider who is not part of the Moda network. Financial records didn't fiscally reveal the rationale for awarding our retiree dental plan to Moda. In fact, after the implementation of the PPO program, Health Deputy Commissioner Barnhill had to figure out how to pay down the six million **over funded** retiree DVA trust.

In order to protect the earned, constitutionally protected retirement benefits of all PERS, TRS and JRS retirees and their dependents, RPEA has found it necessary to file lawsuits against the State of Alaska seeking protection from diminishment or impairment of the retirement health plans that provide those benefits. These lawsuits are still pending in the Alaska court system yet the draft has clearly incorporated many of the changes made since 2013 that RPEA has challenged in the filed lawsuits.

DRB has systematically re-written the terms of the plan by imposing Aetna's policies to determine the Alaska Care Retiree Plan's coverage and benefits. No 'permanent' Retiree Plan document should ever institutionalize specific contractor (TPA) standards to determine plan

coverage. TPA contractors are employed only to administer the terms provided in the 2003 Alaska Care Retiree Plan as guaranteed under Alaska law.

Hence, the revisions to our Defined Benefit Retiree Insurance Information Handbook are premature. It should be obvious that a revised handbook should not be printed and distributed until there has been a final determination whether those changes made comply with the Alaska Constitution and the requirements of the Duncan v. RPEA opinion.

Sincerely,

Kathy Grabowski

A large black rectangular redaction box covers the signature and any handwritten notes that might have been present below the typed name.

Proposals by the Retiree Health Plan Advisory Board change the health plan retirees accepted as a guaranteed part of their retirement package. Expansion or diminishment of benefits as permitted under Duncan vs. RPEA increase benefits for some at the expense of reducing them for others. More effort needs to be made to notify retirees of the rationale behind specific changes that are vaguely referred to as “modernizing” and to provide an opportunity for input. Neither Aetna nor any other administrator should be in a position to promote its preferences for changes. Notifying retirees through a website is not sufficient before changes are proposed or finalized. Likewise a policy such as one implemented this year to arbitrarily restrict certain prescriptions (as happened to us) should never occur without prior notification. Proposals to extend coverage to dependents to age 26 and increase lifetime benefits have a significant impact on the wellbeing of others through offsets such as raising deductibles, redefining the definition of medical necessity, reducing physical therapy visits, dental implants and other benefits.

Rather than redefining medical necessity to restrict physical therapy or other therapies to a limited number of visits, the goal should be to return patients to their best possible function and/or relieve pain and suffering. In particular, a 20 week physical therapy limit per year for major surgery or injury is inadequate, as we know from [REDACTED] experience. A 53 page Aetna document full of medical legalese does not belong as a part of AlaskaCare. Disqualification of pre-existing conditions and ignoring the treating physician and therapist recommendations that could resolve a medical condition are in conflict with the original health plan.

Proposed changes to incorporate Medicare Part D require a thorough analysis, which is coming we understand, with an opportunity for input from retirees. Imposing Medicare rules, like possible denial of a prescribed drug and requiring a five step federal appeal process impose a scary scenario if that is a drug your doctor believes you need. The Step Therapy is another scary option. Both of us have had prescriptions with side effects, and we should not have to wait for an outside review by another entity rather than a change recommended by our physician.

The basic criteria should be to benefit the patient/retiree, not to conform to the plan administrator guidelines or to other plans. The State of Alaska must not relinquish control of AlaskaCare and final authority over claims adjudication. In the past we have twice had need to request intercession by the State and have had adjustments made in our favor.

Reprinting of the health care plan with finalized changes is badly needed; however, it should wait for completion of court review to ensure it reflects the correct information without requiring a second, expensive reprinting.

Other aspects of the proposed amendments may affect other retirees or us at another time; these are the ones we see now as impacting us. We hope issues that we and others raise will receive your consideration.

(Jack & Elaine Vander Sande)

In reviewing the new plan for pharmacy benefits it becomes very clear that this is an unconstitutional diminishment of pharmacy benefits.

With Alaska Care, the pharmacy benefit guaranteed to retirees remains within the authority of the State of Alaska.

Alaska has no authority over changes made to federal programs and removes the constitutional protections guaranteed to State of Alaska retirees.

EGWP is subject to the political whims of whatever administration is currently running the federal government.

CMS has requirements and impositions not currently in the constitutionally protected Alaska Care program.

EGWP puts all communications in the slow and cumbersome CMS pre-authorization, communication and appeals process.

EGWP has Part D pharmacy requirements not currently imposed on retirees.

Separate requirements based on income is confusing and adds to the paperwork burden of retirees.

All Alaska Care retirees have been told NOT to enroll in Medicare Part D and have been able to provide federal proof of health care and pharmacy benefits that EXCEED federally provided care. This alone proves an unconstitutional diminishment of benefits.

The change from commercial networks, formulary and clinical programs and placing them under the non guaranteed CMS requirements is also a clear indication of diminished benefits.

The mandate to fall under the annual changes and whims of CMS requirements with absolutely no guarantee of the continuation of benefits in the future or of constitutional protections is an absolute diminishment of benefits and is unconstitutional.

The switch to allowing the federal government to make decisions regarding medication prescribed by a physician removes the benefit of the physician actually knowing the patient and their needs and gives the responsibility to someone whose primary concern is the cost of the medication. Cost should be considered but not above the physician's detailed knowledge of the patient and their needs.

Retirees will no longer be able to use their current pharmacies where the pharmacist knows the patient and their allergies and the full list of medications used.

This plan makes it impossible for independent private pharmacies ***owned and operated by Alaskans*** to be used.

It is possible there are CVS pharmacies in the two largest cities, but what about the rest of us?

The burden of increased layers of appeal may be somewhat possible for those recently retired but is an unreasonable burden for those in their late 80s and 90s.

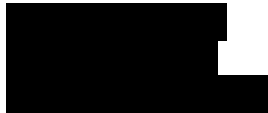
A phone call to the Department of Administration, whose responsibility it is to administer the plan, is a far easier task for the elderly.

There has clearly not been enough notification to those whose benefits are being diminished or removed in a few short months. This is inadequate time to respond to these very significant changes.

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Most retirees are completely unaware of this change.

Mary Diven



After sending comments on the AlaskaCare revisions earlier today we received an acknowledgement from the Advisory Board that included a website where the minutes of the July 27 meeting and discussion of the EGWP plan were available. After reading that, we are glad the Step Therapy in our comments would not apply.

As brought up in our comments and at the meeting, it is still a concern how to handle a situation where a medication is critical and a physician has not requested pre-authorization. An example in the minutes was after a [REDACTED] where the need might not have been known in advance, or what about a [REDACTED]? In our case it was discharge after [REDACTED] where the [REDACTED] was not covered because we and the physician/hospital in [REDACTED] were unaware of the need. There must be a way to reimburse the patient in such cases. In our case at our [REDACTED] we were told Aetna required that we drive 50 miles back to the hospital where [REDACTED] had total shoulder replacement the day before, a surgery known as one of the most painful. There we might or might not be able to reach the physician before close of business and through him get Aetna approval. Then the [REDACTED] would be required to hand carry the prescription back 50 miles to the pharmacy before it closed because the prescription could not be filled without his physical presence, then drive another 50 miles home hopefully with the medication covering one week. If the timeframes could not be met, he would have to suffer and hope to return the next day driving the 100 plus miles. A refill would require the same procedure. We chose to pay the two-week prescription ourselves and request reimbursement, which has been denied despite full, written documentation.

Keeping AlaskaCare provisions as outlined in the minutes where the EGWP program does not fully support them including the appeal process is reassuring. (Jack & Elaine Vander Sande)

Dear Sir,

I have a few suggestions that I hope you will take seriously as you renegotiate our current contracts. For those retirees on Medicare: most advantage plans that are out on the market offer any needed vaccines, acupuncture and Senior Sneakers (free or significantly reduced memberships). I definitely want to see acupuncture on the plan- not just for anesthesia. I pay for my dental and vision coverage as a supplemental through my Alaska retiree plan. I think the vision plan needs serious revision. Every time I try to purchase glasses I encounter problems with their offices. The charges always default to the Aetna discount plan-not the Atena Plan (card), which becomes a night mare to work through, and their is so little covered. The vision plan is not sufficient.

In terms of Delta Dental: we need a plan that includes full coverage for porcelain crowns for molars. This is just not sufficient to offer us only full coverage for gold (for molars). No one that I know wants metal showing in their mouths. When you do not use all of the coverage for a calendar year any remaining coverage should be able to be transferred to any remaining balance for crowns. I not only pay the 60.00 each month but then have to pay an extra 500.00 each year for a [REDACTED] [REDACTED] and need another one- which I have to wait until next year because it is too expensive this year to pay for two of them- and I am in pain). I also think seniors should be allowed to have three cleanings not two. Doctors used to be able to request three cleanings much more easily with Delta. Delta states it is Alaska Care that has made this now impossible- with the exception of full on periodontal disease. Many of us retirees have teeth with crowns and fillings and the three cleanings helps so very much in keeping periodontal disease from occurring in the first place. Please reconsider this.

Thank you for your review,
Kathleen Clarkson

To the Alaska Retiree Health Plan Advisory Board,

I received your email contact information today. I have a couple of comments/requests.

1. Vaccinations should be covered. They are preventive so this should save money in the long run. Contracting an illness and the subsequent Doctor office visits or ER visits and treatments must cost more in the long run. Besides the goal should be health and wellness and avoiding illness. It is costly on a retirement income to afford vaccinations. I just paid \$153 for the first of two doses of Shingrix. I have a friend who said he couldn't afford it, and guess what, he just came down with shingles, a very painful illness.
2. I take some [REDACTED], which are covered by Alaska Care retirement coverage. However the saliva test to determine my dosage isn't covered. This is ridiculous. I can't really afford the test so I end up delaying long past when it is due and beg my doctor for extensions on the medicines until I can get the test done for an update. Not covering the test for proper dosing of a medicine is just plain wrong.
3. It seems quite unfair for our dental coverage to not be double covered (spouse to spouse) when it was before retirement and our medical was and is. The subsequent percent we cover out of pocket can be quite high.
4. Dealing with Aetna when [REDACTED] or I have a question or issue has been worse than any company we've dealt with in the past. Previous companies had easy to follow EOBs. Aetna's are difficult to follow. When I called other companies I spoke to someone who understood the plan and rules and resolved issues. Phone calls to Aetna are pointless. The uninformed phone call receivers can't even forward me to someone who can help. They say all concerns must be sent in writing. That is just a lengthy delay and run around. No one has time for that. I for one am a busy person. None of my past health insurance companies had such poor and devious customer service.

[REDACTED] I hope you are able to review and improve the retiree plan. Thanks for your work.

Shelly Nielsen
[REDACTED]
[REDACTED]

Dear SOA DRB Staff & Retiree Health Plan Advisory Board Members,

I am a retiree of the State of Alaska, and am currently covered under the Defined Benefit Retiree Health Plan.

This e-mail is in response to your request for comments on your intention to publish an updated, "Defined Benefit Retiree Insurance Information Handbook".

Although I would encourage and applaud a simpler and updated version of our plan handbook, I DO NOT support your intent to publish a new handbook at this time.

There are currently lawsuits pending in the courts over past changes to the plan that have been made by the SOA. Additionally, the SOA is proposing other changes to take effect in January that impact members that are on Medicare. It's my opinion that publishing and distributing a new booklet before any major litigation is settled or before the proposed changes to members on Medicare are finalized would be premature and an egregious waste of our medical plan's funds. The reasoning for many of the plan's changes the last few years is to cut costs and protect the future of the fund. Publishing a handbook prematurely at this time is counter-intuitive to this goal.

In summary, a simplified and easy to use plan handbook is very much needed and a worthy goal. BUT, I am NOT in favor of the publication and distribution of the revision until the lawsuits are finalized and the plan stabilizes from the upcoming, proposed changes. The SOA and the Retiree Health Plan Advisory Board have a fiscal responsibility to use our medical plan funds wisely. Please postpone the well intentioned publication of this handbook.

Respectfully submitted,

Brad B. Zimmerman



I have attached my family's comments on the proposed changes

DB Retiree Health Plan Modernization – Proposed Revisions

It is my understanding that the State of Alaska, Department of Administration is once again planning to tinker with the retirees' health plan. The advertised goal is to make things better for the retirees and save money for the state; unfortunately, these two equation parts are not usually equal and normally find the retired employee losing something. Having spent many hours dealing with the state's many plan administrators over the past 10 years, I believe the desired cost savings could be found through a much better plan description, explanation and management.

Article 12, Section 7 of the Alaska Constitution states that "membership in employee retirement systems of the State or its political subdivisions shall constitute a contractual relationship. Accrued benefits of these systems shall not be diminished or impaired". There is a reason this was put into the Constitution to protect our elder Alaskans from attempts to downgrade the quality of our health benefits at a time when we would need them the most and would not have extra cash to pay for it out of pocket.

If the intent of these proposed changes is to truly improve and modernize health care for the retirees, I'm sure most of us would greatly appreciate it. If the intent is to save money by taking away the medicines and medical care we need to live a long, healthy life after leaving state employment where most of us gave many, dedicated years of our work lives to the state, then we have been lied to and duped. If this is where the process takes us, then remember: (as my mother would say) do unto others as you would have them do unto you when as retired employees your medical plan is weakened.

My specific comment on the plan:

1. Limited Preventive Care Services: Yes, the plan is inadequate in Preventative Care. So much so that many retirees joke that the plan does not cover preventative services which many other plans consider essential, because the state wants retirees to die off early to save retirement dollars.... a sad comment of the way they have been treated. Paying for that service is a concern, but many plans offset that cost by using the results of the preventative actions to head off more costly medical needs later on. Incentives for taking preventive steps may be a better course of action than penalizing members for these services. Not everyone has the spare cash to pay a large out of pocket and if that cost is too much, will only make the retiree forgo the preventative action costing the state more later. Any out of pocket cost should be available for meeting the annual out of pocket limit and not counting it is a double whammy for the retired individual.
2. Lifetime limit of \$2 Million: Raising the lifetime limit to a more reasonable amount makes sense, especially if many retirees are having a problem. I am curious, how many people do exceed the 2 million dollar limit and how much more does it cost the state to raise the limit?
3. Low cost share: What a crazy statement of concern! Because my out of pocket is not high, I don't know that prices are going up.... Really. Does the state think its retirees are stupid? First, the retirees are not responsible for cost increases. Second, we are not getting medical services we do not need I hope. The state promised these benefits in their contract with their employees many years ago and the employees agreed to work for the state instead of working with industry or outside of state government...taking less pay in many cases because of that contract. Now, is it really ok to raise the retirees' costs because the state believes its retirees are to stupid to realize costs for medical services have gone up???? Give us a raise in the monthly retirement sufficient to cover these increases and we can talk. State retirees are on fixed income.... A smaller increase might be more palatable if nothing else can be worked out.

4. Increasing Cost of Pharmacy Benefits: So, how many more members **do** use brand name medicationshundreds, thousands10? Where did these numbers come from? Do you really think the retirees trust Aetna's statistics? Has anyone looked into why a member uses brand name prescriptions? Do you realize how hard it is to get the pharmacies to fill a prescription with a brand name drug even when the prescription says that? While generics and name brands are all "supposed" to be the same they are not. Ok, this is not important to some people, but for others it is. This "concern" sounds like you will make it very difficult for some to get what they need. I don't know why the [REDACTED] med I take makes me lightheaded sometimes, but it does. The Brand name does not. It took me several iterations to find a [REDACTED] that works for me so I don't want to start all over again with some older type drug if this Pharmacy benefit is shuffled off to Medicare this would definitely be a decrease in my medical. Implementing a tiered pharmacy benefit was not listed in my agreement with the state when I agreed to work for them for over 20 years. When a generic works well for an individual, using a generic makes sense. No one should be penalized for having to use a drug that works for them. What is a preferred brand..... so now the state knows better than my doctor what medicine I need? Does DOA have a doctor on staff that has medically evaluated me and can prescribe drugs for me? A "preferred brand" is that which my Doctor prescribes.

There are no in network providers in the State of Alaska. If there were, the state DRB would send out an updated list every year so I could easily know who I could use. The list would be updated during the year if needed This would make life easier for everyone and help keep pharmacy and medical costs down. It would make life much easier if the state could figure out how to contract with a provider that actually was **in state**. I get really frustrated when my Urgent Care office makes an appointment for me with a doctor I later find out is not in the network.

I'm assuming since changing the prescription plan to Medicare is not mentioned here it is off the table where it needs to be.

5. Outdated Pharmacy Design: Not sure why this is an issue??? We have never been allowed to get more than a 90-day supply even when it made sense or there was an unusual problem that made it necessary. Same comment on OTC drugs. The local pharmacy tells me if a drug is covered or not and if an over the counter equivalent is available which I can purchase on my own.
6. Safety and efficacy of drugs: It would have been nice if this was explained a little better. I assume most retirees did not understand "non-bulk, FDA -approved legend drug"?
7. Limited Travel Benefits: Unfortunately, the cost of many medical procedures is so high in Alaska that travel outside to perform the procedure is cost effective for the state. To that end, it makes a lot of sense to develop a new set of procedure which allow retirees to get medical services outside the state.
8. Confusion over rehabilitative services: I thought the limitations were in place all ready? Clear, concise guidance what a novel thought. It would be nice to understand what is covered, how to get that coverage (if I hurt my back do I need a Dr referral or can I save the state money and go directly to the chiropractor, or physical therapy clinic? Was the possible solution 20 or 45 visits? Was that annual, forever, per injury event? If the state provided more general

information on injury diagnosis and rehabilitation to include general strengthening of the lower back, legs and feet, (preventative) maybe money could be saved here also maybe a lot of money. What you limit here may bite the state later if rehabilitation is incomplete. Not sure why the state wants to add another medical manager more wasted money. The key is not in who watches who, its in the quality of the rehab.

9. Confusion over dental implants: Is this a general thought so that the state can raise costs or a genuine need to clarify between the two causes for dental implants? Clarification is needed in many parts of the plan to help everyone understand their roles.
10. High use of Hi-tech Imaging & Testing: Yes, there is higher use of diagnostic and testing services Isn't it wonderful? The higher use is related to the recent improvements in technology which allow doctors to see things they couldn't in the past and conduct high tech quality surgeries. Isn't that wonderfulwhat was the question? Ok, we have more access to the high tech than we ever did before. Investigative procedures using these technologies have improved medical services greatly. Now if these diagnostic procedures are frivolous or dangerous, education on those subjects would be very helpful. Maybe use of a medical helpline would be value added here. Maybe a contract lab for the state in larger communities where lower costs were agreed upon?

And since you brought it up what percentage of the retirees are on Medicare? Since Medicare is primary and decides what is allowed and what is not and the state only pays a very small part of the bill, maybe the cost of the new technology is not that big of an issue after allat least for the majority of us???

11. Confusing Plan Booklet: Yes, the booklet is confusing and requests for something that works better for all has been asked for, for years. Even (especially) the plan administrators have had frequent problems understanding/interpreting the content of the plan.

Thank you for the opportunity to provide my thots and concerns about the retirees' medical plan. I'm sure a better, working plan can be developed if the state was willing to work with the retirees, instead of in a vacuum.

(Gerald & Cathy Guay)

I am a retiree and [REDACTED].

I asked the Division of Retirement and Benefits if coverage for [REDACTED] persons is on the list presented to the Retiree Health Plan Advisory Committee for consideration? I was advised that it was not. Please add this topic to your agenda.

To assist in your deliberations, I would offer the following.

Please see the link below and note the changes that were made to retiree benefits effective 1 Jul 2018, 1 Jul 2017 and 1 Jul 2015.

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

As a pertinent side note, ASEA Local 52, effective 1 Jul 2015 posted a PDF, which reads in part "Plan Changes Effective July 1, 2015 [REDACTED]. The Plan will cover medically necessary treatment of [REDACTED] including surgery and related medical treatment necessary for [REDACTED]."

It is my understanding that the coverage is retroactive to that date.

[file:///C:/Users/Ken/AppData/Local/Packages/Microsoft.MicrosoftEdge_8wekyb3d8bbwe/TempState/Downloads/benefits_ASEA-summary-benefit-plan-changes-rev08-2018-0701_2018-0628%20\(3\).pdf](file:///C:/Users/Ken/AppData/Local/Packages/Microsoft.MicrosoftEdge_8wekyb3d8bbwe/TempState/Downloads/benefits_ASEA-summary-benefit-plan-changes-rev08-2018-0701_2018-0628%20(3).pdf)

I am specifically interested in the State of Alaska retiree plan in "2) **Medical Expenses Not Covered** The following provision is hereby repealed: Services, therapy, drugs, or supplies for [REDACTED] or related to [REDACTED] or any treatment of [REDACTED]." which was amended to read:

"Amended provision to include the following limitation and exclusion: Any treatment, drug, (excepting [REDACTED]) and, service or supply related to [REDACTED], including [REDACTED] to [REDACTED], and prosthetic devices."

First, let me apologize for any errors in keying in the above sections. The PDF's are locked so I had to transcribe the verbiage manually.

My question is does the State of Alaska intended to update the retiree health benefit plan to extend similar coverage's as specified in the revised ASEA plan?

If not, why?

Having [REDACTED] is either a medical condition or it is not. I believe we can stipulate that [REDACTED] in fact a medical condition given the State's amendment of January 1, 2018.

I ask what the State's reasoning was behind the limitation to coverage to [REDACTED]?

One can reasonably argue that Aetna, the State's third party administrator, is a recognized expert in things medical, perhaps even stipulate that they are in fact an expert in things medical. It is my understanding that Aetna provides full coverage for its employees relating to [REDACTED]. As a for profit entity, Aetna clearly felt that providing the coverage to its own employees was in the company's financial best interest.

One can also argue that system wide, full coverage for [REDACTED] would not be a large sum of money given the relatively few people that suffer from [REDACTED]. Among the small population of persons suffering from [REDACTED] a significant number of people, I believe the vast majority, never intend, or in fact, do go for surgery.

I suspect that the total cost must be almost insignificant given the fact that ASEA Local 52 was able to provide coverage retroactively to their members with, I presume, no further contribution from the State. The legal term I've heard over the years is de minimis, or "too trivial or minor to merit consideration, especially in law."

<https://www.bing.com/search?q=de+minimis&form=EDNTH&mkt=en-us&httpsmsn=1&refid=594ad6e6175e45def88d1e5d10c86c8e&sp=1&ghc=1&q=SC&pq=deminim&sc=8-7&cvid=594ad6e6175e45def88d1e5d10c86c8e&cc=US&setlang=en-US>

Given treatment is demonstrated to significantly lower the risk of [REDACTED] ([REDACTED]), significantly reduces the need for [REDACTED], significantly reduces employee costs due to [REDACTED] and thereby reduces employee tardiness and absenteeism, etc., there may well be a net savings to a plan sponsor by providing all needed medical treatment for [REDACTED]

I can only presume that the State has considered all of the above, plus most probably, many other factors.

Having considered the above, I contemplated the possibility that some present or past policy maker in state government, based on a personal philosophical or religious belief system, might have made the decision to not provide surgical benefits relevant to [REDACTED]. But, in as much as there is a constitutional separation of church and state, I decided that most likely no sane person would have made that sort of decision. I recognize that the prohibition of some actions such as murder or theft may be both based on religious and social needs. That said I can think of no societal reason to reject such medically necessary surgeries as they impact only the person involved and have a major positive impact on the quality of life of that individual. Quality of life is generally covered, as an example, Viagra for men.

So, is the State going to amend the retiree health plan to provide full medical coverage for [REDACTED] [REDACTED] as already granted by ASEA with funds available? Was an actuarial study conducted at the request of the Division prior to their decision to not provide surgical services to [REDACTED] [REDACTED]? If so, what did the actuarial study find?

May I have a copy of the studies, analysis of the studies and copies of meeting notes that led up to the State's decision to not provide full medical coverage for [REDACTED] including why the decision

was made the way it was; ie you have a medical condition but we will only pay part of the associated costs?

Precedent is there where surgery is provided solely to improve the quality of life for an employee, for example, a woman has breast cancer, the breast (often both) are removed. The cancer is gone.

Yet the plan pays for reconstructive surgery for the woman in consideration of her quality of life. I see no difference between [REDACTED] and subsequent surgery to provide quality of life to a [REDACTED] person as provided to other employees and retirees.

Thank you for your help and I look forward to your reply.

[REDACTED]

My husband and I would be affected by the new plan. I am a group 1 Alaska State retiree, and [REDACTED] is a [REDACTED] [REDACTED]. My health plan covers both myself and pays [REDACTED] and [REDACTED] health plan covers [REDACTED] for me. Therefore, after deductibles are met we do not pay for doctor visits or for our drugs. In many cases we have tried the generic drugs and had reactions to some of them. 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

Draft DB Retiree Insurance Booklet

Comments from Gary Miller

The booklet lists Aetna as the TPA and their contact information. Does that mean that Aetna will always be the TPA? Maybe use “medical TPA” and “dental TPA”.

I really like the table of contents. It is excellent! There is obvious that a lot of work was put into the document.

On page three (3), the penalty seems unfair if it turns out the treatment was medically necessary. It feels like, “Ha! We got you!”.

On page twelve (12), “**2.5.2. Open Enrollment**”, do you want to state when the open enrollment period is?

On pages seventeen (17) and eighteen (18), Aetna is setting what it will pay. This seems to be a violation of the Alaska Constitution. The constitution and the Alaska Supreme Court decision would probably not allow Aetna to set benefits since the State of Alaska is self-insured and therefore setting rate, coverage etc. are its responsibility. I can see a potential lawsuit here. Currently, as the TPA, Aetna is supposed to be processing the claims only, on behalf of the State of Alaska, not defining benefits.

On page thirty (30), I really like how clearly medical providers is listed **3.3.3. Provider Services**

“If you do not have time to **received** written acknowledgement, you **must** call the claims administrator **before** you travel”.

On page 48, the word “received” should be “receive”. There are two locations on the page with the typo.

On page 49, one of these needs to be changed to correct the grammar. Inpatient treatment that **are precertified**, excluding provider services which are described above, is covered at normal plan benefits. Inpatient treatment received without

precertification is paid at 50% after the deductible. “precertified” needs a hyphen, “pre-certified”.

Page eighty-seven (87) needs the word “in” added. “The following covered persons should consider enrolling this program:”

Gary Miller



The proposed increase in the deductible and out-of-pocket maximum expenses would be hardship. We were promised a level of care for a lifetime of service. You are slowly trying to rob us of those benefits we worked so hard for. The increased cost of pharmacy benefits is another hardship you propose and a detriment to my family and their health. It is difficult enough now to survive the process of an appeal much less be successful in that process.

Change under EGWP with its substantially more difficult and time-consuming appeal procedures in nothing more than an outright denial and further the hardship and is a detriment to my benefits. The change to limiting hi-tech imaging and testing through in-network clinical review will cause hardship to a me and my family.

Thank you for considering this opinion.

Rosemarie Martell-Greenblatt

[REDACTED]

Commissioner Ridle,

In reviewing the remaining questions about the EGWP proposal, I wondered whether DOA has requested an AG opinion or guidance on two questions:

First, whether the Medicare Part D regulations and requirements for an enhanced EGWP, such as the one proposed here, require use of the Medicare appeal procedures, or if Medicare will grant a waiver to allow Alaska to continue to utilize its state-mandated retiree health care appeal procedures? If it has, can you share the opinion; if not, will you request an opinion on this?

In addition, has DOA made any formal or other type of request for waiver by CMS to allow Alaska to continue to utilize the existing appeal procedures under the current retiree health care plan? If it has, what is the status of the request; if it has not, does it intend to do so and when?

Second, whether an equivalency analysis under *Duncan* is required prior to implementing the proposed EGWP changes? If it has, will you share the opinion; if not, will you request an opinion on this?

If you decline these requests, would you please advise me why you are doing so? My purpose in making this inquiry and request is to see if we can obtain answers to these questions promptly, given the intention of DOA to implement the EGWP January 1, 2019.

Let me know if you have any questions. Thanks,

Brad Owens

Dear Sir/ Madame:

I am a State of AK Retiree Tier I... and I am married. I turned 65 last year and [REDACTED] this year in November. Which given this crazy plan .. it will impact us right in the middle of her sign up which she has already done and only signed up for Part A... NO Part D.... because we are covered by both my present employer and State of AK's pharmacy plan...

First off, I am adamantly opposed to the change concerning our pharmacy plan... The State continues to whittle away at our benefits with smoke and mirrors to justify their desire to decrease the State's costs to the detriment of the Retirees..

As we get older It is more difficult to navigate all the if ands and buts the State and the Federal government put in front of us as savings and supposedly simplifications... The reality is that you are making the whole process of getting the prescriptions more difficult for us and in the long run we likely are going to have to pay more for them because we won't be able to navigate the complex labyrinth that you have created. Not to mention any and all of the new pre-authorizations that we will need to go thru to get our existing prescriptions given the new requirements that the EGWP will be part of what we have to deal with... Stop messing with our benefits ... leave them alone.

Second, Neither [REDACTED] nor I have signed up for Part D nor Part B of Medicare because I continue to work and have health benefits from my present Employer... We both have signed up for Part A Hospital Coverage and nothing else (NO Part D)

Since both have not signed up presently for Part D... I am wondering how we are supposed to sign up for Part D sometime in 2019 when this boondoggle that the State is implementing without our concurrence is going to be allowed by the Federal Government (Social Security Administration)??? I have no clue as to whether Medicare will allow us to sign up for Part D in January 2019 ... despite the fact that this whole thing likely is going to go into litigation.... There likely is going to be a law suit to stay the action by the State. It is my understanding that if we don't sign up... we will be at risk for paying it all out of pocket...

What is going to happen when we go to refill prescriptions in December??? Will we still be covered by the old plan?? What is going to happen when we go to refill prescriptions in January?? The reality is nothing will be settled and we will have to pay for it out of pocket... because there will not be any kind of smooth transition... neither the State nor the Federal government is very good at any kind of transition... there will be all kinds of issues and guess who will take it in the shorts... .. You got it... the Retirees... but the state will be happy with all of its savings.. so much for taking care of the Retiree..

If we are to sign up... we will have to pay out of pocket for Part D... yea the State will supposedly pay us back later down the line but that does nothing for our day to day cash flow... If the State wishes to pay for the premium then make a deal with the Federal Government to pay it up front... The State has the long list of Retirees over 65 to calculate its savings... just multiply the dollar amount times those employees and send the Social Security Administration a check or wire the funds.. If you really are going to make this work... then make it work easier for the retirees.... Not harder..... If not .. then don't do the deal... We should not be forced into a system that costs us both in time, stress, and money... It is time the State stops jerking us around.. and makes life easier not harder..

This is absurd... this whole program is in flux and the State is just shoving it down our throats.. This whole thing needs to be put on hold until a very detailed analysis is done and factual information provided to ALL Retirees so that they can handle the issue.

I have received nothing in the mail on this change yet the State of AK has had my address since I retired and even when I moved south.. The State seems to find me as required by law to send me my 1099 R so it probably has my mailing address that should have been used to send me whatever information you are trying to trick us with. I just confirmed that my address is listed in Retirement & Benefits so there is no excuse for not sending me the info..

The only information I have received to date is from RPEA .. which does not say much for the State of AK keeping its employees informed... Essentially you are trying to ram rod this thru with as little resistance as possible!

Please step back from this whole mess and put it on hold... it needs a lot more work before implementation..
If not, it will likely cost the State in legal fees when a law suit is filed to stay it..

Eric & Mary Marchegiani

[REDACTED]

[REDACTED]

[REDACTED]

2018 Defined Plan Booklet Public Comment

From: Timothy Shine <[REDACTED]>
Sent: Sunday, June 24, 2018 1:04 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Draft of plan

The draft of the retiree health plan is so confusing and time consuming that it was useless for me (a retiree over 65). I could find no guide or directory at the front end that would put me quickly in the areas of my concern. I could not help but wonder why money would be spent for a September 2018 update of the booklet, when DOA is proposing major revisions to the Retiree Plan for 2019? The proposed changes, especially to pharmacy benefits for retirees over 65, as I have heard them, are most disturbing to me. They seem to be casting older retirees to the wolves in the interest of cost savings. This diminishment of benefits is a betrayal that I predict will be resisted by each and every retiree, like myself, that settled for lower than market wages on the promise that the State of Alaska would provide top notch health care in retirement. I will be watching closely for explanations and justifications by the DOA that violate the spirit of the contract Alaska has with it's retirees, and will take part enthusiastically in any legal effort to retain undiminished health benefits.

Timothy Shine
[REDACTED]

From: Terry Marquart <[REDACTED]>
Sent: Wednesday, June 27, 2018 7:11 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Cc: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <alaskarhpab@alaska.gov>; Sharon Hoffbeck <sharonhoffbeck@gmail.com>
Subject: Proposed Retiree Plan Booklet

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 husband has a medication that is administered through the skin with a patch. The generic brand has an adhesive that does not stick (my husband tried it) 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

From: Sally and Chuck Laird <[REDACTED]>
Sent: Thursday, June 28, 2018 9:44 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Feedback on DRAFT Retiree Booklet

Your draft is a good start, but to truly be up to date with "Best Practices", the booklet needs to be online in an electronic format. This means the booklet is like a website where one can look at the table of contents and click on a subject to which you are immediately taken. Right now, to see a subject, I have to "page down" or scroll—sometimes scores of pages. Just put it out there in electronic (e-form) to make it easier to read and navigate.

Charles Laird
Retiree
[REDACTED]

From: John Sadusky <[REDACTED]>
Sent: Thursday, June 28, 2018 10:26 AM

To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Benefits book

I looked over the changes you have made to AlaskaCare and I think this will be a help to all that need to use it. I would like to get a paper copy of the new book. When do you expect to have them available?

John Sadusky

From: Sue Royston <[REDACTED]>
Sent: Thursday, June 28, 2018 12:47 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: The new handbook

Hello,
I work with Cancer patients as a volunteer, helping them sort and chronicle their medical invoices/EOB's, etc. I'm a little concerned that people who have insurance coverage through the Alaska State Retirement system aren't always aware that they need to sign up for Medicare at age 65, thinking that they are already covered and don't need additional by paying for Medicare. They don't realize that their insurance will apply their coverage as though they have Medicare, whether they are signed up for Medicare or not. So many don't read through their handbook!

I'm wondering if there might be an "Alert" towards the beginning of the new handbook that would elude to this. Thinking of our seniors, especially those with exorbitant costs from cancer-related illnesses.

Thank you so much for your consideration,

Susan Royston
PERS Retiree
[REDACTED], AK

From: KEN & ANITA DUCKETT <[REDACTED]>
Sent: Thursday, June 28, 2018 4:35 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Plan Booklet

The booklet is pretty straight forward and easy to read and navigate.
I would have liked to read it with the strikeouts but the strikeouts obliterated the text so it was impossible to read.
I think there is a "typo" on page 61: "Any refill to cover a replacement...." you have "signal" where I think you intended to write "single"

Anita Duckett, retiree
[REDACTED]

From: Philip and Lynn Covlasky <[REDACTED]>
Sent: Thursday, June 28, 2018 9:51 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: re: plan booklet drafts

The updated plan booklet is definitely clearer and easier to read. I waded through enough of the marked up booklet to see what kind of changes are being made. I looked at parts of the updated clean copy and compared them to the present booklet. I am glad to say that I could find information more easily.

My one suggestion is to either number the booklet to match Adobe Reader or use the Adobe bookmarks. It is difficult to use the Table of Contents to find information when the page numbers are off by 18 pages! Since most insurance booklets are used online or on computer, it would make sense to set pages to match the numbering in Adobe Reader.

I am still learning what my benefits are and are not, so I look at the plan booklet often. Because it is so difficult to find pages that I refer to most of the time, I have printed sections of the booklet. If the sections were bookmarked in Adobe Reader, it would be easy to navigate the plan booklet.

Thank you for the opportunity to comment on the updated plan booklet.

Sincerely,

Alma Covlasky

retired teacher

From: Ben Hardwick <[REDACTED]>
Sent: Saturday, June 30, 2018 6:37 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: We Have Heard You!

Alaska Care is a wonderful health care system. Unfortunately, Aetna and the administration is not listening to the retirees. The booklet that retirees were hired under should be followed. For the past 10 - 12 years the booklet benefits have not been followed as they were before or to the letter. As you know the lawsuits have increased because of actions that have been taken to reduce benefits to MAKE the administration and Aetna follow the booklet benefits. All I see is a lot of effort to change the booklet. If I see the booklet change, I plan on filing a lawsuit of my own! Live Up to the Current Booklet First!!!!!! Do not continue to anger those you serve.

Sincerely,

Benjamin D Hardwick

Tier 1

From: Jean S Brown <[REDACTED]>
Sent: Sunday, July 1, 2018 3:01 PM

To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Draft Retiree Medical Plan Booklet

What an innovative, wonderful idea coming out of the State of Alaska! Many kudos to you guys!

I especially appreciated the references to the Alaska State Statutes and the Alaska Administrative Code! If we want to delve deeper for greater clarity, we can.

The easy reading format eliminates getting bogged down and overwhelmed by all the excess verbiage. Just the facts, please. This provides what we need to know without a lot of "stuff" to confuse the sometimes slower and more easily rattled mind.

This is a refreshing change. I looked at both versions. Thank you very much. I really like the idea of having this online, readily available. Please consider keeping the references. Jean Brown

From: Roger Helmer <[REDACTED]>

Sent: Wednesday, July 4, 2018 1:57 AM

To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>

Subject: Comments on AlaskaCare_Draft_Update_09-2018

1. Table of Contents (TOC) – it should be bookmarked so all you have to do is click on the page number, not have to scroll through to the page you want to read. Only some of the TOC are bookmarked.
2. Each page should have a return to prior page and/or return to TOC, not have to scroll all the way back.
3. All hyperlinks should be active.
4. All page numbers listed in body of text should be bookmarked so you could quickly go to the page referenced in body of text and return to prior page.
5. Life time limit says -- \$2,000,000 – is this correct?
6. Vision benefit year says – two lenses per year. Does this mean if only one lens has to be replaced at a time, this will be covered?
7. If one lens has to be replaced and then both lenses, will the cost of one of the two lenses be covered?
8. 2.2.1 – a space is needed – and the Teachers' Retirement
9. Need to give example of the following situation – out-of-network doctor expense covered vs in-network for the same treatment if expense for out-of-network doctor is above Recognized Charge.
10. Give example of out-of-network doctor charges and the 90% rule.
11. Give example of in-network doctor charges and the 90% rule, if it applies.

Roger Helmer

[REDACTED]
[REDACTED], AK [REDACTED]

Home: [REDACTED]

Email: [REDACTED]

From: Cheryl Plowman <[REDACTED]>
Sent: Wednesday, July 4, 2018 12:21 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Defined Benefit Plan Booklet comments

I prefer the draft with no markups. When you open the Defined Benefit Plan Booklet it should be the current policy with all changes added and could have an "as of" date at the top.

It would be very helpful and much appreciated if there was a way to search by key words or phrases rather than having to scroll through 175 pages and it would be nice to be able to click on the table of contents and have it go to that page.

Thank you,

Cheryl Plowman

From: S Harrel <[REDACTED]>
Sent: Thursday, July 5, 2018 11:16 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Aetna and [REDACTED]

Hello,

Our son has [REDACTED] and has received some medical treatment services in the past based on his [REDACTED] diagnosis. I just received a letter from the Retirees Alaska Care Aetna stating that medical services for [REDACTED] are not covered only the diagnosis is covered. See attached letter from Aetna.

My question is that in reviewing both the 2003 and the 2018 Retirees Insurance Information Booklet pre-certificated services for the treatment of [REDACTED] should be covered. My plan number is [REDACTED]. Am I wrong in how I am reading the plan booklets? Can you email me with the section of the booklet that states that treatment services for [REDACTED] are not covered? Or I can pull it up if you can give me the booklet page number.

Thank You,
Buddy & Sandra Harrel

[REDACTED]
[REDACTED] AK
Cell: [REDACTED]

Work number for Sandra Harrel: [REDACTED]

From: Steven M Cook <[REDACTED]>
Sent: Monday, July 9, 2018 8:18 PM
To: Michaud, Michele M (DOA) <michele.michaud@alaska.gov>
Cc: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <alaskarhpab@alaska.gov>; Sharon

Hoffbeck <sharonhoffbeck@gmail.com>

Subject: AlaskaCare Book updates

Hello Ms. Michaud

I got the postcard from AlaskaCare this past week and today took the time to download the draft of the rewrite of the Plan Booklet. Well, consider me confused, but there is no explanation to the file with the mark-ups in it. Some are self-explanatory with font and size changes, but nearly the entire rest of the booklet is either in red with lines through it, or green with lines through it. Some is green or red underline and elsewhere nothing is marked.

Are some parts being moved to another section or what? It's all very confusing and I wish there was some sort of legend or explanation.

Any insight would be most helpful.

Thanks

Steve

From: stampsalot Bruce <[REDACTED]>

Sent: Wednesday, July 11, 2018 1:58 PM

To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>

Subject: Plan Booklet Update Feedback

I received your notice that the Plan Booklet had been revised and, per your request, I checked it out. While I wasn't looking for anything specific, I did find it to be quite straightforward and it seemed very useable and arranged in a way that made sense. I approve!

Diana Bruce

From: Lund <[REDACTED]>

Sent: Thursday, July 12, 2018 10:33 AM

To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>

Subject: changes in writing

I've been reviewing the changes in the retiree health plan. I would like the entire health plan with the changes sent to me in writing. It is too hard to read online and I want to be able to read it in print.

Thank you!

Trudy Lund

[REDACTED]
[REDACTED] WA [REDACTED]

From: Gordon <[REDACTED]>
Sent: Saturday, July 14, 2018 6:20 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Comments on the draft of the Plan booklet

I have reviewed the draft plan booklet. I have a couple of suggestions:

1. Have a "Search" option so people who have some familiarity with the booklet can just enter a keyword or phrase.
2. In the table of contents, make it possible for people to click on the page number and then it would take them directly to that page. It makes it a lot easier instead of having to scroll down to the page one needs.

Achieving excellence in living,
Gordon

From: Deborah Pock <[REDACTED]>
Sent: Saturday, July 14, 2018 11:17 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Draft AlaskaCare Retirees

Draft booklet is very straightforward and clear. So happy that it is being updated. 15 years is a long time for a document to be around and seems like the sections can now be easily updated as needed. Really like the numbered sections, table of contents and index for quick reference. Deb Pock

From: Cathy Edgerton <[REDACTED]>
Sent: Thursday, July 19, 2018 11:13 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Benefit Booklet

Thank you for reworking the plan booklet. It's so nice to go directly to the table of contents and to find amended information in its appropriate section. Good work.

From: Clarence Jackson <[REDACTED]>
Sent: Thursday, July 19, 2018 6:24 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: THE PLAN

Thank you for your efforts to clarify and provide a user-friendly retiree plan. I will continue to read and review. Marleta J Jackson

From: Jim Barnes <[REDACTED]>
Sent: Sunday, July 22, 2018 2:17 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Alaska Care Plan Booklet Draft Comments

- I submit the following suggestions:

When a referral is made to another section please include either or both the page number or the paragraph reference in the referral so one does not have to look up the location. Example of no reference follows.

Eye refractions or hearing aids, or the fitting of eye glasses or hearing aids, except as described under Vision and Optical Benefits and Audio Benefits sections.

Please have the page numbers on the same side of all pages and in the same format instead of as follows:

32 —	Retiree Insurance
Information Booklet September 2018	
September 2018 Retiree Insurance Information Booklet —	33

Thank you for this opportunity.

If I have any other comments I will forward them at a later date.

Jim Barnes

Ph [REDACTED]

From: Jim Barnes <[REDACTED]>

Sent: Sunday, July 22, 2018 2:48 PM

To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>

Subject: Re: Alaska Care Plan Booklet Draft Comments

Every retiree should be able to receive a hard copy of the plan. Some retirees are not proficient on the computer or may not have a printer.

Thanks

From: Gottlieb, Peter (DOA)

Sent: Tuesday, July 24, 2018 11:59 AM

To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>

Subject: Typographical error in the Draft Retiree Plan

I believe there is a typo on page 61 which states (with emphasis):

Any refill to cover a replacement for covered prescription medication(s) in a signal instance due to loss, theft or damage in excess of one incident in a benefit year.

I believe you meant "single."

Thanks,

Peter Gottlieb

From: Linda Duychak <[REDACTED]>
Sent: Thursday, July 26, 2018 11:32 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: New retiree plan booklet suggestion

Hello and thank you for updating and improving the Alaskacare Retiree Plan booklet. It is very much improved.

I am still confused by the situation of coverage for drugs that are not taken orally. I believe the appropriate text is around the vicinity of 3.4.4.

The definition of 'drug' does not seem to exclude injected drugs or vaccines. Under the exclusions section, the words 'administration or injection of any drugs' seems to me to exclude cost of the service of injection (which would possibly be covered under medical services).

To me, the Alaskacare document does not go so far as I was told by Aetna—i.e., that the plan specifically excludes any injected drugs or vaccines, except flu shots. (Aetna denied claims for three [REDACTED] shots that my doctor certified as necessary, on the grounds that ALL injections were excluded.)

If, in fact, Alaskacare does exclude all injections, then the plan document should really be clearer. I would appreciate it if the plan booklet could specifically address IV and injected drugs. Either Aetna or I or both of us need clarity on this point.

Thanks again for the edit.
Linda Duychak

From: Edie B <[REDACTED]>
Sent: Sunday, July 29, 2018 1:32 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: AlaskaCare Plan Booklet draft comments

First of all, thank you for revising the Plan Booklet – your efforts are much appreciated.

My comments are in regard to Section 10.1.1 How benefits are coordinated when a claim is made. I am fortunate to have coverage as a State of Alaska retiree and also as the spouse to a Kaiser Permanente retiree. Our insurance worked wonderfully with AlaskaCare as my primary insurance and Kaiser as my husband's primary insurance. The problems began when we became eligible for Medicare. We turned our Medicare over to Kaiser Permanente (an HMO) under Medicare Advantage Part C. Now, AlaskaCare pays for nothing except for our Kaiser copays even though I was assured by an Aetna representative that if I went to Kaiser, AlaskaCare would still continue to pay (as before) and AlaskaCare would pay for providers outside of Kaiser networks.

Your Plan Booklet needs to include how payment will be made when AlaskaCare is the secondary insurer but the primary insurer cannot pay when services are rendered outside of their approved provider network. I have tried to get answers on the correct procedures for this from Medicare, SHIBA, Aetna and Kaiser, all to no avail.

Under HMO Medicare Part C provisions, there is coverage only for services/providers that are part of the specific HMO network. Concurrently, these services and providers would not be covered by AlaskaCare since they are not part of the AlaskaCare-approved network/providers. It would seem to me that both health insurance policies are, therefore, mutually exclusive in their coverage. What then, would AlaskaCare cover if I continue to enroll in Medicare Part C through the Kaiser HMO system but go to a provider outside of the Kaiser system?

Please, please provide clarification for this in your Plan Booklet as I cannot be the only one who is "fortunate" enough to have three sources of insurance coverage: AlaskaCare, Kaiser and Medicare.

Thank you,

Edith G Buhle

[REDACTED]
[REDACTED] OR [REDACTED]

From: barbara hembree <[REDACTED]>
Sent: Tuesday, July 31, 2018 11:18 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Draft Precertification Section Needs Edits

Greetings from beautiful Arkansas!

I read the draft plan booklet (without markups) and was pleasantly surprised at the clear language regarding benefits and exclusions. However, there are two pieces of the Precertification table that need to be edited for missing words.

On page 22 For Non-emergency Admissions the description ends "14 days before the date you."

On page 23 For Out Patient Non-emergency services the description "You or your physician must call at 14 days before services...."

Thanks for the opportunity to preview the booklet.

Barb Hembree

From: J Lynn Copoulos <[REDACTED]>
Sent: Wednesday, August 1, 2018 10:26 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Error 3.4.4

Hi,
Responding to request for review of 2018 sept. Plan booklet:
Prescription Drugs- 3.4.4
Should "signal" be replaced with "single"

Thx
Lynn C

From: Diane Lex <[REDACTED]>
Sent: Wednesday, August 1, 2018 3:04 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Plan Book draft

Whoa. I'm not even sure I was looking at the right document. I put "Plan Booklet Draft" in the search box and got 7 possibilities. The first one I opened said May 2018 and had everything crossed out. The next one I assumed was correct. It said "September 2018" but then went on for pages and pages and pages. I will be ordering a hard copy of the Plan Booklet tomorrow so that I can highlight info and put tabs on pages that seem important. I am newly retired and haven't used my Alaska Care Retiree Health Plan yet, so I need to start at the beginning, but I don't need to wade through all that stuff sequentially. At least I learned that there is an enormous amount of 'stuff' I don't know and that I probably need to learn. :) Diane Lex

From: Betty Barats <[REDACTED]>
Sent: Friday, August 3, 2018 9:29 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Plan Booklet

I have scanned the draft booklet and it seems pretty easy to follow. My only concern is that there is no mention of any type of program like Silver Sneakers. Why does this retirement health plan not include something all seniors need - something preventative that will help to keep them healthy and fit? If Aetna refuses to provide such a service, then perhaps it is time to find a new provider.

Thank you,

Betty Barats
Retiree since 1995

From: Sharon Hoffbeck <sharonhoffbeck@gmail.com>
Sent: Tuesday, August 7, 2018 12:27 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Cc: Brad Owens-Executive Vice President--RPEA <bowensak@gmail.com>; Alaska Retiree Health Plan Advisory Board (DOA sponsored) <alaskarhpab@alaska.gov>
Subject: RPEA COMMENTS--Retiree Health Plan Book

Dear Michele,
Attached please find RPEA's comments concerning the Retiree Health Plan Book revision.

Thanks,

Sharon Hoffbeck
President
Retired Public Employees of Alaska
sharonhoffbeck@gmail.com



Retired Public Employees of Alaska,
APEA/AFT
3310 Arctic Blvd., Suite 200, Anchorage, Alaska 99503
Phone: (907) 274-1703, Fax: (907) 277-4588
Email: rpea@alaska.net
Web site: www.rpea.afea-aft.org

August 7, 2018

COMMENTS ON DRAFT ALASKACARE INSURANCE BOOKLET

The Division of Retirement and Benefits (DRB) announced its proposed rewrite of the AlaskaCare "Defined Benefit Retiree Insurance Information Booklet,"¹ seeking comments by August 15, 2018. The following are comments on behalf of the Retired Public Employees of Alaska (RPEA).

RPEA is the largest public employee retiree organization in Alaska. Its mission is to protect the interests of all 68,000-plus PERS, TRS, JRS and other participating retirees and their dependents, working to ensure that they receive the retirement benefits they earned, that were promised to them and that are guaranteed by the Alaska Constitution.

DRB's "Defined Benefit Retiree Insurance Information Booklets" webpage appears to assure members that the only reason it is rewriting the plan handbook is to make it more user-friendly; that is, to make it easier to read, to understand and to find answers to what the plan does and does not cover. These are laudable goals.

DRB further assures that the proposed redraft simply moves prior amendments into the body of the handbook to make it easier to read, incorporates all prior plan benefit clarifications, adds existing regulations into the eligibility section, numbers the sections for ease of reference and notably, that the proposed "draft is NOT adding, removing, or changing the plan benefits."

If DRB disagrees with any of these statements about its purposes and intent in rewriting the plan handbook, and what the draft does and does not do, then we ask that you please notify RPEA as soon as possible and explain the reasons for any such disagreement.

¹ We respectfully suggest that the diminutive term "booklet" is not the best way to characterize the publication. We believe the title should clearly state what the publication is and therefore recommend that, when it is eventually published, the title of the revised publication be: "The AlaskaCare Defined Benefit Retiree Health Plan Insurance Policy and Information Handbook."

The Proposed Revisions Are Premature and Are Likely to Prove to Be a Waste of Time and Trust Monies

As you know, the RPEA contends that changes imposed by DRB since 2013 in how it administers the AlaskaCare Retiree Health Plan have resulted in diminishment and impairment of benefits. We submit that those changes are invalid because they violate Art. XII, § 7 of the Alaska Constitution and were implemented in contravention of the substantive and procedural requirements established by the Alaska Supreme Court in *Duncan v. RPEA*.

Cases are currently pending in the Alaska courts where the validity of those changes are being challenged. Suffice to state here that there are substantial legal and factual grounds supporting the challenges to those changes.

The main concern and objection that RPEA has with the proposed revisions of the AlaskaCare Plan handbook are that they incorporate benefit changes that are being challenged in the court cases and may well be found to be invalid.

The costs of revising, reprinting and distributing tens of thousands of revised handbooks to retirees will be substantial. If the Alaska courts rule that the reductions in benefits that DRB has made to the AlaskaCare plan since 2013 are unconstitutional and must be rescinded, then the revised handbooks, if they have been printed, would become obsolete.

Were that to happen, the printing and distribution of those handbooks would then have been a complete waste of Trust monies. More Trust monies would then need to be spent for re-revising, reprinting and redistributing a corrected version of the handbook. Furthermore, faulty handbooks would be in circulation that could potentially cause even greater confusion and uncertainty among retirees concerning the coverages provided.

The Proposed Revisions Incorporate Changes Imposed by DRB Since 2013 That Have Resulted in Substantial Reductions in Benefits That Continue to Cause Serious Hardship to Many Retirees

Many of our members have related numerous instances in which plan amendments since 2013, including new or revised definitions of terms or interpretations of plan language, have resulted in diminished and impaired medical benefits—benefits that they had been receiving and had been relying upon under the 2003 AlaskaCare plan.

Protecting and Enriching Your Retirement Years

We offer the following example as an illustration.

Among the most common reports of diminishment and impairment of benefits since 2013 are claims for physical therapy. Up until the end of 2013, the AlaskaCare Plan provided coverage for physical therapy that was considered "medically necessary" as that term is defined in the AlaskaCare handbook and has been since it was first published in 2003. According to the handbook, a medical service or supply is considered medically necessary when it is for:

Care or treatment which is expected to improve or maintain your health or to ease pain and suffering without aggravating the condition or causing additional health problems.

2003 AlaskaCare Retiree Health Plan handbook at page 16.

At some point, DRB unilaterally decided that after 2013, it would no longer apply that definition of "medically necessary" when determining whether to pay claims for physical therapy. Instead, DRB began applying Aetna's definition of "medically necessary" for purposes of physical therapy. Aetna's definition is 53 pages long and is published as Aetna Clinical Policy Bulletin (CPB) No. 0325.

Please compare the clear, concise and straightforward definition of "medically necessary" contained in the AlaskaCare plan, quoted above, to Aetna's 53 page definition in CPB 0325. A copy of Aetna's CPB 0325 is provided with this Comment as Exhibit 1.

Even a cursory, comparative review of the two definitions of "medically necessary" reveal why, beginning in 2014, so many retired Alaska public employees suddenly began having their claims for physical therapy denied.

The consequences of the stratagem employed by DRB and Aetna to reduce AlaskaCare benefit coverage by substituting Aetna's definition of "medically necessary" have been serious. The Alaska retirees who could not afford the needed treatment guaranteed them under the 2003 AlaskaCare retiree plan definition of 'medically necessary' did not receive it. Those who could afford that treatment have been forced to shoulder medical expenses that previously were covered, and should have been covered by the AlaskaCare plan.

Protecting and Enriching Your Retirement Years

Put simply, the stratagem has resulted in an unconstitutional diminishment and impairment of medical benefits—a cost-shifting of rehabilitative care and treatment to retirees who are guaranteed such benefits to ease their pain and suffering in the years of their lives they are most likely to require these services.

This is just one specific example wherein DRB has systematically re-written the terms of the plan by imposing Aetna's policies to determine the AlaskaCare Retiree Plan's coverage and benefits. No 'permanent' Retiree Plan document should ever institutionalize specific contractor (TPA) standards to determine plan coverage. TPA contractors are employed only to administer the terms provided in the 2003 AlaskaCare Retiree Plan as guaranteed under Alaska law.

Summary and Conclusion

In sum, to the extent the proposed revisions to the handbook incorporate changes that are being challenged in the Alaska courts (including the proposed EGWP, which is not described in the rewrite), the revisions are premature and may prove to be a complete waste of time and money.

If a new version the AlaskaCare Retiree Health Plan insurance coverage handbook contains language that incorporates the benefit changes implemented since 2013, and if those changes are determined by the Alaska courts to be invalid, then there would be at least three serious consequences: 1) there would be a substantial waste of money and resources as a result of the printing and distribution of the handbooks; 2) the distribution of policy handbooks with incorrect information would be a potential source of further confusion and uncertainty to retirees concerning coverages; and 3) corrected handbooks would have to be reprinted and distributed at an additional significant cost.

For these reasons, we respectfully urge DRB to refrain at this time from making any revisions to the handbook that incorporate any of the coverage benefit changes made since 2013. A revised handbook should not be printed and distributed until there has been a final determination whether those changes comply with the Alaska Constitution and the requirements of the *Duncan v. RPEA* opinion.

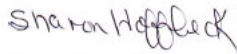
If DRB wants to make the handbook easier to navigate and understand, then RPEA suggests it make non-substantive organizational changes to an on-line version of the handbook until the court cases are finally resolved.

Protecting and Enriching Your Retirement Years

Furthermore, we urge that in furtherance of its fiduciary duties to Alaska's retired public employees, DRB take appropriate steps to alert AlaskaCare Plan beneficiaries which benefit changes DRB has imposed since 2013 that are currently being challenged in the Alaska courts.

Please let us know if you have any questions.

Sincerely,



Sharon Hoffbeck
President



Brad Owens
Executive Vice-President

Protecting and Enriching Your Retirement Years

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EXHIBIT 1
to the RPEA COMMENT
to DRB's PROPOSED
REVISIONS of the
ALASKACARE HANDBOOK
August 7, 2018

Physical Therapy

[Clinical Policy Bulletins](#) | [Medical Clinical Policy Bulletins](#)

Number: 0325

Policy

Aetna considers physical therapy medically necessary when this care is prescribed by a chiropractor, DO, MD, nurse practitioner, podiatrist or other health professional qualified to prescribe physical therapy according to State law in order to significantly improve, develop or restore physical functions lost or impaired as a result of a disease, injury or surgical procedure, and the following criteria are met:

- The member's participating physician or licensed health care practitioner has determined that the member's condition can improve significantly based on physical measures (eg, active range of motion (AROM), strength, function or subjective report of pain level) within one month of the date that therapy begins or the therapy services proposed must be necessary for the establishment of a safe and effective maintenance program that will be performed by the member without ongoing skilled therapy services. These services must be proposed for the treatment of a specific illness or injury; *and*
- The PT services provided are intended to cover only episodes of therapy for situations where there must be a reasonable expectation that a member's condition will improve significantly in a reasonable and generally predictable period of time; *and*
- PT services must be ordered by a physician or other licensed health care practitioner and performed by a duly licensed and certified, if applicable, PT provider. All services provided must be within the applicable scope of practice for the provider in their licensed jurisdiction where the services are provided; *and*
- The services provided must be of the complexity and nature to require that they are performed by a licensed professional therapist or provided under their direct

Policy History

Last Review

08/03/2018

Effective: 07/20/1999

Next

Review: 03/22/2019

Review

[History](#)

Definitions

Additional Information

[Clinical Policy](#)

[Bulletin](#)

[Notes](#)

EXHIBIT 1 RPEA "COMMENT" TO PROPOSED ALASKACARE HANDBOOK REVISION 1 of 53

REMAINDER OF THE 53 PAGE RPEA EXHIBIT 1 can be found at:

http://www.aetna.com/cpb/medical/data/300_399/0325.html

From: T. E. Nordgren <[REDACTED]>

Sent: Tuesday, August 7, 2018 1:28 PM

To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>

Subject: Retirees Draft Benefit Book.

No, no, no! You have incorporated illegal changes!

Theodore E Nordgren

From: DAVID B PATRICIA A WAGNER <[REDACTED]>

Sent: Tuesday, August 7, 2018 2:42 PM

To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Plan Medical Benefits

After reviewing the draft, I'm confused. Does it mean we have to pay 20% of the first \$4,000 of medical expenses, then we have 100% coverage after the first \$4,000. Which Tier retirees does this pertain to? Does it only apply to employees hired after 1986, or does it include employees hired prior to 1986?? Also, when does this go into effect???

Also, we may be behind our membership dues. IF you could let us know whether or not we're current and where we mail dues to?

Thanks,
David B Wagner
Patricia A Wagner

From: William Ennis <[REDACTED]>
Sent: Tuesday, August 7, 2018 3:53 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Disagreement with your "there are no changes"

Dear Sir or Madame,

I taught in the Anchorage School District for 26 years, for the great portion of that time at East Anchorage High School. During those years, I was the first recipient of the BP Teacher of the Year and the 1999 Milken National Teacher Award. It is both my right and responsibility to respond to the proposed changes in the new "handbook".

As you are aware, Article 12, Section 7 of our Alaskan Constitution clearly states that, "Accrued benefits of these systems shall not be diminished or impaired."

As a member of RPEA, I am concerned with the unilateral use of the TPA's (Aetna, in this case) definitions. I will be [REDACTED] years old at week's end and after a career spent teaching Anchorage's students, the DRB has decided to reduce my benefits without negotiation and in complete disregard of an Alaskan-Constitutionally-protected contractual relationship between the state and the retired employees. Several three-letter acronyms came to mind when I learned of your actions, but in the interests of civility I shall refrain.

I stand firmly with my association's statement on this unwarranted diminution of our mandated retirement care. I am unsure whether the decision to move ahead with this by the DRB assumed that we were asleep or that we didn't care if our health care is decreased, but can assure you that neither is correct.

It should be your job to ensure that the system is adequately administered, and not to squeeze every penny from a contractual obligation between the State of Alaska and the retired public employees. It certainly seems that DRB is slowly reducing our health care by picking away at definitions and the like in the hopes that it goes unnoticed. If that's not the case, we would all appreciate a more clearly stated rationale.

Regards,

William Ennis
[REDACTED]

From: memoree cushing <[REDACTED]>
Sent: Tuesday, August 7, 2018 3:53 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Benefit plan proposed changes

When will DRB reward insurees who make lifestyle changes to keep medical et al charges to a minimum.

My husband and I both work out 5 days a week and control our weight and diet through healthy food options. We use minimal medical care but are now told you will cut any compounded drugs and further reduce dental, implants etc.

Overusers of medical care who refuse lifestyle changes should be paying insurance commensurate with their usage. Instead, we are being charged for all the medical associated to obesity and you are proposing a reduction in services/coverage.

Thank you!
Memoree Cushing, MSSW
[REDACTED]

From: Peter Michalski <[REDACTED]>
Sent: Tuesday, August 07, 2018 3:15 PM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <alaskarhpab@alaska.gov>
Cc: sharonhoffbeck@gmail.com
Subject: Changes

I strongly object to the short deadline for response to the proposed new handbook. If comments are truly desired, more time for serious review and consideration is called for. A number of its positions and improper practices have been applied by the current provider in violation of retiree's rights, and adoption of these interpretations are really changes to long standing and expected benefits of loyal state employees.

One example of this is the failure to pay anything when a provider does not take social security. The manual I was employed under provides that in such a situation the reimbursement will be as if the provider had accepted the social security coverage, not that the retirement program pays nothing.

In addition, as in the previous example, some of the misapplications are too costly for an individual to meaningfully fight, though they chisel away at the retirees benefits. This is a technique long applied by insurance companies, but is completely unseemly for a state retirement system.

Another example of the general disregard of retirees' rights is the discounting of the of network rates for dental providers outside the network. This can only be based on money saving goals that disregard the provider patient relationship and punish the retiree without justifiable cause.

I request that the division send me a hard copy of the manual, and hard copies of the two draft versions.

Thank you for your consideration of my thoughts.

Peter A. Michalski

[REDACTED], AK [REDACTED]

From: Mark Miller <[REDACTED]>

Sent: Tuesday, August 7, 2018 5:06 PM

To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>

Cc: Gary Miller <[REDACTED]>; Sharon Hoffbeck <sharonhoffbeck@gmail.com>

Subject: Comment on the AlaskaCare Retiree Benefit Book

Hi:

I've attempted to read the draft proposal of the AlaskaCare Retiree Benefit Book. I find it to be poorly written with many confusing run on sentences. My eighth grade English teacher would have failed me for such poor, incomprehensible writing.

I suggest that the composers of this document give a copy to their spouse or friends. Ask them to read it and paraphrase it back to them. You will find what I suspect is already evident. This book is a confusing work that will do little to provide benefits to retirees.

I suggest you start over with a clear purpose of serving retirees honestly.

Sincerely, Mark Miller

From: Juanita Young <[REDACTED]>

Sent: Tuesday, August 7, 2018 6:05 PM

To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>

Subject:

We strongly disagree with these new purposed plans to change our retirement medical benefits....there is nothing...absolutely NOTHING that is of benefit to the retiree and their spouse....

Dan & Nita Young in [REDACTED], Alaska

From: Juanita Young <[REDACTED]>
Sent: Tuesday, August 7, 2018 6:11 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject:

Our health care plan needs to be left alone...all of it...leave it alone....there is not one thing in these purposed changes that is of benefit to the retiree or their spouse....fix the dental, that you took upon yourselves to change that certainly does not benefit us...leave it like it was!....and leave everything else alone....there is absolutely nothing that is of benefit to the retiree or their spouse....with the changes you are trying to change....do NOT allow it!!

Dan & Nita Young in [REDACTED], Alaska...

From: Bill Burgess <[REDACTED]>
Sent: Tuesday, August 7, 2018 6:44 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Cc: Sharon Hoffbeck RPEA <sharonhoffbeck@gmail.com>
Subject: You Made unconstitutional Changes

Where is your conscious. How can you say you haven't decrease some of coverage. I am [REDACTED] years old and thought the State of Alaska would honor their commitment pertaining to retired benefits. Please honor the State Constition and promise made at time of employment.

From: Jim O'Toole <[REDACTED]>
Sent: Tuesday, August 7, 2018 7:09 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Retiree Medical Plan

Please add me to the State of Alaska retiree who is adamantly opposed to the duplicity that is being attempted by the Division of Retirement and Benefits.

The obvious adjustments/changes to the plan that have not been approved by anyone other than the administration is an appalling display of a lack of fair play in regard to the health benefits of our retired employees.

I respectfully ask that everything be done to ensure that changes to our health care plan are negotiated as required by state law.

Thank you,

James L. O'Toole

[REDACTED]
[REDACTED] Ak [REDACTED]

From: Beth Adams <[REDACTED]>
Sent: Tuesday, August 7, 2018 7:37 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Comment on Updated AlaskaCare Retiree Benefit Book

I don't understand why you would re-write this handbook and incorporate changes that are currently in litigation. That is a waste of time and money.

Respectfully,

Beth Adams
Alaska Court System retiree

(Of course, my comment in no way represents the views of the Alaska Court System.)

From: Leonard Revet <[REDACTED]>
Sent: Tuesday, August 7, 2018 8:56 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Changes

Hello, I have read through what is presented. I have one question. If my MD says I need my [REDACTED] changed, will this procedure be questioned? In other words, if the MD says, I need a procedure, do I need to check with DOA to see if they approve?

Sincerely,
Leonard Revet

From: Harold Campbell <[REDACTED]>
Sent: Tuesday, August 7, 2018 10:44 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>; Alaska Retiree Health Plan Advisory Board (DOA sponsored) <alaskarhpab@alaska.gov>
Subject: AlaskaCare Plan Booklet rewrite

To whom it may concern,

I have reviewed the updated version of the Retiree Insurance Information Booklet and concur with the RPEA conclusion that the booklet does contain "changes." Furthermore, I concur that spending time and monetary resources to print "information" that is currently being contested with factual data supporting a diminishment of benefits for retirees would be a misuse of the already strained Health Trust assets.

Our family has experienced and submitted to the RPEA examples wherein DRB has systematically allowed AETNA to interpret the terms of the plan by imposing Aetna's policies to determine the AlaskaCare Retiree Plan's coverage and benefits. In spite of conversations with the DRB which acknowledged the miscarriage, I have had to endure the time and energy to fight through the 3 levels of appeals before the DRB would intervene to correct the claim and restore the correct interpretation of benefits, as originally set by the DRB.

Therefore I urge the DRB and RHPAB to consider, at a minimum, the suggestion by RPEA to make the changes only online until there has been a final determination whether those changes comply with the Alaska Constitution and the requirements of the Duncan v. RPEA opinion.

Sincerely,
Harold Campbell

From: Stan Jacobs <[REDACTED]>
Sent: Wednesday, August 8, 2018 3:41 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Cc: sharonhoffbeck@gmail.com
Subject: proposed changes retiree benefits

Good Day

My name is Stanley Jacobs and I am a retired Alaska special education teacher. I successfully completed my teaching career and implemented the guidelines and curriculum set out by the school districts I worked for. (Sand Point and Anchorage). I loved my job as a teacher, but one of the reasons I worked as a teacher was because the retiree system and associated retiree benefits would provide for my family and I in retirement. I am now retired and want to see the benefits offered to me while I was teaching remain in place, and not be diminished or reduced.

Since Aetna took over as the administrator, the retiree benefits system has been more difficult to navigate and my benefits have been reduced. (Had I decided to reduce or change the curriculum in the middle of my contract I am confident I would have been fired.) For example, I [REDACTED] and got my [REDACTED] exam and [REDACTED] from [REDACTED]. [REDACTED] stopped taking Aetna because Aetna was not paying claims. I had to find a different place to place to have my [REDACTED] care.

I am writing to ask you not to make any changes to our benefits until the Alaska court system has heard all the cases now pending and ruled on the validity of those cases. If the DRB makes changes now and prints booklets and the courts rule against the reduction of benefits you are proposing, the state will have to spend a lot of money reprinting and distributing the booklets. This would be an incredible waste of money. I am sure that everyone would rather see the State of Alaska's revenues be spent on students and providing quality education to our youth, rather than spending money on reprinting and distributing booklets.

Please contact me with any questions you have.

Thank you
Stan Jacobs

From: Dan Motley <[REDACTED]>
Sent: Wednesday, August 8, 2018 5:28 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: New Health Care Plan Booklet

To Whom It May Concern:

It is virtually impossible for my wife and I to read through, digest, and evaluate the proposed new plan manual in order to make an informed evaluation and comment on the manual and the contention that it "does not add, remove, or change" any of my promised, current plan benefits. Performing such a review analysis would take far longer than the limited time allowed.

DRB should be publishing an analysis of the differences between the current and proposed manuals, along with estimated "Duncan" cost change estimates to support its contention of no additions, removal, or changes to the Retiree Health Care Plan. This would be the proper and responsible way to present a new manual of such importance.

It is our opinion that DRB is being unfair and unreasonable in the time allowance to review and comment on this new Plan document. Please consider the interests of plan beneficiaries as well as benefactors.

Sincerely,
Dan & Martha Motley
[REDACTED] OR

From: Mark Miller <[REDACTED]>
Sent: Wednesday, August 8, 2018 7:52 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Cc: Sharon Hoffbeck <sharonhoffbeck@gmail.com>; Gary Miller <[REDACTED]>
Subject: Comment on the AlaskaCare Retiree Health Plan Book.

Hi:

Please extend the comment period for the AlaskaCare Retiree Health Plan Book from August 15 to November 15, 2018.

I only received the draft on August 7, which currently only gives retirees eight days to review the draft and make comments. I hope your team of experts were assigned more than eight days to produce this draft. Please give retirees more time to assess the draft.

Also, August is the middle of the prime summer travel season with retirees traveling to visit friends and relatives or hosting friends and relatives. Many retirees will not even know of the comment deadline before it has passed. I wouldn't want any appearance that such a short comment period at a distracted time of year was intentional to limit the number of comments.

Thank you for your consideration.....Mark Miller

From: Bob Valantas <[REDACTED]>
Sent: Wednesday, August 8, 2018 8:15 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Cc: 'Sharon Hoffbeck' <sharonhoffbeck@gmail.com>
Subject: Updated Handbook

Alaska State Department of Retirement and Benefits:

We strongly support the RPEA position that your "Updated Alaska Care Retiree Benefit Book " should not be published until all issues regarding your proposed revisions are resolved by the State courts.

Very truly yours,

Beulah and Robert Valantas

[REDACTED] AK [REDACTED]

From: Brenda Muller <[REDACTED]>

Sent: Wednesday, August 8, 2018 9:01 AM

To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>;
Alaska Retiree Health Plan Advisory Board (DOA sponsored) <alaskarhpab@alaska.gov>

Subject: Comments on Draft Alaskacare Insurance Booklet

In response to The Division of Retirement and Benefits (DRB) proposed rewrite of the AlaskaCare "Defined Benefit Retiree Insurance Information Booklet," seeking comments by August 15, 2018.

I am in support of the comments provided August 7, 2018 on behalf of the Retired Public Employees of Alaska (RPEA). There were many opportunities during my career with the State of Alaska where I could have made more money working in the private sector. However, I chose to continue my career with the State for the security of a promised defined retirement benefit and healthcare benefits (that would not be diminished or impaired) for my senior years. I respectfully request DRB refrain from making any revisions to the handbook that incorporate any of the coverage benefit changes made since 2013.

Sincerely,

Brenda Muller

From: Jan Carolyn Hardy <[REDACTED]>

Sent: Wednesday, August 8, 2018 10:02 AM

To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>;
Sharon Hoffbeck <sharonhoffbeck@gmail.com>

Cc: Jan Carolyn Hardy <[REDACTED]>

Subject: Comments on Draft AlaskaCare Insurance Booklet

To Whom It May Concern:

Firstly I am in entire agreement that the name of any publication which serves to clarify and enumerate benefits should be considered a Handbook and not a Booklet. According the Webster's Ninth New Collegiate Dictionary a Booklet is a little book;a pamphlet. According to the same source a Handbook is a book capable of being conveniently carried as a ready reference: manual; a concise reference book covering a particular subject.

Secondly the issues proposed in the Draft are still in litigation. To waste the Trust's money on the publication of a document not fully settled is unwise and a waste of precious funds.

Thirdly any changes to the 2003 Handbook are invalid because they violate Article XII, Section 7 of the Alaska constitution and were implemented in contravention to substantive and procedural requirements established by AKSC in Duncan vs. RPEA.

Fourthly as of 2014 the DRB determined that it would not longer implement the definition of medical necessity as published in the 2003 Handbook. Rather the DRB chose to use the Aetna version of medical necessity. The latter is an extensive, ambiguous, and pedantic 53 page document. Aetna is a provider and not a member of DRB, the State of Alaska, or any of its constituent parts.

Lastly it would be financially expedient to publish the Draft on the DRB website for purposes of comment and full disclosure.

An explanation by DRB on its website that this Draft is in apposition to Duncan vs. RPEA and is not the result of settled litigation currently being heard by the courts must accompany the publication. Full disclosure.

In Solidarity,

Jan Carolyn Hardy
Executive Secretary, Board of Directors
AFSCME Alaska Retiree Chapter 52

Jan Carolyn Hardy
Residential and Commercial Sales

CCIM Candidate
NAGLREP National Policy Committee
SAGE Alaska Steering Committee
Older Persons Action Group Executive Board
AFSCME Retiree Local 52 Executive Board
ASEA/AFSCME Local 52 Trustee
Central Labor Council Member
Disability and Aging Coalition Member

GTK Real Estate

 Cell
 Alaska


www.AlaskaCommercialLeasing.com

Everybody does better when everybody does better.

Please spay or neuter your pets!

If they don't give you a seat at the table, bring a folding chair.

If you have come to help me you are wasting your time. But if you have come because your liberation is bound up with mine, then let us work together.

== Please remember that if this email was sent to multiple recipients to use the "Reply to All" button so everyone sees the reply ==

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From: JANE PETRICH <[REDACTED]>
Sent: Wednesday, August 8, 2018 10:33 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: comment on draft of retiree benefits

Consider the following comments on the draft retiree plan:

To the extent the proposed revisions to the handbook incorporate changes that are being challenged in the Alaska courts (including the proposed EGWP, which is not described in the rewrite), **the revisions are premature and may prove to be a complete waste of time and money.**

If a new version the AlaskaCare Retiree Health Plan insurance coverage handbook contains language that incorporates the benefit changes implemented since 2013, and if those changes are determined by the Alaska courts to be invalid, then there would be at least three serious consequences: 1) there would be a substantial waste of money and resources as a result of the printing and distribution of the handbooks; 2) the distribution of policy handbooks with incorrect information would be a potential source of further confusion and uncertainty to retirees concerning coverages; and 3) corrected handbooks would have to be reprinted and distributed at an additional significant cost.

For these reasons, we respectfully urge DRB to refrain at this time from making any revisions to the handbook that incorporate any of the coverage benefit changes made since 2013. **A revised handbook should not be printed and distributed until there has been a final determination whether those changes comply with the Alaska Constitution and the requirements of the Duncan v. RPEA opinion.**

If DRB wants to make the handbook easier to navigate and understand, **then RPEA suggests it make non-substantive organizational changes to an on-line version of the handbook until the court cases are finally resolved.**

Furthermore, we urge that in furtherance of its fiduciary duties to Alaska's retired public employees, **DRB take appropriate steps to alert AlaskaCare Plan beneficiaries which benefit changes DRB has imposed since 2013 that are currently being challenged in the Alaska courts.**

Jane Petrich, Retiree

From: dusek <[REDACTED]>
Sent: Wednesday, August 8, 2018 10:45 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: draft Alaskacare Ins. booklet

To: DOA DRB

I am a retired Alaska State employee, continue to live in Alaska, and belong to the Retired Public Employees of Alaska APEA-AFT.

I have read the Draft Alaskacare Ins.Booklet recently issued by the DOA, DRB and also the comment on this Booklet by the RPEA, dated 8/7/18.

I completely agree with and support RPEA's letter of comment.

I do not believe that this revised booklet should be printed and distributed before benefit changes challenged in court are resolved in court.

Diane Dusek

An Alaskan State employee from the early 1970's to the late 1990s

From: Will Ellis <[REDACTED]>
Sent: Wednesday, August 8, 2018 12:14 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: AlaskaCare "Defined Benefit Retiree Insurance Information Booklet Comments"

Dear DRB Director

The following are my comments/concerns regarding the draft AlaskaCare "Defined Benefit Retiree Insurance Information Booklet:

1. DRB states this draft booklet is not adding, removing, or changing plan benefits; I disagree. Alaska retirees, through RPEA, have challenged the State in court concerning dental and vision coverage that the State has unilaterally reduced. Currently RPEA has received a favorable interim decision from the Alaska Supreme Court. The draft booklet incorporates the reduced dental and vision benefits the State unilaterally implemented. Therefore the draft booklet is implementing unfair and contested changes to our health plan. This is not fair and ethical.

2. I currently am receiving [REDACTED] for two separate and different conditions. Medical science is changing their approach to various injuries such as meniscus tears and ligament tears to the knee. In the past these common type of knee injuries were treated with medical procedures, now the prevailing guidance is to not conduct these procedures and instead have the patient undergo physical therapy to restore/repair the joint and/or relieve pain. Additionally, seniors (retirees) are at the age when joint problems and issues manifest themselves and thereby necessitating the need for physical therapy. The State's planned use of the 3rd party (Aetna) administrator's definition for what constitutes "medically necessary" physical therapy will result in a reduction of needed physical therapy for retirees, especially those relying on this critical medical treatment for managing joint pain and quality of life issues. Physical therapy is much cheaper than waiting for the pain/quality of life for a member to deteriorate to the point where a knee replacement is now needed. The State may also want to review the recent U.S. Court of Appeals decision (Saunders v. Wilkie) that overturned a lower-court ruling that for 19 years

served as the legal basis for the VA to deny claims from veterans with disabling pain that a doctor can't explain. Based on Aetna's definition of "medically necessary" I am unable to determine if physical therapy would be authorized for a condition such as patellofemoral pain syndrome.

3. If the State moves forward with these reduced dental and vision changes, along with others such as the reduction of physical therapy treatments through unilateral changes of policy definitions and then prints and issues a new benefits book/policy; it may result in wasted expenses on publishing a booklet. Because contrary to the State's claim, this draft booklet does contain changes/reduction to our medical coverage. If the retirees' prevail in their suit against the State for the reduction of our medical benefits, then the State will have to publish a revised benefits book.. Please wait until the recent litigation is finalized before publishing the new benefits book/policy.

Regards

Will Ellis

From: Eric Marchegiani <[REDACTED]>

Sent: Wednesday, August 8, 2018 12:30 PM

To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>;

Alaska Retiree Health Plan Advisory Board (DOA sponsored) <alaskarhpab@alaska.gov>

Cc: Eric(Desktop) <[REDACTED]>; RPEA - Sharon Hoffbeck <sharonhoffbeck@gmail.com>;

Saddler, Dan (LEG) <representative.dan.saddler@akleg.gov>; MacKinnon, Anna (LEG)

<senator.anna.mackinnon@akleg.gov>

Subject: New Plan Benefits Booklet - Not

August 8, 2018

Eric & Mary Marchegiani

[REDACTED]
TN [REDACTED]

Division of Retirement & Benefits

PO Box 110203

Juneau, AK 99811-0203

Dear Sir/ Madame:

It is my understanding that the Division of Retirement and Benefits is planning on issuing a new Plan Benefits Book. I also understand that the draft of this book states "This draft is not adding, removing, or changing plan benefits."

Just because the Division says that statement does not make it fact... by attempting to include it in the book, I take offense that you are pushing an agenda that is not true!!!

For several years Division has been whittling away at Retiree Benefits with denials by the Service providers. I spent something like two years appealing a prescription case in which it was denied for no reason... the previous Service Provider had reimbursed the cost of the prescription without any pre – authorization... I obtained the documentation and provided the necessary documentation for the pre-authorization...to the new Service provider and they denied it for over two years before I was able to finally get the Division involved and finally got it approved... I dare say your new prescription plan likely will give me the same fits again all over. I don't know how to say this but to be frank the Division is throwing the Retirees under the bus to save a dime.

My wife and I both utilize a [REDACTED] which has avoided any need for surgery (i.e. higher costs and less mobility). The interpretation of "medical necessity" by Aetna is an issue that we both disagree with because in the past it was fairly easy to have the [REDACTED] send in the information and obtain the exemption i.e. for more visits in any given year... Now with Aetna's determination... it is almost impossible to obtain a waiver due to their definition of "Medical Necessity".

These are just two of the various items that the Division continues to diminish the Retiree's benefits. The publishing of a new Benefits Plan will cost a bundle of money along with its distribution. The fact that there continues to be litigation with the State of AK/ Division of Retirement & Benefits concerning our benefits... likely means that the new book will be obsolete before it actually gets to the Retirees which would mean that the Plan Book would need to be revised and republished along with distribution cost.

All in all, it is a poor move on the part of the Division of Retirement & Benefits. It reflects bad faith on the part of the State of AK. It continues to reinforce the belief and expectation that the Division is only looking to cut costs to the detriment of the Retiree.

I recommend that you cease and desist any future publication of the Plan Booklet until previous litigation and the recent proposals for changes are litigated and finalized. If the State of AK/ Division of Retirement & Benefits stopped changing various aspects of our benefits... it would result in a time whereby a new Plan Booklet could be issued but until that occurs... there is absolutely no reason to issue a booklet that is worthless and provides mis-information.

Sincerely,

Eric & Mary Marchegiani

From: Kathryn Carssow <[REDACTED]>

Sent: Wednesday, August 8, 2018 2:15 PM

To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>

Cc: Sharon Hoffbeck <sharonhoffbeck@gmail.com>

Subject: AlaskaCare Retiree Benefit Book

I respectfully disagree that the changes in the benefit book do not represent substantial changes and reductions to the plan and that they warrant much greater publicity and discussion, as well as legal challenge. I've read through the mock-up draft and find the changes to comprise a reduction in benefits and a formalization of the hand-off of administration of the plan to Aetna. This concerns me generally and specifically due to my most recent exchange with Aetna in which I was denied coverage given one reason, which I appealed on-line and was then given another even more obfuscated reason, which I appealed again on-line and was denied given another vague reasoning, about which I then called and spoke to an Aetna rep who looked into it and determined I should not have been denied coverage. This is a game that serves Aetna well but not me, much less others not as tenacious.

What I can decipher from the manual draft are further changes in the denial appeal process that disadvantages beneficiaries, along with precertification requirements added in, coverage for services reduced, and the doubling of the deductible for Medicare recipients. The changes are difficult to decipher in the mock-up without hours of poring over it. This shouldn't be the case. The DOA should allow more time and provide for a more honest and straightforward presentation of the changes from the previous handbook. The DOA needs to be honest with retirees about what they are administering away in terms of what the original contract with public employees provided.

I have further read the RPEA law suit document and believe that there be no further documentation of changes in the plan from the original until that case has been decided. The reductions in benefits and the abdication by DOA of its responsibility for administering the plan by allowing AETNA free reign is simply wrong.

I appreciate your consideration of this input and hope you will reach out more effectively to retirees who may not realize what this draft represents and the potential impact on their health and wellbeing.
Kathryn Carsow

From: Stephen Fried <[REDACTED]>
Sent: Thursday, August 9, 2018 10:44 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Draft Revisions of AlaskaCare Retiree Health Plan Handbook

I am writing in support of the Retired Public Employees of Alaska review of the draft online revision of the AlaskaCare Retiree Health Plan handbook. Please remove any revisions that incorporate coverage benefit changes made since 2013 until a final determination is made on whether these revisions comply with the Alaska Constitution and requirements of the Duncan vs. RPEA opinion. Thank you for considering my comments.

Sincerely,
Stephen Fried

From: Dianne Bolling <[REDACTED]>
Sent: Thursday, August 9, 2018 11:54 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: RPEA handbook rewrite

Please note that as definitions of handbook wording is changed, so are benefits. Please do not allow the revision of the health plan handbook go forward until all proposed definitions are reviewed in court. We retirees planned our futures based on promises made to us while employed.
Thank you

Dianne Bolling retiree

From: Renda Heimbigner <[REDACTED]>
Sent: Thursday, August 9, 2018 12:48 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: proposed changes to retiree health care management plan

Thank you for the opportunity to comment on your proposed changes to our retiree health care management plan as proposed in your most recent suggested rewrite.

To the extent the proposed revisions to the handbook incorporate changes that are being challenged in the Alaska courts (including the proposed EGWP, which is not described in the rewrite), the revisions are

premature and may prove to be a complete waste of time and money. If a new version the AlaskaCare Retiree Health Plan insurance coverage handbook contains language that incorporates the benefit changes implemented since 2013, and if those changes are determined by the Alaska courts to be invalid, then there would be at least three serious consequences: 1) there would be a substantial waste of money and resources as a result of the printing and distribution of the handbooks; 2) the distribution of policy handbooks with incorrect information would be a potential source of further confusion and uncertainty to retirees concerning coverages; and 3) corrected handbooks would have to be reprinted and distributed at an additional significant cost. For these reasons, we respectfully urge DRB to refrain at this time from making any revisions to the handbook that incorporate any of the coverage benefit changes made since 2013. A revised handbook should not be printed and distributed until there has been a final determination whether those changes comply with the Alaska Constitution and the requirements of the Duncan v. RPEA opinion. If DRB wants to make the handbook easier to navigate and understand, then RPEA suggests it make non-substantive organizational changes to an on-line version of the handbook until the court cases are finally resolved. RPEA Comment Proposed Redraft of the AlaskaCare Handbook August 8, 2018 Page 5 of 5 Protecting and Enriching Your Retirement Years Furthermore, we urge that in furtherance of its fiduciary duties to Alaska's retired public employees, DRB take appropriate steps to alert AlaskaCare Plan beneficiaries which benefit changes DRB has imposed since 2013 that are currently being challenged in the Alaska courts.

Please contact me for any questions or further discussion.

Warm regards,
Renda Heimbigner
State of Alaska retiree Tier 1

From: Margo Waring <[REDACTED]>
Sent: Thursday, August 9, 2018 7:29 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: new draft

I am a member of the RPEA and have read their comments on the handbook recently drafted. I concur that this is not the time to publish a new book and send it to thousands of retirees. You appear to be betting on winning the court case or, if losing, then confusing retirees until a new version can be distributed.

I have experienced the continued constriction of benefits I was promised when I signed up as a state employee. I certainly hope RPEA wins in court!

Sincerely,
Margo Waring

[REDACTED]
AK [REDACTED]

From: Jo Boehme <[REDACTED]>
Sent: Thursday, August 9, 2018 9:54 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>

Cc: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <alaskarhpab@alaska.gov>
Subject: proposed updated AlaskaCare Retiree Benefit Book

I've read the draft 2018 Defined Benefit Plan booklet documents on the DRB website and I'm sharing my input. Thank you for the opportunity to comment.

I'm an Alaska PERS retiree; I've experienced improper and unfair claims adjudication on medical travel reimbursement; I've appealed twice, been reimbursed once so far. One is pending. It seems to me that, with the timing of this Retiree Benefit Book re-write, DRB is "putting the cart before the horse" idiomatically speaking. I'm aware that RPEA filed a lawsuit earlier this year. It would make sense for DRB to hold off on this proposed Benefit Book re-write until the lawsuit decision comes in so the Benefit Book doesn't have to be re-written in the near future.

As I've read these documents in detail, I've become increasingly concerned that the contracted third party administrator (presently Aetna) seems to apply their own Clinical Policy Bulletins as guidelines for claims reimbursement rather than adhering to Alaska's constitutionally protected retiree benefits guidelines. This practice reduces my benefits. It has caused me direct hardship because I'm still awaiting reimbursement of travel costs I incurred in 2016.

I suggest DRB puts the project to update the AlaskaCare Benefit Book on hold until the pending lawsuits are resolved. At that time, it makes sense for DRB to solicit comments from retirees/beneficiaries on proposed plan amendments in an effort to balance protection of our defined benefits with fiscal fairness.

Respectfully,

Jo Boehme

[REDACTED]
[REDACTED] AK [REDACTED]

[REDACTED]

From: Sally Gibert <sgibert@aol.com>
Sent: Friday, August 10, 2018 12:10 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Comments on Retiree health care plan

See attached. Thanks for your consideration.
Sally Gibert

August 11, 2018

State of Alaska
Division of Retirement and Benefits
c/o doa.drb.alaskacare.retiree.plan@alaska.gov

Dear DRB,

As background, I retired in 2011 as a Tier 1 beneficiary; and in 2017 I turned 65 and moved into Medicare. I have briefly looked over the changes to the "Defined Benefit Retiree Insurance Information Booklet." I have also read the general comments about the booklet from the Retiree Public Employees of Alaska (RPEA). I appreciate the difficulty of meeting the Division of Retirement and Benefits (DRB) multiple objectives of clarity and merging years of amendments. To help decipher the motivation of many of the changes, more explanation of the rationale for the major changes would be helpful. Such explanations occur in the right-hand comment field in some instances, but more explanations would be useful.

I find the tone of the RPEA comments to be unnecessarily divisive and lacking in specifics, yet I agree with several of their recommendations, which I will state in my own words:

- On the short term, the work-in progress "booklet" (I prefer RPEA's recommended "Handbook" terminology) should remain an on-line publication only, with easy to download PDF chapters that can be printed at home. Many people will want to personally print specific parts that concern them, and some may want to print the whole document; but because of the active legal challenges I agree with RPEA that widespread distribution of printed documents is unwise for now. Waiting at least a year or so to see what comes out of the courts seems prudent.
- The sections of the booklet available electronically or eventually in printed form that are being contested in court should be specifically flagged so that retirees will know that further changes may (or may not) be afoot. If possible, develop a short neutral statement about each issue or group of issues under judicial scrutiny, perhaps by working directly with RPEA. There is no need to get into the weeds in these statements – keep it general. For example, *"The Alaska court system is currently addressing the scope of 'medically necessary' for purposes of determining the appropriate application and amount of prescribed Physical Therapy."* If someone wants to know more about the details they can request copies of legal briefs from litigants.

RPEA used Physical Therapy as an example of a change in the availability of services. I have personally experienced the reduction in the availability of PT services in the last few years and I can confirm that eligibility has clearly gone down. In the past, as long as physical improvements continued, so did the benefits (within some broad parameters). These days, PT benefits are being cut off or reduced pre-maturely seemingly based on arbitrary formulas that are not reflective of individual concerns, goals and degrees of responsiveness. Clients are being released from PT before they are ready, then left to fend for themselves without professional

1

guidance as they attempt to improve on their own while their relative needs change. As a cost-cutting measure, some of the new PT rubrics may have merit; but to deny there have been changes is disingenuous. Instead of denying the changes, I recommend explaining the basis for these and other similarly-motivated changes since 2013 as part of the larger discussion of health benefits and their costs. The needed debates are important and should not be swept under the rug.

The attachment to the RPEA comments highlights an exclusion for Physical Therapy which I believe is inappropriate. The middle of the second page of the Aetna attachment says: *"Physical therapy... in persons without an identifiable clinical condition is considered not medically necessary."* A doctor may believe that PT will help a person, even if that doctor cannot put their finger on a specific diagnosis. Such initial PT should be covered, and if it creates improvement, its continuation should be covered. The underlying (unidentified) problem may well be resolved through PT without further expensive tests that are sought simply to chase a diagnosis. A major cost savings! I therefore recommend that this PT exclusion from "medically necessary" be removed from the policy.

Thank you for the opportunity to provide these comments. I wish I had more time to review the specifics in more detail.

Sincerely,



Sally Gibert

From: Elaine Thomas <[REDACTED]>
Sent: Saturday, August 11, 2018 2:24 PM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <alaskarhpab@alaska.gov>
Cc: doa.drb.alaskacare.retiree.plan@alaska.gov; sharonhoffbeck@gmail.com
Subject: DRB rewrite of AlaskaCare Retiree Benefit Book

DRB:

Printing the revised plan booklets before Alaskan courts have determined how many of the arbitrary changes you have made to benefits since 2013 are invalid may prove to be another waste of time, money, and resources by your department.

There have been substantial reductions in our benefits since 2013. Let the courts decide these matters and then print true and correct information for members.

Thank you,

Elaine Thomas
[REDACTED] AK

From: Val Horner <[REDACTED]>
Sent: Saturday, August 11, 2018 2:55 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>; Alaska Retiree Health Plan Advisory Board (DOA sponsored) <alaskarhpab@alaska.gov>
Cc: sharonhoffbeck@gmail.com
Subject: Comments on the Health Care Plan

Attached are my specific comments on the proposed changes to the Retirees' health care plan. I did not review any of the old proposed changes that have not implemented and were stricken. I looked only for the new text and stricken text from the current 2003 Plan.

I did not find any text referring to the use of Medicare Part D. If this proposal is still on the table, please advise me of the section in the Plan that details how this will work.

Valerie Horner
Tier 1 Retiree

From: Roy Dudley <[REDACTED]>
Sent: Saturday, August 11, 2018 3:15 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Updated AlaskaCare Retiree Benefit Book

Upon review of the draft updated AlaskaCare Retiree Benefit Book is it obvious that it does make significant changes to my health plan and constitutes a reduction to my health benefits. I object to the changes.

Roy Dudley

AK

From: C Cuenin <[REDACTED]>

Sent: Saturday, August 11, 2018 4:12 PM

To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>

Subject: comments on new insurance benefits handbook

To whom it may concern,

While I appreciate the effort you have gone to to make the new handbook easier to read and understand, I feel it is premature to be putting this out while some issues remain contested by lawsuits. It's possible you may then have to re-write it. I know fiscal responsibility is very important to you.

Thank you,
Catherine Cuenin

From: Richard F. Lytle <[REDACTED]>

Sent: Sunday, August 12, 2018 10:54 AM

To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>

Subject: Comment on Alaska Care Retiree Health Plan

Ref: 2018 Defined Benefit Plan comment

I have partialy reviewed your changes to the Alaskacare Retirree Pland Booklet and would like to make the following comments.

The appeal process does not follow the State statue.

The States over the last 40 some years has developed the Uniform Comercial code which the State of Alaska has addoped under their statutes.

Under the code you must exaust your administrative remedy, which means you must have a final decision by an administrative Judge before going to a State or federal court.

Richard Lytle

AK

From: Gcl Mail <[REDACTED]>

Sent: Sunday, August 12, 2018 4:02 PM

To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Retiree Health Plan Booklet

To whom it may concern:

I have read the draft of the Retiree Health Plan Booklet and suggest that implementation of the proposed changes be delayed until after the RPEA and State of AK settle the court case currently pending regarding changes made to the health plan.

It would be unwise to move ahead with changing the booklet before this lawsuit is settled due to the potential costs and confusion of more changes to the booklet if the court rules in favor of RPEA.

Thank you for your kind consideration,
D. Levan
SOA Retiree / Alaskan resident

From: Christel Petty <[REDACTED]>
Sent: Sunday, August 12, 2018 4:29 PM
To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <alaskarhpab@alaska.gov>
Cc: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: 2018 Retiree Insurance Information Booklet

To whom it may concern:

I do not think that the new 2018 Draft Plan Booklet makes understanding the benefits any easier.

For example: I am trying to understand if my husband's [REDACTED] are covered. He's had [REDACTED] disease for many years, had several surgeries and ongoing treatments. When he had previous [REDACTED] done in 2013, the procedure was covered by Aetna (Medical Plan). He now has had two more [REDACTED] done and coverage was denied by Moda Health. Reading through the various plans it is my understanding that the [REDACTED] should be covered but I don't know how to go about getting them covered.

Perhaps someone could comment on this.

Thank you,

Christel Petty

From: Allan & Judy Morotti <[REDACTED]>
Sent: Monday, August 13, 2018 8:34 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Changes to health plan

Re Retiree Plan,

Please do not diminish our plans. It's harder than ever to stretch dollars to meet rising costs at a retirement pension.

Any changes should be reviewed by those affected the most.

Sincerely,

Judith Morotti

From: Young [REDACTED] >

Sent: Monday, August 13, 2018 2:30 PM

To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>

Subject: Comments on AlaskaCare Booklet

Attached is my letter commenting on the proposed update and consolidation of the AlaskaCare insurance booklet.

Sharon Young

August 13, 2018

State of Alaska
Department of Administration
Division of Retirement and Benefits

Re: Draft AlaskaCare Insurance Booklet

To Whom It May Concern:

I am a State of Alaska retiree. Health insurance is provided by the state for both myself and my husband. We also purchase Dental/Vision/Audio coverage and Long Term Care coverage and pay monthly premiums for those coverages. The purpose of this letter is to provide input on the state's proposed updated Plan Booklet.

Like all retirees, I view all retiree insurance (medical, dental, vision, audio, long term care and life insurance) as critical to my health and wellbeing and a valuable asset derived from my many years of work for the State of Alaska. While I received my Retiree Insurance Information Booklet in 2003, it is apparent that there have been many unilateral changes and amendments made to that insurance coverage in the past fifteen years that have not always been well communicated to the retirees. So I do applaud the state's project to update and consolidate all of the retiree insurance information and fifteen years of changes and amendments into a single concise and easily understood source. However, I also feel that this effort is vastly premature at this point due to ongoing pending litigation by the Retired Public Employees of Alaska (RPEA) regarding some of the amendments that have been implemented by the state. Judicial resolution of the RPEA's lawsuits is critical to determining exactly what the retiree benefits are and to ensure that there has been no impairment or diminishment of those benefits via the state's unilateral amendment process.

I personally believe many of the plan provisions and amendments are incapable of being understood by the average retiree without further clarification. I further believe that incorporating all of the many references to the TPA contractor Aetna and its Clinical Policy Bulletins (CPB's) into the Plan Booklet is a mistake. Every time a new TPA is selected, the booklet would need to be revised again. The Retiree Health Plan is provided by the State of Alaska, not Aetna, and neither Aetna nor its CPB's should be referenced anywhere in that plan. The state has a fiduciary obligation to its retirees to ensure that their benefits are sustained in the long term and that the plan is not diminished in any way.

I do hope the state and RPEA can reach agreement soon on the benefit issues under litigation. In the meantime, it appears to me that the booklet consolidation project should be put on hold until the litigation outcomes are known.

Sincerely,

Sharon Young
[REDACTED ADDRESS]
[REDACTED ADDRESS]

cc: RPEA, Sharon Hoffbeck President

From: Kathy Grabowski <[REDACTED]>

Sent: Monday, August 13, 2018 3:04 PM

To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Comment re: revisions to Defined Benefit Retiree Insurance Info Handbook

To: Alaska Department of Administration
Alaska Department of Retirement and Benefits

I disagree with your statement that the drafted revisions of the Defined Benefit Retiree Insurance Information Handbook is NOT adding, removing, or changing plan benefits.

As you have been made aware, Article XII, § 7 of Alaska's Constitution provides that membership in a state employee retirement system constitutes a contractual relationship and the accrued benefits of these systems "shall not be diminished or impaired." The Alaska Supreme Court has held specifically that medical benefits available to retirees are part of the benefits protected by the Alaska Constitution, and that health insurance coverage therefore may not be diminished or impaired. Changes are permitted, but only to the extent that any disadvantages are offset by comparable advantages.

When Commissioner Curtis Thayer selected Aetna as the third-party claims administrator of the retiree medical, visual and audio health plan (Plan) in January of 2014, retirees' coverage and benefits were depreciated. This change permitted Aetna, without oversight by DRB, to use its own clinical policies and discretion in determining coverage and benefits under the Plan resulting in substantial diminished benefits and wrongful denials of claims often leaving retirees little recourse due to a very convoluted and flawed appeals process. Aetna's reduced coverage for chiropractic care plus physical and massage therapy services, restrictions in the provision of medical travel benefits, new pre-certification requirements on medical treatment, and denial of coverage for certain prescriptive drugs and medicines previously covered and paid by the Plan before January of 2014 are examples of this impairment to our medical benefits.

Without seeking the input of the Alaska Care DVA beneficiaries, DOA also repealed the provisions of the retiree dental insurance plan that had been in effect through 2013, and hastily implemented the Moda Delta network, effective January 1, 2014. The Moda plan significantly reduced the excellent dental benefits and coverage available to retirees who had initially opted into the Alaska Care DVA plan. It negatively affected both preventive and restorative dental care for retirees and also penalized Alaskan resident patients who use services from a provider who is not part of the Moda network. Financial records didn't fiscally reveal the rationale for awarding our retiree dental plan to Moda. In fact, after the implementation of the PPO program, Health Deputy Commissioner Barnhill had to figure out how to pay down the six million **over funded** retiree DVA trust.

In order to protect the earned, constitutionally protected retirement benefits of all PERS, TRS and JRS retirees and their dependents, RPEA has found it necessary to file lawsuits against the State of Alaska seeking protection from diminishment or impairment of the retirement health plans that provide those benefits. These lawsuits are still pending in the Alaska court system yet the draft has clearly incorporated many of the changes made since 2013 that RPEA has challenged in the filed lawsuits.

DRB has systematically re-written the terms of the plan by imposing Aetna's policies to determine the Alaska Care Retiree Plan's coverage and benefits. No 'permanent' Retiree Plan document should ever institutionalize specific contractor (TPA) standards to determine plan coverage. TPA contractors are

employed only to administer the terms provided in the 2003 Alaska Care Retiree Plan as guaranteed under Alaska law.

Hence, the revisions to our Defined Benefit Retiree Insurance Information Handbook are premature. It should be obvious that a revised handbook should not be printed and distributed until there has been a final determination whether those changes made comply with the Alaska Constitution and the requirements of the Duncan v. RPEA opinion.

Sincerely,

Kathy Grabowski

[REDACTED], WA [REDACTED]

Alaska TRS and PERS retiree

From: mary fuller Leykom <[REDACTED]>

Sent: Tuesday, August 14, 2018 8:13 AM

To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>

Subject: AlaskaCare Retiree Benefit Book

Dear DRB:

I am grateful to DRB for it's goal to rewrite the AlaskaCare Retiree Plan Book, in an effort to make the information more easily understood. However, preparing the Plan Book NOW is premature. Pending court cases may affect and ultimately change retiree benefits under the Plan.

I urge you to wait to complete the Plan Book until the court cases have been determined, thereby saving your office time and effort.

Very sincerely, Mary Leykom

From: Jack & Elaine Vander Sande <[REDACTED]>

Sent: Tuesday, August 14, 2018 8:51 AM

To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <alaskarhpab@alaska.gov>; Michaud,

Michele M (DOA) <michele.michaud@alaska.gov>

Cc: RPEA <rpea@alaska.net>

Subject: Revisions to AlaskaCare Retirees Health Plan

Proposals by the Retiree Health Plan Advisory Board change the health plan retirees accepted as a guaranteed part of their retirement package. Expansion or diminishment of benefits as permitted under Duncan vs. RPEA increase benefits for some at the expense of reducing them for others. More effort needs to be made to notify retirees of the rationale behind specific changes that are vaguely referred to as "modernizing" and to provide an opportunity for input. Neither Aetna nor any other administrator should be in a position to promote its preferences for changes. Notifying retirees through a website is not sufficient before changes are proposed or finalized. Likewise a policy such as one implemented this year to arbitrarily restrict certain prescriptions (as happened to us) should never occur without prior notification. Proposals to extend coverage to dependents to age 26 and increase lifetime benefits have a

significant impact on the wellbeing of others through offsets such as raising deductibles, redefining the definition of medical necessity, reducing physical therapy visits, dental implants and other benefits.

Rather than redefining medical necessity to restrict physical therapy or other therapies to a limited number of visits, the goal should be to return patients to their best possible function and/or relieve pain and suffering. In particular, a 20 week physical therapy limit per year for major surgery or injury is inadequate, as we know from personal experience. A 53 page Aetna document full of medical legalese does not belong as a part of AlaskaCare. Disqualification of pre-existing conditions and ignoring the treating physician and therapist recommendations that could resolve a medical condition are in conflict with the original health plan.

Proposed changes to incorporate Medicare Part D require a thorough analysis, which is coming we understand, with an opportunity for input from retirees. Imposing Medicare rules, like possible denial of a prescribed drug and requiring a five step federal appeal process impose a scary scenario if that is a drug your doctor believes you need. The Step Therapy is another scary option. Both of us have had prescriptions with side effects, and we should not have to wait for an outside review by another entity rather than a change recommended by our physician.

The basic criteria should be to benefit the patient/retiree, not to conform to the plan administrator guidelines or to other plans. The State of Alaska must not relinquish control of AlaskaCare and final authority over claims adjudication. In the past we have twice had need to request intercession by the State and have had adjustments made in our favor.

Reprinting of the health care plan with finalized changes is badly needed; however, it should wait for completion of court review to ensure it reflects the correct information without requiring a second, expensive reprinting.

Other aspects of the proposed amendments may affect other retirees or us at another time; these are the ones we see now as impacting us. We hope issues that we and others raise will receive your consideration.

From: Jack & Elaine Vander Sande <[REDACTED]>

Sent: Tuesday, August 14, 2018 1:06 PM

To: Alaska Retiree Health Plan Advisory Board (DOA sponsored) <alaskarhpab@alaska.gov>; Michaud, Michele M (DOA) <michele.michaud@alaska.gov>

Cc: RPEA <rpea@alaska.net>

Subject: Retiree Health Plan

After sending comments on the AlaskaCare revisions earlier today we received an acknowledgement from the Advisory Board that included a website where the minutes of the July 27 meeting and discussion of the EGWP plan were available. After reading that, we are glad the Step Therapy in our comments would not apply.

As brought up in our comments and at the meeting, it is still a concern how to handle a situation where a medication is critical and a physician has not requested pre-authorization. An example in the minutes was after a tooth is pulled where the need might not have been known in advance, or what about a broken bone or other injury? [REDACTED]

[REDACTED]

Keeping AlaskaCare provisions as outlined in the minutes where the EGWP program does not fully support them including the appeal process is reassuring.

From: Jennifer <[REDACTED]>
Sent: Tuesday, August 14, 2018 5:06 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Concerns regarding our insurance booklet!

I believe that the name Aetna should not be listed in our booklet. I also find it unfair that our state gives more power, in appeal decisions, to Aetna than is given to medical personnel that actually examine and treat the individual retirees. The wording in the draft consistently supports Aetna versus the patient's medical needs. I am disappointed that this is the best you intend to present.

Jennifer Gremmel

From: Brad & Terry Zimmerman <[REDACTED]>
Sent: Wednesday, August 15, 2018 5:31 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>; Alaska Retiree Health Plan Advisory Board (DOA sponsored) <alaskarhpab@alaska.gov>
Subject: Comment - Updated Defined Benefit Retiree Insurance Handbook

Dear SOA DRB Staff & Retiree Health Plan Advisory Board Members,

I am a retiree of the State of Alaska, and am currently covered under the Defined Benefit Retiree Health Plan.

This e-mail is in response to your request for comments on your intention to publish an updated, "Defined Benefit Retiree Insurance Information Handbook".

Although I would encourage and applaud a simpler and updated version of our plan handbook, I DO NOT support your intent to publish a new handbook at this time.

There are currently lawsuits pending in the courts over past changes to the plan that have been made by the SOA. Additionally, the SOA is proposing other changes to take effect in January that impact members that are on Medicare. It's my opinion that publishing and distributing a new booklet before any major litigation is settled or before the proposed changes to members on Medicare are finalized would be premature and an egregious waste of our medical plan's funds. The reasoning for many of the plan's changes the last few years is to cut costs and protect the future of the fund. Publishing a handbook prematurely at this time is counter-intuitive to this goal.

In summary, a simplified and easy to use plan handbook is very much needed and a worthy goal. BUT, I am NOT in favor of the publication and distribution of the revision until the lawsuits are finalized and the plan stabilizes from the upcoming, proposed changes. The SOA and the Retiree Health Plan Advisory Board have a fiscal responsibility to use our medical plan funds wisely. Please postpone the well intentioned publication of this handbook.

Respectfully submitted,

Brad B. Zimmerman
State of Alaska Retiree

[REDACTED]

From: Paul Haggland <[REDACTED]>
Sent: Wednesday, August 15, 2018 8:30 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>; rpea@alaska.net
Subject: State of Alaska Draft Alaskacare Insurance Booklet

After a full review of the Draft Alaska Insurance Booklet and Prior Booklet/s I whole heartedly agree with the REPA's August 7, 2018 review/reply to the proposed Draft Alaskacare Insurance Booklet. The pending legal issues must be decided prior to any new Booklet being printed and any Aetna language should be removed.

I find the changes in the proposed booklet offensive to the Retired State of Alaska Employees dependent upon their hard earned benefits they rightly deserve.

From: carol downs <[REDACTED]>
Sent: Wednesday, August 15, 2018 10:27 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: Our Retiree Dental plan changes

The changes to our dental plan as you can see in the attachment have affected us greatly. It is almost impossible to see how the medical plan changes will affect us until we try to use them. There are so many pages to read and unless you are a lawyer you most likely will not be able to fully understand the outcome. Both my husband and I are retired State Employees and were promised certain benefits when we retired. Thank you for your help in this. Tom and Carol Downs

THE ATTACHED DENTAL PLAN APPEAL WAS NOT INCLUDED AS IT CONTAINED PROTECTED HEALTH INFORMATION.

From: Shirley Pittz <[REDACTED]>
Sent: Wednesday, August 15, 2018 11:02 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: AlaskaCare Retiree Benefit Book

I would urge DRB to hold off on issuing a new benefit booklet until the lawsuits filed by RPEA have been resolved. Let's get out the right information at the right time!

Thank you-

--

Shirley Pittz, M.S.
[REDACTED]

From: Mary Ann Nunley <[REDACTED]>
Sent: Wednesday, August 15, 2018 11:18 AM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Cc: Mary Ann Nunley <[REDACTED]>
Subject:

Don't rewrite our plan booklet until you know the status of any changes. It's a waste of money, time and effort for anyone involved in the process. Please wait for the court decision.

Thank you,
Mary Ann Nunley

From: akienitz <[REDACTED]>
Sent: Wednesday, August 15, 2018 3:03 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: SPD draft comments

Thank you for the opportunity to review the SPD draft document. First time I've ever had such an opportunity with any employer – and I've had many 😊!

3.3.20. Medical Treatment of Mouth, Jaws, and Teeth – if this is a medical service section, maybe make clear that it is separate and distinct from the Dental Plan. Or, if not, specify that.

3.4.2. Mail Order Program – draft states “There is no cost to you for drugs filled through the mail order program. The program bills the medical plan for the full cost.” Does this mean no-coinsurance or is it referring to no mailing costs? Could be clearer.

3.4.4. Exclusions:

- A device of any type.– an example would be helpful because it seems to me, as I read it, that it would include “any medical device” which could be a DME item or surgical implant, etc.
- Any refill to cover a replacement for covered prescription medication(s) in a signal instance due to loss, theft or damage in excess of one incident in a benefit year. – typo, should be “single”?

It might be helpful to number this section instead of using bullets.

One thing I have run into is Aetna using a “not covered under your plan” when a cross-over claim is submitted to Aetna but it is for a Medicare covered service (like a flu shot). This cause me much confusion until I figured out that the Medicare EOMB state Medicare paid and patient could not be billed for any balance. It would be helpful to either make that clear (that Aetna doesn’t cover what Medicare pays for in full) in the SPD or tell Aetna to maybe use a different CARC/RARC code to make it clear Medicare paid full patient responsibility.

Anne Kienitz

"I may not live by the water, but in my mind, I live in a cozy beach front cottage!"

From: Susan Miller <[REDACTED]>

Sent: Wednesday, August 15, 2018 8:46 PM

To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>; sharonhoffbeck@gmail.com

Subject: 2018 Defined Benefit Plan Booklet (DRAFT)

If you want comments on the above draft booklet, I'm not sure why you didn't send it to me. I only found out that you had drafted this new booklet when I got an email from the Retired Public Employees of Alaska. If you really wanted comments, I think you would have sent this information to all retirees.

I am trying to review the "with markup" version of the booklet. But deleting about the first third of the booklet doesn't make it easy.

Where is the appeals process explained in the new booklet?

Where does the booklet explain who decides whether an item is covered, the Division of Retirement & Benefits or one of the groups you contract with?

Why did you delete the paragraph in the Out-Of-Pocket Limit section that explains how that limit works. I think the explanation was helpful.

I don't understand the travel benefits on pages 3 - 4. Is it explained better somewhere else? Has that always been in the plan or is it new?

Is the precertification penalty on page 4 new?

Page 5 uses the term "network pharmacy." Does the booklet identify what those pharmacies are or describe where I can find out if a pharmacy is a "network pharmacy"?

Also on page 5, it looks like the Depo-Provera section is new. When was that added to the plan?

Page 5-6 Dental Benefits. Maybe you could add a pagereference to where I can find out what is included in the three classes of service, assuming that is explained somewhere.

Page 7 Vision Benefits uses the term "benefit year." What does that mean? Is it a calendar year or something else?

Also in that page 7 section, it looks like the \$400 lifetime limit on contact lenses is new. When was that added to the plan?

Also, if a benefit like an eye exam is only covered once each benefit year, is there any required number of months between each exam? The plan currently seems to cover one exam in December and another the following January.

Page 8 Audio Benefits. What does "rolling 36 month period" mean? It seems different from "3 consecutive benefit years." This change seems to lengthen the time a person has to wait to get insurance coverage for a new hearing aid. When was that change made to the plan?

Page 18. What does "claims administrator" mean in the pre-certification paragraph?

Page 20. Why is Aetna determining the "recognized charge" for services, and why is it done "in accordance with Aetna reimbursement policies"? When did this become part of the plan? Why do Aetna policies rather than State of Alaska policies govern this? Does the state ever audit how Aetna makes these determinations and whether they comply with the intent of the retiree plan? If there is an audit, is the audit report public?

Page 20. Prescription Drug Expenses. How does DRB determine "110% of the average wholesale price or other similar resource"?

Page 43. What does "your full annual spent maximum" mean in the Lifetime Maximum section?

Page 45. Medicare. When did the plan start requiring retirees age 65 to enroll in Medicare, thus reducing plan benefits? Why are these retirees still subject to the \$150 medical deductible since the plan is now only "supplemental" to Medicare coverage? I don't understand the meaning of the following new sentence you are adding: "Relevant deductibles, coinsurance amounts and out-of-pocket limits continue to apply to both Medicare and the Plan." How can the plan limit Medicare?

Page 56 The Nurse Advice Line section says the claims administrator's number is listed in the front of the booklet. I didn't see it. It appeared that everything in the front of the booklet has been deleted.

Pages 98 - 99. I don't think your description of the Mail Order Pharmacy is accurate.

Page 119. The annual maximum dental benefit has been \$2,000 for years. Why are these maximums not increased periodically to reflect inflation? (like our premiums are increased)

Page 120. What is the authority for turning over to Delta Dental determinations about what is a "recognized charge"? Does the state ever audit and report on Delta Dental procedures? Is the audit report public?

Page 126. You've changed the name of the decision maker from Delta Dental to "Moda/Delta Dental."

Page 130. When was the limitation of porcelain restorations added to the plan? I'm not entirely sure what it means.

Page 131. Why are implants listed in Class III Prosthetic services? I thought implants were a medical procedure covered by the medical plan.

Page 145. Audio. The description of the \$2,000 limit over three years is not the same as the one earlier in the booklet.

I'm out of time.

Susan Miller

From: lamoreau [REDACTED] <[REDACTED]>
Sent: Wednesday, August 15, 2018 9:39 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Subject: booklet

Administrator

I have been reviewing your proposed booklet changes and find much to disagree with. Essentially, the use of "Aetna" as the plan administrator in any part of the book just assumes that they will continue to be the third party administrators forever.

When calculating medical/dental/audio/vision expenses, the "prevailing rate" is determined by Aetna's methodology, not the State of Alaska.

I take exception to the section in which Aetna determines if certain services are "medically necessary" when this decision should be between the patient and their doctor, not someone at a desk who knows nothing of the situation.

Regarding precertification for hospital stays beyond the original intended time, or other services needed to be extended, that, also should be between the doctor and the patient.

Under medical expenses not covered, Aetna determines if services are beneficial.

Dental, if retiree does not want to change from the dentist they have been using for years to a "network" dentist who is paid less, there is a financial penalty in that the financial benefit is lowered. This was not the case under the previous administrator, and points to a diminishment of coverage.

Both of us are Alaska retirees and have witnessed a gradual but consistent attempt to diminish coverage guaranteed to us by the State of Alaska.

Emily Lamoreaux
Bill Lamoreaux

had to fight to have this benefit paid for, and Aetna constantly required excessive documentation. It is also clear that Aetna's process of "review" is very flawed and does not actually "review" submitted documents. I fully support accountability by providers to show "progress", but Aetna's system is unwieldy, onerous, requires excessive time by me and my providers. [REDACTED]

[REDACTED]

Aetna repeatedly denies these claims, when they were never denied prior to Aetna's administration of AlaskaCare. One was recently just denied, delayed, repeatedly, inefficiently processed, now for 3 months. It just took over 3 hours of phone calls by me, and my provider, with Aetna staff, plus repeated faxes that we were told were "lost" or "sent in wrong way", etc etc" to get one claim [REDACTED] paid -- 3 months, 3 hours! This is gross inefficiency on Aetna's part, and appears to be aimed at discouraging submitting the claims. The claim was clearly wrongly denied in the first place! I contend that these problems are the result of the State of Alaska's acceptance of Aetna's blanket Clinical Policy Bulletin which REDefines the term "medical necessity". No longer is my care defined by my physicians -- Aetna doesn't even review the material provided by my physicians. The CPB is simply a quasi-medical/quasi-legal mechanism that allows Aetna to limit and deny members claims!

Secondly, my contract for Health Care is not with Aetna, but with the State of Alaska. Several times in the past State of Alaska has changed Administrators of the Plan. Why are references specific to Aetna inserted in the plan booklet? Aetna is a contracted company whose role is simply to administer the plan, not be "part of it", and certainly not to "define" it. This choice is a poor one for plan members, because it means that the State of Alaska has relinquished authority for maintaining the integrity of the plan to Aetna.

Finally, the Retired Public Employees Association (RPEA), has challenged the State of Alaska on several issues, including specifically the reduction of benefits by changing the definition of "medical necessity" in court. These legal battles are not yet resolved. You should not change the plan before all issues are fully resolved, least you create more confusion than already exists.

So I respectfully request that you do not update this plan booklet at this time. And the underlying nature of diminishing benefits (there are others that I have not mentioned in this letter) by simply posing a "clearer writing", is underhanded and simply not appropriate.

Thank you AlaskaCare -- I am grateful for my insurance coverage. My expectation has been that it would be available when I needed it, and that it would be managed well and it's full integrity preserved by the State of Alaska.

Sincerely,
Melinda Rowse

From: Brenda Arney <[REDACTED]>
Sent: Wednesday, August 15, 2018 11:08 PM
To: AlaskaCare Retiree Plan, DOA DRB (DOA sponsored) <doa.drb.alaskacare.retiree.plan@alaska.gov>
Cc: sharonhoffbeck@gmail.com; Alaska Retiree Health Plan Advisory Board (DOA sponsored) <alaskarhpab@alaska.gov>
Subject: ALASKACARE INSURANCE BOOKLET COMMENTS

You have asked for the retirees to give our input on the draft of the Plans booklet reprint. However, with all the confusing mark ups it's hard to decipher what your intentions are and in comparing it to the unmarked up draft, it appears to me that you are inserting amendments into the body of the booklet, supposedly making it easier to read. After several hours of trying to compare the two booklets (marked up and non-marked up) I gave up.

I do know this, reprinting the booklet now does not even make sense since there are pending lawsuits by RPEA. The outcome of those lawsuits may require another reprinting, which would be a waste of trust money. Remember, you are claiming moving retirees over 65 into the Medicare Part D EGWP to save the trust money, yet you're wanting to potentially waste that trust money by prematurely doing a reprint.

Amendments which are being inserted into the body have changed the plan to the point of diminishing my health care and therefore, should not be added to the plan booklet until the courts rule.

Thank You,

Brenda Arney

RECEIVED THROUGH US POSTAL SERVICE:

██████████
██████████ AK ██████████

August 10, 2018

Division of Retirement and Benefits
State of Alaska
AlaskaCare
PO Box
Juneau, AK 99801

Division of Retirement and Benefits:


This letter is in regard to the proposed rewrite of the AlaskaCare insurance information booklet. It is my perception, after reading the proposal, that the rewrite will indeed result in a diminishment of benefits for the retiree, and, therefore, I ask that the division work more carefully with the concerned parties, the retirees and their representative organizations, to create a rewrite that will not only be more useful to the reader but also be accurate and just.

Currently, many of the changes in the revision are under litigation. It would prove wise and cost effective to wait until the litigation is complete before a rewrite and republishing is undertaken. To publish without waiting for legal decisions could be easily construed as deliberate and intentional obfuscation of the issues and corresponding denial of services.

Diminishment of services as defined by new/proposed language is clear. I make reference specifically to chiropractic and massage therapy services which now, according to the new definition of "medically necessary," I have not been able to obtain.

I have spent more time in letter writing, appealing, phone calls, and research than I ever have before in order to obtain benefits that I have earned. Still, over and over and over, the insurance manager has refused to pay on ██████████. Recently, I was told by a representative of the Division of Retirement and Benefits, after a lengthy and "escalated" phone call, that perhaps I should consider taking it easy now that I was over ██████████. Well, I have no intention of taking it easy. I intend to keep moving because that is the road to good health. And to do so, I need ██████████. I need "care or treatment which is expected to improve or maintain" my "health or to ease pain and suffering without aggravating the condition of causing additional health problems." It is clear that the current language causes problems.

Do not rewrite the booklet or publish rewrites until problems like this are solved. Doing so will only cause more confusion and chaos in a system that is already fraught with confusion, chaos, and resentment.

Sincerely,

Kathleen McCrossin

RECEIVED
AUG 16 2018
DOA-RET & BEN

Sharon,

Please add my name to the list of people choosing NOT to attend the teleconference under these egregious third party terms. I would think this would qualify as a suppression of dissent in the event of a lawsuit.

Sincerely,

Cathy Fliris

Please read message below.

Thank you,

Beverly Anne Dela Cruz
Retirement & Benefits Technician II
State of Alaska – Dept of Administration
Division of Retirement and Benefits

PO Box 110203
Juneau, AK 99811-0203

Phone: (907) 465-4460
FAX: (907) 465-3086
Toll-Free: 1-800-821-2251

From: Brad Parker <[REDACTED]>
Sent: Monday, August 20, 2018 2:03 PM
To: Benefits (DOA sponsored) <doa.drb.benefits@alaska.gov>
Subject: NO ENHANCED EGWP !

Dear DRB-

My Alaska Care is working fine. The last time you changed pharmacy plans it took over half a year to get it all straighten out with my pharmacy so that Alaska Care would pay.

You are merely seeking more federal money which just adds to the tremendous debt and taxes. We (the taxpayers and Alaska Care Beneficiaries) will all have to pay more because of this.

I do not want a new ID Card and a new set of Pharmacy Managers again. I do not want and should not have to get re-authorizations from new managers for prescriptions for which I currently have letters stating that I am approved until the year 2034. Promises have already been made to me and now you are saying they are no good and I have to reapply.

I do not want to participate in a Medicare Plan and screw around with paperwork and re-imbursements. Right now my pharmacy processes everything.

So your idea to change the pharmacy plan to get more money from my pocket and those of other citizens is not alright with me.

B. E. Parker- S.O.A. Retiree



Virus-free. www.avast.com

EGWP is a terrible idea and please don't touch benefits we have worked so hard for.

1. AlaskaCare pay or reimburse drug premium....ha. That creates another layer of bureaucracy.
2. Medicare Part D is NOT what I signed up for. Washington DC would love to get their hands on my retirement benefits.
3. It does change benefits.....just not immediately. This "wrap" is not accessible and more worries.
4. "If federal law and regs change, so will my drug benefit." I don't care how popular it is in other states. Other States don't have the benefits Alaska now has.
5. We are guaranteed our benefit. If it doesn't work you say "we can change the plan or get a new one". Wouldn't our Republican Senators in Juneau love that!

Please, just leave it alone. Until you can present a better argument that you presented in news letter, just leave alone.

Dorothy Sue Martin
AK retired NEA

To the Advisory Board:

I would like to offer some feedback related to the fall health fairs offered to state employees and retirees. I am very appreciative of this opportunity and have utilized this offering in past years. I was on a boat when the registration opened this year and tried to register (unsuccessfully) on August 20 where I found all sites throughout the state were already closed. I live in [REDACTED] and usually travel 250 miles to attend the fair in Anchorage.

I noted on the website they make mention of the process for cancelling an existing reservation, but I'm informed by a Retirements & Benefits employee that there is no wait list to fill vacancies as they occur. While I appreciate that space is limited, it seems a waste not to fill openings which are bound to occur over the next few months. It's clear the demand for these health clinics far exceeds the offerings. I would also encourage, if at all possible, either more openings for the Anchorage area since it has the largest population in the state or offering a fair on the Kenai Peninsula. At the very minimum, however, I request a process that reallocates health fair cancellations.

Beverly Cronen

I have attached a copy of a letter, in .pdf format, which I also mailed to two other addresses within the State system on this date. I will appreciate your taking my concerns into consideration.

Thank you,

Kathie Livesley



Kathie Livesley

August 22, 2018

Alaska Department of Administration
Division of Retirement and Benefits
PO Box 110203
Juneau, AK 99811-0203

Retiree Health Plan Advisory Board
c/o Alaska Department of Administration, Division of Retirement and Benefits
PO Box 110203
Juneau, AK 99811-0203

Gentlepersons:

I submit the following concerns regarding (1) the AlaskaCare switch to OptumRx as the new benefit manager and (2) the possibility of AlaskaCare retiree pharmacy coverage changing to an EGWP.

I received a flyer from you last week wherein you claim that, "[T]he retiree health trust would receive much higher subsidies than we do today for the same benefits." I believe this statement may or may not be true in 2019. My reason is that the House of Representatives has already prepared a 2019 budget that proposes to cut \$537 billion from Medicare over the coming decade. ([https://www.washingtonpost.com/news/business/wp/2018/06/19/house-gop-plan-would-cut-medicare-social-security-to-balance-budget/?hpid=hp_hp-top-table-main-budget%3Ahealthcare%3Ahomepage%2Ft%3Ahealthcare&utm_term=.f323f582b9e7](https://www.washingtonpost.com/news/business/wp/2018/06/19/house-gop-plan-would-cut-medicare-social-security-to-balance-budget/?hpid=hp_hp-top-table-main-budget%3Ahealthcare%3Ahomepage%2Ft%3Ahealthcare&hpid=hp_hp-top-table-main-budget%3Ahealthcare%3Ahomepage%2Ft%3Ahealthcare&utm_term=.f323f582b9e7)). While the budget does not specifically state that EGWP subsidies are to be cut, there are no specifics and the actual cuts will be determined if the bill is passed. Both the House and Senate have made it abundantly clear that they intend to pay for the \$1 trillion tax cut by eliminating "entitlements" like Medicare. Additionally, over the last eighteen months, when House bills have failed, the Administration has taken it upon itself to implement cuts via executive order and presidential memoranda directions to the various departments. Congress has in the past threatened to revoke state subsidies on more than one occasion relative to the Affordable Care Act if States did not take certain steps; there is no guarantee that such tactics would not be employed when it comes to Medicare subsidies. At the very least, with such huge cuts to Medicare on the horizon, the State of Alaska could almost certainly expect to pay increased deductibles and copays under EGWP with the same amount of subsidy. Given the current uncertainty in our government, it seems irresponsible to rely on current subsidies as being "written in stone" for any future period.

While the State believes that the switch to an EGWP will provide funds to sustain pharmacy benefits into the future, I have read that Medicare Advantage plans have already seen changes to their EGWPs and the driving force appears to be the cost of PPO vs HMO plans, the former costing more than the latter. Since our plans are all PPOs, it seems reasonable to expect that a change to the AlaskaCare subsidy might also be on the horizon.

Aloha,

I was surprised to find that not only is the shingles vaccine not covered in my prescription care from AlaskaCare, but NO vaccines are covered.

This seems short sighted financially; ie members do not get vaccines as they are expensive, as a result some of those insured get the medical conditions that the vaccines would prevent so they go to the hospital. AlaskaCare then pays for the hospitalization of members who might have avoided the hospital stay by getting the proper vaccine. Bottom line: isn't it cheaper to pay for the vaccines in the first place and avoid the potential for expensive hospital care later?

How can this be resolved?

Mahalo,

Peter Anderegg

