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

Meeting: Modernization Committee
Date: December 12, 2018
Time: 9:30am -12:30pm
Location: **Anchorage:** Atwood Building, 550 W 7th, 19th Floor Conf. Room
Juneau: State Office Building, 6th Floor Conf. Room
Teleconference: **1-855-244-8681 / Event number: 281 827 078**
WebEx Link:
<https://stateofalaska.webex.com/stateofalaska/onstage/g.php?MTID=efd2fbd365dfeeb21a3455db61217b5fd>

Committee Members: Cammy Taylor (chair), Joelle Hall and Mauri Long

December 12, 2018

9:30am	Call to Order Cammy Taylor <ul style="list-style-type: none">• Approve Agenda• Approve previous Meeting Minutes• Introductions
9:40am	Public Comment <ul style="list-style-type: none">• Read the Oral Public Comment Script
10:00am	Discuss Modernization Topics Analysis – DRB Presentations <ul style="list-style-type: none">• Enhanced Travel Benefits with Wrap• Increase Deductible/Out-of-Pocket Maximum
11:00am	Break
11:20am	Continue to Discuss Modernization Topics Analysis – DRB Presentations <ul style="list-style-type: none">• Enhanced Clinical Review for High-Tech Imaging
12:25pm	Final Thoughts Announce date of next meeting
12:30pm	Adjourn

Meeting Minutes

Retiree Health Plan Advisory Board

Modernization Committee Meeting Minutes

Date: Tuesday, October 30, 2018 9:30 a.m. to 12:30 p.m.

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

Meeting Attendance

Name of Attendee	Title of Attendee	Attendance
<i>Retiree Health Plan Advisory Board (RHPAB), Modernization Committee Members</i>		
Cammy Taylor	Committee Chair	Present
Joelle Hall	Committee Member	Present
Nanette (Nan) Thompson	Board Member	Present
Mauri Long	Board Member	Present
Judy Salo	Board Chair	Present (phone)
<i>State of Alaska, Department of Administration Staff</i>		
Ajay Desai	Director, Division of Retirement + Benefits (DRB)	
Michele Michaud	Deputy Director + Chief Health Official, DRB	
Emily Ricci	Chief Health Policy Official, DRB	
Andrea Mueca	Health Operations Manager, DRB	
Betsy Wood	Health Policy Manager, DRB	
Vanessa Kitchen	Administrative Assistant, Office of the Commissioner	
<i>Others Present + Members of the Public</i>		
Richard Ward	Segal Consulting (actuary for AlaskaCare plans)	
Noel Cruse	Segal Consulting (actuary for AlaskaCare plans)	
Tom Atkinson	Office of Rep. Josephson; RPEA member; Retiree	
Hali Duran	Aetna	
Brad Owens	Retiree Public Employees Association	
Stephanie Rhoades	Retiree Public Employees Association	
Duane Connell	Public	
Gordon Glaser	Public	
William Hauser	Public	
Clark Milne	Public	
Ann Preston	Public	
Anna Brawley	Agnew::Beck Consulting (contracted meeting support)	

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 and 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 Arrangement account, a mechanism for the employer to reimburse high-income Medicare enrollees for any premium charge for their Medicare plan (IRMAA)
- IRMAA = Income Related Monthly Adjustment Amount, a surcharge from CMS for a Medicare plan for individuals or households earning above certain thresholds
- MAGI = Modified Adjusted Gross Income, based on an individual or household's tax returns and used by CMS to determine what if any premium must be paid for a Medicare plan.
- OPEB = Other Post Employment Benefits; an accounting term used to describe retirement benefits other than pension benefits
- OTC = Over the counter medication, does not require a prescription to purchase
- PBM = Pharmacy Benefit Manager, a third-party vendor that performs claims adjudication and network management services
- PHI = protected health information, a term in HIPAA for any identifying health or personal information that would result in disclosure of an individual's medical situation.
- RDS = Retiree Drug Subsidy program (the pharmacy subsidy program AlaskaCare currently has)
- RHPAB = Retiree Health Plan Advisory Board

Meeting Minutes

Item 1. Call to Order + Introductions

Committee Chair Cammy Taylor called the meeting to order at 9:40 a.m. after some teleconference technical issues were resolved. The committee conducted roll call for members present.

- **Motion** by Joelle Hall to approve the meeting agenda. **Second** by Cammy Taylor.
- **Result:** No objection. Meeting agenda approved.

The committee briefly reviewed the minutes from the September 28 committee meeting.

- **Motion** by Joelle Hall to approve the previous meeting minutes. **Second** by Cammy Taylor.
- **Result:** No objection. Minutes from the previous meeting approved.

Board members and Emily Ricci welcomed Nan Thompson, the newest RHPAB member who was appointed to replace Mark Foster after his term ended. Welcome, Nan!

Item 2. Public Comment (Part 1)

Before beginning public comment, Cammy Taylor 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 were reminded 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

- Brad Owens requested time at the end of the meeting to make public comment.
- Stephanie Rhoades commented that she is aware that in the previous meeting on 9/28/18, rehabilitative care services were discussed, and the current standard provided is for injuries or illness to restore function. She pointed out that many people within the demographic of retirees experience neuromuscular degenerative conditions over time, and need these types of services in order to maintain physical functioning and quality of life. The plan should cover services for chronic conditions, not just rehabilitation after an injury. She noted that the current interpretation of Aetna is very narrow, and that RPEA's position is that this benefit has been part of the plan since its beginning, and should be restored without being considered an additional benefit.
- Gordon Glaser commented that he thanks the board for taking on this project, he appreciates the work of the advisory board and staff regarding the plan modernization proposals.

Item 3. Continue Discussion of Modernization Proposals: Travel Benefits

Materials: Modernization Topics Table in 10/30/18 meeting packet, "Enhanced Travel Benefits w/ Wrap"

Cammy Taylor invited staff to present additional information about the travel benefit proposal with SurgeryPlus for certain qualifying procedures, previously discussed in the 9/28/18 meeting.

Proposal: Travel Benefit Analysis

Staff presented a summary of the information shared last meeting about this proposed benefit:

SurgeryPlus is a travel and wraparound benefit for certain non-emergency surgeries, and includes travel coordination and coverage for the patient and potentially a companion to travel to another location for a procedure from a Center of Excellence certified provider for that surgery. This is being implemented for the employee plan already. This is an enhancement of benefits for these types of surgeries, and can be provided generally at lower cost but at consistent or higher quality because the providers must meet stringent quality standards. SurgeryPlus schedules with providers and helps the patient match up with the appropriate provider, books travel including flight and hotel, provides a per diem payment for the duration of the visit.

In the last meeting, the committee discussed the fact that this may leave gaps or inconsistencies in the plan, if there are other procedures not available locally and require travel, but which are not part of the SurgeryPlus network since it is for specific procedures. The group discussed a wrap of travel benefits for other procedures as well, reducing the need for members to pay for travel out of pocket. It was noted that these benefits would include in-state travel to Alaska providers as well.

Staff presented updates to the memo. Note: the edits in the document are shown in track changes in multiple colors, those colors only show the different authors and do not have any other meaning.

The new proposal would extend current coverage for travel not available locally or less expensive elsewhere to cover diagnostic procedures which are otherwise not part of the SurgeryPlus network. Currently diagnostic procedures are not included in the provision in the retiree plan, although they are in the active employee plan.

- Nan Thompson asked whether this includes in-state travel, and whether "locally" means in state, within a certain number of miles in state? She suggested this be defined and that the services be available for in state travel, since many people need to travel to a hub community or Anchorage.
 - Emily Ricci and Michele Michaud commented that "locally" in the plan means within 100 road miles. They will update the memo to reflect this definition.
 - This would include in-state travel.
 - Currently, no Alaska providers are participating in the SurgeryPlus program, but could if they meet the quality standards and agree to the negotiated rates.
- Cammy Taylor asked whether the travel benefit would be limited to procedures not covered by SurgeryPlus, and would allow travel into Anchorage for example? If a surgery is covered by SurgeryPlus, would someone be required to use this service rather than a service available in state?
 - Emily Ricci responded that the wrap benefit was envisioned to include coverage for services members require, regardless of whether they are in-state or out-of-state.

- Staff are in discussion with SurgeryPlus about the travel benefits generally and whether they can provide other administrative services to coordinate travel, beyond the procedures they cover as surgery services.
- Mauri Long asked for the definition of “less expensive,” and does this factor in the travel costs when considering the total cost of the procedure? And does the active employee plan cover travel for diagnostic services?
 - Emily Ricci noted that “less expensive” does include the travel costs, and considers the total cost of the procedure including travel. Staff is also looking at a threshold differential cost for diagnostic services, which is a large category, so people are not traveling for a minor blood test rather than a more significant procedure.
 - She also noted that the employee plan does cover travel for diagnostic services, unlike the retiree plan, and in September implemented the SurgeryPlus benefit so they have two months of data (including participation from some members already) and have some more information about how it is working. The benefit has the potential to save money both for the plan and for members in terms of out of pocket costs.
 - Staff will add definition for “less expensive” in the memo.

The current plan only allows for travel of a companion with for organ transplants or when the patient is a minor; the wrap proposal would expand this to allow coverage of travel with a companion if the patient will receive general anesthesia, and potentially with a primary care physician’s note that a companion is necessary for patient safety.

- Cammy Taylor commented that often in Alaska, a person may be referred by a specialist to an outside provider for a procedure, not just a primary care provider, she believes this will be more appropriate for cases where a specialist made the referral.

The proposal would also cover lodging and per diem for the length of stay for second opinions and certain diagnostic procedures not available locally. This is covered for the surgery procedures in the SurgeryPlus program, but the additional wrap proposal would cover these expenses for other situations.

Financial and Actuarial Impact: The staff is updating the analysis, but believes that this will generate net savings to the plan and for members, as more member out-of-pocket costs will be covered and procedures can be done at another location at lower cost. They will be updating the analysis; previously, the analysis estimated \$2.8 million in net savings. There is no anticipated actuarial impact to the plan.

- Mauri Long asked about the administrative cost (payment to SurgeryPlus) to provide this benefit, and whether the almost \$3 million in savings will also have the effect of reducing business for in-state medical and surgical providers, in a state where it is difficult to recruit and maintain providers. She also asked whether there is any data on actual savings to date, for other plans that have implemented travel benefits.
 - Emily Ricci responded that the Medicare reimbursement rates in Alaska must also be factored in, for Medicare eligible retirees. She also noted that the impact on the Alaska health care landscape is part of the general discussion and should certainly be considered, but the State spends billions each year in state on health care costs, this is a small amount.
 - Joelle Hall also commented that in several cases, Alaska providers cost up to 500% to 600% of similar services and procedures available in Seattle, for example. This is one of the ways

- to leverage in the market and negotiate for competitive rates, and would only impact some procedures. She noted that in other Alaska health care discussions she's participated in, she has seen very high costs compared to most other places in the U.S.; other health plans have been changing incentives to try to address high health care costs and allow for more competition with out of state providers. She is very concerned about the issue of providers charging high rates and would like to see tools like this implemented to move Alaska's market closer to the rest of the U.S.
- Emily Ricci added that in many areas of practice in Alaska, there has been a significant increase in participation in networks and willingness to participate in networks, as other large plans have changed their plan design to incentivize this competition, and providers have had to respond in spite of having a high degree of consolidation and limited options. She sees this proposal as a means of expanding the market.
 - Joelle Hall noted that many of the health care coalitions have successfully negotiated better rates over the years by being able to leverage with a large number of members and get more competitive rates from providers. There are many efforts underway to control health care costs including for the public and private sectors; AlaskaCare is an exception to this, and has limited mechanisms for negotiating leverage unlike the other plans. They must look to other plan design options such as this benefit to encourage competition in the market.
 - Emily Ricci added that, as an example, an Alaska-based hip replacement procedure from one hospital costs \$80,000, a cost much higher than most other locations. They are researching other costs to see if this is an anomaly or a typical cost in Alaska.
 - Mauri commented that she would like to see a percentage of savings from other plans as a benchmark for this discussion.
 - Joelle Hall will request this information from the Health Care Coalition, as they have offered travel benefits for several years and have been happy with the results.
 - Emily Ricci will request information from the University of Alaska as well, who provides a travel benefit for their members.
 - Emily also added that the intent is to give people access to high quality care, since the SurgeryPlus providers must meet quality standards and have very low rates of post-procedure complications. She noted that travel is often cost-prohibitive for lower-income members, and this would give them access to high quality care without having to pay the additional cost for travel.

Currently, the travel costs covered in the plan do not generally include lodging, a companion travel, ground transportation and per diem. Or, lodging may be covered for one night only, and not post-surgery recovery. Table 1 (page 24 in the packet) outlines the current provisions related to travel in the plan booklet, and proposed changes. She also noted that at this time, the plan would still cover travel to Aetna Institute of Excellence providers as it does currently, this may be revisited depending on the outcome of the third party administrator (TPA) RFP, i.e. if Aetna is no longer the provider of medical services in the plan. Any change to the TPA would be determined in 2019 and take effect in 2020.

The proposed lodging amount is \$80 per day, and per diem is \$31 per day per person (\$62 for a person and a companion), based on the numbers already included for travel for a minor and companion in the plan. Emily posed to the group, consider whether this is a sufficient reimbursement rate.

- Joelle Hall asked whether it is possible to not put a set dollar amount in the plan, since plan updates do not happen very often and could lock in the rate for several years, and instead look at a formula or other guidelines that still control costs without making the plan out of date? She understands the need to set limits, but does not want to artificially constrain the plan over time.
 - Emily Ricci commented that they did look at the federal rate and found a differential rate for Alaska, but it is helpful for members who make their own travel arrangements and submit for reimbursement, as many people prefer to do that and be reimbursed.
 - Richard Ward commented that the dollar amount could be referenced in the plan, as well as referencing an index (such as CPI) for future updates.
 - Nan Thompson commented that for members making their own arrangement, it is helpful to have an easy to understand rate, for example federal rates are different depending on the city and market for the cost of living or lodging in that area.
- Cammy Taylor commented that the group should discuss the benefit for longer-term treatments, the current cap proposed is 14 days but this should be discussed for longer-term stays and surgeries with more than 14 days recovery time.
 - Emily Ricci noted that SurgeryPlus does not deal with long-term treatment or stays, but the plan can adjust and allow for an extension under certain circumstances. This could be put in place. She also noted that staff have discussed a possible maximum (a set dollar amount, for example) for the travel benefit so that there isn't an open-ended benefit to cover a very long stay. They have also considered a longer-term rate, such as per month or per week, with a maximum rate and/or number of weeks or months, to set reasonable limits on the benefit particularly for longer-term stays.
- Emily Ricci asked if the committee would like to recommend further research into long-term stays?
 - Judy Salo commented that yes, she supports this option and would like some analysis of it. She understands the need for, and supports, a limit on the benefit to avoid abuse or overuse, but for situations such as radiation therapy, she has concerns about members feeling they cannot afford the treatment because they need to be in the same location for a long time and may not have a local option. She supports further research on this.
- Judy also requested that SurgeryPlus look into low-cost housing options near the procedure facility, such as guest housing, and whether this could be included for longer-term stays. They will know the local market better than the Alaska-based member.

Emily continued presenting the information: the proposal would cover lodging and per diem for second opinions as well, currently only transportation is covered. Additionally, the plan would add lodging and per diem for treatment and diagnostic services not available locally. She noted that the proposal also includes steerage toward a network provider, and would only be covered for an in-network provider.

- Judy Salo commented that she believes there should be an exception provision, for example if the person has been receiving treatment for a long time and has a relationship with a provider.
 - Cammy Taylor added that there may be few options for some conditions or procedures (few or no in-network providers from the third party administrator) so there should be some mechanism for reviewing this case.
- Cammy Taylor asked about the rational of the 60 day limit?
 - Emily clarified this number was proposed as an option for discussion, it can be changed.

Emily noted that the proposal also includes similar travel benefits for procedures that may be available locally, but are much more expensive locally. Travel for these procedures would only be covered if it is not part of the SurgeryPlus network: in this case, it would need to be done through that program. If the local service is more expensive than the out of area service plus travel costs. This would be intended to address procedures not otherwise covered under the provisions above.

- Mauri Long commented that there is a gap between the two proposals: one covers services not available locally (treatment and diagnostics), but the other covers surgeries and other diagnostic services that are significantly more expensive. Should that second category also include travel for less expensive “treatment” which is not covered in the current plan, or as written?
 - Emily commented that the current plan booklet does say surgery, she was primarily contemplating long-term treatment. She noted that the group can discuss including treatment generally, but she pointed out that the intent is to make sure people are utilizing travel for procedures when there is a significant cost savings, versus paying for travel when an equivalent and similarly-priced service is available locally.
 - Mauri Long responded that she still feels it may be worth considering other procedures, with the example of giving birth, which may or may not include surgery (C section) but which would still be significantly less cost and/or may be available with higher quality from out of area providers. She believes this should be considered, since the plan includes the requirement that the procedure and travel be less expensive than a locally-available option.
 - Cammy Taylor pointed out that some guidelines may still be necessary, the intent is not to cover lower-cost procedures or ones that don’t have a significant differential in quality.

Member impacts: Emily noted that the Division recently received some data on past utilization of this travel benefit, and will share those soon, they need to be added to the document. They do anticipate utilization of this benefit would increase if made available as proposed.

- Cammy Taylor asked for clarification about the benefit for Medicare eligible retirees: they would not be able to use all the travel benefit services, and if the provider does not accept Medicare, they would not be included?
 - Emily responded that for these members, SurgeryPlus can still provide travel coordination for Medicare enrolled members, but even if the provider accepts Medicare, it would not be covered in the same way. Either way, SurgeryPlus would still coordinate with the providers within their network since they have an existing agreement, but individual providers may interact differently depending on the individual provider. This likely would not impact interaction between SurgeryPlus and the member.
 - Cammy requested staff discuss with SurgeryPlus the implications for Medicare eligible retirees, and what would happen if a provider is or is not in the Medicare network.
 - Emily Ricci agreed and staff will do this. She noted that SurgeryPlus has also been asked to provide some member guidance to ensure that members look at quality providers, and help them find a provider in the Medicare network.
- Nan Thompson commented that since there are no Alaska providers within the SurgeryPlus network, it would be helpful to research this and be able to respond to questions about why in-state travel is not covered under this network.
 - Emily Ricci noted that none of the other travel benefit providers have Alaska providers in network, it may be due in part to not meeting the required quality standards, but also

because a provider must have sufficient volume to demonstrate expertise and efficiency for that procedure. Alaska providers could participate, but would need to meet those standards, and may not have enough incentive currently to participate.

- Joelle Hall commented that it is also unlikely that someone would travel to Alaska from another state for the same procedure, as generally our costs are higher and providers have done less volume of most procedures than in other places. Generally, Alaska-based members can still access Alaska-based doctors under the network. This simply allows those members to have greater access to doctors outside Alaska.
- Cammy Taylor commented that there is still a population who would like to travel within Alaska for a procedure, preferring this to traveling out of state. The question is how to address travel benefits for this situation: for example, travel coverage for people in rural areas who travel to Anchorage, or another Alaska facility.
- Emily Ricci clarified that the travel benefits would also cover Alaska-based travel for those procedures, not under SurgeryPlus per se but as part of the larger travel wrap benefit.

Emily concluded by pointing out the recent changes to the memo, and pending additional changes. The operational impact to the third party administrator will be significant, as it will require coordination with the travel provider and changes to their procedures since it is a change to plan benefits.

- Cammy Taylor asked for clarification: is it accurate that the current plan waives co-pay for outpatient procedures such as ambulatory surgical center? Would this be a cost saving measure?
 - Emily Ricci confirmed that there is a provision in the current plan incentivizing use of ambulatory surgical centers compared to inpatient settings. This provision is not utilized frequently and may warrant review.

Emily also posed to the group: should there be a waived prior authorization for this service, given that there are already stringent quality measures in place for the SurgeryPlus network? This would make the process easier for both members and for providers, if they do not require authorization. The group will discuss this at the November committee meeting.

The committee took a 15-minute break at 11:08 a.m., returning at 11:23 a.m.

Item 4. Continue Discussion of Modernization Proposals: Network Incentives

Materials: Modernization Topics Table in 10/30/18 meeting packet, "Network Incentives"

Emily Ricci presented a summary of this proposal: currently, there is no differentiation in coverage between in-network and out-of-network as relates to meeting deductibles. Once the individual reaches a \$150 deductible, they are responsible for 20% of costs, up to \$800 of additional cost, so the total cost is \$950 to the member. The 20% is referred to as co-insurance in plans.

Emily reiterated the goals of the plan modernization project: 1) respond and evaluate proposals for benefits that members have asked for, and 2) implement cost savings to the plan where possible. One way to address costs is to incentivize in-network care, and therefore incentivize providers to join a network, because they will see more members in that network who will be paying less co-insurance, although the provider would get the full negotiated rate from combined payments from the member and insurance. By creating a disincentive for out-of-network care, members will seek care from in-network providers and therefore managing costs for the plan. Currently, the plan provides 80%

coinsurance for both in-network and out-of-network services; and for out-of-network reimbursement, the plan follows a 90th percentile rule, which results in very high reimbursement rates and a disincentive for providers to be in network unless they can offset that rate with higher volume.

The proposal would increase co-insurance to 90% for in-network providers (i.e., member would pay 10% of the costs in that co-insurance tier, not 20%) and decrease coinsurance to 70% for out-of-network providers (member pays 30%). Because the total cost of care is often higher than the \$950 limit for members, and because many major providers in Alaska are already in network, this would add value to the plan for members because the plan will cover more of their care, which would increase actuarial value of the plan and increase actual costs to the plan because it would cover a higher percentage. Emily also noted that there is flexibility within the proposal, for example the plan could continue to cover in-network at 80% and reduce the co-insurance to some other variable like 60%. This is up for discussion.

Richard Ward commented that normally, network steerage (incentivizing in-network care through different coverage rates) are a best practice in plan design, and can provide significant cost containment. However, he noted that 80% of the plan costs each year are attributable to care for members who have already reached the out of pocket maximum for that year, and therefore the co-insurance would not have as much of an impact as anticipated by staff originally, as the low out of pocket maximum sets a low threshold for the amount of co-insurance and most people end up meeting that threshold. Typically steerage policies do have an impact on member utilization of in-network care, but in this case this change alone may not have the desired effect, and would increase costs to the plan as more care would be covered with 90% co-insurance. There is still benefit to establishing stronger network provisions in the plan, but not as much as with most other health plans.

- Nan Thompson asked whether the third party administrator has quality requirements for in-network providers? Would there be a provision of credentialing or otherwise requiring minimum quality standards? Or is this proposal more about pricing, compared with SurgeryPlus which has specific quality requirements?
 - Cammy Taylor responded that this is more a discussion about pricing. She also expressed concern about penalizing members for not having an in-network option either locally or in Alaska generally. For example, there are no general surgeons in the Aetna network in Alaska. She understands the overall benefits, but without a robust network in Alaska this may negatively impact retirees who have no other options.
- Cammy Taylor asked for clarification, does this proposal include separate deductible and out of pocket maximum limits for the plan?
 - Richard Ward responded no, but it is a typical plan design to have a higher deductible and out of pocket limit for out-of-network care.
- Cammy Taylor asked whether there are exceptions allowed in the employee plan?
 - Emily Ricci responded that in Anchorage and out of state, there is a difference between in-network and out-of-network coverage, and this has changed employee members' utilization. However, she noted that there are exceptions (including in Juneau) where there are no in-network providers. She agrees there needs to be a process for granting exceptions, and to hold the member harmless if they do not have a feasible alternative.
 - Richard Ward commented that the negotiation between provider and insurer about network participation includes not just pricing, but also the service, number of other providers, and generally a balance of incentives for provider and insurer to both enter an

agreement. The lack of access to an in-network provider is an issue not just in Alaska, but in other rural areas, so these considerations need to be made. Generally it is a best practice in plan design to use differential co-insurance rates, and differences in deductible and out-of-pocket limits, and does have an impact on the negotiations in network, meaning having stronger network steering provisions can save the plan money in negotiated rates.

- Emily Ricci added that the Division supports some form of steerage because it is a common practice in modern health plans. She also shared that the plan's lack of steerage has impacted the plan's ability to negotiate with hospitals, who have noted that the lack of steerage within the plan meant that the hospital did not offer lower rates. There are many variations of steerage and pricing incentives that can be used within the negotiations, and it would benefit the plan to address this.
- Mauri Long asked whether staff have considered the impacts of this proposal on the other proposal regarding travel? Would it negate the potential savings from that travel benefit?
 - Emily Ricci shared that staff believe the two proposals are complementary, covering travel will help members access an in-network provider in another area. The wrap benefit would provide coverage for members, particularly travel costs not being covered now, and can still help members access in-network providers for certain higher-cost procedures.
- Joelle Hall asked whether the negotiations for inpatient rates differ for hospital facilities versus the providers in the hospitals?
 - Emily responded that there are potential savings with facilities as well as providers who are not employees of facilities. Based on past negotiations, staff believe there are additional savings that can be available if this policy is adopted.

Emily continued: currently, out-of-network providers can bill patients for the remainder of the recognized charge if they are not reimbursed enough by the plan, a practice known as balance billing. This can leave the member vulnerable to additional charges, on top of their co-insurance and out of pocket costs. Balance billing cannot occur with in-network providers as they agree not to balance bill members as part of their network participation. She noted this does not apply to pharmacy benefits.

- Judy Salo asked for clarification, Medicare enrolled members cannot be balance-billed by providers who accept Medicare?
 - Emily responded that yes, this is correct, Medicare providers cannot balance-bill.

Emily shared that in actual claims incurred (Table 1 on page 49), the numbers will change according to the time frame and whether the claims are shown as incurred (billed) or paid (actually reimbursed). She also noted that this includes Medicare eligible retirees, for whom Medicare is the primary insurer, and who can go to any Medicare provider and will be reimbursed the same rate whether they are in network or out of network. This skews the numbers to some degree, but does not necessarily represent a cost differential since Medicare is paying the same rate. Emily also noted that it is not surprising to see inpatient claims primarily in-network, since both Providence and Regional (the state's two largest hospitals) are in network for AlaskaCare. There is greater opportunity for cost savings for the outpatient professional services; she noted that for outpatient services, there may be a separate facility charge and professional charges for one procedure, such as the physician, anesthesiologist, etc.

- Cammy Taylor noted that there is a significant difference for Medicare eligible members' claims, much more out of network use than in network. She asked for reasons why this may be? Why would Medicare eligible retirees be using out-of-network facilities?
 - Emily Ricci clarified that this is Aetna's network, so there may be people accessing Medicare providers who are not in Aetna's network. She also noted that the data was pulled only recently, they need to do additional analysis, particularly related to impacts on Medicare, and whether the data is accurately showing Medicare claims. Staff is working on this.
- Cammy Taylor requested staff look at the top locations where retirees live, out of state, and what the network coverage looks like for those retirees, including those who are Medicare eligible? This would give more information about possible impacts on out of state and Medicare eligible retirees.
 - Mauri Long commented that her understanding is, Medicare eligible members must go to a provider who accepts Medicare, which is challenging in Alaska, because primary care providers are reimbursed at a low rate in Alaska and therefore few accept Medicare.
 - Michele Michaud responded that yes, for a Medicare enrolled member, AlaskaCare will not pay for a provider who does not accept Medicare.
- Mauri Long asked for clarification: in this table, why are so many claims overall out of network?
 - Michele Michaud clarified that this is the Aetna (TPA) network, there are many Medicare providers who are not in Aetna's network. For example, the Mayo Clinic in Arizona accepts Medicare but is not in the Aetna network.
- Mauri Long expressed concern about penalizing Medicare eligible members for seeking out of network care, even if the overall cost is lower.
 - Emily Ricci noted that because Medicare is the primary payer, there would not be any additional cost savings for Medicare covered services. Including this information illustrates the breakdown of these two age groups, but the Medicare population is not the primary focus of this proposal.
 - Cammy Taylor requested that staff review the data and break out information on Medicare eligible retirees' costs for services not covered by Medicare.
 - Richard Ward noted that this can be done because they have raw claims data, but the same limitations will apply: the plan has a relatively small opportunity for co-insurance because of low deductible and out of pocket costs, so most costs would still be covered by the plan.

Emily Ricci commented that the proposal can include an exception for members who do not have easy access to an in-network provider. Members who have reached their out of pocket limit would not be impacted; members who are Medicare eligible will generally not be impacted, only when the member uses services that are not covered by Medicare. There would be operational impacts to the plan primarily as relates to processing exceptions, if the plan allowed for out-of-network exceptions. She also noted that while there are already existing and competitive networks in the rest of the U.S., implementing this proposal could increase incentives to participate in the network in Alaska.

Richard Ward reiterated that the financial impact to the plan is anticipated to be an increase since it would increase in-network utilization, but most of this would be absorbed by the plan as it covers costs above the members' out of pocket maximum. However, the overall increase would estimated to be \$800,000, which in the context of total plan spending is relatively small.

- Mauri Long asked when the out of pocket maximum and deductible were last adjusted in the plan?

- Michele Michaud responded that the limits were last changed in 2000; the deductible increased from \$100 to \$150. She would need to research the increase to the out of pocket limit, currently \$800. [Note: She researched this during the meeting, and found that the previous out of pocket amount was \$690, and was increased to current amount of \$800.]
- Mauri Long asked for clarification about “clinical considerations” in this proposal?
 - Emily Ricci noted that this category is being explored for all the proposals, but in this particular proposal there may not be any clear clinical impacts. So far they have not identified negative clinical impacts for the other proposals. And, for example, the SurgeryPlus proposal may have positive clinical impacts since it would likely reduce the number of members’ complications, therefore less subsequent costs after a procedure.
- Joelle Hall commented on multiple items:
 - She is interested in furthering discussion about the deductible limit, since it has been almost 20 years since the last increase. She would like to better understand the financial impacts to the plan and actuarial impacts to the plan if this is changed, for example using a hypothetical \$100 increase to the deductible for analysis. She understands this would impact members. She would like to know how this would impact the current 80% of members who utilize services enough to the \$150 deductible now. Would this actually result in significant savings to the plan, or would everyone still reach that limit, and not save the plan that much?
 - Richard Ward commented that 80% is not number of people, but total spending. A relatively small number of people have much higher costs.
 - Joelle Hall requested that staff research the number of members meeting this threshold, in addition to the total spending, to understand the breadth of impacts. She wants to ensure a transparent and informed discussion with retirees about why the changes are being considered, what the actual impacts will be, and ensure that there is clear consideration of who will be impacted and how.
 - She is also interested in the discussion about savings from network steerage and travel benefit together, and what money is left on the table regarding negotiations with providers. Would one or more of these proposals, such as implementing the travel benefits first, have enough leverage in the market to get more Alaska providers in network? Would this have the intended impact, and not require additional measures that would have more negative impacts to members, such as increasing members’ share of out-of-network costs? She would like to see the relative merit of the individual proposals, particularly as it relates to prices for inpatient facilities.
 - Emily Ricci reiterated that steerage proposals would not only impact out-of-network participation, but also that within the in-network inpatient facilities, there may be additional savings related to negotiated rates.
- Nan Thompson requested common metrics across proposals to be able to do a big-picture analysis of the proposals overall, and understand what impacts they will have. She noted that in the context of the *Duncan* decision, this would allow the committee and staff to consider these proposals as a whole, and where there might be diminishments and enhancements to the plan.
 - Emily Ricci agreed this is important, staff have been preparing this type of comparative table but have not finalized it in time for this meeting. It will be shared with the Board soon.
- Mauri Long requested more information about coordinated/dual coverage members, people who are covered under multiple plans (such as, spouses who both have an AlaskaCare plan). How does

this apply for meeting deductibles and out of pocket maximums?

- Michele Michaud commented that there are approximately 10,000 members covered under multiple plans; they would theoretically never reach the out of pocket maximum because the other plan would cover the remaining costs.
- Emily agreed it is a good idea to include this as a member impact, and will add to the memo.

Item 5. Public Comment (Additional Round)

The committee invited the public to make comment.

- Tom Atkinson: he is staff for Rep. Josephson, Tier I PERS and TRS retiree. He notes that he is speaking on behalf of Rep. Josephson's office, and concerned constituents. He asked whether the network outside of Alaska is stronger or weaker than in Alaska?
 - Emily Ricci stated that the network is actually stronger outside of Alaska, as more providers participate in those networks in the rest of the U.S. Retirees outside Alaska generally have more network options, depending how many providers operate in their local area.
- Tom also asked whether for out of state retirees, is there a difference in benefits for retirees living in other states, such as travel within Oregon?
 - The travel benefit proposal would cover travel U.S. wide, and would be available to retirees living in other states who would travel to a place outside their home state. It would not cover international travel for procedures outside the U.S.
- Tom also asked for clarification regarding payment for Medicare eligible retirees: does AlaskaCare pay anything for Medicare covered care?
 - Michele Michaud commented that those members must go to a Medicare provider, and if the provider does not cover Medicare, they are considered an opt-out provider and the member must sign a contract that they understand they are responsible for the costs. AlaskaCare will not pay in this instance. Otherwise, for Medicare providers, Medicare pays 80% of the cost and AlaskaCare, as the secondary plan, pays the remaining 20%.
- Gordon Glaser reiterated his appreciation for the work of this board and the modernization project, and understands how complicated it is and that it will take significant work to complete.
- Brad Owen was not present at the end of the meeting, and did not provide comments.

Item 6. Final Thoughts + Meeting Adjournment

- Judy Salo thanked staff and the committee for a great discussion, and for all the research and analysis done to date. She looks forward to further discussion at the November 28 board meeting.
- Cammy Taylor also thanked staff for their work, and noted that at the November 28 board meeting, the committee members will propose setting the next committee meeting date and will be recruiting at least one new committee member from the Board.
- Scheduling: Joelle Hall and Cammy Taylor proposed possible meeting dates of December 12 or 13. Staff stated that December 12 is the best option. Michele noted that the Alaska Retirement Management Board meets that day, so Gayle Harbo may not be available, but is not a member of this committee. The next committee meeting date will be set at the 11/28 RHPAB meeting.
- **Motion** by Joelle Hall to adjourn the meeting. **Second** by Cammy Taylor.
- **Result:** The meeting was adjourned at 12:35 p.m.

Public Comment Guidelines

Retiree Health Plan Advisory Board Public Comment Guideline

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

Retiree Health Plan Advisory Board Public Comment Guideline

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

Enhanced Travel Benefits with Wrap – DRB Analysis

DRAFT-Summary of Responses to Proposed Plan Design Change

Proposed change: Enhancing travel benefits

Plans affected: DB Retiree Plan

Reviewed by: Retiree Health Plan Advisory Board

Proposed implementation date: TBD

Review Date: ~~October 30~~December 11, 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 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).
- 5) Expand travel coordination services to include prospective travel arrangement paid and coordinated by SurgeryPlus for services that are not part of their network but meet the expanded criteria outlined in points 3 to 5 above.
- 4)6) Provide members access to the SurgeryPlus credentialing and physician recommendations, records transfer, scheduling assistance, and follow-up and adherence support for services received locally as well as those covered under the expanded criteria in points 3 – 5 above.

DRAFT-Summary of Responses to Proposed Plan Design Change

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.¹

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 with access to surgeons who demonstrate they meet and maintain a combination of objective and subjective quality metrics.² 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, 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 situations³
- 2) For a minor (under 18 years of age) with a parent/legal guardian⁴
- 3) For certain transplant services at an Aetna Institute of Excellence (IOE) with a companion and lodging⁵
- 4) Second surgical opinions⁶
- 5) Treatment not available locally⁷
- 6) Surgery in other location if provided less expensively⁸

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

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

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

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

⁴ Page 41, Ibid.

⁵ Page xxxvii-xl. Ibid.

⁶ Page 43, Ibid.

⁷ Page 42, Ibid.

⁸ Page 44, Ibid.

DRAFT-Summary of Responses to Proposed Plan Design Change

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:

- 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 locally⁹)
 - 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 2: Comparison of current and proposed changes 1, below, outlines the proposed changes.

Circumstance	Current	Proposed
Emergency travel ¹⁰	Transportation to nearest hospital by professional ambulance	No change
Transplant via Aetna IOE ¹¹	-Member and companion -Overnight stay: -\$50 per person/night	No change

⁹ Page 42-43, Ibid.

¹⁰ Page 42, Ibid.

¹¹ Page xxxvii, Ibid.

DRAFT-Summary of Responses to Proposed Plan Design Change

	<ul style="list-style-type: none"> - \$100/night maximum - Companion expense: - \$31/night 	
Travel for minor	<ul style="list-style-type: none"> - Minor and companion - Transportation covered¹² 	<ul style="list-style-type: none"> - Add overnight lodging benefit of \$80/night of 3-star <u>or above hotel within 30 minutes of appointments,</u> up to 14-day maximum; - Add per diem benefit of \$31 60 per patient/day; or \$62 120 per patient & companion/day <u>to reflect State of Alaska per diem rates.</u> ¹³per diem rates for state employees during work travel.
Second surgical opinion	<ul style="list-style-type: none"> - Transportation covered for member only 	<ul style="list-style-type: none"> - Add lodging and per diem benefit as described above.
Treatment and diagnostic services not available locally	<ul style="list-style-type: none"> - Transportation, lodging and per diem covered for member only. - Limited to treatment only - Limited to the following visit per benefit year: <ul style="list-style-type: none"> - 1 treatment for condition - 1 for follow-up - 1 pre- or post-natal care - 1 for maternity delivery - 1 pre- or post-surgery - 1 per surgical procedure - 1 per allergic condition 	<ul style="list-style-type: none"> - Restrict to services received from a network provider. - Add lodging and per diem benefit as described above to cover the member's entire length of stay subject to medical necessity. - Allow for both pre- and post-op visit coverage if post-op received within 60-days of discharge. - Add companion benefit if procedure requires general anesthesia (as well as minors, or members with physical disabilities requiring a travel companion (requires medical necessity) or when appropriate or necessary (e.g. minors, members with physical

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

¹³ [See Attachment C: State of Alaska Per Diem Rates Revised 12/10/2018](#)

DRAFT-Summary of Responses to Proposed Plan Design Change

		<u>disabilities, etc. subject to medical necessity):-</u>
Surgery and diagnostic services in other locations less expensive	<ul style="list-style-type: none"> -Only applicable for surgery. -Transportation covered for member only. -Total cost may not exceed the recognized charge for same expenses received locally. -Total cost must include: <ul style="list-style-type: none"> -surgery -hospital room and board -travel to another location 	<ul style="list-style-type: none"> -Restrict to services received from a network provider. <u>-Restrict to services over \$2,000 locally (including 2nd opinions) measured using EDH data and floor of 200% of Anchorage Medicare.</u> -Add “if not available through the SurgeryPlus program.” -Add coverage for companion <u>if procedure requires general anesthesia as described above.</u> -Add lodging and per diem benefit as described- <u>above.</u> <u>above to cover the member’s entire length of stay subject to medical necessity.</u>
SurgeryPlus Program	-Not currently available to retiree members	<ul style="list-style-type: none"> -All travel includes member and companion -Travel costs arranged for and covered up front by SurgeryPlus. -Hotels arranged and paid for by plan. <u>-State of Alaska per diem rate for meals & incidentals.</u> <u>-Companion travel covered if medically necessary as described above. \$31-60 per diem for member/\$120-62 with companion</u> -Members receive pre-loaded debit card in advance of trip.
<u>Long-term stay</u>		<u>Requires additional review-</u> <u>Suggested per diem rate of \$33-</u> <u>-Defined as more than 30 days.</u> <u>-Long term lodging and meals and incidental rates apply as</u>

DRAFT-Summary of Responses to Proposed Plan Design Change

		outlined in State of Alaska Per Diem Rates.
Maximum Reimbursement	None	-No more than \$10,000 per diagnosis.¹⁴

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 an ~~an~~ ~~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~~~~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

¹⁴ [Reflects current limit for travel costs related to transplant occurrence.](#)

DRAFT-Summary of Responses to Proposed Plan Design Change

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.

In addition to their traditional travel and network access services, SurgeryPlus can also provide prospective travel coordination and support for members eligible to travel under the expanded criteria listed in Table 2 even if those services are not available through the traditional SurgeryPlus network. Prospective support would include booking tickets and hotel rooms along with providing a card with per diem in advance of the member's travel. This would be available for members traveling outside of their community, which could include travel both in and outside of Alaska.

Supplemental to the prospective travel arrangement, members could also access SurgeryPlus for assistance with finding a physician for their specific procedure, as well as scheduling, records transfer, and follow up after the procedure. This could be available to members independent of their decision to travel. Meaning members could use this service to find providers within their community, and to gain assistance in records transfer and scheduling. For example, a member in the Anchorage area who seeks an orthopedic procedure could call SurgeryPlus for assistance in finding a board certified provider in Anchorage, and get assistance in scheduling and records transfer as well as follow up after the procedure.

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. The additional physician credentialing and recommendations along with scheduling assistance and records transfer can greatly assist members who are seeking care both within their community as well as outside. It can be extremely difficult to identify the best physician or surgeon for a procedure and tools to do so are limited. This is one way to assist members in navigating that process.

WHO IS IMPACTED:

DRAFT-Summary of Responses to Proposed Plan Design Change

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.¹⁵

Members receiving care locally: Members receiving procedures locally will have an additional resource to assist in finding a provider, transferring records, and scheduling procedures.

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.

Medicare-eligible members will also be able to use SurgeryPlus to assist with finding a physician, coordinating records, and scheduling procedures for services they receive either inside or outside of their community.

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 and from the ability to access Surgery Plus to assist with finding a physician.

DRAFT-Summary of Responses to Proposed Plan Design Change

[coordinating records, and scheduling procedures for services they receive either inside or outside of their community.](#)

Members will be required to pay their deductible and co-insurance to SurgeryPlus prior to receiving care [unless coinsurance is waived](#); 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 ¹⁶

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.
- 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:

¹⁶ See Attachment A **This will be updated to include the wrap services**

DRAFT-Summary of Responses to Proposed Plan Design Change

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 SurgerPlus 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 \$3,000.¹⁷ The fiscal impact of the expanded travel wrap is under analysis.

[The financial impact needs to be updated to reflect the additional changes described in this document.](#)

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 network¹⁸ 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).

[Assisting members in finding a provider, transferring records, and scheduling appointments can improve the quality of care a member receives by directing them to high-quality providers either in, or outside of, their community. This can also support members quality of care by assisting them in adhering to their treatment plan.](#)

Third Party Administrator (TPA) operational impacts:

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

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

¹⁷ See Attachment A

DRAFT-Summary of Responses to Proposed Plan Design Change

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	
SurgeryPlus Overview Updated	B	This presentation has been updated to reflect the presentation provided to the board on November 28, 2018
State of Alaska Per Diem Rates	C	Online at http://doa.alaska.gov/dof/travel/resource/rates.pdf
Current AlaskaCare Travel Utilization - Retiree	D	
Public Comments	CED	TBD

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

Actuarial Value

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

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

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

Financial Impact

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

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

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

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

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

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

SugeryPlus

Employer Direct for



Uniquely positioned to meet the State's evolving needs

Executive Summary

- On January 30th, 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 1st, 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

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

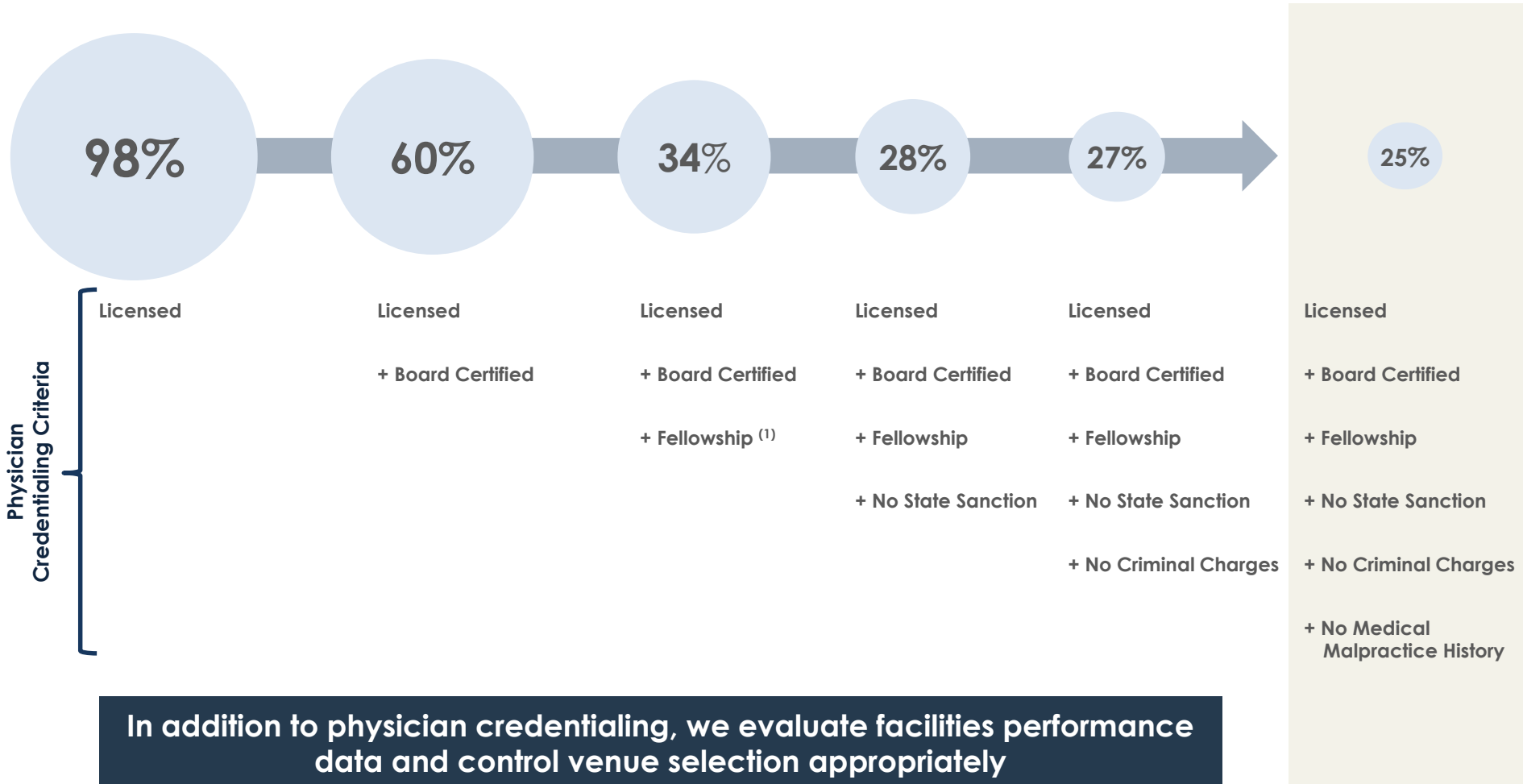
Hard-Dollar ROI SAVINGS

Pre-Negotiated Bundled Rates
Reduced Employer & Employee Costs

How We Evaluate Physician Quality

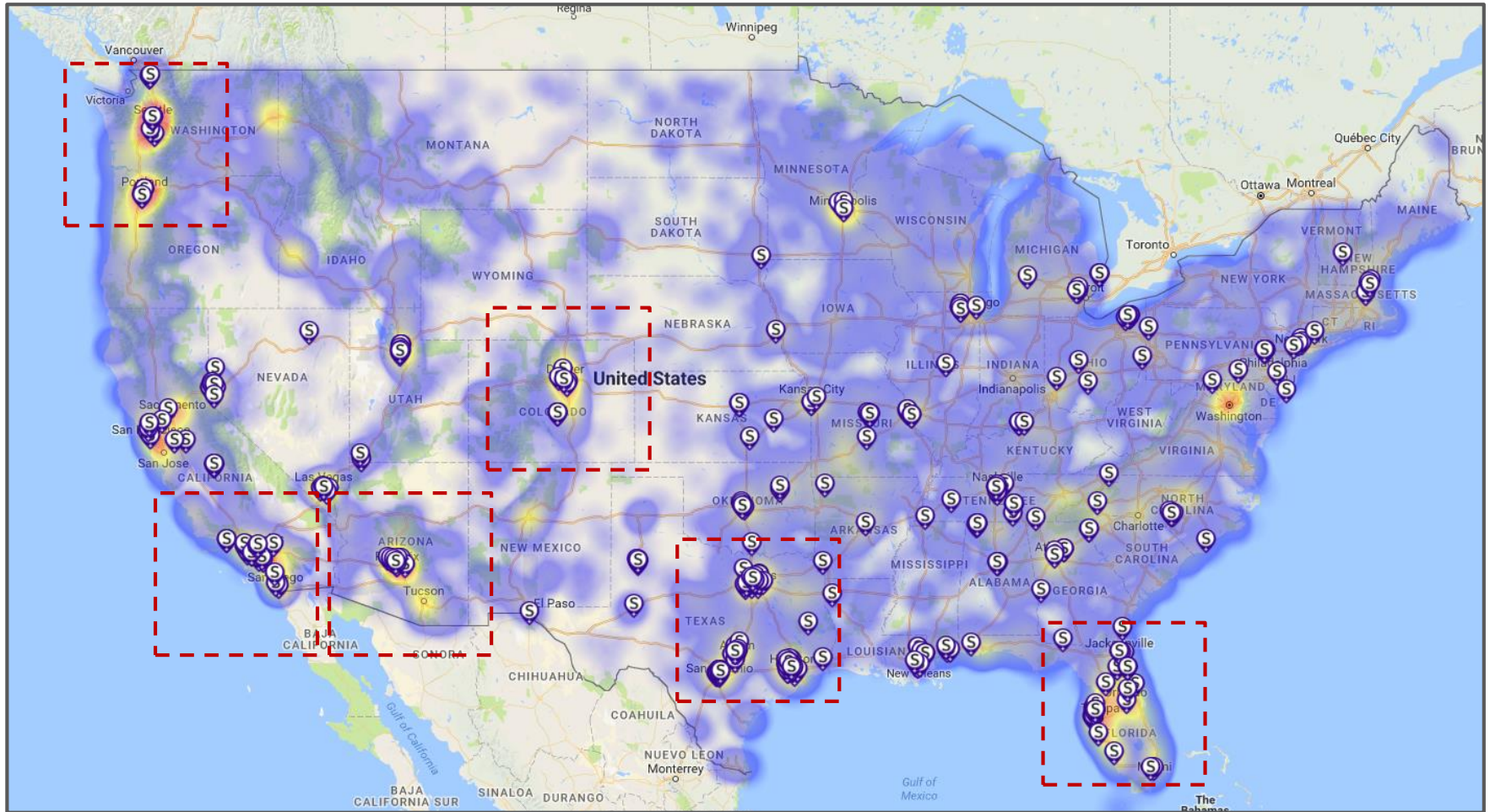
A More Comprehensive Evaluation Process

- 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



SurgeryPlus Provider Network

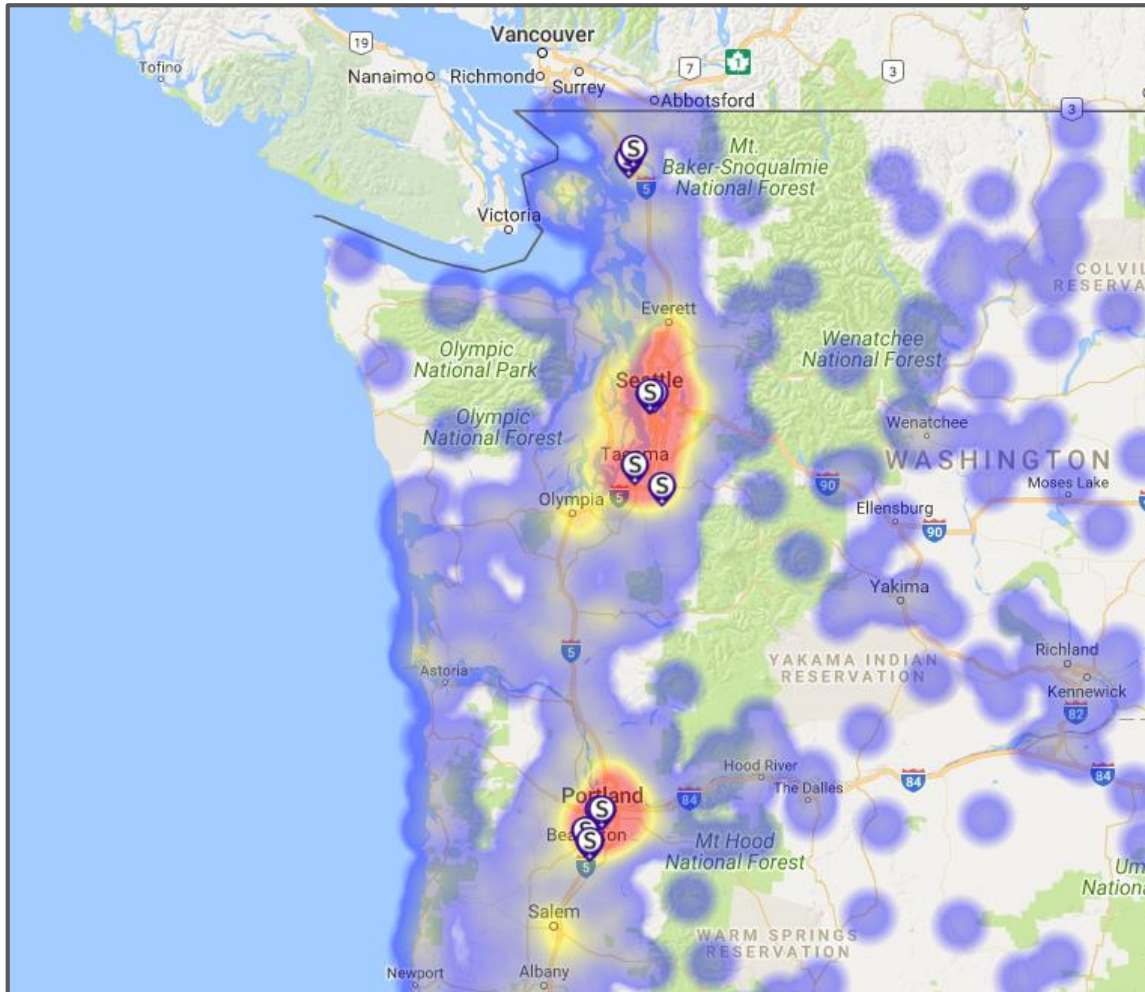
State of Alaska Member Population





Legend:  SurgeryPlus Provider

SurgeryPlus Provider Network

Seattle / Portland



Legend:  SurgeryPlus Provider

Seattle, WA		
Category	Covered?	S+ Facilities
Orthopedics	✓	
Spine	✓	
Bariatrics	✓	
General	✓	
GYN	✓	
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



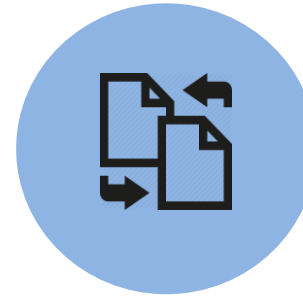
Locate

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

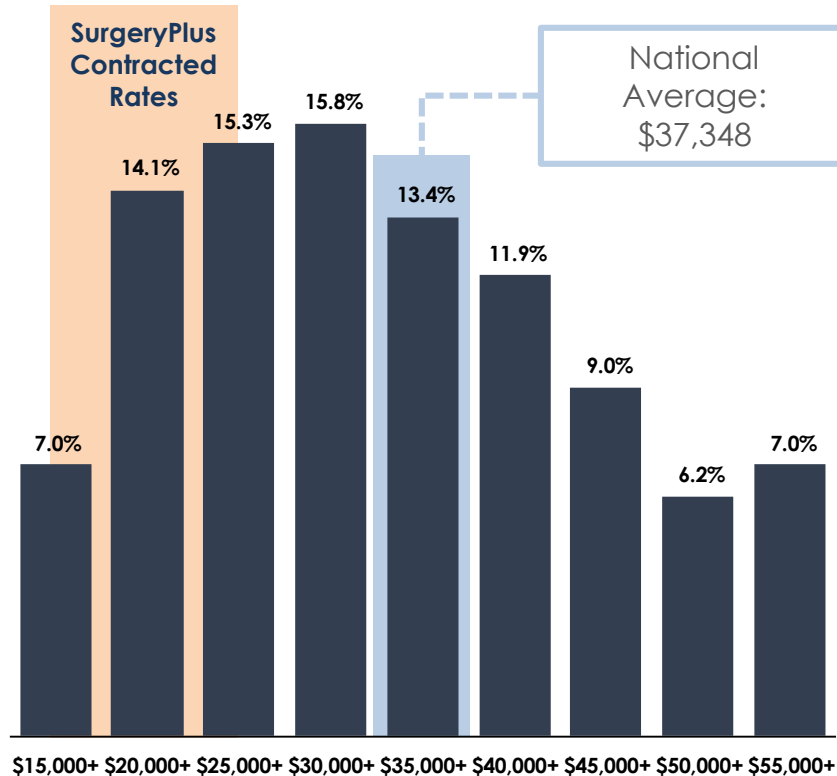
SurgeryPlus' Bundled Rates Provide Consistent and Lower Costs

Orthopedics (27130) – Total Hip Replacement

(% of Total Claims)

% of National
Medicare

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

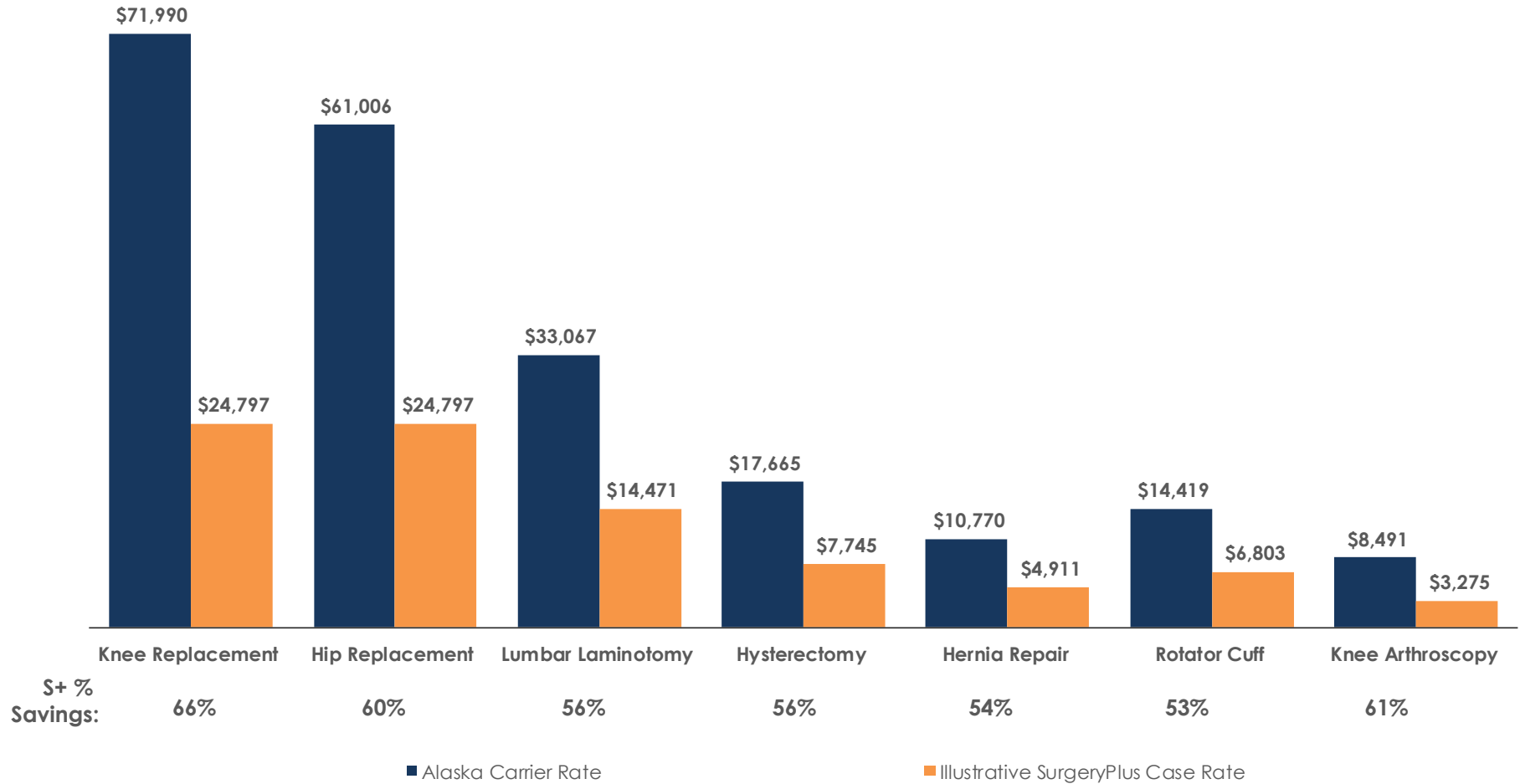


**Market Rates Exhibit
Tremendous Volatility**

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. 47
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	
Illustrative Knee Replacement Example				
Replacement Surgery	\$40,000	\$20,000	\$20,000	
Employee Costs:				
- Deductible	\$150	\$150	—	
- Coinsurance	\$800	— [*]	\$800 [*]	Savings resulted from SurgeryPlus' pre-negotiated bundled rates
Total Employee Costs	\$950	\$150	\$800 [*]	
Plan Net Cost to State	\$39,050	\$19,850	\$19,200	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

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

State of Alaska Objectives

- 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"> Reimbursement for qualified expenses <ul style="list-style-type: none"> Limited in scope Limited utilization Requires verification retrospectively that conditions were met <ul style="list-style-type: none"> Potentially unreasonable burden on member given lack of healthcare transparency 	<p>Same as Status Quo, but:</p> <ul style="list-style-type: none"> 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]) Pay for 100% of lodging & reasonable per diem Provide full SurgeryPlus offering including its travel benefits to retirees for SurgeryPlus procedures 	<ul style="list-style-type: none"> Prospective travel arrangement paid by state/vendor with member contribution as needed 24/7 support for travel related issues Provide full SurgeryPlus offering including its travel benefits to retirees for SurgeryPlus procedures 	<p>Same as Concierge Travel, but:</p> <ul style="list-style-type: none"> Credentialing and doctor recommendations on all services (<u>local or travel</u>) Care Advocacy & Concierge Medicine Services <ul style="list-style-type: none"> Records transfer Scheduling Venue selection Adherence support Follow-up and continuity communications
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>+ No additional bandwidth required</p> <p>– No benefits realized</p>	<p>+ Potentially limited increase in non-SurgeryPlus utilization</p> <p>+ Potential strong improvement for SurgeryPlus events</p> <p>+ Limited additional administrative costs</p> <p>– Does not impact quality</p> <p>– Not full solution</p>	<p>+ Superior experience on all travel</p> <p>+ Better control for state</p> <p>+ Reduction of vendors for service</p> <p>– No impact on care side</p>	<p>+ Quality of care</p> <p>+ Member experience</p> <p>+ Cost containment</p> <p>– New offering design (bandwidth, creation & 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.

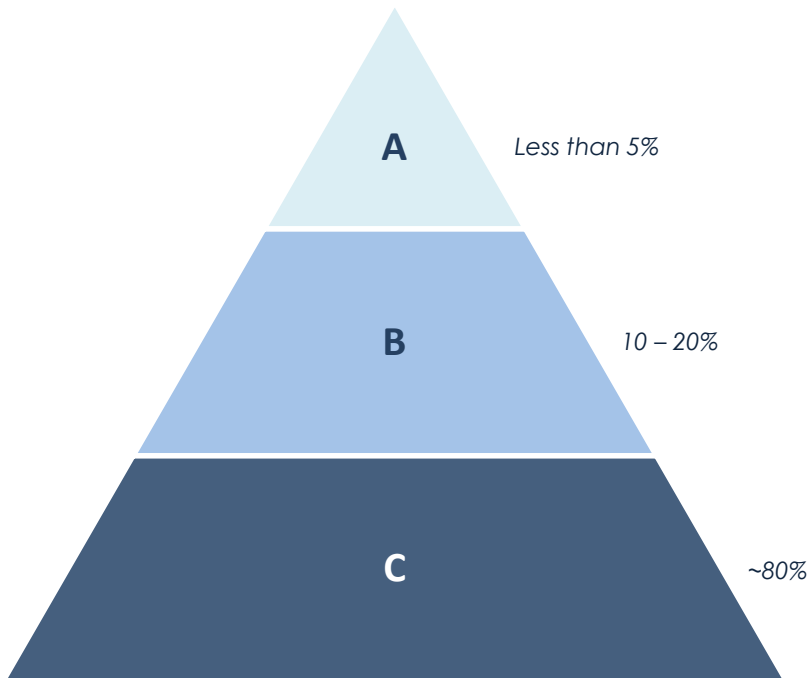
6 FOLLOW-UP

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

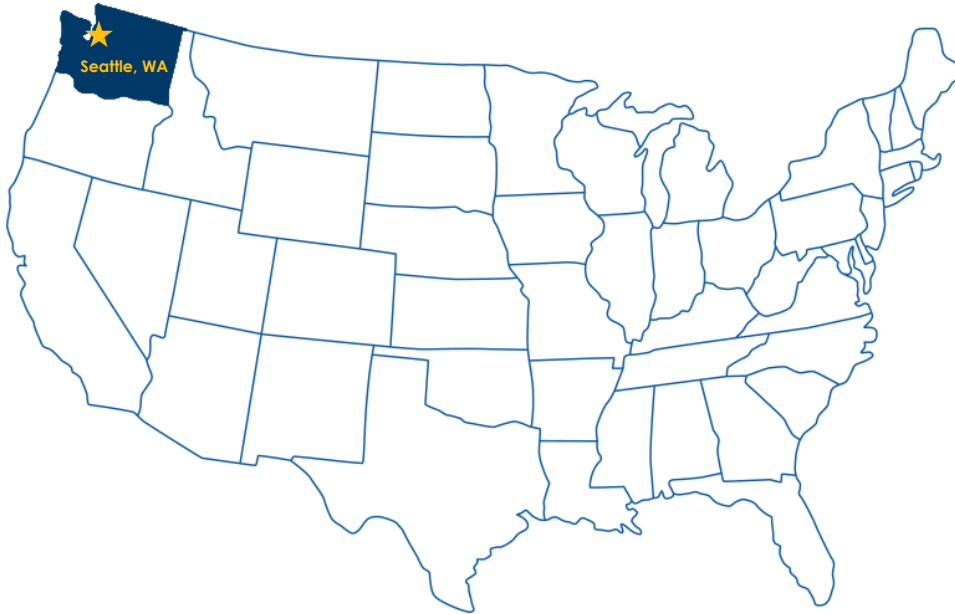
- 1:1 care advocacy & concierge medicine services
- Outreach based on expected episodes, where appropriate
- Inbound call & episode-driven
- Focus on doctor selection, venue selection, and continuity of care

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 ⁽¹⁾

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 nd 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

Per Diem

State of Alaska Per Diem Rates

		Alaska				Contiguous U.S., Hawaii, & Foreign					
		M&IE		Lodging		M&IE		Lodging			
Bargaining Unit		Short-Term	Long-Term	Short-Term (30 days or less)	Long-Term (more than 30 days)	Short-Term	Long-Term	Short-Term	Long-Term	First and Last Day of Travel **	Travel Less Than 24 Hours
AAM		\$60	\$33	Actuals OR \$30 noncommercial option	\$45 for commercial OR \$30 noncommercial option	Federal M&IE rate	55% of federal M&IE rate	Actuals OR \$30 non-commercial option	55% of federal lodging rate	75% of the Daily M&IE Amount (see TABLE A on next page for proration)	75% of the Daily M&IE Amount (see TABLE A on next page for proration) if more than 12 hours and at least 2 hours longer than normal work hours
KK – CEA GC - ACOA XE - Executive TA - AVTECTA EE - Excluded TM - TEAME NG – Nat’l Guard Boards & Commissions											
General Government (GG/GY/GP/GZ) Contract eff. July 1, 2016 through June 30, 2019											
SS – Supervisory (SU) Contract eff. July 1, 2016 through June 30, 2018											
AA, AP - State Troopers and Airport Police Contract eff. July 1, 2014 through June 30, 2017											
BB - Marine Engineers Beneficial Assoc. (MEBA) Contract effective 7/1/2014 – 6/30/2017 CC - International Organization of Masters, Mates, and Pilots (MMP) Contract effective 7/1/2014 – 6/30/2017 MM - Inlandboatmen’s Union (IBU) Contract effective 7/1/2014 – 6/30/2017	Cash Allowance for Subsistence and Quarters when not provided by the State	AAM*		Greater of \$95 Peak (May 16 - Sept. 15), \$85 Off-peak (Sept. 16 - May 15) OR Actuals		AAM*		Greater of \$95 Peak (May 16 - Sept. 15), \$85 Off-peak (Sept. 16 - May 15) OR Actuals		AAM*	AAM*
	Travel due to relief at other than port of engagement or between temporary assignments	Actuals									
	Travel between regular assignments (if change port is not the same as the residence port)	Deadheading only									
LL – Labor, Trades, and Crafts (LTC) Contract effective 7/1/2015 – 6/30/2018		AAM*	AAM*	Lodging Allowance in LTC Alaska Lodging Rates by Region Chart below OR Actuals (with advance approval) OR If utilizing a bunkhouse with heat, light, adequate cooking, sleeping and lavatory facilities, members are paid lodging allowance less \$10 OR Commuting allowance (See Notes)		AAM*	AAM*	AAM*	AAM*	For Travel Within Alaska the Prorated M&IE based on time of travel applies (see TABLE B on next page for proration)	50% of the daily or the prorated meal allowance, whichever is greater and not less than \$30, (see TABLE B on next page for proration), if more than 10 hours in travel status
				For Travel Outside of Alaska the AAM* policy applies							

* See first row for description of AAM Per Diem Rates. These are the current rates and also those that were effective July 1, 2010.

** The M&IE rates for Alaska and the contiguous United States (CONUS) are prorated on the next page. If total daily amount does not equal a CONUS amount listed in table, you may manually calculate meal period prorated amounts based on the percentages supplied. The Standard CONUS Rate (\$55) applies to all cities or counties not listed on the Federal GSA table.

State of Alaska Per Diem Rates

MEALS & INCIDENTAL EXPENSES (M&IE) PRORATION

TABLE A. AAM RATES														
Rates effective 07/01/2018 – 09/30/2018														
	AK Short-Term	AK Long-Term	Outside Alaska Short-Term (CONUS)						Outside Alaska Long-Term (CONUS)					
Total Daily Amount	\$ 60	\$ 33	\$ 74	\$ 69	\$ 64	\$ 59	\$ 54	\$ 51	\$ 41	\$ 38	\$ 35	\$ 32	\$ 30	\$ 28
Pro-Rated Amount (75%)	\$ 45	\$ 24.75	\$ 55.50	\$ 51.75	\$ 48	\$ 44.25	\$ 40.50	\$ 38.25	\$ 30.75	\$ 28.50	\$ 26.25	\$ 24.00	\$ 22.50	\$ 21.00
Rates effective 10/01/2018														
	AK Short-Term	AK Long-Term	Outside Alaska Short-Term (CONUS)						Outside Alaska Long-Term (CONUS)					
Total Daily Amount	\$ 60	\$ 33	\$ 76	\$ 71	\$ 66	\$ 61	\$ 56	\$ 55	\$ 41	\$ 38	\$ 35	\$ 32	\$ 30	\$ 28
Pro-Rated Amount (75%)	\$ 45	\$ 24.75	\$ 57	\$ 53.25	\$ 49.50	\$ 45.75	\$ 42.00	\$ 41.25	\$ 30.75	\$ 28.50	\$ 26.25	\$ 24.00	\$ 22.50	\$ 21.00

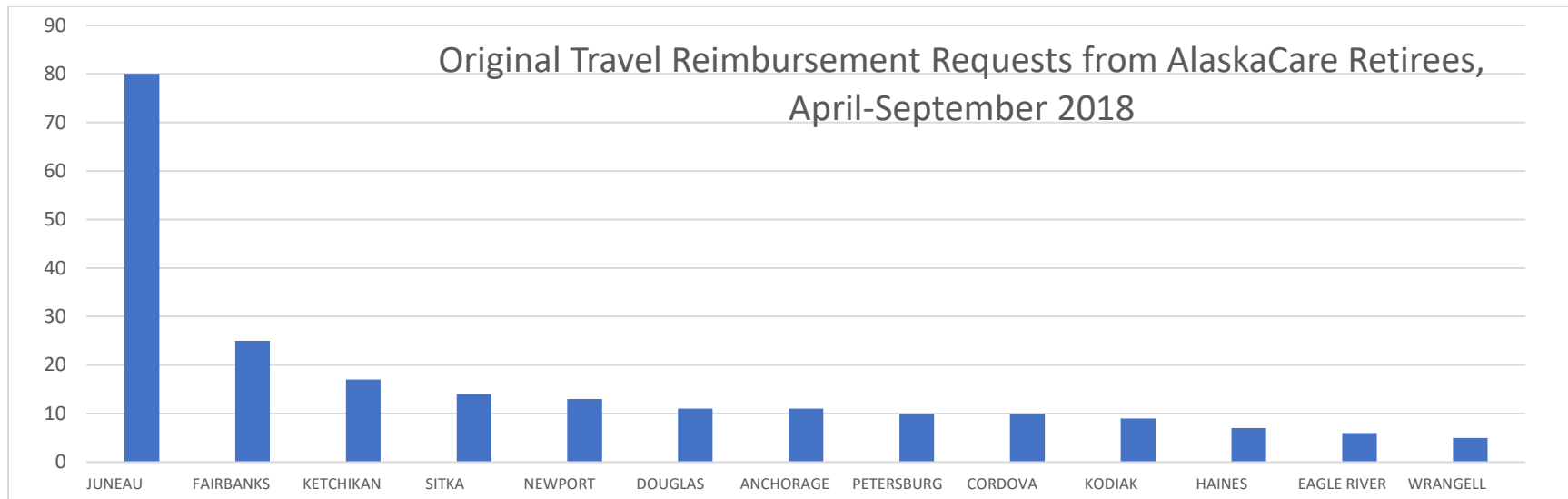
TABLE B. MEAL PERIODS AND PRORATED M&IE AMOUNTS															
Rates effective 07/01/2018 – 09/30/2018															
	Meal Period %	AK Short-Term	AK Long-Term	Outside Alaska Short-Term (CONUS)						Outside Alaska Long-Term (CONUS)					
Midnight-10:00 AM	Breakfast (21%)	\$ 12	\$ 7	\$ 17	\$ 16	\$ 15	\$ 13	\$ 12	\$ 11	\$ 9	\$ 9	\$ 8	\$7	\$ 7	\$6
10:00 AM-3:00 PM	Lunch (26%)	16	9	18	17	16	15	13	12	10	9	9	8	7	6
3:00 PM-Midnight	Dinner (53%)	32	17	34	31	28	26	24	23	19	17	15	14	13	13
Incidentals		included above	included above	5	5	5	5	5	5	5	3	3	3	3	3
Total Daily Amount		\$ 60	\$ 33	\$ 74	\$ 69	\$ 64	\$ 59	\$ 54	\$ 51	\$ 54	\$ 38	\$ 35	\$ 32	\$ 30	\$ 28
Rates effective 10/01/2018															
	Meal Period %	AK Short-Term	AK Long-Term	Outside Alaska Short-Term (CONUS)						Outside Alaska Long-Term (CONUS)					
Midnight-10:00 AM	Breakfast (21%)	\$ 12	\$ 7	\$ 18	\$ 17	\$ 16	\$ 14	\$ 13	\$ 13	\$ 9	\$ 9	\$ 8	\$7	\$ 7	\$6
10:00 AM-3:00 PM	Lunch (26%)	16	9	19	18	17	16	15	14	10	9	9	8	7	6
3:00 PM-Midnight	Dinner (53%)	32	17	34	31	28	26	23	23	19	17	15	14	13	13
Incidentals		included above	included above	5	5	5	5	5	5	3	3	3	3	3	3
Total Daily Amount		\$ 60	\$ 33	\$ 76	\$ 71	\$ 66	\$ 61	\$ 56	\$ 55	\$ 41	\$ 38	\$ 35	\$ 32	\$ 30	\$ 28

LTC ALASKA LODGING RATES BY REGION NOTES

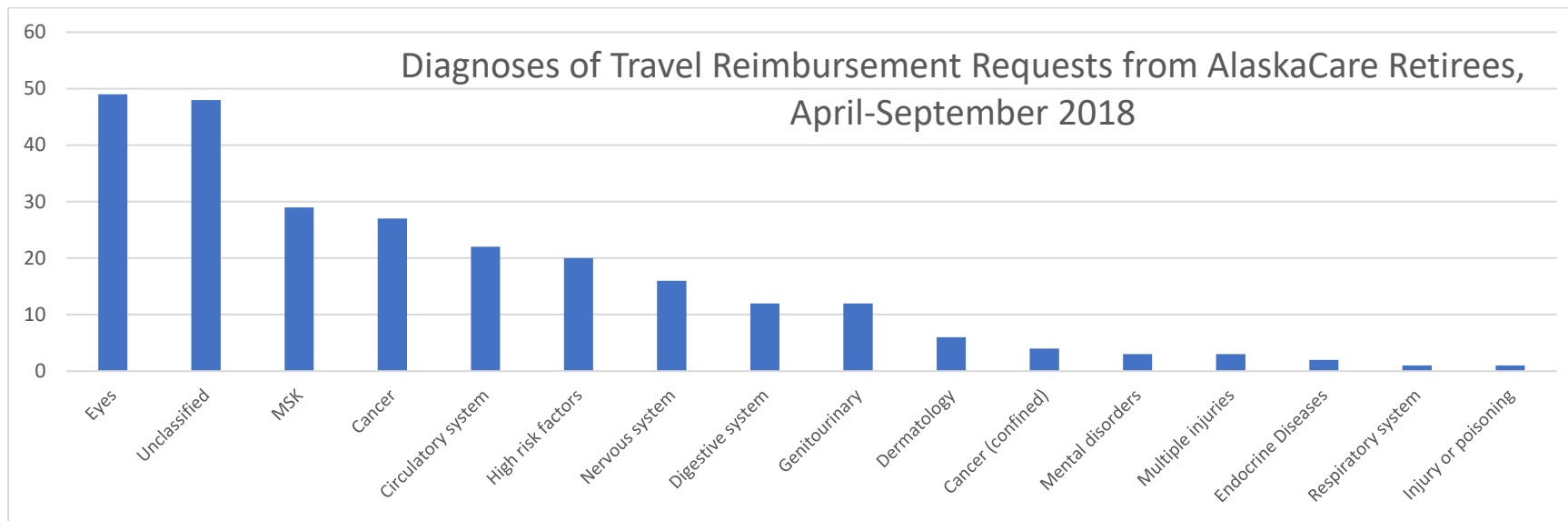
See Community-Region Listing for the locations in each region				
Region	Peak Season (5/16 - 9/15)		Off Season (9/16 - 5/15)	
	Short-Term = First 30 days	Long-Term = Days 31-Travel Completion	Short-Term = First 30 days	Long-Term = Days 31-Travel Completion
1 - Southeast Alaska	\$ 74.00	\$ 44.40	\$ 64.00	\$ 38.40
2 - Southcentral Alaska	\$ 79.00	\$ 47.40	\$ 59.00	\$ 35.40
3 - Interior Alaska	\$ 64.00	\$ 38.40	\$ 54.00	\$ 32.40
4 - Southwest Alaska	\$ 64.00	\$ 38.40	\$ 60.00	\$ 36.00
5 - Barrow, Kotzebue	\$ 64.00	\$ 38.40	\$ 60.00	\$ 36.00

1. Actuals refers to reimbursable expenses supported by receipts.
2. All M&IE payments in excess of federal M&IE rates are reported as taxable compensation. In addition, M&IE payments for trips without overnight lodging are taxable compensation.
3. All lodging allowance payments (including LTC commuting allowance) in excess of submitted receipts are reported as taxable compensation.
4. Boards & Commission members receive Administrative Manual rates, except for at-home meetings during which, in general, they are not allowed lodging per diem.
5. LTC members assigned to work more than 50 miles from their permanent duty station are entitled to a commuting allowance if they return to their residence on their own time (e.g., weekends). The commuting allowance is 90% of lodging allowance (see chart) plus applicable M&IE.

Current AlaskaCare Retiree Travel Utilization



- The distribution is expected, given Juneau's high retiree population and status as a medically-underserved area
 - Where diagnosis is specified, 41% of Juneau travelers are seeking ophthalmology care.



DRAFT

- 256 Unique Claims, or \$651 in travel-based (transportation, lodging, meals) expenditures per Claimant
- This will rise on a per-claimant basis as restrictions on travel companions are loosened, and additional travel expenses are incurred on their behalf.

Travel Reimbursements (Retirees, April-September 2018)	Amount
A0140 Non-emergency transportation and air travel (private or commercial) intra or inter state.	\$ 144,771
A0180 Non-emergency transportation: ancillary: lodging – recipient	\$ 10,045
A0170 Transportation: ancillary: parking fees, tolls, other	\$ 2,931
A0110 Non-emergency transportation and bus, intra, or inter state carrier	\$ 2,886
A Other Travel Expense Not Otherwise Specified	\$ 1,558
A0200 Non-emergency transportation: ancillary: lodging – escort	\$ 1,518
A0090 Non-emergency transportation, per mile - vehicle provided by individual (family member, self, neighbor) with vested interest.	\$ 1,284
A0190 Non-emergency transportation: ancillary: meals – recipient	\$ 1,048
A0120 Non-emergency transportation: mini-bus, mountain area transports, or other transportation systems	\$ 438
A0100 Non-emergency transportation; taxi	\$ 245
Total	\$ 166,723

Increase Deductible/Out-of- Pocket Maximum

DRAFT-Summary of Responses to Proposed Plan Design Change

Proposed change: Increase deductible and OOP limit

Plans affected: DB Retiree Plan

Reviewed by: Retiree Health Plan Advisory Board

Proposed implementation date: TBD

Review Date: December 12, 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							

As the Division and the Retiree Health Plan Advisory Board (RHPAB) consider different proposals to modernize the health plan by including provisions that add benefits to the plan, the RHPAB and the Division must also seek to maintain the overall existing actuarial value of the plan. To achieve this, the Division and the board are considering several different types of changes to offset the addition of new benefits. Increasing member's cost share, defined here as the deductible and out-of-pocket (OOP) limit, is the most direct way to achieve a comparable offset.

In this initial draft proposal, the Division has identified three different options for consideration by the RHPAB and membership. Similar to other proposals, these options serve as a starting point for discussion and can be designed differently than proposed here depending on input from the board and membership.

Description of proposed change:

Increase the deductible and OOP limit in the defined benefit retiree health plan as follows:

Option 1 – Increase deductible by \$50 per individual and the OOP limit by \$100

Option 2 – Increase deductible by \$150 per individual and the OOP limit by \$300

Option 3 – Increase deductible by \$500 per individual and the OOP by \$1,000

DRAFT-Summary of Responses to Proposed Plan Design Change

For all of these options, this proposal includes limiting the OOP limit to no more than 3 per family, reflecting the limit currently in place for the deductible.

Table 2: Comparison of current and proposed options for deductible and OOP limits

	Current	Option 1	Option 2	Option 3
Deductible Individual	\$150	\$200	\$300	\$650
Deductible Family (up to 3x individual)	\$450	\$800	\$900	\$1,950
OOP Individual	\$800	\$900	\$1,100	\$1,800
OOP Family	Unlimited	\$2,700	\$3,300	\$5,400
Actuarial Impact ¹	None	-0.5%	-1.6%	-4.6%
Plan Savings ²	None	\$2.9 million	\$9.3 million	\$27.3 million

This change could:

- increase the amount members pay for medical services
- increase member's incentive to use network-providers
- strengthen the health plan's purchasing power with providers
- offset additional value added to the plan through other proposals (e.g. preventive care, removal of lifetime maximum, etc.)

Background:

In 2017, approximately 57,000 (78%) members had \$150 in expenses that applied to their deductible and 22,000 (30%) members met their OOP limits.

Compared to other commercial health plans in the United States, the AlaskaCare defined benefit health plan features deductible and out-of-pocket limits that are significantly lower than the average health plan. While it is difficult to find an exact comparison for the health plan because it is a retiree-only plan and has unique features, a good benchmark is other large employer plans. As reported by the Agency for Healthcare Research and Quality, the average deductible in 2017 for employer-sponsored health plans with over 100 employees was \$1,681 for single and \$3,195 for family, and the average out-of-pocket maximum was \$4,158 for single and \$8,066 for family. These represent sharp increases over 2004 deductibles of \$457 (single) and \$959 (family), and 2004 out of pockets maximums of \$2,095 (single) and \$4,383 (family).³

A 2017 Segal study of state health plans reports that the average PPO plan deductible for state employee health plans was \$483/\$1,100 (single/family) in

¹ Attachment A: Segal Memorandum dated December 10, 2018

² Ibid.

³ Medical Expenditure Panel Survey Insurance Component 2017, https://meps.ahrq.gov/data_files/publications/cb22/cb22.pdf

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2017. Average PPO OOP limits were \$4,092/\$8,409 (single/family). Retiree plan designs generally do not vary much from those for active employees, and many states provide coverage for retired employees within their active employee plan.

Lower cost share provisions have multiple effects on both the members and the health plan. First, they reduce barriers to care for members by ensuring the plan picks up the cost of medical services early on in a member's course of treatment. With the higher cost of health care in Alaska, members may meet their individual deductible in full through a single primary care appointment.⁴ Once they meet their deductible, they are responsible for up to 20% of the cost (subject to recognized charge) while the plan pays 80%. When they reach their OOP limit, the plan pays 100% of the cost in full (subject to recognized charge). This substantially limits members' financial exposure.

Lower cost share provisions as expressed by higher actuarial plan values are associated with higher utilization of medical services. Higher utilization of services in and of itself should not be viewed negatively; the purpose of health insurance is to assist members in affording necessary medical services in the most appropriate setting at the appropriate time. However, utilization of low value services, those which provide little benefit, are not proven to be efficacious, or which could be avoided without any impact to a member's overall health outcome, add cost to the member and the plan without providing substantial benefit.

The concern with lower cost share provisions, such as those in the retiree plan is that it reduces member's sensitivity to price, making them less likely to distinguish between high value and low value services, and less likely to distinguish between provider type, e.g. network or non-network providers.

Most health plans include provisions in their benefit design to promote use of network providers. Network providers are contracted facilities, providers, or provider groups who have agreed to certain reimbursement schedules and other policies. These policies may include credentialing requirements for participating providers, an agreed upon fee schedule, and/or 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

⁴ In 2018, the two most common (established) office visit codes for general practice were 99213 (allowed amount in AK= \$155) and 99214 (allowed amount in AK= \$232).

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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 90th 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.”⁵

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 plans try to incentivize member use of network providers through benefit design, e.g. providing a 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 or OOP limit, they may not be as sensitive to provider type and may have limited incentives to use network providers.

Member impact:

Members impacted by these changes: Approximately 61,000 members, (78%) would experience a change in their OOP costs by any of these options.

This change would increase the financial cost of using health plan services to the majority of members for each of the options under consideration. Regardless of the option selected, a deductible increase would affect all members who would meet the current deductible, whether by having \$150 in expenses in that plan year, or having some expenses from a prior year carried forward to apply towards the next year’s deductible

⁵ Page 15, AlaskaCare Retiree Health Insurance Information Booklet.
<http://doa.alaska.gov/dr/pd/ghlb/retiree/RetireeInsuranceBooklet2018final.pdf>

DRAFT-Summary of Responses to Proposed Plan Design Change

(61,000 members in 2017). However, the option selected would have different impacts. The larger the change in deductible and OOP limits, the smaller number of people that would experience the full impact of the changes. For those who do reach their deductible and OOP limit, the impact per member affected would be more significant under options 2 and 3.

Table 3: Comparison of estimated member impact across options

	Option 1	Option 2	Option 3
Potential Impact on Annual Member OOP	\$150	\$450	\$1,500
Members Experiencing Full Impact*	10,500	8,700	5,100

* Full impact is defined as the full change in deductible and full change in OOP limit.

Members who are not Medicare-eligible: While this change will apply to all members, it is anticipated to impact members who are not Medicare eligible more immediately as:

- 1) Plan costs for services are higher than Medicare's fee schedule in most cases; and
- 2) Members are responsible for those first dollar costs through the deductible and OOP limit.

Members who are Medicare-eligible: This plan change is anticipated to impact Medicare-eligible members as well, however the impact may be reduced as:

- 1) The AlaskaCare plan is secondary to Medicare for most medical services;
- 2) Depending on the Medicare deductible, Medicare may pay a portion of the services applied to the AlaskaCare deductible; and
- 3) Medicare's fee schedule is lower meaning members cost share requirement may be lower in between their deductible and OOP limit than those in the commercial plan.

Actuarial impact:

Neutral / Enhancement / Diminishment

Table 4: Actuarial Impact

Actuarial Impact ⁶	
Current	N/A
Option 1	Decrease of 0.5%
Option 2	Decrease of 1.6%
Option 3	Decrease of 4.6%

⁶ See Attachment A: Segal Memorandum dated December 10, 2018

DRAFT-Summary of Responses to Proposed Plan Design Change

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 will vary depending on the option being considered. All of the options produce additional savings for the plan.

Table 5: Financial savings to the health plan

	Financial Impact ⁷ (\$)
Current	No impact
Option 1	\$2,900,000
Option 2	\$9,300,000
Option 3	\$27,300,000

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.


⁷ See Attachment A: Segal Memorandum dated December 10, 2018

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Provider considerations:

Increasing members cost share 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; December 10, 2018	A	 Segal Ded OPMax Memo 20181210 UPD

Segal Memo



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MEMORANDUM

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

From: Richard Ward, FSA, FCA, MAAA

Date: December 10, 2018

Re: Deductible and Out-of-Pocket Maximum Change – Focus on Actuarial and Financial Impact for the Retiree Plan - **UPDATED**

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:

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

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

A change to the benefits under consideration would replace the current annual individual/family deductible and individual out-of-pocket maximum limit with one of the following options:

	Annual Individual/Family Deductible	Annual Individual Out-of-Pocket Limit
Option 1	\$200 / up to 3x per family	\$900
Option 2	\$300 / up to 3x per family	\$1,100
Option 3	\$650 / up to 3x per family	\$1,800

Actuarial Value

Our analysis determines the impact of increasing the annual individual/family deductible and annual individual out-of-pocket limit would result in the following decreases in actuarial value:

	Change in Actuarial Value
Option 1	-0.5%
Option 2	-1.6%
Option 3	-4.6%

Financial Impact

Based on the current retiree claims projection of \$590,000,000 for 2019, the financial impact would result in the following annual savings to the plan:

	Annual Savings
Option 1	\$2,900,000
Option 2	\$9,300,000
Option 3	\$27,300,000

A change in deductible and out-of-pocket limit would impact most plan members, due to these provisions being rather low. We estimate that about 61,000 members would experience a change in their out-of-pocket costs due to any change in the deductible or out-of-pocket limit. The magnitude of the change, of course, is determined by the dollar amount of the deductible change and out-of-pocket limit.

The larger the change in deductible and OOP limits, the smaller number of people that would experience the full impact of the changes, but for those that do experience the full impact, the changes would be more significant.

	Option 1	Option 2	Option 3
Potential Impact on Annual Member OOP*	\$150	\$450	\$1,500
Members Experiencing Full Impact	10,500	8,700	5,100

* The full impact is the full change in deductible and full change in OOP limit.

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 medical services, 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.

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
Daniel Haar, Segal

Aetna

Enhanced Clinical Review for High-Tech Imaging

Quality health plans & benefits
Healthier living
Financial well-being
Intelligent solutions



Enhanced Clinical Review program



Enhanced Clinical Review – U65 Retiree Plan

- **WHAT**— Lower costs for high tech radiology, certain cardiac and MSK
- **WHY**—To mitigate inappropriate utilization by following evidence-based guidelines of appropriate care
 - Plan Radiology utilization increased **11.5%** w/ MRI & CT Scans up **8%**
 - Plan PMPM is **\$82** vs. Aetna BOB at **\$53**
- **HOW**—Add provider preauthorization of certain radiology and cardiology services, sleep studies, pain mgmt. and MSK.

Network providers only.

- **RESULTS**— Estimated Net Annual Savings:
 - U65 Retiree Plan - TBD
- **REPORTING**-- AetInfo

The Enhanced Clinical Review program: a solution to help you contain health care costs

Critical touch points of care



Represents 11% of Alaska Care medical costs that you can improve

Testing and diagnosis

High-tech radiology

Diagnostic cardiology

Sleep management studies

Treatment

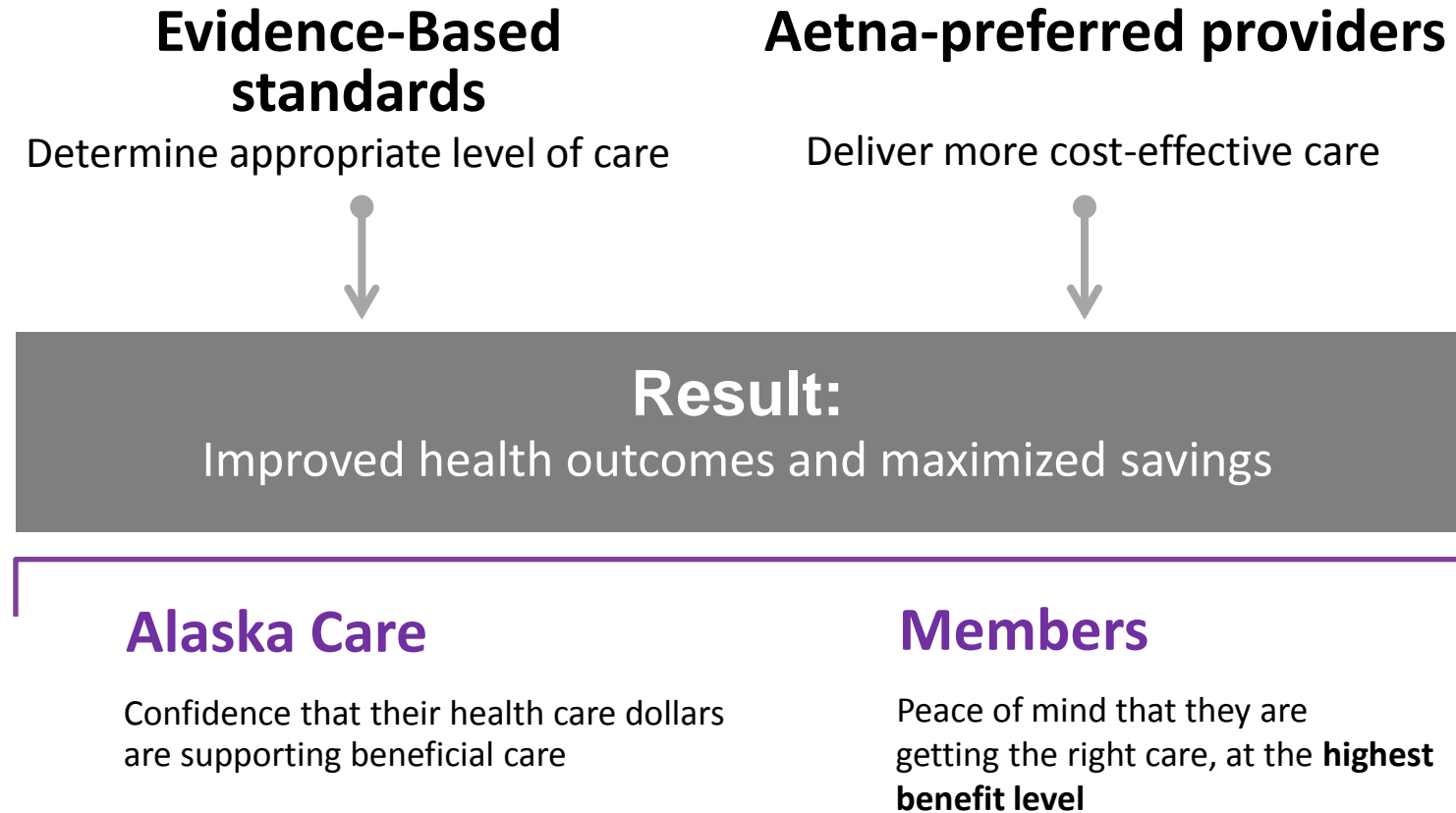
Cardiac rhythm implant
devices

Interventional pain
management*

Hip and Knee replacements
(arthroplasties)*



Appropriate care leads to better outcomes and proven savings, for the State and members



Thank you

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