

## **Retiree Health Plan Advisory Board Meeting Agenda**

**Date:** Wednesday May 08, 2019  
**Time:** 9:00am - 4:00pm  
**Location:** **Anchorage:** Atwood Building, ACC 102  
**Juneau:** State Office Building, 10<sup>th</sup> Floor Conf. Room  
**Teleconference:** 1-650-479-3207 ID#: 809 005 226  
**Committee** Judy Salo (chair), Joelle Hall, Gayle Harbo, Dallas Hargrave, Mauri  
**Members:** Long, Cammy Taylor, and G. Nanette Thompson

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- 9:00 am**      **Call to Order – Judy Salo, Board Chair**
- Roll Call and Introductions
  - Approval of Agenda
  - Approve Previous Meeting Minutes
    - February 6, 2019
  - Ethics Disclosure
- 9:10 am**      **Public Comment**
- 9:30 am**      **Department & Division Update**
- Update from Commissioner’s Office
  - Update from DRB
- 10:00 am**      **Retiree Plan**
- OptumRx Transition
  - EGWP
  - Travel Coordination
  - Chiropractic Group
- 10:30 am**      **Break**
- 10:45 am**      **Retiree Plan Updates Continued**
- 12:00 pm**      **Lunch on Your Own**
- 1:15**          **Modernization Topics**  
DRB Presentations
- Rehabilitative Care
  - Out of Network Reimbursement
  - Teladoc
- 2:45 pm**      **Break**
- 3:00 pm**      **Public Comment**
- 3:20 pm**      **Final Thoughts**
- Next meeting: Wednesday August 7<sup>th</sup>, 2019
  - Set 2020 Meeting Dates
- 3:30 pm**      **Adjourn**

# Retiree Health Plan Advisory Board

## Board Meeting Minutes

Date: Wednesday, February 6, 2019 9:00 a.m. to 4:00 p.m.

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

### Meeting Attendance

| Name of Attendee                                    | Title of Attendee  |         |
|---|--|---------|
| Retiree Health Plan Advisory Board (RHPAB) Members  |  |         |
| Judy Salo   | Chair  | Present |
| Cammy Taylor  | Vice Chair   | Present |
| Joelle Hall   | Member   | Absent  |
| Gayle Harbo   | Member   | Present |
| Dallas Hargrave                                     | Member   | Present |
| Mauri Long  | Member   | Present |
| Nan Thompson  | Member   | Present |
| State of Alaska, Department of Administration Staff |  |         |
| Dave Donley   | Deputy Commissioner, Alaska Department of Administration |         |
| Ajay Desai  | Director, Division of Retirement + Benefits              |         |
| Emily Ricci   | Chief Health Policy Administrator, Retirement + Benefits |         |
| Andrea Mueca  | Health Operations Manager, Retirement + Benefits         |         |
| Betsy Wood  | Deputy Health Official, Retirement + Benefits            |         |
| Steve Ramos   | Vendor Manager, Retirement + Benefits                    |         |
| Teri Rasmussen                                      | Program Coordinator, Retirement + Benefits               |         |
| Vanessa Kitchen                                     | Administrative Assistant, Office of the Commissioner     |         |
| Others Present + Members of the Public              |  |         |
| David Broome  | Aetna  |         |
| Julian Nadolny                                      | OptumRx  |         |
| Stephanie Gaffney                                   | OptumRx  |         |
| Nicole Utley  | OptumRx  |         |
| John Zutter   | SurgeryPlus  |         |
| Richard Ward  | Segal Consulting   |         |
| Noel Cruse  | Segal Consulting   |         |
| Scott Young   | Buck Consulting (contracted support)                     |         |
| Anna Brawley  | Agnew::Beck Consulting (contracted support)              |         |
| Sharon Hoffbeck                                     | Retired Public Employees of Alaska (RPEA)                |         |
| Brad Owens  | Retired Public Employees of Alaska (RPEA)                |         |
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## Meeting Minutes

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

Chair Judy Salo called the meeting to order at 9:05 a.m.

Staff introduced Deputy Commissioner Dave Donley, he planned to listen to the discussion in today's meeting as his schedule allows. He also shared that he is a retired state employee as well, and appreciates the work of this group

Staff also introduced a new member of the team, Teri Rasmussen, who is starting this month as a Program Coordinator based in Juneau. Teri has several years' experience working in the Department of Administration, and previously worked in the health care industry for 15 years. Among other tasks, she will be supporting the Board.

#### Approval of Meeting Agenda

*Materials: Agenda packet for 2/6/19 RHPAB Meeting*

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

#### Ethics Disclosure

Judy Salo requested that Board members state any ethics disclosures in the meeting, rather than completing the ethics form as previously instructed. DRB staff have advised that the form isn't necessary, provided that any needed ethics disclosures are made on the record in the meeting and noted in the minutes.

Dave Donley stated that, prior to becoming Deputy Commissioner, as a state retiree, he filed an appeal regarding a medical claim, and that appeal is pending. He does not anticipate having any involvement in that appeal other than as a plan member but noted this as a disclosure.

#### Approval of Previous Meeting's Minutes

*Materials: Draft minutes from 11/28/18 RHPAB Meeting*

- **Motion** by Gayle Harbo to approve the 11/28/18 minutes as presented. **Second** by Nan Thompson.
  - **Discussion:** Cammy noted that on page 19, change "value" to "of value" to clarify meaning.
  - **Result:** No objection to approval of minutes as corrected. Minutes are approved.

### Item 2. Public Comment

Before beginning public comment, the Board established who was present in Anchorage and Juneau, on the phone or online, and who intended to provide public comments. Individuals were asked to state their full name for the record, and that if there are several people wishing to provide comment, comments will be limited to 3 minutes per person, at the discretion of the chair. Judy Salo also reminded Board members and members of the public of the following:

- 1) A retiree health benefit member's retirement benefit information is confidential by state law;
- 2) A person's health information is protected by HIPAA;

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

#### Public Comments

- **Brad Owens, RPEA.** Brad welcomed Deputy Commissioner Donley and new board member Nan Thompson to this effort. He commented on page 30 in the agenda packet, regarding the transition update: he thanked DRB for this information, but also asked for a report on items that are not working or have been challenges during the transition, what kinds of problems retirees are experiencing, how many people have experienced these issues, and what steps the State and OptumRx have taken to address these issues. He noted that RPEA has received comments and questions from several members during the transition and has provided these to DRB.
  - Judy Salo requested that DRB staff address this topic in their presentation. Emily Ricci agreed, staff are prepared to give a thorough account of the positives and negatives encountered during the transition.

No further public comments.

### Item 3. Department of Administration Updates

Emily Ricci provided updates:

#### Administration Updates

- The Department of Administration has a new commissioner, Kelly Tshibaka. Emily met with her prior to her appointment and was impressed with her qualifications and leadership and looks forward to her team working with Commissioner Tshibaka.
- Teri Rasmussen will serve as coordinator for the Board as well as other stakeholders. She will take on responsibilities currently held by Betsy and Vanessa in support of the Board.
- Michele Michaud will be intermittently in and out of the office over the coming months for a personal matter: if you would like to contact her, please copy Emily and Andrea on the messages to ensure a prompt response.
- The DRB team has been extremely busy with the pharmacy benefit manager transition and reorganizing the staff office to cover the work. This means they are somewhat behind on their original timeline for the modernization project. They will propose a longer timeline to work on the modernization project, to be discussed later in the morning.

#### Third Party Administrator Procurement Update

- Betsy Wood shared that DRB has received proposals for the TPA medical and dental contract starting January 1, 2020. Staff will convene the first meeting of the proposal evaluation committee (PEC), including Board member Nan Thompson.
- They anticipate completing the initial round of review by the end of February and are currently on target to enter the clarification process with proposers beginning March 1.

### Review of January 17, 2019 Tele Town Hall

- The January 17 town hall was the 6<sup>th</sup> event since August: The Long-Term Care plan was the topic of this event, but retirees were also encouraged to ask questions about the pharmacy benefits transition and any other questions of interest.
- DRB plans to continue holding these events monthly as long as retirees find them informative. So far the feedback has been positive and retirees report that the events give helpful information. At the peak of one event, there have been about 562 people who stay on the phone for 5 minutes or longer. The contractor has commented that the level of engagement has been very high, unusually high for these calls, and shows the level of engagement in the number of people who stay on the phone. This means that retirees are interested in the events and willing to listen to the full call.
- Technical issues: Juneau staff's landline phones have had intermittent problems recently, including dropping calls. This occurred during the February town hall, causing a short interruption in the event. For future meetings, staff will use a cell phone as a backup phone line in case the landline's call drops again during the meeting. They are also working with the contractor to address some members' calls being dropped: so far, the research into these calls shows that it was a problem with the callers' carrier. They will continue to monitor this and hopefully avoid future issues.
- The next Tele Town Hall will be February 21, 2019.

### Board Questions and Discussion

- Judy Salo commented that she attempted to connect to the most recent town hall while in Anchorage and was unable to connect; she spoke with a few others with the same problem.
  - Betsy Wood responded that they are working on allowing streaming online and making it easier to listen in, to minimize technical difficulties.
  - Betsy also noted that there are written summaries online, similar to meeting minutes, available online afterwards, as well as the audio recording posted to DRB's website.
- Cammy Taylor noted that connecting by phone rather than computer may be more successful. She also praised DRB staff for the quality of the information and format of the event, she found it useful and very much appreciates the opportunity.
- Gayle Harbo echoed this sentiment.
- Judy Salo asked DRB staff about the Long-Term Care discussion: were there new issues brought up or items that the Board should be aware of?
  - Emily Ricci shared one new question: how does the plan handle payment for members who spend a period of time away from their assisted living facility, either in the hospital or under other circumstances, and whether they can reserve their space at the facility during this time. [Answer: the plan does not cover days that a person is not residing in the assisted living facility and does not allow payment for reserving one's bed. However, individual facilities may allow for bed reservation.]
  - She also noted that members commented that they would have appreciated an overview of the plan and the available benefits in the beginning of the call, since fewer people are familiar with this benefit, compared to medical, pharmacy and other benefits. Staff have tried not to talk for more than 5 minutes to maximize the time

available for questions, but for this particular topic would change the format in future. They plan to do another call on this topic in a future event.

- Judy Salo responded that she appreciates this idea and agreed providing an overview of the plan would be helpful. She noted that the plan booklets are available, but it is unlikely people read them in detail, especially for this plan.
- Emily Ricci commented that after the modernization project has further along, the next project (lower priority, but still needed) is to review the Long-Term Care plan booklet, which has not been updated since 2002. This is a future project for DRB and the Board.

*The Board took a break at 9:33 a.m. and resumed at 9:45 a.m.*

#### **Item 4. OptumRx Pharmacy Benefit Manager Transition Update**

*Materials: Transition update materials beginning pg. 30 in 2/6/19 meeting agenda packet*

Emily Ricci shared that overall, she believes that the transition process has been successful and generally very smooth, particularly compared to the last major transition in the last 4 years. There have been some issues, but staff and OptumRx have worked to address these as they came up.

Andrea Mueca provided an overview of the transition to date: overall it has been successful and DRB staff and OptumRx have been working closely to address issues as they arise. She noted that there have been several issues that members have encountered with enrollment or existing prescriptions, but they have been tracking them closely, identifying whether it is a common problem or an individual situation. When several members have the same issue, they have been able to diagnose and address the problem.

The most common contact method is through the contact center—OptumRx staff document the issue in writing and provide that summary via e-mail to DRB. A ticket is created, including what the issue is, the timeline of resolving the issue, and when and how it was resolved. Since January 1, 2019, there have been 150 tickets created.

One of the trends that they had not anticipated is that Blue Cross Blue Shield (BCBS), which is a primary plan for several members, has had specific problems coordinating with the enhanced EGWP. Pharmacies are unable to collaborate among BCBS and AlaskaCare plans. OptumRx has been contacting pharmacies individually and educating them how to properly process prescriptions and coordinate benefits, so this has begun to resolve the issue.

Several members also have Medicare Advantage (MA) plans, which cannot coordinate with EGWP. When members want to keep their existing plan, DRB has disenrolled these members from the EGWP to be able to keep their MA plans.

DRB staff have also encountered issues enrolling members through CMS, and unable to fully enroll in EGWP until the process is completed. There are 378 members in the “EGWP Hold Group” to be transitioned within the next month. There is a step in the process that CMS needs to complete before they can be fully enrolled; in the meantime, these members remain in the non-EGWP plan. This plan mirrors the standard plan, and is not the “opt-out” plan.

There have been intermittent problems in the mail order program; OptumRx is calling members individually who initiate a mail order prescription to work with them to complete the process correctly.

Several members have been concerned that the contacts they have received from OptumRx are a scam, attempting to get personal information. DRB staff and OptumRx have sent regular information confirming that these contacts are legitimate, encouraging members to verify the legitimacy of these contacts independently by calling DRB or OptumRx to verify that this is an official contact.

DRB staff and OptumRx staff have daily 1- to 2-hour calls to review all current tickets, troubleshoot issues, and identify improvements such as new or updated FAQs, information to post online, and other strategies to minimize impacts on members. OptumRx underscored the value of the collaboration and responsiveness of DRB staff and how that partnership has made the process smoother.

Emily Ricci added that the team has created a “triage team” to discuss communications, having plans in place to address issues quickly as they arise, and what inputs and outputs are necessary: what information and questions they anticipate receiving (inputs), and what communications they need to provide (outputs). They prepared detailed information for call center staff to be able to answer questions, identify clear processes for addressing issues, etc. This model has been effective and helped the team work efficiently, and they anticipate using this model in the future.

High income retirees may be subject to the IRMAA, the monthly premium surcharge for those enrolled in EGWP and whose income is above the thresholds set by Social Security. There are approximately 1,100 members who have signed up to date, and members work directly with PayFlex to ensure that their account is set up and monthly reimbursement is arranged. The process is completed manually, with staff completing each step to get the accounts set up.

- Gayle Harbo shared that she has not yet received the paperwork from PayFlex to set up her IRMAA account after submitting the request. She asked whether she should follow up.
  - Andrea Mueca will follow up directly with Gayle about this issue.
- Cammy Taylor thanked staff for the information about the trending issues. She asked how many one-off or isolated issues they have encountered, and how they are handling these issues?
  - Andrea Mueca shared that their typical process is to create a ticket, work on the issue directly with OptumRx, and research the origin of the issue and how to resolve it. In some cases, this involves working with Aetna to determine how the situation was handled in the past. Typically, if there is an issue with an individual claim, the team works with the pharmacy to minimize impacts to the member. They also get specific guidance on what if anything the member needs to do to resolve the issue. Additionally, the team has been working with physicians proactively to initiate any prior authorizations for prescriptions that have not been completed yet.
  - Emily Ricci added that they continue to get contacts from members, typically after members encounter an issue when they use their new benefits for the first time, so this will likely continue throughout the year. This has helped DRB and OptumRx troubleshoot issues in coding, for example, as members alert them to a problem. She acknowledged it is challenging to carry out a large transition like this, and staff and OptumRx are still in a learning curve and establishing a solid working relationship.
- Cammy Taylor shared that a member recently received a shingles vaccine, and the pharmacy did not submit this claim. The member submitted this directly but received a different reimbursement level than they would have received if the pharmacy had submitted the claim. Is DRB staff aware of this, and have they addressed it?

- Andrea Mueca shared that she is not aware of an issue to date with the shingles vaccine but noted that they have been working through some pharmacy billing issues and coding issues. If members believe they have been charged incorrectly for their prescription, they should contact the Division so that staff can look into their specific case.
- Steve Ramos commented that one issue they have encountered in the past is a pharmacy not having access to the plan information, due to a technical issue or other problem, and therefore the member is charged the retail price for that prescription, rather than the contract price under the plan. These need to be addressed as one-offs, as they are individual claims issues with the pharmacy.
- Judy Salo commented: she believes the transition has been going well overall, and members also need to take action to ensure the transition is completed, such as submitting their new ID card to their pharmacy. This will continue to occur as people utilize their benefits this year. She thanked DRB for the overview.
- Mauri Long shared that she recently filled an ongoing prescription with the new benefits. She shared that the pharmacy was able to contact OptumRx and pull her plan and coverage information directly. She was impressed with the level of service and the ease of changing over her plan information, and complimented OptumRx on their service.
  - Emily Ricci noted that she has been impressed with OptumRx's ongoing engagement with pharmacies, particularly independent pharmacies in Alaska who have historically not participated in the AlaskaCare network. These ongoing communications and relationship building with pharmacies has been productive and allows DRB and OptumRx to share information about the plan and help pharmacies understand the benefits and processes.

## EGWP Update

Stephanie Gaffney shared highlights from their transition report:

- The new pharmacies in Alaska were added to the network and could be utilized by members prior to the January 1, 2019 transition.
- Over 41,000 members have been enrolled in the enhanced EGWP. After addressing a variety of administrative issues with enrollment for individual members, almost everyone has been successfully enrolled who was identified as eligible. Those still in the enrollment process are included in the non-EGWP standard plan until the enrollment is complete.
- To date, approximately 23,000 members have utilized EGWP benefits, and in January 2019 there were 82,000 paid claims. Most of the pharmacy claims have been covered by Medicare Part D, with the wrap covering the remaining claims. The summary presentation includes statistics on generic prescription dispensing rate (81%; generic prescriptions represent a cost-savings to the plan and member) and percentage of claims filled at retail (84%). There are similar statistics for non EGWP members regarding generics and location of dispensing.
- Cammy Taylor asked about specialty prescriptions, and whether the mail order program still has a \$0 co-pay?
  - Emily Ricci responded that specialty prescriptions filled through BrivoRx are \$0. If filled at Costco, through Diplomat or another service, they are subject to co-pays.
- Stephanie also reported on the statistics of customer service calls.



- In January 2019 the concierge service received 13,270 calls and were able to resolve almost every call. Calls were answered quickly (within 13 seconds on average) and were able to resolve most calls in approximately 12 minutes. The goal is not to end the call as quickly as possible, but to resolve the call and provide the necessary information.
- The most common topics were, in order of frequency:
  - Mail order prescriptions: how to sign up or make changes to their account
  - Claims processing
  - Benefits and coverage, what is or isn't covered under the plan
  - Member materials, concerns or questions about the communications members received in the mail
  - Eligibility, confirming whether a member can still utilize benefits.
- Julian Nadolny shared an overview of the EGWP as a program, including the types of federal subsidies (page 31 in the packet). There are 5 subsidies:
  - Direct subsidy to the plan, as a per member per month payment
  - Low income premium subsidy (LIPS)
  - Low income cost sharing subsidy (LICS)
  - Medicare Part D coverage gap discounts, paid by manufacturers as discounts on drug prices, even though there is not a coverage gap in the enhanced EGWP
  - Catastrophic reinsurance, which provides federal 80% coverage of pharmacy costs if a member reaches their out of pocket maximum under Medicare Part D.
- Together, these subsidies represented approximately \$2.8 million in federal subsidies for claims paid in January as well as monthly subsidies to the State. Some payments are made quarterly or annually, so revenue will change somewhat from month to month.
- Judy Salo asked for clarification: the subsidies and other revenue presented for January 2019 were not available to the State prior to implementing EGWP, correct?
  - Julian Nadolny confirmed that these are all new subsidies related to EGWP.
  - Emily Ricci added that DRB staff are also pleased with the strong performance of these subsidies so far.
  - Judy commented that she congratulates the State on securing these subsidies to improve the health of the plan, and that this illustrates that the effort and due diligence associated with implementing the EGWP has paid off.

Richard Ward presented a summary of the Retiree Drug Subsidy (RDS) and EGWP subsidy programs and relative impacts. He noted that it is not possible to project future subsidies from the RDS program to the Other Postemployment Benefits (OPEB) liability, but it is possible to project future subsidies under EGWP.

He also reported that the initial estimate of overall savings to the state health plan was anticipated to be approximately \$20 million net savings per year when compared with the RDS program; this includes higher subsidies as well as accounting for additional administrative fees associated with administering the EGWP. Their revised estimate of total net savings to the health plan have been revised upward based on a variety of factors including a change to the base subsidy in the EGWP program, higher levels of subsidy under other programs, and number of participants in IRMAA resulting in higher total reimbursement. Overall, the current estimate is that the EGWP subsidies, as a whole, represent \$30 million annual savings compared with the RDS program.

- Judy Salo asked Segal to provide another update to the Board at the August 2019 meeting with the first six months performance of the program (January – June 2019).
  - Richard Ward confirmed they can provide information up to June 30 at that meeting.

Scott Young with Buck Consulting shared an overview of the illustrative example of potential impacts of the implementation of the enhanced EGWP they prepared with updated estimates of projected savings to the health plan. Buck analyzed Segal’s initial 2017 estimate and updated 2019 estimate of net savings to the plan and prepared an illustrative example of what the reduction of the unfunded liability could have been if EGWP had been implemented in 2017.

There is a two-year delay between when something is reflected in the valuation and when that gets reflected in the contribution rates, so the savings to the state assistance contribution rates associated with EGWP won’t begin to materialize until FY 2021.

Scott clarified that the state assistance contributions are determined beyond the already-set contribution rates for other employers that contribute to the plans, such as local governments and school districts. This means that other employers will not see a change in their own contribution rates; the savings will flow to the State in the form of lower assistance rates to make up the gap. He also noted that the JRS contribution is not impacted, as this is all directly to the pension fund.

The estimated higher savings to the plan due to EGWP subsidies are projected to generate a total of \$58 million per year (primarily in PERS, at \$50.9 million) in state assistance contributions. He explained that the present value of the plan, which represents the total estimated cost over time to meet the obligations of the plan to its members (pension and health benefits), includes the unfunded liability which is the gap between the current value of the plan and the rate of contribution, compared with the estimated total cost of these benefits. He noted that currently, there is a \$7.7 billion unfunded liability for PERS, and \$2.7 billion unfunded liability for TRS. For both PERS and TRS, the estimated savings due to implementing EGWP would achieve an approximately 10% reduction in those liabilities. Together, the total reduction in the liability over time has been revised upward and would reduce the liability by approximately \$1 billion in total.

Ajay Desai commented that the initial estimate was a \$750 million in savings due to implementing EGWP; the revised estimate shows savings of over \$1 billion—he underscored that this is good news!

- Judy Salo commented that the Alaska Retirement Management Board (ARMB) will be happy to see this information as well.
- Gayle Harbo noted that the next ARMB meeting is in April 2019, and this information will be shared at this time. She anticipates that this will be favorably received.

## **Item 5. Modernization Process Outline**

*Materials: Communications plan draft and timeline in 2/6/19 meeting agenda packet*

Betsy Wood shared an overview of the materials to review: the goal in today’s meeting is to discuss a feasible timeline and robust communications plan for moving forward with the modernization project, to ensure that DRB and the Board can maximize stakeholder input and engagement on the proposals throughout, as well as maintaining a realistic timeline to ensure that DRB and the Board can do

adequate due diligence and research about each proposal, and thoroughly engage with plan members about proposed changes and how and when they will be implemented.

### Proposed Timeline

Betsy shared the three options for timelines for the project and implementation of changes:

1. Timeline A, showing completion of the project by end of year 2019 and first implementation on January 1, 2020. DRB staff noted that this is an aggressive timeline and is likely not realistic to conduct sufficient engagement with stakeholders to achieve this goal.
  2. Timeline B, showing completion of the project in summer 2020, with first implementation on July 1, 2020.
  3. Timeline C, showing completion of the project by end of year 2020, with first implementation on January 1, 2021.
- Cammy Taylor commented that the Board and DRB staff should also discuss the number and specific list of proposals to be considered, as this will also drive the timeline to some degree. She thanked DRB for preparing the timeline options and presenting them clearly.
  - Nan Thompson commented that she also appreciates the timeline and the draft communications plan and feels these are a good start. She asked DRB staff to also share how this may be impacted by DRB's other responsibilities and priorities, so that they are not overloaded with research and other tasks to accomplish this timeline.
    - Betsy stated that this is a high priority for DRB, she acknowledged that they do have other responsibilities, but do not yet know how this might impact the timeline or how much time they need to protect for other tasks. Staff want to work with the board to set a realistic timeline, and these can change as needed.
  - Judy Salo asked staff for clarification about what input they are seeking from the Board at this point? Should the Board recommend one of the timelines, or just provide comments?
    - Betsy shared that they are interested in the discussion about the options, and any guidance from the Board about other factors to consider in making the timeline.
  - Mauri Long commented that there will be times of year that DRB staff have increased responsibility and limited time, such as during legislative session, in January during a new plan year, and other known times of higher activity. She commented that, for example, Timeline B places a burden on staff to complete a draft plan amendment during legislative session in 2020, as presented. She encouraged staff to be realistic about the amount of time they need to complete their portions of this project and noted that the Board is available and will be playing a role in this project, but that most of the work will be completed by staff.
  - Judy Salo commented that Timeline A is not realistic, Timeline C may be realistic, but she is concerned about pushing this project even further if the timeline slips. She recommends Timeline B, with the possibility that the timeline slips as needed during the process, so that there is not undue delay in moving forward.
  - Cammy Taylor commented that it is difficult to determine a timeline without knowing the number and specific list of proposals to be considered, particularly before moving forward and proposing a set of changes with stakeholders. She recommends refining the list of options to be considered, as each will take work to review, and this will inform the scope of the work and how long it would take to review all proposals. She believes Timeline A should be disregarded, it

is not realistic. She encouraged setting the timeline based on the list of proposed changes to the plan, and asked DRB staff to be realistic in the amount of time they need for research.

- Gayle Harbo commented that she also supports not following Timeline A and agreed with concerns about staff capacity during legislative session.
- Dallas Hargrave commented that in reviewing comments from the public, he saw that the highest priority for members is considering preventive and wellness benefits—he encourages focusing on the items that members have requested the most. He also suggested engaging a consultant to help with public outreach, to optimize staff capacity.
- Nan Thompson also noted that in the previous meeting, the group discussed implementation in phases—some items may be more time sensitive, or may have greater positive impact for members, and/or greater savings to the plan. It would be realistic to consider implementation in phases, and prioritizing items accordingly. She noted, for example, changes could be done January 1 in subsequent years if they are not considered time sensitive.
- Cammy Taylor noted that staff will need to conduct actuarial analysis and consideration of how these would be evaluated per *Duncan*: members have requested additional benefits, but these must be considered in the context of actuarial value and balancing additional benefits against possible offsets, to address any possible diminishments. She noted that even if implementation is phased, they need to be considered as a package because they will impact each other in the context of *Duncan* analysis (meaning, whether they are considered an enhancement or diminishment of benefits). Staff and the Board will need to discuss all the proposals as a package to understand the cumulative impacts to the plan value; for example, some additional benefits may be implemented first, followed by implementation of offsets in future years, to provide adequate time for member outreach and education.
- Cammy Taylor directed the group to the list of proposals to be considered: she noted that some benefits are identified as additional benefits to the plan (actuarial value); some proposals will have no actuarial impact, but represent financial savings to the plan; and the remaining items are options for potential offsets to the plan to allow for these enhancements. She asked staff to identify any additional items to add to the list; other items members have asked for that are not on this list; and what if any items are priorities from perspective of staff.
  - Emily Ricci responded that one of the priorities for staff is implementing enhanced travel benefits (#2), as discussed with the modernization committee previously; she noted there are two options being considered for that benefit.  
She also identified the high-value pharmacy network (#5) would be a benefit to the member, based on their preliminary review of this item.  
Additionally, she noted that adding wellness benefits is also a potential benefit to members and should be considered.
- Mauri Long asked whether the Board will be discussing the member satisfaction survey in this meeting? She noted that the lowest degree of satisfaction was with the dental plan, and the only item on the list for discussion is about dental implants. She noted that dental implants have significantly changed in recent years, and that clinically there is a relationship between medical and dental issues, such as Alzheimer's and related dementia and gingivitis and other oral health issues, and that there is more overlap between these two benefits. She encouraged more discussion about the dental benefits, particularly as they relate to medical benefits.
  - The survey will be discussed in today's meeting, later this afternoon.

- Cammy Taylor noted that the dental plan (Dental, Vision and Audio plan) is a separate fund than that of the medical plan, so they cannot be changed together. She asked staff to comment on whether this is feasible?
- Emily Ricci commented that the DVA plan is indeed separate; all the proposals being considered are to the medical plan only. She noted that there have also been comments about the benefits in the audio plan, as well as interest in the Long-Term Care plan, and these could be reviewed in future. They are different because they are fully funded by member premiums, so they cannot be rolled into the medical plan. However, she believes it would be possible to discuss what dental health benefits should be addressed in the medical plan, specifically dental implants; some dental services are covered in the medical plan in some circumstances.
- Judy Salo and Mauri Long noted that there is growing evidence of the relationships between dental health, audio health and overall health, so this is worth considering.
- Richard Ward commented that it is helpful to look holistically at the benefits when considering impacts of the plan, including actuarial impacts and impacts to the health trust. He suggests working with staff to determine how best to research this.
- Mauri Long shared some of the emerging clinical evidence related to impacts of audio and hearing on sleep, on heart function, and the other inter-related impacts on health of these various body systems. She emphasized that the impacts of Alzheimer's and related dementia in the retiree population will continue to be significant, and also have cost implications of the plan as well as the health and well-being of members. She understands that there are many other issues to consider but encouraged including this in the analysis as it has major impacts for members' care as well as the administration and fiscal health of the plan.
- Judy Salo asked the group to return to the timeline, and which timeline is appropriate: how much time will be needed to address all the proposed changes?
  - Betsy Wood confirmed that this timeline can be refined based on staff's estimate of how much time is needed to work through the proposals. She also noted that there will be different levels of urgency for different proposals, particularly those that would have positive impact on members.
- Cammy Taylor suggested staff should advise the Board how much time is needed for staff to complete initial analysis of all of the items on the list, some of which have been researched and others have not. She requested staff determine a realistic deadline for having all proposals prepared for discussion. She noted that the modernization committee can plan to meet in March and April to continue discussing the proposals.
- Mauri Long noted that she would like to see a full list of proposals prepared by the Board's August 2019 meeting, so that they can all be available.
  - Emily Ricci noted that with Teri Rasmussen now on board, the team will have some additional capacity to complete their work. However, DRB also anticipates an extensive clarification period with the selected bidder over the next three months to finalize the contract with the new TPA of the medical and dental plans.
  - Betsy noted that the modernization committee would benefit from having adequate time for discussion on each proposal. Given the timeline of legislative session and the clarification period, she suggested instead that the modernization committee schedule

a 2- or 3-day work session together in late spring to focus on the proposals and allow ample time for discussion. Would the modernization committee be open to a more focused effort in a work session?

- Judy Salo suggested that it may be worth scheduling a work session in person, prior to the May or August meeting, to take advantage of meeting in person.
- Emily Ricci noted that the in-person meeting can change, that should not drive the overall timeline.
- Cammy Taylor commented that she supports a work session as proposed, but also noted that there is a two-step process: first, an initial review of the proposal and analysis, giving time to ask and identify questions for further research. Second, a more in-depth review and discussion of the proposal after those questions have been answered, which could be done in the in-depth work session.
- Dallas Hargrave reminded the group that the meetings of board members are subject to the Open Meetings Act, so there needs to be time for public notice and scheduling. The group agreed; this discussion is about a modernization committee meeting, which is a committee of the Board and is publicly noticed like the quarterly meetings.

DRB staff will coordinate with the committee chair and members to schedule meetings to do initial review of the proposals and schedule a work session.

#### Communications Plan and Outreach Opportunities

Betsy Wood presented the draft communications plan: the intent of this plan is to identify how members will be engaged and informed, and at what points in the process, with the broad goals of improving the health plan in ways that benefit members as well as the plan itself. She encouraged feedback on this draft, identification of other groups to engage, and any other comments.

- Judy Salo commented that she believes this is a good framework, and that it provides a good level of detail that can be expanded later. She noted that some of these communications are already happening, such as the Tele Town Halls, and this has encouraged members to engage with each other, the Board and DRB staff about what changes they would like to see in the plan. She suggested that there should be more engagement with the constituent groups at their regular meetings or other avenues, such as their own newsletters. She recognized that DRB staff have already begun improving relations and communications in this area and encouraged this to continue throughout the project.
- Gayle Harbo shared that the Tele Town Halls seem to be a very effective means of engagement, and easy to measure member engagement. It is difficult to know how many people read the newsletters, for example.
- Betsy Wood directed the group's attention to the list of contact points, including avenues for DRB to proactively communicate as well as other entities who can provide information about the modernization project if questions arise. Are there any key contacts missing from the list? The group did not have any specific suggestions of additional contacts.
- Nan Thompson recalled an online tool created in recent years where a person could engage with balancing the state budget and understand the implications of adding or subtracting items from the budget. She encouraged researching who made this tool, how much it cost, whether it is feasible to create a similar tool.

- Judy Salo asked staff whether the polling question on the Tele Town Halls continue to get good response from attendees on the call?
  - Emily Ricci responded that yes, callers are responsive on those polls. She noted that staff plan to focus at least one Tele Town Hall event on the modernization project, when the package of proposals is completed and out for review.
  - Judy also suggested using online polls on DRB’s website to ask members for feedback.
  - Emily Ricci agreed this would be useful. She noted the poll will need to be designed to not allow a person to submit repeated responses to “stack” the results, but this would be a great way to gather feedback from people at their convenience.

Staff concluded by noting that the timeline and the communications strategy are both works in progress, and they encourage feedback and suggestions from the Board and the public on how to improve and build on this work.

*The Board took a lunch break at 12:00 p.m., and returned to the meeting at 1:15 p.m.*

## **Item 6. Review Modernization Topic Analyses**

*Materials: Modernization Table and related materials in 2/6/19 meeting agenda packet*

Judy Salo called the meeting to order at 1:15. She invited staff to present the table of proposed modernization topics (page 42 in the packet).

### [Retiree Health Plan Modernization Topics Table](#)

Emily Ricci directed the Board to the table on page 42 and asked for feedback on the table as well as ideas for additional items to include.

- Mauri Long commented that she would like to see dental implants added to the list, and suggested item #16 could be changed or removed. She would like to see exploration of inclusion of dental implants under the medical plan, given the information she shared this morning about the connections between oral health and overall health.
  - Emily Ricci commented that it would be helpful to look at both proposals, excluding dental implants in the medical plan due to periodontal disease, as well as including dental implants in the medical plan for any reason.
  - Steve Ramos commented that currently, the medical and dental plan do not coordinate, so the issues Aetna and Moda have experienced have to do with this lack of coordination and confusion about which plan should cover the service. Additionally, the medical plan requires pre-authorization, while the dental plan does not. He also noted that there was a court case recently that found that coverage of a dental implant due to periodontal disease is “a disease” and therefore should be covered under the medical plan. Currently, dental implants are covered under the medical plan for other reasons, such as due to loss of teeth in an accident. He also noted that the coverage for implants is better for members under the medical plan. There are certain claims that are considered medical in nature and can be covered in that plan, and other claims that are dental in nature and covered under that plan—but there is some overlap. Generally, where there is overlap, such as surgeries and dental implants, the medical plan can cover some claims that are dental in nature.

- Cammy Taylor commented that this administrative issue of overlapping coverage already exists today, as it relates to implants as a result of an accident or other injury. She also noted that separating the Third-Party Administrators of the medical and dental plans was a decision of Department of Administration and is an administrative issue rather than a plan benefits issue. She suggests that the issue of which plan covers which service should not be part of the modernization project, as it is an administrative issue due to the Department's decisions regarding TPAs and could be addressed by the Department.
- Mauri Long commented that there are other overlap issues, such as certain eye procedures, and she agrees with Cammy's comments that this should not be considered an amendment to the plan under this project.
  - Emily Ricci acknowledged that these are administrative issues but noted that administrative issues should be discussed because of the impacts and implications for members, staff administering the plan, and providers. She gave the example of EGWP, previously DRB had determined that there were too many administrative issues to proceed with this, but those were resolved. She agreed that the network overlap issue is a problem that needs to be addressed and educating members about which plan covers which services.
  - Cammy Taylor noted that this will continue to be an issue related to accident or injury and which plan covers the plan, so she believes it should be addressed, either under the modernization project or separately.
  - Ajay Desai noted that the medical plan, particularly related to an accident or injury, the medical plan is considered the primary plan. Unlike the dental and audio plans, which are specific to those body parts, but not considered primary in the case of an injury.
- Mauri Long also commented that there are also implications for which plan covers the service because of differing networks—a provider may be in the medical network but not the dental network, or vice versa. She is concerned about the negative impacts on the patient navigating this issue, and would like to see it addressed, and is aware of an example where the patient was approved for a service but only at out of network prices, since the provider is a dentist.
  - Steve Ramos noted that when this situation arises, even if the plans cannot coordinate directly, because it is not a medical claim it would not result a denial of a medical claim but would be handled by the other plan (in this case, dental). He also noted that there is no network steerage in the medical plan. There are several codes that are considered medical that relate to dental implants, such as general anesthesia.
  - Cammy Taylor asked for clarification about which providers are considered medical: she shared that in Anchorage, several dentist surgeons are MDs, but other types of dental providers who are not necessarily covered under the medical plan are also conducting these implants. Does the plan deny or otherwise evaluate these claims differently if they are a dentist?
    - Steve Ramos commented that he has not seen a correlation between which provider conducts the service, and the outcome or cost or coverage of the service. He noted that the procedure may require additional specialty procedures, depending on how advanced the deterioration of the area is and how long the tooth has been gone, so it depends on the individual case.



- Judy Salo suggested that the group table this discussion of the details now, but that this topic should be addressed, both the administrative issues and the implications for plan coverage. She proposed changing the word “exclude” in the proposal and to have the Board further discuss this at a future time. She requested that staff find alternative language and to do further research on the scope of issues related to this topic.
  - Emily Ricci agreed, and suggested changing to “include” or “expand coverage of dental implants under the medical plan” as a working title.

Emily Ricci directed the group to #7, looking at out of network reimbursement (generally known as “steerage”) for providers as a priority item and potential offset. She noted that in several conversations with specialty providers and speaking with Aetna representatives, there is currently a negative incentive for specialty providers to participate: because the plan reimburses at the 90<sup>th</sup> percentile of billed charges, specialty providers do not have a financial incentive to join the network. Changing this would require significant engagement with members and protections against balance billing for charges out of network. She also noted that DRB is exploring the feasibility of reimbursement as a percentage of Medicare rates, which has already been implemented in the active employee plan (for Anchorage and reimbursement outside Alaska) and in other public plans such as the University of Alaska. The greater challenge is addressing communities that do not have a network provider or otherwise have less access to specialty care, where there would be less incentive to participate in the network. She reiterated that these changes (steerage to network providers and a change to reimbursement rates out of network) would need to be thoroughly vetted but have potential for achieving significant savings that can be redirected to new benefits. The plan would also have to account for members in areas with limited provider options, who may have little to no choice of provider in their region and for whom network steerage would not work for local care.

- Mauri Long asked for clarification about the percentage of Medicare rates policy?
  - Emily Ricci stated that as of January 1, 2017, the rate is 185% of Medicare for hospitals and ambulatory surgical centers, within Anchorage and out of state. The new reimbursement rate was also implemented for imaging centers, but they did not see as much of an impact. This change, combined with similar changes in other health trust plans as well as steerage toward the services at Alaska Regional in network, has had a positive impact and has increased other specialists’ participation in the network, which as she stated earlier is a significant barrier to addressing Alaska’s high rates.
  - Mauri asked what impacts this has had, such as the ambulatory surgical centers?
    - Emily responded that DRB had anticipated potentially a large number of balance billing issues for members, but so far this has not been the case, and providers are simply absorbing the difference in charges instead. She believes this has had a positive impact on the cost of the plan, and they have seen significant savings in the active employee plan.
- Cammy Taylor asked what rate the University implemented recently?
  - Emily Ricci commented that initially the University set rates at 125%, but has since revised that upwards. (She did not have the specific rate available in the meeting). She noted that it appears that 185% is a common rate. She noted that for primary care, there may not be a significant decrease in the rate by adopting this rate structure; it may actually be an increase for some providers. For specialty care, this may be a

reduction, but she noted that some specialty providers in Alaska are currently billing at 400% to 700% of Medicare rates for their services, this is where there is most potential for rates to be adjusted.

- Richard Ward added that the 185% rate was chosen to represent generally what charges are today for facility services; the change to Anchorage and out of state reimbursement rates alone has reduced total claim spend on the active employee plan by 3.5% so far. He recommends considering what the current level of billed charges is for services, across different provider types, and looking at a percentage of Medicare rate that is not too high or too low in that context, to set an appropriate rate. Richard also noted that this is a national trend in health plans, to set rates at a percentage of Medicare. He shared the example of Montana's health plan, who set a percentage of Medicare rates as a requirement for participation in network, and if a facility did not accept that rate, they would not be in network. He cautioned that this was an aggressive approach and that he is not necessarily recommending this for the retiree plan but providing it as an example. He also noted that North Carolina's health plan is also looking at this option, as well as their strategy to publish whether facilities accepted the network rate or not, with the implication that out of network facilities might balance bill members.
- Judy Salo commented that the Board would like to see more information on this item.
- Mauri Long shared that she does not understand the incentive from the provider's perspective—they can either enter the network and forgo additional billing or collect additional billing out of network through a high reimbursement rate and potentially balance bill the members.
  - Richard Ward commented that there is a public and community relations aspect for providers, and what level of reimbursement is acceptable for providers—making the rate too low could be financially disruptive, but if a provider does not accept a moderate rate for financial reasons, this is difficult to justify.
- Cammy Taylor noted that in the November Board meeting, the CEO of Bartlett Hospital made public comments, including that their hospital's margin last year was 1.1%. She is concerned about negative financial impacts on smaller hospitals and particularly rural hospitals, particularly given the large economic contribution of this plan to the state's health care system.
  - Emily Ricci agreed that this is certainly a consideration, but also pointed out that it is the responsibility of the plan to reimburse at appropriate rates that maximize value to members; there cannot simply be higher reimbursements for the benefit of hospitals. She is aware of many facilities' financial vulnerability, but noted that there are other factors, and this is not sufficient rationale to not make changes to the plan that could benefit members and the plan. She believes there are other options that do not threaten hospitals' solvency and can still present savings to the plan, and that this should be discussed further to find a solution that works for everyone.
  - Richard Ward returned to the example of Montana and pointed out that hospitals had similar concerns; ultimately, choosing an appropriate rate of reimbursement was very important for finding middle ground.
- Judy Salo acknowledged the concerns that hospitals, other providers and retirees will have, including concerns about steerage and having to participate in the network, and that thorough

analysis will be needed if this proposal moves forward. She requests that this be discussed further at the modernization committee.

Emily Ricci also noted that another item not currently on the list is use of telehealth services through Teladoc. This was implemented recently in the active employee plan, and allows members to access a provider remotely, including prescribing medications for a routine illness, for example. She noted that each service is \$45, with options for the member to share the cost at some level.

- Dallas Hargrave shared that he has personal experience with this service, he utilized it when his child was sick during a weekend, when they could not see their regular provider
- Judy Salo asked where Teladoc is based?
  - Emily Ricci responded that staff was not aware of their headquarters location, they are a national company.
  - Betsy Wood shared that Teladoc is also helpful for accessing specialty care when one is not available locally, such as a dermatology specialist, which is not available in Juneau. She shared that in this example, the service is more expensive but allows using video conferences and submission of photos to help with diagnosis. It would be a great option for people in rural areas or where there aren't specialists.
  - Emily Ricci commented that also added to the active employee plan was an option for caretakers to access a provider on behalf of their patient; the service is not covered in the active plan, and the member is responsible for the \$45 charge, but allows the caregiver to access a patient's provider.
- Deputy Commissioner Dave Donley noted that #6 references preventive benefits and noted that some of these services are likely to either break even or save money over time. He requested actuarial analysis of what potential savings could accrue to the plan, such as vaccinations for children.
  - Mauri Long noted that in a previous modernization committee meeting, this was discussed as an option, including identifying which services would be covered by tying these to the list of current U.S. Preventive Task Force recommended services.
  - Emily Ricci added that there are many reasons to cover these benefits: it improves population health and well-being, it is "the right thing to do," and it may produce future savings. However, it is very difficult to measure these savings and consider the counterfactual costs if they are not covered, so that alone would not be sufficient rationale or basis for analysis. The literature so far has been mixed on whether these services return a clear and consistent financial benefit, although anecdotally this makes sense. There may be more evidence over time as more studies are done.
  - Richard Ward noted that in actuarial terms, it would be very difficult to account for long-term savings or potential savings to the plan for covering these services and would not be feasible to anticipate savings in the first year of the change. In the short term, he would expect to see an increase in use of those services over the first year or more, but over time this would level out as people routinely access the benefits as needed. He noted, for example, increased cancer screenings would not necessarily prevent cancer in the first year but would allow for early identification of cancer in future years, with potentially savings at that point. Additionally, it is difficult to effectively model over the long term the avoided costs of early detection.

Judy Salo returned the group to discussing process and suggested that the Board determine whether this list of options is complete, and that it would be helpful to organize the list in a different way such that they are prioritized for next steps. She suggested that the group identify which proposals should be discussed in the next modernization committee meetings, and the list re-arranged accordingly to reflect which will be addressed first.

Proposed order of topics, in terms of timing and level of priority to address: the group discussed the proposals that have not already had analysis completed by staff and presented to the committee in previous meetings. Below is the tentative schedule for discussion at the modernization committee.

- First modernization committee meeting: Items #7 (out of network reimbursement), #4 (enhanced clinical review), and #6 (wellness / preventive benefits) should be addressed first. Teladoc (new item) will be added to this list.
  - These could be the topics of the first modernization committee meeting.
- Second meeting: Items #13 (3-tier pharmacy network benefits), #14 (exclude over the counter drugs) and item #17 (medically necessary treatment for gender dysphoria) should also be addressed. Emily noted that #17 is a regular topic of members' comments and questions.
- Third meeting: #5, #8, #16, potentially #11 and #12 are related, and DRB staff need to reach out to rehabilitative services providers. Items #5, #12 and #15 need additional outreach and discussion by staff before the analysis can be prepared.
- Mauri Long asked whether there is a wellness program in the active employee plan?
  - Yes, there is not a gym membership reimbursement per se, but there are other features in this program for employees.
  - Mauri also asked for clarification about the tax implications for gym memberships?
    - Betsy Wood responded that it is not possible to provide a reimbursement through an HRA for a gym membership, without this being a taxable benefit. There are other options for implementing a similar benefit, that would not have the same tax implications.
- Cammy Taylor asked whether there needs to be revisiting of item #2 (network steerage), given subsequent discussions about other considered changes?
  - Emily Ricci noted that further analysis will be warranted to consider the changes under consideration may interact.

The group determined that the modernization committee will proceed with review of the topics outlined in the above meeting schedule. The general process will be to hold meetings to have a first discussion and review of the staff analysis, as they have been doing with the proposals already covered, and that following these meetings they will hold a 2-3 day work session to talk about the package as a whole, discuss what if anything to remove, and address additional questions that arise. This means all proposals will be discussed at least twice, with an initial round of questions and analysis, and an opportunity for staff to conduct follow-up research to answer those questions or consider other options.

#### Topic: Enhanced Travel Benefits Proposals

Emily Ricci directed the group to page 43 in the packet and noted that the revised proposal has all revisions shown in Track Changes, to make clear what changed. Staff will continue to maintain this documentation of revisions.

Emily reviewed the proposal and noted that in addition to the proposal for enhanced travel benefits through SurgeryPlus (item 1a), item 1b would cover procedures plus travel if that procedure is significantly less expensive or not available locally; would cover travel of a companion in some situations; and would allow for adding a health concierge service for coordinating procedures not offered by SurgeryPlus, which would be accessible for Medicare and non-Medicare members.

The financial impact to the plan is estimated to be \$2.8 million in savings annually.

- Cammy Taylor asked for clarification for Medicare eligible members: she understands that the cost differential will not be a factor for Medicare rates, and is likely may be more expensive when considering cost of travel. Would this service still be available for Medicare eligible members to coordinate travel, even if there is not a cost savings? She believes there could be a benefit for Medicare eligible members to travel if the service is not available locally, and/or they are interested in choosing services from another facility, and want help finding a qualified provider as well as coordinating travel as with other services.
  - Emily Ricci noted that Medicare rates are higher in Alaska, so in some circumstances it may still be cheaper, but will depend on the procedure and cost of travel as it compares to getting that service locally. She reminded the group this also includes in-state travel.
  - John Zutter with Surgery Plus confirmed that yes, his company could provide this service including for procedures their providers do not offer, including research of qualified providers and making travel arrangements.
  - Cammy shared that she believes this would be very helpful for members, even if they are not reimbursed for all of those services, to get assistance finding a provider and coordinating travel.
- Judy Salo asked if the primary difference between the two (1a and 1b) is the concierge service? She commented that 1b is a much more attractive option. What are the downsides?
  - Emily Ricci clarified that the additional benefit in 1b is to utilize the concierge service not just for travel, but also for researching qualified providers for that service, both in the member's local area as well as other locations.

Emily noted that the primary downside, in terms of impacts to the plan, is that option 1b would be more costly because it would provide additional benefits, and therefore needs to be considered in the context of the other proposals and evaluated with a *Duncan* analysis. However, as discussed above, there are many reasons why this would benefit members, including researching providers to help the member make an informed decision, and not simply incentivizing people to seek care out of state.
  - John Zutter noted that in the second option, the services would allow for coordination and research of local providers and would not simply "help people leave" but also "help people stay."
- Dallas Hargrave asked how many retirees are living outside Alaska? The proposals would not only impact Alaska residents, but also those living outside the state who would be seeking care outside the state, and potentially traveling to another state.
  - Approximately 40% of retirees live outside of Alaska.
  - Emily Ricci added that this could also be relevant for in-state travel, including going from a small community to a larger hub for care.

- Judy summarized that the consensus of the board is that option 1b is a preferable option to consider moving forward.
  - Emily Ricci noted that there are some outstanding financial items to address, but she believes the rest of the analysis is complete and once those updates are made, this piece would complete.
- Nan Thompson asked staff whether there is any update or change to employees' experience with this benefit, that would be relevant?
  - Emily Ricci shared that overall the response has been highly positive from employees, they appreciated the level of service of SurgeryPlus staff, and so far it has been working well. She also noted that they have not quite yet met their return on investment (ROI) after making this change but are close and anticipate continuing to have ongoing financial benefits for this change.
- Dallas Hargrave asked for clarification, if this has no actuarial impact to the plan, can it simply be done outside the modernization project?
  - Emily Ricci noted that option 1a could be done now, and could be implemented sooner, as early as this year. However, option 1b does have an actuarial impact, so it would still need to be considered in the context of the plan. She will follow up with others in the Department and with Department of Law about implications of moving 1a forward in 2019, potentially.
- Mauri Long commented that she sees this benefit, including 1a, as a new benefit: she advises caution and providing more time for the active employee plan to implement this benefit so the State can learn from that experience. She is concerned about the perspective of providers, and what providers' incentives for participating would be. She would like to see the State proceed cautiously with adding this to the retiree plan, even if it does not have an actuarial value to implement part of this, and would like to see a more in-depth, longer evaluation of the benefits in the active employee plan.
  - Emily Ricci suggested that staff request claims information about what SurgeryPlus pays providers; payments are bundled and would need to be analyzed further. She noted that providers' feedback is that the system is easier to use and to understand, because the payment rates are clear. Staff would need to compare network rates for similar services, compared to the bundled rate.
  - Mauri asked staff, what is a reasonable study period to understand impacts from the employee plan?
    - Emily Ricci suggested that this benefit has been in place for 6 months.
    - Richard Ward added that this new benefit does take time for members to get comfortable using and otherwise understanding typical costs. He suggested that at least 6 months is sufficient, or 9 months or a year. There are non-financial benefits for this service as well. He believes that the assumptions they produced are conservative enough to not be overly optimistic.
  - Mauri also asked whether the savings projected based on number of procedures per year is on track, given estimates from the employee plan?
    - Richard Ward commented that in 5 months, 19 cases have been completed, and there are others actively in the queue at this time that will be completed after being scheduled and conducted. He noted that in the active employee

plan, there is approximately 1/10<sup>th</sup> of the total number of members in the active plan than in the retiree plan. The estimate of retiree utilization is approximately 400 services per year.

- Judy Salo pointed out that in the report from Aetna, currently there were approximately 400 travel encounters over 3 quarters in the retiree plan, so retiree travel is already happening.
- Emily Ricci asked John Zutter to confirm the performance guarantee in their contract over the next 2-3 years?
  - John confirmed that yes, there is a guarantee in the plan related to payment of administrative fees and return on investment.
- Dallas Hargrave commented that he sees value in this benefit and recognizes that there is additional outreach and discussion with Alaska providers that should occur. He encouraged staff to continue discussion with providers.
  - Betsy Wood shared that the data they have collected from the active employee plan shows that many people inquire about a surgery but don't necessarily follow through with scheduling and getting that procedure done, so members are not using this as a "pipeline" to seek care out of state. It appears that so far, members have found utilizing the service helpful, regardless of what they decide, because they can research options and make an informed decision. Presumably members who do not complete the process have opted to seek care locally or postponed the procedure if it is not urgent.

Judy asked staff to bring analysis to full board, as well as evaluation of how the service is operating for active employees, at the May 2019 meeting, as this will represent about 9 months of data.

#### Topic: Increase Deductible and Out of Pocket Maximum

Emily Ricci shared that this is one of the more straightforward proposals and would be a clear offset to the value of the plan if considered with other added benefits. She directed the group to page 94 in the packet, and noted that based on previous discussion, Option 3 was stricken as it represented too high of a change at one time and would impact members too drastically. Emily also noted that the proposed numbers in each option can be adjusted, they just present different options for discussion.

Richard Ward noted that the numbers can easily be adjusted, but the intent was to show the impact of a small-magnitude change, moderate-magnitude change, and large-magnitude change, the latter of which was removed from discussion.

Option 1 increases individual and family deductibles, as well as adding an out of pocket maximums for families, representing 3 times the individual limit proposed.

- Judy Salo commented that given that most retiree households are 1 or 2 people, so using the maximum rate of 3 people will encompass most households. It would primarily benefit people with more than 3 members, but this is a relatively small group of retirees based on the data.
- Cammy Taylor commented that the plan also has a rule stating that there can be up to \$4,000 of allowable medical expenses per person (total claim value), of which the retiree's out of pocket limit is \$800 (20%). She noted that about 22,000 people meet this limit each year in the plan; option 1 would increase this amount by \$50 and option 2 by \$500 dollars. She also noted that many people are double covered by the plans, and that Medicare eligible retirees are

double covered by Medicare, so it is difficult to accurately calculate how much people with different coverage types would end up paying under this proposal.

- Richard Ward commented that in look at coordinated coverage, their analysis found that a significant portion of people who are Medicare eligible are either going to a non-Medicare provider, or receiving non-Medicare services. There is also a deductible carryover from year to year, which makes analysis more complicated.
- Cammy also asked whether participation in Medicare Part A is a factor, as it relates to hospital expenses?
- Richard confirmed that this factor (participation or not in Part A) does not have a significant impact.
- Cammy also asked for clarification of the 10,500 members identified as impacted?
  - Richard clarified that the 10,500 people identified here would feel the full impact of the out of pocket expenses, because they current meet those maximums. This is compared with 22,000 who currently meet the lower limits. This means that the remainder of those who would not pay the full limit at the new limit, would pay between \$0 and \$150 in additional costs depending on their level of care. Some people do not meet the current limits, and/or would not meet the higher limits if implemented.
- Mauri Long clarified that the salient point is that impacts will be felt differently by different groups (Medicare eligible, double covered, etc.) but overall, the member's impact will be a portion of the total costs to the plan. Those who are not double covered and those who are Medicare eligible may be impacted more.
- Judy Salo commented that this is likely to be an area of significant pushback from members, so it would be helpful to better understand the demographics, including number of double covered individuals as well as those enrolled in Medicare. Additionally, there will be more Medicare eligible members over time in the plan, as the membership ages into this category.
- Cammy Taylor noted that the Board could consider recommending separate changes the deductible and out of pocket limit.

#### Topic: Highlights of 2018 Member Satisfaction Survey

Emily Ricci shared that as part of the contract with Aetna and as a performance guarantee, an independent company conducts an annual survey of AlaskaCare members about customer satisfaction. The respondents are a representative sample of retirees in Alaska and outside Alaska, who are Medicare eligible or other, as well as active employees.

- Mauri Long asked for verification that the sample size presented (714 respondents out of 60,000 members) is a statistically valid sample?
  - Emily Ricci responded that she will verify but believes this is accurate. She noted that the contract requires a statistically valid survey.

Emily reviewed the results briefly: one key finding is that overall, members' satisfaction with services is high (90% or higher), but slightly lower (~88%) for dental services including dental specialists. She also noted that the satisfaction with Aetna's concierge service has improved over time and is much higher than it has been previously. The survey was primarily designed to get feedback on customer service, as this was a significant comment from members in previous years. She further noted that retirees most



commonly cited the following benefits as ones they would like to add to the plan: vaccinations and flu shots are most common among retirees.

Comparing responses from active employees, retirees in Alaska and retirees not in Alaska, generally retirees outside Alaska are happier with benefits. Emily speculated that this is directly related to network participation and availability of providers, which tends to be more robust outside Alaska. The table on page 111 summarizes reasons why people are dissatisfied with their care, with higher dissatisfaction in Alaska than outside.

- Betsy Wood shared that her mother, who lives in another state, has found that having AlaskaCare benefits compares very favorably with other states' retiree benefits. She speculated that retirees living out of state may encounter others with lesser benefits and are able to reflect on their relative value of their benefits.
  - Dallas Hargrave commented that his parents have had the same experience.
  - Judy Salo noted that she has participated in discussions with other states' retirees about their policies and has found consistently that Alaska's benefits are better and have not been negatively impacted like many other states.

Emily Ricci further noted in the survey that network satisfaction was surprisingly high, even among Alaska retirees, and this may reflect availability of network options.

Dental benefits received consistently lower scores in Alaska, which may be due to the limited network and/or dissatisfaction with Moda as the administrator. Emily noted that unlike the medical plan, the State administers the dental plan (via Moda) but it is funded through member premiums. For retirees, this means that any changes or enrichments to the plan would have a direct impact on member premiums and needs to be considered carefully in terms of financial impact to members. While Alaska retirees expressed willingness to pay more to expand their network, those outside Alaska were generally unwilling to pay more. This may reflect a more robust network out of state; people are not as constrained in their choice of provider, as well as lower costs in other states, so they do not have an issue with the coverage they have now.

Emily Ricci directed the group to the table on page 133: retirees (not active employees) were asked which benefit(s) they would like to see added to the plan, if possible. The table lists the top responses.

- Mauri Long asked about the format of the question: was there is a list of options to consider, or was this an open-ended question?
  - Cammy Taylor offered that she had been contacted to respond to this survey this year, it was an open-ended response, the respondent could list as many things as they'd like.

The group reviewed the list and confirmed that most of these topics are being covered under the modernization project or have to do with the other plans (Dental, Vision and Audio as well as Long Term Care plans).

#### **Item 7. Public Comment**

*See Item 2 in the minutes for public comment guidelines.*

No one present in the meeting wished to provide public comment during this time.

## Item 8. Closing Thoughts + Meeting Adjournment

- Cammy Taylor requested that staff address how members would research and understand the proposed rate changes, using a percentage of Medicare rates.
- Gayle Harbo thanked DRB staff and contractors for their hard work!
- Dallas Hargrave reiterated thanks to the team for their work. He also appreciates the work involved with organizing public comments.
- Judy Salo suggested that the August meeting date be extended to two days, potentially starting later morning on the first day, so members can arrive on the morning flight to Juneau. She also asked staff to consider how the scheduled quarterly meeting would be impacted by this change. Could the quarterly meeting be moved to another date, or after the RHPAB meeting, for this time?
  - Emily Ricci also suggested that the in-person could be moved to Anchorage, particularly if there are relatively more board members and staff in Anchorage rather than Juneau. There hasn't been an in-person meeting in Anchorage in recent years, so this is perhaps an option.
  - Judy agreed this can be considered: she would like the whole Board to be involved and stay informed throughout and suggested that an in-person meeting would be very productive.
  - Emily added that staff could also coordinate some in-person meetings in Anchorage with other stakeholder groups, to make best use of staff's time during the trip.
- Judy Salo shared with Deputy Commissioner Donley, who stepped out of the meeting after requesting information about preventive services, that this question was answered and will be documented in the minutes. Dave will follow up with staff to get caught up.
- The next RHPAB quarterly board meeting is scheduled for May 8, 2019.
- Cammy Taylor will follow up with DRB staff to coordinate scheduling of the next modernization committee meeting, so it can be scheduled and noticed.
- **Motion** by Cammy Taylor to adjourn the meeting. **Second** by Nan Thompson.
  - **Discussion:** None.
  - **Result:** No objection to adjournment. The meeting was adjourned at 3:45.

## 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)
- ARMB = Alaska Retirement Management Board
- CMS = Center for Medicare and Medicaid Services
- COB = Coordination of Benefits
- 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 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
- PEC = proposal evaluation committee (part of the procurement process to review vendors' bids)
- 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 (a federal pharmacy subsidy program)
- RFP = Request for Proposals (a term for a procurement solicitation)
- RHPAB = Retiree Health Plan Advisory Board
- TPA = Third Party Administrator

## Retiree Health Plan Advisory Board Public Comment Guideline

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

## Retiree Health Plan Advisory Board Public Comment Guideline

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

# AlaskaCare Retiree Plan

## Pharmacy Program Q1 2019 Highlights

### Non-Med D Retiree Plan

- 8,582 utilizing members
- 72,494 total paid claims
- 56 Avg member age
- 80.4% generic dispensing rate
- 57.2% filled at retail (30 DS)
- 31% filled at retail (90 DS)
- 11.8% filled at mail
- 80.4% generic dispensing rate
- 1,116 specialty claims
- 38.7% Plan Paid is specialty
- \$16,361,041 Total Plan Paid
- \$ 225.69 Avg Plan Paid/Rx
- \$236,748 Total Member Paid
- \$3.27 Avg Member Paid/Rx
- 1.4% Member Cost Share

### EGWP Retiree Plan

- 26,407 utilizing members
- 237,373 total paid claims
- 227,658 Part D paid claims
- 9,751 Enhanced wrap claims
- 73.5 Avg member age
- 81% generic dispensing rate
- 51.8% filled at retail (30 DS)
- 33.1% filled at retail (90 DS)
- 15.1% filled at mail
- 2,115 specialty claims
- 26.9% Plan Paid is specialty
- \$41,199,010 Total Plan Paid
- \$173.56 Avg Plan Paid/Rx
- \$641,206 Total Member Paid
- \$2.70 Avg Member Paid/Rx
- 1.4% Member Cost Share

# AlaskaCare Retiree Plan

## Pharmacy Program Q1 2019 Highlights

### Member Services Q1 2019 Call Stats

**26,330 Calls Received**

**26,194 Handled**

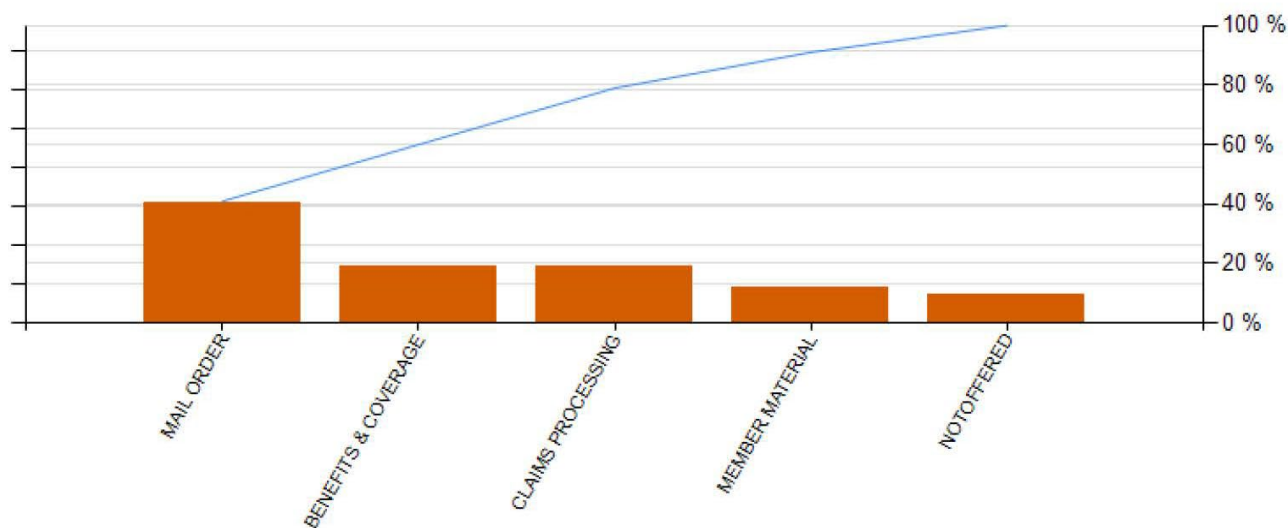
**9 second Avg Speed to Answer**

**0.52% Abandonment Rate**

**11 min 18 sec Avg Handling Time**

**83.5% Service Level**

### Navigator - Top 5 by Call Type



# AlaskaCare Med D Eligible Retirees

## CMS Part D EGWP Subsidies Paid January through April 2019

|          | Direct Subsidy | LIPS        | Prospective Reinsurance |
|----------|----------------|-------------|-------------------------|
| January  | \$90,847.19    | \$16,774.30 | \$1,495,984.00          |
| February | \$85,003.64    | \$17,305.50 | \$1,483,962.70          |
| March    | \$80,902.66    | \$17,471.50 | \$1,479,450.20          |
| April    | \$81,536.51    | \$17,222.50 | \$1,478,006.20          |



# AlaskaCare EGWP Subsidy Projections

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- Certain EGWP subsidies from CMS are not paid on a monthly prospective basis, but rather there is a lag in payment from CMS to AlaskaCare.
  - Coverage Gap Discounts
  - Catastrophic Reinsurance
  - Low-Income Cost Sharing Subsidy (LICS)
- To assist the DRB with financial planning, OptumRx is able to provide month-by-month projections for these EGWP subsidies as the plan year progresses.
- These projections are derived from actual 2019 AlaskaCare EGWP claims/Prescription Drug Event (PDE) data.
- These projections are estimates, and could be subject to change based on certain factors such as claims reprocessing, retroactive eligibility changes, and other timing issues.

# AlaskaCare EGWP Subsidy Projections

## AlaskaCare EGWP Projected Subsidies Based on Accepted PDE

|                  | Paid by CMS Annually                   | Paid by CMS Monthly,<br>Reconciled Annually by<br>CMS | Paid by Pharma Manufacturers<br>Quarterly |
|------------------|--|---|---|
| 2019 - Month     | Low-Income Cost-Sharing Subsidy (LICS) | Catastrophic Reinsurance                              | Coverage Gap Discount Payment             |
| JAN (Q1)         | \$133,259                              | \$41,041  | \$1,124,178                               |
| FEB (Q1)         | \$77,774                               | \$21,870  | \$1,306,886                               |
| MAR (Q1)         | \$81,633                               | \$158,589   | \$1,739,253                               |
| APR (Q2)         |  |   |   |
| MAY (Q2)         |  |   |   |
| JUN (Q2)         |  |   |   |
| JUL (Q3)         |  |   |   |
| AUG (Q3)         |  |   |   |
| SEP (Q3)         |  |   |   |
| OCT (Q4)         |  |   |   |
| NOV (Q4)         |  |   |   |
| DEC (Q4)         |  |   |   |
| <b>YTD Total</b> | <b>\$292,666</b>                       | <b>\$221,500</b>                                      | <b>\$4,170,317</b>                        |

# State of Alaska Overview

## Lifetime Results Summary (Through April 30, 2019)

|                                     | Lifetime                                   |           |
|-------------------------------------|--|-----------|
| Members                             |  | 14,789    |
| First-time Member Calls             | 1.1% <sup>(2)</sup><br>1.3% <sup>(2)</sup> | 161       |
| Cases Opened                        | 68% <sup>(3)</sup><br>67% <sup>(3)</sup>   | 109       |
| Procedures Completed <sup>(1)</sup> | 28% <sup>(4)</sup><br>33% <sup>(4)</sup>   | 31        |
| Procedure Savings                   |  | \$910,698 |
| ROI                                 |  | 6.54x     |

Legend:

SoA

BoB Avg.

Note:

(1)

(2)

(3)

(4)

Procedure savings and ROI are estimates and are subject to change upon completion of invoicing.

Total includes procedures completed as of 4/30/2019 that are pending passes or have not been invoiced by SurgeryPlus yet.

Percent of total members.

Percent of total member first-time calls.

Percent of cases.

# State of Alaska

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CareCentral for Retiree Population

# Executive Summary

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- The State contracted with Employer Direct Healthcare for health travel services in 2018
  - Employer Direct Healthcare is the specialty vendor offering solutions to the State, inclusive of SurgeryPlus and CareCentral
  - SurgeryPlus is a full spectrum surgery concierge product rolled out to the AlaskaCare employee plan members in July of 2018. Initial feedback has been very strong and positive
  - The State is interested to provide the retiree population with travel coordination services through Employer Direct through its CareCentral concierge product
    - Benefits will be available under substantially similar guidelines to current surgical travel benefits, with several benefits to participants
      - Participants would have access to a full service Care Advocate for all surgical coordination activities
      - Travel would be managed and booked by the service
    - Both Pre-65 and Post-65 retirees would have access to the CareCentral services
  - The State and the Retiree Health Plan Advisory Board are evaluating a broader provision of both SurgeryPlus and CareCentral's full scope of services as part of the Modernization process
    - SurgeryPlus – opportunity to broaden eligible events and travel guidelines (e.g. travel companions, per diem, lodging expenses)
    - CareCentral – expansion of health concierge services beyond surgery
      - The State has an Active population pilot program under evaluation

# What is CareCentral

## Full-Concierge Service Creates a Better Member Experience

### 1 ENGAGE + EDUCATE

Our focus is to help ensure patients receive the best treatment paths.

### 2 LOCATE

Identify best-in-class, high-quality providers and/or venues specific to the member's needs.

### 3 ARRANGE + SCHEDULE

Schedule appointments and follow-up visits

Transfer medical records

Manage logistics on case-by-case basis

### 4 COORDINATE TRAVEL

Schedule and book all necessary travel subject to plan guidelines. Can coordinate travel arrangements not eligible for coverage, but the member will need to cover those costs.

### 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 process. We are there to address any concerns a member may have.

# CareCentral Capabilities

| Capabilities   | Pre-Modernization        | In Evaluation for Future |
|--|--------------------------|--------------------------|
| <b><u>Surgical Case Management</u></b>                                     |                          |                          |
| Travel Coordination for Eligible Events <sup>(1)</sup>                     | ✓                        |                          |
| Provider Selection   | ✓                        |                          |
| Concierge Support  | ✓                        |                          |
| <b>Chronic Condition Support</b>   | <input type="checkbox"/> | ✓                        |
| <b><u>Complex Condition Support (e.g. oncology, transplants, etc.)</u></b> |                          |                          |
| Travel Coordination  | <input type="checkbox"/> | ✓                        |
| Provider Selection   | <input type="checkbox"/> | ✓                        |
| Concierge Support  | <input type="checkbox"/> | ✓                        |
| <b>Primary Care Support</b>  | <input type="checkbox"/> | ✓                        |
| <b>Vendor Referrals</b>  | <input type="checkbox"/> | ✓                        |
| <b>Central Call Line Support</b>   | <input type="checkbox"/> | ✓                        |
| <b>Benefits Guidance and Education</b>                                     | <input type="checkbox"/> | ✓                        |

Expect services piloted with the active population as first step

# Benefits and Considerations of Offering this Service to Retirees



## Benefits

- Eligible travel expenses paid in advance
- No reduction in benefits (neutral on value), but improves choice and convenience
- Potential savings with doctor selection, etc. (e.g. steerage, SurgeryPlus network where appropriate, etc.)
- Concierge access
- Already procured and tested positively with employees

## Considerations

- Another solution to educate on which could create confusion for members
- No SurgeryPlus network providers in Alaska



# AlaskaCare | Chiropractic Community

## 1 Overview

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John Lehe, Special Investigator DOA, was asked by the Governor's office to solicit feedback from the chiropractic community. Feedback was gathered and provided to DRB on 02/25/19 from Arctic Chiropractic, Arctic Billing and Consulting, 7<sup>th</sup> Generation Medical Billing LLC, and Adkins Chiropractic. An initial meeting to bring the chiropractic community, health policy team and Aetna together was scheduled on 03/01/19 by DRB. Subsequent meetings have occurred on 03/28/19 and 05/03/19.

## 2 Goals

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**Short Term Goal:** Provider partnership to improve process and service for AlaskaCare members.

**Long Term Goal:** Comprehensive effort to address the rehabilitative care provisions in both the Active and Retiree plans, that meets our fiscal and evidence-based care goals, while removing barriers to billing that the chiropractic community is experiencing.

## 3 Objectives

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- ✓ **Knowledge Sharing:** Close any information gaps identified during this process so that all participants have the same basis of understanding.
- ✓ **Claim Issues:** From the list of claim issues submitted, identify specific actionable items that can be follow up on and addressed.
- ✓ **Process Improvement:** Resolve the immediate issues that can be addressed, then step back and review the overall process to determine if there are areas of change that could be considered to improve the member and the provider experience.

## 4 Action Plan

---

### Knowledge Sharing

- |  |                                   |
|--|-----------------------------------|
| • AlaskaCare Plan Structure              | • Definition of Medical Necessity |
| • The Appeal and Reconsideration Process | • Training on the NaviNet Tool    |
| • Contact Information for DRB and Aetna  | • Aetna Webinars for Providers    |

### Claim Issues

- |   |                                    |
|---|------------------------------------|
| • Visit threshold prior to Predetermination | • Claim Note Process               |
| • Coding Combinations                       | • COB when Medicare Denies Service |

### Process Review and Improvement

- |                                       |   |
|---------------------------------------|---|
| • Review of NCCI edits                | • Review of Claim and Appeal Turn Around      |
| • Review of Rehabilitative Care Spend | • Review of Rehabilitative Care Plan Language |



**aetna<sup>®</sup>**

# Agenda

- **Introductions**
- **Overview of SecureCare**
- **Network Management Process**
- **SecureCare Differentiation**
- **Open Discussion**



# Leadership



Louis M. Andersen

|                                   |  |
|-----------------------------------|--|
| <b>CEO:</b>                       | SecureCare, Inc.                               |
| <b>CEO:</b>                       | Aetna / Coventry Health Care of Nebraska, Inc. |
| <b>President:</b>                 | Health Data Management, Corp.                  |
| <b>COO &amp; CFO:</b>             | Midlands Choice Regional PPO                   |
| <b>Vice President, M &amp; A:</b> | United Health Group, Hartford, CT              |
| <b>Director, Strategy:</b>        | Prudential Health Care, Inc.                   |
| <b>Education:</b>                 | MBA Finance, Columbia University               |



# Medical Directors



Mark Knoll, DC

**Senior Medical Director:** SecureCare, Inc.  
**President & Owner:** Knoll Chiropractic Clinic  
**Associate Doctor:** Shreve Chiropractic Clinic  
**Education:** Logan College of Chiropractic



Erick Alvarez, PT

**Physical Therapy Medical Director:** SecureCare, Inc.  
**Physical Therapy Clinical Reviewer / Telerehabilitation Site Coordinator:** MedRisk, HealthSouth Sports Medicine and Rehabilitation Center  
**Clinical Director/ Industrial Rehab:** Heartland Rehabilitation Services  
**Staff Physical Therapist:** Nebraska Spine Center, Aventura Hospital & Medical Center, B & V Thera-Pro & Associates  
**Education:** Florida International University



# Operations



Ann E. Bruns

**Vice President, Operations:** SecureCare, Inc.

**Provider Contracting:** Aetna / Coventry Health Care

**Marketing & Provider Relations Manager:** Midlands Choice Regional PPO

**Nebraska Group Services:** BCBSNE Independent Broker Services

**Education:** MCC; HIA



# Company Overview

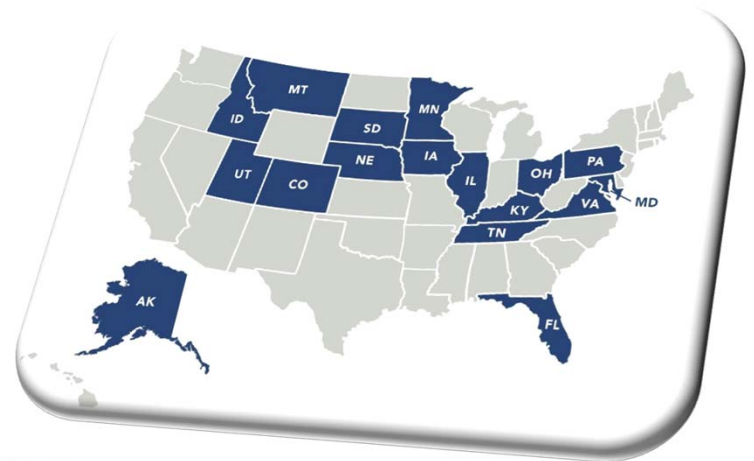
SecureCare, Inc. was founded in 1994 in Omaha, Nebraska.

## Our Mission:

- Deliver the highest standard of network management utilizing fair and efficient management practices
- Improve relationships between musculoskeletal providers and the insurance industry
- Ensure that patient care is delivered in a clinically appropriate and cost-effective manner

## Operational Footprint:

SecureCare operates in 16 states and has strong partnerships with professional state associations.



# Current Payer Partners

## Commercial Health Plans



## Government Programs



SecureCare, Inc. is currently contracted with 15 health plans serving approximately four million members with insurance billings exceeding \$500 million.





# Our Services



- Utilization Management
- Credentialing
- Network Performance Reporting
- Network Development
- Payer & Provider Services
- Contract Management



# Why SecureCare?

- We understand the necessity for payers to control costs and retain a satisfied provider panel.
- We do not charge payer partners any access fees for providing full network management services.
- We provide payer partners certainty around annual spend regardless of the reimbursement model.
- Due to our technology-driven and transparent business model, we deliver results at a fraction of the cost compared to our competition.

**Reimbursement Methodologies: Full Risk/Capitation; Fee for Service; Shared Savings. SecureCare has a very flexible business model.**



# Changing Industry Dynamics

## We eliminate Prospective Medical Necessity Review. Why?

- It is expensive and creates both member and provider dissatisfaction.
- It forces patients to seek care in more expensive settings, which is not consistent with the trend of increasing the utilization of cost-effective, conservative care.

We allow most providers to care for patients without oversight because the network is efficiently and effectively managed by a comprehensive Utilization Management process.



# Utilization Management (UM) Services

Our UM model is customizable to ensure the needs of the payer are met and specifically targets overutilization, fraud, waste, and abuse.

The process begins through retrospective analysis of payer data in order to establish mutually agreeable clinical and network compliance benchmarks for a specified reporting period. These include:

- Services per visit
- Visits per patient
- Allowed dollars per visit
- Allowed dollars per patient

Further data analysis based on the benchmarks identifies potential outliers who are non-compliant. We educate providers on SecureCare UM guidelines and expectations. Each provider has online access to a secure monthly report card to track network compliance.

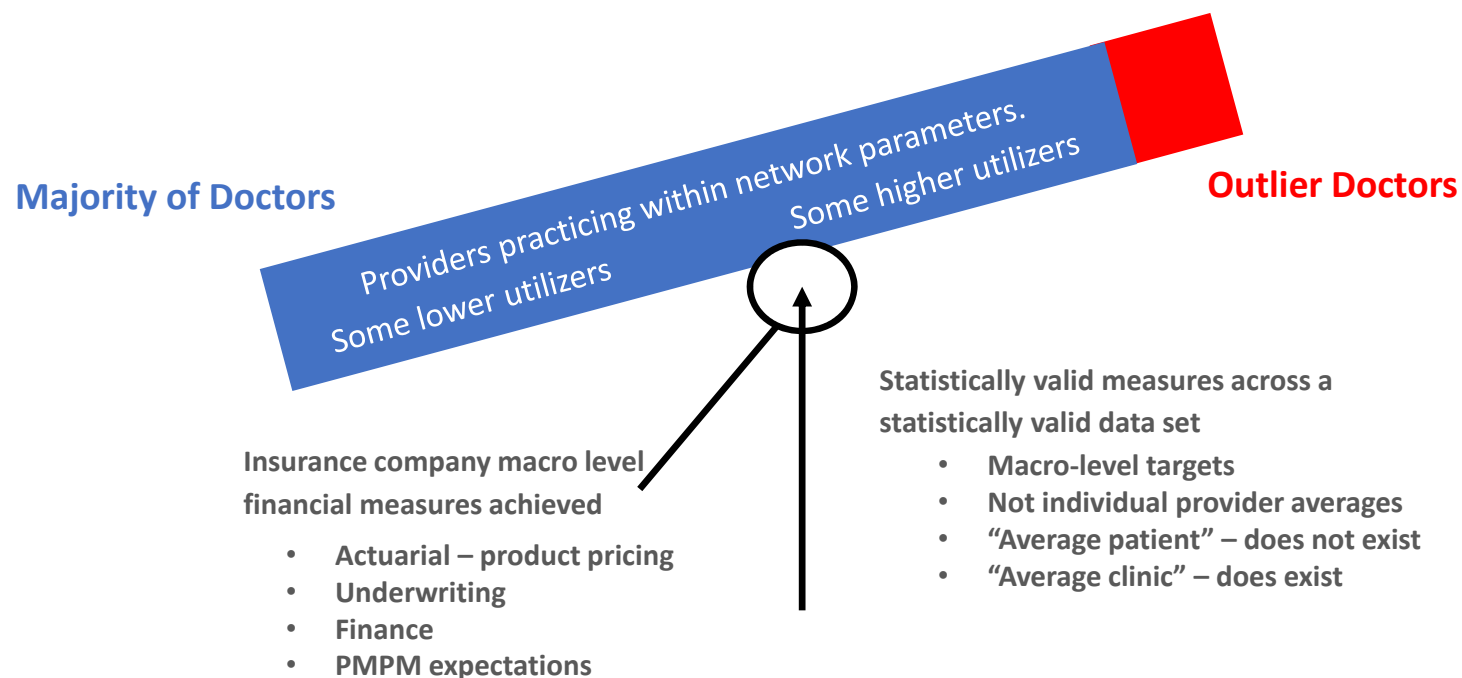


# Utilization Management (UM) Services

- Providers practicing appropriately within established benchmarks of the specified reporting period are allowed to practice without undue interference.
- For outlier providers, we offer a comprehensive evidence-based clinical assistance education program offering coaching and assistance to get them to return to compliance.
- Outliers who are repeatedly non-compliant will be terminated from the network.
- Payers are provided quarterly reports that include provider performance based on established benchmarks, number of credentialed providers, and other pertinent metrics.



# Statistically Valid Network Management



# Credentialing

**SecureCare, Inc. has been URAC accredited in Provider Credentialing since 2012, and became an accredited CVO in 2018. Our credentialing process is simple and electronic.**



Our Quality Management Program is guided by three committees, including:

- Credentialing Committee
- Quality Management Committee
- Clinical Review Committee

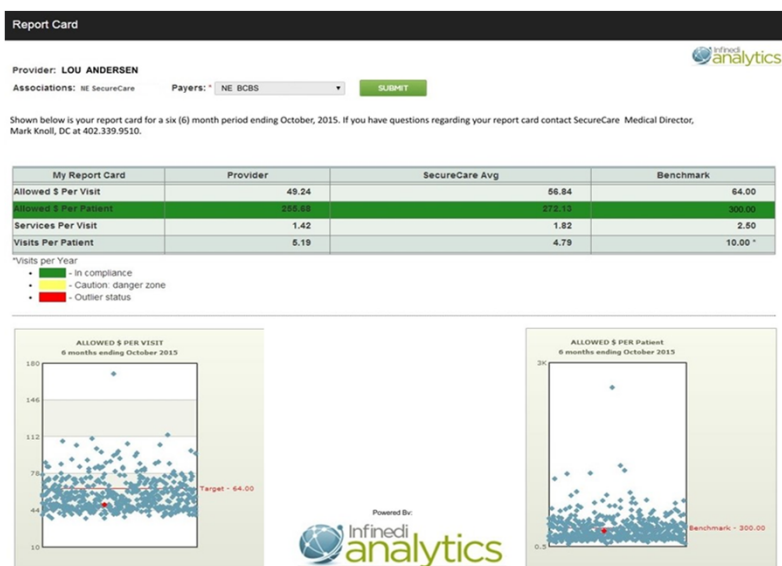
Credentialing performance metrics include:

- Quality of Care
- Complaint Handling
- Credentialing and recredentialing turn-around-time
- Credentialing notices within 10 days of committee determination





# Information Technology



**SecureCare is primarily a paperless company.**

- Verity, a HealthStream® Company (electronic credentialing platform)
- CAQH contracted
- Adobe Sign™ (electronic widgets that include a SecureCare contract, Ownership/Disclosure form, W-9, regulatory compliance form, etc.)
- Evolent Health, Inc. (messenger model platform whereby providers indicate their willingness to either “accept” or “reject” a managed care contract)

## SecureCare Online Portal

- Monthly provider report cards (see example to the left)
- Provider manual (updated electronically as-needed)
- Provider billing

## Company Communications

- Dispute Resolution
- Appeals and Medical Records
- Utilization Management Updates
- Newsletters
- Dedicated emails to reach Payer & Provider Services, Credentialing, & Accounting departments





# Choosing the Right Partner

## SecureCare

- No cost to payer
- Targeted, statistically valid network management
- Embraced by providers and professional state associations
- Efficient and technology-driven
- Claims submitted directly to payer which keeps EOB and other systems in alignment
- Results in increased satisfaction and less administrative oversight



# Choosing the Right Partner

## SecureCare

- Addresses payer business needs by establishing macro-level targets with minimal network disruption
- Predictability in actuarial, finance, product design and underwriting
- Providers paid directly by payer at 100% of the amount allowed by the fee schedule
- SecureCare collects a small fee directly from providers of about 3%
- SecureCare is able to deliver results at a fraction of the cost of competitors' due to our focus on targeted technology
- SecureCare is focused on deploying a new approach to managing musculoskeletal professions, along with improving the relationship between providers and payers



# Connectivity

**SecureCare makes it easy and flexible for Aetna to connect:**

**Contracting Options:**

- Aetna retains direct contracts with their providers; SecureCare requires the providers to sign an administrative contract.
- Aetna terms all direct provider contracts according to the provisions in the contract; SecureCare re-contracts with Aetna's network within a defined period.

**Credentialing Options:**

- Aetna retains all credentialing and recredentialing activities.
- Aetna deems all credentialing and recredentialing responsibilities to SecureCare utilizing an electronic data import tool.

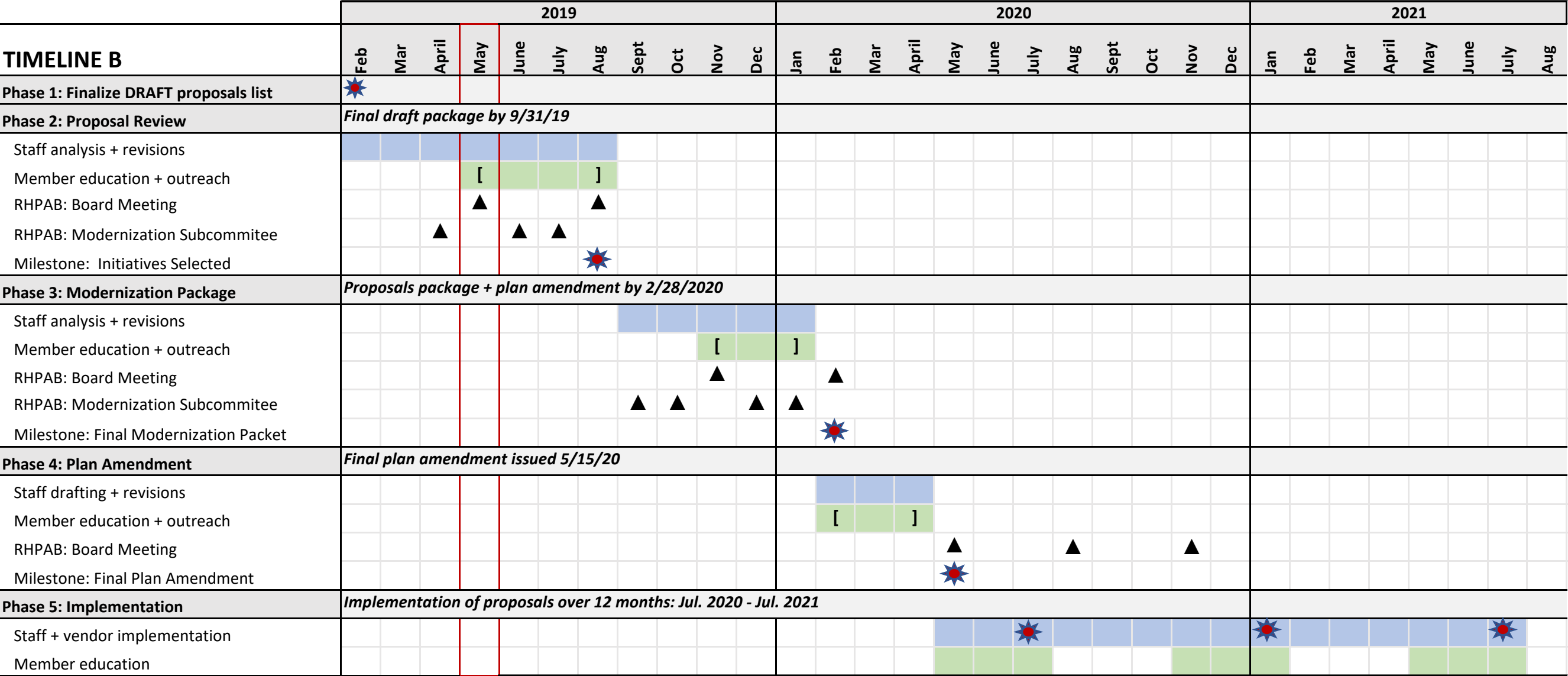


# Questions?



Alaska Retiree Health Plan Modernization Project Timeline

REVIEW DRAFT 5/08/19



Today

LEGEND

Member outreach, education + input

DRB research + analysis

▲

RHPAB meetings

[ ]

Public comment period

★

Milestones

**DRAFT**

**Retiree Health Plan Modernization Topics\***

| #                              | Analysis Begun/Ongoing  | Actuarial Impact | Fiscal Impact                      |
|--------------------------------|---|------------------|------------------------------------|
| 1a.                            | Enhance travel benefits   | +0.00%           | -\$2,800,000/yr                    |
| 1b.                            | Enhance travel benefits, add health concierge   | +0.00%           | -\$2,500,000/yr                    |
| 2.                             | Network steerage: 70% out-of-network and 90% in-network   | +0.14%           | +\$800,000/yr                      |
| 3.                             | Increase deductible and out-of-pocket maximum   | -0.50%<br>-1.60% | -\$2,900,000/yr<br>-\$9,300,000/yr |
| 4.                             | In-network enhanced clinical review of high-tech imaging and testing  | +0.00%           | -\$350,000/yr                      |
| 5.                             | Out-of-network reimbursement as a percentage of Medicare  |                  |                                    |
| 6.                             | Expanded telehealth services  | +0.00%           | -\$250,000/yr                      |
| 7.                             | Expand preventive coverage to add full suite of preventive services   | +0.75%           | +\$5,000,000/yr                    |
| 8.                             | Remove or increase lifetime limit (currently \$2M)  | +0.40%           | +\$2,700,000/yr                    |
| 9.                             | Implement clear service limits for rehabilitative care such as chiropractic, physical therapy, occupational therapy, etc. and expand rehabilitative services to include rolfing, acupuncture, and/or acupressure – <i>public comment proposal</i> |                  |                                    |
| 10.                            | Exclude coverage for drugs with over-the-counter (OTC) equivalents  |                  |                                    |
| 11.                            | Implement high-value pharmacy network with lower copays for chronic meds, medical synchronization, counseling, and packaging options for participating members.   |                  |                                    |
| 12.                            | Add wellness benefits such as gym membership or program like Silver Sneakers – <i>public comment proposal</i>   |                  |                                    |
| <b>Upcoming topics</b>         |   |                  |                                    |
| 13.                            | Clarify coverage of implants related to periodontal disease under the medical plan and/or under the dental plan   |                  |                                    |
| 14.                            | Implement 3-tier pharmacy benefit; change out-of-network pharmacy benefits  |                  |                                    |
| 15.                            | Limit compound coverage to high-quality, narrow network of pharmacies   |                  |                                    |
| 16.                            | Add medically necessary treatment of gender dysphoria including surgery – <i>public comment proposal</i>  |                  |                                    |
| 17.                            | Copayment for primary care  |                  |                                    |
| <b>Plan Housekeeping Items</b> |   |                  |                                    |
| 18.                            | Clarify reimbursement policies for surgical assistants in the plan booklet  |                  |                                    |

\*These are subject to change as the proposals evolve through additional analysis and committee guidance and discussion.

## DRAFT-Summary of Responses to Proposed Plan Design Change

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

**Plans affected:** DB Retiree Plan

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

**Proposed implementation date:** January 1, ~~2019~~2020

**Review Date:** ~~September 28, 2018~~May 8, 2019

Table 1. Plan Design Changes

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

### **Description of proposed change:**

The plan currently covers outpatient rehabilitative care designed to restore and improve bodily functions lost due to injury or illness.<sup>1</sup> This care is considered medically necessary only if significant improvement in body function is occurring and is expected to continue. The plan does not cover maintenance care, that is, care to maintain or prevent deterioration of a chronic condition. The provider must submit clinical records that document a member continues to experience significant improvement. If the records fail to demonstrate significant improvement in accordance with the established clinical criteria, the services are denied as being maintenance or preventive care.

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

The proposed change would increase and clearly define the plan's coverage of rehabilitative care, alleviating confusion amongst members and providers, and would

<sup>1</sup> See 3.3.12 Rehabilitative Care, page 43 of the AlaskaCare Retiree Insurance Information Booklet January 2019. <http://doa.alaska.gov/drb/pdf/ghlb/retiree/DBRetireeInsuranceBooklet-01012019.pdf>

Author: ~~Michele Michaud~~Division of Retirement and Benefits

~~September 26, 2018~~May 8, 2019

## DRAFT-Summary of Responses to Proposed Plan Design Change

change the plan language to allow for maintenance or preventive therapies of chronic conditions.

The proposed change would not set visit limits on rehabilitative and chiropractic care received from an in-network provider, but would set visit limits on rehabilitative and chiropractic care received from an out-of-network provider. If care is received from an out-of-network provider, the individual would be provided:

- up to 45 visits per benefit year for outpatient rehabilitative care, and separate
- up to 20 visits for spinal manipulation chiropractic care.

and 10 visits for acupuncture. The out-of-network provider visit limits would reset at the start of each benefit year.

The proposed change would also provide coverage for:

- up to 10 visits per benefit year for acupuncture regardless of the provider's network status.

The acupuncture visit limits would reset at the start of each benefit year.

The increase in coverage combined with the opportunity to reset the out-of-network provider visit limit with the new benefit year would eliminate the need for visit-triggered medical necessity determinations, and the corresponding appeals if the determination found that the additional services were not medically necessary. This would provide members and their providers with clear guidelines on what the plan covers.

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

*Table 2: Comparison of Current to Proposed Change*

| CURRENT: <del>Page 36-37 2003 Booklet as amended</del>  |   |
|---|---|
| Current<br>(Page <del>36-37</del><br><u>43-44</u> )<br><u>Section</u><br><u>3.3.12</u> of<br><u>2003-2019</u> | <b>Rehabilitative Care</b><br>The Medical Plan covers <b>outpatient</b> rehabilitative care designed to restore and improve bodily functions lost due to injury or illness. <b>This care is considered medically necessary only if significant improvement in body function is occurring and is expected to continue.</b> [Emphasis added.] Care (excluding |

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## DRAFT-Summary of Responses to Proposed Plan Design Change

|  |   |
|--|---|
| <b>Retiree Insurance Information Booklet, <del>as amended</del></b>                          | <p>speech therapy) aimed at slowing deterioration of body functions caused by neurological disease is also covered.</p> <p>Rehabilitative care includes:</p> <ul style="list-style-type: none"><li>• Physical therapy and occupational therapy.</li><li>• Speech therapy if existing speech function (the ability to express thoughts, speak words, and form sentences) has been lost and the speech therapy is expected to restore the level of speech the individual had attained before the onset of the disease or injury.</li><li>• Rehabilitative counseling or other help needed to return the patient to activities of daily living but excluding maintenance care or educational, vocational, or social adjustment services.</li></ul> <p>Rehabilitative care must be part of a formal written program of services consistent with your condition. Your physician or therapist must submit a statement to the claims administrator outlining the goals of therapy, type of program, and frequency and duration of therapy.</p> |
| <b><u>Current (Page 72-77) Section 5.1 of 2019 Retiree Insurance Information Booklet</u></b> | <p><u>The following is a list of services and supplies that are not covered and are not included when determining benefits:</u></p> <p><u>...</u></p> <ul style="list-style-type: none"><li>• <u>Acupuncture therapy, unless performed by a physician as a form of anesthesia in connection with surgery covered under the plan.</u></li></ul>  |
| <b>Proposed</b>  | <p><b>Neurological Disease (no change)</b></p> <p>Cognitive therapy associated with physical rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function or slow deterioration of body functions caused by neurological disease.</p> <p><b>Rehabilitative Care</b></p> <p><del>Outpatient benefits are limited to 45 visits per benefit year.</del></p> <p>Covered expenses include charges made by a physician on an outpatient basis for physical therapy, occupational therapy and speech therapy. Inpatient services will be covered under inpatient hospital and skilled nursing facility benefits.</p> <p>Massage therapy is covered when it is prescribed by a licensed physician, chiropractor or naturopath and performed under the physician's, chiropractor's</p>   |

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## DRAFT-Summary of Responses to Proposed Plan Design Change

or naturopath's supervision, and is considered part of the overall treatment plan.

Outpatient rehabilitative care received from an out-of-network provider is limited to 45 visits per benefit year.

### **Chiropractic**

~~Covered expenses are limited to 20 visits per benefit year.~~

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

Covered chiropractic care received from an out-of-network provider is limited to 20 visits per benefit year.

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

### **Acupuncture**

Covered expenses are limited to 10 visits per benefit year.

Covered expenses include charges made by a licensed physician or acupuncturist, practicing within the scope of his or her license, on an outpatient basis.

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

### **Member Impact:**

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

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## DRAFT-Summary of Responses to Proposed Plan Design Change

removing the exclusion of maintenance coverage. However, to be eligible for coverage under the plan, services received must still fit the criteria outlined in Section 3.3 Covered Medical Expenses of the Retiree Insurance Information Booklet.

This proposed benefit will ~~result in gains for some~~expand coverage for members seeking care from a network provider, particularly those who have chronic conditions or who are making only slight improvement, who would receive additional services beyond what is covered today. However, while the proposed limits are sufficient to achieve a rehabilitated state in many patients, members who utilize an out-of-network provider and have not reached~~reach their~~ maximum therapeutic benefit within a single benefit year must either seek additional care from an in-network provider, or may be denied care that might otherwise have been found to be medically necessary for the interim period before the visit limits are reset.

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

**Actuarial Impact** – \*Please note that the changes in this version of the proposal necessitate an update to the actuarial impact.

Neutral / Enhancement (Diminishment)

Table 3: Actuarial Impact

|   | Actuarial Impact             | Notes  |
|---|------------------------------|--|
| Current   | N/A                          | N/A  |
| 10 Visit Limit on Acupuncture treatment                     | 0.010% increase <sup>2</sup> |  |
| <del>10 Visit Limit on Rolf therapy treatment</del>         | <del>0.005% increase</del>   |  |
| 20 Visit Limit on <u>out-of-network</u> Spinal Manipulation | 0.02% reduction <sup>3</sup> | <u>Limiting the visit cap to out-of-network care necessitates an update to the actuarial analysis.</u> |

<sup>2</sup> Therapy Benefits – Focus on Actuarial and Financial Impacts for the Retiree Plan, Segal Consulting Memo updated September 26, 2018.

<sup>3</sup> ~~Chiropractic Benefits – Focus on Actuarial and Financial Impacts for the Retiree Plan, Segal Consulting Memo updated September 25, 2018.~~

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## DRAFT-Summary of Responses to Proposed Plan Design Change

45 Visit Limit on out-of-network other Rehabilitative Services (OT/PT/ST)

0.05% reduction<sup>4</sup>

Limiting the visit cap to out-of-network care necessitates an update to the actuarial analysis.

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

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

### **DRB operational impacts:**

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

**Financial Impact to the plan:** ~~\*~~**Please note that the changes in this version of the proposal necessitate an update to the actuarial impact.**

*Table 4, Estimated Savings*

| Proposed Change | Estimated Annual Financial Impact <sup>5</sup> |
|-----------------|--|
|-----------------|--|

<sup>4</sup> ~~Therapy Benefits – Focus on Actuarial and Financial Impacts for the Retiree Plan, Segal Consulting Memo updated September 26, 2018.~~

<sup>5</sup> ~~Therapy Benefits – Focus on Actuarial and Financial Impacts for the Retiree Plan, Segal Consulting Memo updated September 26, 2018 and Chiropractic Benefits – Focus on Actuarial and Financial Impacts for the Retiree Plan, Segal Consulting Memo updated September 25, 2018.~~

Author: ~~Michele Michaud~~Division of Retirement and Benefits

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## DRAFT-Summary of Responses to Proposed Plan Design Change

|  |   |
|--|---|
| 10 visit-limit for acupuncture             | \$ 65,000 in additional cost            |
| <del>10 visit limit for rolf therapy</del> | <del>\$ 30,000 in additional cost</del> |
| 20 visit-limit for chiropractic            | <del>\$120,000 in savings</del>         |
| 45 visit-limit for rehabilitative care     | <del>\$300,000 in savings</del>         |

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

### **Clinical considerations:**

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

Although there are always exceptions for acute cases, we believe the out-of-network provider visit limits are sufficiently generous, when combined with the annual reset and the opportunity to seek additional care from an in-network provider, to provide little to no negative impact to clinical considerations for most patients.

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

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

### **Provider considerations:**

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

### **Documents attached include:**

| <u>Document Name</u> | <u>Page numbers</u> | <u>Notes</u> |
|----------------------|---------------------|--------------|
|----------------------|---------------------|--------------|

Author: ~~Michele Michaud~~ Division of Retirement and Benefits

~~September 26, 2018~~ May 8, 2019

## DRAFT-Summary of Responses to Proposed Plan Design Change

|   |   |  |
|---|---|--|
| Summary of public comment   |   |  |
| <b><i>Chiropractic Benefits – Focus on Actuarial and Financial Impacts for the Retiree Plan, Segal Consulting Memo dated July 25, 2018.</i></b>   | <br>Chiropractic Benefits<br>7.25.18   |  |
| <b><i>Therapy Benefits – Focus on Actuarial and Financial Impacts for the Retiree Plan, Segal Consulting Memo dated July 24, 2018.</i></b>        | <br>Therapy Benefits<br>7.25.18  |  |
| <b><i>Chiro Benefits – Focus on Actuarial and Financial Impacts for the Retiree Plan, Segal Consulting Memo updated September 25, 2018.</i></b>   | <br>Chiropractic Benefits<br>9.25.18   |  |
| <b><i>Therapy Benefits – Focus on Actuarial and Financial Impacts for the Retiree Plan, Segal Consulting Memo updated September 26, 2018.</i></b> | <br>Therapy Benefits<br>9.26.18  |  |
| HealthMatters Article – May 2018  | <i>Outpatient Rehabilitative Care Coverage in the AlaskaCare Retiree Health Plan</i><br><a href="http://doa.alaska.gov/drb/newsletters/healthmatters/issue/30.html">http://doa.alaska.gov/drb/newsletters/healthmatters/issue/30.html</a> |  |
| HealthMatters Article – May 2017  | <i>Outpatient Rehabilitative Care Coverage in the AlaskaCare Retiree Health Plan</i><br><a href="http://doa.alaska.gov/drb/newsletters/healthmatters/issue/28.html">http://doa.alaska.gov/drb/newsletters/healthmatters/issue/28.html</a> |  |
| HealthMatters Article – April 2015  | <i>Outpatient Rehabilitative Care Coverage in the AlaskaCare Retiree Health Plan</i><br><a href="http://doa.alaska.gov/drb/newsletters/healthmatters/issue/24.html">http://doa.alaska.gov/drb/newsletters/healthmatters/issue/24.html</a> |  |

## DRAFT-Summary of Responses to Proposed Plan Design Change

**Proposed change:** Determine non-network recognized charge as a percentage of Medicare's fee schedule

**Plans affected:** DB Retiree Plan

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

**Proposed implementation date:** TBD

**Review Date:** April 23 ~~March 20~~, 2019

Table 1: Plan Design Changes

|                | Member | Actuarial | DRB<br>Ops | Financial | Clinical | TPA | Provider |
|----------------|--------|-----------|------------|-----------|----------|-----|----------|
| No impact      |        | ?         |            |           | X        |     |          |
| Minimal impact |        |           | X          |           |          |     |          |
| High impact    | X      |           |            | ?         |          | X   | ?        |
| Need Info      |        |           |            |           |          |     |          |

Note: we've indicated our estimate for the impacts using question marks in areas where the information is still under development.

### **Description of proposed change:**

Amend the plan booklet to change the methodology for determining the recognized charge for non-Medicare covered professional and facility services obtained from a non-network provider from the 90<sup>th</sup> percentile of the prevailing charge rate for the geographic area to a percentage of Medicare's fee schedule.

### **Background:**

The AlaskaCare retiree health plan utilizes a network of providers contracted with the plan's Third-Party Administrator (TPA) to access discounted prices and to ensure certain credentialing requirements, quality metrics, and billing practices. Not only do facilities, groups, or professionals in the network agree to certain reimbursement schedules and other policies, but they also agree not to seek the difference between the agreed-upon fee schedule and their billed charges from the member - a practice commonly referred to as balance billing. Balance bills can be quite substantial and are solely the responsibility of the member; the health plan does not cover balance bills. However, Medicare-accepting providers (regardless of network participation status) cannot balance bill Medicare-covered members.



## DRAFT-Summary of Responses to Proposed Plan Design Change

When non-Medicare covered members use a non-network provider, the plan must determine what to pay for services because without a network agreement the provider and the payer have not agreed to a fee schedule or reimbursement rates. In the AlaskaCare retiree health plan, the determination of what the plan pays for non-network services is called the recognized charge, and “is the lesser of:

- what the provider bills or submits for that services or supply; or
- the 90<sup>th</sup> percentile of the prevailing charge rate for the geographic area where the service is furnished as determined by Aetna in accordance with Aetna reimbursement policies.”<sup>1</sup>

Currently, the AlaskaCare retiree health plan determines the prevailing charge rates by relying on benchmarks produced by FAIR Health, a company that aggregates claims data and produces cost benchmark information based on what providers in a specific geographic area bill for services. This information is updated biannually.

Because the recognized charge is determined based on the amount providers bill, over time the FAIR Health benchmark increases based on billing amounts resulting in both higher prevailing charge rates and greater compensation for non-network providers. In some cases, the recognized charge may be 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. When non-network providers and facilities are reimbursed at substantially higher rates than in-network providers, it can be difficult to incentivize providers and facilities to join the network.

The AlaskaCare Defined Benefit retiree health insurance plan does not differentiate between care received by network providers and non-network providers when paying benefits. Once a member reaches their deductible (\$150/individual, limited to no more than \$750/family) the plan pays a flat 80% coinsurance, regardless of provider status, until the member reaches their annual out-of-pocket limit (\$800/individual). Even though members’ cost share does not vary based on the network status of their provider, if members receive services from a non-network provider they may be subject to balance billing and the plan may end up paying more than it would if the same services had been received from network provider.

The proposed change would alter the methodology used to determine payments to non-network providers by changing from the 90<sup>th</sup> percentile of the prevailing

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<sup>1</sup> Page 16, AlaskaCare Retiree Health Insurance Information Booklet.  
<http://doa.alaska.gov/dr/pd/ghlb/retiree/DBRetireeInsuranceBooklet-01012019.pdf>



## DRAFT-Summary of Responses to Proposed Plan Design Change

charge rate for the geographic area to a percentage of the Medicare Physician Fee Schedule. The Centers for Medicare & Medicaid Services (CMS) sets the Medicare fee schedule through a formula that takes into account the time and intensity associated with providing a service, the expense of maintaining a practice, the cost of malpractice insurance, and the cost of practicing medicine in different geographic areas.<sup>2</sup>

Analysis is underway to represent current non-network reimbursement rates as a percentage of Medicare's fee schedule for comparison purposes, but this analysis has not yet been completed.

This proposal evaluates reimbursing non-network charges, both professional and facility, at 185% of Medicare's fee schedule.

In areas where network access is adequate, this proposal would encourage utilization of network providers, bringing savings to both the plan and to members.

However, in some areas, network access is not adequate. Members accessing non-network services in these areas would receive an exception, or a waiver, to allow for a higher reimbursement to their provider to help circumvent the possibility of balance billing.

### **Member impact:**

The impacts of the proposed change will be most apparent in medical claims incurred by non-Medicare eligible-covered retirees because the AlaskaCare plan is supplemental to Medicare. Members who are enrolled in Medicare can seek services from any provider that accepts Medicare; any services provided would be subject to Medicare's fee schedule. Medicare will pay first, and AlaskaCare will coordinate to pay 100% of covered expenses, less any deductible not yet met. If a Medicare-eligible member chooses not to enroll in Medicare, the AlaskaCare plan will estimate what Medicare would have paid, and deduct that amount before paying expenses.

There is substantially higher non-network use by Medicare-eligible-covered retirees, but because most of those claims are already based on Medicare's fees schedule, the impact to the plan's spend is not likely to be significant. However, analysis is warranted and underway to understand how this proposal would impact the amount the plan spends on non-network Medicare claims.

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<sup>2</sup> <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/medcrephysfeeschedfctsht.pdf>

## DRAFT-Summary of Responses to Proposed Plan Design Change

In reviewing claims incurred by non-Medicare eligible AlaskaCare retiree health plan members in calendar year 2018 in the AlaskaCare data warehouse, there was approximately \$220 million paid for medical benefits (this excludes pharmacy benefits). Approximately 84%, or \$185 million was paid to network providers, and approximately 16%, or \$35 million was paid to non-network providers. This is outlined in Table 2.

Table 2. AlaskaCare Non-Medicare Eligible Retiree Medical Claims Incurred Calendar Year 2018<sup>3</sup>

|                  |                                    | Network       |                 | Non-Network  |                 |               |
|------------------|------------------------------------|---------------|-----------------|--------------|-----------------|---------------|
|                  | Service Category                   | Paid          | % of Total Paid | Paid         | % of Total Paid | Total Paid    |
| Retiree under 65 | Inpatient Facility                 | \$41,702,439  | 96%             | \$1,515,494  | 4%              | \$43,217,933  |
|                  | Outpatient Facility                | \$74,715,222  | 89%             | \$9,338,289  | 11%             | \$84,053,511  |
|                  | Primary Care Provider Professional | \$13,828,385  | 79%             | \$3,745,962  | 21%             | \$17,574,347  |
|                  | Specialty Provider Professional    | \$55,017,094  | 73%             | \$20,625,847 | 27%             | \$75,642,941  |
|                  | Summary                            | \$185,263,140 | 84%             | \$35,225,592 | 16%             | \$220,488,732 |

Amongst non-Medicare eligible retirees:

- 17% of non-network utilization is responsible for 27% of total specialty provider professional costs, and
- 12% of non-network utilization is responsible for 21% of total primary care provider professional costs.<sup>4</sup>

Use of network inpatient facilities is quite high at 96% of total paid among non-Medicare retiree claims. This is unsurprising, as both Providence Alaska Medical Center and Alaska Regional Hospital in Anchorage are both considered network providers.

Members using network providers: Members currently using network providers would not experience an impact.

<sup>3</sup> Information provided based on AlaskaCare data warehouse claims pull as of the week of 3/18/2019.

<sup>4</sup> Ibid.

## DRAFT-Summary of Responses to Proposed Plan Design Change

Members using non-network providers: These members could be disadvantaged by the change as they may be subject to balance billing from non-network providers.

Members who cannot access a network provider: Members who live in areas without access to a network provider may face higher out-of-pocket costs the form of balance bills. To care for these members who do have the option to access network providers, the plan proposal includes an exception or a waiver that would reimburse non-network providers using the current methodology if a member cannot access a provider in their community. Alternatively, the addition of enhanced travel benefits may provide further options for members in this situation.

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

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

### **Actuarial impact:**

Neutral / Enhancement / Diminishment

Table 2: Actuarial Impact

| Actuarial Impact |     |
|------------------|-----|
| Current          | N/A |
| Proposed         | N/A |

Actuarial analysis forthcoming.

### **DRB operational impacts:**

The Division anticipates minimal operational impacts as follows:

- Staff will need to review and distribute communications to educate members about the potential impacts and increase awareness of the new reimbursement approach.
- 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 TPA.
- Staff will need to coordinate with the TPA to ensure that providers are made aware of the new reimbursement approach.

## **DRAFT-Summary of Responses to Proposed Plan Design Change**

### **Financial impact to the plan:**

The financial analysis is forthcoming.

### **Clinical considerations:**

This proposal is not anticipated to impact members from a clinical perspective.

### **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.

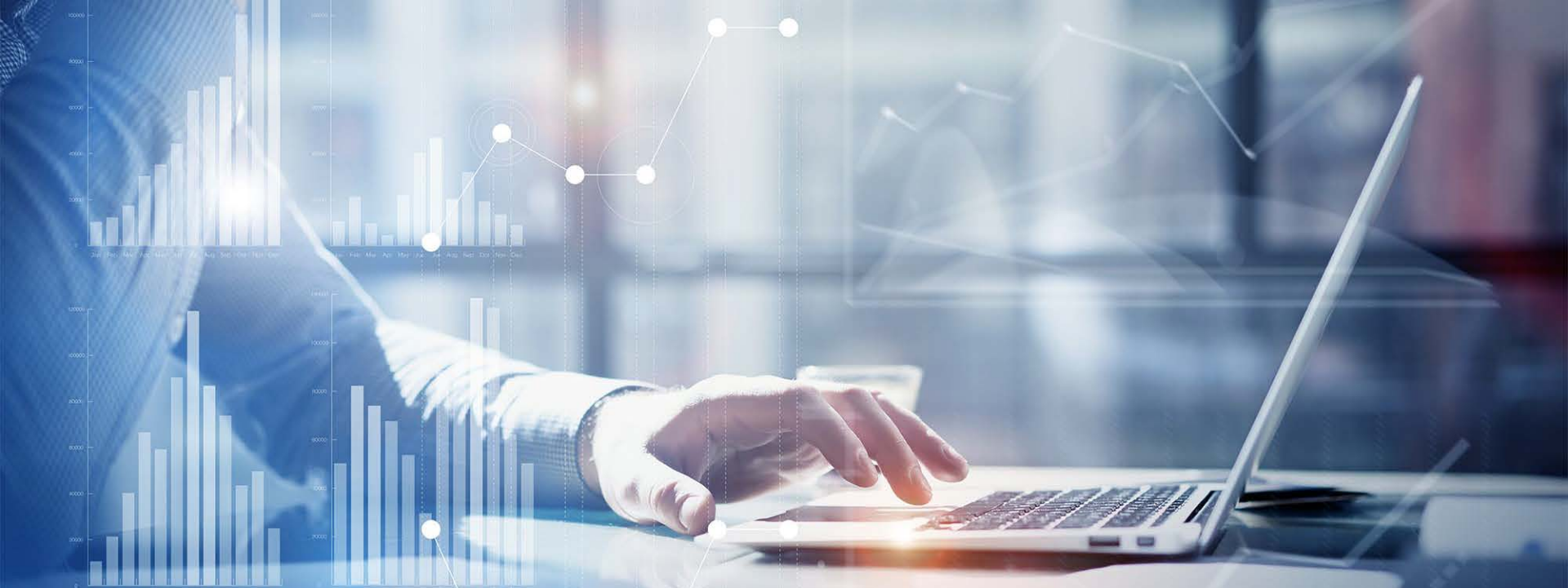
### **Provider considerations:**

Implementing a new non-network reimbursement methodology would alter the level of reimbursement received by non-network providers. Many non-network providers may experience a reduction in reimbursement, while some others may experience an increase. Non-network specialty providers are most likely to be more heavily impacted than primary care providers. Specialty providers' billed charges tend to be significantly higher than Medicare's fee schedule, resulting in considerable non-network reimbursement rates.

The proposed change 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     | A                 | Forthcoming  |



# Medical Claims as a Percentage of Medicare Review

**May 8, 2019**

**DRAFT**

**Presented by:  
Richard Ward, FSA, FCA, MAAA**

 **Segal Consulting**

Page 77 of 102

# Overview

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- Segal Consulting has completed a **preliminary** review of AlaskaCare's medical plan's allowed claims costs as a percentage of Medicare for non-Medicare members in the Retiree Plan.
  - A business partner, Green Light, was utilized to assist with determining the Medicare pricing.
- The medical claims data used to complete the review was provided by Aetna, and covers FY2018.
- All claims were reviewed as of October 1, 2018 for the purpose of this analysis.
- Due to the complexity of the claims data for professional services, preliminary results for professional services in Alaska are based on Aetna book of business
- Some inpatient facility claims lacking diagnosis-related group (DRG) data and the absence of diagnosis codes, which prevented grouping to a DRG for Medicare reimbursement.
- Despite these restrictions, the preliminary review provides a reasonable initial overview of AlaskaCare's medical claims as a percentage of Medicare.

## Medical Claims - *All Locations*

- The following chart shows medical claims for all providers regardless of location as a percentage of Medicare:

| Percent of Medicare Allowed |              |          |       |
|-----------------------------|--------------|----------|-------|
|                             | Professional | Facility | Total |
| <b>In-Network</b>           | 206%         | 240%     | 226%  |
| <b>Out-of-Network</b>       | 262%         | 336%     | 272%  |
| <b>Total</b>                | 216%         | 243%     | 230%  |

- AlaskaCare's medical plan's allowed claim costs as a percentage of Medicare for non-Medicare members in the Retiree Plan was 230% based on the reviewed claims.
  - Allowed claims costs are Aetna contracted rates for network claims and 90% of Fair Health for non-network claims.

**Non-network claims, whether professional or facility and whether in Alaska or not, are paid at a higher percentage of Medicare.**

# Medical Claims – Inside vs. Outside Alaska

| Percent of Medicare Allowed – INSIDE Alaska |              |          |       |
|---|--------------|----------|-------|
|   | Professional | Facility | Total |
| <b>In-Network</b>                           | 235%*        | 266%     | 253%  |
| <b>Out-of-Network</b>                       | 260%*        | 341%     | 270%  |
| <b>Total</b>                                | 241%         | 268%     | 255%  |

\* Based on Aetna's book of business

| Percent of Medicare Allowed – OUTSIDE Alaska |              |          |       |
|--|--------------|----------|-------|
|  | Professional | Facility | Total |
| <b>In-Network</b>                            | 160%         | 211%     | 190%  |
| <b>Out-of-Network</b>                        | 266%         | 330%     | 278%  |
| <b>Total</b>                                 | 171%         | 213%     | 195%  |

- The higher percentage of Medicare for Alaska providers can be due to:
  - The higher cost of medical care in Alaska compared to the United States' as a whole
  - The ability of providers in rural markets to demand higher reimbursement to be in-network because of a lack of competition - Alaska has more rural markets
  - More retirees that reside in the Lower 48 live in areas with more provider competition and greater overall network access



# Next Steps

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- A second data file will be requested from Aetna with expanded data fields and a more current pricing date.
- Perform an updated analysis on the second data file and provide an updated review of Medical claims as a percentage of Medicare.
- Determine what the cost savings impact may be based on a change in allowed as a percentage of Medicare.
- Refine the professional services analysis to be more AlaskaCare specific.
- Perform comparison with greater detail:
  - Compare at the service and facility category level
  - Compare at the 3 digit zip code level within Alaska
  - Compare within urban and rural area

## DRAFT-Summary of Responses to Proposed Plan Design Change

**Proposed change:** Expanding Telehealth Services to AlaskaCare Retirees

**Plans affected:** DB Retiree Plan, DC Retiree Plan

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

**Proposed implementation date:** TBD

**Review Date:** ~~April 23~~ May 8, 2019

Table 1: Plan Design Changes

|                | Member | Actuarial | DRB<br>Ops | Financial | Clinical | TPA | Provider |
|----------------|--------|-----------|------------|-----------|----------|-----|----------|
| No impact      |        | X         |            |           |          |     | X        |
| Minimal impact | X      |           | X          | X         | X        | X   |          |
| High impact    |        |           |            |           |          |     |          |
| Need Info      |        |           |            |           |          |     |          |

### **Description of proposed change:**

Expand access to Teladoc, a telehealth service currently used by AlaskaCare active employees to the retiree health plan. This proposal would provide retirees and their dependents access to a medical provider over the phone, via mobile devices or the internet, and by video for non-emergency medical episodes, dermatology consultations, and caregiver consultations. The costs to the member associated with accessing Teladoc currently under consideration are:

- general medical consultation: for a flat \$5 member copay ~~per call~~.
- dermatology consultation: \$75 member copay, and
- caregiver consultation: \$45 member copay.

### **Background:**

In 2017, low severity care<sup>1</sup> accounted for 31% (\$237 million) of health care spend across both the AlaskaCare employee and retiree health plans. Low severity care encompasses non-emergency and minimally-invasive services. \$178 million (or 75%) of low-severity care costs were incurred by the retiree health plan, including \$25.7 million in out-of-

<sup>1</sup> Low severity care is not and should not be confused with medically-unnecessary care. Low-severity care is defined as services within an episode treatment group that is either unadjusted or labeled as "level 1" by OptumInsight's severity index. More information is provided in the accompanying document titled "Episode Treatment Groups: Analyzing Health Care Data from Episodes of Care."

## DRAFT-Summary of Responses to Proposed Plan Design Change

pocket expenses (this number may be conservative in that it does not include any expenditures from ‘balanced billing,’ or the additional sum out-of-network providers may request from members).

Teladoc is a telehealth service where members can call in and speak to a licensed health care provider and receive medical consultation for low-severity issues at a reduced cost relative to traditional options which may include an office visit, urgent care visit, or Emergency Room use. Adopting this program will increase care options available for members and may generate savings for the plan and membership if enough substitution of higher cost alternatives (i.e. emergency room visits) occurs.

Teladoc providers have limited prescribing privileges and comply with state statutory and regulatory requirements. Some states require the first visit to be conducted via video, while other states require all visits be conducted via video.<sup>2</sup>

To use Teladoc’s services, members must first set up an account through the Teladoc website. Then, members can request a consult through the website, or by phone. A doctor will reach out by phone within minutes. If a member misses the call, the doctor will try two more times to reach them. There is no time limit on consultations. The Division is exploring registration options for members that do not require members to access the service through a website.

Analysis is ongoing to evaluate how fees associated with Teladoc would be assessed to members with multiple coverages.

### **Member impact:**

AlaskaCare provides health and pharmacy benefits for nearly 72,000 retirees and their dependents. Within Alaska, nearly 20,000 retirees and their dependents live in communities outside of the population centers of Anchorage, Fairbanks, and Juneau and frequently in medically-underserved areas. Expansion of telehealth services for AlaskaCare Retirees will provide an accessible and low-cost means of reaching a medical provider in non-emergency health episodes.

This would be available to both Medicare and non-Medicare eligible members, and could provide an additional source of access to care.

### **Actuarial impact: UNDER DEVELOPMENT**

Neutral / Enhancement / Diminishment

*Table 2: Actuarial Impact*<sup>3</sup>

<sup>2</sup> Teladoc Health Presentation dated May 8, 2019

<sup>3</sup> Segal Memorandum dated April 19, 2018

~~March 20, 2018~~ May 8, 2019

## DRAFT-Summary of Responses to Proposed Plan Design Change

| Actuarial Impact |   |
|------------------|---|
| Current          | N/A   |
| Proposed         | <del>N/A—Under development</del> <u>No Impact</u> |

### **DRB operational impacts:**

As AlaskaCare currently has a contract with Teladoc, the operational impact of expanding benefits is expected to be minimal. Teladoc is currently subcontracted through Aetna, the current medical Third Party Administrator (TPA). In the event of a transition, the Division may need to divert operational resources to transition telehealth services to a separate contract or a new vendor.

In order to maximize utilization of the benefit, AlaskaCare will communicate the benefit to members and participate in awareness campaigns to assist in benefit registration.

### **Financial impact to the plan:**

The cost of implementing Teladoc in the AlaskaCare retiree plan ~~would~~ could vary be between \$653,000 and \$852,900 a year, depending on member-usage. Savings would potentially arise through the avoidance of traditional high-cost services for low-severity episodes, and will therefore also vary depending on actual utilization and member experience.- Assuming 5% of members utilize Teladoc, the projected annual savings to the plan is approximately \$250,000.<sup>4</sup>

~~The savings estimates are under development.~~

~~If over 12% of non-emergency care was substituted through Teladoc, the plan would expect to see net savings as a result.~~

~~Table 1 below estimates plan costs given PY 2018's Retiree Plan enrollment and current Teladoc terms.<sup>5</sup> Cost estimates assume a low end utilization of 7% (5040 calls/yr) and a high end of 15% (10,800 calls/yr).~~

~~Table 3: Cost Estimates for \$5 Copay, \$0.93 PEPM and 2018 Retiree Plan Populations~~

| Member             | Subscriber | PEPM Costs | 7%        | 15%       | Annual Cost         |
|--------------------|------------|------------|-----------|-----------|---------------------|
| Retiree (Under 65) | 11,415     | \$127,391  | \$50,446  | \$108,098 | \$177,836-\$235,488 |
| Retiree (Over 65)  | 31,375     | \$350,145  | \$124,725 | \$267,267 | \$474,869-\$617,412 |
| <b>Total</b>       | 42,790     | \$477,536  | \$175,170 | \$375,365 | \$652,706-\$852,900 |

<sup>4</sup> Segal Memorandum dated April 19, 2018

<sup>5</sup> The per member per month (PEPM) cost is \$0.93, and each call is \$40. Utilization is calculated as # of calls divided by covered lives.

## DRAFT-Summary of Responses to Proposed Plan Design Change

Utilization rates are determined by number of calls per year, divided by size of membership. This means utilization is not necessarily linked to plan savings unless telehealth services substitute for more expensive care. Below are incurred costs of low-severity care episodes by select provider-type that may be substituted through a telehealth benefit.

Table 4: Evaluation of Avoidable, Low-Severity Care<sup>6</sup>

| Retirees, 2017 | Emergency Room | Urgent Care | Primary Care | Specialist  | Total       |
|----------------|----------------|-------------|--------------|-------------|-------------|
| Paid           | \$2,150,312    | \$12,926    | \$258,858    | \$1,092,239 | \$3,514,335 |
| Out of Pocket  | \$202,515      | \$6,141     | \$160,885    | \$544,095   | \$913,636   |
| Total          | \$2,352,827    | \$19,067    | \$419,743    | \$1,636,334 | \$4,427,971 |

### **Clinical considerations:**

These changes are anticipated to impact clinical considerations minimally by providing an additional access-point of care.



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

This may require manual adjudication of claims.

### **Provider considerations:**

Members should ask their physician about telehealth services and how they may be used in tandem with more traditional care. It should be communicated to membership that telehealth services are not a substitute for having a dedicated primary care provider.

### **Documents attached include:**

| Document Name                      | Attachment | Notes  |
|------------------------------------|------------|--|
| Segal Memorandum                   | A          | <br>Segal Telemedicine<br>Memo 20190419 UPD |
| <u>Teladoc Health Presentation</u> | <u>B</u>   | <br>Teladoc<br>Overview_RHPAB_0508          |

<sup>6</sup> These estimates are intentionally conservative as to not overestimate substitutable care. The following are expenditures for the least-intensive care episodes in 2017 for the Retiree Plan as determined through OptumInsights.



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

## MEMORANDUM

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

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

**Date:** April 18, 2019

**Re:** Telemedicine – Focus on Actuarial and Financial Impact for the Retiree Plan

---

Teladoc, Inc. is a telemedicine company that uses telephone and videoconferencing to provide on-demand remote medical care via mobile devices, the internet, video and phone. Teladoc provides access to board-certified, state-licensed physicians 24 hours a day for non-emergency medical issues.

| 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<br>• 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 provide access to Teledoc's services at a \$5 member copay per consultation. Caregiver consultations have a \$45 copay and dermatology consultations have a \$75 copay, which includes one follow-up consultation. The benefit would provide an additional access point for members who are experiencing acute medical conditions.

## Actuarial Value

Our analysis determines the impact of adding Teledoc would result in a 0.04% increase in actuarial value. The Plan does not currently cover telemedicine consultations. Therefore, this coverage enhancement would have an impact on the Plan's actuarial value.

## Financial Impact

Utilization of telemedicine services is often driven by inadequate access to physician services and a familiarity with technology services. Many of the retirees currently live in areas with acceptable levels of access to primary and specialty care, which will affect the uptake of Teladoc within the retiree population. Adding coverage for telemedicine consultations will enhance access and promote efficient utilization.

Additionally, while many in the telemedicine industry have been mindful of the ease of use issue with these services, the technology is still seen as a barrier to some. However, as younger retirees enter the plan and members become more comfortable with the process of using Teladoc, utilization can be expected to increase in future years.

For this analysis, we are assuming that the total cost of a Teladoc consultation is \$40 with a \$5 member copay for most services. Based on the member copay and considerations discussed previously, it is assumed that 5.0% of the members will utilize Teladoc, resulting in approximately 5,000 calls annually. Additionally, it is to be expected that a portion of those calls will not lead to a resolution, and necessitate a follow-up visit to either a primary care physician or specialist,

resulting in additional cost to the plan. The plan will also be charged a per member per month administration fee of \$0.93.

Savings achieved by this program are a result of members avoiding higher cost office visit services. Considering the assumptions provided above, the implementation of Teladoc is projected to result in annual savings to the plan of approximately \$250,000. Based on the most recent annual claims projection of \$590,000,000, this equates to an annual savings of approximately 0.04%.

This analysis is based on medical claims data from January 2017 through December 2017, which was summarized specifically to analyze the opportunity for telemedicine services. The data was reviewed, but not audited, and found to be sufficient and credible for this analysis.

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

cc: Emily Ricci, Division of Retirement and Benefits  
Betsy Wood, Division of Retirement and Benefits  
Linda Johnson, Segal  
Noel Cruse, Segal  
Dan Haar, Segal  
Quentin Gunn, Segal





# A Doctor's Care, Anywhere

**State of Alaska  
Retiree Health Plan Advisory Board**

May 8, 2019

# General Medical Care

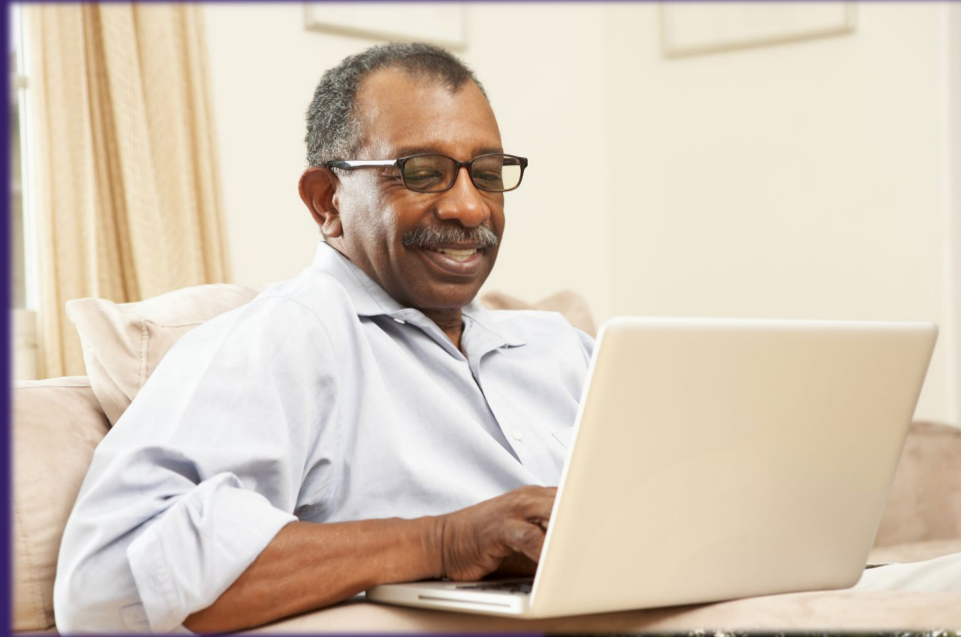


# Talk to a anytime

Teladoc® is a national network of U.S. board-certified doctors available on-demand 24/7 to diagnose, treat and prescribe medication, if necessary, for many non-emergency medical issues.

It's quality care when patients need it, at an affordable price.

Care delivered  
**conveniently**  
and **securely**,  
however  
members want  
to receive it





# When should Teladoc be used?



If there's no time  
for an office visit



When traveling or  
away from home



Short-term prescription  
refills



If a PCP  
is unavailable



If distance makes an  
office visit difficult



For pediatric care  
for any age

# Effective resolution for a wide range of non-emergency conditions

## Top Diagnoses

- Flu
- Cough
- Sinus problems
- Upper respiratory infection
- Pink eye
- Nasal congestion
- Sore throat
- Sinusitis
- Seasonal allergies
- Rash/poison ivy
- Food poisoning

## Prescriptions as needed

- Best practices in prescription management
- Appropriate prescribing following CDC guidelines
- No controlled substances, psychiatric or lifestyle drugs
- 98% generic prescribing rate
- Member convenience through e-prescribing

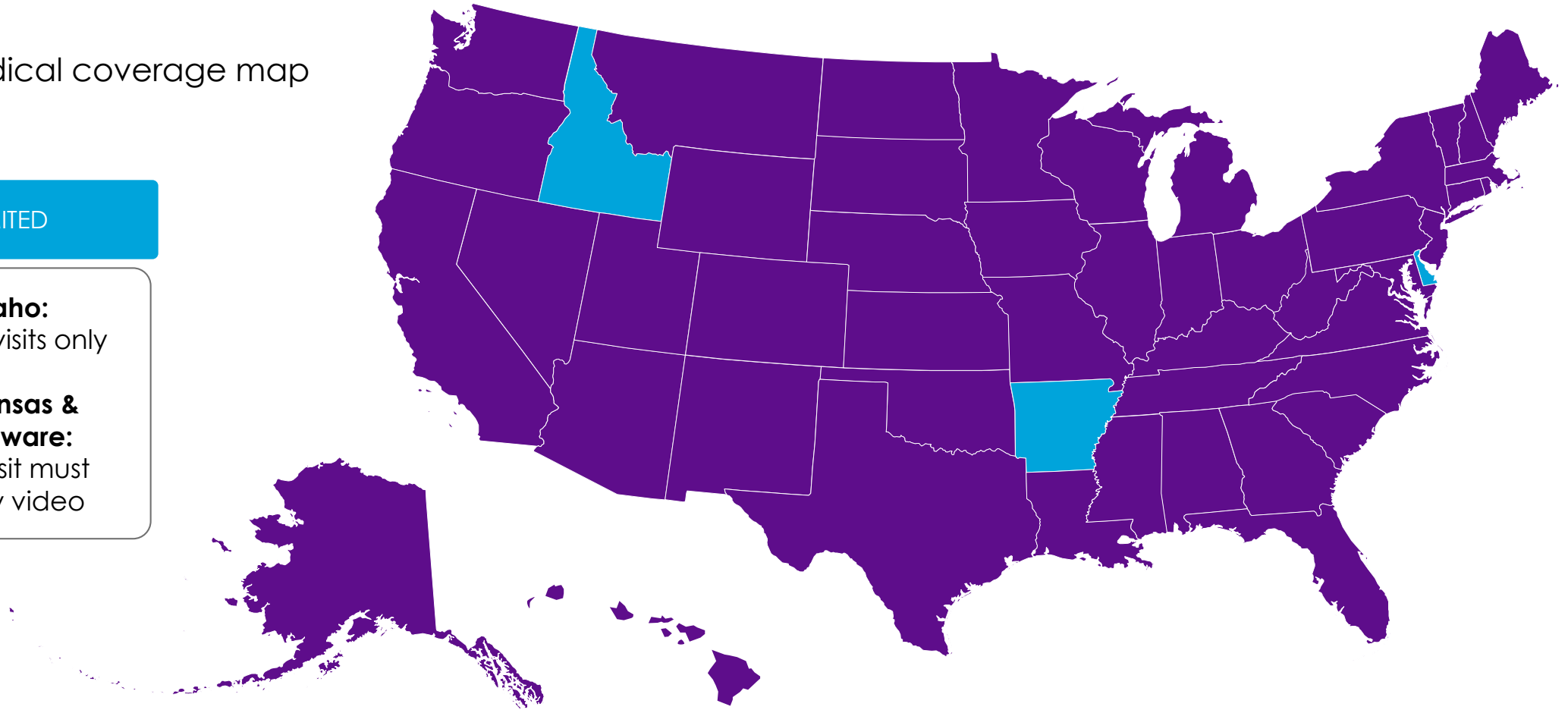
# General Medical network

General Medical coverage map

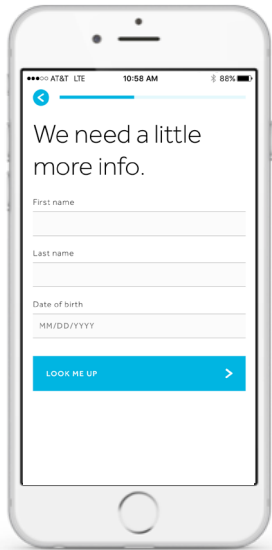
LIMITED

**Idaho:**  
Video visits only

**Arkansas &  
Delaware:**  
First visit must  
be by video

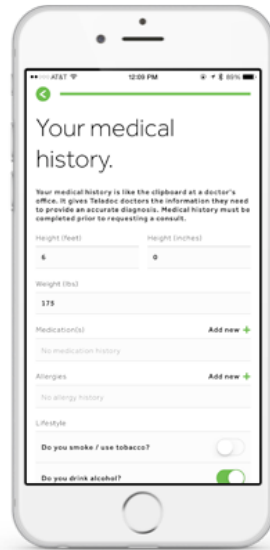


# How General Medical works



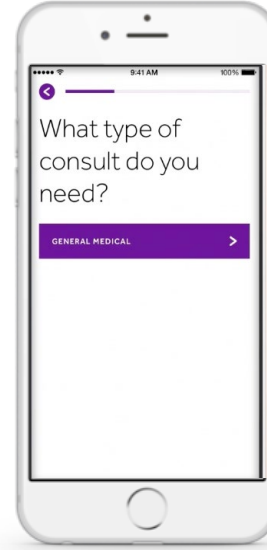
## Set up an account

Set up an account by app, web or phone



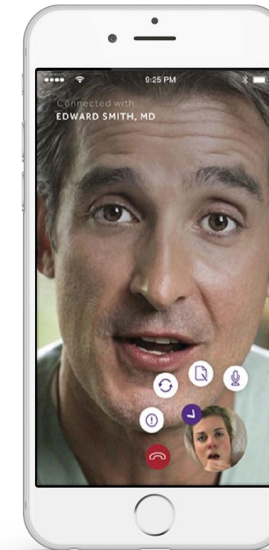
## Complete medical history

The doctor will review information about past conditions, medications, allergies and the family's medical history



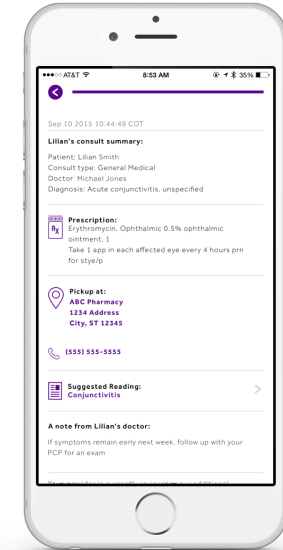
## Request a visit

Request a visit with the next available doctor or schedule for a specific time



## Talk to a doctor

Talk to a doctor 24/7 by phone or video



## Get resolution

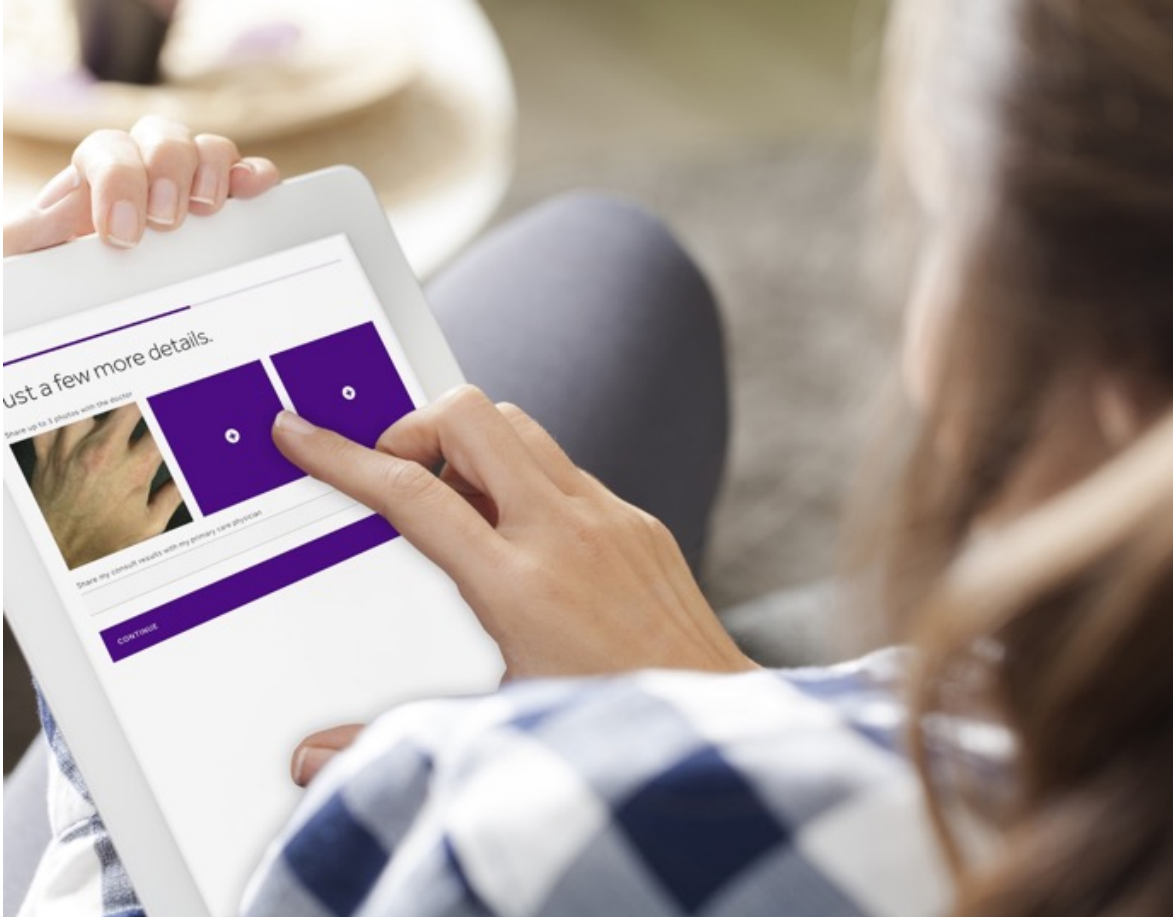
If medically necessary, the doctor will send a prescription to the patient's pharmacy of choice



# Dermatology

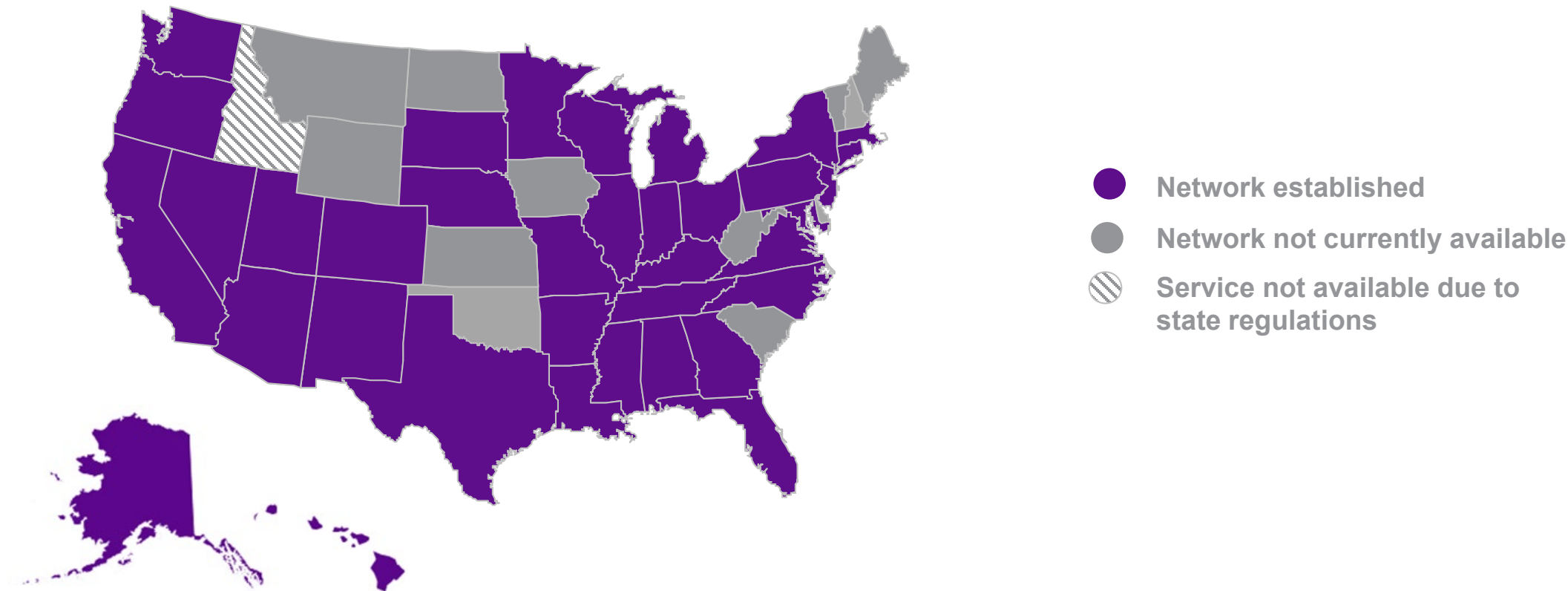


# Dermatology services



- Access licensed dermatologists via web or mobile app
- Treat acute or ongoing skin conditions like psoriasis, skin infection, rosacea, and more
- Share high-quality images and receive a diagnosis within 48 hours
- \$75 visit fee

# Dermatology network

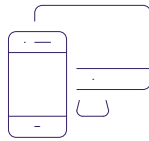


# How Dermatology works



## **Request initial consult**

Log in to Teladoc account online or through the mobile app anytime, anywhere



## **Upload images**

Upload a minimum of three pictures of the skin issue for the dermatologist to review



## **View results online**

Within two business days, the licensed dermatologist will respond through the online message center

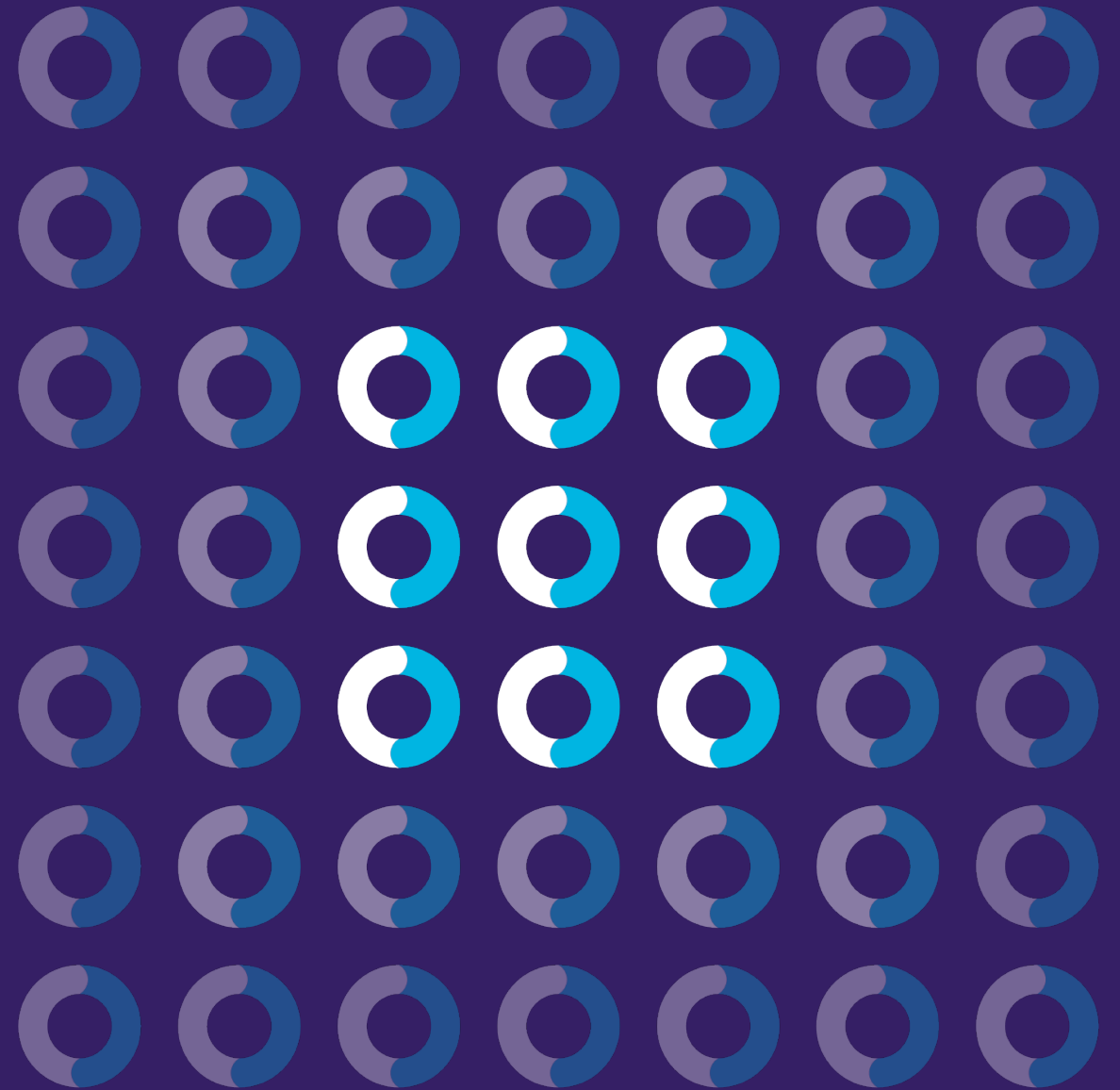


## **Follow up**

Follow up with the doctor through the message center for free within seven days after the visit



Questions?



## **Proposed list of RHPAB Meeting Dates for 2020**

Thursday February 6<sup>th</sup>, 2020

Thursday May 7<sup>th</sup>, 2020

Thursday August 6<sup>th</sup>, 2020

Thursday November 5<sup>th</sup>, 2020