

Retiree Health Plan  
Advisory Board  
Meeting  
November 28, 2018  
Board Packet

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**Retiree Health Plan Advisory Board  
Meeting Agenda**

**Meeting:** Advisory Board  
**Date:** November 28, 2018  
**Time:** 9:00am to 4:00pm  
**Location:** Juneau: State Office Building, 333 Willoughby Ave, 10<sup>th</sup> Floor Large Conference Room  
Anchorage: Atwood Building, 550 W 7<sup>th</sup>, Suite 1270 Conference Room  
**Teleconference:** **1-855-244-8681 / Event Number 803 575 398**  
WebEx Link:  
<https://stateofalaska.webex.com/stateofalaska/onstage/g.php?MTID=eb79d58a941df5402f439abdc1ec165a5>  
**Board Members:** Judy Salo, Joelle Hall, Gayle Harbo, Dallas Hargrave, Mauri Long, Cammy Taylor, E. Nannette Thompson

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November 28, 2018

**9:00am**      **Call to Order – Judy Salo, Board Chair**  
Roll Call  
Approval of Agenda\*  
Introduction of new board member  
Ethics Disclosure  
Approval of Minutes\*

- August 29, 2018

Meeting Dates\*

- Finalize where board members want the August 2019 Meeting - **8/7/19**

**9:15am**      **Public Comment**

**9:45am**      **Department Update - Leslie Ridle, Commissioner**

- **Review of Tele Townhall**
- **Housekeeping Items**

**10:00am**      **Break**

**10:15am**      **PBM Transition & EGWP Update**

**10:45am**      **SurgeryPlus Presentation**

**12:00pm**      **Lunch on your own**

**1:15pm**      **Modernization Committee Report / Review Modernization Table**

- 2:15pm**      **Discuss Modernization Process and Timeline**
- **By Feb 2019 Meeting, have a finalized list of what topics will be considered**
- 2:45pm**      **Break**
- 3:00pm**      **Board Member Volunteers**
- **Participation needed in the evaluation committee for the Third-Party Administrator procurement**
  - **Modernization Subcommittee Meeting member**
- 3:15pm**      **Public Comment**
- 3:45pm**      **Closing remarks**
- 4:00pm**      **Adjourn\***

*\*Indicates a required motion*

# Meeting Minutes

## 8/29/18

# Retiree Health Plan Advisory Board

## Board Meeting Minutes

Date: Wednesday, August 29, 2018 9:00 a.m. to 4:00 p.m.

Location: State Office Building 333 Willoughby Avenue 10<sup>th</sup> Floor, Juneau, AK 99801 and  
Robert B. Atwood Building 550 West 7<sup>th</sup> Avenue, 12<sup>th</sup> Floor, Anchorage, AK 99501

### Meeting Attendance

Name of Attendee	Title of Attendee	
Retiree Health Plan Advisory Board (RHPAB) Members		
Judy Salo	Chair	Present
Cammy Taylor	Vice Chair	Present
Mark Foster	Member	Present
Joelle Hall	Member	Present
Gayle Harbo	Member	Present
Dallas Hargrave	Member	Present
Mauri Long	Member	Present (phone)
State of Alaska, Department of Administration Staff		
Leslie Ridle	Commissioner, Alaska Department of Administration	
Ajay Desai	Director, Retirement + Benefits	
Michele Michaud	Deputy Director of Retirement + Benefits	
Emily Ricci	Health Care Policy Administrator, Retirement + Benefits	
Betsy Wood	Deputy Health Official	
Vanessa Kitchen	Administrative Assistant	
Andrea Mueca	Health Operations Manager, Retirement + Benefits	
Others Present + Members of the Public		
Lynda Gable	Aetna Representative	
Hali Duran	Aetna Representative	
Julian Nadolny	OptumRx Representative	
Stephanie Gaffney	OptumRx Representative	
Richard Ward	Segal Consulting (designated actuary for state health plans)	
Grant Callow	Public (phone), representing Retired Public Employees of Alaska	
William Kantola	Public	
Lynn Hartz	Public	
Brad Owens	Public, representing Retired Public Employees of Alaska	
Nancy Shima	Public (phone)	
Sam Trivette	Public	
Kim Lea	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 Medicare & Medicaid 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 Social Security 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 Social Security 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.
- RDS = Retiree Drug Subsidy program (the federal pharmacy subsidy program AlaskaCare currently has)
- RHPAB = Retiree Health Plan Advisory Board

## Meeting Minutes

### Item 1. Call to Order + Introductory Business

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

#### Approval of Meeting Agenda

*Materials: Agenda packet for RHPAB Meeting 8/29/18; Draft minutes from RHPAB Meeting 5/8/18*

- **Motion** by Gayle Harbo to approve the agenda as presented. **Second** by Cammy Taylor.
  - **Discussion:** None.
  - **Result:** No objection to approval of agenda as presented. Agenda is approved.

#### Approval of Previous Meeting's Minutes

- **Motion** by Gayle Harbo to approve the 5/8/18 minutes as presented. **Second** by Joelle Hall.
  - **Discussion:** Board members reviewed the minutes. Judy Salo noted that there was one technical correction to be made in Item 4, there was a copy and paste error in one of the motions that has been corrected, regarding the proposed 2019 meeting dates.
  - **Result:** No objection to approval of minutes as presented. Minutes are approved.

#### Ethics Disclosure

Judy Salo reminded the Board members that they must complete a form if there are any updates to their ethics disclosures.

#### Approval of 2018 and 2019 Meeting Schedule

*Materials: Meeting Calendar Options in 8/29/18 meeting agenda packet*

Judy Salo noted that in the previous meeting, the group proposed dates for 2018 and 2019, including dates early in the month for the four 2019 Board meetings. The proposed calendar is included in the agenda packet.

The group discussed the 2019 dates and scheduling quarterly meetings at the beginning of the month, and which of the proposed 2019 dates should be the group's face-to-face meeting.

- **Motion** by Gayle Harbo to approve the proposed 2018 and 2019 meeting dates (August 29, 2018; November 28, 2018; February 6, 2019; May 8, 2019; August 7, 2019; November 6, 2019; and to designate the August 7 meeting as the face-to-face meeting. **Second** by Joelle Hall.
  - **Discussion:** Judy Salo commented that designating August as the face-to-face meeting will allow the board to take any relevant advisory votes on initiatives proposed to take effect at the beginning of the new plan year, leaving adequate time for staff to begin most implementation activities associated with any such initiatives.
  - **Result:** The board voted to approve the motion.

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

Motion passes, the 2018 and 2019 RHPAB meeting dates are set.

#### Approval of Bylaws

*Materials: Draft Bylaws in 8/29/18 meeting agenda packet*

The agenda packet includes updated bylaws with corrections approved in the May 8, 2018 meeting, as well as one additional proposed correction.

- **Motion** by Joelle Hall to correct the bylaws to change “ARB” to “ARMB” to reflect the correct acronym of the Alaska Retirement Management Board. **Second** by Cammy Taylor.

- **Discussion:** None.
- **Result:** The board voted.

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

Motion passes, bylaws will be amended accordingly.

## Item 2. Public Comment

Before beginning public comment, the board established who was present in Anchorage and Juneau, on the phone or online, and who intended to provide public comments. Individuals were asked to state their full name for the record, and that they have 3 minutes to provide testimony. Judy Salo also reminded Board members and members of the public of the following:

- 1) A retiree health benefit member’s retirement benefit information is confidential by state law;
- 2) A person’s health information is protected by HIPAA;
- 3) Testimony will be posted on the Board’s website and will be publicly available, including both written comments and statements made verbally in meetings and recorded in the minutes;
- 4) By giving public testimony on those subjects, the person will be treated as having waived their right to confidentiality regarding the subject of their testimony;
- 5) An individual cannot waive this right on behalf of another individual, including spouse or family member;
- 6) The chair will stop testimony if any individual shares protected health information.

### Public Comments

- **William Kantola.** William is a retiree and now eligible for Medicare. He was informed by the State that he was required to sign up for Medicare Parts A and B, and that he was not required to sign up for Medicare Part D. He did not have to pay premiums previously, but now has to pay \$134 per month for Medicare. Previously, he did not have trouble with his benefits covering the cost of claims as identified in the Explanation of Benefits. Now that he is enrolled in Medicare, he has found that his claims have not been paid at the same level, and payment is “pending or non-payable” and that the State plan has not paid many of these claims. He is concerned that enrolling in EGWP will cost him more, will cause more paperwork, and will have more claims unpaid or not sufficiently paid similar to his experience with Medicare Part B. He is concerned that he may have to pay more, but is unsure whether this will be the case. He is also concerned that the paperwork will be confusing and burdensome. Part of the reason he worked for the State of Alaska was to secure lifetime retirement benefits, and was not aware that he would need to sign up for Medicare when he became eligible. He urges the Board to consider voting against the EGWP proposal as an advisory vote.
  - Judy Salo thanked him for his comment and encouraged him to remain during the afternoon portion of the meeting when this item will be discussed. She also encouraged him to speak directly with Division staff to address his specific questions and concerns.

- **Kim Lea.** She submitted written comments as well. Gender dysphoria is a recognized diagnosis and pharmaceutical treatments are covered by the State plan, but sexual reassignment surgery is not covered. After inquiring with Aetna, Aetna does provide this service to their own employees; she believes that this service should also be provided under the State retiree plan. She provided statistics about behavioral health risks associated with being transgender, including increased risk of suicide or substance misuse, because of the social stigma associated. There may be more medical costs if a transgender person does not have options to undergo gender reassignment. She requested information on the actuarial analysis for not covering this surgery, and believes that it should be included in the plan. She listed examples of other cosmetic or non-emergency procedures that the plan does cover.
- **Grant Callow.** He is a member of RPEA, but is making comments on his own behalf. He is concerned about the amount of public notice provided in advance of this meeting, including over 100 pages in the agenda packet and over 500 pages of public comment. He also had difficulties connecting to the teleconference prior to the meeting. He also asked for clarification regarding the federal appeals process for denied claims under EGWP: he noted that in previous versions of the documents, the State was unsure whether the federal appeals process would apply, as it typically does with Medicare cases. He later read that the federal appeals process would not be required, but the materials were unclear; he also noted that federal appeals have a threshold dollar amount that must be met, versus no threshold in the state process.
  - Judy Salo recommended that Grant reconnect to the meeting at 1:00 p.m. to hear the discussion about EGWP.
- **Nancy Shima.** Nancy made two comments:
  - A recent change to the audio plan regarding Evaluation and Management codes related to diagnostic services for hearing disorders, for which the treatment is hearing aids. She believes that payment for this service should be included in the medical plan, not an audio plan, and costs the member more to receive this service if under the audio plan.
  - Naming Aetna, and adopting Aetna's reimbursement policies, in the plan booklet may cause administrative issues and confusion regarding appeals. She recommends not including them by name.
- **Brad Owens.** Brad requested the meeting include an opportunity for a second round of public comment following the EGWP discussion. He commented that overall, the EGWP proposal seems to be a positive change and includes estimates of what will likely happen if it is implemented. He believes that the documentation outlining the proposal is not sufficient and that the State should put forward a clear plan with more certain information about what will happen in the future if this proposal is implemented. For example, the State recently shared that the federal appeals process will not apply—he would like more documentation regarding the plan language and where this information or ruling came from. He also commented that there is a significant disincentive for not enrolling in EGWP, which would represent a diminishment of benefits because it penalizes them for not participating in the EGWP program. If the new pharmacy plan is a good plan, few people will likely opt out; if it is not, he is concerned that retirees will have diminishment. He requests more and clearer information about the pros and cons of this proposal for retirees to make an informed decision. He also commented that all 50,000 retirees must be informed of this change and raised legal concerns about the State's actions.

- **Sam Trivette.** Sam commented that as a former State employee, former chair of the Alaska Retirement Management Board, and former president of RPEA, he believes that it is positive to have the Board constituted, able to listen to retirees' concerns about health plan matters, and bringing people to the table for discussion. He gave an example of the long term care plan, which is paid for by members, which was challenging to get information about from the State and its contractors. He thanked the Board for their service and playing an important role in decisions that impact the many members of the retiree health plan. He gave an example regarding benefits for the audio and vision plan, raising the level of benefits that the State will cover since it had not been updated for several years. The State had determined that it was too expensive to raise the benefits. Many members advocated that the State increase the benefit, with less cost increase than expected and premiums did not increase. Health care for retirees is a large business and part of the Alaska economy, so the decisions have economic impacts.

### **Item 3. Department Update – Leslie Ridle, Commissioner**

Commissioner Leslie Ridle recognized the staff and contractors in the room during the meeting, including new staff member Betsy Wood, the new Deputy Health Official, the position formerly held by Natasha Pineda. She provided updates on several items:

#### [RHPAB Board Vacancy](#)

- Mark Foster will be retiring from the board, his term was scheduled to end first in order to create staggered terms, and he is not seeking reappointment.
- The State will be recruiting for a new position. This seat must be filled by a PERS Tiers I, II, or III/TRS Tiers I or II/JRS retiree. The application period ends 9/11/18. Eligible individuals can apply through the State of Alaska Boards and Commission's website.

#### [Pending Decision on 2014 Court Case Regarding Health Plan Amendments](#)

- DOA is facing litigation connected to 2014 amendments to the dental, vision, audio (DVA) plans for retirees. The State has been participating in the court process this summer.
- Closing argument briefs from the State must be submitted to the state in October.
- RPEA will then submit their closing arguments in late October or early November.
- The Court has 6 months from the date of closing arguments to issue a decision on the case.

#### [New Pharmacy Benefits Manager](#)

- The State finalized the PBM contract with OptumRx, and addressed a protest they received during the bidding process.
- OptumRx's call center and member portal will be operational on October 31, 2018 and available to address members' questions and concerns.
- Members can expect to receive communications from OptumRx in late November or early December with new ID cards and other welcome packet information.
- The new contract and Optum's PBM services will go into effect on January 1, 2019.

#### [Third Party Administrator for AlaskaCare Plans](#)

- The State is preparing an RFP for the state health plan Third Party Administrator (TPA) for the AlaskaCare medical/vision/audio plan (except pharmacy services, which will be provided by OptumRx) and dental plan.

- RFP will be released in October, after a period of draft review, and will be open through the winter. The RFP will be due in the spring, and the contract tentatively awarded in summer 2019. The new contract would start on January 1, 2020.
- Staff would like to invite a Board member to participate in the process, and asked for a volunteer. RHPAB members have participated in the evaluation committees of previous contracts. The Board members did not determine in the meeting who would participate.

#### Tele Town Hall

- DRB is exploring ways to engage and communicate with retirees, and hosted the first one-hour Tele Town Hall on Thursday, August 23, 2018.
- There was high turnout! Over 1,000 people connected to the call, and a high retention rate throughout the hour call.
- Staff answered 28 questions. They addressed questions from people across Alaska and elsewhere in the U.S., and on a variety of topics to try to cover as much information as possible.
- There will be another Town Hall event on Thursday, September 20, 2018.
- The recording is posted online, and a written summary is being prepared.

Judy Salo commented that the Board is still working to find ways to run public comment efficiently and effectively, including sharing written public comments that must be carefully reviewed and redacted if they include protected health information, per HIPAA. Betsy commented that DRB staff will be preparing public comment packets and updating the comments monthly, and will compile comments in advance of each meeting. Staff will not print copies of the public comment packet unless a Board member requests, since each packet can be several hundred pages.

Judy Salo asked staff member Vanessa Kitchen to comment on preparation of the agenda packet and public comments: Vanessa noted that the team carefully reviews each comment and works to organize the information so the comments are available but do not disclose confidential information.

#### **Item 4. Modernization Committee Report**

*Materials: Retiree Health Plan Modernization materials in 8/29/18 meeting agenda packet*

*Note: Mauri Long joined the meeting via phone at this time.*

- Mark Foster, chair of the Modernization Committee, commented that the purpose of the State's modernization project is to continue to provide high-quality benefits for retirees, and ensure that retirees receive good customer service and a smooth transition when changes are made. He noted that the modernization committee met three times (June 12, July 26 and August 10, 2018) to review the materials, and thanked the staff for preparing detailed analysis and to his fellow committee members for taking time to review and discuss the materials. He encouraged other committee members to provide their thoughts.
- Joelle Hall commented that she agreed with Mark's comments, that she looks forward to continuing the conversation, continuing to analyze in detail each proposal, including positive changes to the plan being proposed in the modernization project. She also requested that staff and the Board provide clear information about the proposal throughout the process, and a clear communications plan (including available resources and a timeline) about the process. She

would like “a long runway” regarding public comment and engagement, and requested specific budget information from staff regarding communications.

- Leslie Ridle commented that she agreed, engagement with stakeholders is important, and she noted that the timeline for these changes is generally flexible, and can be implemented at any point in the year, versus some changes that must be done at the beginning of the new plan year. She also noted that the proposed changes incorporate suggestions received through public comment.
- Cammy Taylor commented that people always request more services, and those must be balanced with the cost of providing those services. She requested that staff make clear what all proposals are, including additive benefits to the plan and offsets for the associated increased costs, if any. The modernization project should be inclusive of all proposed changes to the plan.
- Emily Ricci agreed that the Board should be involved in all discussions, including additions and offsets to the plan that have or will be proposed, and that staff will provide information and analysis about each proposal as it is available.
- Judy Salo asked staff whether it would be possible to share a survey with all members?
  - Emily Ricci responded that yes, this is certainly feasible to do surveys, and it may be helpful to do multiple surveys. For example, some people will respond to an Internet survey, while others may be better reached via a phone survey. Mailing is one of the most expensive methods of communication, so staff must be strategic about using this resource and maximize limited funds. She also noted that the Tele Town Hall was well received, with over 90 percent of participants saying they like the format.
- Judy Salo also asked whether the Board should continue scheduling committee meetings?
- Commissioner Ridle asked staff, could the modernization project be considered as a large package, or should individual proposals be considered separately?
  - Emily Ricci commented that it would be helpful to look at the entire package, even if not all proposals are being considered, and to have a realistic timeline when each change would go into effect. Changes do not necessarily have to be done at the beginning of the calendar year, it is generally easier to make changes at the same time, but some (particularly additional benefits, such as removing lifetime maximum limits) would benefit members as soon as possible.
  - Mark Foster commented that he also is in favor of considering the proposals as a package, because remaining with the status quo will have tradeoffs if the plan changes result in new benefits as well as offsets. This helps individual members evaluate the pros and cons of the plan changes, to understand the implications of choosing to opt out of components associated with the plan.
  - He also noted that generally change creates uncertainty and anxiety, some of which may not be able to be addressed, and some of which is due to individual past experiences. Having all the information and plenty of time to consider the tradeoffs would help members during the transition. He also noted there are already complications having multiple groups of retirees, such as those living overseas. There should be a distinction between potential issues or administrative burden, versus verifiable facts about impacts. He encouraged the State to be more consumer-friendly and not replicate issues people experience with commercial insurance in the U.S. It is important to lay out a

clear framework for the status quo (“safe harbor”) and how it compares with proposed changes, and an “on ramp” method for transitioning from the status quo to a new plan.

- Judy Salo asked for an example of consumer-friendly policies the State could adopt?
  - Mark commented that he has access to other health plans out of state such as through alumni associations and has found that Medicare Advantage programs (which provide a concierge service to easily enroll in and access Medicare services) are very consumer-focused and can help transition and implement a program smoothly. Making one of these services available for AlaskaCare retirees may be helpful.

Judy Salo commented that she would like to spend the remainder of the time discussing the proposals in more detail, so that Board members understand and can respond to others’ questions or concerns regarding what is being proposed.

She also noted that with Mark Foster retiring from the Board, the modernization committee will need another member and will need to select a new chair. The group will discuss this further in the meeting, to give current committee members time to consider.

#### Presentation of Preventive Services Proposal

Joelle Hall summarized the preventive services proposal: the current plan covers some specific preventive services, but does not cover many preventive services that are now considered standard in health plans. The proposed change would remove reference to those specific procedures, which were appropriate at the time the plan was created, but not necessarily relevant now, and would instead state that the plan covers all recommended preventive services (immunizations and screenings) recommended by the U.S. Preventive Services Task Force.

Cammy Taylor thanked staff for including the list of immunizations and screenings recommended by the U.S. Preventive Services Task Force in the packet, so members can review the proposed changes.

- Cammy asked whether the shingles vaccine, not covered by Medicare Part B, would be covered as a preventive service?
  - Julian Nadolny, OptumRx, confirmed it is covered under Medicare Part D.
  - Michele Michaud added that services that are covered under Medicare Part D would be included in the EGWP, and so the shingles vaccine is covered. Some immunizations, such as the flu vaccine, are covered under Medicare Part B and would not be covered under the EGWP.

Cammy Taylor requested that staff prepare a list of preventive services that may be covered under EGWP, rather than the medical plan or Medicare Part B.

Judy Salo commented that this is helpful information for members to know, that the shingles vaccine would be covered under EGWP.

- Cammy Taylor asked Richard Ward about the estimated increase in claims (medical and pharmacy) for retirees related to preventive care, and the \$680 million cost for all claims, this information does not track with the estimated claims in the most recent Aetna report.
  - Richard noted that he would need to communicate with Aetna about which specific claims were included, the information provided was for all retirees (Medicare eligible and otherwise) and more detailed information would need to be researched.

- Cammy Taylor asked staff for clarification about impacts for people eligible for Medicare versus not eligible for Medicare?
  - Michele Michaud explained that people who are already eligible for Medicare have some preventive services covered, so this change would not impact them as much as those who are not Medicare eligible.
- Joelle Hall asked for the estimated number of retirees who are not Medicare eligible and whose preventive services are not covered by Medicare? She underscored that this is a significant number of people who are implemented.
  - Staff estimated the current number is 21,241 (approximately 30% of the total 77,000 retirees), with more people anticipated to retire over the next several years.
  - Judy Salo also commented that people who were on the active employee plan and have since retired have commented to her that they wish that these services were covered.
- Joelle asked the Board a process question: what will be the process for considering and taking an advisory vote on the proposals? Will each one be examined in detail before any decisions are made, or will the Board consider some proposals at a time and take an advisory vote on those before moving forward?
  - Judy Salo suggested that Board members make comments on their current feelings on each item presented, and asked staff for guidance on the process overall.
  - Emily Ricci commented that it would be difficult to consider all the proposals without having all the analyses complete that can quantify the impacts of each. She encouraged the Board to wait for analyses to be complete in order to make informed decisions. She noted that identifying everything in the package will be important, and at that point the package can be presented for public comment, in addition to seeking public input throughout the process.
  - Joelle Hall noted that the analyses are being updated as new information is gathered, so they will necessarily change. She strongly encouraged Board members, and members of the public, to read the proposals and read new versions when they are available. She also noted that the Board has spent time in committee meetings to discuss each in more detail than can be done at a Board meeting, so she encouraged Board members and the public to review the minutes from those meetings or attend to hear the discussion.
  - Judy Salo commented that she appreciates the need for more analysis, and looking at the package as a whole—but she cautioned against considering all of the positive changes first, some or all of which will cost more than the current plan, because these will need to be offset by other changes to control costs.

Cammy Taylor shared one point taken away from the meeting with Aetna on Tuesday, that there are many different ways to encourage members to make different choices, depending on the plan design, such as incentives or disincentives for some options. This can influence health decisions without taking away core benefits. She is interested in exploring these further in order to make the plan better.

Emily Ricci commented that there are many different offsets being proposed, but staff do not anticipate that all of these offsets would be implemented. The intent is to provide a menu of options for consideration and determine which are most appropriate. She also noted that changing the design of the plan in a way to negotiate with providers and leverage more purchasing ability is important, more so than making changes that would increase costs for members. She feels that the current plan design is

outdated and very limited, and there are more options to improve the value of the plan for members and for the State by negotiating better prices within the health care system.

Judy Salo noted that the November 28 Board meeting will include this item, with the expectation that the discussion of these proposals already discussed be closed and the Board consider action.

Joelle Hall reiterated that this is a continuous process and will take time, and will need to have an implementation strategy for each proposal in order to make decisions along the way, without losing sight of the overall goals and package of proposals. She requested a more detailed schedule for the process and more detailed information about how the discussion will occur in the November Board meeting.

Judy Salo requested that the modernization committee prepare a more detailed schedule of the in-depth discussions about each proposal, and staff prepare a more detailed schedule for review of the package overall as well as the Board's role. The modernization committee will schedule additional meetings to continue its work, and discuss a calendar.

#### Questions and Discussions from Board Members

- Mauri Long added to Joelle Hall's comment on medical standards or best practices, such as the immunizations. She requested that staff indicate where the plan changes or current plan policies follow standards regarding medically necessary or appropriate procedures. For example, the proposal regarding rehabilitative care, what the standards are for various diagnoses (such as multiple sclerosis) and from what source. She believes this would help the Board evaluate the medical value of the proposals. Can other aspects of the plan be phrased in a way to keep the plan flexible and respond to changing best practices, and to allow a member to read about what practices are medically accepted?
  - Emily Ricci commented that the Affordable Care Act established standards for preventive care, this is a good example of an existing standard.
  - Michele Michaud responded that in the case of preventive services, the proposal is that the plan document references any preventive service (immunization and screening) that is rated with an "A" or "B" by the United States Preventive Services Task Force (USPSTF), which would allow for changes over time as USPSTF releases new information or revises its recommendations.
- Commissioner Ridle asked how often the list is updated, how frequent might changes occur?
  - Michele Michaud commented that she believes updates are made periodically, as new information or evidence is available.
  - Richard Ward noted that typically updates are made annually, with small incremental changes each year. Looking back 10 years ago, there may be cumulatively several changes, but the recommendations do not generally change drastically each year.
  - Emily Ricci added that evidence-based practices are built over time as new studies are released, and there are always studies that can confirm a particular assumption or conflicting assumptions. USPSTF reviews studies regularly and considers the quality or applicability of the study, evaluating whether the study provides sufficient evidence and methodology to be considered reliable. There is always some degree of controversy or disagreement with recommendations, such as mammogram recommendations. There will still be subjective elements to considering medical necessity, but the criteria for

medical necessity is generally standardized. It may vary somewhat from insurer to insurer, but the standards are posted publicly for many services and is intended to be evidence based and consistent. The State must rely on the third party administrator to determine medical necessity, and there may or may not a standard for every service.

- Judy Salo asked the meaning of “a full suite of preventive services,” and for clarification about the USPSTF recommendations, how is the rating determined?
  - Emily Ricci commented that USPSTF considers the benefits and risks for preventive services, and for which populations. For example, mammograms may detect breast cancer, but also expose people to radiation. Pap smears can generate false positives.
  - Judy Salo commented that the list appears to be very comprehensive, including coverage for adolescents and other populations.
  - Emily reiterated that the recommendations are for specific populations based on medical necessity and risks, so not all of the listed services would be available to every person. Many will not be appropriate, for example, screenings for women’s health issues would not be applicable to men.
- Cammy Taylor asked for clarification on the comparison table and what the current recommendation is for breast cancer screening?
  - Michele Michaud reviewed the documents, she will review the list again to ensure she listed the correct recommendation.
- Richard Ward commented that the analysis provided, including actuarial analysis, are dynamic numbers—they are revised as new information is provided, such as updating projections based on actual claims data from the current or previous year. He also noted that while the numbers may change, they may not change significantly for general purposes of policy and decision making. But, it may make discrepancies between tables.
- Emily Ricci commented that staff will request new actuarial analysis as changes are made to the proposal package, and it will be an iterative process as the proposals change during discussion. Staff will work with the actuary to consider different options and how they would impact value.
- Commissioner Ridle recommended that when considering the plan design, the State adopt a list each year with a clear date so members have a reference document to determine what services are covered. There may be changes if new recommendations are made, but generally members could rely on this list until a new one is published the following year.
- Joelle Hall requested from the public members present, which proposals are of interest to consider, specifically those that are “thorny” issues or offsets? Some may not have significant cost savings, but are problematic now, such as rehabilitative care or compounded pharmacy.
  - Mark Foster commented that he would like to see a meeting to discuss Proposal 11 (steerage toward in-network providers with less out of pocket cost to the member)
- Lynn Hartz (member of the public) commented that she is a health care provider, and appreciates the proposal to rely on the USPSTF recommendations each year, and shared that typically USPSTF publishes the recommendations annually. She suggested this is a good standard to put in the plan, and one that providers use themselves. She also asked about the timing of this change—would it occur January 1?
  - No, these changes would not take effect January 1, they could be implemented at any time, after the appropriate decision process.

- The proposed EGWP change would take effect January 1, this is a more time-limited item because it has to be done at the beginning of the calendar/plan year.
- Brad Owens, representing RPEA, commented on his understanding of state law. Previous changes to the retiree health plan included additional benefits in the plan. In 1999, there were significant changes to the plan, including positive and negative changes from members' perspective, but a 2004 court decision (*RPEA v. Duncan*) determined that because there was significant discussion and analysis of the tradeoffs, it was determined not be an overall diminishment. There has not been a court case since that time to further settle the issue, but he noted that it is important to consider the enhancements and offsets of the proposed changes and look at the package overall. He encouraged the Board and State to work with these proposals as a package, and to speak with Department of Law regarding legal requirements to follow statute and case law.
  - Commissioner Ridle agreed that considering the changes as a package is important for the reasons stated.
  - Judy Salo added that analysis, including actuarial analysis, will be done throughout the process, as changes are made or other information is gathered. At the end of the process, there will need to be an overall actuarial analysis of the whole package.
- Brad Owens also commented that from the retirees' perspective, the actuarial analysis must be performed to illustrate benefits or costs to retirees.
  - Judy Salo noted that the analysis differentiates between actuarial value and financial impact to members, as well as other impacts to members. These items are all being considered for each proposal.
  - Brad responded that there has been significant consideration of impacts to the State in the analysis, but not necessarily sufficient information about impacts to retirees.

Judy Salo commented before the Board broke for lunch, that she has gained an appreciation of what "modernization" means and why it is important when thinking about changes to the plan.

*The Board took a lunch break at 11:45 p.m., and returned to the meeting at 1:00 p.m.*

## **Item 5. EGWP Discussion**

The Employer Group Waiver Plan (EGWP) is a Medicare Part D pharmacy plan, that provides significant subsidies for pharmacy prescription costs for group retiree plans. The proposal is to implement an enhanced EGWP, meaning AlaskaCare would cover all drugs covered under Medicare Part D, and a "wrap" of additional benefits so the new plan matches what drugs are covered now.

Among Medicare eligible retirees, approximately 60 percent live in state and 40 percent out of state. Medicare eligibility is generally determined by age (age 65) but those who live outside the U.S. or who are actively working would not be considered Medicare eligible.

This is considered an administrative change to how Alaska's retiree pharmacy benefits are paid for and reimbursed by the federal government and not a change in plan benefits, as Medicare eligible retirees will still have coverage of the same prescriptions as they do today. Retirees and dependents who are not Medicare eligible will not be enrolled; however, when they do become Medicare eligible in the future, they would be enrolled when they become eligible.

There will not be a change at the pharmacy when a member goes to fill a prescription: there will be a single ID card, and the member would pay their co-pay as normal. The change will be to whether the prescription drug cost receives a subsidy under Medicare, or if it is paid directly by the health trust.

Retirees with double coverage who currently have a \$0 co-pay for prescriptions will continue to have a \$0 co-pay.

Additionally, staff had previously shared information that changing to EGWP would require changing prescription limits from a 100-unit supply to a 90-day supply. Staff have since learned this change is not necessary: the new plan can cover the greater of a 100-unit or 90-day supply, like the current plan.

Medication Therapy Management Plan: For members with multiple conditions and high cost prescriptions, there is a Medication Therapy Management Plan (MTMP) that CMS requires the State to enroll people in, as it is considered a benefit and protects the member's health by making them aware of possible drug interactions or side effects. It is not a requirement that members stay in the MTMP; a member can opt out. Participating in the program will entail receiving a letter about current prescriptions and potential risks, interactions or side effects; it will not require specific action or deny prescriptions. Staff estimates about 12 percent of members will qualify for this program.

There will continue to be coordination of plans in most cases, meaning that people will continue to have coverage from all sources of health care coverage they have now. A notable exception to this will be those with double coverage between AlaskaCare and Veterans Affairs, since CMS does not allow coordination of plans between Medicare plans and the VA. There are approximately 1,400 members who have VA pharmacy benefits, and still have access to the \$0 co-pay mail order pharmacy benefit. Additionally, staff is considering making prescription co-pays for VA-eligible members to be \$0, similar to other double coverage coordination, in place of coordination which is prohibited.

A question raised during the Town Hall regarding coordination required further research. Staff determined that in some cases, where AlaskaCare is secondary coverage for pharmacy benefits, changing to an EGWP would make the plan primary coverage.

A few retirees are currently enrolled in individual Medicare Part D, including paying premiums, and these individuals would be unenrolled in the individual plan and enrolled in the group plan. This is anticipated to be a benefit to those members, as they are paying higher premiums now; additionally, the enhanced EGWP plan will cover more prescriptions than the Medicare Part D formulary alone.

IRMAA for high income retirees: For retirees with high income (over \$85,000 for a single-person household and \$170,000 for a married-couple household), Medicare requires a premium surcharge that scales up with income. This is known as Income Related Monthly Adjustment Amount (IRMAA). Members who qualify for this premium surcharge will receive a letter from Social Security each year stating the amount they are required to pay, and this is determined by income reported to the IRS from two years previous (for example, the 2019 IRMAA would be determined by 2017 tax information). For those receiving social security, the amount is automatically deducted from that monthly payment; for those who do not, the member is billed directly each month. For pharmacy benefits under the enhanced EGWP, members charged this amount will be reimbursed by the State via a health reimbursement account. The State is prohibited from directly paying the premium to Medicare, so the reimbursement would return to the member each month. Members will need to notify the Division as soon as they

know they are subject to this premium, and at what amount, so a reimbursement arrangement can be made. The intent is to fully cover the cost of this premium for the member, for pharmacy benefits.

Staff have analyzed the potential for members to experience serious hardship, and have determined that there will not be serious hardships for members enrolled in the plan. If a member feels there is a serious hardship by being enrolled in the enhanced EGWP, the State will have a process in place to address those hardships, including unenrolling them in the plan if necessary. Staff continue to research the possible impacts and scenarios for members, and address any impacts accordingly.

Prior Authorizations: Prior authorizations will need to be filed with the new Pharmacy Benefit Manager. The prior authorizations do not have to do with medical necessity, but with what plan will pay the pharmacy cost—it may be a medical cost under Medicare Part B, a pharmacy cost under Medicare Part D, or if it is not covered by either plan, it would be covered by the State under the wrap benefits.

During the fall 2018 transition, the State and OptumRx will identify which prescriptions need prior authorization and who may be affected. The State will post information about which medications may be impacted and instructions for members or their medical providers to follow up. Members also have a 30-day grace period to receive medications (up to a 30 day supply) even if prior authorization has not been taken care of by January 1. For example, a person who did not receive prior authorization by the deadline could still access a shorter-term supply of their medications. They would receive a letter in the mail following this short-term prescription fill, asking them to complete prior authorization.

Obtaining prior authorizations does not require a trip to the doctor's office; it is an administrative process that can be initiated by a pharmacist at the point of sale, by a member by calling the PBM or their doctor to request that the process be taken care of, or by the doctor's office contacting the PBM.

- Cammy Taylor asked whether any prior authorizations involve medical necessity?
  - Generally, some prior authorizations involve determination of medication necessity. In this process, however, prior authorizations have to do with billing and which part of the plan will cover the prescription—it will not impact the actual prescription, but will determine how it is paid for and by whom.
- Cammy Taylor also asked about the formulary: will prescriptions be excluded?
  - Emily Ricci responded that the formulary is an open one, which means that the State can choose to cover new or other medications as the need arises. The PBM is aware of this requirement.

Staff also confirmed that they have fully mitigated the issue of the federal appeals process. CMS determined in 2013 that any wrap benefits provided under an EGWP are not considered Medicare benefits, and therefore not subject to appeal. Because prescriptions that aren't covered under Medicare will be covered by the State, the federal appeals process does not apply. Appeals regarding the State's decisions will be subject to the same state appeals process. The California Public Employees Retirement System (CalPERS) uses a similar approach, with an enhanced EGWP and using their own state appeals process. The federal appeals process would be available if an individual member feels that their prescription should be subsidized under the federal plan if it was denied under that plan, and that member could appeal in order to return more money to the state health trust, but this scenario is unlikely as the member will have already had their prescription covered under the State plan.

- Dallas Hargrave asked what the benefit to CMS is for subsidizing pharmacy benefits for retirees?
  - Michele Michaud responded that CMS is interested in preserving pharmacy benefits for retirees, and providing an incentive to states or other large employers to continue providing these benefits for retirees. While Alaska will not discontinue retiree pharmacy benefits, this is a concern in many other states and for other large employers with retiree health plans. If retiree drug plans are discontinued, more people will enroll in Medicare Part D, which would mean the federal government shoulders more of the cost. Subsidizing state and employer plans is in everyone's interest.
- Mauri Long asked about what costs the State may incur if they need to change the plan significantly, if Medicare changes, and/or EGWP is changed or discontinued in the future?
  - Michele commented even the one-year savings to the State are significant by participating in this plan, even factoring in the additional administrative cost, so it seems advantageous for the State to participate as soon as possible, even if future changes make it less advantageous and necessitate the State to change the plan.
  - Emily added that there is significant administrative cost with making this change, and some administrative cost for EGWP generally. However, the savings projected are net of these additional costs, and much of the cost is related to staff time (salary and benefits).
- There is an opt out plan and CMS requires members to provide an opt out option. Most other states have an opt out provision, but do not provide an alternative plan. Alaska will provide an alternative plan, with a less generous benefit (that is modeled on the active employee plan) as a disincentive for opting out. Staff believes that any potential impacts can be addressed or mitigated, and that most members will find it advantageous to remain enrolled in EGWP.
- There is no anticipated change to actuarial value by implementing an EGWP.
- There are estimated financial impacts:
  - CMS provides subsidies through the RDS program, approximately \$19 to \$21 million annually. The enhanced EGWP would provide subsidies between \$35 to \$44 million back to the State, a much greater level of support than RDS.
  - The proposal also allows for more favorable accounting of the state health trust's unfunded liability, reducing the annual State assistance payment by between \$40 and \$52 million dollars.
- Cammy Taylor asked about the distinction between actuarial impact versus financial impact? She noted that staff have said in the past, the savings associated with a transition to EGWP could be utilized to provide additional benefits in the plan.
  - Richard Ward provided a definition of actuarial value: the portion of the total cost of an average member's health care costs each year that is covered by the health plan. It is typically expressed as a percentage, such as 90% which means that the plan covers about 90% of members' health care costs, and the member is responsible for the remaining 10% of costs.  
There can be significant financial impacts without changing the share of costs covered by the plan versus the member. Where that share changes, through deductibles or co-pays or other coverage changes, that could change actuarial value.  
He also stated that the second question is a policy question: what should be done with the projected savings as it relates to the health plan or other decisions about plan changes? He noted that the actuarial value is intended to stay the same, or not

decrease, in order to keep the same level of benefits, but if there is financial impact without actuarial impact, it is a policy decision to assign savings to another purpose, or accrue it back to the health cost to cover future costs.

- Cammy Taylor asked if it is possible to have a negative financial impact, without a change to actuarial value?
  - Richard Ward gave an example: if the structure of the plan changes, and retains 90% actuarial value, and hospital costs rise dramatically over a period of time. While there would be a financial impact to both member and the State by paying more for care, the split of responsibility remains the same, so the actuarial value remains consistent.
  - It is possible to have other negative financial impacts to members and not impact actuarial value, but any changes to the plan itself (deductibles, co-pays and other costs) would trigger an actuarial change. Some financial impacts may be outside the control of the plan, such as the above example of increased prices for health care.
  - Richard also commented that because the cost of care and inflation have increased over time, holding co-payments at the same level (for example, \$4) is actually of more value to the member, because the nominal cost of that prescription did not increase for them while the real value of the dollar was decreased due to inflation.
- Joelle Hall asked for clarification about price negotiations with drug manufacturers, and whether the problematic drug negotiations in the Medicare formulary will negatively impact Alaska?
  - Richard Ward clarified that the PBM will act similar to how it does in commercial plans, which includes negotiations with manufacturers on drug prices. While the State will be using the Medicare Part D formulary and the wrap, prices are not set by Medicare but by the PBM as part of its overall negotiations with drug manufacturers. There are differences between commercial plans and EGWP, but prices are not determined by Medicare.  
For example, two members under the same PBM but with different plans (EGWP and non-EGWP) may result in different prices, depending on what has been negotiated for the two plans and what subsidies or discounts are available for each prescription drug.
- Joelle Hall also asked about vaccines covered under Medicare Part B, versus Part D?
  - Julian Nadolny clarified that some drugs will be covered under Part B, others under Part D, and others would not be covered and would be covered by the State. This is not just by medication, but depends on the diagnosis and other circumstances, if they are determined to be medical costs or pharmacy costs.
- Mark Foster requested information about which drugs will be covered under the enhanced EGWP that are not covered now?
  - Stephanie Gaffney, also with OptumRx, provided an example of Cialis: this medication is covered by Medicare Part B if it is used to treat an enlarged prostate. It is covered under Part D if it is used to treat erectile dysfunction.
  - Another example: the shingles vaccine is covered under Medicare Part D, and is not covered now but would be under EGWP. There are other vaccines that would be similarly covered under Medicare Part D.
- Judy Salo asked OptumRx regarding the transition: how will OptumRx receive members' information in advance of the transition on January 1, including any active prescriptions and other medical history?

- Michele Michaud responded that staff are working on this, and plan to provide transitional files from Aetna to OptumRx around October or November 2018. This will help OptumRx identify which prescriptions need addressing. Large health companies are accustomed to handling members' records and making these types of transitions.
- Emily Ricci added that most prescriptions will likely transfer automatically, but there will be exceptions, such as opioid medications which are controlled for safety reasons.
- Judy Salo also asked about transition of specialty drugs?
  - Stephanie Gaffney noted that OptumRx does provide a specialty pharmacy service, Briova, similar to the current Aetna specialty pharmacy program. Details will be worked out, but this is a specific list of medications and individual members who are impacted, and staff will work with members and with OptumRx to take care of this transition.
  - Emily Ricci added that the State is working with OptumRx to open the concierge and call service earlier than 30 days in advance of the transition (November 1, not December 1), to provide members more time to address the questions. This also pushes the timeline for this proposal up by a month for staff, who are working through the due diligence.
- A question submitted in advance: Will this require a plan amendment?
  - Michele Michaud responded that yes, a plan amendment will be required in order to accommodate the required language regarding Medicare.
  - The plan amendment will be drafted and posted soon for public comment, with ample time to review and provide input on the plan amendment.
- Cammy Taylor asked whether significant changes or discontinuation of EGWP would represent a loss or interruption of benefits?
  - AlaskaCare's plan is considered credible coverage. If EGWP is discontinued, the State is still the plan administrator—the plan will not change, only the subsidies received from CMS. Medicare eligible members would simply be moved into the existing commercial plan for non-Medicare eligible members.
- Joelle Hall reminded the Board and staff that any comments made in the meeting are on the record and that Board members should be very clear about what they are supporting or taking a position on. She anticipates adding additional clauses to the resolution regarding EGWP.
- Mark Foster commented that he has some proposed amendments to the resolution, but will make this comment during discussion of the resolution, and not comment now.
- Judy Salo solicited additional comments and questions from the public.
  - Brad Owens, RPEA. Brad Owens asked staff whether the plan amendment has been written yet?
    - Emily Ricci responded that staff have not prepared the actual plan amendment draft, but have focused on investigating and addressing all of the anticipated impacts of the proposed change. She anticipates that the content of the analysis already shared covers the necessary components of the plan amendment.
  - Brad also asked who has authority to make the final decision about this change?
    - Emily Ricci stated that the Commissioner is the plan administrator and has the decision-making authority.
    - Emily added that Commissioner Ridle needed to step out of a portion of the meeting this afternoon (at approximately 2:00 p.m.), but was present during the morning portion of the meeting, and returned for the rest of the meeting

(approximately 2:30 p.m.). She is also available to meet with anyone interested in discussing this item further.

- Brad referenced a determination issued by CMS in 2013 that permitted a state plan (CalPERS) to maintain a state appeals process under EGWP. He also asked whether the CalPERS plan is protected in the California constitution, and whether there is a protected appeals process? Is there available documentation of the CMS determination?
  - Michele Michaud responded that she is not aware of California's level of protection for retiree benefits, or details about their appeals process. Documentation of the CMS determination is available, and had not previously been available because the research process is ongoing.
  - Richard Ward added that an important distinction between Alaska's plan and many other EGWP plans is that many other employers do not offer a wrap of benefits. Since Alaska (and any other employer with an enhanced EGWP that covers additional benefits) does require an appeals process, it is difficult to compare California to this proposal, as the states' plans are different.
  - Stephanie Gaffney noted that this language can be included in the plan booklet specifically, as well as in the plan amendment.
  - Michele Michaud and Emily Ricci clarified that the State is responsible for updating the plan booklet and the plan amendment, not OptumRx, and would address any needed changes to the booklet.
- Brad also asked whether any denial of a claim under Medicare Part D would automatically go next to the State for consideration under the wrap?
  - Emily Ricci responded that yes, the next step in that process would be to go to the State for coverage under the wrap, not directly to an appeals process.
- Brad also asked if there is a clear definition of "serious hardship" as identified under the *RPEA v. Duncan* (2004), and whether staff will develop a clear definition of this as it relates to EGWP?
  - Michele Michaud noted that it would not be feasible to have a single definition of serious hardship, or a single threshold for each member, since it would differ by circumstance and diagnosis.
  - Richard Ward added that he does not believe it is accurate to say that there is no criteria for serious hardship in current or past decisions. He commented that the analysis included cost to members, formularies, pharmacy network and access, and whether there are additional requirements on members that will impact their access to prescriptions. There are some changes to specialty drugs, but this is not related to EGWP, it is a function of changing to a new Pharmacy Benefits Manager. He also stated that it is impossible to know in advance whether all 50,000 members will be negatively impacted or face serious hardship, but the State has mechanisms for addressing this as it comes up.
  - Brad responded that developing criteria for serious hardship should be done this year by the modernization committee, and could be done by November.

- Grant Callow, RPEA (phone). He agreed with Brad’s comments, and stated that in a previous meeting, DRB staff stated that they are waiting for a determination from CMS regarding the federal appeals process.
  - This item was addressed earlier in today’s meeting: the federal appeals process does not apply. Michele Michaud clarified that staff were waiting for confirmation directly from CMS that 1) the federal appeals process will not apply because prescriptions can be covered under the state plan and 2) the AlaskaCare wrap is not considered a Medicare plan and therefore not subject to federal appeal.
- Grant also commented that he believes that the State needs to develop criteria for serious hardship, and that it is the responsibility of DRB staff to do so, working with the committee and RHPAB. He quoted from the *Duncan* case, including “coverage for a specific disease or condition should not be deleted, even if other benefits are enhanced, and this would constitute a serious hardship.”
  - Judy Salo suggested this language is most relevant for the other modernization discussions, since it refers to coverage of specific diagnoses.
  - Emily Ricci agreed, this language appears to apply to a group of people with a specific diagnosis, and would therefore not be relevant for the pharmacy plan because the same drugs will be covered as they are today.
- Brad Owen asked when the plan amendment will be drafted and made available, and whether it can include language such as “No step therapy will be required”?
  - Emily Ricci responded that the plan amendment will be drafted this fall and posted in late September or early October, after a decision is made. She added that the plan amendment language would be silent on items that are not covered in the plan, and focus on what is covered in the plan. The State would also not make statements about whether or not it would cover or not cover certain services in the future, the document addresses the current plan. The plan booklet will be posted in the fall. The booklet and other materials from OptumRx will include information applicable to the individual member from Medicare, as well as information about the State wrap for medications not covered under Medicare.
- Brad made an additional comment: if the State is unsure how many people will opt out, the disincentive to opt out may be problematic. He speculated that more people may opt out than the State is anticipating, and that this may be a diminishment since the alternative plan is less generous than the current plan or the EGWP plan.
  - Cammy Taylor noted that if a person chooses to opt out of the plan, they are opting out of the same level of coverage they receive today.
  - Richard Ward added that for many state plans, the opt out option is not having pharmacy coverage. Alaska would offer an alternative plan, which is unusual.

<b>Item 6. Advisory Vote: Enhanced EGWP Proposal</b>
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- **Motion** by Mark Foster approve Resolution 2018-01 regarding the enhanced Employer Group Waiver Program proposal. **Second** by Gayle Harbo.

- **Discussion:** The resolution has been amended to correct a typo, adding a dollar sign in front of \$10.4 billion in the fourth clause.
- **Amendment:** Motion by Mark Foster to consider the package of amendments presented in the meeting (reproduced below). Second by Gayle Harbo.
  - Amendment 1: In the ninth clause, add the phrase “... enhanced EGWP has been evaluated by an independent certified Fellow of the Society of Actuaries, who found that the enhanced EGWP does not change ... plan to the members; and”
  - Amendment 2: in the eleventh clause, ... “has included: evaluating evaluation of the... experience; evaluation of the impact ... administrative change ~~on~~ to the...” and corrections to the punctuation to reflect this change.
  - Amendment 3: add a new twelfth clause “Whereas, the current AlaskaCare appeals process remains unchanged and members will not be required to use the federal appeals process; and”
  - Amendment 4: add a new fourteenth clause (the last before the “Therefore”), “Whereas, the Retiree Health Plan Advisory Board has evaluated the public comment, and found that the comments reinforce our collective commitment to providing a high value benefit to members and we aspire to a seamless transition in a manner that maintains current benefits:”  
Mark stated that he would like to recognize and appreciate the people who took the time to send comments, and for staff and Board to review and consider these comments, as well as clarify the Board’s goals of continuing to provide high-quality benefits and ensure a smooth transition in the plan.
  - The Board voted on the amendment: no objection (Mauri Long had not had a chance to review the amendments yet and did not vote).
  - Result: Accepted, the resolution will be amended as noted.
- **Amendment:** Motion by Joelle Hall to amend with a new “Whereas” clause to include “Whereas, step therapy will not be required as part of the enhanced EGWP.” This should be inserted following the language about the appeals process. Second by Mark Foster.
  - Judy asked staff if they foresee any problems with this amendment?
  - Emily stated that staff supports this amendment, given the concerns expressed by members, and does not see a problem including this in the resolution.
  - The Board voted on the amendment: no objection.
- **Amendment:** Motion by Dallas Hargrave to add the word “annually” in the fifth clause referring to annual savings. Second by Mark Foster.
  - The Board voted on the amendment: no objection.
  - Result: Accepted, the resolution will be amended as noted.
- **Amendment:** Motion by Mauri Long to specify in the following clause, regarding total savings to the unfunded liability.
  - The group clarified that this is not an annual change, the total presented to reduce the unfunded liability is a single number in net present value, future savings calculated back to total value in today’s dollars.
  - Judy Salo ruled the amendment out of order, and the Board did not vote.
- **Discussion on the motion as amended:**

- Mark Foster commended the staff for the work completed to date to prepare the discussion and research the implications, thanked stakeholders for engaging in the process and expressing their views, and thanked the administration for allowing him to participate on the Retiree Health Plan Advisory Board.
- Mauri Long commented that she would like to review the amendments prior to voting, and will do so as soon as possible. She also noted some administrative changes such as typos (“a” rather than “an”).
- **Result:** The board voted on Resolution 2018-01 as amended.

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

Motion passes, Resolution 2018-01 is approved as amended. Staff will update the resolution to reflect the accurate language as amended in today’s meeting.

\*Mauri initially abstained but after reviewing the amendment she voted yes.

Judy reiterated appreciation for the efforts of staff and the Board, and very much appreciated the Town Hall event and looks forward to future events.

Staff noted that Town Hall events will be scheduled monthly into the foreseeable future.

#### **Item 7. Additional Items and Closing Remarks**

Judy invited representatives from OptumRx to give a brief update on the progress of transitioning as the new Pharmacy Benefit Manager.

Stephanie Gaffney OptumRx, shared that their transition process is on schedule, now that the contract has been finalized, and their team is working to put all the necessary infrastructure in place.

- Judy Salo asked if the company will be able to set up and operate the concierge service starting in November, rather than December?
  - Yes, if the team stays on the timeline, which they have been able to so far.
  - A key milestone will be confirming the benefit design.
- Cammy Taylor asked who at OptumRx is the project manager overseeing the transition?
  - Stephanie responded that she is a customer relations manager, she is working closely with the operations manager overseeing this transition. She can direct any questions to the operations manager if she does not know the answer.

Commissioner Ridle commented in response to an earlier question regarding who is making the final decision, and the significance of this advisory vote. She clarified that as the plan administrator, she is responsible for the final decision about whether Alaska will implement an enhanced EGWP. She will make that decision and announce the result in late September or early October.

Brad Owen commented that RPEA is committed to working closely with the Retiree Health Plan Advisory Board and the Division of Retirement and Benefits, and to continue working with all parties to find the best solutions for retirees and members.

Emily Ricci commented that she also appreciates the work of the Board and of stakeholders, as well as DRB staff, in this process, and felt that the engagement and analysis process was productive and a good model for future discussions of the modernization project.

Judy Salo recognized Cammy Taylor as the new chair of the modernization committee, starting in October when Mark Foster leaves the Board.

Judy Salo also requested that Board members consider who may be good candidates for filling Mark Foster's seat on the board, and connect with those individuals for nominations.

<b>Item 8. Meeting Adjournment</b>
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- **Motion** by Dallas Hargrave to adjourn the meeting. **Second** by Judy Salo.
  - **Discussion:** None.
  - **Result:** No objection to adjournment. The meeting was adjourned at 3:25.

# Meeting Dates 2018 and 2019

# RHPAB Board Meeting Dates & Locations

<b>Meeting Dates - 2018</b>	<b>Conference Rooms in Anchorage</b>	<b>Conference Room in Juneau</b>
August 29th, 2018	Atwood Conf Rm Suite #1270	10th Floor of State Building
November 28, 2018	Atwood Conf Rm Suite #1270	10th Floor of State Building
<b>Meeting Dates - 2019</b>	<b>Conference Rooms in Anchorage</b>	<b>Conference Room in Juneau</b>
February 6, 2019	ACC Atwood Conf Rm 102	10th Floor of State Building
May 8, 2019	ACC Atwood Conf Rm 102	10th Floor of State Building
August 7, 2019	ACC Atwood Conf Rm 102 & 104	10th Floor of State Building
November 6, 2019	ACC Atwood Conf Rm 102 & 104	10th Floor of State Building

# Public Comment Guidelines

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

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

# State of Alaska SurgeryPlus

# Employer Direct for



Uniquely positioned to meet the State's evolving needs

# Executive Summary

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- On January 30<sup>th</sup>, 2018 Alaska issued a RFP for travel and supplemental health services focused on ensuring Plan Participants had adequate access to high-quality, appropriately priced healthcare
  - Employer Direct Healthcare LLC, with its SurgeryPlus offering, won this contract award
  - The SurgeryPlus benefit was launched for the active employee population on August 1<sup>st</sup>, 2018, and since that launch Employer Direct has opened over 50 cases for the State
  - As part of that contract, the State may choose to make SurgeryPlus available to the retiree population as well
- We understand that the State is interested in evaluating a broader range of services including:
  - Expanded travel benefits, including for services beyond non-emergent surgeries
  - Greater customer service to advocate on behalf of member's health needs
- Employer Direct and SurgeryPlus are able to meet these requirements

**Employer Direct and SurgeryPlus are uniquely positioned to meet the State's needs immediately and can be deployed in less than 60 days**

# SurgeryPlus Overview

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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

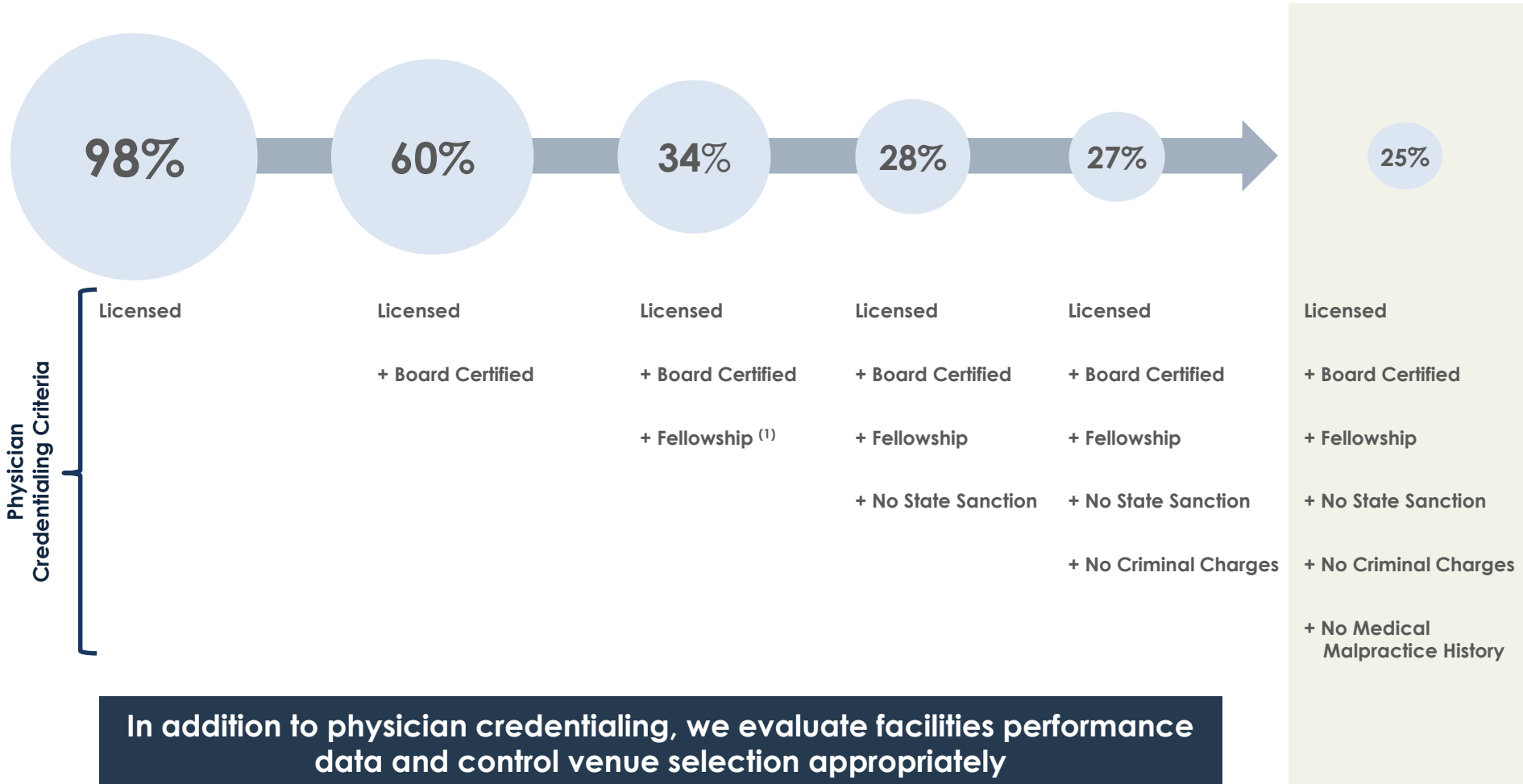
## Hard-Dollar ROI SAVINGS

Pre-Negotiated Bundled Rates  
Reduced Employer & Employee Costs

# How We Evaluate Physician Quality

## A More Comprehensive Evaluation Process

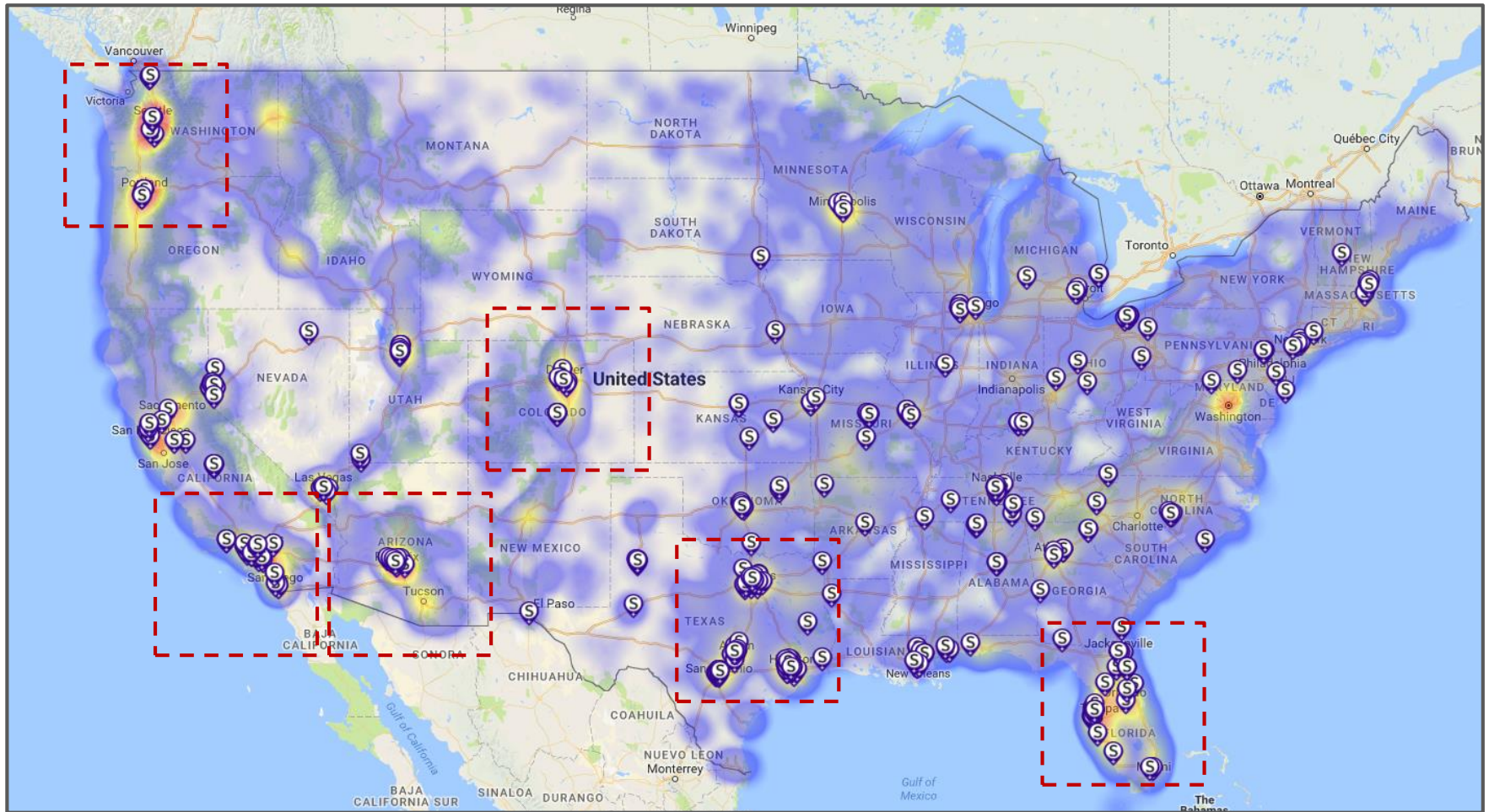
- Unlike some of our peers, our quality starts with the physician; a poor doctor will lead to a poor result even in the best facility



(1) Where appropriate, category dependent.

# SurgeryPlus Provider Network

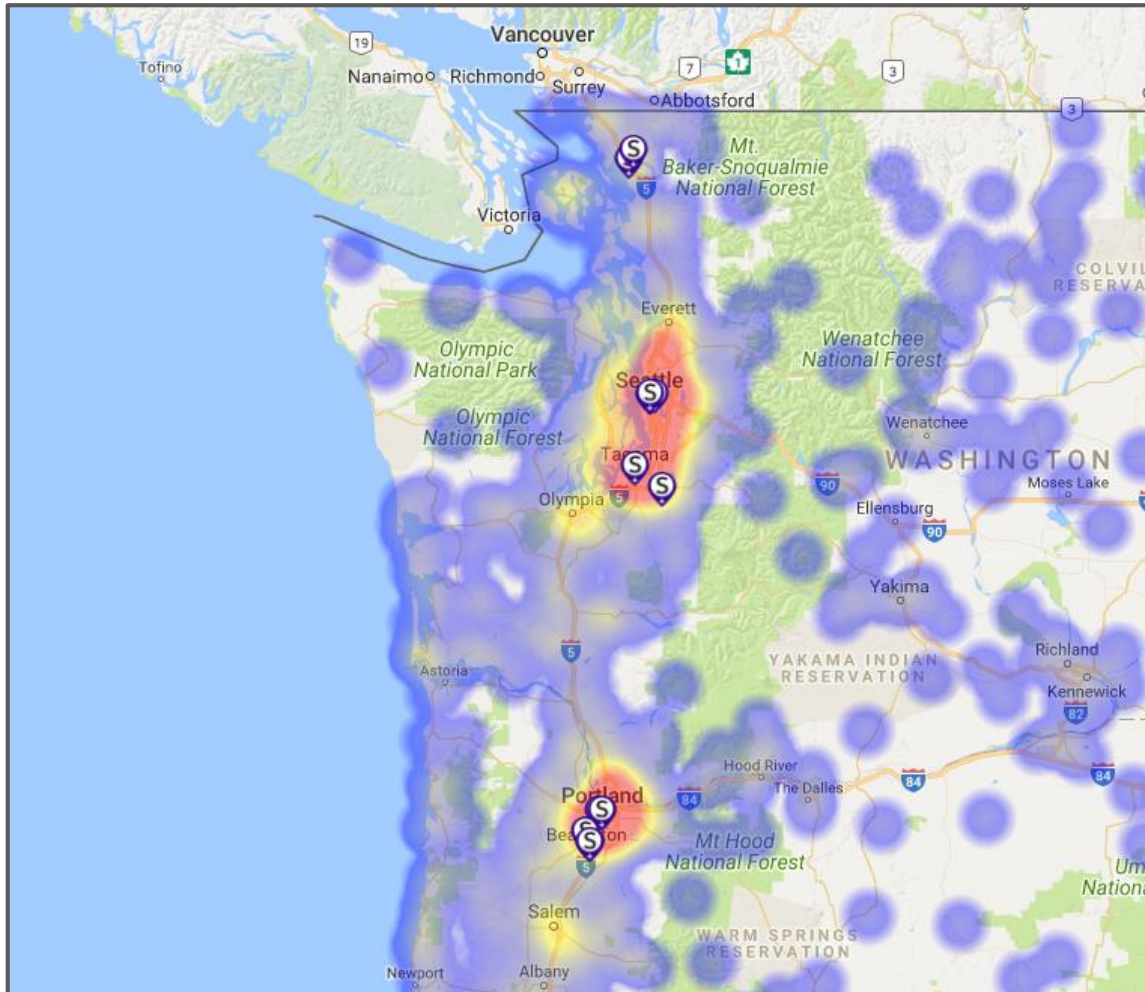
## State of Alaska Member Population



Legend:  SurgeryPlus Provider



# SurgeryPlus Provider Network

Seattle / Portland



**Legend:**  SurgeryPlus Provider

Source: SurgeryPlus Provider Network as of March 23, 2018.

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

\*In Discussions

## Provider Spotlight



### Virginia Mason

- 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

# Care Advocates Handle It All

Full-Service Concierge Creates a Better Member Experience



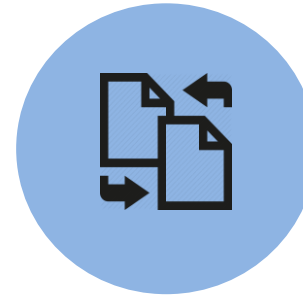
## Locate

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

# Healthcare Today: Price Volatility

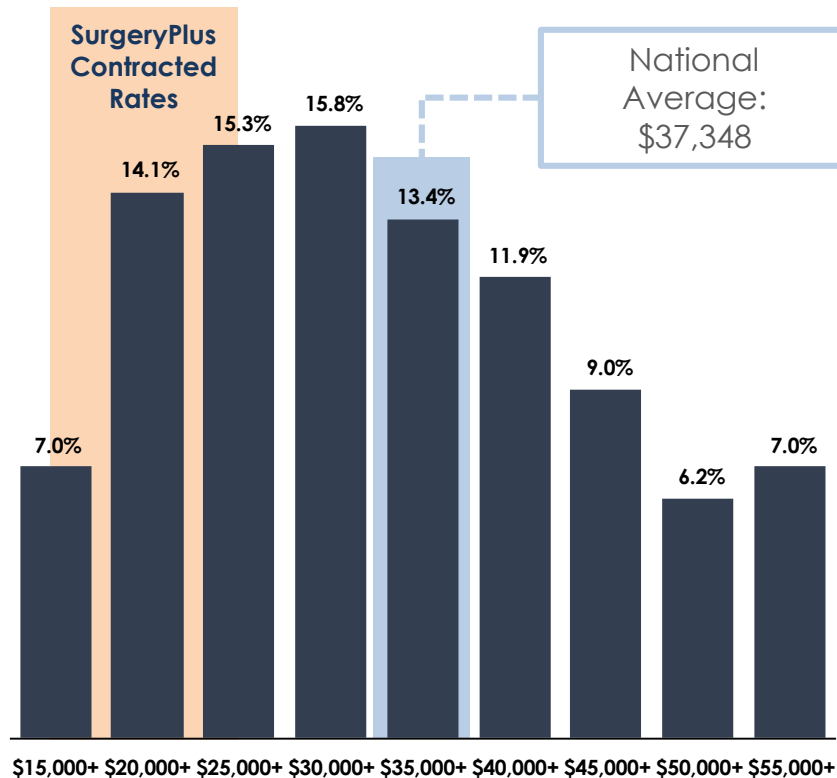
SurgeryPlus' Bundled Rates Provide Consistent and Lower Costs

## Orthopedics (27130) – Total Hip Replacement

(% of Total Claims)

% of National  
Medicare

113% 151% 189% 227% 265% 303% 340% 378% 416%

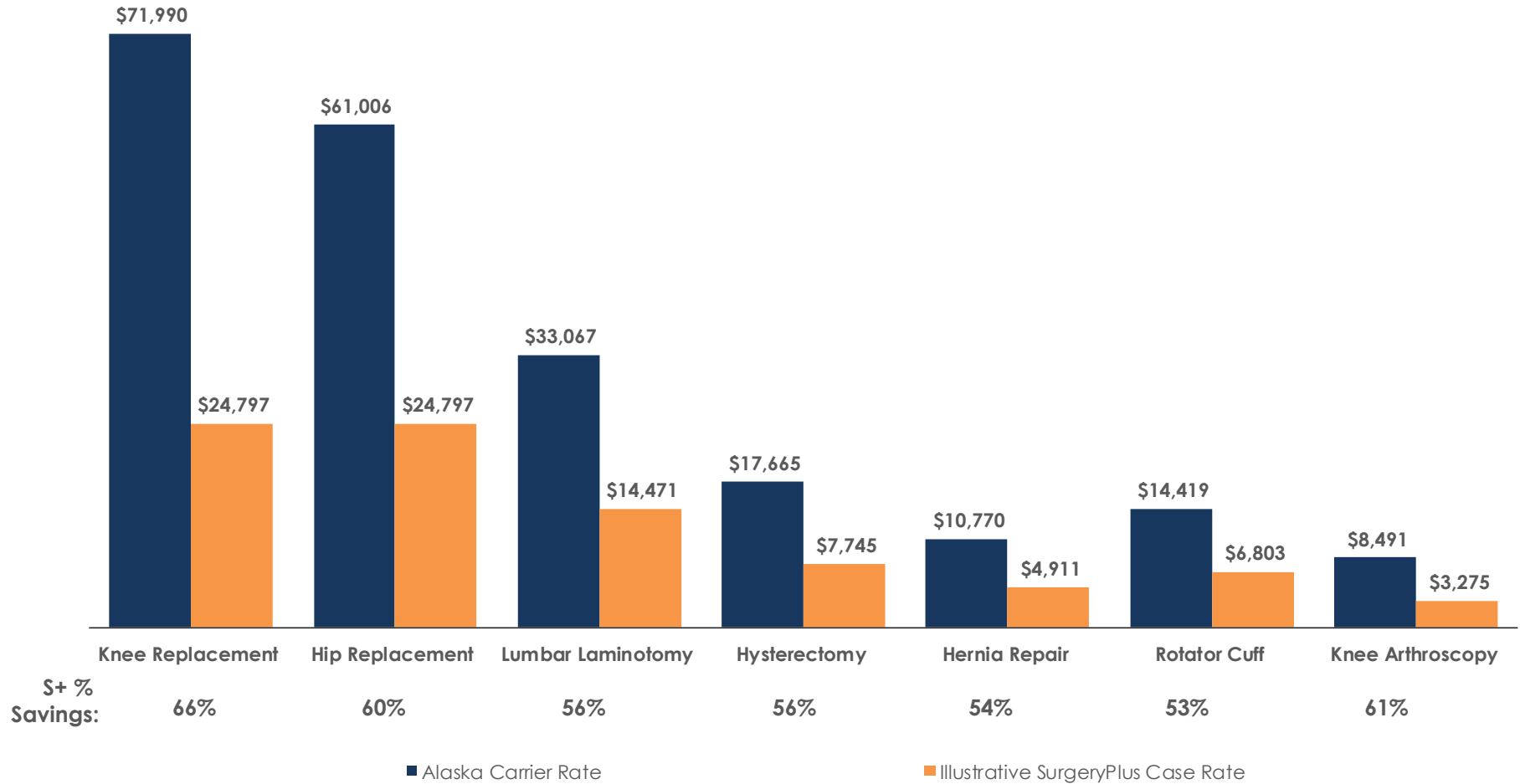


**Market Rates Exhibit  
Tremendous Volatility**

Little transparency or  
incentive for member  
around cost

# Illustrative SurgeryPlus Savings Examples

## Common SurgeryPlus Procedures vs. Carrier Rates



Notes: Alaska carrier case rates based on estimated case rates in the Juneau, AK MSA. **44**  
Illustrative SurgeryPlus case rate based on best existing contracts in the Seattle, WA MSA. Outpatient case rates shown where available and applicable.  
Procedure pricing can vary substantially based on specific codes billed and physician / facility used.

# Savings for Clients and Members

## Plan Design Illustration: Waived Coinsurance



	Plan	Cost	Savings	
<b>Illustrative Knee Replacement Example</b>				
<b>Replacement Surgery</b>	\$40,000	\$20,000	\$20,000	
<b>Employee Costs:</b>				
- Deductible	\$150	\$150	—	
- Coinsurance	\$800	— <sup>*</sup>	\$800 <sup>*</sup>	Savings resulted from SurgeryPlus' pre-negotiated bundled rates
<b>Total Employee Costs</b>	\$950	\$150	\$800 <sup>*</sup>	
<b>Plan Net Cost to State</b>	<b>\$39,050</b>	<b>\$19,850</b>	<b>\$19,200</b>	Total employer savings after waived coinsurance

\* If coinsurance is waived similar to the AlaskaCare employee plan design.

# 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:**

- 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

# **Expansion** of Travel Health Concierge Services

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Employer Direct and SurgeryPlus are ideally positioned to immediately deliver best-in-class health concierge services to the State

# State of Alaska Objectives

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- Broaden the scope of services included under the travel program
- Seek to provide the best possible experience for plan participants
- Provide education and advocacy to allow members to make the most informed decisions about their healthcare
  - Quality
  - Access
  - Appropriateness
  - Cost
- Increase utilization of the services
- Consolidate vendors to the extent possible for operational efficiency

# Program Design

## Scope of Services Should Inform Vendor Selection and Design

	Status Quo	Limited Expansion of Services	Concierge Travel	Concierge Medicine
Description	<ul style="list-style-type: none"> <li>Reimbursement for qualified expenses               <ul style="list-style-type: none"> <li>Limited in scope</li> <li>Limited utilization</li> </ul> </li> <li>Requires verification retrospectively that conditions were met               <ul style="list-style-type: none"> <li>Potentially unreasonable burden on member given lack of healthcare transparency</li> </ul> </li> </ul>	<p>Same as Status Quo, but:</p> <ul style="list-style-type: none"> <li>Allow travel companion for appropriate situations (e.g. any service including general anesthesia, minors, or members with physical disabilities requiring a travel companion [requires medical necessity])</li> <li>Pay for 100% of lodging &amp; reasonable per diem</li> <li>Provide full SurgeryPlus offering including its travel benefits to retirees for SurgeryPlus procedures</li> </ul>	<ul style="list-style-type: none"> <li>Prospective travel arrangement paid by state/vendor with member contribution as needed</li> <li>24/7 support for travel related issues</li> <li>Provide full SurgeryPlus offering including its travel benefits to retirees for SurgeryPlus procedures</li> </ul>	<p>Same as Concierge Travel, but:</p> <ul style="list-style-type: none"> <li>Credentialing and doctor recommendations on all services (<u>local or travel</u>)</li> <li>Care Advocacy &amp; Concierge Medicine Services               <ul style="list-style-type: none"> <li>Records transfer</li> <li>Scheduling</li> <li>Venue selection</li> <li>Adherence support</li> <li>Follow-up and continuity communications</li> </ul> </li> </ul>
Vendor Choices	Aetna / primary administrator	Aetna / primary administrator AND / OR Employer Direct (SurgeryPlus)	Employer Direct (SurgeryPlus) OR Pure travel vendor + Employer Direct (SurgeryPlus)	Employer Direct (SurgeryPlus & CarePlus)
Pros + Cons	<p><b>+ No additional bandwidth required</b></p> <p>– No benefits realized</p>	<p><b>+ Potentially limited increase in non-SurgeryPlus utilization</b></p> <p><b>+ Potential strong improvement for SurgeryPlus events</b></p> <p><b>+ Limited additional administrative costs</b></p> <p>– Does not impact quality</p> <p>– Not full solution</p>	<p><b>+ Superior experience on all travel</b></p> <p><b>+ Better control for state</b></p> <p><b>+ Reduction of vendors for service</b></p> <p>– No impact on care side</p>	<p><b>+ Quality of care</b></p> <p><b>+ Member experience</b></p> <p><b>+ Cost containment</b></p> <p>– New offering design (bandwidth, creation &amp; perfection of offering, etc.)</p>

# What We Do For Members

## Full-Concierge Service Creates a Better Member Experience

### 1 ENGAGE + EDUCATE

Many high-cost patients were not in that category the prior year. Our focus is to proactively identify prospective high-cost claimants before diseases or conditions reach advanced stages, or for existing conditions, help ensure patients receive and follow the best treatment paths.

### 2 LOCATE

Identify best-in-class, high-quality providers and/or venues specific to the member's needs, whether that may be driven by geographic, socioeconomic, or demographic needs.

### 3 ARRANGE + SCHEDULE

Schedule appointments and follow-up visits  
Transfer medical records  
Arrange travel (e.g. flights, hotels, car services)  
Manage logistics on case-by-case basis

### 4 GUIDE

Our focus is to always improve the quality of care for the member. Our holistic approach focuses on medical, behavioral, financial and other aspects of each individual, not just their health condition. We ensure all of the member's needs are being met throughout their journey.

### 5 MEMBER COMMUNICATION + ADVOCACY

Our top priority is to ensure members are staying on track to meet their healthcare goals.

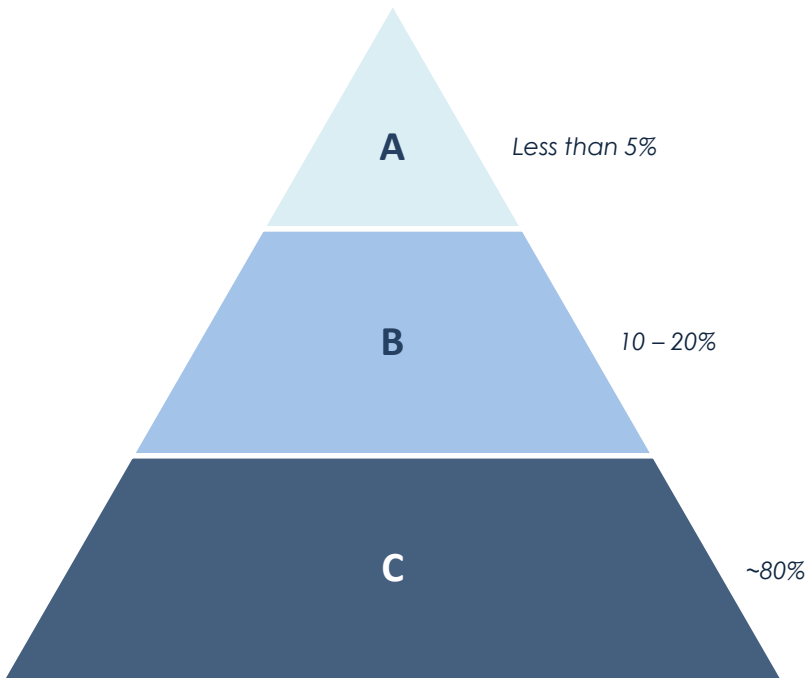
### 6 FOLLOW-UP

Our advocates are there every step throughout the recovery process – including treatment and medication needs. We are there to address any concerns a member may have post-discharge and focus on compliance/adherence to their recovery plan.

# [CarePlus] for Alaska

## Identifying Population Segments

### Alaska Membership by Profile Tier



### Description of Tiers

**A**

#### Chronic high-risk, high-cost members

- 1:1 care advocacy & concierge medicine services
- Outreach efforts where appropriate
- High touch and ongoing
- Focus on care advocacy & concierge medicine services and plan adherence in conjunction with treating physicians

**B**

#### High-risk, high-cost but more episodic

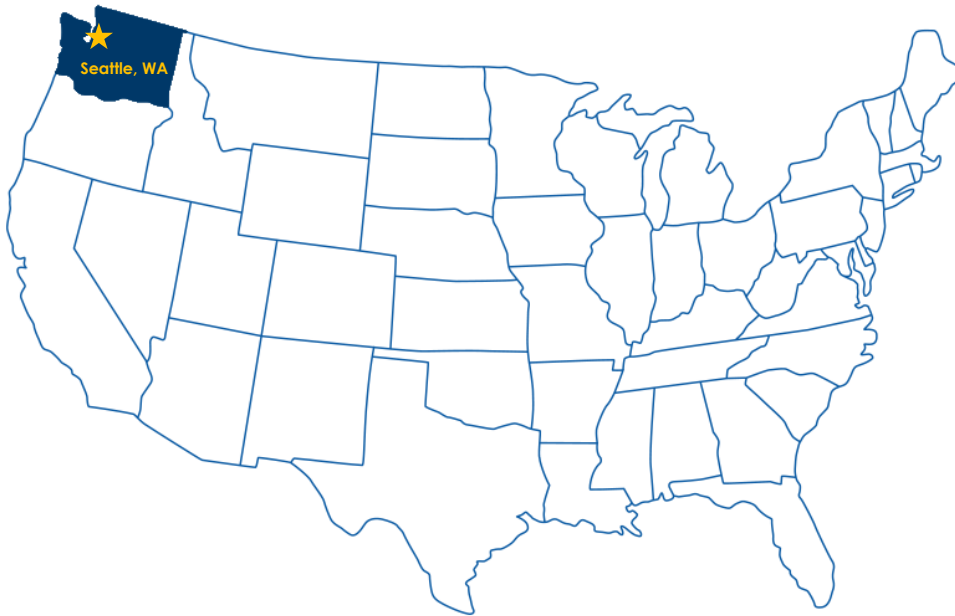
- 1:1 care advocacy & concierge medicine services
- Outreach based on expected episodes, where appropriate
- Inbound call & episode-driven
- Focus on doctor selection, venue selection, and continuity of care

**C**

#### Low-risk, low-cost members

- Focus on customer service only
- Passive communication efforts

# Value Generation – Impact of Venue Selection



## Rotator Cuff Case Study



Procedure Setting	ASC	Hospital
% of Frequency Observed in Claims	38.8%	61.2%
Illustrative Carrier Rate	\$13,075	\$20,075
Carrier Price Difference (\$)	\$7,000	
Carrier Price Difference (%)	153.5%	
Memo: Average S+ Rate	\$6,803	NA <sup>(1)</sup>

# Value Impact

## Appropriate Diagnosis

### Accessing Care and Second Opinions

- Second opinions are welcomed, at minimum they only confirm initial diagnoses
- About 25 percent of treatment plans change based on second opinions from additional pathology teams
- Second opinions help identify new innovative therapies that may not be available with member's primary provider, geography, etc.

### Clinical Evaluation and Diagnosis

- Stage and the anatomical extent of the tumor will guide surgical, radiation and medical oncologists on how to approach treatment
- Our top-quality, rigorously credentialed providers will provide their recommended treatment plan and explain the recovery process

### Holistic Treatment Plan

- Following a treatment plan can be difficult and time-consuming once a patient leaves a facility, but it's crucial to complete remission
- Advocate has full transparency around chemotherapy, specific drugs used, treatment cycles completed, surgeries done, future-check ups, and any additional treatment given to member

### How [CarePlus] Can Help

- Identify a high-quality, credentialed oncology provider and coordinate all scheduling, medical records transfer and travel logistics

- All-encompassing resource for all medical or financial related questions member may have

- Assist member post-discharge (e.g., follow-up visits, fitness monitoring, Rx support, etc.)
- Monitor treatment plan progress

# [CarePlus]: What We Aren't

## What We Aren't

- An outsourced status quo prior authorization vendor
- A traditional insurance call center experience
- A purely clinical case management offering
- A limited scope travel agency

## Our Perspective

- We believe prior authorization can be more efficient and nuanced
- We believe in advocacy
- Our focus is on avoiding industry pitfalls and making educated decisions
- Health travel is more complicated and we rise to that challenge

**Employer Direct and SurgeryPlus have the capability to positively impact Alaska's plan members**

# Proposed Coverages for Concierge/Planned Travel

Coverage Option	Proposed Policy Guideline
Care Advocacy and Concierge Services	Available on-demand to all plan participants
Travel Expenses	Paid, subject to Travel Policy limitations
<u>Travel Policy:</u>	
<i>Flights</i>	Cheapest, most-direct economy route within 24 hours, avoiding overnight stay where possible
<i>Hotel</i>	Cheapest within estimated 30 minutes of appointments at 3-star level or above
<i>Car / Other</i>	Consistent with SurgeryPlus, will reimburse for ground transportation to/from airport and facility (e.g. taxi)
<i>Per Diem</i>	Flexible at the discretion of the State
Travel Eligible Services	Procedures/services with cost estimate of at least \$2,000 locally (includes 2 <sup>nd</sup> opinions), measured using EDH data and floor of 200% of Anchorage Medicare, or where care is not available locally
Companion Travel	When appropriate or necessary (e.g. any service including general anesthesia, minors, or members with physical disabilities requiring a travel companion [requires medical necessity])
Buy-up	Member can upgrade services with their money through the program

The above guidelines are solely recommendations for consideration

# Retiree Health Plan Modernization List

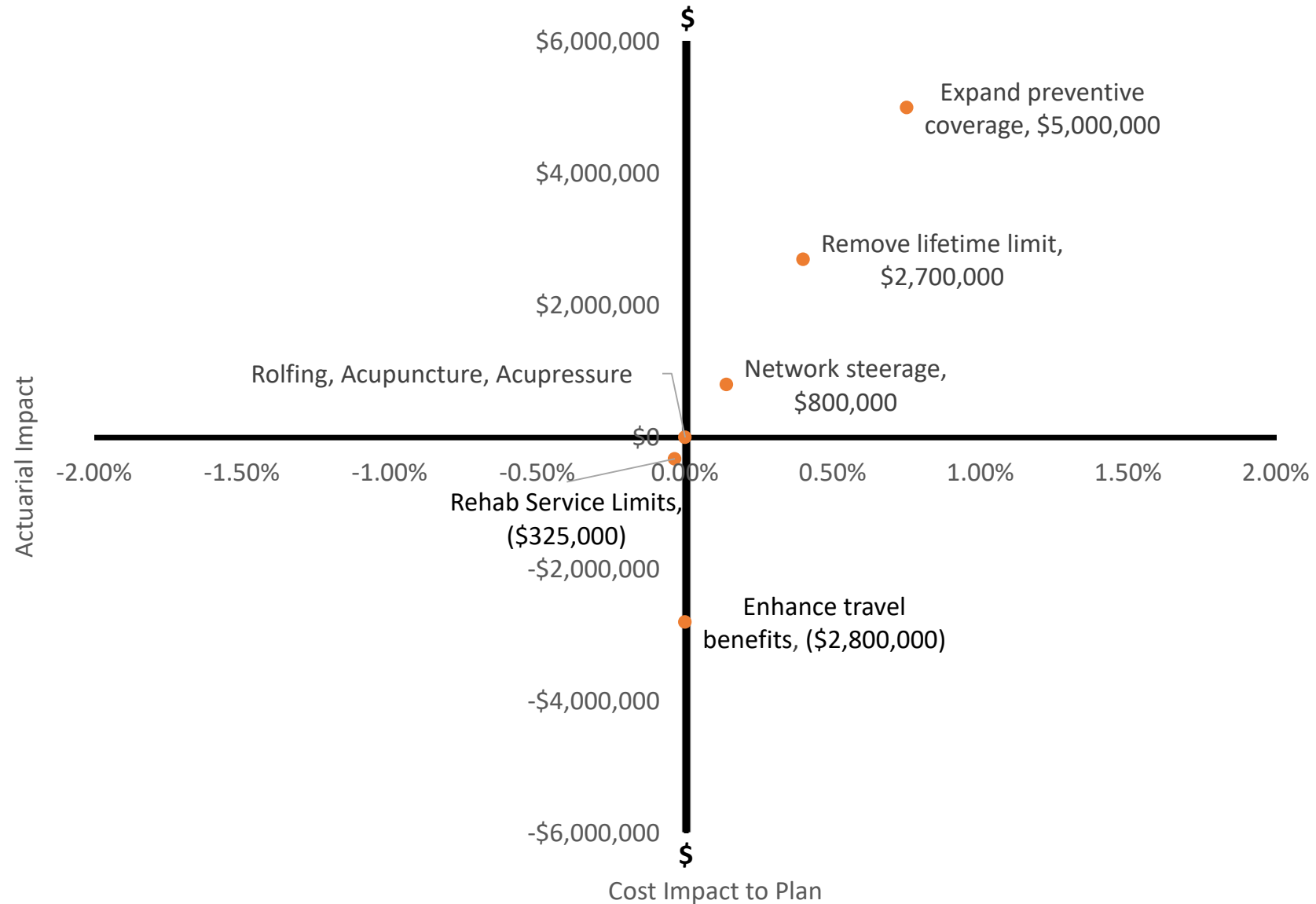
**DRAFT - Retiree Health Plan Modernization Topics**

#	Current or Upcoming Topics for Analysis*	Actuarial Impact	Fiscal Impact
1.	Enhance travel benefits	+0.00%	-\$2,800,000/yr
2.	Network steerage: 70% out-of-network and 90% in-network	+0.14%	+\$800,000/yr
3.	Implement high-value pharmacy network with lower copays for chronic meds, medical synchronization, counseling, and packaging options for participating members		
4.	Add wellness benefits such as gym membership or program like Silver Sneakers - <i>public comment proposal</i>		
5.	Out-of-network reimbursement		
6.	Copayment for primary care		
<b>Previously Discussed Topics (Analysis may be on-going)</b>			
7.	Expand preventive coverage to add full suite of preventive services	+0.75%	+\$5,000,000/yr
8.	Remove or increase lifetime limit (currently \$2M)	+0.40%	+\$2,700,000/yr
9.	Implement clear service limits for rehabilitative care such as chiropractic, physical therapy, occupational therapy, etc.	-0.035%	-\$325,000/yr
10.	Expand rehabilitative services to include Rolwing, Acupuncture, and Acupressure – <i>public comment proposal</i>	Minor enhancement	Minor Expenditure Increase
<b>Topics for Potential Future Analysis</b>			
11.	Increase deductible and out-of-pocket maximum		
12.	Implement 3-tier pharmacy benefit; change out-of-network pharmacy benefits		
13.	Exclude coverage for drugs with over-the-counter (OTC) equivalents		
14.	Limit compound coverage to high-quality, narrow network of pharmacies		
15.	Exclude implants related to periodontal disease from medical plan and cover under dental plan		
16.	In-network enhanced clinical review of high-tech imaging and testing		
17.	Add medically necessary treatment of gender dysphoria including surgery – <i>public comment proposal</i>		
<b>Plan Housekeeping Items</b>			
18.	Clarify reimbursement policies for surgical assistants in the plan booklet		

\*These are subject to change as the proposals evolve through additional analysis and committee guidance and discussion.  
Updated November 28, 2018

# Impact Matrix

## AlaskaCare Retiree Modernization Proposals [DRAFT]



\*These are draft estimates subject to change as analyses continues and other proposals are modified or added.

# AlaskaCare Retiree Health Plan Modernization Process

**DRAFT**

**AlaskaCare Retiree Health Plan Modernization Process**

Action	Date
<b>Step 1</b>	
Finalize proposals under consideration	February 6, 2019
<b>Step 2</b>	
For each proposal:	
Initial analysis drafted	Mid/End February
Modernization committee review 1	Beginning March
Public comment	Ongoing
Update analysis	Mid/End March
Modernization committee review 2	Beginning April
Update proposal	Mid/End April
Board review	May 8, 2019
<b>Step 3</b>	
Compile initial draft proposal package	Mid May
Modernization committee review 1	End May
Public comment	Ongoing
Update draft package	Beginning July
Modernization committee review 2	Mid July
Update draft package	End July
Public comment	Ongoing
Board review (possible recommendation vote)	August 7, 2019
<b>Step 4</b>	
Draft plan amendment (include effective dates)	End of August
Public comment	September - October
Update amendment	End October
Final Board review	November 6, 2019
<b>Step 5</b>	
Issue amendment	November 15, 2019
Implementation	November to December 2019
Phase 1	Jan 1, 2020
Phase 2	Jan 1, 2021
Phase 3 (If needed)	Jan 1, 2022

**Updated November 28, 2018**

# Communication Avenues

## AlaskaCare Retiree Health Plan Modernization Communication Avenues

Communication Method	Frequency
Retiree e-newsletters	Monthly
Telephonic townhalls	Monthly
Postcards	As needed
Letters	As needed
Topic-specific email addresses	As needed
Website updates (FAQs)	As needed
Social media (e.g. Facebook)	Weekly
<i>Health Matters</i> newsletter	2/3 times per year
WebEx seminars	As needed
Multimedia products (e.g. videos)	As needed

# Enhanced Travel Benefits with Wrap

**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~~ TBD

**Review Date:** ~~July 26~~ October 30, 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~~ expand travel benefits for members as follows:

- 1) 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.
- 2) Cover travel for diagnostic procedures not covered by the SurgeryPlus travel program and either not available locally or less expensive in other locations.
- 3) Cover travel for a companion when a member receives treatment or a diagnostic procedure that requires general anesthesia.
- 4) Provide lodging and per diem benefits for the length of stay for second opinions, or when treatment or diagnostic procedures are not available locally or less expensive in other locations (subject to certain limitations described below).

The fiscal impact to the plan is estimated to be \$2.8 million a year in savings associated with the SurgeryPlus travel program. The additional financial impact for expanding other travel services is under development. There is no anticipated actuarial impact to the plan.<sup>1</sup>

The increase in covered travel costs will benefit the membership and will increase their options for treatment. The addition of the SurgeryPlus network will provide members

<sup>1</sup> See attachment A; Segal Consulting Memorandum, July 25, 2018.

with access to surgeons who demonstrate they meet and maintain a combination of objective and subjective quality metrics.<sup>2</sup> The expansion of travel benefits for diagnostic services will address an unmet need among the membership as well the expansion of lodging and per diem expenses for the member and companion as applicable.

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

The expansion of travel benefits ~~to include~~, particularly 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 members in small communities seek care elsewhere, any fixed cost for providing those services could be spread across a smaller number of patients increasing costs for those who receive care at home.

### **Background:**

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

- 1) In emergency situations<sup>3</sup>
- 2) For a minor (under 18 years of age) with a parent/legal guardian<sup>4</sup>
- 3) For certain transplant services at an Aetna Institute of Excellence (IOE) with a companion and lodging<sup>5</sup>
- 4) Second surgical opinions<sup>6</sup>
- 5) Treatment not available locally<sup>7</sup>
- 6) Surgery in other location if provided less expensively<sup>8</sup>

The current plan language regarding travel costs is confusing and covered expenses are narrow in most circumstances. The portions of covered travel costs vary depending on the qualified circumstance above. Generally, unless otherwise specified, travel costs include the following:

<sup>2</sup> See attachment B for a list of SurgeryPlus provider metrics.

<sup>3</sup> Page 42, AlaskaCare Retiree Health Insurance Information Booklet, 2003:

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

<sup>4</sup> Page 41, Ibid.

<sup>5</sup> Page xxxvii-xl. Ibid.

<sup>6</sup> Page 43, Ibid.

<sup>7</sup> Page 42, Ibid.

<sup>8</sup> Page 44, Ibid.

- Round-trip transportation, not exceeding the cost of coach class commercial air transportation, to the nearest professional treatment. This is limited to the member unless a companion benefit is clearly stated (e.g. travel for a minor, transplant IOE).
- Documented travel expenses for ground transportation including fares, mileage, food and lodging for the most direct route if ground transportation and the most direct one-way distance exceeds 100 miles. This applies only while the member is in transit, and ends once they arrive at the location of treatment.
- In most circumstances, travel costs do not include the following:
  - Travel for a companion
  - Lodging (with the exception of transplants at IOE, travel via ground transportation, and travel in certain circumstances where treatment is not available locally<sup>9</sup>)
  - Food (with exceptions including transplants at IOE and travel via ground transportation)
  - Other transportation costs (e.g. taxis, etc.)

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

Table 1, below, outlines the proposed changes.

<b>Circumstance</b>	<b>Current</b>	<b>Proposed</b>
Emergency travel <sup>10</sup>	Transportation to nearest hospital by professional ambulance	No change
Transplant via Aetna IOE <sup>11</sup>	-Member and companion -Overnight stay: -\$50 per person/night -\$100/night maximum -Companion expense: -\$31/night	No change

<sup>9</sup> Page 42-43, Ibid.

<sup>10</sup> Page 42, Ibid.

<sup>11</sup> Page xxxvii, Ibid.

Travel for minor	<ul style="list-style-type: none"> <li>-Minor and companion</li> <li>-Transportation covered<sup>12</sup></li> </ul>	<p><del>No change</del>-Add overnight lodging benefit of \$80/night up to 14-day maximum;</p> <p>-Add per diem benefit of \$31 per patient/day; or \$62 per patient &amp; companion/day</p>
Second surgical opinion	<ul style="list-style-type: none"> <li>-Transportation covered for member only</li> </ul>	<p><del>No change</del>-Add lodging and per diem benefit as described above.</p>
Treatment <u>and diagnostic services</u> not available locally	<ul style="list-style-type: none"> <li>-Transportation, lodging and per diem covered for member only.</li> <li>-Limited to treatment only</li> <li>-Limited to the following visit per benefit year: <ul style="list-style-type: none"> <li>-1 treatment for condition</li> <li>-1 for follow-up</li> <li>-1 pre- or post-natal care</li> <li>-1 for maternity delivery</li> <li>-1 pre- or post-surgery</li> <li>-1 per surgical procedure</li> <li>-1 per allergic condition</li> </ul> </li> </ul>	<p><del>No change</del></p> <p><del>-Restrict to services received from a network provider.</del></p> <p>-Add lodging and per diem benefit as described above to cover the member's entire length of stay subject to medical necessity.</p> <p>-Allow for both pre- and post-op visit coverage if post-op received within 60-days of discharge.</p> <p>-Add companion benefit if procedure requires general anesthesia.</p>
Surgery <u>and diagnostic services</u> in other locations less expensive	<ul style="list-style-type: none"> <li>-Only applicable for surgery.</li> <li>-Transportation covered for member only.</li> <li>-Total cost may not exceed the recognized charge for same expenses received locally.</li> <li>-Total cost must include: <ul style="list-style-type: none"> <li>-surgery</li> <li>-hospital room and board</li> <li>-travel to another location</li> </ul> </li> </ul>	<p><del>No change</del></p> <p><del>-Restrict to services received from a network provider.</del></p> <p>-Add "if not available through the SurgeryPlus program."</p> <p>-Add coverage for companion if procedure requires general anesthesia.</p> <p>-Add lodging and per diem benefit as described above to cover the member's entire length of stay subject to medical necessity.</p>

<sup>12</sup> This includes either airfare or round-trip transportation and associated costs (including \$80/day for lodging) if distance exceeds 100 miles one-way.

SurgeryPlus 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.
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**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 follows:

- 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 necessary 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 and/or diagnostic services less expensive elsewhere and not otherwise covered by the SurgeryPlus network).

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

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

### **Member Impact:**

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

### **WHO IS IMPACTED:**

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

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

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

In reviewing claims data, SurgeryPlus estimates utilization at around 400 procedures per year.<sup>13</sup>

Members who are Medicare-eligible: Medicare [does not cover travel, so the expansion of the standard travel coverage and per diem for a member and companion will be of benefit to members who are Medicare eligible.](#)

Medicare-eligible members will not fully benefit from the provider network offered through the SurgeryPlus travel program, which is pre-empted 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 fiscally and through anticipated positive outcomes associated with high quality care from the SurgeryPlus network of providers and the travel arrangement and coordination offered. [Members will also benefit from the expansion of the standard travel coverage.](#)

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

### **Actuarial Impact**

Neutral / Enhancement / Diminishment

*Table 2: Actuarial Impact*

Actuarial Impact	
Current	N/A
Proposed	No actuarial impact <sup>14</sup>

### **DRB Operational Impacts**

The Division anticipates minimal operational impacts as follows:

- Staff will need to manage [another](#) vendor and the routine work associated with that including quality control, reporting, billing, responding to eligibility questions, and communications.
- Staff will need to review and distribute communications to educate and increase awareness of the new plan benefit.

<sup>13</sup> See attachment A; Segal Consulting Memorandum, July 25, 2018

<sup>14</sup> See Attachment A [\\*\\*This will be updated to include the wrap services\\*\\*](#)

- 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 financial impact to the plan for the addition of the SurgeryPlus travel network and services is estimated to be savings of \$2.8 million annually. This is based on members using the SurgeryPlus network for 400 procedures per year. The total savings is net of the administrative costs for SurgeryPlus and the estimated cost per member per trip of \$3,000.<sup>15</sup>

The fiscal impact of the expanded travel wrap is under analysis.

### **Clinical Considerations:**

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

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

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

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

<sup>15</sup> See Attachment A



- 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, [particularly](#) 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 members in small communities seek care elsewhere, [any](#) fixed [cost](#) 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:**

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

# Segal Consulting Travel Memo



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

## Actuarial Value

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

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

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

## Financial Impact

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

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

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

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

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

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

# Network Incentives

**Proposed change:** Adding a network incentive

**Plans affected:** DB Retiree Plan

**Reviewed by:** Retiree Health Plan Advisory Board

**Proposed implementation date:** TBD

**Review Date:** October 30, 2018

*Table 1: Plan Design Changes*

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

**Description of proposed change:**

Amend the plan booklet to increase the plan coinsurance from 80% to 90% for services received from a network provider and decrease the plan coinsurance from 80% to 70% for services received from a non-network provider.

**Background:**

Most health plans include provisions in their benefit design to promote use of network providers. Network providers are facilities, provider groups, or professionals that have a contractual relationship with an insurance company in which both parties agree to a certain reimbursement schedules and other policies. These policies may include credentialing requirements for participating providers, an agreed upon fee schedule, and an agreement from the provider to write off the difference between the fee schedule and their billed charges rather than seeking the difference from the member- a practice commonly referred to as balance billing.

When members use a non-network provider, the plan has to determine what to pay for services since there is not an agreed upon fee schedule with the provider. In the AlaskaCare retiree health plan, this is called the recognized charge, and “is the lesser of:

- what the provider bills or submits for that services or supply; or

- the 90<sup>th</sup> percentile of the prevailing charge rate for the geographic area where the service is furnished as determined by Aetna in accordance with Aetna reimbursement policies.”<sup>1</sup>

The recognized charge is, with very few exceptions, higher than the negotiated charge, meaning both the plan and the member are paying more for the same service than they would if the service was received through a network provider.

Most health plan try to incentivize member use of network providers through benefit design, e.g. provide higher level of plan coverage for use of network providers, and requiring higher cost share by the member when using non-network providers. This incentive encourages use of the network providers which creates both cost savings for the plan and the member while further increasing the negotiating leverage of the plan. Plans with stronger incentives for network use and disincentives for non-network use are able to steer members towards network providers and away from non-network providers more effectively which in turn can create pressure for providers to come into network in order to increase patient volume.

Uniquely, the AlaskaCare Defined Benefit retiree health insurance plan does not differentiate between care received by a network provider and non-network providers when paying benefits. Once a member reaches their deductible (\$150/individual, limited to no more than \$750/family) the plan pays a flat 80% coinsurance, regardless of provider status, until the member reaches their annual out-of-pocket limit (\$800/individual).

In reviewing claims incurred in calendar year 2017 in the data warehouse, there was approximately \$316 million paid for medical benefits in the AlaskaCare retiree health plan (this excludes pharmacy benefits). This is outlined in Attachment B.

Approximately 60%, or \$189 million was paid to network providers, and approximately 40%, or \$128 million was paid to non-network providers. This includes medical claims for both Medicare-eligible and non-eligible retirees.

<sup>1</sup> Page 15, AlaskaCare Retiree Health Insurance Information Booklet.  
<http://doa.alaska.gov/drb/pdf/ghlb/retiree/RetireeInsuranceBooklet2018final.pdf>

Table 1. AlaskaCare Retiree Medical Claims Incurred Calendar Year 2017

Network Indicator		Network		Non-Network		
Employee Status	Service Category	Paid	% of Total Paid	Paid	% of Total Paid	Total Paid
Retiree under 65	Inpatient Facility	\$43,090,566	94%	\$2,845,387	6%	\$45,935,952
	Outpatient Facility	\$62,367,382	83%	\$12,565,761	17%	\$74,933,143
	Professional	\$59,270,689	63%	\$34,530,858	37%	\$93,801,547
	Summary	\$164,728,637	77%	\$49,942,006	23%	\$214,670,642
Retiree 65 and over	Inpatient Facility	\$5,617,693	32%	\$11,752,270	68%	\$17,369,963
	Outpatient Facility	\$9,881,264	29%	\$23,710,559	71%	\$33,591,823
	Professional	\$8,872,952	17%	\$42,375,095	83%	\$51,248,047
	Summary	\$24,371,908	24%	\$77,837,925	76%	\$102,209,833
Summary		\$189,100,545	60%	\$127,779,930	40%	\$316,880,475

While this differential is high, it may be a misleading, as members with Medicare as their primary insurance can use any provider who accepts Medicare and will not be impacted by network incentives. There is substantially higher non-network use by Medicare-eligible retirees, but additional analysis is warranted to understand this differential and rule out any data discrepancy.

Looking further at the non-Medicare eligible retirees, network usage increases to 77% of the paid among incurred at network providers and 23% at non-network providers. The highest use of non-network providers is in professional services, where 37% of claims incurred were paid to non-network provider. This aligns with consistent trends observed in the quarterly reports, and represents an opportunity to understand why non-network usage is high (e.g. lack of incentive, limited provider participation, limited access, etc.) and increase network utilization.

Use of network inpatient facilities is quite high at 94% of total paid among non-Medicare retiree claims. This is unsurprising, as both Providence Alaska Medical Center and Alaska Regional Hospital in Anchorage are both considered network providers.

### **Member impact:**

Members using network providers: As the majority of members use network services already, members overall would benefit from this change as the coinsurance would

increase from 80% to 90%, representing a reduced cost share for the period between when they meet their deductible and out-of-pocket limit. \*\*Additional information will include an estimate for how many member this is.\*\*

Members using non-network providers: These members would be disadvantaged by the change as the coinsurance would decrease from 80% to 70% representing an increase cost share for the period described above. \*\*Additional information will include an estimate for how many members this is.\*\*

Members who cannot access a network provider: Members who do not have access to a network provider are in a difficult position, and given the remoteness of Alaska there are several communities where this may be an issue. The plan proposal does not assume an exception currently, however the proposal could be modified to include an exception or a waiver if a member cannot access a provider in their community. Alternatively, the addition of enhanced travel benefits may provide an option for members in this situation.

Members who meet their deductible but who have not yet met their out-of-pocket limit: As proposed, this would only impact members who utilize enough health care services to meet their annual deductible and continue to incur costs. This would not impact members who meet their out-of-pocket limit, and this would not impact members who have not met their deductible. Approximately 80% of plan costs are from members who have reached their out-of-pocket limit.<sup>2</sup>

Members who are not Medicare-eligible: This will impact members who are not eligible for Medicare as described above.

Members who are Medicare-eligible: This will have limited impact on members who are Medicare eligible and only in circumstances where Medicare does not cover a benefit that is covered under the AlaskaCare plan causing AlaskaCare to be the primary payer.

### **Actuarial impact:**

Neutral / Enhancement / Diminishment

*Table 2: Actuarial Impact*

Actuarial Impact	
Current	N/A
Proposed	Increase of 0.14% <sup>3</sup>

<sup>2</sup> See Attachment A

<sup>3</sup> See Attachment A

**DRB operational impacts:**

The Division anticipates minimal operational impacts as follows:

- 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 of the new benefit to ensure it is accurately administered by the Third-Party Administrator.

**Financial impact to the plan:**

The overall financial impact to the plan is estimated to increase costs by \$800,000.

From Segal Consulting Group, Attachment A:

“The impact of reducing out-of-network coinsurance is limited due to the relatively low out-of-pocket maximum. Approximately 80% of the Plan’s costs are from claimants that have reached the out-of-pocket maximum. Changing the coinsurance does not impact plan, or member, costs for these claimants.”

Segal notes that “Increasing the out-of-pocket maximum would result in more of these claimants’ costs being affected by the change in coinsurance and, therefore, there would be a greater impact on plan, member, and costs.”

Note- this analysis does not consider savings that could accrue as the result of improved pricing due to strong network negotiations. The AlaskaCare employee plan has achieved substantial savings from providers by implementing stronger network incentives and disincentives.

**Clinical considerations:**

These changes not anticipated to impact any clinical considerations.

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

The impact to the TPA is anticipated to be moderate as:

- The TPA will need to program these changes and ensure all member communications, claims systems, and call center staff are aware of the change.
- This could provide the TPA with additional leverage to negotiate with providers; either to bring them into network or to negotiate improved contractual provisions with existing network providers.

- Exceptions for members who cannot access a network provider will have to be managed manually.

**Provider considerations:**

Implementing a network differential could increase providers willingness to participate in the network, particularly in the Anchorage area where there is competition amongst providers.

**Documents attached include:**

<u>Document Name</u>	<u>Attachment</u>	<u>Notes</u>
Segal Memorandum; October 25, 2018	A	
Network Claims Pull	B	
Public Comments	C	Under development

# Segal Consulting Coinsurance Memo

## MEMORANDUM

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

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

**Date:** October 25, 2018

**Re:** Coinsurance Change 90%/70% In-Network/Out-of-Network – Focus on Actuarial and Financial Impact for the Retiree Plan

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The AlaskaCare Retiree Plan currently provides coverage for medical treatments and 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:

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

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

A change to the benefits under consideration would replace the current 80% coinsurance for all medical expenses to a 90% and 70% coinsurance for medical expenses in-network and out-of-network, respectively.

### Actuarial Value

Our analysis determines the impact of implementing an in-network and out-of-network coinsurance of 90% and 70% respectively, would result in an increase in actuarial value of 0.14%. This analysis is focused on the change to network benefits.

### Financial Impact

Based on the current retiree claims projection of \$590,000,000 for 2019, the financial impact is approximately an \$800,000 increase in costs. This increase accounts for the savings associated with the reduction in coinsurance for out-of-network claims.

The impact of reducing out-of-network coinsurance is limited due to the relatively low out-of-pocket maximum. Approximately 80% of the Plan's costs are from claimants that have reached the out-of-pocket maximum. Changing the coinsurance does not impact plan, or member, costs for these claimants. Increasing the out-of-pocket maximum would result in more of these claimants' costs being affected by the change in coinsurance and, therefore, there would be a greater impact on plan, and member, costs.

Claims for services from network providers are currently paid utilizing the Aetna network discount. Therefore, increasing the coinsurance for network services increases costs. If the Plan was not currently benefiting from network discounts, then it is likely the impact of accessing the discounts would offset the cost of increasing the coinsurance, resulting in net savings.

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.

*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

# Network Claims Pull

## Calendar/Fiscal Incurred - Original Claims: New Dashboard

AlaskaCare

Employee Status = Retiree under 65,Retiree 65 and over

Incurred Calendar Year = 2017

Network Indicator		In-Network					Non-Network					Summary			
Employee Status	Service Category	Paid	% of Total Paid	Paid PMPM	Claims	Claimants /1000	Paid	% of Total Paid	Paid PMPM	Claims	Claimants/ 1000	Total Paid	Paid PMPM	Claims	Claimants /1000
Retiree under 65	Inpatient Facility	\$43,090,566	94%	\$155.30	3,130	50.0	\$2,845,387	6%	\$10.26	406	5.9	\$45,935,952	\$165.56	3,536	53.6
	Outpatient Facility	\$62,367,382	83%	\$224.78	48,121	544.7	\$12,565,761	17%	\$45.29	6,347	62.2	\$74,933,143	\$270.07	54,468	568.5
	Professional	\$59,270,689	63%	\$213.62	257,970	904.7	\$34,530,858	37%	\$124.45	112,449	728.1	\$93,801,547	\$338.07	370,419	1,001.4
	Summary	\$164,728,637	77%	\$807.93	627,578	994.6	\$49,942,006	23%	\$180.00	119,192	732.8	\$214,670,642	\$987.92	746,770	1,040.2
Retiree 65 and over	Inpatient Facility	\$5,617,693	32%	\$9.51	1,345	10.8	\$11,752,270	68%	\$19.90	13,702	109.8	\$17,369,963	\$29.41	15,047	119.9
	Outpatient Facility	\$9,881,264	29%	\$16.73	21,976	105.7	\$23,710,559	71%	\$40.14	183,697	614.2	\$33,591,823	\$56.87	205,673	703.1
	Professional	\$8,872,952	17%	\$15.02	96,669	165.7	\$42,375,095	83%	\$71.74	832,381	928.1	\$51,248,047	\$86.76	929,050	976.4
	Summary	\$24,371,908	24%	\$334.99	1,177,392	892.6	\$77,837,925	76%	\$131.77	1,029,722	939.0	\$102,209,833	\$466.76	2,207,114	1,008.6
Summary		\$189,100,545	60%	\$486.14	1,804,968	889.9	\$127,779,930	40%	\$147.18	1,148,908	854.8	\$316,880,475	\$633.32	2,953,876	978.9

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# Rehabilitative Care

**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 1/3<sup>rd</sup> 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

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><b>Rehabilitative Care</b></p> <p>The Medical Plan covers outpatient rehabilitative care designed to restore and improve bodily functions lost due to injury or illness. <b>This care is considered medically necessary only if significant improvement in body function is occurring and is expected to continue.</b> [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"> <li>• Physical therapy and occupational therapy.</li> <li>• 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.</li> <li>• 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.</li> </ul> <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><b>Neurological Disease (no change)</b></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>

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.

### **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 <sup>1</sup>	
10 Visit Limit on Rolf therapy treatment	0.005% increase	
20 Visit Limit on Spinal Manipulation	0.02% reduction <sup>2</sup>	
45 Visit Limit on other Rehabilitative Services (OT/PT/ST)	0.05% reduction <sup>3</sup>	

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

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

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

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

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*

<b>Proposed Change</b>	<b>Estimated Annual Financial Impact<sup>4</sup></b>
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.

<sup>4 4</sup> *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.

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		
<b><i>Chiropractic Benefits – Focus on Actuarial and Financial Impacts for the Retiree Plan, Segal Consulting Memo dated July 25, 2018.</i></b>	 Chiropractic Benefits 7.25.18	
<b><i>Therapy Benefits – Focus on Actuarial and Financial Impacts for the Retiree Plan, Segal Consulting Memo dated July 24, 2018.</i></b>	 Therapy Benefits 7.25.18	
<b><i>Chiro Benefits – Focus on Actuarial and Financial Impacts for the Retiree Plan, Segal Consulting Memo updated September 25, 2018.</i></b>	 Chiropractic Benefits 9.25.18	
<b><i>Therapy Benefits – Focus on Actuarial and Financial Impacts for the Retiree Plan, Segal Consulting Memo updated September 26, 2018.</i></b>	 Therapy Benefits 9.26.18	

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

Segal –  
Chiropractic Benefit  
7.25.18



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## 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:

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

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

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



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## 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:

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

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Segal –  
Chiropractic Benefit  
9.25.18



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## 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:

<b>Deductibles</b>	
Annual individual / family unit deductible	\$150 / up to 3x per family
<b>Coinsurance</b>	
Most medical expenses	80%
Most medical expenses after out-of-pocket limit is satisfied	100%
Second surgical opinions, Preoperative testing, Outpatient testing/surgery • No deductible applies	100%
<b>Out-of-Pocket Limit</b>	
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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9.26.18



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## 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:

<b>Deductibles</b>		
Annual individual / family unit deductible		\$150 / up to 3x per family
<b>Coinsurance</b>		
Most medical expenses		80%
Most medical expenses after out-of-pocket limit is satisfied		100%
Second surgical opinions, Preoperative testing, Outpatient testing/surgery		100%
• No deductible applies		
<b>Out-of-Pocket Limit</b>		
Annual individual out-of-pocket limit		\$800
• Applies after the deductible is satisfied		
• Expenses paid at a coinsurance rate other than 80% do not apply against the out-of-pocket limit		
<b>Benefit Maximums</b>		
Individual lifetime maximum		\$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
<b>Prescription Drugs</b>		Up to 90 Day or 100 Unit Supply
		Generic      Brand Name
Network pharmacy copayment		\$4      \$8
Mail order copayment		\$0      \$0

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

*continued on page 6*

## 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](http://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](http://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](http://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](http://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](http://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](http://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

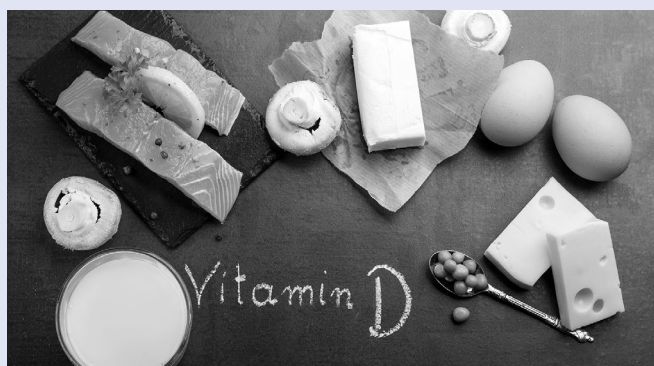
their educational materials, programs, and resources for diabetes prevention, control of high blood pressure, and smoking cessation. 🌿



## 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](https://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

*continued from page 2*

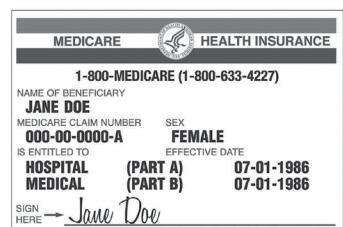
don't get SSA or RRB benefits and submit premium payments should use the MBI on incoming premium remittances. However, CMS will accept the HICN on incoming premium remittances after the transition period (Part A and Part B premiums, Part D income related monthly adjustment amounts, etc.)

### How will the MBI look?

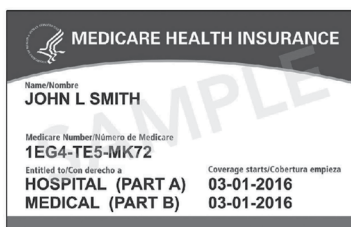
The MBI will be:

- 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](http://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](http://alive.turnaroundhealth.com). 🍇

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## 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](http://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](http://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](http://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](http://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](mailto:Josie.Wilson@hcahealthcare.com). ❁

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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.*

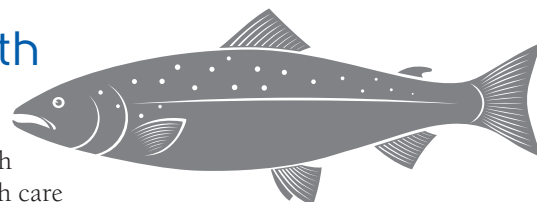
**Disclaimer:** Information in this newsletter summarizes the plan provisions, is supplemental only, and does not supersede the applicable Information Booklet's provisions. The Division is unable to unsubscribe members from our mailing list at this time.

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## 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](http://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.

*continued on page 2*

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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](http://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](http://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...

*continued on page 10*

# 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](https://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](http://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](http://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](http://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](http://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.

*continued on page 11*

# 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	<b>Primary:</b> Active employee plan <b>Secondary:</b> Retiree plan
Retiree plan and as dependent under another person's plan through active employment	<b>Primary:</b> Retiree plan <b>Secondary:</b> Other person's plan
Retiree plan and Medicare-eligible	<b>Primary:</b> Medicare <b>Secondary:</b> Retiree plan
Two retiree plans	<b>Primary:</b> Plan in force the longest <b>Secondary:</b> Other plan
Retiree plan, as dependent under another person's plan through active employment, and Medicare-eligible	<b>Primary:</b> Other person's plan <b>Secondary:</b> Medicare <b>Pays third:</b> Retiree plan
Active employee plan, retiree plan, as dependent under another person's plan through active employment, and Medicare-eligible	<b>Primary:</b> Active employee plan <b>Secondary:</b> Other person's plan <b>Pays third:</b> Medicare <b>Pays fourth:</b> 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)

*continued on the next page*

# 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](http://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](http://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

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- 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](http://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](http://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:

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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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## 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](http://Alaska.gov/drb) or call toll-free at (800) 821-2251. For more tips, visit the Identity Theft Resource Center at [idtheftcenter.org](http://idtheftcenter.org) and type "deceased" in the search box or call toll-free at (888) 400-5530. 🍷