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

Meeting: Modernization Committee
Date: September 28, 2018
Time: 9:30am - 12:30pm
Location: **Anchorage:** Atwood Building, 550 W 7th, 19th Floor Conf. Room
Juneau: State Office Building, 10th Floor Conf. Room
Teleconference: **1-855-244-8681 / Event number: 807 107 256**
WebEx Link:
<https://stateofalaska.webex.com/stateofalaska/onstage/g.php?MTID=e41b99d15f31d61b4b050dc2262e84aaa>
Committee Members: Mark Foster, Cammy Taylor and Joelle Hall

September 28, 2018

9:30am	Call to Order – Mark Foster <ul style="list-style-type: none">• Approve the agenda• Approve the previous meeting minutes (8/10/18)• Introductions
9:40am	Public Comment <ul style="list-style-type: none">• Read the Oral Public Comment Script
10:00am	Continue to Discuss Analysis – DRB Presentations <ul style="list-style-type: none">• Revisit Modernization Table<ul style="list-style-type: none">○ Identify next items for analysis• Rehabilitative Care
11:00am	Break
11:15am	Continue to Discuss Analysis – DRB Presentations <ul style="list-style-type: none">• Rehabilitative Care (continue discussion if needed)• Travel Benefit
12:25am	Final thoughts Announce date of next meeting
12:30pm	Adjourn

Meeting Minutes

8/10/18

Retiree Health Plan Advisory Board

Modernization Committee Meeting Minutes

Date: Friday, August 10, 2018 1:00 to 5:00 p.m.

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

Meeting Attendance

Name of Attendee	Title of Attendee	
Retiree Health Plan Advisory Board (RHPAB) Members		
Mark Foster	Committee Chair	Present (phone)
Joelle Hall	Committee Member	Present
Cammy Taylor	Committee Member	Present
Judy Salo	Board Chair	Present
Mauri Long	Board Member	Not Present
State of Alaska, Department of Administration Staff		
Leslie Ridle	Commissioner, Alaska Department of Administration	
Emily Ricci	Health Care Policy Administrator, Retirement + Benefits	
Vanessa Kitchen	Administrative Assistant	
Michele Michaud	Deputy Director of Retirement + Benefits	
Andrea Mueca	Health Operations Manager, Retirement + Benefits	
Betsy Wood	Health Policy Manger, Retirement + Benefits	
Others Present + Members of the Public		
Richard Ward	Segal Consulting (actuary for AlaskaCare plans)	
Scott Young	Conduent (actuarial analysis conducted by the State)	
Anna Brawley	Agnew::Beck Consulting (meeting support)	
Grant Callow	Public	
John Northcott	Public	
Brad Owens	Public	
Wendy Wolf	Public	
Nancy Woolford	Public	
Carol Fleek	Public	

Common Acronyms

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

- ACA = Affordable Care Act (formal name: Patient Protection and Affordable Care Act)
- CMS = Center for Medicaid and Medicare Services
- DB = Defined Benefit plan (for Tier 1, 2, 3 PERS employees and Tier 1, 2 TRS employees)
- DCR = Defined Contribution Retirement plan (for Tier 4 PERS employees and Tier 3 TRS employees)
- DOA = State of Alaska Department of Administration
- DRB = Division of Retirement and Benefits, within State of Alaska Department of Administration
- DVA = Dental, Vision, Audio plan available to retirees
- EGWP = Employer Group Waiver Program, a federal program through Medicare Part D that provides reimbursement for retiree pharmacy benefits
- EOB = Explanation of Benefits, provided by the plan administrator detailing claims coverage
- HIPAA = Health Insurance Portability and Accountability Act (1996)
- HRA = Health Reimbursement Account, a mechanism for the employer to reimburse high-income Medicare enrollees for any premium charge for their Medicare plan (IRMAA)
- IRMAA = Income Related Monthly Adjustment Amount, a surcharge from CMS for a Medicare plan for individuals or households earning above certain thresholds
- MAGI = Modified Adjusted Gross Income, based on an individual or household's tax returns and used by CMS to determine what if any premium must be paid for a Medicare plan.
- OPEB = Other Post Employment Benefits; an accounting term used to describe retirement benefits other than pension benefits
- OTC = Over the counter medication, does not require a prescription to purchase
- PBM = Pharmacy Benefit Manager, a third-party vendor that performs claims adjudication and network management services
- PHI = protected health information, a term in HIPAA for any identifying health or personal information that would result in disclosure of an individual's medical situation.
- RHPAB = Retiree Health Plan Advisory Board

Meeting Minutes

Item 1. Call to Order + Introductions

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

- **Motion** by Joelle Hall to approve the meeting agenda. **Second** by Cammy Taylor.
- **Result:** Meeting agenda approved.

The committee briefly reviewed the minutes from the July 26 committee meeting.

- **Motion** by Cammy Taylor to approve the meeting agenda. **Second** by Joelle Hall.
- **Result:** Minutes from the previous meeting approved.

Emily Ricci introduced a new DRB staff member, Betsy Wood, the new Deputy Health Official who started on Monday 8/6. She will be taking on responsibilities to support this board, and other duties.

Item 2. Public Comment (Part 1)

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

Public Comment

- Brad Owens, Anchorage: He would like to provide comments at the end of the meeting, and requested that DRB staff indicate what if any changes have been made in the packet since these materials were first shared at the July 26 committee meeting.
 - Emily Ricci confirmed that the materials provided in the August 10 agenda packet have not changed since the last meeting, which includes analyses of the individual proposals being considered. The only change to the overall materials was including additional pages incorporating public comments on the proposals, which are available online (not printed for the meeting, as each packet includes over 200 pages of public comments).
- Wendy Wolf, phone: Wendy requested information about the opt out provision for EGWP as a Medicare Part D plan. If someone opts out of EGWP and then opts back in at a later date, will they be subject to a late enrollment penalty like there is with some other Medicare plans?
 - Michele Michaud responded that there will not be a late enrollment penalty, both the proposed AlaskaCare enhanced EGWP and the alternative plan for members who opt out are considered "credible coverage" and would not trigger a penalty.

Item 3. Continue to Discuss DRB Analysis from 7/26 Meeting: EGWP

Materials: EGWP Analysis Memo in 8/10/18 meeting agenda packet

Mark Foster invited staff to provide updates on the modernization project.

Commissioner Ridle stated that the intent of today's meeting is to finish review of the EGWP proposal, and answer the committee's questions in advance of the August 29 RHPAB full board meeting.

Emily Ricci shared that DRB staff has included public comments on these proposals in the committee packet, but there is a lot of material: DRB staff is working on how to summarize these and provide the information to the board, since there are over 200 pages of comments. In the meantime, the full packet of public comments is posted on the RHPAB web page and available for download.

EGWP Impact Analysis Memo

The analysis conducted is categorized by benefit impacts, financial impacts, impact to the plan's actuarial value if any, members who will be impacted, administrative impacts for implementation and ongoing operations, and any other relevant impacts. Staff use these categories to consider various possible impacts for each proposed change.

Richard Ward continued presentation of the memo summarizing actuarial impacts to EGWP, beginning on page 34 in the packet. He reiterated that the actuarial impact of implementing an EGWP is neutral, meaning that it will not change the fundamentals of the benefit design (co-pays, deductibles and relative coverage between an individual member and the State for the member's health care costs each year). Taken on its own, Medicare Part D would be a change to the plan, but the State's proposed wrap of benefits to cover additional medications, matching the State's current pharmacy plan and formulary, means that the medications covered are the same.

- Mark Foster asked whether Richard Ward has conducted analysis of other states' EGWPs, including a follow-up analysis after implementation of an EGWP to determine whether the actuarial value was not impacted, as projected?
 - Richard Ward commented that the analysis can get complicated, as most other states have adopted some form of EGWP, but have differences between their previous plan and the EGWP, such as using a closed pharmacy network or adopting the Medicare Part D formulary only, and/or adjust their plan design in other ways when adopting. He cautioned against conflating these other changes with adoption of EGWP, since those other changes (changes to what medications are covered, to co-pays, and to pharmacy networks) may impact actuarial value, but not EGWP itself.
- Joelle Hall asked about the example of Illinois, and whether they adopted an EGWP?
 - Richard responded that Illinois adopted a different kind of Medicare Advantage plan that includes pharmacy benefits, so there are some similarities, but not all of the characteristics that would be implemented in Alaska's proposal. He also stated that Alaska is somewhat unique in having constitutionally protected benefits for state employees. Illinois has several key differences, including a less-well-funded retirement fund and other characteristics; they moved to a per member per month payment of \$200, but are also at least a year behind in paying claims, so their situation is different and not necessarily comparable.
- Cammy Taylor asked about whether implementing an EGWP would change the price of drugs purchased under the plan?
 - Richard responded that the EGWP does not change the pricing for drugs, but because the State is also changing to a new pharmacy benefit manager (PBM), there will be changes in drug prices due to the negotiations, contracts and relationships that may be

different between the current PBM (Aetna, CVS Caremark) and the new PBM (OptumRx). This means that drug prices will be differences, but due to the individual PBMs. The general structure is the same, where the PBM negotiates prices with network pharmacies and negotiates discounts with pharmacy manufacturers.

Michele directed the group to page 36 to review financial impacts, and Attachment B (page 45).

Financial impacts: Scott Young, an actuary with Conduent who provides services to the Alaska Retirement Management Board, commented that in Attachment B, there are multiple analyses including some for Aetna's proposal, which would have included some changes to the plan design. These will not be discussed since Aetna was not selected as PBM; the focus is on the Segal Consulting estimates. Segal estimated that by implementing EGWP, the State can achieve significant savings in multiple areas: 1) a per member per month subsidy payment, 2) coverage gap discount (referred to as a "doughnut hole"), and 3) catastrophic reinsurance subsidies. Additionally, estimated impacts include potential changes to member costs, either \$100,000 more or less than the current plan, reduction in administrative costs, lower fees associated with requirements in the Affordable Care Act, and a change in drug rebates, and the estimate projects between \$35 million to \$44.7 million in federal subsidies under an enhanced EGWP, compared with between \$19 million to \$21 million in federal subsidies under the currently utilized Retiree Drug Subsidy program.

Commissioner Ridle clarified that the line "Change in Member Costs" does not refer to a cost incurred by the member, but the average cost of covering each member. The analysis does not project additional out of pocket costs to the member: the costs are specific to the State.

- Mark Foster asked what cost drivers were used to estimate changes to gross claims projected in EGWP?
 - Richard Ward responded that the changes projected have to do with estimated changes in pharmacy network contracts and drug prices, to reflect the new PBM. Segal Consulting estimated that there will be additional rebates and changes in prices by being part of an EGWP, these are reflected in estimated changes to gross claims.

Scott Young continued: the analysis also shows estimated costs and savings for employers and the State. For non-State employers, there are caps in what employers must contribute; the State pays the excess of the cost beyond that cap. There are different contributions and rates by group (PERS, TRS and JRS). Because employers continue to pay up to the cap, and the State pays the extra, most of the savings would accrue to the State by having to pay less of the excess. For example, implementing an EGWP in FY 2019 would potentially have resulted in a total of \$39.9 million to \$52 million in savings to the State. The analysis also estimates the present value of the plans to illustrate the total estimated savings: most of the savings would be achieved through the Defined Benefit plans, which have the largest number of people and include a larger percentage of people who are Medicare eligible. Total savings over time (present value) for all plans, including DB, DCR and JRS plans, would be between \$520 million and \$694 million, representing the sum of money that would not need to be paid by the State for pharmacy costs, as they would receive additional subsidies.

- Joelle Hall asked about the projected reduction in the State's unfunded liability, would this impact that as well?

- Scott responded that yes, this would reduce that liability as well, since it is funds the State does not have to pay back into the plan over time. The PERS currently has an unfunded liability of around \$7.7 billion and TRS around \$2.7 billion for a total unfunded liability of approximately \$10.4 billion. So the reduction in the present value of future payments would represent approximately 5-7% improvement in funding.
- Commissioner Ridle reiterated that the current total unfunded liability is about \$10 billion, so this would be a significant improvement, but does not cover all the unfunded liability.

Emily Ricci added that there is currently some discrepancy between the narrative about financial impacts and the numbers in Appendix B. DRB staff will correct these discrepancies in the narrative, the numbers in Appendix B are correct.

Michele directed the group to return to the operational impacts section (page 35).

Operational impacts: DRB will have additional cost as it relates to implementation of the new PBM contract. Michele also responded to the earlier question during public comments, that there will be no late enrollment penalty if someone is currently covered under AlaskaCare or opts out of the EGWP for other coverage. The opt-out option is considered “credible coverage” under the Affordable Care Act, and does not trigger a penalty. DRB will need to work with members who self-enrolled in an individual Part D plan, as those members will lose their individual Part D coverage when enrolled in the EGWP.

Additionally, the State can remain the plan fiduciary, and not the PBM: incorrect information was provided earlier this year, but DRB since confirmed that under an EGWP, the State remains the fiduciary.

Emily Ricci added that much of the additional administrative and operational burden will be in the months prior to implementation and during the transition to the new program in early 2019. There will be additional work upfront, but maintenance program should be minimal, similar to the workload for managing the current process.

- Mark Foster asked about the overall plan and timeline for addressing known implementation issues, such as people who are high-income retirees who would be subject the IRMAA premium for Medicare plans?
 - Emily responded that staff will be meeting with the Medicare Information Office in Juneau next week to learn more, they are hoping to get a sense of how many retirees may be currently enrolled in Medicare and who are subject to the IRMAA.

Clinical considerations (page 38): Some prescriptions will require new pre-authorizations, because the plan is a Medicare plan. However, none of the CMS required pre-authorizations have a step therapy component. The retiree health plan currently requires prior authorization for some very high-cost prescriptions, and may require for these prescriptions that the member try alternative medications or a statement that the particular brand or drug is a medical necessity. This is part of the current plan, and is not a change related to EGWP.

- Judy Salo asked whether a hypothetical prescription that the member has already received prior authorization for, would they be required to get a new one? How does this differ from the current plan? Do different prescriptions have different length of time for authorizations?

- Michele responded that will differ by individual case, because prior authorizations are different lengths of time depending on the drug, diagnosis, and other circumstances. In many cases, pre authorization will be able to be rolled over into the new plan. In other cases, it may simply involve a determination of which plan (Medicare Part D, the state wrap, or Medicare Part B) should cover the medication, which is an administrative decision that will not impact the member but determines which part of the plan it is covered under. She added that the Division is working to have the concierge service running beginning early November, so the new PBM can work with doctors and members to take care of this information in advance.

Third Party Administrator (PBM) impacts: The new PBM will have a significant workload to transition to the new plan and work with members. The PBM will also manage which medications qualify for federal subsidies and those that are fully the responsibility of the health trust. A few plan members are considered low income and therefore eligible for some new federal subsidies for pharmacy costs available under the EGWP. This low income subsidy will be managed by the PBM.

- Judy Salo asked whether the PBM contract implementation is on schedule?
 - Michele responded that while they have not signed the contract yet and are still negotiating, they have met with the new PBM and are also working through the required protest period. They are slightly behind schedule, but anticipate staying on schedule overall once the contracting piece is completed.
 - Emily Ricci added that DRB staff have requested data and analysis to review how many people will be impacted by the transition, such as how many prescriptions will require pre-authorization.

Provider impacts: Overall, providers will have minimal impacts, following the transition period to the new plan information and taking care of pre-authorizations. Pharmacists will also have limited impacts, but will generally operate the same as it does under the current plan. Pharmacists may need to manage two network contracts with the PBM, but this is handled by pharmacies and the PBM. Additionally, DRB has meetings scheduled with independent pharmacies to discuss the transition and identify and anticipate any additional impacts.

- Cammy Taylor asked if pharmacies will be able to handle coordination of benefits for someone with multiple health plans at the retail point of sale?
 - Michele confirmed that yes, these will be handled at point of sale.

Additional follow-up: At the previous meeting, DRB staff shared that four communities do not currently participate in the new PBM's EGWP network. Michele Michaud clarified the current status of these communities (below). The PBM will be working with pharmacies to try to bring them into the network.

- Dillingham: there are two pharmacies, one at the hospital and another run by a tribal health corporation. The hospital pharmacy is in the commercial network today, but not the EGWP network at this time.
- Bethel: one pharmacy, which is not in the current commercial or the EGWP network.
- Petersburg: one pharmacy, which is in the current network but not the new EGWP network.
- Wrangell: one SEARHC pharmacy, which is in the current network but not the new EGWP network.

Michele Michaud shared that CMS requires members be given an initial option to opt out of the EGWP, but the State cannot afford to pay more for members who opt out of EGWP especially given that the copayments and covered medications will be the same under an EGWP as they are today. The Division is proposing an opt out plan that would be significantly different than that under EGWP, which matches the current plan, because it does not come with additional federal subsidies. The State is also proposing to not allow coordination between plans on the opt out plan, as it would also result in additional cost for the same benefits.

- Judy Salo asked for clarification about the opt out plan and coordination between plans?
 - Michele responded that the State hopes that at most, only a small number of people will opt out; the opt out plan is designed to disincentivize opting out since it would forfeit the subsidies for pharmacy costs that are available under the EGWP.
- Judy Salo asked if it is possible to send additional information for members when they receive the welcome packet from the new PBM?
 - Yes, the PBM contract will allow for some customization of materials that go out to members, so DRB will work with the vendor to make sure that members are informed, and addressing any specific situations that members are likely to ask.
- Cammy Taylor commented that Medicare enrolled individuals who are subject to an IRMAA premium receive information in the fall from CMS. She asked if DRB will be asking the Medicare office for information about how many people are subject to this premium, and how many people have failed to make premium payments?
 - Michele responded that DRB staff will work with the Medicare office to get more information about members subject to the IRMAA. Additionally, for members who are moved to the Opt-Out plan due to an inadvertent failure to make premium payments to CMS, the Division will assist the member in being reinstated to the enhanced EGWP without a break when the member takes action to make the retroactive IRMAA payments.
- Cammy Taylor also asked about payment by the state for IRMAA to cover members' premiums, and what a member's options are?
 - DRB is still working through this, but generally, CMS deducts premiums from members' monthly Social Security payments if they are receiving Social Security; if the member is not receiving Social Security, CMS will invoice members directly. The prefunded HRA could be used to pay the premium directly to CMS when the member is receiving invoices, or could reimburse the member if the payment is deducted automatically from Social Security.
- Cammy Taylor asked whether DRB has researched situations in which a member's denied claim would be put into a federal appeal process, instead of being covered at the State plan?
 - Michele Michaud commented that DRB asked the PBM to research this, and they did not see a scenario in which it would trigger a federal appeal rather than being covered by the State under the wrap of benefits. There may be rare cases where this could happen, but DRB is working with the PBM to address this and figure out if it is possible, as a policy, to intervene in a federal appeal to ensure that the claim is covered under the State wrap rather than pursuing the appeal.

The committee took a 15-minute break from 2:15 p.m. to 2:30 p.m.

Item 4. Impact Analysis Memos: Lifetime Maximum

Materials: Removal of Lifetime Maximum Memo in 8/10/18 meeting agenda packet

Commissioner Ridle commented that generally, the modernization project is being presented today, but this is the first of many steps: she anticipates that the Board will request more information, will want to see proposed offsets to complement the additional benefits proposed, and other analysis as the discussion continues. The intent is to share this information now, but not to vote on or make decisions about these proposals in this meeting or at the August 29 meeting.

Emily Ricci provided an overview of the Lifetime Maximum proposal:

Currently, the AlaskaCare health plan has a lifetime maximum for each member of \$2 million for all medical expenses. (Pharmacy expenses are excluded from this). Currently, at the end of each benefit year, up to \$5,000 in benefits is restored if someone hits the maximum, with additional options for restoration if the member submits proof of good health. For example, a person who uses \$2 million in health care services would be limited to coverage of up to \$5,000 per year of health expenses under the retiree health plan, unless and until their health situation changes. The proposed change would also prospectively restore benefits to people who have hit the lifetime maximum (not retroactively).

- Joelle Hall asked whether there is any legal concern regarding prospective restoration of members' benefits if they have hit the lifetime maximum?
 - Emily Ricci commented that any of the State's decisions are subject to litigation, but generally speaking the State is not obligated to retroactively provide benefits if they were not provided at a prior time. Similarly, the health plan has changed over the years (such as increasing the lifetime maximum) but this does not obligate the State to go back and provide these benefits for members for prior years.

This change would add approximately 0.4% actuarial value to the plan (making it slightly more valuable), and likely result in approximately 2% in additional health plan costs to the State.

This currently impacts a relatively small number of members (5 currently were identified as having reached this maximum), but DRB anticipates that more people will continue to be subject to this rule in the future, and it has huge impact on individuals who become subject to this rule. Lifetime maximum payments are not standard anymore, and the Affordable Care Act required most health plans to remove it, primarily active employees. Another 25 individuals have used over \$1 million in benefits to date. The lifetime maximum is measured by individual, not household: a household of 2 covered under the retiree health plan would each have a \$2 million maximum, this is not pooled among household members.

- Judy Salo asked Richard Ward whether other states have implemented alternatives to the lifetime maximum rule, such as catastrophic coverage pool?
 - Richard responded that states and other large plan sponsors have been removing lifetime maximums. States that already removed them often have pooled active and retiree employees in the plan, thus the change was because of the ACA requirement to remove maximums for active employees.
- Judy also asked what the actuarial and financial impacts will be by implementing this change?

- Richard responded that financial impacts will vary from year to year, depending on utilization and claims made each year. The larger the utilization of a provision across an entire pool, the more stable the average is; for this provision that impacts a relatively small number of people, but impacts them significantly. The smaller number of impacted people means more variation from year to year, so it is difficult to model.
- Judy commented that when considering offsets, the financial impacts may be spread across more people who would consider it a negative impact, compared with a proposal like this, where a small number of people will be significantly positively impacted. The State needs to take this into consideration when comparing across multiple proposals.
 - Commissioner Ridle agreed this is a valid consideration. However, the magnitude of impact on the few individuals is considerable, with serious health and financial implications for their members, so this should also be factored in when considering the number of people impacted and the scale of the impacts. She provided examples of individuals who are currently impacted by this change, including serious financial and potentially health and safety impacts for individuals who cannot have care paid for anymore with the current lifetime maximum for this policy.
 - Judy speculated whether the lifetime maximum is a deterrent for people utilizing care unnecessarily or choosing whether or not to use the benefits.
 - Richard commented that as people approach the maximum, their economic decision making would change.

Commissioner Ridle added that the change to the plan does not have to occur at the start of the plan year, and that the Board can request analysis of additional options such as a higher lifetime maximum, a higher amount for benefits if you exceed the maximum in a year, and other options.

Judy Salo also commented that because this is being considered in the context of other plan changes, some of which may be considered a diminishment in benefits, it would make sense to hold implementation of all these proposed changes until they can be considered as a whole.

- Joelle Hall asked how many people have reached the limit, or have used a significant portion of benefits, and their age, for purposes of understanding the magnitude of this issue?
 - Emily Ricci pointed to the table on page 52, outlining the number of members in each tier of benefits utilized. She also noted that some members will have other options for coverage, such as Medicare or potentially the individual insurance marketplace, so not all individual members' costs have the same impacts to the health plan. Additionally, even having \$5,000 per year in benefits is considered credible coverage for purposes of enrolling in the individual marketplace or other coverage, so they would need to wait until the open enrollment period, typically in late fall to December.
- Judy Salo asked about the status of active employees who are on disability, are they enrolled in Medicaid or another plan?
 - Michele Michaud commented that as active employees, they are not subject to a lifetime maximum since that plan does not have a limit. If they are appointed to a PERS or TRS disability they are enrolled in the retiree health plan, and are subject to the lifetime maximum—it is set by the plan.
 - Emily Ricci added that members may be able to enroll in the state's high-risk pool to provide coverage. There is a premium for the plan, stratified by age, but the premium is

thousands of dollars per month for a \$1,000 deductible plan. For a \$15,000 deductible plan, the premium is over \$1,000.

- Commissioner Ridle asked DRB staff to consider whether the State can cover the cost of the premiums of this high-risk plan for the few people who have met the lifetime maximum, since it is a small population of people currently?
 - Emily Ricci commented that there would be a cost for the premium, that based on historical data will continue to increase over time, and likely to become significantly more expensive over time. Additionally, the member would still be subject to significant health care costs because of the deductibles.
- Joelle Hall asked if this high-risk pool is the same as the one secured by Division of Insurance to supplement the State's individual market to pay for high-cost individuals?
 - Emily Ricci commented that it is the same entity, but this particular program pre-dated the Affordable Care Act and is primarily used now by people who are not eligible for Medicare, Medicaid or other subsidies.
- Joelle Hall also asked if these individuals could enroll in the individual market?
 - Emily Ricci shared that the guidance from the federal government is that individuals could enroll in the marketplace, but would have to wait until the open enrollment period, which is relatively short, and would not be eligible for the special enrollment period.
- Judy Salo asked whether members are aware of the lifetime maximum, and how many people are unaware of this policy?
 - Michele commented that the information is in communications and seminars presented by DRB and is in the booklet, but not all members have seen it. The lifetime maximum is also on the explanation of benefits members receive with a tally of how much they have used toward that lifetime maximum. She speculated that most people do not become aware of this policy until they have high-cost care episodes or start to get closer to the maximum. She added that DRB is seeing an increasing number of high-cost episodes of care, such as \$500,000 for one episode. This will continue to be an issue. She also noted that the information is tracked for each member and included on every Explanation of Benefits (EOB) as an ongoing tally.
 - Emily Ricci added that for some treatments, such as oncology and cancer treatments, new medications, etc. it is possible to use in excess of \$1 million for one course of treatment. Physicians are wary of beginning a course of treatment if they know that the member will likely meet their maximum for the treatment. Providers may also require a financial contribution from the member. This will continue to increase as health care costs continue to increase.

Commissioner Ridle suggested another alternative to consider, since the last time the maximum has been increased was 1999. There are still a relatively small number of people impacted, so there may also be an option to propose a series of steps to progressively increase the maximum over time, such as \$3 million for the next 2-3 years, and a higher maximum after that.

Emily Ricci added that from a policy perspective, health plan administrators want to align incentives: making sure that people have access to the care they need, utilize it at the appropriate times and levels, and that the plan can be financially sustainable over the long term. For example, the plan may

incentivize preventive care by lowering cost for those services (high value to members), and increase cost sharing for lower value, high-cost care. She is not sure whether lifetime maximums are the best policy to achieve this alignment of incentives, especially since it comes into play when someone is in dire need of health care or dealing with a complex and serious medical issues, and may not factor into health care decisions until a member is closer to that limit.

- Judy Salo commented that she is interested in considering how best to implement a policy like this, making sure that the plan manages the additional risk of higher costs if the lifetime maximum is removed. Longer life spans, expensive treatments like dialysis, and expenses associated with end of life care will also continue to impact health care costs.
- Cammy Taylor commented that she knows three individuals who have met the maximum, all of whom live in Anchorage, and she speculated whether it is easier to meet the maximum when you have more access to health care (in an urban area, versus a rural area with few providers).
- Joelle Hall commented that she believes the key question is not if, but when, to implement this change: health care costs will continue to rise rather than decrease, and more people will reach this maximum. She believes it is worth considering for its long-term implications.

Actuarial impacts: This is considered an enhancement, as it would increase members' access to benefits over their lifetime by not capping the total benefit at a dollar amount.

- Mark Foster asked Richard Ward for more information about the assumptions and features in the actuarial model did he use to estimate by demographics, price escalation, and geography.
 - Richard responded that the model they used is built for a "typical" health plan, with options to calibrate assumptions in the model that reflect a specific plan, in order to customize the model to be relevant to a specific plan. The team adjusted the age distribution based on the plan's current membership, percentage of Medicare enrollees, gender, geography including relevant information for the Lower 48, and adjusting cost assumptions for inpatient, outpatient, pharmacy, and others. There are some comparable plans in other states, for which they used a similar model as a comparison. Generally speaking, non-Medicare costs are significantly higher in Alaska than in other states; Medicare costs are slightly higher, as rates are more comparable between Alaska and other states. This reflects the difficulty in negotiating comparable prices in Alaska with providers compared with other states. Drug costs are generally similar, as PBMs in Alaska and elsewhere are able to negotiate prices.
- Regarding cost escalation: generally speaking, cost increase trends are higher in Alaska than other states. However, the retiree health plan is experiencing relatively lower cost escalation compared with other plans in Alaska: low single digit increases in medical costs and high single digit increases in pharmacy costs. This is due in part to the large number of Medicare eligible retirees, and Medicare pays much of the cost for these members (approximately 75%). While as people age they generally have more health care needs and therefore more cost, coverage by Medicare mitigates the cost increases the State would otherwise experience like other plans have without Medicare enrollees. Additionally, the large size of the plan allows for more competitive pricing than a smaller plan, as the plan and its vendor have more negotiating power.

- Mark responded that he is interested in risk associated with cost escalation, and mitigating that risk. Having a self-insured plan with a large number of members helps with this risk. He supports the idea of removing the lifetime maximum, as he does not see it as a cost driver on the order of magnitude of some other policies, and therefore lower risk for the sustainability of the plan. He also thanked DRB for bringing this forward as a positive policy change for non-financial reasons, he believes this is a compassionate and supportive policy for retirees, since the situations when this comes up are very difficult for members.
 - Richard commented that the OPEB has approximately \$10 billion in total, he does not anticipate that this would be a significant financial risk to the solvency of the trust.
 - Emily Ricci added that Medicare also has cost sharing requirements for members, and for large claims that cost share can be significant. Simply becoming eligible for Medicare does not remedy the situation for members who have reached the limit.
 - Richard Ward agreed, Medicare also has limits on inpatient hospital stays, it will not cover over a certain amount of hospital stays. The committee clarified that currently, AlaskaCare will cover additional hospital days if needed, subject to lifetime maximum.

Operational impacts: There would be minimal impact on the State, since this policy would simply be removed. Other options suggested today may have additional administrative burden, since it would mean the lifetime maximum would stay in place. Managing the lifetime maximum is currently done by the third party administrator of the plan, but as it becomes less mainstream vendors may no longer be able to provide this without significant cost, and could result in the need to be brought in-house and done by DRB staff instead.

Financial impacts: Of the projected \$680 million of total medical and pharmacy claims costs for the retiree health plan in 2019, this would add approximately \$2.7 million in costs on average for a plan year.

Clinical impacts: Generally, members will benefit from removal of the maximum and will benefit their access to care, it is currently a barrier if they meet the maximum. The change would also remove the need to track members' progress toward meeting the maximum. DRB believes that providers will respond positively to this proposed change, as this may affect their decisions for patients as well.

- Joelle Hall asked whether it is possible to index plan costs for medical inflation in the analysis, to understand overall impacts over time?
 - Richard responded that the analysis is considered for 2019, and did not include long-term trend. Generally, costs increase over time, but it is difficult to project costs at the level of individual claims since they depend on individual experiences. The consultant can produce a range of estimated costs per year and make some general assumptions about costs over time, but this would be difficult to predict with too much accuracy and extrapolate over the long term.
- Judy Salo commented that personally, in the course of the discussion, her position has moved toward favoring removal of the lifetime maximum rather than imposing a higher limit, given the work associated with tracking the cap.
- Cammy Taylor asked Richard Ward whether the consultant has considered other options such as a higher cap?

- Richard responded that the initial direction for the analysis was to consider removal of the cap, so they did not complete this analysis. Generally speaking, the impact diminishes as the maximum increases significantly, meaning that relatively fewer people will reach very high caps and therefore the projected risk to the plan will be smaller. For example, moving from \$2 million to \$3 million would have a projected higher impact than moving from \$3 million to \$4 million, and so on. Above a certain point, it is very unlikely that any individual would incur that level of cost, so the estimated actuarial and financial impact will be very small to zero.

The committee determined that they will not request additional analysis of alternatives at this time.

Item 5. Impact Analysis Memos: Preventive Services

Materials: Preventive Services Memo in 8/10/18 meeting agenda packet

Michele Michaud presented an overview of preventive services.

The original retiree health plan was first created in 1975, and at the time health care did not emphasize preventive services and wellness, and focused on care to address specific incidents or conditions and services like hospital stays. The plan does cover limited preventive services, such as specific screenings: mammograms, prostate screenings and Pap smears. Otherwise the plan is not in line with many other health plans, or the active employee plan in terms of preventive services.

The proposal is to cover preventive services, similar to the active employee plan, and follow the recommendations of the U.S. Preventive Services Task Force (USPSTF), rather than defining specific preventive services are covered, and having to change the plan over time as those recommendations change. This is consistent with the plan design of other plans and recommended in the Affordable Care Act. Additionally, Medicare does cover some preventive services at no cost, such as age-appropriate vaccines and screenings, so this benefit is already available to Medicare eligible members. This change primarily benefits non-Medicare eligible members.

The evidence regarding savings by encouraging use of preventive services is mixed, recent studies have shown that contrary to expectations that identifying health conditions earlier would result in savings to health plans; individuals who are considered higher risk may still not get these screenings and therefore would not know about health conditions early in order to address them early. However, covering preventive services does have potential to save lives and improve quality of life for individuals whose conditions are caught earlier, or prevents them against infectious diseases.

The proposal includes a feature called “steerage,” which is an incentive for remaining in network rather than paying the same amount for in-network versus out-of-network care. For example, like the current plan, this plan would cover 80% of the preventive care after the deductible is met for an in-network provider. For an out-of-network provider, the coverage would be 60% after deductible, unless an in-network provider is not available. Coinsurance would apply for all preventive services. Additionally, the proposal changes the specific coverage details in the plan, since the coverage of screenings and for which populations has changed over time, as new information is available. The new plan would follow the USPSTF recommendations for vaccines and cancer screenings, and including less frequent screenings per current guidelines for populations not considered high risk—this represents a change in covered benefits, in order to align with current best practices on screenings.

- Cammy Taylor commented that she knows several women in Alaska who were diagnosed with breast cancer in their 40s, and did not have family history or other clear risk factors, and would not have known but for a mammogram and/or manual exam. She is concerned that not covering the benefit at a lower age would be detrimental.
 - Emily Ricci commented that DRB is aware of the controversy about the mammogram recommendations that occurred at the national level when it was implemented, and this is the first proposal; staff can request additional analysis of other options.
 - Commissioner Ridle added that the State can change or cover additional recommendations beyond the USPSTF recommendations.
- Judy Salo recommended an analysis of coverage for the new shingles vaccine. She has heard from several retirees and other seniors who are concerned about having access to this vaccine.
 - Joelle Hall clarified that the proposal is to cover any recommended preventive screening as determined by USPSTF, by population and risk level. She recommends that staff make the list available to the public to review, as it will represent covered preventive services as proposed to be changed in the plan.
 - Emily added that providers are very familiar with what preventive screenings are covered and for whom, they stay current with the recommendations and other plans also cover these.
 - Michele pointed out that vaccines are addressed in the table on page 62.
- Joelle Hall asked for clarification about the Pap smear language in the packet? She is confused by the specific requirements stated here.
 - Emily Ricci responded that DRB will use the policy language in the recommendation, but this is certainly confusing and has changed significantly over the last few years. Individual recommendations will depend on the person's history and diagnoses, and members will need to consult with their provider about their personal situation.
- Judy Salo asked why the Prostate Specific Antigen (PSA) test is no longer covered? She also noted that this service is being provided free of charge at the upcoming health fairs.
 - Emily Ricci responded that the coverage guidelines for this test have changed due to a number of false positive tests. However, because the coalition who organizes the health fairs does cover this test, it is not likely to be removed from their plan. Additionally, members routinely ask for this coverage, so the State continues to offer it.
 - Commissioner Ridle recommended changing the document to reflect what other prostate cancer screenings will be covered instead of the PSA. Staff will change the table to better reflect what the new relevant services would be.
- Joelle commented that another member shared her experience, that she went for an annual visit to her gynecologist and was expecting to get a Pap smear, but was upset to find that her well woman visit was not covered, her doctor did not perform the service since it was against current best practices. She had to pay the bill for the entire visit.
 - Judy Salo suggested that the well woman and annual physical could be combined?
 - The group clarified that these are often two separate services, and may not be performed by the same provider, so they should remain separate.
- Joelle Hall asked about other cancer screenings, such as skin cancer, will these be covered?
 - Michele commented that as a policy this is important to clarify, but as a matter of putting the benefits in place, she recommends against specifying these in the plan

booklet, and instead referencing to current USPSTF recommendations that will be covered based on current evidence.

- Emily added that the State did put this level of detail in the employee plan booklet in 2013, but all the recommendations changed in the following year, and caused a great deal of work for staff to amend the booklet to reflect the new recommendations. She also noted that DRB can post information separately online with the latest coverage, and that providers know how to research this list and will be aware of which services are recommended and which are covered.

Member impacts: Generally this is an added benefit for members, as most of these services are not currently covered. In particular the colonoscopy is recommended once every 5 years after age 50, unless someone is high risk and should be tested more frequently; there are approximately 20,000 members between age 50 and 64, and Medicare covers this service at 100%. This also benefits Medicare eligible retirees as well, as it covers annual physicals and shingles vaccination. The addition of preventive services is the top request by retirees to add to the plan.

Commissioner Ridle also commented that they have seen wide variation in prices for colonoscopy services, to the order of thousands of dollars difference between providers' prices. The proposal of steerage to in-network providers would help address this issue and control costs for this service.

Actuarial impact: Richard Ward presented that this is considered an enhancement, as it would cover services that are not covered now.

- Judy Salo proposed that the committee not further discuss the preventive services proposal, and bring this item to the full board for discussion.
- Mark Foster commented that he commends staff for their thorough analysis and consideration of this proposal, and encourages the committee to minimize consideration of coverage, other than what is recommended by USPSTF, to avoid having to do additional analysis by changing assumptions about which services are covered.
- Judy Salo asked DRB staff whether this packet will be considered at the August 29 meeting?
 - Commissioner Ridle noted that staff will make some changes per discussion today, clarifying areas of confusion and updating financial consideration. But otherwise, yes, this packet will be presented at the August 29 meeting.
- Cammy Taylor asked whether staff have received other requests for benefits that aren't represented here?
 - Michele and Emily shared that members have requested coverage for rolfing, acupuncture, and occasionally other wellness benefits such as gym memberships. Members have also requested something like Silver Sneakers, a wellness program for retirees. Members have also requested enhanced travel benefits; they are not able to use the concierge service for travel, this benefit is only available for active employees.
 - Cammy requests that staff provide a list of any other additional benefits to the Board that member have asked for, for the Board to consider.

Item 6. Public Comment (Part 2)
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Joelle Hall restated the required information about HIPAA, protected health information, and that providing public testimony means it will become part of the public record. Testifiers waive their right to protection of health information shared during their testimony if they share it in the meeting.

Public Comment

- Grant Callow asked the committee about EGWP: he asked for clarification about whether there is a mandatory federal appeals process in place, instead of the claim being covered by the wrap?
 - Michele Michaud responded that they requested this information from the vendor and researched what situations would trigger this appeal process. The vendor and DRB were not able to identify a situation in which the federal appeals process would occur instead of the claim being covered under the state wrap. They will continue to research and work with the vendor, but they believe that generally the federal appeals process would not be necessary as the State will cover the medications they cover currently, even if they are not covered by Medicare Part D.
 - Grant asked when the State will have that information?
 - Staff does not have a specific timeline currently.

Brad Owens, on behalf of RPEA (Anchorage): Brad thanked DRB staff for consideration of adding these additional benefits into the retiree health plan, echoing comments of committee members. He also stated that at the annual plan meetings, retirees have an opportunity to ask questions of DRB staff, vendors and their consultants; so far, committee and board meetings have not included a question period, only public comment. He suggests providing more opportunities for retirees to ask questions directly. He also asked whether there will be a new plan document or guidance or policy statement regarding EGWP, or amendment to the current plan document, to provide more information about how this differs from the current plan? This may also include information about the appeals process and if/when it applies, changes to the plan document, etc.

- Michele Michaud responded that there will need to be changes to the plan booklet for other reasons as well, such as clarifying information about the appeals process, providing contact information for the new PBM vendor, and anything else that needs to change as a result of this transition. DRB will get more information about the appeals process and a final determination of how this would work under the EGWP.

He would also like clarification on the appeals process, and whether it is true that the federal appeals process would not apply because any denial of coverage under Medicare Part D, and the claim would instead be covered by the State wrap?

- This item is covered in the previous person's public testimony.
- John Northcott (Anchorage): John asked whether and how retirees can participate in the August 29 board meeting, and whether the committee will have another meeting prior to that meeting?
 - Judy Salo responded that it is unlikely that this committee will meet again prior to August 29, and the information in the packet that was not covered today will go to the full Board for discussion.
 - Yes, retirees will be able to participate in the meeting. The information about in person and telephonic participation is available on the website, including room numbers.

John also commented that as the State moves toward finalizing these proposals, he is concerned that information about the financial impacts of these changes and when this information will be

available. He appreciates the opportunity to participate. He knows that retirees will have a lot of questions, and he is happy to hear that a concierge service will be available to ask questions.

- Joelle Halle commented that the Board's responsibility is to provide guidance on these proposals, and to also speak to their constituencies about members' priorities, which are most valuable to retirees and provide the best value to the health plan overall. Financial analysis has a cost, and therefore the State is looking for more guidance and input from retirees before embarking on a more detailed financial analysis.
- Judy Salo commented that the intent is to get the new PBM's concierge service operational in the fall, to address members' questions and concerns and help with transitions such as pre-authorizations.

Item 7. Impact Analysis Memos: SurgeryPlus Travel Benefits

Materials: SurgeryPlus Travel Benefit Analysis Memo in 8/10/18 meeting agenda packet

Emily Ricci provided an overview of this proposed benefit, to add the SurgeryPlus travel program to the retiree plan, which helps members coordinate travel and a companion to a network of surgeons, meeting clear quality metrics and provide a deep discount because it is a negotiated benefit and SurgeryPlus brings higher volume of clients from across the country. This does not apply for all surgeries, but specific procedures that are conducive to this arrangement. Typically it would be for non-emergency surgeries such as a knee replacement. A member can still seek surgery through provider in their community, but this benefit would be available as an option. DRB added this benefit to the active employee plan, and will test implementation in 2019, including any lessons learned.

How it works: A member would contact SurgeryPlus, who would solicit 3 provider options for the member to consider, and the member would choose which of the 3 they prefer. SurgeryPlus would provide the member's medical records to the provider, who would determine that the member is still a good candidate for this surgery. If the provider agrees the member is eligible, SurgeryPlus would arrange travel (flight), lodging and per diem loaded on a pre-paid debit card for their travel. SurgeryPlus would also get transportation to and from the airport, to ensure they can make their appointment and return to their hotel or the airport. Services would be provided including any follow-up services needed, including outpatient to the patient's hotel room, and then they return home. Follow-up could also occur in the community if available.

SurgeryPlus maintains rigorous standards and a network of approved providers who have credentials to perform the surgery, meaning that there will be high quality care from a thoroughly vetted provider. This proposal would benefit members by having access to this care with travel arrangements made for them, guaranteed high quality care from a credentialed provider, and members and the State benefit because the negotiated prices are much lower than what members can access in state. For Medicare eligible retirees, they would not utilize the provider network because it is superseded by Medicare's own network, but these retirees could still access the travel arrangement benefit. Currently, members are responsible for all upfront travel costs for getting care outside their community or state.

Actuarial impact: Neutral. The payment (co-payment, deductible) for the member remains the same, the travel arrangements and associated costs are not specified in the plan booklet.

Financial impact: This proposal is estimated to generate over \$2 million in savings to the State, as it gives members access to quality surgery services at a discounted rate, without additional cost. Additionally, members could have travel arrangements made upfront and therefore also paid upfront, resulting in less upfront cost to members, rather than being reimbursed for out of pocket costs.

Clinical impact: These services have a lower than 1% rate of complications (and associated costs and health impacts), compared with approximately 14% complications with Alaska-based because the surgery providers are screened for certain quality metrics.

- Mark Foster commented that he appreciates the analysis, and in particular the information about relative complication rates between in-state procedures and SurgeryPlus, to help compare the value of this option for members.

Item 8. Meeting Adjournment

Mark Foster reiterated the committee's intent: there will not be another meeting prior to August 29, and the full Board will consider the information presented in these analyses and discuss further. Judy Salo suggested that the committee meet again briefly prior to the 9 a.m. meeting start in order to discuss how the information will be presented to the board. Committee members will coordinate.

- **Motion** by Cammy Taylor to adjourn the meeting. **Second** by Joelle Hall.
- **Result:** The meeting was adjourned at 4:50 p.m.

Public Comment Guidelines

Retiree Health Plan Advisory Board Public Comment Guideline

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

Retiree Health Plan Advisory Board Public Comment Guideline

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

Retiree Modernization Topics

Retiree Modernization Topics

#	Topic
1	Expand preventive coverage to add full suite of preventive services
2	Remove or increase lifetime limit (currently \$2M)
3	Increase deductible and out-of-pocket maximum
4	Implement 3-tier pharmacy benefit, change out-of-network pharmacy benefits
5	Exclude coverage for drugs with OTC equivalents
6	Limit compound coverage to high-quality, narrow network of pharmacies
7	Enhance travel benefits
8	Implement clear service limits for rehabilitative care such as chiropractic, physical therapy, occupational therapy, etc.
9	Exclude implants related to periodontal disease from medical plan and cover under dental plan
10	In-network enhanced clinical review of high-tech imaging and testing
11	Network steerage: 70% out-of-network and 90% in-network
12	Implement high-value pharmacy network with lower copays for chronic meds, medical synchronization, counseling, and packaging options for participating members.
13	Expand rehabilitative services to include Rolfing, Acupuncture, and Acupressure – Proposed through public comment
14	Add wellness benefits such as gym membership or program like Silver Sneakers –Proposed through public comment
15	Add medically necessary treatment of gender dysphoria including surgery – Proposed through public comment

Rehabilitative Care

DRAFT-Summary of Responses to Proposed Plan Design Change

Proposed change: Fixed Visit Cap on Treatment of Spinal Disorders, Acupuncture and Physical/ Occupational/Speech Therapy

Plans affected: DB Retiree Plan

Reviewed by: Retiree Health Plan Advisory Board, Alaska Retirement

Proposed implementation date: January 1, 2019

Review Date: September 28, 2018

Table 1. Plan Design Changes

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

Description of proposed change:

The plan currently covers outpatient rehabilitative care designed to restore and improve bodily functions lost due to injury or illness. This care is considered medically necessary only if significant improvement in body function is occurring and is expected to continue. The plan does not cover maintenance care, that is, care to maintain or prevent deterioration of a chronic condition. The provider must submit clinical records that document a member continues to experience significant improvement. If the records fail to demonstrate significant improvement in accordance with the established clinical criteria, the services are denied as being maintenance or preventive care.

The existing plan coverage of rehabilitative services is highly problematic and is the number one appealed provision of the plan. It accounts for approximately 1/3rd of all retiree appeals received by the Division for each of the last 3 years. The member's clinical record often does not support the medical necessity of continued care because the provider fails or was unable to objectively document measurable improvement that is expected to continue.

The proposed change would increase coverage to allow for maintenance or preventive therapies of chronic conditions. The individual would be provided up to 45-visits per benefit year for outpatient rehabilitative care, and separate 20-visits for spinal manipulation and 10-visits for acupuncture. The increase in coverage combined with the opportunity to reset the visit limit with the new benefit year would eliminate the need for

DRAFT-Summary of Responses to Proposed Plan Design Change

visit-triggered medical necessity determinations, and the corresponding appeals if the determination found that the additional services were not medically necessary. This would provide members and their providers with clear guidelines on what the plan covers.

Rolfing was also considered, but there was insufficient documentation in the medical literature at this time to support the medical efficacy of this treatment. It is considered an experimental and investigational service. This is not a mainstream benefit, and should it be covered, it would require significant manual processing making this difficult to administer. It could not be included in the visit limits above and would need to be considered a separate benefit. For these reasons, we recommend revisiting this benefit once additional clinical studies are available.

Table 2: Comparison of Current to Proposed Change

CURRENT: Page 36-37 2003 Booklet as amended	
Current (Page 36-37 of 2003 Retiree Insurance Information Booklet, as amended)	<p>Rehabilitative Care</p> <p>The Medical Plan covers outpatient rehabilitative care designed to restore and improve bodily functions lost due to injury or illness. This care is considered medically necessary only if significant improvement in body function is occurring and is expected to continue. [Emphasis added.] Care (excluding speech therapy) aimed at slowing deterioration of body functions caused by neurological disease is also covered.</p> <p>Rehabilitative care includes:</p> <ul style="list-style-type: none">• Physical therapy and occupational therapy.• Speech therapy if existing speech function (the ability to express thoughts, speak words, and form sentences) has been lost and the speech therapy is expected to restore the level of speech the individual had attained before the onset of the disease or injury.• Rehabilitative counseling or other help needed to return the patient to activities of daily living but excluding maintenance care or educational, vocational, or social adjustment services. <p>Rehabilitative care must be part of a formal written program of services consistent with your condition. Your physician or therapist must submit a statement to the claims administrator outlining the goals of therapy, type of program, and frequency and duration of therapy.</p>
Proposed	<p>Neurological Disease (no change)</p> <p>Cognitive therapy associated with physical rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is part of a</p>

DRAFT-Summary of Responses to Proposed Plan Design Change

treatment plan intended to restore previous cognitive function or slow deterioration of body functions caused by neurological disease.

Rehabilitative Care

Outpatient benefits are limited to 45 visits per benefit year.

Covered expenses include charges made by a physician on an outpatient basis for physical therapy, occupational therapy and speech therapy. Inpatient services will be covered under inpatient hospital and skilled nursing facility benefits.

Massage therapy is covered when it is prescribed by a licensed physician, chiropractor or naturopath and performed under the physician's, chiropractor's or naturopath's supervision, and is considered part of the overall treatment plan.

Chiropractic

Covered expenses are limited to 20 visits per benefit year.

Covered expenses include charges made by a licensed physician or chiropractor, on an outpatient basis. The covered services include office visit, examination, consultation, regional manipulations, or other physical treatment for conditions caused by or related to biomechanical or nerve conduction disorders of the spine, massage therapy in conjunction with and for the purpose of making the body more receptive of the spinal manipulation.

The 20-visit maximum does not apply to expenses incurred during your hospital stay, or for surgery, including pre- and post- surgical care provided or ordered by the operating physician.

Acupuncture

Covered expenses are limited to 10 visits per benefit year.

Covered expenses include charges made by a licensed physician or acupuncturist, on an outpatient basis.

The Plan will also pay for acupuncture therapy performed by a physician as a form of anesthesia in connection with surgery covered under the Plan, and these services are not subject to the 10-visit limit.

DRAFT-Summary of Responses to Proposed Plan Design Change

Member Impact:

Under the current benefits, many patients can become frustrated because subjectively they feel better but there are no measurable gains supported in the clinical records, and the services are denied after the member has already incurred the expense. The proposed change would make the plan coverage clear for members and their providers by reducing the requirement that there be demonstrated clinical gains as a criteria for coverage.

This proposed benefit will result in gains for some members, particularly those who have chronic conditions or who are making only slight improvement, who would receive additional services beyond what is covered today. However, while the proposed limits are sufficient to achieve a rehabilitated state in many patients, members who have not reached maximum therapeutic benefit within a single benefit year may be denied care that might otherwise have been found to be medically necessary for the interim period before the visit limits are reset.

Expanding acupuncture coverage, would be an added benefit to members seeking this treatment.

Actuarial Impact

Neutral / Enhancement / Diminishment

Table 3: Actuarial Impact

	Actuarial Impact	Notes
Current	N/A	N/A
10 Visit Limit on Acupuncture treatment	0.010% increase ¹	
10 Visit Limit on Rolf therapy treatment	0.005% increase	
20 Visit Limit on Spinal Manipulation	0.02% reduction ²	
45 Visit Limit on other Rehabilitative Services (OT/PT/ST)	0.05% reduction ³	

The net change would result in a slight reduction in the actuarial value of the benefits of 0.035%.

¹ Therapy Benefits – Focus on Actuarial and Financial Impacts for the Retiree Plan, Segal Consulting Memo updated September 26, 2018.

² Chiropractic Benefits – Focus on Actuarial and Financial Impacts for the Retiree Plan, Segal Consulting Memo updated September 25, 2018.

³ Therapy Benefits – Focus on Actuarial and Financial Impacts for the Retiree Plan, Segal Consulting Memo updated September 26, 2018.

DRAFT-Summary of Responses to Proposed Plan Design Change

The plan change will be an enhancement for those retirees with a chronic condition, whose treatment is maintenance or preventive. Should the member require more than 45 visits for physical/occupational/speech therapy and/or more than 20 spinal manipulation visits in a *single* benefit year, the benefits would be exhausted during that benefit year. However, the reset of the visit limit in the next benefit year would reduce this impact.

DRB operational impacts:

Rehabilitative care is the most frequent reason members submit appeals to the Division of Retirement and Benefits. Additionally, the Division spends considerable amount of time attempting to educate and explain the difference between the care that results in significant improvement, covered under the plan, and care that is maintenance or preventive care and not covered under the plan. Setting a limit on the number of visits covered per benefit year simplifies the benefits for members and providers. Simplifying the benefits and removing the exclusion of maintenance and preventive care should help alleviate member and provider confusion over what is a covered expense and reduce the administrative burden and expense of fighting costly and complicated appeals.

Financial Impact to the plan:

Table 4, Estimated Savings

Proposed Change	Estimated Annual Financial Impact⁴
10 visit-limit for acupuncture	\$ 65,000 in additional cost
10 visit-limit for rolf therapy	\$ 30,000 in additional cost
20 visit-limit for chiropractic	\$120,000 in savings
45 visit-limit for rehabilitative care	\$300,000 in savings

The savings analysis were based on 2017 and 2018 medical and pharmacy claims data, and projected expenses through 2019 based on a 3.0% and 6.0% respective trend. Visits that result in \$0 paid by the plan (due to other coverage or other reasons) were assumed to not count towards the visit limit.

Clinical considerations:

The proposed changes would allow for coverage of acupuncture and maintenance or preventive care, not currently covered under the plan.

^{4 4} *Therapy Benefits – Focus on Actuarial and Financial Impacts for the Retiree Plan*, Segal Consulting Memo updated September 26, 2018 and *Chiropractic Benefits – Focus on Actuarial and Financial Impacts for the Retiree Plan*, Segal Consulting Memo updated September 25, 2018.

DRAFT-Summary of Responses to Proposed Plan Design Change

Although there are always exceptions for acute cases, we believe the visit limits are sufficiently generous, when combined with the annual reset, to provide little to no impact to clinical considerations for most patients.




Third Party Administrator (TPA) operational impacts:

The proposed changes are ones that can be easily accommodated by the third-party administrator. The proposed change would further reduce the number of medical necessity determinations and corresponding appeals when the services were found to be maintenance or preventive.

Provider considerations:

The proposed changes would reduce the administrative tasks related to clinical documentation and appeal support. It would allow the provider to clearly understand what is covered under the plan, and work with the member on the treatment plan to include educating the member if the proposed treatment exceeds plan limits.

Documents attached include:

<u>Document Name</u>	<u>Page numbers</u>	<u>Notes</u>
Summary of public comment		
<i>Chiropractic Benefits – Focus on Actuarial and Financial Impacts for the Retiree Plan, Segal Consulting Memo dated July 25, 2018.</i>	 Chiropractic Benefits 7.25.18	
<i>Therapy Benefits – Focus on Actuarial and Financial Impacts for the Retiree Plan, Segal Consulting Memo dated July 24, 2018.</i>	 Therapy Benefits 7.25.18	
<i>Chiro Benefits – Focus on Actuarial and Financial Impacts for the Retiree Plan, Segal Consulting Memo updated September 25, 2018.</i>	 Chiropractic Benefits 9.25.18	
<i>Therapy Benefits – Focus on Actuarial and Financial Impacts for the Retiree Plan, Segal Consulting Memo updated September 26, 2018.</i>	 Therapy Benefits 9.26.18	

DRAFT-Summary of Responses to Proposed Plan Design Change

HealthMatters Article – May 2018	<i>Outpatient Rehabilitative Care Coverage in the AlaskaCare Retiree Health Plan</i> http://doa.alaska.gov/drb/newsletters/healthmatters/issue/30.html	
HealthMatters Article – May 2017	<i>Outpatient Rehabilitative Care Coverage in the AlaskaCare Retiree Health Plan</i> http://doa.alaska.gov/drb/newsletters/healthmatters/issue/28.html	
HealthMatters Article – April 2015	<i>Outpatient Rehabilitative Care Coverage in the AlaskaCare Retiree Health Plan</i> http://doa.alaska.gov/drb/newsletters/healthmatters/issue/24.html	

Segal –
Chiropractic Benefit
7.25.18

MEMORANDUM

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

From: Richard Ward, FSA, FCA, MAAA

Date: July 25, 2018

Re: Chiropractic Benefits – Focus on Actuarial and Financial Impact for the Retiree Plan

The AlaskaCare Retiree Plan currently provides coverage for chiropractic care in the same manner that other medical treatments and services are covered. The Plan applies the general plan provisions, such as deductible, coinsurance and out-of-pocket limitations, to determine any portion of the costs that are the member's responsibility. If the member has additional coverage, such as Medicare or other employer provided coverage, any portion of the costs covered by that plan is also considered. Below is a table outlining the current benefits offered under the Plan:

Deductibles	
Annual individual / family unit deductible	\$150 / up to 3x per family
Coinsurance	
Most medical expenses	80%
Most medical expenses after out-of-pocket limit is satisfied	100%
Second surgical opinions, Preoperative testing, Outpatient testing/surgery	100%
• No deductible applies	
Out-of-Pocket Limit	
Annual individual out-of-pocket limit	\$800
• Applies after the deductible is satisfied	
• Expenses paid at a coinsurance rate other than 80% do not apply against the out-of-pocket limit	
Benefit Maximums	

Individual lifetime maximum • Prescription drug expenses do not apply against the lifetime maximum	\$2,000,000	
Individual limit per benefit year on substance abuse treatment without precertification. Subject to change every three years	\$12,715	
Individual lifetime maximum on substance abuse treatment without precertification. Subject to change every three years	\$25,430	
Prescription Drugs	Up to 90 Day or 100 Unit Supply	
	Generic	Brand Name
Network pharmacy copayment	\$4	\$8
Mail order copayment	\$0	\$0

A change to the benefits under consideration would apply a 20 visit annual limitation to chiropractic care, while otherwise continuing the member to be subject to the current plan provisions.

Actuarial Value

Our analysis determines the impact of implementing a 20 visit annual limitation to chiropractic care would be a reduction of 0.02% in actuarial value.

Financial Impact

Based on a preliminary retiree claims projection of \$680,000,000 for 2019, this equates to approximately \$140,000 in annual savings to the plan.

This analysis is based on 2016 and 2017 medical and pharmacy claims data, projected to 2019 at 3.0% and 6.0% annual trends, respectively. The data was reviewed, but not audited, and found to be sufficient and credible for this analysis.

With over 60,000 members and a high incidence rate of chiropractic care, the data is considered credible for this analysis and recent utilization patterns are considered to be a sound basis for determining the impact of this prospective change. Visits that result in \$0 paid by the plan (due to other coverage or other reasons) are assumed not to apply towards the annual 20-visit limitation.

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

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

Segal –
Therapy Benefits
7.25.18



330 North Brand Boulevard Suite 1100 Glendale, CA 91203-2308
T 818.956.6700 www.segalco.com

MEMORANDUM

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

From: Richard Ward, FSA, FCA, MAAA

Date: July 25, 2018

Re: Therapy Benefits – Focus on Actuarial and Financial Impact for the Retiree Plan

The AlaskaCare Retiree Plan currently provides coverage for Physical Therapy, Occupational Therapy and Speech Therapy in the same manner that other medical treatments and services are covered. The Plan applies the general plan provisions, such as deductible, coinsurance and out-of-pocket limitations, to determine any portion of the costs that are the member's responsibility. If the member has additional coverage, such as Medicare or other employer provided coverage, any portion of the costs covered by that plan is also considered. Below is a table outlining the current benefits offered under the Plan:

Deductibles	
Annual individual / family unit deductible	\$150 / up to 3x per family
Coinsurance	
Most medical expenses	80%
Most medical expenses after out-of-pocket limit is satisfied	100%
Second surgical opinions, Preoperative testing, Outpatient testing/surgery • No deductible applies	100%
Out-of-Pocket Limit	
Annual individual out-of-pocket limit • Applies after the deductible is satisfied • Expenses paid at a coinsurance rate other than 80% do not apply against the out-of-pocket limit	\$800

Benefit Maximums		
Individual lifetime maximum • Prescription drug expenses do not apply against the lifetime maximum	\$2,000,000	
Individual limit per benefit year on substance abuse treatment without precertification. Subject to change every three years	\$12,715	
Individual lifetime maximum on substance abuse treatment without precertification. Subject to change every three years	\$25,430	
Prescription Drugs	Up to 90 Day or 100 Unit Supply	
	Generic	Brand Name
Network pharmacy copayment	\$4	\$8
Mail order copayment	\$0	\$0

A change to the benefits under consideration would apply a 45 visit annual limitation in aggregate to physical therapy, occupational therapy and speech therapy, while otherwise subject to normal cost share provisions.

Actuarial Value

Our analysis determines the impact of implementing a 45 visit annual limitation in aggregate to physical therapy, occupational therapy and speech therapy would be a reduction of 0.06% in actuarial value.

Financial Impact

Based on a preliminary retiree claims projection of \$680,000,000 for 2019, this equates to approximately \$400,000 in annual savings to the Plan.

This analysis is based on 2016 and 2017 medical and pharmacy claims data, projected to 2019 at 3.0% and 6.0% annual trends, respectively. The data was reviewed, but not audited, and found to be sufficient and credible for this analysis.

With over 60,000 members and a high incidence rate of therapeutic care, the data is considered credible for this analysis and recent utilization patterns are considered to be a sound basis for determining the impact of this prospective change. Visits that result in \$0 paid by the plan (due to other coverage or other reasons) are assumed not to apply towards the annual 45-visit limitation.

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

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Segal –
Chiropractic Benefit
9.25.18

MEMORANDUM

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

From: Richard Ward, FSA, FCA, MAAA

Date: September 25, 2018

Re: Chiropractic Benefits – Focus on Actuarial and Financial Impact for the Retiree Plan - **UPDATED**

This is an updated version of our memo from July 25, 2018. Our results and comments are based on updated data and analysis.

The AlaskaCare Retiree Plan currently provides coverage for chiropractic care in the same manner that other medical treatments and services are covered. The Plan applies the general plan provisions, such as deductible, coinsurance and out-of-pocket limitations, to determine any portion of the costs that are the member's responsibility. If the member has additional coverage, such as Medicare or other employer provided coverage, any portion of the costs covered by that plan is also considered. Below is a table outlining the current benefits offered under the Plan:

Deductibles	
Annual individual / family unit deductible	\$150 / up to 3x per family
Coinsurance	
Most medical expenses	80%
Most medical expenses after out-of-pocket limit is satisfied	100%
Second surgical opinions, Preoperative testing, Outpatient testing/surgery • No deductible applies	100%
Out-of-Pocket Limit	
Annual individual out-of-pocket limit • Applies after the deductible is satisfied • Expenses paid at a coinsurance rate other than 80% do not apply against the out-of-pocket limit	\$800

Benefit Maximums		
Individual lifetime maximum • Prescription drug expenses do not apply against the lifetime maximum	\$2,000,000	
Individual limit per benefit year on substance abuse treatment without precertification. Subject to change every three years	\$12,715	
Individual lifetime maximum on substance abuse treatment without precertification. Subject to change every three years	\$25,430	
Prescription Drugs	Up to 90 Day or 100 Unit Supply	
	Generic	Brand Name
Network pharmacy copayment	\$4	\$8
Mail order copayment	\$0	\$0

A change to the benefits under consideration would apply a 20 visit annual limitation to chiropractic care, while otherwise continuing the member to be subject to the current plan provisions.

Actuarial Value

Our updated analysis determines the impact of implementing a 20 visit annual limitation to chiropractic care would be a reduction of 0.02% in actuarial value.

Financial Impact

Based on an updated retiree claims projection of \$590,000,000 for 2019, this equates to approximately \$120,000 in annual savings to the plan.

This analysis is based on 2017 and 2018 medical and pharmacy claims data, projected to 2019 at 3.0% and 6.0% annual trends, respectively. The data was reviewed, but not audited, and found to be sufficient and credible for this analysis.

With over 60,000 members and a high incidence rate of chiropractic care, the data is considered credible for this analysis and recent utilization patterns are considered to be a sound basis for determining the impact of this prospective change. Visits that result in \$0 paid by the plan (due to other coverage or other reasons) are assumed not to apply towards the annual 20-visit limitation.

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

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Betsy Wood, Division of Retirement and Benefits
Linda Johnson, Segal
Michael Macdissi, Segal
Noel Cruse, Segal
Dan Haar, Segal

Segal –
Therapy Benefits
9.26.18

MEMORANDUM

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

From: Richard Ward, FSA, FCA, MAAA

Date: September 26, 2018

Re: Therapy Benefits – Focus on Actuarial and Financial Impact for the Retiree Plan - **UPDATED**

This is an updated version of our memo from July 25, 2018. Our results and comments are based on updated data and analysis.

The AlaskaCare Retiree Plan currently provides coverage for Physical Therapy, Occupational Therapy and Speech Therapy in the same manner that other medical treatments and services are covered. The Plan applies the general plan provisions, such as deductible, coinsurance and out-of-pocket limitations, to determine any portion of the costs that are the member's responsibility. If the member has additional coverage, such as Medicare or other employer provided coverage, any portion of the costs covered by that plan is also considered.

Additionally, the AlaskaCare Retiree Plan does not provide coverage for acupuncture unless performed by a physician as a form of anesthesia in connection with surgery covered under the plan and does not cover Rolf therapy. The updated therapy benefits would cover acupuncture and Rolf therapy procedures, which would be subject to their own individual frequency limitations of 10 annually. Currently the Plan covers acupuncture being performed by a physician as a form of anesthesia in connection with surgery covered under the Plan. The following table outlines the current benefits offered under the Plan:

Deductibles		
Annual individual / family unit deductible		\$150 / up to 3x per family
Coinsurance		
Most medical expenses		80%
Most medical expenses after out-of-pocket limit is satisfied		100%
Second surgical opinions, Preoperative testing, Outpatient testing/surgery		100%
• No deductible applies		
Out-of-Pocket Limit		
Annual individual out-of-pocket limit		\$800
• Applies after the deductible is satisfied		
• Expenses paid at a coinsurance rate other than 80% do not apply against the out-of-pocket limit		
Benefit Maximums		
Individual lifetime maximum		\$2,000,000
• Prescription drug expenses do not apply against the lifetime maximum		
Individual limit per benefit year on substance abuse treatment without precertification. Subject to change every three years		\$12,715
Individual lifetime maximum on substance abuse treatment without precertification. Subject to change every three years		\$25,430
Prescription Drugs		Up to 90 Day or 100 Unit Supply
		Generic Brand Name
Network pharmacy copayment		\$4 \$8
Mail order copayment		\$0 \$0

A change to the benefits under consideration would apply a 45 visit annual limitation in aggregate to physical therapy, occupational therapy, and speech therapy while otherwise continuing the member to be subject to the current provisions. Additionally, plan coverage would be added to allow for acupuncture outside of solely being performed by a physician as a form of anesthesia in connection with surgery covered under the Plan and Rolf therapy separately. Acupuncture and Rolf therapy would have their own separate 10 visit annual limitation. However, it should be noted that there is a lack of Current Procedural Terminology (CPT) code and International Classification of Disease, Tenth Edition (ICD-10) structure in place to process claims specific for Rolf therapy. This may prevent the ability to properly identify Rolf therapy claims and administer an annual visit limitation.

Actuarial Value

Our updated analysis determines the impact of implementing a 45 visit annual limitation in aggregate to physical therapy, occupational therapy, and speech therapy would be a reduction of 0.050% in actuarial value. The addition of the acupuncture benefit with a 10 visit annual limitation would result in 0.010% increase in actuarial value. The addition of the Rolf therapy claims will

result in a 0.005% increase in actuarial value. The net change from these three benefits will be a 0.035% decrease in actuarial value.

Financial Impact

Based on an updated retiree claims projection of \$590,000,000 for 2019, this equates to approximately \$300,000 in annual savings from the change in physical therapy, occupational therapy, and speech therapy benefit, approximately \$65,000 in additional cost from the change in the acupuncture therapy benefit, and approximately \$30,000 in additional cost from the Rolf therapy benefit. The next decrease in costs to the Plan from these three benefit changes will be approximately \$205,000.

This analysis is based on 2017 and 2018 medical and pharmacy claims data, projected to 2019 at 3.0% and 6.0% annual trends, respectively. The data was reviewed, but not audited, and found to be sufficient and credible for this analysis.

With over 60,000 members and a high incidence rate of therapeutic care, the data is considered credible for this analysis and recent utilization patterns are considered to be a sound basis for determining the impact of this prospective change. Visits that result in \$0 paid by the plan (due to other coverage or other reasons) are assumed not to apply towards the annual 45-visit limitation.

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

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Health Matters

May 2018

HealthMatters



May 2018

Number 30

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:

- **Senator Judy Salo** (*Board Chair*)

TRS retiree

Judy is a past president of NEA/Alaska and served on the Board of Directors of the National Education Association. She is a retired teacher and a former State Senator who represented the Northern Kenai and south Anchorage. Judy now lives with her husband in Big Lake.

- **Cammy Taylor** (*Board Vice-Chair*)

PERS retiree

Cammy Oechsli Taylor, of Anchorage, is a PERS retiree and retired lawyer who worked in various state departments including the Department of Law, Department of Natural Resources, and the Oil and Gas

Conservation Commission. Since retiring, she has worked as a volunteer with retiree groups on various retiree benefits issues.

- **Mark Foster**

PERS retiree

Mark Foster is a management consultant who has provided financial and economic analysis of health care markets in Alaska for a variety of clients. His work includes an analysis of the impact of the Affordable Care Act on Alaska for the Alaska Health Care Commission and an analysis of the potential value of consolidation Alaska public employee health plans and medical service procurement.

- **Gayle Harbo**

Alaska Retirement Management Board; TRS retiree

Gayle Harbo of Fairbanks, is retired and currently serves on the Alaska Retirement Management Board representing TRS. She holds a BS in Math and MA in teaching and has served on the ARM Board since its inception in 2005.

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New Medicare Cards Coming April 2018

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 requires the Centers for Medicare and Medicaid Services (CMS) to remove Social Security numbers (SSN) from all Medicare cards by April 2019. A new Medicare Beneficiary Identifier (MBI) will replace the SSN-based Health Insurance Claim Number (HICN) on the new Medicare cards for Medicare transactions like billing, eligibility status, and claim status.

Under the current system, for each person enrolled in Medicare, CMS currently uses an SSN-based HICN to identify people with Medicare and to administer the program. CMS used the HICN with their business partners:

- The Social Security Administration (SSA)
- The United States Railroad Retirement Board (RRB)
- State Medicaid Agencies
- Health care providers
- Health plans

Under the new system, for each person enrolled in Medicare, CMS will:

- Assign a new MBI
- Mail a new Medicare card

The MBI, like the SSN, is confidential and should be protected as Personally Identifiable Information (PII).

Why are the new Medicare cards important?

The biggest reason CMS is removing the SSN from Medicare cards is to fight medical identity theft for people with Medicare. By replacing the SSN-based HICN on all Medicare cards, CMS can better protect:

- Private health care and financial information.
- Federal health care benefit and service payments.

What's the timeline for the new Medicare cards and what does it mean for me?

Getting Started

Beginning in April 2018, CMS will start mailing the new Medicare cards with the MBI to all people with Medicare in phases by geographic location.

Transition Period

CMS plans to have a transition period where you can use either the HICN or the MBI to exchange data with them. The transition period will begin no earlier than April 1, 2018 and run through December 31, 2019.

Incoming premium payments: People with Medicare who

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MyMedicare.gov Personalizes Information

MyMedicare.gov is an innovative web portal—a free, secure online service for accessing personalized information regarding your Medicare benefits and services. Only people with Medicare who register as portal users, or trusted individuals they choose, will be able to view their information using a unique password. This tool is available in English and Spanish. You can use **MyMedicare.gov** to do the following:

- View claim status (excluding Part D prescription claims).
- Order a duplicate Medicare Summary Notice (MSN) or replacement Medicare card.
- View eligibility, entitlement, and preventive services information.
- View enrollment information, including prescription drug plans.

- View or modify your drug list and pharmacy information.
- View your address of record and Part B deductible status.
- Access Centers for Medicare and Medicaid (CMS) online forms, publications, messages.

To get started, have your red, white, and blue Medicare card handy and register at **MyMedicare.gov** for a password. You can then take a tour and use the website.

It's important to review the Medicare Summary Notices that you receive by mail or view them online to be sure you received the services for which Medicare was billed. If you don't have a convenient way to track your healthcare services, feel free to ask for a Personal Health Care Journal from Alaska's Medicare Information Office. Call toll-free at (800) 478-6065 or in Anchorage at (907) 269-3680. 🌸

Coalition Health Centers in Anchorage and Fairbanks Welcome Alaskacare Employee Health Plan Members

The Coalition Health Centers, sponsors of the annual fall health fairs, are now welcoming AlaskaCare Employee Health Plan eligible members and dependents in Anchorage and Fairbanks. The Centers offer wellness and preventive care, as well as walk-ins for acute care (unexpected illness or injury.) Appointments are required for wellness and preventive care.

Services received at Coalition Health Centers are not subject to your plan's annual deductible; you will only be charged a \$25 co-pay for the office visit. Do not submit claims for these services. Coordination of benefits does not apply. See the AlaskaCare Employee Health Plan amendment effective March 1, 2018 for additional information on the AlaskaCare website at alaska.gov/drb/alaskacare/employee/publications/booklet.html



Payment for services at the Centers is as follows:

- Acute/Unexpected Illness/Injury:
Co-Pay \$25/Office Visit
- Wellness & Preventive Care:
Preventive \$0/Office Visit

Coalition Health Center schedule:

Monday through Friday

- 7:30 a.m. – 6:30 p.m. (By appointment)
- 8:30 a.m. – 4:30 p.m. (Walk-ins welcome for acute care)

Coalition Health Center locations:

Anchorage Coalition Health Center

Ages 5 and up

Alaska Regional Hospital
2741 Debarr Rd., Suite C210
(907) 264-1370

Fairbanks Coalition Health Center

Ages 2 and up

Ridgeview Business Park
575 Riverstone Way, Unit #1
(907) 450-3300

Online: coalitionhealthcenter.com 🌐

Introducing Your New Retiree Health Plan Advisory Board

continued from page 1

• Joelle Hall

Public member

Joelle Hall is the Director of Operations of the Alaska AFL-CIO. She has a Bachelor's in Foreign Language and lives in Peters Creek with her husband and two children.

• Dallas Hargrave

Human Resources Official

Dallas Hargrave, of Douglas, is the Human Resource / Risk Management Director for the City and Borough of Juneau, where he oversees the City's health benefits plan and other benefits. He holds a Master of Public Administration from the University of Alaska Southeast and a Juris Doctorate from University of Denver.

• Mauri Long

PERS retiree

Mauri Long, of Anchorage, is a PERS retiree and a

lawyer whose practice was dedicated to trial and litigation. She is knowledgeable about the provision of medical care, insurance and dispute resolution.

The board will meet quarterly. Additional information, including meeting dates and how you can attend and participate in these public board meetings, is available online on the AlaskaCare website 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.

For more information about the AlaskaCare Retiree Health Plan, see the plan booklet online at alaska.gov/drb/alaskacare/retiree/publications/booklets.html. 🌐

Outpatient Rehabilitative Care Coverage in the AlaskaCare Retiree Health Plan

This article does not apply the AlaskaCare Employee Health Plan. For details about coverage in the Employee Plan, see the plan document at AlaskaCare.gov.

Outpatient rehabilitative services such as chiropractic care, physical therapy, massage therapy, and occupational therapy are commonly obtained following joint replacement surgery or after suffering an injury to your back, knee, shoulder, or other joints. If you are planning an upcoming surgery or are currently under care for this type of condition, it is important to understand your rehabilitative care benefits under the AlaskaCare plan.

What coverage for rehabilitative services does the AlaskaCare Retiree Health Plan offer?

The Medical Plan covers outpatient rehabilitative care designed to restore and improve bodily functions lost due to injury or illness. This care is considered medically necessary only if significant improvement in body function is occurring and is expected to continue. Care (excluding speech therapy) aimed at slowing deterioration of body functions caused by neurological disease is also covered.

How does the plan determine if the services are medically necessary?

The AlaskaCare claims administrator (currently Aetna) is required to verify that services are medically necessary per the guidelines listed in the AlaskaCare plan document. In order to do so, they will request copies of your treatment records from your provider. Generally medical review is

not needed for these services if the course of treatment does not exceed 25 visits. Under Aetna, clinical records are requested from your provider when the claim for the 20th visit for a condition is received.

What information does my provider need to supply?

Your provider will need to supply clinical records that contain information on the initial evaluation, the most recent therapy re-evaluation with an updated plan of care, the last five daily therapy and progress notes, and documentation supporting the need for ongoing supervised rehabilitative care including dates of surgery, invasive procedures or a change of diagnosis. The goal of therapies and treatment should be to rehabilitate the patient to a point where he/she can function adequately in his/her normal daily activities. There must be reasonable expectations that the therapy/ treatment will produce significant improvement in the patient's condition within a reasonable period of time. The AlaskaCare plan does not cover "maintenance" care, that is, services to keep the patient in his/her "rehabilitated" state. Maintenance is not considered a "medically necessary service".

What happens if my provider does not submit my records after the 20th visit?

The AlaskaCare claims administrator will continue to process claims until the claim for the 25th visit is received. At that point all claims in excess of the 25th visit will be pended awaiting clinical records that support medical necessity. If no records are received within 45 days, the claims will be denied. (If you live in North Carolina or Texas the timeline may vary, please contact Aetna Concierge at 1-855-784-8646 for additional information.)

What if the AlaskaCare claims administrator determines the clinical records do not support the treatment as medically necessary?

It is essential that AlaskaCare members understand that "medical necessity" in this instance requires continued significant clinically documented improvement. You may want to direct your provider to Aetna's Clinical Policy Bulletin found online at Aetna.com/cpb in advance of your 25th visit. (The bulletins are numbered as follows: 0243



continued on page 7

New! Aetna In Touch Care Program Offers Case Management and Disease Management

Effective April 1, 2018, the AlaskaCare Employee Health Plan transitioned from Active Health Disease Management program to Aetna's In Touch Care Program for both Case Management and Disease Management services.

Historically, members facing chronic or acute health challenges would be assigned to either Active Health's Disease Management team or Aetna's Case Management team. As part of our streamlined, more focused approach to wellness, both services are now provided by Aetna's Health Care Deliveries Division of Medical Professionals, through the InTouch Care Program. Through the adoption of a new holistic approach that provides connected one-on-one nurse support for urgent circumstances and/or 24/7 virtual care using online tools for chronic cases, we can anticipate an improved member experience.

We will keep Active Health's member engagement platform, My Active Health, for member-driven access to health risk assessment data, digital coaching, and wellness-related resources. In addition, we will be coordinating efforts with the State of Alaska Department of Health and Social Services (DHSS) to take advantage of

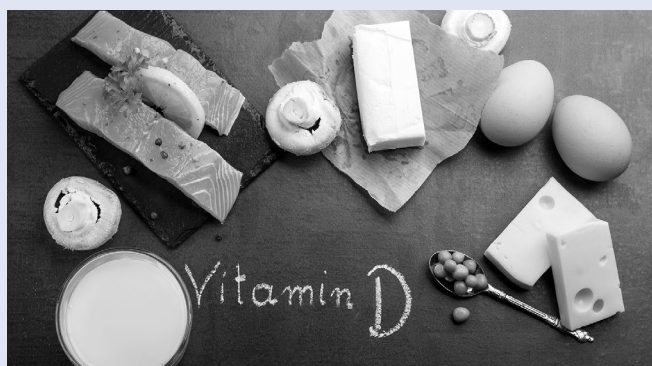
their educational materials, programs, and resources for diabetes prevention, control of high blood pressure, and smoking cessation. 🌿



Headed into Allergy Season

Alaskans start celebrating the great outdoors when the ice breaks up, lawns green up, and your eyes well up with tears. It's not just because you're overly emotional—welcome to allergy season! It's right around the corner. Allergy sufferers, you can find relief for your runny noses, sore throats, tearing eyes, coughing, sneezing, sometimes wheezing, at your local drug store.

The Food and Drug Administration (FDA) has approved the allergy drug ZYRTEC® as an over-the-counter (OTC) medication. It's available without a prescription in its original prescription strength. This drug is used for the relief of symptoms such as sneezing, runny nose, and watery eyes due to hay fever or other upper respiratory allergies. ZYRTEC-D® has the added benefit of relieving nasal congestion but may be kept behind the pharmacy counter because it contains a decongestant. Although your AlaskaCare health plan does not cover OTC medications, the cost of ZYRTEC® can be reimbursed through your Health Flexible Spending Account (Health FSA for active employees only). 🌿



Vitamin D and You

Alaska's northerly latitude results in a lack of the quality sunshine our bodies need to produce Vitamin D naturally. Because of this, Alaskans are especially prone to Vitamin D deficiency, which can affect our health and wellness. You can supplement with foods high in Vitamin D, including salmon, fortified milk and cereal, and even sun-exposed mushrooms. It's spring and days are getting longer, but you still need your Vitamin D! Learn more at ods.od.nih.gov/factsheets/VitaminD-Consumer. 🌿

Scam Alert! What to Know and Do About Scams

Criminals use clever schemes to defraud millions of people every year. They often combine sophisticated technology with age-old tricks to get people to send money or give out personal information. They add new twists to old ploys and pressure people to make important decisions on the spot. One thing that never changes: they follow the headlines—and the money. The advertisement of Medicare's new card roll-out is a prime opportunity for criminals to practice their trade. Protect yourself against unethical practices of scammers.

Stay a step ahead with the latest information and practical tips from the nation's consumer protection agency, the Federal Trade Commission (FTC) at **FTC.gov**. Browse FTC scam alerts by topic or by most recent.

Here's some tips to deal with government imposters:

- Don't give the caller your information. Never give out or confirm sensitive information—such as your bank

account, credit card, or Social Security number—unless you know who you're dealing with. If someone has contacted you, you can't be sure who they are.

- Don't trust a name or number. Con artists use official-sounding names to make you trust them. To make their call seem legitimate, scammers use internet technology to "spoof" the area code—so although it may seem they are calling from Washington D.C., they could be calling from anywhere in the world.

Check with the Centers for Medicare and Medicaid Services (CMS) directly. Contact Medicare at (800) 633-4227 and ask to speak with the Medicare Beneficiary Ombudsman (MBO). Contact Medicare by mail at:

Medicare Contact Center
P.O. Box 1270
Lawrence, Kansas 66044 🌸

New Medicare Cards Coming April 2018

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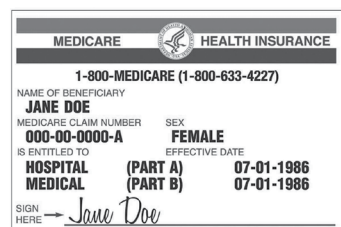
don't get SSA or RRB benefits and submit premium payments should use the MBI on incoming premium remittances. However, CMS will accept the HICN on incoming premium remittances after the transition period (Part A and Part B premiums, Part D income related monthly adjustment amounts, etc.)

How will the MBI look?

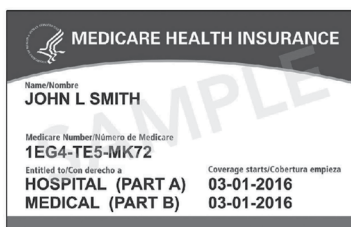
The MBI will be:

- Clearly different than the HICN and RRB number
- 11 characters in length
- Made up only of numbers and uppercase letters (no special characters); if you use lowercase letters, the CMS system will convert them to uppercase letters

Each MBI is unique, randomly generated, and the characters are "non-intelligent," which means they don't have any hidden or special meaning.



Old Card



New Card

What do the new Medicare cards mean for people with Medicare?

The MBI won't change Medicare benefits. People with Medicare may start using their new Medicare cards and MBIs as soon as they get them. The effective date of the new cards, like the old cards, is the date each beneficiary was or is eligible for Medicare.

Where can I get more information about the new Medicare cards?

You can find frequently asked questions, press release, and latest Open Door Forum slides on the CMS website at **CMS.gov**. Also, you can see the new card on the Medicare website at **Medicare.gov/newcard**. 🌸

Do you have questions
about your health plan?

Find answers at
[AlaskaCare.gov/employeeFAQs](https://www.alaskacare.gov/employeeFAQs)
and
[AlaskaCare.gov/retireeFAQs](https://www.alaskacare.gov/retireeFAQs)

Diabetes—Are You At Risk?

If you have prediabetes, you may be at risk. To find out, take the test at doihaveprediabetes.org.

Prediabetes is real. It's common. And most importantly, it's reversible.

You can stop prediabetes from developing into Type 2 diabetes with simple, proven lifestyle changes.

People can have prediabetes for years but have no clear symptoms, so it often goes unnoticed until serious health problems show up. That's why it's important to talk to your doctor about getting your blood sugar tested if you have any of the risk factors for prediabetes, which include:

- Being overweight
- Being 45 years or older
- Having a parent or sibling with type 2 diabetes
- Being physically active fewer than 3 times a week
- Ever having gestational diabetes or giving birth to a baby who weighed more than 9 pounds

If you do have prediabetes, you can enroll in a free online diabetes prevention program called “TurnAround Health!” Alaskans can take advantage of a free one-year subscription with the promo code *Alaska2015*. Sign up today at alive.turnaroundhealth.com. 🍇

Outpatient Rehabilitative Care Coverage in the AlaskaCare Retiree Health Plan

continued from page 4

for speech therapy, 0325 for physical therapy and 0107 for chiropractic services.) This will allow your provider to see additional detail on what services and procedures are considered medically necessary. If it is determined by the AlaskaCare claims administrator that the treatment is not medically necessary, all claims after the 25th visit for that condition will be denied.

Is the need to verify medical necessity a change with this administrator?

No, the requirement for treatment to be medically necessary is a provision of the AlaskaCare retiree health plan. Previous claims administrators were also required to make medical necessity determinations per the guidelines listed in the AlaskaCare plan document.

What can I do if my rehabilitative care is denied?

You have the right to appeal a denial. You should work with your provider to ensure all clinical records supporting that the services were medically necessary are supplied to AlaskaCare Claims Administrator with your level I appeal. The Member Complaint and Appeal form is available at AlaskaCare.gov.

If your appeal is denied, you may apply for an external review. At this level an independent review organization (IRO) will consider the AlaskaCare plan provisions, your clinical information, your provider's recommendation, Aetna's recommendation, and other applicable information, such as appropriate practice guidelines, etc.

Should the IRO find that the denied claims were medically necessary, Aetna will process the denied claims upon receipt of the IRO's determination. If the IRO upholds Aetna's denial, you can advance your appeal to the Alaska Office of Administrative Hearings.

What should I do if I am approaching the 25th visit?

Claims for services after the 25th visit may be denied. In advance of the 25th visit, you should consult with your provider to ensure that the “medical necessity” requirements of the AlaskaCare plan have been met. Direct your provider to Aetna's Clinical Policy Bulletin for additional information.

If treatment after the 25th visit is determined to be medically necessary, will I be asked to provide clinical records again for the same condition?

If treatment after the 25th visit is considered medically necessary, based on a person's individual clinical situation, Aetna may at some later date(s) request treatment records to verify that services continue to be medically necessary.

What if I have a new injury or condition after I have reached maximum benefit from another series of rehabilitative services?

Your provider should submit the proper diagnosis codes for the course of treatment designed to restore and improve bodily function lost due to the new injury or illness. 🍇

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The Alaska Department of Administration complies with Title II of the 1990 Americans with Disabilities Act (ADA). This health newsletter is available in alternative communication formats upon request. To make necessary arrangements, contact the ADA Coordinator for the Division of Retirement and Benefits at (907) 465-4460 or contact the TDD for the hearing impaired at (907) 465-2805.

Disclaimer: Information in this newsletter summarizes the plan provisions, is supplemental only, and does not supersede the applicable Information Booklet's provisions. The Division is unable to unsubscribe members from our mailing list at this time.

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Aetna Nurse Advice Line

A registered nurse is available to you by phone 24 hours a day, free of charge. Nurses can be a great resource when considering options for care or helping you decide whether you or your dependent needs to visit your doctor, an urgent care facility, or the emergency room. They can also provide information on how you can care for yourself or your dependent. Information is available on prescription drugs, tests, surgery, and many other health related topics. This service is completely confidential.



Call (800) 556-1555!

Health Matters

May 2017

HealthMatters



May 2017

Number 28

Medicare Direct, aka Medicare Crossover

The AlaskaCare Retiree Health Plan becomes supplemental to Medicare Parts A and B when you or your dependent reach age 65, beginning on the first day of that month. As the supplemental plan, AlaskaCare will require information regarding what Medicare has paid on your claim before a secondary payment can be processed.

Medicare Direct is the electronic process that eliminates the need for a retiree to file a paper supplemental claim with Aetna, the AlaskaCare third party claims administrator (TPA), when Medicare Part B is primary. The Medicare carrier forwards claims automatically and electronically. Medicare Direct is sometimes referred to as Medicare Crossover.

Medicare uses a unique identifier called a Health Insurance Claim Number (HICN). The HICN for the retiree is most commonly, but not always, the 9-digit Social Security Number (SSN) followed by the letter "A," indicating a wage earner. Aetna will automatically enroll retirees using their SSN plus the letter "A" as their Medicare number. If your Medicare number is not your SSN+, you must call Concierge Services and to let them know what your number is.

Spouses in every instance need to call Concierge Services and ask to be enrolled, as Aetna cannot assume their

Medicare number. Since many spouses over age 65 may not have been wage earners, Aetna must have confirmation of an accurate Medicare number.

Enrolling a retiree in Medicare Direct has many benefits, including:

- Saving the retiree time and paperwork. The retiree will no longer have to file Part B claims to Aetna. (Note: Medicare Direct does not apply to Part A hospital claims.)
- Turnaround time is quicker, because claims come to Aetna electronically; therefore, reimbursement is quicker.
- No postage is required.
- No cost to the retiree or provider to enroll or send claims.

After Medicare Direct is in place and Medicare has considered a claim, the remaining expenses are automatically forwarded to Aetna. Your EOMB (Explanation of Medicare Benefits) will have a comment to the effect of "your claim has been forwarded to your secondary carrier for further consideration." You will always receive an EOMB from Medicare; however, you will not receive a BILL from Medicare.

If you or your spouse become covered under another plan in addition to AlaskaCare and Medicare, please contact the AlaskaCare Concierge to notify them of the change, as it may impact your Medicare Direct participation. In addition, if you or your spouse's Medicare number changes for any reason, Aetna will need to be notified or the Medicare Direct process will no longer work for you. 🌸

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AETNA Nurse Line

Did you wake up this morning feeling just a *little* under the weather? Not bad enough to go to the ER, but not good enough to wait to see your doctor? Are you tired of rumbling through your medicine cabinet while your spouse rattles off a multitude of diagnoses from Google's symptom search? You need advice from a medical professional. Why not start with the Nurse Line? It's free and available 24/7. Call (800) 556-1555! 🌸

Outpatient Rehabilitative Care Coverage in the AlaskaCare Retiree Health Plan

This article does not apply to the AlaskaCare Employee Health Plan. For details about coverage in the Employee Plan, see the plan document at AlaskaCare.gov.



Outpatient rehabilitative services such as chiropractic care, physical therapy, massage therapy, and occupational therapy are commonly obtained following joint

replacement surgery or after suffering an injury to your back, knee, shoulder, or other joints. Coverage for these services is based on the concept of a “rehabilitative program of care,” or treatment which pairs a specific illness, injury, or surgical procedure and a care provider. Each program of care should include:

- documentation of the illness or injury,
- an initial evaluation with objective and subjective measurements of the patient’s functionality,
- a written program of care with an expectation of improvement, and
- periodic follow-up evaluations showing continued improvement.

Every program of care will also have a point of maximum therapeutic benefit after which additional services are considered not medically necessary (i.e. maintenance therapy). After that maximum therapeutic benefit has been reached, additional treatment in that program of care, regardless of the relief from symptoms it may provide, would not be considered medically necessary by the Plan.

If you have a new injury, illness, surgery etc., to a body part or location where a prior program of care was denied coverage, the new claim would also be denied. Through the appeal process, a patient and provider would have to submit new medical records and the initial evaluation as well as any new re-evaluations, etc. to establish medical necessity and receive coverage. If you are planning an upcoming surgery or are currently utilizing the rehabilitation services benefit, it is important to understand your Plan’s requirements for coverage. This way, you will have a clear understanding of what claims for rehabilitative services would be covered by the Plan, and when Plan coverage of rehabilitative services end.

How does the Plan determine if the services are medically necessary?

The AlaskaCare claims administrator (currently Aetna) is required to verify that services are medically necessary as required by the AlaskaCare Plan document, and will request copies of your treatment records from your provider. Generally, medical review is not needed for these services if the course of

treatment does not exceed 25 visits. For a new rehabilitative program of care, Aetna will typically request medical records from your provider when it receives the claim for the 20th visit in a rehabilitative program of care.

What information must my provider supply to the AlaskaCare claims administrator?

Your provider will be required to supply clinical records that contain sufficient information for the claims administrator to determine both your condition and that the associated treatment meets the policy requirements stated in the Plan document and Aetna’s applicable Clinical Policy Bulletins (available at Aetna.com/cpb). The bulletins are numbered as follows:

- 0107 for chiropractic services
- 0243 for speech therapy
- 0325 for physical therapy

The documentation submitted should include at least

- the initial evaluation and diagnosis,
- a written program of care,
- the most recent therapy re-evaluation with an updated plan of care,
- the last five daily therapy and progress notes, and
- documentation supporting the need for ongoing supervised rehabilitative care, including dates of surgery, invasive procedures, or a change of diagnosis.

The Plan provides coverage of treatment to rehabilitate the patient to a point where they have reached the optimum functional benefit that can be reasonably expected. There must be reasonable expectations that the therapy or treatment will produce significant clinically documented improvement in the patient’s body function within a reasonable period and continued improvement is expected. The AlaskaCare Plan does not cover “maintenance” care, that is, services to keep the patient in their “rehabilitated” state. Maintenance is not considered a “medically necessary service.”

What if the AlaskaCare claims administrator determines the clinical records do not support the treatment as medically necessary?

It is essential that AlaskaCare members understand that “medical necessity” in this instance requires continued significant clinically documented improvement. You may wish to review Aetna’s Clinical Policy Bulletins with your provider **before you begin treatment**. This will allow you and your provider to review the Plan’s criteria for determining when services and procedures are considered medically necessary. If it is determined by the AlaskaCare claims administrator that the treatment is not medically necessary, all claims after the 25th visit for that condition will be denied. ❄️

Alaska Regional Hospital: Important Information For All AlaskaCare Plans

Alaska Regional Hospital is the only hospital in the municipality of Anchorage where all the hospital-based physicians are in-network. (Hospital-based providers are anesthesiologists, radiologists, emergency room doctors, hospitalists, and pathologists.) This means there shouldn't be any surprise balance-billing when you receive care at Alaska Regional Hospital.

Alaska Regional Hospital is an award-winning facility and offers a full range of services comparable to other full-service hospitals in Alaska. The last three years have been spent improving the facility to make it more attractive and inviting. In addition, its technology and documentation systems have had state-of-the-art upgrades to support the delivery of high quality patient care. AlaskaCare's agreement with Alaska Regional Hospital provides our members with access to high quality service, provided by your doctor, at competitive prices.

AlaskaCare Employee Health Plan

Alaska Regional Hospital is the preferred provider hospital for members of the AlaskaCare Employee Health Plan. Members are encouraged to choose the preferred hospital for facility services received in the municipality of Anchorage to avoid reduced reimbursement rates, reduced allowed charges, and increased maximum out-of-pocket costs. It is now more important than ever to use a preferred facility to avoid costly balance bills and increased cost shares. Visit the AlaskaCare website for full details at: Alaska.gov/drb/benefits/employee/openEnrollment/2017/facilities.html

AlaskaCare Retiree Health Plan

The AlaskaCare Retiree Health Plan does not require members to choose a preferred provider for hospital services. While

Alaska Regional Hospital is the preferred provider hospital in the Anchorage area, there will be no penalty for retired members who receive services at another facility. However, the discounts offered by Alaska Regional Hospital will help minimize costs to AlaskaCare members and to the plan. By using the preferred provider hospital, you will also help conserve and wisely use the resources of the retiree health trust. In addition, retirees can take advantage of the Senior Health Clinic and the new concierge "Josie" (see below). ❁

Alaska Regional Hospital Senior Health Clinic

Providing Care to Alaska's Medicare Beneficiaries

Alaska Regional Senior Health Clinic offers integrated health services to Medicare B beneficiaries in Anchorage and its surrounding communities. Here, you can see medical providers who specialize in primary care for Alaska's Medicare beneficiaries, as well as outpatient adult medicine and mental health services.

Conditions treated include, but are not limited to:

- Acute illnesses
- Asthma
- COPD
- Diabetes
- Heart disease
- High blood pressure
- High cholesterol
- Other chronic disorders

Appointments are available Monday through Friday from 8 a.m. to 5 p.m. Call (907) 433-5100 to make an appointment. ❁

Alaska Regional Hospital Health Care Concierge: "Just Ask Josie"



Have you ever wanted to meet the person behind the customer service 800 number you called at your bank or telecommunications company? Alaska Regional Hospital has done just that with its new Healthcare Concierge Department. Meet the concierge, Josie, your one-stop-shop for all Alaska Regional Hospital departments. With Josie, there's no more calling a general phone number

and having to experience multiple transfers before reaching your intended party. You now have access anytime via email. This designated confidential email has been specifically created for members of the AlaskaCare Employee and Retiree Health Plans. With just one email, you can get the information you need, or if you prefer, provide your telephone number and

request to have the concierge call you. *It will happen!* You may also receive a personalized visit from the concierge when visiting an Alaska Regional Hospital department. Whether you or a loved one are an in-patient at Alaska Regional or utilizing one of the numerous out-patient services on campus, the concierge's sole purpose is to help ensure that your health care experience with Alaska Regional Hospital is a good one. Specifically, the concierge acts as your interface between Alaska Regional Hospital departments to help you with patient navigation, billing questions, transfers between facilities, and directing you to in-network options to ensure AlaskaCare members are maximizing their full benefits and savings.

We are pleased to introduce you to Josie Wilson and Alaska Regional Hospital's "Just Ask Josie" Concierge Program.

You can "Just Ask Josie" by emailing: Josie.Wilson@hcahealthcare.com. ❁

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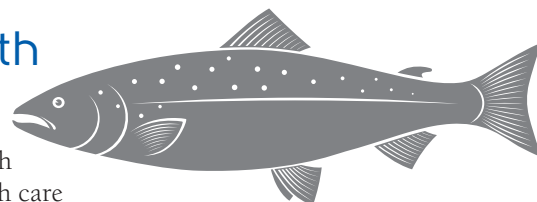
Disclaimer: Information in this newsletter summarizes the plan provisions, is supplemental only, and does not supersede the applicable Information Booklet's provisions. The Division is unable to unsubscribe members from our mailing list at this time.

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Vitamin D and Your Health

Vitamin D is important for strong bones and may contribute to overall good health. Alaskans should select foods that are high in vitamin D, such as Alaska salmon, and should talk with their health care provider about vitamin D and the risks and benefits of supplementation. 🍷



Retiree Health Plan Dependent Eligibility Audit Has Been Postponed Until August 2017

AlaskaCare has contracted with Health Management Systems, Inc. (HMS) to conduct an audit of all currently eligible dependents. Important information on this audit will be sent to retirees starting in August 2017.

Dependent eligibility audits are performed periodically and are intended to protect the health trust by ensuring only eligible dependents are receiving benefits. Beginning in August 2017 you should receive communications from HMS outlining what

documentation you will need to provide. For example, verification documents for a spouse may include copies of your marriage certificate and a current tax record or household bill that list your spouse's name and address. Examples for dependent children include birth certificates or adoption records, and if age 19 or older, their full-time school attendance records.

In anticipation of this audit, you may wish to begin gathering copies of your documents now. Please watch your mailbox for additional information about this audit. 🍷

Health Matters

April 2015

HealthMatters



April 2015

Number 24

This volume of HealthMatters provides answers to many AlaskaCare frequently asked questions. Disclaimer: The information is provided for information purposes. In the event of a conflict between the above information and the AlaskaCare plan document, the plan document controls.

Medical Necessity

Health plans pay for covered services and supplies. The expenses covered through AlaskaCare are often called “eligible expenses.” To be eligible, an expense must be medically necessary. These frequently asked questions (FAQ) provide information about how determinations of medical necessity are made under the AlaskaCare plans.

What is “medical necessity?”

Medical necessity is one factor the AlaskaCare health plans consider in determining whether to provide coverage for a service or supply. The AlaskaCare health plans do not pay for services or supplies that are not medically necessary, such as cosmetic procedures.

The AlaskaCare medical plans use Aetna’s current Medical and Pharmacy Clinical Policy Bulletins to determine medical necessity. You may access the bulletins at: Aetna.com/cpb.

Determinations of medical necessity for dental procedures are made by Moda Health.

How does Aetna determine if a service or supply is medically necessary?

Aetna’s clinical policy bulletins are based on:

- Reports in published, peer-reviewed medical literature
- Studies on a particular topic

- Evidence-based consensus statements
- Expert opinions of health care professionals
- Guidelines published by nationally recognized health care organizations that include supporting scientific data

Are there any limitations as to what kinds of services and supplies can be considered medically necessary?

Under the AlaskaCare plans, services or supplies are never considered medically necessary if they:

- Do not require the technical skills of health care professionals who are acting within the scope of their license;
- Are provided mainly for the personal comfort or convenience of you, your family, anyone who cares for you, a health care provider, or a health care facility;
- Are provided only because you are in the hospital on a day when you could safely and adequately be diagnosed or treated elsewhere; or
- Are provided only because of where you are receiving the service or supply, if it can be provided in a doctor’s or dentist’s office or other less costly place.

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Medical Necessity

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If a service or supply fits the definition of medical necessity, is it always covered by the plan?

No, not all medically necessary services or supplies are covered by a health plan. For example, a medically necessary service or supply is not covered by the AlaskaCare plans when:

- It is specifically excluded; or
- The duration of the medically necessary service reaches a plan limitation (for example, some benefits are limited to a certain number of days or visits).

Shouldn't medical necessity be defined by the plan document, and not the Third-Party Administrator?

The number of medically necessary procedures and unique circumstances of their application are virtually limitless. Thus, it is simply not feasible to produce a plan document that can account for every scenario.

Determinations of medical necessity are part of the claims processing function. Because AlaskaCare contracts with a Third-Party Administrator (TPA) to perform this function, it is the TPA who makes determinations of medical necessity as part of the claims processing function. This is not new. Prior TPAs also made medical necessity determinations as part of the claims processing function for the AlaskaCare plans. What is new is the publication of the data used by the TPA to make medical necessity determinations. This information is now available to AlaskaCare plan members through Aetna's contract with the State.

The clinical policy bulletins provided by Aetna set guidelines that are transparent to members and their physicians, and clearly show the medical evidence relied upon to make the determination. The evidence basis of the policy bulletins are reviewed regularly and the bulletins are updated as necessary.

If my doctor recommended the treatment isn't that enough to support medical necessity?

The National Institute of Health estimates that nearly 30% of all medical procedures or services performed in the United States

are either unnecessary and provide no benefit to the patient, or even worse, are harmful. Aetna's clinical policy bulletins rely on medical evidence to make decisions about coverage that are weighed against clinically accepted standards of medical practice.

We encourage you to have your doctor review the clinical policy bulletins used to guide coverage decisions related to medical necessity. After your provider completes this review, and if they disagree, your provider may request a pre-determination of coverage and present additional medical evidence for consideration during the pre-determination review.

To review your doctor's recommended treatment plan, and verify whether the services or supplies fit the definition of medical necessity, contact Moda Health at (855) 718-1768 for services covered under the dental plan, or contact the Aetna Concierge at (855) 784-8646 for services covered under the medical plan.

If there continues to be a difference in opinion, you or your provider are encouraged to appeal the coverage decision.

What can I do if a claim is denied because the Third-Party Administrator determined my service is not medically necessary?

If a claim is denied based on a medical necessity, you may request an explanation of the scientific or clinical judgment for the determination, free of charge.

If you believe it's warranted, you may also initiate written appeal to the plan. The AlaskaCare Employee Health Plan booklet and the AlaskaCare Retiree Health Plan amendment describe the process and timeline required for submitting an appeal. These plan booklets and an informational brochure on the appeals process are available at AlaskaCare.gov.

Effective January 1, 2014, the appeals process used by AlaskaCare was enhanced to allow for the use of Independent Review Organizations (IRO) at level two for clinical appeals. Use of an IRO allows for an impartial review by a third-party medical expert when there is disagreement regarding medical necessity. 🌱

Premera Blue Cross Security Breach

On March 17, 2015, Premera Blue Cross / Blue Shield reported a security breach that may have resulted in the loss of sensitive personal information of their current and former clients. Among those affected are current and former Alaska state employees. To answer common questions related to this incident, the Division of Retirement and Benefits has provided some of its own information to help Alaska state employees understand how they may be affected. You can find this information at:

Alaska.gov/go/E7N4

To contact Premera directly, please call (800) 768-5817, Monday through Friday, between 5:00 a.m. and 8:00 p.m. Pacific Time (closed on U.S.-observed holidays).

Medical, Vision and Audio Recognized Charge

This FAQ applies to the medical plan set forth in the AlaskaCare Employee Health Plan and to the medical, vision and audio plans set forth in the AlaskaCare Retiree Benefit Plan.

What is a recognized charge?

A *recognized charge* is the maximum amount that AlaskaCare's medical, vision and audio plans will pay for a covered service. The term *recognized charge* is sometimes referred to as the usual, customary and reasonable (UCR) charge, or the maximum allowed charge.

An out-of-network provider has the right to bill you for the difference between the recognized charge and the actual charge. This is sometimes referred to as balance billing.

When you use a network provider, you are not subject to balance billing for covered services. In other words, the provider has agreed to accept, as payment in full, the recognized charge for the service provided. You are only responsible for payment of other applicable charges such as deductibles, co-insurance, and/or non-covered charges.

The recognized charge is the **lesser of**:

- The amount the provider bills; or
- The 90th percentile of the prevailing charge rate for the geographic area where the service is furnished. The 90th percentile of the prevailing charge rate means the charge that is at or below 90% for all of the charges reported for a service within a specific geographic area.

How is the recognized charge amount determined?

The recognized charge for out-of-network providers is the 90th percentile of the prevailing charge rate for the geographic area where the service is furnished. The AlaskaCare plans establish the percentile (i.e., 90th percentile) to be applied to the prevailing charge rate; however, the prevailing charge rate is reported by FAIR Health, an independent not-for-profit corporation. FAIR Health collects charge data from claims received by insurance plans and health plan administrators across the country for charges billed by physicians, hospitals and other healthcare providers. Charges reported are the full fees that healthcare professionals report to insurers as part of the claims process—not the negotiated rates that apply when visiting a network provider. Charges reported are maintained by FAIR Health in its database, which is comprised of billions of claims for billed medical procedures from across the United States. New charge data is continually added to the FAIR Health database.

How does the plan know that FAIR Health's information is reliable?

FAIR Health has audit and validation programs in place to ensure the integrity of its data. Part of the validation process entails testing the data with statistical algorithms and



examination by FAIR Health's in-house statistical and technology experts. A team of healthcare researchers from leading academic institutions advise FAIR Health on the best methods for analyzing its national claims data. FAIR Health is also advised by an independent Scientific Advisory Board of prominent researchers who review FAIR Health's statistical methods and data. FAIR Health also seeks input from other stakeholders such as consumer and patient advocacy groups, healthcare providers, actuaries and federal officials.

How are the services identified in the FAIR Health database?

Each specific service, procedure or supply in the FAIR Health database has a unique *Current Procedural Terminology (CPT) code*. CPT codes are numbers assigned to medical services and procedures. CPT codes are part of a uniform system of coding maintained by the American Medical Association and are used by providers, facilities and insurers. Each CPT code is unique. There are currently over 10,000 medical services and procedures classified by CPT code. Most CPT codes are very specific. For example, the CPT code for a 15-minute office visit is different from the CPT code for a 30-minute office visit.

How are the geographical areas determined?

FAIR Health organizes its data by **geozip**—a geographical area usually defined by the first three digits of the U.S. zip codes. Geozips may include areas defined by one three-digit zip code or a group of three-digit zip codes. Geozips generally do not include zip codes in different states.

The State of Alaska is currently defined into three geozips:

- 995 and 997 – including Anchorage, Bethel, Fairbanks, Kotzebue, etc...
- 996 and 998 – including Homer, Kodiak, Juneau, Sitka, etc...
- 999 – including Ketchikan, Prince of Wales, Wrangell, etc...

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Dental Plan Recognized Charge

This FAQ applies to the AlaskaCare Dental Plans only.

The AlaskaCare Dental Plans limit payment of covered services to the recognized charge.

An out-of-network provider has the right to bill you for the difference between the recognized charge and the actual charge. This is sometimes referred to as balance billing.

When you use a Delta Dental network provider, you are not subject to balance billing for covered services. In other words, the provider has agreed to accept, as payment in full, the recognized charge for the service provided. You are only responsible for payment of applicable deductibles, co-insurance and/or non-covered charges.

What is the recognized charge?

The *recognized charge* is the maximum amount the AlaskaCare Dental Plans will pay for a covered service.

The recognized charge for each service or supply provided by a *network* provider in Alaska is the lesser of:

- 100% of the covered expense;
- 100% of the provider's accepted filed fee with Delta Dental; or
- 100% of the provider's billed charge.

The recognized charge for *out-of-network* providers in Alaska is the lesser of:

- The provider's billed charge; or
- 75% of the 80th percentile of the prevailing charge rate as determined by Delta Dental.

The recognized charge for *out-of-network* providers outside Alaska is the lesser of:

- The provider's billed charge; or
- the prevailing charge rate as determined by Delta Dental.

How is recognized charge determined in Alaska?

Delta Dental of Alaska maintains a database of billed charges from its adjudicated claims in Alaska. The 80th percentile is calculated for every American Dental Association (ADA) procedure code using a statistically valid methodology, which removes outlier charges. This calculation is based on the most recent 12 months of processed claims and serves as the starting point for determining updates to the prevailing charges.

How is the prevailing charge determined in Alaska?

Delta Dental of Alaska incorporates a number of additional processes in order to validate the results of the 80th percentile calculation before making changes to the prevailing charges:

- a) The 80th percentile is determined statewide in order to maximize the statistical significance of the calculation.



- b) Additional data sources are compared to the results of the 80th percentile calculation for consistency purposes.

Other data sources reviewed by Delta Dental are:

- ~ The Delta Dental Submitted Charges Database (DSC): This dataset is maintained by Delta Dental nationally and includes submitted charges from all Delta Plans for services rendered in Alaska.
- ~ The rates reported by Fair Health, an independent non-profit corporation.
- ~ Market research on prevailing charges used by other insurance carriers.

- c) For each procedure code, the current prevailing charge is compared to the 80th percentile calculation. Any changes to the current prevailing charge indicated by the 80th percentile calculation must be consistent with the other data sources referenced above. For new procedure codes, or those where there are too few procedures for a statistically valid 80th percentile calculation, additional considerations taken into account are:

- ~ The complexity of the service or supply.
- ~ The degree of skill needed, and
- ~ The cost of any materials required for the service.

- d) When a change in the prevailing charge is indicated, the change is limited to maximum percentage change unless otherwise indicated.

Is this same 80th percentile calculation used for specialists?

If the service provided by the specialist is exactly the same as that provided by the general dentist, the prevailing charge is the same for both (e.g. full mouth X-rays). However, if the services provided are specific to a specialist's training, the specialist will be reimbursed at a higher prevailing charge.

How does the prevailing charge rate determination differ outside of Alaska?

The prevailing charge is determined by Delta Dental methodology for each individual state. If you are receiving services at an out-of-network provider outside of Alaska, please contact Moda Health/Delta Dental at 1-888-718-1768 for more details. 🌸

Retiree Vision Benefits

Why is my vision claim being denied?

Many retirees have reported that Aetna denied their vision claims in error. Over the past few months, Aetna completed a thorough review of AlaskaCare vision claims and identified a few issues, which, at this point should be resolved. Here's what happened:

- Aetna asked some members to provide a Medicare Explanation of Benefits (EOB) document to support a routine vision claim. AlaskaCare is the primary payer for routine vision benefits—a Medicare EOB should not be needed. Be sure to note that Medicare does cover certain vision exams (for example, glaucoma screenings for people with diabetes). When you receive these services, Aetna may contact you to request a Medicare EOB.
- Vision Claims Denied as Not Covered. Aetna erroneously denied some members' vision services. Aetna updated its claims system mid-May and has reprocessed impacted claims retroactive to January 1, 2014.

What should I do if my provider tells me I don't have vision coverage but I know I do?

Providers may receive incorrect information when verifying your vision benefits through Aetna's self-service tool. While Aetna continues to update its systems, you can call Aetna Concierge at (855) 784-8646 to verify your vision benefits.

How do I find a network vision provider?

The retiree vision plan does not have a network. This means you may choose to see any provider and receive benefits for covered services. However, payments are subject to recognized charge limitations discussed on page 3.

Will my vision provider submit my claims for me?

No, you are responsible for returning your vision claims. Your

provider may be willing to file the claim for you, but it is the member's responsibility. The vision claim form can be located at [AlaskaCare.gov/drb/pdf/ghlb/retiree/visionBenefitsRequest.pdf](https://alaskacare.gov/drb/pdf/ghlb/retiree/visionBenefitsRequest.pdf).

What should I do if I am only enrolled in the AlaskaCare dental-vision-audio plan (and not medical) and do not have an ID card to show my provider?

For vision and audio with Aetna, you can log on to Aetna's online Navigator tool and click on "Get an ID Card" to print an ID card that includes your name and Aetna ID number. You can access Aetna Navigator through the AlaskaCare Web site at [AlaskaCare.gov](https://alaskacare.gov). If you are not registered for Aetna Navigator, you can call Aetna Concierge at (855) 784-8646 to obtain your Aetna ID number to give your provider.

For dental, Moda Health/Delta Dental will send you an ID card for your dental services. If you need assistance with your dental cards, please contact their Customer Service Center at (855) 718-1768.

What is VSP?

Vision Services Plan (VSP) is not part of the AlaskaCare Retiree optional vision benefit currently. However, it has been requested we consider this plan (currently used with the AlaskaCare Employee Health Plan) for our retiree population. The plan has a similar benefit structure to our existing retiree vision plan, and offers discounts and exclusive savings that can save our members money. The VSP vision network has over 63,000 access points across the country, including retail outlets, such as Costco and Walmart. Under VSP, you have the freedom to choose any eye care provider, but your benefits may differ from the coverage you receive with a VSP doctor. Additional information on this plan can be found at: Vsp.com/eye-insurance.html. 🌟

Dental Plan Updates

Why is nitrous oxide no longer covered by my dental plan?

After talking to our members, we have added coverage for nitrous oxide to the dental plan. This change is retroactive to January 1, 2014. Denied claims were automatically reprocessed. If you have had a claim for nitrous oxide denied and have not received a revised Explanation of Benefits, please contact Moda/Delta Dental at (855) 718-1768.

Why are cleanings limited to once every six months?

Some of our members have advised us of scheduling challenges when making appointments, especially for those members that have to travel to see a dentist. To address this issue, we have changed the frequency for exams and cleanings from once every six months, to twice per benefit year.

What if my health condition makes more frequent cleanings necessary?

Recognizing that some members may need more frequent cleanings, we have increased the frequency limits in some cases. Your dental professional can contact Moda/Delta Dental to determine if cleanings in excess of the following limits can be approved.

- Two cleanings per year, under normal circumstances.
- Up to three cleanings per year for pregnancy.
- Up to four cleanings per year for diabetes or periodontal disease.

Additional cleanings are available when dentally or medically necessary with Moda/Delta Dental of Alaska prior approval. 🌟

Save Yourself Money by Using Network Providers

Using “network” providers can provide substantial benefits to members through the elimination of what’s known as “balance billing.” It can also generate substantial savings to members through negotiated provider discounts. To find out whether your doctor is a member of the Aetna network, call Aetna’s Health Concierge at (855) 784-8646 or select the “Find a Doctor” button on our Web site at AlaskaCare.gov. To find out whether your dentist is a member of the Moda/Delta Dental network call Moda/Delta Dental at (855) 718-1768 or select the “Find a Dentist” button on our Web site.

What is “balance billing?”

The AlaskaCare plans limit payment of covered services to the recognized charge. The recognized charge is the maximum amount the AlaskaCare plans will pay for a covered service. Aetna and Moda/Delta Dental, and their respective network providers (sometimes referred to as participating providers), agree to a set of discounted negotiated rates for services provided. The recognized charge for network providers is the negotiated rate. For an explanation of how the recognized charge is calculated for out-of-network providers, please see the recognized charge questions under the Medical, Vision and Audio and Dental sections.

An out-of-network provider has the right to bill you for the difference between the recognized charge and the actual charge. This is often referred to as balance billing. Network providers have agreed to accept, as payment in full, the negotiated charge. Therefore, you are not subject to balance billing when you use a network provider.

If I have a procedure or service at a network facility, can I be balance billed?

You may find that not all providers at a “network” facility are part of the Aetna network. For example, if you have a surgical procedure performed at a network hospital, you may find that the hospital and surgeon are in the network, but the anesthesiologist is out-of-network. When you get your bill, you’ll see that it reflects the negotiated network rates for your hospital and surgeon. The anesthesiologist, however, may charge what s/he chooses since s/he has no negotiated contract with Aetna. If the anesthesiologist claim exceeds the recognized charge, you may receive a bill for the balance.

How do I avoid receiving a balance bill?

You may prevent balance billing by verifying all medical providers are in the Aetna network and making sure your AlaskaCare Plan covers the services you need. For example, if you’re having x-rays, MRIs, CT scans, or PET scans, make sure both the imaging facility and the radiologist who will read your scan are in the network. If you’re planning surgery, ask whether the anesthesiologists are in the network. If available, the facility should accommodate your request to use a network provider for your services.



Similarly, for AlaskaCare covered dental services, you may prevent balance billing by verifying the provider is in the Moda/Delta Dental network.

What if there is no network provider available?

If your provider is not a network provider, you may ask for an estimate of charges, the codes that will be used for billing, and the provider’s zip code. When you receive this information, contact the Aetna Concierge at (855) 784-8646 or Moda/Delta Dental at (855) 718-1768. A member of the Aetna Concierge or Moda Customer Service team can review the estimated charges and will advise you if the charges fall within the recognized charge for your area. If the estimated charges exceed the recognized charge, you may request that your provider accept that amount and not balance bill you, or you may request payment arrangements with their office.

If your current provider is not listed as a network provider, you can ask your provider to contact Aetna at (800) 720-4009 or Moda at (855) 718-1768 for a participation application. Members are also encouraged to nominate their out-of-network providers to join the network. Contact the Aetna Concierge or Moda Customer Service to find out how.

In some cases, unfortunately, there will not be a network provider for the service you need in your area. The Division, Aetna and Moda/Delta Dental are working diligently to improve network access, but please understand that we cannot force providers into the network.

Is there a “network” for durable medical equipment (DME)?

Aetna does have a DME national provider listing on their DocFind Web site. To get the current listing, contact the concierge at (855) 748-8646 or go to AlaskaCare.gov and select the Find a Doctor tool. In DocFind under the Search by Location tab, use the Search for: drop down menu to select Other (X-ray, Surg Ctrs; Med Equip, etc.) and the Type: drop down menu to select Durable Medical Equipment-National.

For local DME providers, change the Type: to Durable Medical Equipment-Local and enter the appropriate zip code and plan. 🌸

Outpatient Rehabilitative Care Coverage in the AlaskaCare Retiree Health Plan

This article does not apply the AlaskaCare Employee Health Plan. For details about coverage in the Employee Plan, see the plan document at AlaskaCare.gov.

Outpatient rehabilitative services such as chiropractic care, physical therapy, massage therapy, and occupational therapy are commonly obtained following joint replacement surgery or after suffering an injury to your back, knee, shoulder, or other joints. If you are planning an upcoming surgery or are currently under care for this type of condition, it is important to understand your rehabilitative care benefits under the AlaskaCare plan.

What coverage for rehabilitative services does the AlaskaCare Retiree Health plan offer?

The Medical Plan covers **outpatient** rehabilitative care designed to restore and improve bodily functions lost due to injury or illness. This care is considered medically necessary only if significant improvement in body function is occurring and is expected to continue. Care (excluding speech therapy) aimed at slowing deterioration of body functions caused by neurological disease is also covered.

How does the plan determine if the services are medically necessary?

The AlaskaCare claims administrator (currently Aetna) is required to verify that services are medically necessary per the guidelines listed in the AlaskaCare plan document. In order to do so, they will request copies of your treatment records from your provider. Generally medical review is not needed for these services if the course of treatment does not exceed 25 visits. Under Aetna, clinical records are requested from your provider when the claim for the 20th visit for a condition is received.

What information does my provider need to supply?

Your provider will need to supply clinical records that contain information on the initial evaluation, the most recent therapy re-evaluation with an updated plan of care, the last five daily therapy and progress notes, and documentation supporting the need for ongoing supervised rehabilitative care including dates of surgery, invasive procedures or a change of diagnosis. The goal of therapies and treatment should be to rehabilitate the patient to a point where he/she can function adequately in his/her normal daily activities. There must be reasonable expectations that the therapy/ treatment will produce significant improvement in the patient's condition within a reasonable period of time. The AlaskaCare plan does not cover "maintenance" care, that is, services to keep the patient in his/her "rehabilitated" state. Maintenance is not considered a "medically necessary service".



What happens if my provider does not submit my records after the 20th visit?

The AlaskaCare claims administrator will continue to process claims until the claim for the 25th visit is received. At that point all claims in excess of the 25th visit will be pended awaiting clinical records that support medical necessity. If no records are received within 45 days, the claims will be denied. (If you live in North Carolina or Texas the timeline may vary, please contact Aetna Concierge at 1-855-784-8646 for additional information.)

What if the AlaskaCare claims administrator determines the clinical records do not support the treatment as medically necessary?

It is essential that AlaskaCare members understand that "medical necessity" in this instance requires continued significant clinically documented improvement. You may want to direct your provider to Aetna's Clinical Policy Bulletin found online at Aetna.com/cpb in advance of your 25th visit. (The bulletins are numbered as follows: 0243 for speech therapy, 0325 for physical therapy and 0107 for chiropractic services.) This will allow your provider to see additional detail on what services and procedures are considered medically necessary. If it is determined by the AlaskaCare claims administrator that the treatment is not medically necessary, all claims after the 25th visit for that condition will be denied.

Is the need to verify medical necessity a change with this administrator?

No, the requirement for treatment to be medically necessary is a provision of the AlaskaCare retiree health plan. Previous claims administrators were also required to make medical necessity determinations per the guidelines listed in the AlaskaCare plan document.

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Coordination of Benefits

What is Coordination of Benefits?

Coordination of Benefits (COB) is a method of ensuring that people covered by more than one medical plan will receive the benefits they are entitled to but not more than 100% of their covered expenses. The AlaskaCare health plans coordinate benefits with other group health care plans to which you or your covered dependents belong. Coordination of benefits can be very confusing, even for people who work at a physician's office.

With COB, if you are covered by more than one health care plan, the plans work together to provide benefits. One plan is considered "primary" and pays your covered expenses first. The other plan is "secondary" and pays any remaining covered expenses up to 100%. In some cases, there may be a third or fourth plan, as well.

It is important to remember that not all expenses are covered expenses.

Who sets COB rules?

Most COB rules are set by the National Association of Insurance Commissioners (NAIC). Rules for coordinating with Medicare and Medicaid are set by federal and state law. Most plans follow the NAIC rules, but there is no requirement that they do so. The AlaskaCare health plans follow standard NAIC rules to ensure ease of coordination with other plans.

What are the rules?

Here are examples of common COB situations and rules:

If You Are Covered Under...	Here's How the Plans Pay
Active employee plan and retiree plan	Primary: Active employee plan Secondary: Retiree plan
Retiree plan and as dependent under another person's plan through active employment	Primary: Retiree plan Secondary: Other person's plan
Retiree plan and Medicare-eligible	Primary: Medicare Secondary: Retiree plan
Two retiree plans	Primary: Plan in force the longest Secondary: Other plan
Retiree plan, as dependent under another person's plan through active employment, and Medicare-eligible	Primary: Other person's plan Secondary: Medicare Pays third: Retiree plan
Active employee plan, retiree plan, as dependent under another person's plan through active employment, and Medicare-eligible	Primary: Active employee plan Secondary: Other person's plan Pays third: Medicare Pays fourth: Retiree plan

If your dependent children are covered under more than one plan, in most cases, the plan of the parent whose birthday falls earlier in the year (not the oldest) is primary. If both parents have the same birthday, the plan that has covered the children longer is primary. If the parents are separated or divorced, here's how the plans pay:

- **Primary:** plan of the parent whom the court has established as financially responsible for the child's health care (the claims administrator must be informed of the court decree)
- **Secondary:** plan of the parent with custody of the child
- **Pays third:** plan of the spouse of the parent with custody of the child
- **Pays fourth:** plan of the parent who does not have custody of the child

What if none of the rules describe my situation?

If none of the above rules applies, the plan that has covered the patient the longest is primary.

How do the plans coordinate if my AlaskaCare plan is secondary?

When an AlaskaCare plan is secondary, the amount the plan pays after the deductible is met is figured by subtracting the benefits payable by the other plan from 100% of expenses covered by the AlaskaCare plan on that claim.

Example:

- You obtain a filling from a network dentist who charges \$200.
- Both your dental plans pay 80% for class II (restorative) services.
- You have met your deductibles for the year.
 - ~ Primary plan pays: \$160 (80% of \$200)
 - ~ Secondary plan pays: \$40 (20% of \$200)
 - ~ Total paid: \$200

Will the coverage from two AlaskaCare plans always pay 100% of what the provider charges?

No, you may receive a balance bill if you use an out-of-network provider. In this case, the plan will pay up to the recognized charge for this service in your area. For more information on how recognized charges are calculated, see the Recognized Charges FAQ on the AlaskaCare Web site.

Example:

- You obtain a filling from an out-of-network dentist who charges \$250 for a filling.
- The recognized charge for this service in Alaska is \$150.
- Both your plans pay 80% for class II (restorative) services.
- You have met your deductibles for the year.
 - ~ Primary plan pays: \$120 (80% of \$150)

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Coordination of Benefits

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- ~ Secondary plan pays: \$30 (20% of \$150)
- ~ Total paid: \$150
- ~ Potential balance bill amount: \$100 (\$250 - \$150)

You may also receive a balance bill if one of your plans has a lower coinsurance rate (the percentage of the cost you pay for covered expenses once you meet any deductible) or excludes coverage for the service.

Example:

- You obtain a filling from a dental network provider who charges \$200.
- Your dental plan pays 80% for class II (restorative) services, but your spouse's plan only pays 10%.
- You have met your deductibles for the year.
 - ~ Primary plan pays: \$160 (80% of \$200)
 - ~ Secondary plan pays: \$20 (10% of \$200)
 - ~ Total paid: \$180
 - ~ Potential balance bill amount: \$20 (\$200 - \$180)

Are there other benefits to being covered by more than one plan?

If you are covered under two AlaskaCare plans, the annual maximum that the plan pays will double. For example, under the Alaska care retiree dental plan, the annual \$2,000 individual maximum would double to \$4,000.

Do frequency limits double?

No, the maximum frequency of services per year is not increased due to having other coverage. For example, if you have two plans that each cover a single vision exam each year, the plans coordinate to pay up to 100% of the single vision exam. They do not pay for two vision exams in a year.

How do the AlaskaCare plans coordinate with Medicare?

If you are covered under AlaskaCare and eligible for Medicare, Medicare is your primary coverage. This means that the AlaskaCare plan reduces your benefits by the amount you are eligible to receive from Medicare Parts A and B, regardless of whether you actually enroll in Medicare.

It's your responsibility to enroll in Medicare Parts A and B as soon as you become eligible and to pay applicable Medicare Part B premiums.

I am covered under the AlaskaCare Employee Health Plan. Is there anything my spouse or qualified same-sex partner should consider when making elections to a State employee union health trust?

The AlaskaCare Employee Health Plan will only pay 30% of the covered charges for your dependents if your spouse, qualified

same-sex partner or child(ren) are covered by a state employee health trust and that coverage:

- Has been waived,
- Pays less than 70% of covered expenses, or
- Has an individual out-of-pocket maximum (including deductible) of more than \$3,500.

This applies to any dependent covered by the AlaskaCare Employee Health Plan whether the plan pays as primary or secondary.

Example:

- You incur covered expenses of \$1,000. Your spouse elected limited coverage under a union health trust that pays 20% coinsurance, so your AlaskaCare Employee Health Plan will pay 30% after the deductible.
 - ~ Spouse's plan pays: \$200 (20% of \$1,000)
 - ~ AlaskaCare plan pays: \$300 (30% of \$1,000)
 - ~ Total paid: \$500
 - ~ Potential balance bill amount: \$500 (\$1,000 - \$500)

I am retired and eligible for Medicare, but covered under my spouse's active employee plan...

Am I required to enroll in Medicare Parts A and B?

You are not required to enroll in Medicare Parts A and B, but the AlaskaCare Retiree Health Plan will estimate the portion that Medicare would have covered and pay third (after spouse's plan and Medicare).

Do I have to pay a premium for Medicare?

For many people, Medicare Part A is premium-free. However, if you are not eligible for premium-free Part A, you may submit a copy of the denial letter from Social Security to the Third-Party Administrator. The claim administrator will document your file to reflect that the estimation of Medicare coverage will not occur for an expense that would have been covered under Medicare Part A. All coordination rules, including estimating Medicare benefits, would continue to apply to Part B expenses, even if you do not enroll.

You do need to pay a monthly premium for Medicare Part B. For additional information, visit [Medicare.gov](https://www.medicare.gov).

What if I am only enrolled in Medicare Part B, and/or enrolled in Medicare Part A on a premium-paying basis?

In this limited situation, standard Medicare coordination of benefits provisions do not apply. The plans will pay as follows:

- Primary: Medicare
- Secondary: Your spouse's active employee plan
- Pays third: Your retiree plan 🍀

Medical, Vision and Audio Recognized Charge

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What if there are not enough occurrences of a procedure in a particular geozip?

If there are fewer than nine occurrences of a procedure in a geographic area, the plan uses FAIR Health's "derived charge data" instead. This data is based on the charges for comparable services, multiplied by a factor that takes into account the relative complexity of the service. If this information cannot be obtained locally, then national data is used.

What factors can affect the recognized charge?

The following factors can affect the recognized charge:

- **Billing errors:** when a provider makes a mistake on either the procedure code or zip code.
- **Multiple procedures:** when a provider performs multiple surgical procedures during a single session. The standard practice in such cases is to bill 100% for the primary (largest) procedure, 50% for the secondary procedure and 25% for all others. However, incidental items that require little or no additional time should not have an additional fee.
- **Unbundling:** when a provider shows separate codes on the bill for related or incidental services. For example, instead of being billed separately, related blood tests performed at the same time should be billed under a single General Health Panel code.

How can I make sure an out-of-network provider's rate will be within the recognized charge?

You can verify whether an out-of-network provider's charges are within the recognized charge by calling the Aetna Concierge and providing the following information:

1. The procedure code,
2. The zip code where the service is to be performed, and
3. The projected cost.

Aetna will use this information to estimate whether the proposed amount is within the recognized charge. Remember, if you use an Aetna network provider, those providers have already contracted with Aetna to offer discounted fees and those discounted fees are deemed to be within the recognized charge.

When I use an out-of-network provider, how much of the bill am I responsible for?

If you use an out-of-network provider, you are responsible for the difference between the recognized charge and the amount charged by the provider in addition to other applicable charges such as deductibles, co-payments, co-insurance and non-covered charges.

What should I do if my out-of-network provider charges more than the recognized charge?

If the out-of-network provider's claim exceeds the recognized charge and you have already paid your out-of-network cost-sharing amount, wait for the provider to send you a bill, since the out-of-network provider may adjust their charges after reviewing the claim payment. If not, ask the out-of-network provider to:

1. Consider reducing or waiving their fee to meet the recognized charge amount;
2. Review the bill to ensure the correct procedure code and amount was used (and if not, submit a corrected bill to the plan); and
3. Confirm that the out-of-network provider charged their normal fee for the service, or if the out-of-network provider increased the charge due to unusual circumstances. If so, ask the out-of-network provider to either submit a corrected bill to the plan or provide a written explanation so you may file an appeal with the plan.

Is the recognized charge provision a change in my plan?

No, the plan has always determined claims payment based upon the recognized charge. Prior to January 1, 2014, AlaskaCare plan documents referred to the recognized charge as the "usual, customary and reasonable (UCR) charge or the "maximum allowed charge."

As our claims administrator, what are Aetna's policies for claims reimbursement?

Aetna's claim reimbursement policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:

- The duration and complexity of a service;
- Whether multiple procedures are billed at the same time, but no additional overhead is required;
- Whether an assistant surgeon is involved and necessary for the service;
- Whether follow-up care is included in the price of the service;
- Whether there are any other characteristics that may modify or make a particular service unique; or
- When a charge includes more than one claim line, whether any service described by a claim line is part of, or incidental to, the primary service provided.

These claim reimbursement policies are based on:

- Policies developed for Medicare;
- Peer-reviewed, published medical journals;
- Available studies on a particular topic;
- Evidence-based consensus statements;

Visit AlaskaCare.gov

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Outpatient Rehabilitative Coverage in the Retiree Health Plan

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What can I do if my rehabilitative care is denied?

You have the right to appeal a denial. You should work with your provider to ensure all clinical records supporting that the services were medically necessary are supplied to AlaskaCare Claims Administrator with your level I appeal. The *Member Complaint and Appeal* form is available at AlaskaCare.gov.

If your appeal is denied, you may apply for an external review. At this level an independent review organization (IRO) will consider the AlaskaCare plan provisions, your clinical information, your provider's recommendation, Aetna's recommendation, and other applicable information, such as appropriate practice guidelines, etc. Should the IRO find that the denied claims were medically necessary, Aetna will process the denied claims upon receipt of the IRO's determination. If the IRO upholds Aetna's denial, you can advance your appeal to the Alaska Office of Administrative Hearings.

What should I do if I am approaching the 25th visit?

Claims for services after the 25th visit may be denied. In

advance of the 25th visit, you should consult with your provider to ensure that the "medical necessity" requirements of the AlaskaCare plan have been met. Direct your provider to Aetna's Clinical Policy Bulletin for additional information.

If treatment after the 25th visit is determined to be medically necessary, will I be asked to provide clinical records again for the same condition?

If treatment after the 25th visit is considered medically necessary, based on a person's individual clinical situation, Aetna may at some later date(s) request treatment records to verify that services continue to be medically necessary.

What if I have a new injury or condition after I have reached maximum benefit from another series of rehabilitative services?

Your provider should submit the proper diagnosis codes for the course of treatment designed to restore and improve bodily function lost due to the new injury or illness. 🌱

Medical, Vision and Audio Recognized Charge

continued from page 10

- Expert opinions of health care professionals; and
- Guidelines from nationally recognized health care organizations.

How can I appeal a recognized charge determination for an out-of-network provider?

You may appeal a recognized charge determination by providing additional information to indicate why the recognized charge was not correct, such as incorrect procedure codes, an incorrect zip code, etc. Information on appealing claim decisions is available in the AlaskaCare plan documents or in the appeals brochure on the Division's Web site at AlaskaCare.gov.

Where can I get more information about recognized charges?

Specific plan language regarding recognized charges is available in the January 1, 2014 AlaskaCare Retiree Health Plan Amendment on pages 16 through 18 and in the AlaskaCare Employee Health Plan on pages 187 through 189. Both are available on the Division's Web site at AlaskaCare.gov.

How do I avoid recognized charge issues?

See a network provider if one is available. When you see a network provider, the plan will pay based on the lesser of the billed amount or the provider's discounted fee amount. 🌱

Sign Up for Electronic Notifications

Are you looking for the latest and most up-to-date news about your AlaskaCare Retiree Health Plan?

Consider signing up for our electronic newsletter and following us on social media.

To sign up for our newsletter:

1. Navigate to ***AlaskaCare.gov*** in your Internet browser.
2. Click on the envelope icon.
3. Submit your email address.
4. Select "AlaskaCare Retiree News Updates" under AlaskaCare and click "Submit."

You can also follow us on social media at:

- [Facebook.com/AlaskaDRB](https://www.facebook.com/AlaskaDRB)
- [Twitter.com/AlaskaDRB](https://twitter.com/AlaskaDRB)

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**Member Services
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Fr: 8:30 a.m. - 4 p.m.

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Facebook.com/AlaskaDRB



Twitter.com/AlaskaDRB

The Alaska Department of Administration complies with Title II of the 1990 Americans with Disabilities Act (ADA). This health newsletter is available in alternative communication formats upon request. To make necessary arrangements, contact the ADA Coordinator for the Division of Retirement and Benefits at (907) 465-4460 or contact the TDD for the hearing impaired at (907) 465-2805.

Disclaimer: Information in this newsletter summarizes the plan provisions, is supplemental only, and does not supersede the applicable Information Booklet's provisions. The Division is unable to unsubscribe members from our mailing list at this time.

State of Alaska Division of Retirement and Benefits
P.O. Box 110203
Juneau, AK 99811-0203

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Pre-paid Cash Card Scam Targeting Survivor Benefits

The Division of Retirement and Benefits recently received information of a scam aimed at survivors eligible to receive death benefits from the Public Employees' (PERS) or Teachers' (TRS) Retirement Systems. As a precaution for our members, the Division is providing information about the scam, as well as resources to help our members protect themselves in the remote possibility they are contacted by the scammers.

The objective of the scam is to obtain identity information about the survivor's deceased spouse and thousands of dollars in the form of pre-paid cash cards.

The scam works like this: The scammer contacts the survivor and asserts that the survivor or deceased spouse owes money on an insurance policy and the State of Alaska will either withhold part or all of the death benefits until the amount is paid. The survivor is then

instructed to provide the deceased's Social Security number and to mail pre-paid cash cards, along with the receipt for the cards and his/her signature on the back to a specified address. In one reported case, an individual claiming to be representing the State of Alaska verified that the pension benefits would be withheld if their instructions were not complied with.

Please be assured that State of Alaska retirement system death benefits will never be withheld for debt payment. The Division will never contact you by phone and demand cash cards for any attachments.

For more information how to protect yourself from this scam, visit the Division's web page at Alaska.gov/drb or call toll-free at (800) 821-2251. For more tips, visit the Identity Theft Resource Center at idtheftcenter.org and type "deceased" in the search box or call toll-free at (888) 400-5530. 🍀

Travel Benefit

DRAFT-Summary of Responses to Proposed Plan Design Change

Proposed change: Enhancing the travel benefits to include SurgeryPlus benefits

Plans affected: DB Retiree Plan

Reviewed by: Retiree Health Plan Advisory Board

Proposed implementation date: January 1, 2019

Review Date: July 26, 2018

Table 1: Plan Design Changes

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

Description of proposed change:

Amend the plan booklet to add the SurgeryPlus travel program to the retiree plan which arranges and coordinates travel for a member and their companion to a network of surgeons and facilities that meet rigorous quality metrics for deeply discounted prices.

The fiscal impact to the plan is estimated to be \$2.8 million a year in savings associated with the SurgeryPlus travel program. There is no anticipated actuarial impact to the plan¹.

The increase in covered travel costs will be fiscally beneficial to the membership and will increase their options for treatment. The addition of the SurgeryPlus network will provide members with access to surgeons who demonstrate they meet and maintain a combination of objective and subjective quality metrics.²

These changes will require additional administrative work by the Third-Party Administrator(s) and the Division.

The expansion of travel benefits to include the SurgeryPlus program, could create additional competition in the Alaska medical marketplace as providers compete with those offering the same services outside of their community. This could result in reduced costs and better services as providers work to remain competitive. Alternatively, as

¹ See attachment A; Segal Consulting Memorandum, July 25, 2018.

² See attachment B for a list of SurgeryPlus provider metrics.

DRAFT-Summary of Responses to Proposed Plan Design Change

members in small communities seek care elsewhere, fixed cost for providing those services could be spread across a smaller number of patients increasing costs for those who receive care at home.

Background:

The AlaskaCare retiree defined benefit health plan currently provides reimbursement for certain travel expenses in the following circumstances:

- 1) In emergency situations³
- 2) For a minor (under 18 years of age) with a parent/legal guardian⁴
- 3) For certain transplant services at an Aetna Institute of Excellence (IOE) with a companion and lodging⁵
- 4) Second surgical opinions⁶
- 5) Treatment not available locally⁷
- 6) Surgery in other location if provided less expensively⁸

All travel, excluding emergency travel and surgery less expensive in other locations, require pre-authorization. If travel is not-preauthorized members are not eligible for reimbursement. The plan does not pay for travel costs up front, the member is required to front those costs and submit them for reimbursement following completion of the trip.

Table 1, below, outlines the proposed changes.

Circumstance	Current	Proposed
Emergency travel ⁹	Transportation to nearest hospital by professional ambulance	No change
Transplant via Aetna IOE ¹⁰	-Member and companion -Overnight stay: -\$50 per person/night -\$100/night maximum -Companion expense: -\$31/night	No change
Travel for minor	-Minor and companion	No change

³ Page 42, AlaskaCare Retiree Health Insurance Information Booklet, 2003:

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

⁴ Page 41, Ibid.

⁵ Page xxxvii-xl. Ibid.

⁶ Page 43, Ibid.

⁷ Page 42, Ibid.

⁸ Page 44, Ibid.

⁹ Page 42, Ibid.

¹⁰ Page xxxvii, Ibid.

DRAFT-Summary of Responses to Proposed Plan Design Change

	-Transportation covered ¹¹	
Second surgical opinion	-Transportation covered for member only	No change
Treatment not available locally	-Transportation, lodging and per diem covered for member only. -Limited to treatment only -Limited to the following visit per benefit year: -1 treatment for condition -1 for follow-up -1 pre- or post-natal care -1 for maternity delivery -1 pre- or post-surgery -1 per surgical procedure -1 per allergic condition	No change
Surgery in other locations less expensive	-Only applicable for surgery. -Transportation covered for member only. -Total cost may not exceed the recognized charge for same expenses received locally. -Total cost must include: -surgery -hospital room and board -travel to another location	No change
SurgeryPlus Program	-Not currently available to retiree members	-All travel includes member and companion -Travel costs arranged for and covered up front by SurgeryPlus. -Hotels arranged and paid for by plan. -\$31 per diem for member/\$62 with companion -Members receive pre-loaded debit card in advance of trip.

¹¹ This includes either airfare or round-trip transportation and associated costs (including \$80/day for lodging) if distance exceeds 100 miles one-way.

DRAFT-Summary of Responses to Proposed Plan Design Change

SURGERYPLUS BACKGROUND: The Division competitively bid travel coordination and administrative services in the first half of 2018. The selected bidder was SurgeryPlus. Extensive details are available in Attachment B, but a high-level overview of SurgeryPlus services follow:

- SurgeryPlus develops a network of providers across the United States that meet certain quality criteria, both objective and subjective..
- SurgeryPlus negotiates discounted, case rates for services.
- SurgeryPlus advocates serve as a single point of contact for members.
- When members seek an elective surgery, they can contact Surgery Plus to see if the procedure they are seeking is offered through the SurgeryPlus network and to be provided a list of three surgeons who are best suited to perform the surgery.
- If the member selects a physician, SurgeryPlus arranges for a transfer of the member's medical records to the selected physician who will review the case.
- Upon review, if the surgeon accepts the case SurgeryPlus will begin arrangements for the members' travel.
- When the member is ready to travel they will receive a copy of their itinerary in advance in a format of their preference.
- At admission (or check in) they will present their SurgeryPlus card.
- Their lodging will be covered for a duration necessary as determined by the surgeon.
- Following discharge, a SurgeryPlus advocate will follow up telephonically with the member.
- After the member travels home, follow up care can be provided through their primary care physician combined with telehealth services.
- If necessary, the member can travel back to the surgeon for necessarily follow up care.

SurgeryPlus will also provide travel administration services for members who are Medicare-eligible and are not using the SurgeryPlus network along with members seeking care in other circumstances (e.g. treatment not available locally or surgery less expensive elsewhere).

Members who do not want to use the SurgeryPlus travel administration services to book travel can also use the current method and submit receipts for reimbursement to the Third-Party Administrator.

It is not anticipated that the deductible or cost share would be waived under any of these scenarios.

DRAFT-Summary of Responses to Proposed Plan Design Change

Member impact:

Members would benefit from this change, as it would provide additional financial assistance in covering the cost of travel for themselves and a companion. It may facilitate increased access for members requiring care from specialists that are not available locally and the overall number of members seeking care outside of their community. It may also result in better outcomes through reduced complication rates based on the provider quality of the SurgeryPlus network.

WHO IS IMPACTED:

Members traveling now for care: Approximately 1,200 AlaskaCare retiree members received reimbursement for covered travel in 2017. This number should be viewed with caution in predicting member utilization for several reasons:

- 1) Members may not have realized pre-authorization is required and be denied coverage as a result;
- 2) Members may have traveled and not realize they were eligible for services and therefore did not apply for reimbursement;
- 3) Administrative challenges may have resulted in member's claims not processing correctly.

Given this, the Division estimates utilization of a travel benefits under the proposal will be higher than is experienced today; however, it is difficult to predict with certainty what actual usage will be.

In reviewing claims data, SurgeryPlus estimates utilization at around 400 procedures per year in the retiree plan. This represents about 20% of eligible procedures.¹²

Members who are Medicare-eligible: Medicare-eligible members will not fully benefit from the provider network offered through the SurgeryPlus travel program, which is preempted by Medicare's own provider network. However, they will be able to utilize SurgeryPlus for travel arrangement.

Members who are not Medicare-eligible: Members who are not Medicare-eligible will benefit both fiscally and through anticipated positive outcomes associated with high quality care from the SurgeryPlus network of providers and the travel arrangement and coordination offered.

¹² See attachment A; Segal Consulting Memorandum, July 25, 2018

DRAFT-Summary of Responses to Proposed Plan Design Change

Members will be required to pay their deductible and co-insurance to SurgeryPlus prior to receiving care; which may pose a financial burden to some as these bills are generally received following surgery.

Actuarial impact:

Neutral / Enhancement / Diminishment

Table 2: Actuarial Impact

Actuarial Impact	
Current	N/A
Proposed	No actuarial impact ¹³

DRB operational impacts:

The Division anticipates minimal operational impacts as follows:

- Staff will need to manage an additional vendor and the routine work associated with that including quality control, reporting, billing, responding to member issues, eligibility questions, and communications.
- Staff will need to review and distribute communications to educate and increase awareness of the new plan benefit.
- A plan amendment will need to be developed, put forward for public comment, and published before the benefit takes effect.
- Staff will need to coordinate and oversee implementation including plan education and cultural training for the SurgeryPlus team, ensuring coordination between SurgeryPlus and the Third-Party Administrator are working smoothly, coordinating eligibility, and responding to member questions and/or concerns.

Division staff have already been working with SurgeryPlus on implementing this program beginning August 1, 2018 for the AlaskaCare employee plan, so many of these items are already being worked through. The addition of the retiree plan will require some additional work to ensure the program is being properly administered, but the majority of coordination has already occurred.

Financial impact to the plan:

The overall financial impact to the plan is estimated to be savings of \$2.8 million annually. This is based on members using the SurgeryPlus network for 400 procedures

¹³ See Attachment A

DRAFT-Summary of Responses to Proposed Plan Design Change

per year. The total savings is net of the administrative costs for SurgeryPlus and the estimated cost per member per trip of \$3,000.¹⁴

Clinical considerations:

These changes are anticipated to result in overall better quality of care for members.

Access to SurgeryPlus program- Provider quality is a distinguishing feature of the SurgeryPlus network which reports complication rates of 0.82% among members using their network¹⁵ compared to the 14.1% average for AlaskaCare retirees living in Alaska but seeking care outside of the state in 2017 (13.8% for professional services, 17.1% for outpatient care and 27.6% for inpatient care).¹⁶

Third Party Administrator (TPA) operational impacts:

The impact to the TPA is anticipated to be high for several reasons:

- The TPA will need to coordinate with an external vendor (SurgeryPlus) including sharing prior-authorizations; member accumulator data, eligibility, and claims data.
- The TPA will need to retain the ability to pre-authorize travel even if an external vendor is coordinating that travel on behalf of the member.
- The TPA will provide eligibility to the external vendor.
- The TPA will need to maintain its existing process for travel claims administration in parallel with the additional services provided by the external vendor.
- The TPA will need to ensure its staff are trained and knowledgeable about the new benefits to accurately answer members travel-related questions and appropriately transfer members to the external vendors.

The Division is already working with the Third-Party Administrator and the external vendor to implement this benefit for the AlaskaCare employee plan effective August 1, 2018, so many of these items will have been worked through and resolved prior to any retiree health plan implementation.

Provider considerations:

The expansion of travel benefits to include the SurgeryPlus program, could create additional competition in the Alaska medical marketplace as providers compete with

¹⁴ See Attachment A: Segal Memorandum; July 25, 2018



¹⁵ 2016 average for SurgeryPlus's book of business.

¹⁶ Based off of 2017 claims experience. It should be noted that while SurgeryPlus's overall book of business saw a 0.82% complication rate in 2016, the AlaskaCare retiree population is older, and so higher rates ought to be anticipated to some extent.

DRAFT-Summary of Responses to Proposed Plan Design Change

those offering the same services outside of their community. This could result in reduced costs and better services as providers work to remain competitive. Alternatively, as members in small communities seek care elsewhere, fixed costs for providing those services could be spread across a smaller number of patients increasing costs for those who receive care at home.

Documents attached include:

<u>Document Name</u>	<u>Attachment</u>	<u>Notes</u>
Segal Memorandum; July 25, 2018	A	 Segal Travel Memo
SurgeryPlus Overview	B	 State of Alaska SurgeryPlus.pdf
Public Comments	C	TBD

Segal – Travel Memo



330 North Brand Boulevard Suite 1100 Glendale, CA 91203-2308
T 818.956.6700 www.segalco.com

MEMORANDUM

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

From: Richard Ward, FSA, FCA, MAAA

Date: July 25, 2018

Re: Travel Benefits – Focus on Actuarial and Financial Impact for the Retiree Plan

The AlaskaCare Retiree Plan currently reimburses for coach airfare associated with select services and treatments. Precertification is required and travel is restricted to the treatment facility. The Plan does not reimburse members if airline miles are used to purchase tickets, nor does it reimburse for the cost of food, lodging, or local ground transportation such as airport shuttles, cabs or rental cars.

The Plan applies the general benefit provisions, such as deductible, coinsurance and out-of-pocket limits, to determine any portion of the costs that are the member's responsibility. If the member has additional coverage, such as Medicare or other employer provided coverage, any portion of the costs covered by that plan is also considered. Below is a table outlining the current benefits offered under the Plan:

Deductibles	
Annual individual / family unit deductible	\$150 / up to 3x per family
Coinsurance	
Most medical expenses	80%
Most medical expenses after out-of-pocket limit is satisfied	100%
Second surgical opinions, Preoperative testing, Outpatient testing/surgery	100%
• No deductible applies	
Out-of-Pocket Limit	
Annual individual out-of-pocket limit	\$800
• Applies after the deductible is satisfied	

• Expenses paid at a coinsurance rate other than 80% do not apply against the out-of-pocket limit	
Benefit Maximums	
Individual lifetime maximum • Prescription drug expenses do not apply against the lifetime maximum	\$2,000,000
Individual limit per benefit year on substance abuse treatment without precertification. Subject to change every three years	\$12,715
Individual lifetime maximum on substance abuse treatment without precertification. Subject to change every three years	\$25,430
Prescription Drugs	Up to 90 Day or 100 Unit Supply
	Generic Brand Name
Network pharmacy copayment	\$4 \$8
Mail order copayment	\$0 \$0

Actuarial Value

The Department of Administration is contracting with SurgeryPlus to provide enhanced travel benefits, which include a per diem for lodging and meals, companion airfare, and concierge-level member services to coordinate travel arrangements with medical care. The scope of covered services and procedures eligible for travel benefits will also be expanded.

While these enhancements are favorable for the member, there will be no impact on actuarial value. These changes promote efficient utilization of medical services, which helps manage program costs. However, there are no changes to how the cost share is determined and therefore, the enhanced travel benefits do not affect the actuarial value of the program.

Additional incentives that affect cost sharing (such as waiving deductibles and/or coinsurance) would likely result in an increase to actuarial value.

Financial Impact

While there is no impact on the Plan's actuarial value, there would be a financial impact.

Based on the experience with their book of business, SurgeryPlus estimates that 20% of eligible procedures will result in about 400 procedures annually, resulting in savings due to the utilization of lower cost providers and fewer associated complications. Offset by contractual administrative expenses and assuming \$3,000 per procedure in travel costs, it is estimated there will be approximately \$2,800,000 in annual savings to the Plan.

This analysis is based on medical claims data from December 2016 through November 2017, which was summarized specifically to analyze the opportunity for an enhanced travel benefit. The data was reviewed, but not audited, and found to be sufficient and credible for this analysis.

Segal reviewed the assumptions used by SurgeryPlus and consider them to reasonable. For budgeting purposes, in order to be conservative in projecting the impact of a new program, Segal's analysis utilizes a 20% margin.

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

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

State of Alaska SurgeryPlus

SurgeryPlus for



A supplemental benefit for non-emergent surgeries that provides top-quality care, a better experience and lower costs

Our Differentiators

Surgeons of EXCELLENCE

Rigorous Screening &
Reduced Complications

Employee SATISFACTION

Better User Experience
We Handle It All

Hard-Dollar ROI SAVINGS

Pre-Negotiated Bundled Rates
Reduced Employer & Employee Costs

Surgeons of Excellence Credentialing

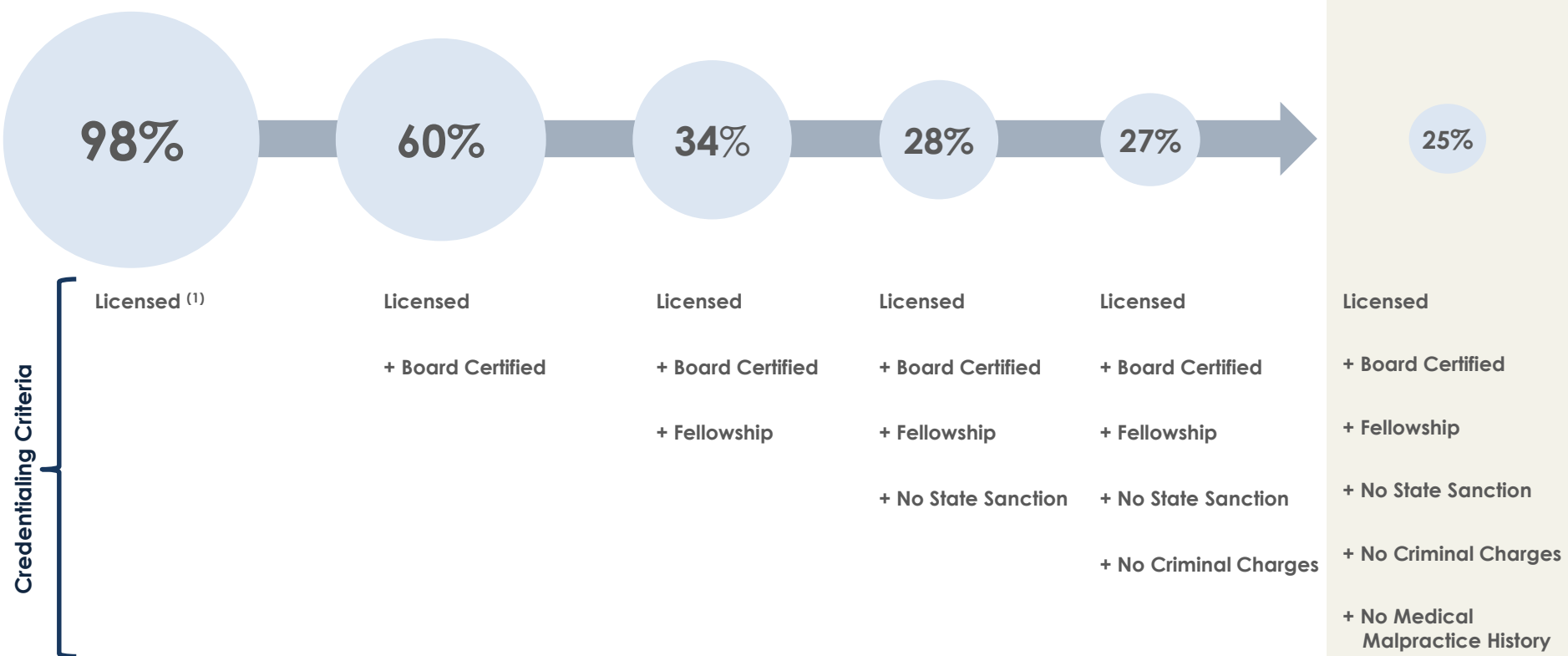
More Comprehensive Evaluation Process

	Other Network	 By  EmployerDirect Healthcare	
Board Certification	Optional	Mandatory	Unlike some of our peers, our quality starts with the physician; a poor doctor will lead to a poor result even in the best facility
Specialty Training Requirements	Optional	Mandatory	
Procedure Volume Requirements		✓	
State Sanctions Check		✓	SurgeryPlus had an overall complication rate of ~1% in 2017 and is under 1.50% life to date
Medical Malpractice Claims Review		✓	
Criminal Background Checks		✓	
CMS Quality Requirements (Hospital Only)		✓	Our surgeons are committed to patient optimization; not risk selection
Monthly Network Management		✓	
ASC Steerage		✓	

Provider Preliminary Credentialing Case Study

Examining our Rigorous Credentialing Process

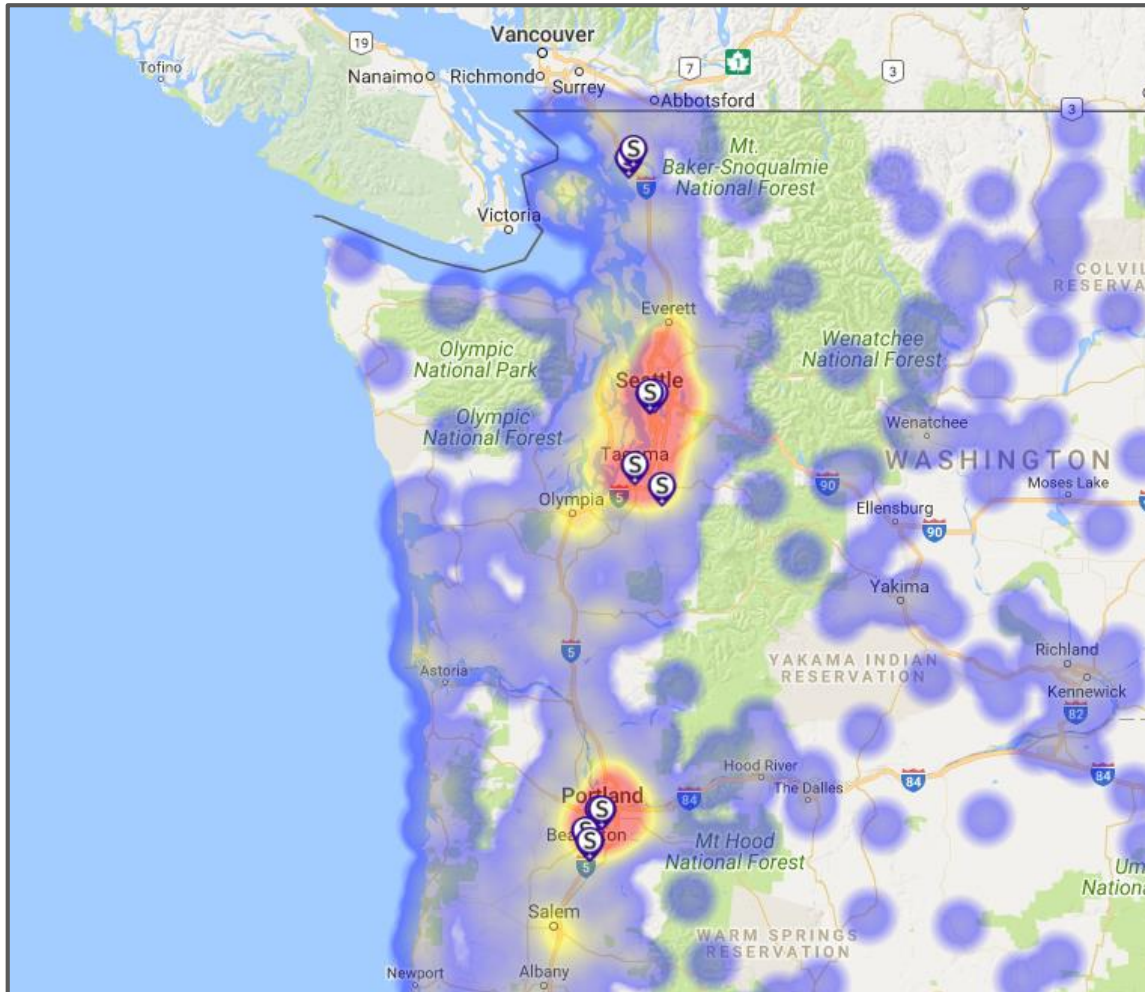
- Reflects 122 Orthopedic surgeons in the Tampa, FL MSA with the following network affiliations: BlueCross BlueShield: 116 surgeons; Aetna: 99 surgeons; UnitedHealth: 82 surgeons; Cigna: 55 surgeons
- The percentages in each bubble (from left to right) represents the total percent of orthopedic surgeons who meet the SurgeryPlus credentialing requirements listed respectively below
- This does not include our interviews, site visits or reviews of standards and volumes





(1) Two doctors remain on the carrier's portal but have retired, licensing is a standard requirement.

SurgeryPlus Provider Network

Seattle / Portland



Legend:  SurgeryPlus Provider

Seattle, WA		
Category	Covered?	S+ Facilities
Orthopedics	✓	 Virginia Mason
Spine	✓	
Bariatrics	✓	
General	✓	
GYN	✓	 THE POLYCLINIC <small>Where you come first.</small>
Thyroid	✓	
GI	✓	
ENT	✗ *	
Cardiac	✓	

*In Discussions

Provider Spotlight



Virginia Mason

- Performed over 15,000 surgical procedures in 2016
- COE for Walmart, Boeing, FedEx
- Recognized 5 consecutive years by US News & World as a national high performer in Orthopedics

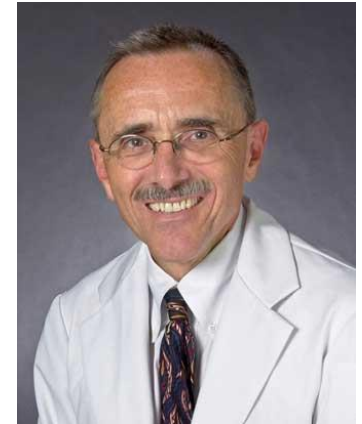
Michael E. Morris, M.D.

Orthopedics

Physician Information

Facility: Virginia Mason Medical Center

1100 9th Ave.
Seattle, WA 98101
(888) 862-2737



Education



Fellowship & Residency



Residency



Fellowship

Select Professional Societies



The American Board of
Orthopaedic Surgery

Notable Leadership

- Dr. Morris is the head orthopedic team physician for the Seattle Sounders (Major League Soccer)
- Voted on of Seattle's top doctors by both Seattle Metropolitan and Seattle Magazine in 2009
- Voted on of Seattle's top doctors by Seattle Met magazine in 2010



SurgeryPlus vs. Average Carrier

State of Alaska Member Experience

Provider Overview

Carrier	
Juneau, AK	Seattle, WA
40 – 60% above SurgeryPlus	\$24,000 – \$26,000



Member Overview

Deductible Amount	\$600	\$600	Member saves \$2,250
OOPM	\$2,850	Waived	
Airline/Car Travel (~\$550)	✗	S+ covers travel costs	
Per Diem Cost (\$25 per person, per day)	✗	S+ covers travel costs	

SurgeryPlus Can Save Members Thousands

Know What Your Procedure Costs Ahead of Time

State of Alaska WAIVES coinsurance

SurgeryPlus collects what is left on member's primary deductible

No medical bills in the mail

SurgeryPlus handles all bills following your procedure

Zero risk of out-of-network charges

Never worry any part of the procedure falls out of network

\$0 coinsurance

Note: SurgeryPlus does not coordinate with current benefits in place by State of Alaska

SurgeryPlus Member ID Card

Unlocking Access to your SurgeryPlus Benefit



John Doe
2100 Ross Ave, Suite 3200
Dallas, TX 75201



**ACTIVATE YOUR
ONLINE PORTAL EXPERIENCE**

1. Visit Alaska.SurgeryPlus.com
2. Click **Register Now**
3. Access Code: **surgeryplus**
4. Complete profile and explore

The State of Alaska has partnered with **SurgeryPlus** to provide a supplemental surgical benefit for AlaskaCare Employee Health Plan members and their families.

SurgeryPlus offers quality surgeons that are all board certified, concierge service, and ways to lower costs for hundreds of non-emergent procedures. With this benefit, your coinsurance is waived. **SurgeryPlus' concierge service** can help you understand your benefits, choose a surgeon, book appointments, facilitate medical record transfer, coordinate travel and anything else you need for a great experience. Members have access to an **online portal** where they can search surgeons and providers for certain procedures, read success stories and learn more about the benefit.

This new travel benefit available through SurgeryPlus, is only available through our Employee Plan member's primary AlaskaCare health plan; it does not coordinate with additional AlaskaCare or other health plans. Services provided are subject to your annual plan deductible.

To learn more, call a Care Advocate at (855) 715-1680, or register online at Alaska.SurgeryPlus.com with the information provided above.

The SurgeryPlus Difference

HIGH QUALITY	GREAT EXPERIENCE	LOW COST
High-performance surgeons are 100% board-certified and rigorously screened.	A dedicated Care Advocate manages the entire procedure process for you.	SurgeryPlus waives coinsurance reducing post-procedure bills and financial burden.

Remove and keep the ID card below for you and your dependants as a reference when needing a surgery or to present at any scheduled SurgeryPlus consultation or procedure.



MEMBER NAME:
John Doe
Includes member's covered spouse and dependents
(855) 715-1680
Alaska.SurgeryPlus.com
Member portal registration access code: surgeryplus



MEMBER ID: XXXXXXXX
GROUP NUMBER: XXXXXXXX

SURGERYPLUS BENEFIT
DEDUCTIBLE COINSURANCE CO-PAYMENT WAIVED



MEMBER NAME:
John Doe
Includes member's covered spouse and dependents
(855) 715-1680
Alaska.SurgeryPlus.com
Member portal registration access code: surgeryplus

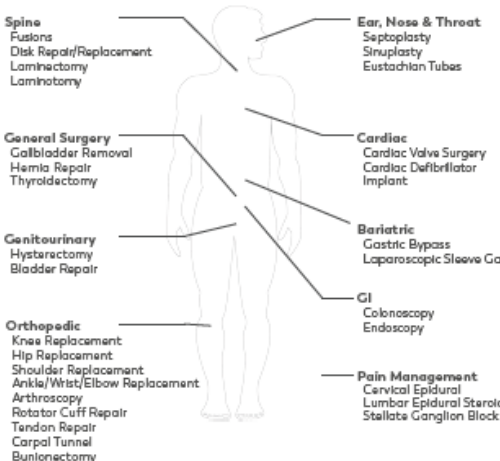


MEMBER ID: XXXXXXXX
GROUP NUMBER: XXXXXXXX

SURGERYPLUS BENEFIT
DEDUCTIBLE COINSURANCE CO-PAYMENT WAIVED

Contact a Care Advocate if you would like additional cards for dependants on your plan

SURGERYPLUS COVERS HUNDREDS OF NON-EMERGENT SURGERIES, INCLUDING:



Not all procedures are listed. If you don't see a procedure listed, speak to a Care Advocate or explore the member portal **(855) 715-1680 | Alaska.SurgeryPlus.com**

Provider Instructions:

1. Employer Direct | SurgeryPlus is the only payer for this consultation/procedure.
2. Send medical claim to the below location(s) after discharge to receive payment.
3. Contact the number below immediately for any questions in providing quality care to the SurgeryPlus member.
4. Please only use the patient's traditional insurance for the following items outside of the scope of care: diagnostic studies, imaging, physical therapy, durable medical equipment, prescriptions, lab work, non-surgery-related pain procedures, pre-operative labs and any other medical tests.

Send Medical Claims To:
Employer Direct Healthcare
2100 Ross Ave. #3200
Dallas, TX 75201
Electronic Payer ID: 48888

Member Service: 1-855-715-1680
Provider Inquiry: 1-855-300-3038
Billing Inquiry: 1-855-200-6689
Hours: 8:00am-5:00pm AEST
Monday - Friday
www.edhc.com

Provider Instructions:

1. Employer Direct | SurgeryPlus is the only payer for this consultation/procedure.
2. Send medical claim to the below location(s) after discharge to receive payment.
3. Contact the number below immediately for any questions in providing quality care to the SurgeryPlus member.
4. Please only use the patient's traditional insurance for the following items outside of the scope of care: diagnostic studies, imaging, physical therapy, durable medical equipment, prescriptions, lab work, non-surgery-related pain procedures, pre-operative labs and any other medical tests.

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Billing Inquiry: 1-855-200-6689
Hours: 8:00am-5:00pm AEST
Monday - Friday
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Care Advocates Handle It All

Full-Concierge Service Creates a Better Member Experience



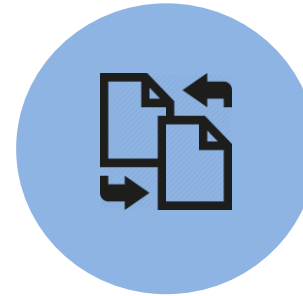
Locate

Find best fitting Surgeon of Excellence



Schedule

Book timely appointments & manage logistics



Coordinate

Bundle service providers & transfer records



Follow Up

Ensure complete member satisfaction

Managed by the Metrics for Scalability

Wait Time

~5 seconds

First-Time Call Length

~4 minutes

Time to Consult

~21 days

% of Calls to Cases

~52.4%

% of Cases to Procedures

~50.7%

Time to Procedure

~35 days

Most Common Covered Procedures

Commonly Covered Procedures by Category

Knee:

- Knee Replacement
- Knee Replacement Revision
- Knee Arthroscopy
- ACL/MCL/PCL Repair

Hip:

- Hip Replacement
- Hip Replacement Revision
- Hip Arthroscopy

Shoulder:

- Shoulder Replacement
- Shoulder Arthroscopy
- Rotator Cuff Repair
- Bicep Tendon Repair

Foot & Ankle:

- Ankle Replacement
- Bunionectomy
- Hammer Toe Repair
- Ankle Fusion
- Ankle Arthroscopy

Spine:

- Laminectomy / Laminotomy
- Anterior Lumbar Interbody Fusion (ALIF)
- Posterior Lumbar Interbody Fusion (PLIF)
- Anterior Cervical Disk Fusion (ACDF)
- 360 Spinal Fusion
- Artificial Disk

Wrist & Elbow:

- Elbow Replacement
- Elbow Fusion
- Wrist Fusion
- Wrist Replacement
- Carpal Tunnel Release

General Surgery:

- Gallbladder Removal
- Hernia Repair (inguinal, ventral, umbilical, and hiatal)
- Thyroidectomy

GI:

- Diagnostic Colonoscopy
- Endoscopy

GYN:

- Hysterectomy
- Bladder Repair (Anterior or Posterior)
- Hysteroscopy

Bariatric:

- Gastric Bypass
- Laparoscopic Gastric Bypass
- Laparoscopic Sleeve Gastrectomy

Cardiac:

- Defibrillator Implant
- Permanent Pacemaker Implant
- Pacemaker Device Replacement
- Valve Surgery
- Cardiac Ablation

ENT:

- Ear Tube Insertion (Ear Infection)
- Septoplasty
- Sinuplasty