

Retiree Health Plan Advisory Board Meeting Agenda

Date: August 7th, 2019
Time: 9:00am - 4:00pm
Location: **Anchorage:** Atwood Building, 19th Floor Conference Room
Juneau: State Office Building, 10th Floor Conference Room
Teleconference: [1-650-479-3207](tel:1-650-479-3207) | 806 227 752
[join the meeting](#)
Committee Members: Judy Salo (chair), Joelle Hall, Gayle Harbo, Dallas Hargrave, Mauri Long, Cammy Taylor, and G. Nanette Thompson

- 9:00 am** **Call to Order – Judy Salo, Board Chair**
- Roll Call and Introductions
 - Approval of Agenda
 - Approve Previous Meeting Minutes
 - Ethics Disclosure
- 9:10 am** **Public Comment**
- 9:30 am** **Department & Division Update**
- 10:15 am** **Break**
- 10:30 am** **Retiree Plan Updates**
- Pharmacy Plan
 - EGWP
 - Retiree Direct Subsidy Recovery
- Historic Legal Review**
- 12:00 pm** **Lunch on Your Own**
- 01:15 pm** **Retiree Health Plan Modernization Update and Discussion**
- 03:00 pm** **Public Comment**
- 03:20 pm** **Final Thoughts**
- Next meeting
- 03:30 pm** **Adjourn**

RHPAB Meeting August 7th, 2019

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Retiree Health Plan Advisory Board

Public Comment Guidelines

Purpose: The public comment period allows individuals to inform and advise the Retiree Health Plan Advisory Board about policy-related issues, problems or concerns. It is not a hearing and cannot be used to address health benefit claim appeals. The protected health information of an identified individual will not be addressed during public comment.

Protocol:

- Individuals are invited to speak for up to three minutes.
- A speaker may be granted the latitude to speak longer than the 3-minute time limit only by the Chair or by a motion adopted by the Full Advisory Board.
- Anyone providing comment should do so in a manner that is respectful of the Advisory Board and all meeting attendees.
- The Chair maintains the right to stop public comments that contain Private Health Information, inappropriate/inflammatory language or behavior.

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.

Protected Health Information

Purpose: Protected health information 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.

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.

How can someone provide comments?

- **IN PERSON** - please sign up for public comment using the clipboard provided during the meeting.
- **VIA TELECONFERENCE** – please call the meeting teleconference number on a telephone hard line. To prevent audio feedback, do not call on a speaker phone or cell phone. You may use the mute feature on your phone until you are called to speak, but do not put the call on hold because hold music disrupts the meeting. If this occurs, we will mute or disconnect your line.
- **IN WRITING** – send comments to the address or fax number below or email AlaskaRHPAB@alaska.gov. For written comments to be distributed to the Advisory Board prior to a board meeting they must be received thirty days prior to the meeting to allow time for distribution and identifying information will be redacted (see “Protected Health Information”).
- **PRIVATE HEALTH INFORMATION:** The state must comply with federal laws regarding Private Health Information. Written information submitted for public comment which contains identifying information will be redacted to ensure compliance with privacy laws.

Can I bring my questions about a claim or medical issue to the Board? The Board does not have authority to decide health benefit claim appeals. Members should call Aetna at 1-855-784-8646 to address their question and/or concern. After contacting Aetna, members can also contact the Division of Retirement and Benefits at 1- 800-821-2251 or 907-465-8600 if in Juneau.

For additional information: Please call 907-269-6293 or email AlaskaRHPAB@alaska.gov if you have additional question.

Retiree Health Plan Advisory Board

Board Meeting Minutes

Date: Wednesday, May 8, 2019 9:00 a.m. to 4:00 p.m.

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

Meeting Attendance

Name of Attendee	Title of Attendee	
<i>Retiree Health Plan Advisory Board (RHPAB) Members</i>		
Judy Salo	Chair	Present
Cammy Taylor	Vice Chair	Present
Joelle Hall	Member	Present
Gayle Harbo	Member	Present
Dallas Hargrave	Member	Present
Mauri Long	Member	Present
Nan Thompson	Member	Present
<i>State of Alaska, Department of Administration Staff</i>		
Kelly Tshibaka	Commissioner, Alaska Department of Administration	
Paula Vrana	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	
Shane Francis	Health Care Economist, Retirement + Benefits	
Teri Rasmussen	Program Coordinator, Retirement + Benefits	
Vanessa Kitchen	Administrative Assistant, Office of the Commissioner	
<i>Others Present + Members of the Public</i>		
Daniel Dudley	Aetna	
Hali Duran	Aetna	
Linda Gable	Aetna	
Blythe Keller	Aetna	
Julian Nadolny	OptumRx	
Stephanie Gaffney	OptumRx	
Richard Ward	Segal Consulting	
Noel Cruse	Segal Consulting	
Quentin Gunn	Segal Consulting	
Anna Brawley	Agnew::Beck Consulting (contracted support)	
Wendy Woolf	Retired Public Employees of Alaska (RPEA)	
Dorne Hawxhurst	Retiree from Cordova	
Kevin Dilg	Alaska Department of Law	
Jessie Alloway	Alaska Department of Law	
Jon Zutter	SurgeryPlus / EmployerDirect Healthcare	
Baron Hoag	SecureCare	

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

Meeting Minutes

Item 1. Call to Order + Introductory Business

Chair Judy Salo called the meeting to order at 9:00 a.m. Staff addressed technical issues with the phone.

Approval of Meeting Agenda

Materials: Agenda packet for 5/8/19 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.

Approval of Previous Meeting's Minutes

Materials: Draft minutes from 2/6/19 RHPAB Meeting

- **Motion** by Gayle Harbo to approve the 2/6/19 minutes as presented. **Second** by Mauri Long.
 - **Discussion:** None.
 - **Result:** No objection to approval of minutes. Minutes are approved.

Ethics Disclosure

Judy Salo requested that Board members state any ethics disclosures in the meeting.

- Judy Salo stated that one of her family members owns a large chiropractic office in Anchorage. This is not an official conflict of interest, as it is not an immediate family member, but she wishes to make this disclosure on the record.
- Mauri Long stated that she owns a small amount of stock in the company Teladoc in her retirement account; Teladoc is a potential vendor of services for the retiree health plan.

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.

Members of the public who provide comments are also encouraged to submit their comments in writing to the Retiree Health Plan Advisory Board: rhpab@alaska.gov.

Public Comments

- **Dorne Hawxhurst, Cordova resident.**

My husband and I have health coverage through the retiree plan and will not be eligible for Medicare for five years. DRBs enhanced clinical review and out of network reimbursement proposals target us retirees under age 65. I object to this disparate treatment and see nothing of value being offered in exchange for DRBs diminishment of our benefits. For the past 9 years until March 31 of this year when I retired, I worked as an attorney healthcare advocate for employees of the Alaska Court system. I watched as DRB gradually shifted the burden of rising health cost onto the shoulders of employees. Among the many things DRB did to diminish the health benefits of active employees, are the same things they want to do to the detriment of under 65 employees. When I say under 65 employees, I mean the pre-Medicare people like us. In a nutshell it seems DRB wants to make under 65 retirees get Aetna's permission to undergo certain common procedures ordered by our doctors. I'm going to call that precertification I'm not going to call that enhanced clinical review because its not. Second, DRB wants to force under 65s to use network facilities and providers and if we don't DRB wants to penalize us by severely reducing coverage from 90% of the UCR to 185% of Medicare rates. I'm going to call this hard network steerage. But first, I think it is very important to keep in mind that DRB and Aetna do not form a competent team. And anything DRB ever presumes to do that inserts a layer of Aetna administration should be strictly scrutinized by this board. In my experience Aetna representatives, concierges, etc. give conflicting information to members as a matter of routine. One rep will say we need precert for something and the next rep will say that we don't. One rep will say a particular facility or provider is in network, and another rep will say its not. Whenever DRB requires Aetna to depart from Aetna's internal workflows, I call it Aetna script, Aetna fails. This was most obvious when DRB added hard facility steerage to the active plan. It was off Aetna's usual script and Aetna couldn't do it. Aetna applied network steerage penalties in the wrong places like Kotzebue and failed to apply them in the right places like Anchorage. Then when Aetna did an audit of its efforts, Aetna reprocessed claims incorrectly again. Aetna is an incompetent administrator, DRB is unwilling or unable to manage Aetna's efforts and sick retirees should not be made to suffer as a result. Please note this is not something in the abstract. It is always important to remember that you are dealing with Aetna and DRB, they are an incompetent TPA and plan sponsor. Regarding precertification, this means that if my doctor orders an MRI for my shoulder, Aetna has to first agree that it is medically necessary. This is an extra layer of Aetna review that adds no value and may delay my MRI for months or deny it outright. The review will be done by a stranger at Aetna who has never seen me or my records or it may be reviewed by an automated system at Aetna not a person at all. Aetna will rely on its outdated CPBs and proprietary guidelines, such as the MCG guidelines, to deny an MRI of my shoulder. Then, assuming I'm not too sick or vulnerable, I can appeal Aetna's denial 3 times before going to court with each level of appeal taking more than a month. If, as part of my appeal, I ask Aetna to produce the specific guideline or other information that was used in making its adverse decision, Aetna will say no. They will say the guidelines are proprietary and deny me access to the information they used to deny my claim. One time they gave me 40 pages of guidelines and omitted the one page that contained the relevant information. Precert for travel is another example. This requires a phone call in advance of travel and results in a letter from Aetna that really only says we hear you. It isn't precert for the travel its more of an acknowledgement. I received one of these 6 months ago while still an active employee and when my trip was done, I submitted the paperwork showing that I had had a diagnostic procedure in Anchorage available in the bush where I live at a higher cost. When processing the claim, Aetna processed it incorrectly confusing the retiree and the active plans. I told senior DRB management about this, asked them to correct it months ago, and as of yesterday Aetna is still giving out misinformation. With the new initiatives before you, DRB will increase the number of procedures requiring precert to include procedures commonly needed by retirees like MRIs, CTs, sleep studies, knee and hip replacements. The data to support this from Segal is inaccurate, indefensible and incomplete. All DRB is doing is adding more procedures to a broken system for a broken TPA to handle. That's not enhanced clinical review its unnecessary review and will result in more denials for sick and

vulnerable seniors. As regards to hard network steerage, retirees now have a choice of facilities and providers. DRB wants to change that for only under 65 retirees and it represents a clear diminishment of my benefits. Let's say my doctor is not in network and he wants to order an MRI of my shoulder and the place I usually go to is not in Aetna's network, DRB wants to make it so that whenever I go to these non-network providers DRB will only pay a small fraction of what would be paid today and leave me with the balance of the bill. This is how it was applied in the active plan. And if I live in an area like I do, like Kotzebue, where there are no network providers, then DRB wants me to have to get a waiver. I first note that Aetna often doesn't even know who is in its own network. Its also important to note DRB implemented hard network steerage under the active plan and it didn't go well, and it's still not going well. The active plan was trying to penalize members who use non-network facilities in Anchorage and the lower 49, paying 195% of Medicare, as proposed here, that information is unavailable to us. We can't discern what 185% of Medicare is. They assigned us 20% more coinsurance and doubled our annual out of pocket max. For non-network imaging this plan reduced coverage by 50% off the top. I know several members were taken by surprise by this and left with balance bills in the 10s of thousands of dollars. Adding insult to injury, Aetna then applied these penalties in the wrong places and when it became clear they were making mistakes they did an audit and reprocessed it and did it wrong again. Aetna can't adjust its systems to apply non network penalties in Anchorage. Aetna can't apply waivers consistently. Aetna can't correctly distinguish between retiree and employee plans. You cannot expect Aetna to apply these so-called new initiatives correctly to just a small subset of retirees. So, in closing, as a licensed attorney with special skills, and in-depth knowledge of these practices, as an under 65 retiree and a long-term resident of Alaska, I emphatically and unequivocally oppose these initiatives. Thank you for your time and your service on the board.

Item 3. Department of Administration + Division of Retirement & Benefits Updates

[Update from the Commissioner's Office](#)

Commissioner Tshibaka provided updates from her office: she has two deputy commissioners, Paula Vrana and Dave Donley. Paula will be overseeing the Division of Retirement and Benefits and IT services and will be liaison to this board. Dave is overseeing Shared Services. There are many ongoing projects! The Commissioner emphasized the advice and praise from former Commissioner Ridle about the importance of DRB staff's work in serving retirees and employees by managing the health plan, and strength of the DRB team. She noted that in addition to working well as a team, the team also achieves results. She shared her appreciation for staff and the board. She shared that she is working closely with the leadership team in the Department to discuss the future direction of the Division and ongoing projects, like the modernization project, while continuing to provide excellent service to members.

[Update from Division \(DRB\)](#)

- Ajay Desai shared the passing of DRB team member Michele Michaud in March and reiterated the important contributions she made to the Division and the strength of the health plan.
- He also shared changes within DRB staffing: Emily Ricci will now be the Chief Health Administrator, overseeing both health policy and health operations work, and in a greater decision-making role: she will have many challenges to address. Andrea Mueca will oversee operations, and Betsy Wood will oversee policy initiatives such as the modernization project.
- He emphasized that the Division is committed to providing excellent service and management of the health plans and taking seriously the input and concerns of members (employees and retirees), while balancing the complex fiscal considerations of keeping the plan financially sustainable. He thanked the Board for their work.

- Emily Ricci on behalf of staff shared their sincere appreciation for the outreach and condolences for Michele’s passing, they have had an outpouring of support from Board members and many others they work with closely.
- Betsy Wood shared updates on the status of the third-party administrator (TPA) procurement process: she noted that the current medical, dental, vision and audio (DVA) vendor is Aetna, with Moda providing dental. In October 2018 an RFP was issued for these services, with the option to bid separately on the medical and DVA plans. They have been conducting review of proposals in response to the RFP, the evaluation committee includes staff as well as Nan Thompson from RHPAB and a member from the Health Benefits Employee Committee for the active employee plan. They are currently in the clarification process and will be concluding this by early summer. Once they issue a notice of award, this information will be public. Currently the team is negotiating with the potential successful vendor and working through a series of detailed questions of the vendor to ensure that they will have strong shared expectations about what type of service the vendor should provide and address a variety of questions in advance that can be used as a reference later when a particular issue comes up.

Board Questions and Discussion

- Judy Salo thanked staff for their updates, and shared that the Board would also be willing to have additional questions for exploration in the clarification process. She also thanked staff for including a RHPAB member in the procurement process: this is the third round that a RHPAB member has participated in, and it is a valuable education and opportunity to participate.
 - Emily Ricci responded that DRB appreciates any input or questions to include in the clarification process, this can be incorporated into the documentation. She noted that the pharmacy clarification document was over 300 pages, and it provides a great deal of clarity and well-defined expectations. Please send any questions via e-mail to Emily or Betsy and they will ensure that they are incorporated.
 - Betsy Wood will send a reminder e-mail to Board members asking for any input on the clarification period questions.
- Judy Salo asked how the clarification document is typically used?
 - Emily Ricci shared that it is a reference document when issues arise, or when there are unclear expectations on either side, they can determine for example whether the vendor committed to providing staff to ensure sufficient service. She also noted that in the beginning of the process, it is especially helpful because it informs and identifies issues to address through the vendor transition process, before the contract is awarded. It is a very useful process for such a complex procurement agreement.

Item 4. Retiree Health Plan Operations Updates

Materials: Documents beginning pg. 30 in 5/8/19 meeting agenda packet

OptumRx Transition

- Andrea Mueca shared an update on the pharmacy benefits transition. They are into month 5 of the pharmacy transition to OptumRx and operating within normal levels: the call volume has dropped about 35% to closer to normal levels, about 10,000 to 6000 calls per month, including all retiree contacts (not just pharmacy).

- DRB staff visited OptumRx’s call center in Salem, Oregon and conducted a variety of oversight activities, including listening to calls, meeting with leadership and staff, working through issues identified, and discussed ways to further improve customer service. Staff are pleased with OptumRx’s dedication to service and treating AlaskaCare members as their customers as well.
- Emily Ricci added that compared with the 2014 transition, which took approximately 9 months to achieve normal operations status, this is months ahead of schedule and already running more smoothly, thanks to incorporating lessons learned from the previous transition.
- Cammy Taylor commented that she appreciates the e-newsletter and Tele Town Hall notices, including the duplicate communications in multiple channels, as this is more likely to reach people who may not closely read each one. She very much appreciates this and noted that many retirees still may not be aware of the transition or for example the IRMAA premium if they are Medicare eligible, it is important to continue sharing this information.
- Dallas Hargrave asked whether 6,000 calls is a normal amount?
 - Andrea Mueca responded that this is within normal range, it fluctuates depending on the share of retirees and employees and the time of year, but her information from the vendor is that 6,000 calls monthly is typical, given the size of the plans.

Dental, Vision and Audio Plan Lawsuit

- Kevin Dilg shared an update on the lawsuit between the State of Alaska and Retired Public Employees Association (RPEA) regarding the Dental, Vision and Audio (DVA) plan.
- April 17: The Superior Court found that the changes in 2014 to the dental, vision and audio plan were considered a diminishment of benefits, and DRB cannot offer the new plan in isolation.
- The Division and Department of Law are still reviewing the decision and considering their next steps, as well as how this will impact the DVA plan and their other work on the retiree plan.
- Jessie Alloway added that the original ruling was that the DVA plan cannot be offered in isolation as of May 1, 2019, but the decision has been stayed (will not yet go into effect) as they work through other court briefings. The change will most likely occur January 1, 2020, or potentially sooner depending on the outcome of these briefings, because it will involve making changes to that plan, that will take time to implement.
- Joelle Hall noted that, beyond the practical implications for implementing the plan and when that takes place, there are major implications for this ruling as it relates to the work of this board and the modernization project. Will the State appeal to the Alaska Supreme Court? Have staff determined how this would impact implementation of added benefits and offsets?
 - Kevin responded that there has not yet been a final decision within the Superior Court, so any appeal would be following that final decision. There would also be an internal review and decision-making process within the State, including Department of Law, and whether the State will appeal this case to the Alaska Supreme Court. The Court has stated that they will not enter a final judgment until at least May 17, and there are many other legal issues that need to be evaluated before they move forward.
 - Jessie added that they have filed a motion for final judgment, and there may also be other briefings filed by plaintiff RPEA, so there are additional steps in the process prior to an appeal decision.
- Joelle Hall commented that in her lay reading of the judgment, there was a fairly narrow judgment on whether there can be roughly equivalent changes to the plan in terms of actuarial value, and that

new benefits would need to be added in the same line of benefits rather than having two categories considered roughly equivalent. She noted that this will pose serious challenges to the concept of the modernization project, particularly adding new benefits to the plan and using other benefit changes as offsets to manage the plan's long-term financial sustainability. She noted her concerns about this issue and its implications for the Board's work, and that retirees will need to understand this ruling and whether it is even feasible to implement a suite of changes to the plan under the assumption that they will not be treated individually as diminishment. She understands that the State is still reviewing this decision.

- Kevin confirmed that Law staff are in close contact with the Commissioner's office and DRB staff, as this ruling will need to be operationalized and what the implications are for administering the plan going forward. Their team is aware of this, they do not specialize in health policy but will collaborate to advise on the best path forward from a legal standpoint. They are reviewing the diminishment analysis framework from the 2006 plan changes as well as the most recent 2014 changes to the DVA plan.
- Jessie reiterated that Law is aware of these concerns and working with staff to address this. She noted that they have clearly stated to the Court that it is not feasible to make immediate changes to the health plan, using the RFP process as an example of how complex health plan changes are.
- Mauri Long commented that as an attorney, she suggested that an interim appeal may be a useful tool in this situation, given that it has the effect of putting the State's work on hold as this decision is being worked out. She noted that there are many legal issues with a formal appeal, whereas an interim appeal could more expeditiously address the outstanding questions. She asked Department of Law staff whether this is being considered as an option?
 - Kevin shared that Law developed a list of options and are reviewing these currently, and in the meantime they have filed a motion for final judgment. One option would be to address the legal issues all at once, but they are still in process of review.
 - Jessie reiterated that they are considering all options on this case. There is a legal question whether constitutional protection of the plan extends to the Dental plan, and a factual issue of if there was a diminishment from the 2014 plan. The interim appeal would allow them to bring the case to the Supreme Court before a final judgment is issued but is at the discretion of the Court which anticipates being close to a final judgment. The State has not filed for alternative remedies, have only filed a stay to delay implementation of the ruling, but RPEA may file a brief for alternative remedies.
- Nan Thompson asked for clarification about the policy implications of the decision: DRB staff and RHPAB members have worked hard on considering ways to modernize the retiree plan and consider adding or changing benefits. While this legal process is moving forward, how does this impact the modernization project and the work of RHPAB's modernization committee?
 - Cammy Taylor, chair of the modernization committee, shared that the committee intends to continue its overall review of the proposed changes to the plan, and is not limited to actuarial value, but is inclusive of many different categories of impacts including financial, impacts to members, administrative impacts, etc. This is a broader look and the analysis has also evolved over time. The original goal was to have all the proposals vetted and discussed by the committee by August and brought back to the full Board at its next meeting in August. They may change how the analysis and decision making about which proposals to

include as plan changes are done, but this is still in development until the ruling is more fully understood and operationalized.

- Commission Tshibaka shared that while this decision-making process is ongoing, she shared her priorities are what will most benefit retirees, consistent in all her discussions with Ajay Desai and Emily Ricci about how to implement the Court's decision. She anticipates that there will be more limited options per the ruling, but she still considers the interests of all members of benefit plans with the State, in this case retirees, and wants to make the best decision possible for the retirees within these new boundaries. For the modernization project, this may mean that there is a narrower set of changes that are possible for the plan; she does not see these efforts as wasted but stated that this is likely to result in fewer possible changes. She needs to balance this with consideration of the health trust and the Administration's priorities, but she reiterated her commitment to retiree members.

Employer Group Waiver Plan (EGWP) Transition

Andrea Mueca shared that approximately 1,500 retiree members have submitted a reimbursement request for IRMAA premiums, and about 630 have completed the welcome packet they received. The remaining 870 members are still in process of completing that reimbursement process and need to take some action to complete this. Members have until March 2020 to complete the reimbursement process for 2019 premium surcharges, but DRB encourages members to take care of this reimbursement in a timely manner to avoid any issues. Andrea also noted that members may submit reimbursement toward the end of the year and receive one payment retroactive to the months they qualify for, back to January 2019 or the year they were Medicare eligible and enrolled in the enhanced EGWP.

Andrea also shared that in the February 2019 Tele Town Hall for retirees, the audience poll question focused on how well they felt the pharmacy transition was going, with options being: Very well, Well but a few bumps, or Needs improvement. Of the 234 people who participated in the poll, 44% felt it went well, 56% went well but with some bumps, and 20% room for improvement. This is approximately 80% who felt it went well or very well, which DRB feels is a success! She invited comments from members.

- Gayle Harbo thanked the DRB team for a smooth transition, she has had personal success in getting her prescriptions in order. She also had assistance with the IRMAA premium reimbursement, and now receives a monthly deposit in the bank equal to that amount. She encourages other retirees to complete their paperwork for reimbursement soon, to ensure they do not have any delay in reimbursement.

Stephanie Gaffney shared information from the first quarter 2019 update from OptumRx: there were two major changes in January 2019, first the transition to OptumRx as new PBM and second, transition to the EGWP for Medicare eligible retirees. Highlights from the presentation:

- Approximately 96% of prescriptions are covered by the plan
- About 25% of prescriptions are eligible for the federal rebates
- OptumRx has fielded about 26,000 calls in the first quarter, with the most popular topics being mail order pharmacy, benefits and coverage questions, and claims processing. These are a typical mix of topics for pharmacy plans.

Julian Nadolny shared information about federal subsidies paid to the State, January through April 2019 (page 32). The numbers presented are actual subsidies received, in the categories of a per member

direct subsidy, the Low-Income Premium Subsidy (LIPS) for low income members for premiums (a smaller amount retained by the State since there are no premiums), and prospective reinsurance for particularly high cost expenditures. Year to date this is approximately \$6.3 million in subsidies. Typically, members are not charged these out of pocket costs under the plan, so the State simply retains this subsidy. There are also payments made not on a monthly basis, but annually or quarterly (see page 34), year to date the State has received approximately \$4.6 million in subsidies from these other sources.

- Judy Salo commented that during the decision-making process to adopt EGWP, the State and Segal Consulting had presented initial projections and estimated subsidies to determine the level of subsidies. Are these projections, or based on actual claims data?
 - Emily shared that all the numbers presented are based on actual claims data.
- Cammy Taylor commented that OptumRx’s slides say, “strictly confidential” and noted that they are in the public record as part of this meeting, is this a concern?
 - Optum will remove this footer from the presentation. These slides can be shared publicly, confidentiality is not an issue, this was an error.
- Judy Salo commented that most of the feedback from members tends to be negative, only when they have a problem. She asked whether there is any feedback, positive or negative, on coverage of the shingles vaccine which was implemented January 1, 2019?
 - Emily Ricci shared that they have not gotten direct feedback of any kind of the extension of coverage for the shingles vaccine. She has gotten some contacts about issues utilizing this benefit, but they were able to quickly resolve these issues, and were primarily pharmacy issues that DRB resolved with the pharmacy. She noted that many members expected this vaccine to be covered already, so in the past they have mainly contacted they discovered it was not covered. Some members she has talked to about these issues have also expressed gratitude for covering this.
 - Betsy Wood noted that the benefit is only covered at a pharmacy, not a physician’s office, so they regularly communicate that retirees need to seek these at a pharmacy for it to be covered in the plan. DRB continues to share this clarification with retirees.
- Judy Salo asked whether the staff have considered covering the shingles vaccine at the State’s annual health fair?
 - Emily Ricci shared they have not talked about this specifically but have not otherwise talked about which services to provide at the health fair. Currently the vaccines provided at the health fair are for influenza. .
- Judy Salo commented that she has personally found that OptumRx’s concierge service has been knowledgeable and helpful.
- Judy also asked whether plan members receive one card per household, or more than one card? Is this different for Medicare eligible household members? Please clarify this.
 - A household will receive more than one card, with all covered family members listed.
 - EGWP members each receive their own card, because they are covered according to whether they are Medicare eligible or not. Each individual will have their own card if they are enrolled in EGWP. For those not enrolled in EGWP, they will be listed on the household’s card.
 - If a member needs a new card or another card, they can contact OptumRx directly to request a new card be mailed.

The Board took a break at 10:37 a.m. and resumed at 10:52 a.m.

Travel Coordination

Emily Ricci prefaced this proposal with a reminder that the services being discussed are ideas, not final decisions. They are still working through the analysis and decision-making process; the specifics of each proposal may change over time, and new information may also result in a proposal not moving forward.

Emily shared that the intent is not for DRB to move ahead with implementation of any changes outside of the modernization project, but the Division has seen recent positive changes in the employee plan with implementation of SurgeryPlus travel benefits. They are considering, as an initial idea, whether to extend these travel benefits to the retiree plan and allow retirees to use SurgeryPlus as well. This would not change the plan benefits themselves or what services are covered for travel but would give retirees access to the SurgeryPlus network outside of any future changes implemented as part of the modernization project. The modernization proposal related to travel benefits would still be under discussion including expanding coverage, concierge services, and others not currently available to retirees; in the meantime, DRB could implement the SurgeryPlus network for any benefits already covered under the retiree plan. The Division is interested in implementing this proposal for retirees, but also needs to consider the pending court decision and implications for any changes to the retiree plan. Emily believes that this proposal would benefit both the plan and the plan members.

- Judy Salo commented that there are two ways to consider this benefit proposal: first, as a phase-in of travel benefits, without changing the plan; and second, as a pilot project to consider whether it is working for retirees. In either case, there would be more analysis prior to any additional roll-out.
 - Emily Ricci agreed that this is accurate.
- Judy Salo asked whether inclusion of this benefit would be interpreted as a diminishment?
 - Emily noted that this would not be a diminishment, as it would simply provide greater access to already covered services; the concern is whether it would then become a service they have to offer in perpetuity, without further adjustments or considerations. She also noted that there is some precedent for having a travel concierge service: prior to 2012 there was an administrative service to assist with travel, except that members had to provide payment upfront. It was not an exact analogue, but that administrative service was eliminated in a previous year.

Emily directed the group to page 35 in the packet, with summary information about travel benefit utilization in the active employee plan from its implementation in August 2018 to April 30, 2019: to date, 31 procedures have been completed under this plan, with a total of 161 inquiries and other cases still in process. Emily also noted that there has been a great deal of positive feedback from members who utilized this service, employees who used this benefit have appreciated it to date.

Jon Zutter shared an overview of the proposal, noting that an appropriate analogy would be greater opportunity to utilize existing benefits through their service. There would be a narrow set of services this could be utilized for, unless the retiree plan benefits are changed at a future date.

Employer Direct Healthcare is the name of the company under contract, with its primary product and set of services they provide known as SurgeryPlus. The hypothetical set of services that would be available to retirees would be known as CareCentral, and help retirees navigate their existing benefits for the procedures and circumstances covered in the plan. It would not include a travel companion and

would be limited to services currently covered. The benefits for retirees would include the knowledge and assistance from staff about selecting a provider and coordinating actual travel for retiree for covered procedures. His team and DRB staff have discussed an appropriate scope of services covered under the retiree plan, such as complex specialty diagnostics, and whether retirees would benefit from having travel covered for existing benefits.

Jon stated that the concierge model provides convenience and helps retirees navigate a complex system, as well as helping them find a qualified provider. The table on page 39 illustrates the scope of proposed covered services, and other services under consideration for future implementation. The three primary services would be: travel coordination for eligible care under the existing plan; provider selection, using SurgeryPlus's provider network and other evaluation tools available to assess provider quality and performance; and concierge support for organizing travel.

- Mauri Long commented that she is interested in the services under consideration as well, RHPAB is responsible for considering long-term implications for the plan. She stated the initial proposal seems like a reasonable idea. She asked about the items listed as under evaluation for future coverage: how many of these services are being offered under the employee plan today?
 - Jon Zutter noted that none of the services listed as “in evaluation” are officially being offered to active employees at this time. If the changes put forward are adopted, DRB is considering piloting these first with active employees before offering to retirees.
 - He also noted that while these are not officially offered today, depending on the needs of the individual member on the employee plan, they may offer provider selection or other supports on a case-by-case basis. (For example, if a certain type of surgery or oncology service is not covered, they may still provide some help).
 - Emily Ricci confirmed that this is under discussion, and they are gathering data on utilization in the employee plan as initial data.
- Mauri also asked about more details about procedures contemplated under “chronic condition support” or “complex condition support” and what services would be offered? Are any of these services offered to other clients now, or is this new for the company also?
 - Jon Zutter responded: to the second question, the company sees this as an opportunity because they can expand the services they offer today. Their 3 core services are: 1) providing data to evaluate the best provider and/or care decisions based on available information; 2) a concierge service to coordinate travel; and 3) an established provider network of surgeons for those services. To first question: Complex or chronic condition support would be for a complex but rare event, since as cancer treatment. This could also be regular check-ins and education for patients regarding medication adherence and other strategies to maintain health.
 - The expanded services proposed would be a new product offering for the company, extending what they can do now, so they are interested in expanding their offerings through this plan as a test. In his experience, they can offer education and guidance, most people do not have a good understanding of how to evaluate the quality of a provider when making a decision, and don't have access to the best data on this. In general, they want to provide education for best care decisions that a patient can make. This could also include acting as a liaison between other vendors, helping select a primary care provider, and other similar services.

- Joelle Hall asked, as an example, a person who is located in Alaska but needs to seek care outside of Alaska. She acknowledged that there are several administrative steps that would need to be taken, such as ruling out other diagnoses and securing approvals to get care and get the procedure needed. She noted that a friend went through a complex diagnosis process recently and had more than a year's worth of other procedures and diagnostics before she could get the surgery she needed. How can the company better support this process or help someone navigate the "box-checking" associated with these procedures?
 - Jon Zutter responded that there are two phases of support: first, working with a member to understand their needs and options, educating them on their options, and helping them make that choice. He used the example of a bariatric procedure which has several components before any final procedure can take place, and some assurance that the member will adhere to other lifestyle changes and actions for long-term success. Second, once the best course of action is determined, the company helps the member manage the process and go through the required steps needed. This is a core service that the company provides.
 - Additionally, he responded to the question about going through multiple procedures prior to accessing a surgery: these may be required steps, but there are also situations in which there are wrong diagnoses, or other ultimately-unnecessary care decisions because of an incorrect diagnosis, lack of experience by a provider, and other issues. He described these as avoidable issues if paying attention to a provider's expertise, experience in their field, and what types of patient outcomes they have. Seeking a knowledgeable provider and selecting the right provider upfront is important and can avoid some of the issues described. He sees their service helping achieve this.
 - Joelle commented that this is particularly a problem in Alaska, with a lack of specialists and general lack of very experienced providers in particularly areas. She believes this will open up access to very qualified providers and improve patient outcomes.
 - Jon agreed, it is core to their business to seek providers who specialize in these procedures and noted that providers who conduct over 100 cases of the same procedure per year, versus 20 or 30 per year, will have a higher degree of expertise and a proven record of success.
- Mauri Long asked whether there is progress to add Alaska providers to SurgeryPlus's network?
 - Jon Zutter responded that there are discussions with some Alaska providers, through a national network of which a local Anchorage-based provider is a member. He noted that the differential in cost is significant, so it is not advantageous to their network to pay that differential when there are other options. For example, a \$24,000 knee replacement in the lower 48, versus \$80,000 in Alaska, is very much the better cost choice, and potentially better outcome depending on the qualifications and record of those two providers. Often Alaska prices are not competitive for their service.
- Judy Salo asked about other very specialized fields or diagnoses: would this service help individuals identify the best providers for these procedures as well? She referenced that Mayo Clinic, for example, is well known for some specialties, but there may not be general knowledge about other qualified specialists.
 - Jon Zutter noted that a team approach is important and ensuring that information is shared back with local providers so that the individual's health records are complete.

Jon concluded the presentation by noting that the last slide (page 40) illustrates anticipated benefits and other considerations for extending this service to retirees. Benefits include travel expenses paid in advance, not by the member; no reduction in existing benefits; access to the concierge service and knowledge base of their team; and the fact that this is already in place for the employee plan. The negative considerations: this would require outreach and education to retirees about what is or isn't covered, and also that there are no Alaska-based SurgeryPlus network providers currently, so members would need to travel out of state to remain in network.

Emily suggested that the Board conclude the presentation, hear the next scheduled presentation in the morning, then take up the discussion about this proposed extension of travel services to the retiree health plan after the lunch break.

Chiropractic Group Engagement + SecureCare Presentation

Emily Ricci shared a brief update on discussions DRB staff have had about chiropractic services, and a presentation from a company potentially interested in providing services to manage utilization of chiropractic services. She noted that this is related to, but not the same as, the existing proposal regarding clarification of rehabilitative services, which has been frustrating to members. The presentation and company's scope of services is limited to chiropractic and physical therapy services.

Barron Hoag is with SecureCare, a company that specializes in utilization and network management of chiropractic services. Pre-authorization and similar services have resulted in more administrative work for providers, not necessarily better care for patients, and frustration for plan administrators in terms of utilization. He noted that there are other companies in the same field, but in the past they have resulted in fraught relationships among insurers and providers because their approach is to focus on managing utilization upfront or otherwise inserting themselves earlier in the process, and a great deal of work without necessarily ideal utilization. He also noted that these services in particular are often related to chronic pain management and finding alternatives such as appropriate utilization of these services may result in less reliance on other pain management, notably opioids. He noted that Alaska has disproportionately high utilization rates for some services, such as massage therapy.

SecureCare uses a different approach than pre-authorization or pre-utilization review, and instead uses available data to evaluate services (reimbursement per visit, outcomes, and benchmarks in terms of number of visits) and providing a monthly report card to providers with this data. This provides better data for providers, who generally want to be performing in line with their peers and best practices but may not have access to this kind of data and may end up being an outlier because they are not following those benchmarks. In most cases, the company has found that providers will self-correct when given this information, and providers see this as an effective and fair version of utilization management, informed by actual data. Their approach has resulted in better relationships with providers, data-driven care decisions, and moving toward best practices and benchmarks results in better outcomes for patients through a higher quality of life and functioning.

- Joelle Hall: is this a service that could be added to the plan, addressing the existing confusion and frustration about the plan design, without changing the actual plan design? Could this be added to the plan, within existing plan design, to address this issue?
 - Emily Ricci noted that SecureCare is operating under Aetna's umbrella, and therefore is considered in network for Aetna. There are in-network and out-of-network chiropractic

providers in Alaska. There is still an existing restriction on maintenance care, which would require a plan design change to address, but this would address utilization for network providers. This could mean that there does not need to be an annual cap on services, leaving it instead to best practices utilization. The rehabilitative care proposal as written would remove the cap for in-network providers but retain a cap for out-of-network providers, given that network providers would be part of SecureCare's network, and their utilization would be guided by the benchmarks provided.

- Mauri Long requested that Aetna staff be available for questions in the afternoon.

Judy Salo thanked both SurgeryPlus and SecureCare for their presentations.

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

Item 4 (Continued). Discussion on Presentations

Chair Judy Salo re-convened the meeting after the lunch break.

[Travel Coordination Services for Retiree Plan \(continuation of morning agenda item\)](#)

- Judy Salo asked DRB staff whether the Division would like any formal action by the Board regarding the recommendation to implement limited travel services for the retiree health plan through SurgeryPlus? She noted that the general feedback from members in the room was interest in and support for this idea, at least in concept.
 - Emily Ricci responded that staff do not see this as an additional plan benefit per se, but an administrative change how services are coordinated for existing benefits. However, while there are many benefits to including this in the plan, she also noted that the primary risk is whether adding this service would be considered a new benefit that would need to be provided in perpetuity, given the recent court ruling, and staff need to consult with the Commissioner on whether this risk is sufficient to table this item for the time being. However, she also noted that given the cost differential between care in Alaska and care in other states, there may still be financial benefit to implementing this, even if the State is required to maintain this benefit in perpetuity. She recommends the Board not take action at this time, until the implications of the court case are known.
- Dallas Hargrave commented that he sees a benefit to providing this service, but also noted that he is concerned about whether this would contribute to specialty expertise leaving the state, which is already a concern. He noted that it would not be likely for an Alaska provider to be competitive for the procedures SurgeryPlus includes.
- Mauri Long asked whether staff have analyzed the scale of administrative and other costs, relative to the potential cost savings?
 - Emily Ricci responded they have not done a formal financial analysis for the retiree plan, but with the experience so far with the employee plan benefit, she does anticipate a return on investment even with relatively small utilization. She noted that the retiree population is larger, so it would have a larger administrative cost, but it may also generate significant benefit, including for those living outside Alaska but who would wish to travel to another location for care.

Chiropractic Group Engagement

Materials: Information on page 41 of 5/8/19 meeting agenda packet

- Teri Rasmussen shared an overview of DRB's engagement with Alaska-based chiropractors. DRB has facilitated engagement between chiropractors and Aetna to explain how the plan works, answering any questions about the current plan and proposed items under discussion, and otherwise discussing anything relative to the health plan. Staff asked providers to share any issues they've had related to claims, so that these can be evaluated for troubleshooting and determine what if any issues in the claims process can be improved.
- DRB will also host a webinar for providers via the Alaska Chiropractic Society in the near future, to provide an overview of the AlaskaCare plans and relevant benefits.
- This engagement is ongoing among DRB, Aetna and chiropractic providers.

Item 5. Modernization Project: DRB Presentations of Analysis

Rehabilitative Care

Materials: Summary memo beginning on page 63 in 5/8/19 meeting agenda packet

Betsy Wood provided an overview of the updated summary memo and reiterated that this and the other proposals are all actively in discussion and revision, so feedback is welcome throughout.

Betsy noted that the original version of this proposal would change the plan design of how rehabilitative care is covered, addressing confusion many members have faced to utilize these benefits. One change proposed is to allow coverage of visits for maintenance care, not just following an injury or other incident, which is not covered today, and which members have asked for. The primary change to the proposal's original version would still implement a cap in the number of visits for outpatient rehabilitative care for out-of-network providers, set by the service type. The plan would cover up to 10 visits for acupuncture. She also noted that massage therapy is considered a type of rehabilitative care, either as chiropractic or physical therapy, so it would be covered and would potentially be subject to the cap for out-of-network providers. For in-network providers, the plan would not set an annual visit limit, but could consider other utilization management such as the service provided by SecureCare.

Emily added that the actuarial analysis for this proposal has not yet been updated; DRB is seeking guidance to give to Segal prior to updating the analysis on a proposed number of visits.

- Joelle Hall noted that there is potential need for these services throughout the state, including in areas with few or no providers, or in-network chiropractic providers. She asked what the provisions would be for those members without an in-network provider close to home?
 - Emily Ricci responded that the original proposal was to set a cap on visits for all rehabilitative care services, not just out-of-network providers, so this would be less restrictive than the original version. However, she acknowledged that there is currently a limited network of chiropractic providers in Alaska; she believes that having a plan design like the proposal could provide incentive for chiropractors in Alaska to join the network. She noted there are multiple options, such as a carve-out for areas with only out-of-network providers, not having a cap on visits, or maintaining the cap on out-of-network services and encouraging extra visits to occur with an in-network provider.

- Dallas Hargrave commented that small communities in Alaska generally do not have many providers, or even in-network providers. He suggested that this is an issue regardless of the service type, so he asked whether this should be treated differently than the other services for which there would be limited or no in-network providers?
 - Emily Ricci noted this is a good point. In the past, this type of service was considered differently than many other services, and unlike most other plans, there are not significant differences currently in reimbursement for in-network versus out-of-network care. She suggested that the rehabilitative care services may be sufficiently different in nature to merit having their own network policies, and also that perhaps not having a cap on in-network services would grow the network by providing an incentive. The main goal is to clarify when and how the benefit applies, as this has been a point of confusion for members and has generated several appeals.
- Cammy Taylor noted that rehabilitative care has been an ongoing administrative and appeals issue, so she understands that this needs to be clarified.
 - Emily also noted that this cap on services is being discussed for outpatient services only, and not those provided in an inpatient setting, which would not have a cap.
 - Betsy Wood directed the group to the memo noting that chiropractic care and acupuncture have been listed as distinct categories
- Cammy Taylor commented that the phrase “rehabilitative care” is a general category, and people misunderstand what is or is not included.
 - Emily agreed, changing the terminology to specifically list the other services would clarify this, and keeping chiropractic services separate would clarify this as well.
- Cammy Taylor asked how a chiropractor would bill in this situation, if they can bill for these other services but not chiropractor services? She understands that a chiropractor’s office may offer some of the other services on this list such as physical therapy
 - Emily noted that this is a good question. The answer would depend on what services are billed and under what codes, but this situation would need to be addressed. She also noted that for a visit with multiple services, they contemplated this as a number of visits, not number of services provided at the visit, so this should also be resolved.
- Judy Salo commented that she is interested in the implications for massage therapy. If, for example, a person attended the chiropractor for an adjustment procedure, and also received massage therapy, this visit would have two codes. Would this be considered two visits?
 - Linda Gable clarified that the CPT (billing) codes would show as one visit, with multiple services being provided each coded accordingly.
 - Betsy Wood clarified this would be one visit with multiple services. She noted that if there are multiple services, then one visit could apply to the limits of multiple services, for example if chiropractic services and physical therapy services are provided.
- Joelle Hall asked if, using a hypothetical example, a person could seek the maximum number of chiropractic, physical therapy, and other visits, and get massage therapy at each of those visits, they could theoretically get reimbursed for up to 65 (45 + 20 maximum visits) visits per year including therapeutic massage?
 - Linda Gable clarified that the plan also requires that the services be part of an overall treatment plan, including a diagnosis code for the CPT (billing) codes submitted on a claim.

- The services billed must be associated with that diagnosis code to be considered medically necessary and related to needed treatment for the patient's condition.
- Emily Ricci added that in the current plan design, there is likely nothing stopping an unscrupulous provider from providing the maximum number of massage services as described above. However, this could be addressed on an exception basis with individual providers, as any disproportionate billing for services would stand out when analyzing claims on a per-provider basis.
 - Betsy Wood noted that there was discussion in the previous day's meeting about a problematic pharmacy in another state (Broadway), and that they can be carved out of the network as needed if there is a significant problem. This was effective in the pharmacy plan based on the action they took, on an exception basis.
 - Emily Ricci noted that in the case of Broadway pharmacy, the actual spending on compound pharmacy medications dropped considerably after carving them out of network, as well as no longer working with a specific mail order pharmacy.
- Mauri Long commented that she is a firm believer in the value of rolfing services and has found that it is effective beyond massage therapy and is preferential for her to chiropractic services. Rolfers are often employed in chiropractic or physical therapy offices to provide those services. She also noted that the documentation of whether it has sufficient medical evidence to be effective is limited, and she also questioned whether there is sufficient evidence for massage therapy being effective, but this service is already covered. She would like more discussion of this item before it is taken off the table as a covered service.
 - Judy Salo asked whether there is emerging evidence or ongoing studies of the efficacy of rolfing, and whether it could be considered an evidence-based practice?
 - Emily Ricci noted that the literature review of this analysis was done last year, but at that time they did not find sufficient evidence in the literature at this time.
 - Additionally, rolfers have not organized into a licensed profession or otherwise taken on the organization that other providers like massage therapists have done, as well as the fact that there are not currently CPT codes for rolfing services, which would make it administratively challenging to handle.
 - Mauri Long noted that in other insurance review work she has done professionally, rolfers will often use massage therapy CPT codes interchangeably. She also noted that in both instances, the massage therapist or rolfers would need a referral from a chiropractor to ensure it is a medically necessary service to restore function. She suggested that the plan could be sufficiently protected by requiring referral. She would like this item brought back for consideration.
 - Judy Salo knows some rolfing providers who have gone to school for that discipline, the program is actually longer than a typical massage therapy program. She has heard a number of concerns from Alaska retirees, as well as rolfing providers, especially on the Kenai peninsula. The Kenai Peninsula Borough School District health plan for employees does now include coverage of rolfing, but they lose that coverage when going into the AlaskaCare retiree plan. She also would like to revisit this and suggested researching the other plan's language.
 - Cammy Taylor asked for the rationale for setting 20 visits for chiropractic care only, versus 45 visits for the other service types?

- Emily Ricci did not recall the specific reason for the number of visits by service type but will review the minutes again. She added that she will research what is in the KPBSD plan, and how they administer this.
- Teri noted that visits are intended for restoring function, the limit would be 45 visits for any of those services.
- Cammy added that for example, a person could use 45 PT visits for a single incident.
- Nan Thompson asked the rationale for the number of visits: 45 for services such as PT, 20 for chiropractic, and 10 for acupuncture?
 - Mauri Long suggested to the board that they give clear guidance for Segal analysis.
 - Emily Ricci will research the specific reasons, some may have to do with the evidence base and literature on the efficacy of these services. Having a different limit for different service types is common in plan design across the country, so the numbers proposed are not inconsistent with other plans that they reviewed. Staff would like guidance on limits to consider for conducting the analysis.
 - Richard Ward responded that in other plans, it is common to have a limited number of visits to address whether those rehabilitative services are necessary over the long term, or whether after a certain point an individual needs a different diagnosis or treatment plan to address their issue.
- Cammy Taylor commented that this may be an issue with a few outliers or problematic providers, but an administrative structure is put into place that places a burden on everyone when the actual issue is limited. She noted that covered services today are intended to address restoring functioning, but this does not address maintenance care, since it has a higher standard for what is covered. She wants to find a balance between providing care for retirees to keep them mobile and functioning, but also ensuring care is medically necessary.
- Mauri Long commented that she appreciates SecureCare's approach of retroactive review using actual claims data and benchmarks, rather than putting new administrative procedures in place. She is interested in the implications for pursuing a proposal for those services, but also understands that SecureCare is in a contractual relationship with Aetna. She asked whether this type of plan policy is more the purview of the third-party administrator as a management issue, rather than a plan design issue? She noted that the current TPA has not administrated this aspect of the plan in a way that retirees find acceptable.
 - Emily Ricci noted that staff have done considerable research, and so far have identified multiple causes of the issue: regardless of the decisions made about the plan design, there are several issues and staff, Aetna and providers will continue to address the issues in their control regarding claims and billing. She also noted that there are multiple contributors to the billing problems. Relations have improved because of more communications, but the underlying problems are still present, including with the plan language. They continue to work on solutions in as many areas as possible.
 - She added that their interest is not specifically in SecureCare, but the concept of retroactive management. She also noted that there are other management strategies used by the TPA that may not make a limited number of visits necessary, at least for in-network providers, she feels this could be addressed through the TPA's contractual agreements with network providers. For out-of-network services, there are not any contract provisions that can be utilized because there are no agreements. Having a clear limit defined for out-of-network

- services would be a way to manage this, outside of the normal network contract agreements. Similar to SurgeryPlus, there needs to be discussion about networks and that the same service is not covered twice over.
- Regarding covered providers, she pointed out that the different provider types for rehabilitative services are all valuable, but there are different levels of education, licensure requirements and other aspects of these professions that should be taken into account. Staff are open to any suggestions regarding number of visits, covered provider types, and how to handle in-network and out-of-network providers.
 - Mauri Long commented that the proposal to limit out-of-network providers, and have less limits on in-network providers, makes sense, assuming that the TPA will effectively manage utilization within the network. She does not see the limit on number of out-of-network visits to be unreasonable but does not want to punish members who do not have easy access to an in-network provider. She also asked for the rationale about number of visits for acupuncture and noted that this service is not typically used as an ongoing service or provided over many visits at a time. She also noted that acupuncturists do have a high level of education.
 - Cammy Taylor commented that she would like to see an option for the administrator to allow coverage of additional visits based on medical necessity. Could this be considered again?
 - Emily Ricci noted that if this is included, she would prefer to see this option limited to members living in areas without an in-network provider, versus allowing a provision for members who do live in an area with network options, as this would undermine the differential between the two, and the incentive to join a network.
 - Cammy Taylor: it may still be challenging if there are one or more in-network providers, if they are not accepting new patients or otherwise will not see the patient, and/or they have a 6-month waiting list, for example. This would not actually be feasible for being considered “in network.” She suggested that there needs to be more thought about whether a network is adequate and whether patients can access those providers.
 - Emily noted that this is an important issue, and there is currently no clear standard for what constitutes a sufficient network. The Division and TPA would benefit from having more clear guidelines about what constitutes a sufficiently robust network. Emily will also connect with Lori Wing-Heier, Director of the Division of Insurance, if they have any standard that they apply when evaluating commercial plans.
 - Cammy appreciated the follow-up. She noted that given that the robustness of the network is a consideration for managed care, because Alaska does not regulate managed care, this may not exist here.
 - Emily Ricci commented that network adequacy is usually calculated on a providers per population basis, as a general ratio.
 - Richard Ward shared that it is typically a geographic analysis, comparing the number of in-network providers within proximity of where members live. He is unsure whether the measure includes capacity / whether the provider can accept new patients. He assumes that it would vary by provider type as well, so it can be measured, but may be complex.
 - Emily reiterated that having some guidance on how to measure network adequacy would help with many different discussions and would inform when a waiver or other carve-out will apply.

- Nan Thompson commented that she supports having guidelines and having Alaska-specific standards would be very useful, as many retirees do not live in Anchorage or other urban areas, and health care access is a general issue in Alaska.
 - Richard Ward added that this is important but needs to be balanced against having plan design features that make it feasible for a third-party administrator to effectively negotiate and maintain incentives for a provider network.
 - Nan added that there are other ways to address access beyond network, such as the enhanced travel benefits and access to telemedicine.

Emily Ricci asked the Board: for purposes of conducting actuarial analysis of this topic, what guidance would the Board like to give on a number of visits per service type?

- Mauri Long asked for any available claims data and guidelines for the average number of visits for a typical incident, from recovery from an injury, to recovery from a stroke and needing a long-term treatment plan to improve or maintain function. Does Aetna or another source have any available data on what level of services are needed for various diagnoses or incident types? Is there Alaska specific data, or national standards?
 - Richard Ward commented that, during the initial analysis, Segal found that the average number of visits for each of these proposed limits is lower than the proposed limit. In some cases, there were more than that number; the data is 9+ months old and should be updated with recent claims. The original proposal did take this into account.
 - Emily Ricci added that the 45-visit limit was above the utilization rate of most (at least 90%) of members, with only a small percentage above that limit. On average, members utilized chiropractic benefits closer to the proposed limit of 20 visits, but it was still higher than most members' utilization across Aetna's book of business.
- Nan reiterated that she wonders whether the visits per year limit is the right way to think about this, or whether another option is better to address the problem that the group is trying to solve? She is unsure whether a set number of visits is the right solution for treatment on a case by case basis, or to maintain functioning.
 - Emily Ricci responded that the current approach is on a case by case basis, for example if a patient exceeds 20 visits, their case triggers a medical necessary and plan of care review today. This is an extremely time-consuming process for the provider, patient and TPA, and requires a great deal of supporting documentation of whether they have shown improvement. There are many issues with this process today; staff are looking for a more clear guidelines, short of conducting this process every time. It is also the #1 appealed plan benefit, which also takes considerable time. She noted that one solution is simply to set a limit, assuming that most will not hit that limit, and for those who do need additional visits, the expectation would be clear members pay for additional visits.
 - Betsy Wood added that the limits are also being proposed for out-of-network providers only, with the idea that there are no management tools for out-of-network providers.
 - Nan agreed that this makes sense, she appreciates the incentive to add providers to the network and ensure quality of care, particularly as a provider in network has other quality control measures.

Emily asked the group again whether the proposed visit limits are appropriate for purposes of Segal's analysis to update this proposal?

- Judy Salo commented that she does not have better information but noted the main discussion has been either about having limits, or not having limits. She encouraged Board members to send their thoughts and suggested limits via e-mail, if not in the meeting today.
- Joelle Hall noted that the table on page 62, outlining the potential costs and impacts, and that there are no clear numbers for the impacts today. She also noted that if the main issue with this proposal is litigation in the form of appeals, what if any savings are associated with this proposal? “Is the juice worth the squeeze,” meaning whether each proposal is sufficiently beneficial to members and/or the State to pursue, given that some proposals will be controversial than others, and anything regarding steerage to in-network providers needs to be carefully considered and ensure that it will have sufficient benefit that it is worth pursuing? She encouraged staff to provide more information.
 - Emily Ricci noted that for this proposal, the primary benefit is not financial, but to be able to provide clear guidance for providers, members and the TPA for this benefit. She noted the initial analysis resulted in a nominal diminishment (about 0.01%). She also noted that these limits are an industry standard, and whether or not this is the ideal plan design, it is more common for providers across the U.S. to operate under these limits, versus the AlaskaCare plan today. Clarifying this benefit would significantly improve administration of this benefit, even if it does not result in savings to the plan.
 - Richard Ward noted that the initial analysis of this proposal is included in the packet and does not show significant cost or cost savings, so the main reason for the State to consider this would be to improve administration of the plan for all parties.
 - Joelle Hall stated that one significant area of confusion is about “progress” and how to define that in terms of medical necessity.
 - Cammy Taylor agreed that establishing clearer guidelines would be helpful.
 - Joelle responded that perhaps the language change could be made, without making any changes to the plan design like a limit on the number of visits? Could this be done and improve the plan without introducing other policies such as steerage, acknowledging that there may be other benefits for such provisions, but they may not be worth the implementation cost?
 - Nan Thompson suggested that maintaining functioning is an important goal, and particularly for older adults, it may not be realistic to expect “improvement” but simply to maintain current functioning.
 - Cammy Taylor clarified that the original proposal did not talk about steerage, only about setting a limit on number of visits. Since that time, the SecureCare model of utilization review, rather than setting limits upfront, became an option and was being considered to address this issue in a more data-driven way. Then the question became, how to address utilization outside a network, since SecureCare requires working in-network and can only manage utilization with network providers? She also asked staff whether they have specifically discussed visit limits with the chiropractic group?
 - Emily Ricci responded that the stakeholders did not specifically discuss the limited number, but that it is already common in other plans, so chiropractors are used to dealing with visit limits. She did not assume to know their reaction to the proposal but noted that if given the option for limits versus no limits, they would likely

choose no limits. But if given the option for clear limits versus what we have today, they would likely choose clear limits.

- Cammy supports the SecureCare model of utilization management but understands that the issue of non-network care would have to be addressed. She would like to hear from retirees whether this is a better solution, compared with the current plan design. She suspects that, if most people do not utilize above the proposed limits today, they would also welcome clear guidelines to reduce frustration and administrative burden.
- Judy Salo would like to see clarification about how visits versus services are treated under those limits, and this addressed in the memo.
- Mauri Long reiterated that staff should also review KPBSD's coverage of rolting services.
- Dallas Hargrave agreed with Cammy's statements, he would like to see more analysis and give retirees opportunity to comment on the proposed limits, compared to the current language.
- Mauri Long asked whether Segal should also conduct analysis of the cost of having no limits, versus applying limits? She believes this would help understand relative costs of the options.
 - Betsy Wood asked whether it would be acceptable to consider two options: a limited number of visits for both in-network and out-of-network, and in-network no limit with a limited number of visits out-of-network. She suggested that even if the State can rely on management within the network, there is no mechanism to do this out-of-network, so they need other ways to address utilization in a way that is more clear than today.

Emily Ricci shared that there is likely not time to address both remaining proposals on today's agenda and asked for the board's preference. The group tabled the Teladoc discussion for a future meeting.

Out of Network Reimbursement

Emily Ricci shared that currently, the AlaskaCare retiree plan reimburses out of network services at the 90th percentile of all charges for that service, which means in some cases that a provider may be reimbursed more if they are not in the network. This is separate from, but similar to, the 80th percentile rule in commercial insurance plans in Alaska, required by regulation and with the protection that a patient cannot be balance-billed if the insurer does not cover the full charge billed by the out-of-network provider. AlaskaCare is not subject to that rule but reimburses at an even higher percentile rate. One challenge with this design is that it may incentivize providers to 1) stay out-of-network and 2) continually increase prices over time, so that the reimbursement range increases over time as well.

This proposal would set the reimbursement rates at a percentage of Medicare charges for those services, which is increasingly common in other public sector and employer plans, as well as being implemented in other Alaska plans. In many cases this would mean lower reimbursement for out-of-network providers and may provide a strong incentive to participate in the network. However, it may also expose members to balance billing since there would be no protection against this, so there is risk for members to be charged more out of pocket, for out-of-network care. The initial proposal is to consider a percentage of Medicare, as a standard well-developed set of rates; the initial number proposed for discussion is 185% of Medicare. It is not perfect: not all services are covered and would need their own rates established, but many are covered by Medicare already. She acknowledged this is a significant proposal and would impact members. However, it is worth considering as an offset as they look at other changes to the plan to enhance benefits, it should be discussed and adjusted as needed.

Richard Ward noted that the presentation beginning on page 77 includes a broad analysis of actual claims data of charges paid today under the retiree plan for in-network and out-of-network providers in the category of professional services, facility (hospital) charges, and overall for medical charges. The numbers on page 79 represent percentage of Medicare charges in each of these situations, only for claims related to non-Medicare members. In all categories, out-of-network charges are reimbursed at a higher rate than in-network, and overall the difference is 226% of Medicare in-network and 272% out-of-network. This finding is not surprising but has not been presented in this way previously. The table on page 80 further shows that reimbursement rates are significantly higher in Alaska than the rest of the U.S.: care in Alaska is generally higher cost than elsewhere, and there are more members and providers in rural areas, which also tend to have fewer network providers and/or higher costs. However, because Alaska's plan reimburses at the 90th percentile, it is likely that non-Alaska providers are also compensated at higher rates than they would get under most other plans.

- Mauri Long asked about data for overall reimbursements, and asked for clarification about Aetna network rates versus Fair Health rates for out-of-network services?
 - Richard Ward explained that using actual claims data, Segal converted claims charges into a percentage of Medicare rate, rather than stating as a 90th percentile charge. They used Medicare rates and compared with the Fair Health database of current charges, from which they derive the 90th percentile charges. He further clarified that these are recognized charges, and based on actual claims paid by the plan, not what the provider billed, so these do represent actual plan expenditures.
- Cammy Taylor asked, given that the data shows is a relatively similar percentage for out-of-network facility care inside and outside Alaska—if generally Alaska is higher cost, why would the plan also reimburse at a high rate in other places?
 - Richard Ward responded that the Medicare rates are determined by geography, so Alaska's charges are higher already in Medicare. Additionally, the analysis just looked at all services that are in-network or out-of-network, and not necessarily down to the level of similar categories of visits broken out for better comparison. These are aggregate analyses and should be evaluated in more detail to understand how this impacts different types of services and settings.
- Cammy Taylor understands that this is a big and controversial topic and needs more specific analysis. She noted that in the Alaska Common Ground series on the high cost of health care in Alaska in 2017, there was data shared about considerable variation among reimbursement rates by discipline or specialty. Additionally, she noted that there are already challenges for finding providers who accept Medicare, or Medicaid, and providers struggle to maintain a balance between lower reimbursement rates for some populations and having other patient populations make up the difference. She stated that for some provider types, it has been challenging to attract new people to practice in Alaska, particularly because they could have a more lucrative practice by staying out-of-network. She asked what general percentage of providers are currently in- or out-of-network?
 - Emily Ricci stated that all these factors are relevant and noted that a reasonable person could find reimbursement rates very high currently. Alaska is consistently #1 or in the top 5 of states or markets for the cost of care. Other plans have started implementing changes that have incentivized providers to join the network, and this may help, but it may be most impactful for the major plans to implement changes like this as a way to shift the overall market. There are certainly extraordinarily high charges by some Alaska providers. She

anticipates this proposal will change, and may not be the best approach, but more analysis is needed to understand how to address the underlying problem, which is that the plan and members are paying a great deal for care.

- Cammy Taylor noted that the percentage of Medicare reimbursement for out-of-state providers was higher than she would have anticipated.
 - Richard Ward noted that a percentage reimbursement is common in other plans in other areas, so Alaska's rates may stand out compared with many other plans.
 - Emily Ricci noted that she believes that it would not be possible to make the Alaska charges equal to lower 48, but there would still be ability to negotiate better network rates relative to what they have today, if the plan allowed it. The focus has been on getting more providers in network, and not so much attention on how much it costs to add them to the network in terms of negotiated rates, so the plan is still paying a lot.
- Joelle Hall asked whether the 90th percentile of reimbursement is on billed charges, and how it is determined?
 - Richard Ward responded there is a national database, Fair Health, used as a comprehensive reference because it is based on actual provider billed charges, by geography and provider type. An algorithm removes outliers on either end of the price spectrum, then calculates the 90th percentile of the claims other than those outliers. It is not a percentage, but a statistical determination from actual data.
 - Emily Ricci added that the Fair Health database includes all provider charges, including in-network charges (at whatever the negotiated rate is) and out-of-network charges billed, without differentiating in the system. Unlike commercial insurance plans, in which the insurer can determine which database they will use as the basis for the 80th percentile rate, the State uses Fair Health as a policy.
 - Betsy Wood added that the Fair Health database is updated every 6 months with actual claims data. If billed charges continue to rise in the database, then the percentile charge would also rise over time; it could also drop, if overall charges drop.
- Cammy Taylor commented that, in theory, rates would be impacted by the number of Medicare providers (who must bill Medicare rates for their patients) and also in areas or specialties in which there is only one provider.
- Emily Ricci concluded by sharing that DRB will direct Segal to conduct additional analysis, including a more detailed analysis by provider or service type, and will present this at a future meeting.
- Judy Salo thanked staff for the overview and looks forward to further discussion at the modernization committee meeting. Will this analysis be available at the August meeting?
 - Richard Ward confirmed that the next analysis can be completed by August.
- Cammy Taylor asked whether the team is on track to review these proposals in the modernization committee over the summer, to bring all proposals to the board in August?
 - Emily Ricci stated that she believes the team is still on track to complete all analyses prior to the August meeting.
 - The group will schedule two (or more) modernization committee meetings prior to the August meeting via e-mail, given the members' overlapping travel schedules.
 - Cammy Taylor stated that the committee discussed scheduling over the break, and would be available June 11 (a Tuesday), or July 30 (also a Tuesday).
 - DRB staff will review these dates and complete scheduling.

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

Set 2020 Meeting Dates

Page 102 in the packet includes proposed dates for calendar year 2020 meetings, following the same general schedule of one per quarter and corresponding with quarterly vendor meetings. DRB asked the group whether it is possible to move the day of the week for quarterly board meetings from Wednesday to Thursday, which would allow the quarterly meetings with Aetna (TPA vendor) to be Tuesday-Wednesday instead of Monday-Tuesday, to accommodate their travel schedules.

- **Motion** by Gayle Harbo to adopt the proposed dates for 2020 meetings as presented in the packet. **Second** by Nan Thompson.

- **Discussion:**

- Judy Salo: the group needs to discuss the date of the August 2019 meeting as well. She noted that these dates may be subject to change, but that it is helpful to calendar them well in advance. The group did not have objection to moving to a Thursday meeting. They may also consider more than one day of meeting.

- **Result:** The board voted to approve the 2020 calendar dates.

Hall	Harbo	Hargrave	Long	Salo	Taylor	Thompson
Absent	Yes	Yes	Yes	Yes	Yes	Yes

Motion passes, the 2020 RHPAB meeting dates are set.

August 2019 Meeting

- Judy Salo noted that given the amount of material and discussion to cover, she believes there could be need for a two-day RHPAB quarterly meeting, since some items were not addressed today and knowing that there will be significant discussion time needed. She proposed a two-day meeting on August 7-8, following the quarterly review with vendors on August 5-6.
- Emily Ricci commented that staff intend to give more time for RHPAB members to review materials prior to meetings, including time to respond to questions and analyses in writing.
- Cammy Taylor commented that she often feels pressed for time given the amount of information being presented, and suggested reserving time for the second meeting day now if possible.
- Judy Salo suggested that having the second day would be helpful, but also it is common that the quarterly meeting concludes before the end of the day. Perhaps part of the RHPAB meeting could begin the second day of those meetings, time permitting. She noted that the July 30 date proposed for the modernization committee is only one week away from the board meeting, this may be challenging for staff. Is this sufficient time for staff to prepare materials?
- Betsy Wood commented that much of the analysis has been completed, she anticipates it would be feasible to conduct most of the analysis and heavy discussion in the June meeting, and address as much as possible before the July 30 meeting, to minimize turnaround work needed before August.

- Wendy Woolf commented that RPEA has a big organizational meeting on Tuesday, June 11, and would like to have someone present for the modernization subcommittee meeting. She requested that the committee consider a different date.
- The Board will address scheduling of the committee meeting via e-mail.
- Mauri Long asked whether the August 2019 meeting will be in person?
 - Yes, the discussion was to hold the in-person meeting in Juneau in August.
 - Judy Salo shared with Paula Vrana in the Commissioner's office, having the in-person opportunity to engage with the Board and staff is very valuable. She requested that Paula relay this to the Commissioner as it relates to travel resources.

Closing Thoughts

- Board members thanked all staff and the rest of the team for their hard work!
- Judy Salo asked for information about the memorial service planned for Michele Michaud?
 - Emily Ricci shared that the memorial will be open to the public, and publicly noticed in the Juneau paper. It will be held on June 8, 4 to 8 p.m. at the local yacht club. It was organized primarily by the Commissioner's office but DRB staff were also involved. Gov. Dunleavy also granted Michele an honorary 30-year pin and formal recognition for her service. The Legislature is also considering a formal commendation as well.
 - Board members informally discussed collaborating on a gift for Michele's family.

Motion by Gayle Harbo to adjourn the meeting. **Second** by Cammy Taylor.

- **Discussion:** None.
- **Result:** No objection to adjournment. The meeting was adjourned at 3:57.

The next Retiree Health Plan Advisory Board meeting is planned for Wednesday, August 7, 2019.

Check RHPAB's web page closer to the meeting to confirm the schedule, location and to download materials for upcoming meetings. <http://doa.alaska.gov/drb/alaskacare/retiree/advisory.html>

Pharmacy Market and Dynamics



Dynamics of trend

Price Inflation

National drug spending to reach \$500B by 2025¹

- Price inflation is a top contributor, outpacing utilization growth 4:1²
- Nearly 80% of drug spend has price inflation rates between 7-10% annually

Pipeline and Technology

40% of drugs in the development pipeline are specialty³

- 59 new drug approvals in 2018 – new all-time record and up 28% from 2017
- 58% of approvals for rare diseases including first FDA-approved CBD drug

Biosimilars and Generics

Competition drives down costs but biosimilars face unique challenges

- Slow progress for biosimilars due to litigation
- Generics for traditional drugs continuing to mitigate trend, but reaching saturation

Drug Promotion

Pharma TV ad spending up again in 2018 to \$3.73B⁴

- ~80 drug commercials every hour, focusing more on specialty conditions
- Top 10 drugs by DTC spend accounted for half of spend; Humira DTC = \$375M

Sources: 1. U.S. Centers for Medicare & Medicaid Services, "National Health Expenditures Data". 2. Peterson-Kaiser Health System Tracker, "Recent drug spending growth has largely been due to new brands, high prices for existing drugs, and fewer patent expiries", Feb. 21, 2019. 3. US Food and Drug Administration, "2018 New Drug Therapy Approvals". 4. Fierce Pharma, "In Another Record Year for Pharma TV Ads, Spending Soars to \$3.73B in 2018", Jan. 2, 2019.

Specialty drugs continue to gain attention

Washington Post

April 18, 2019

Gene Therapy Cures Infants Suffering from 'Bubble Boy' Immune Disease

NPR

April 16, 2019

First U.S. Patient Treated with **CRISPR** as Human Gene-Editing Trials Get Underway

Forbes

June 20, 2018

What's Holding Back Market Uptake of **Biosimilars?**

American Journal of Managed Care

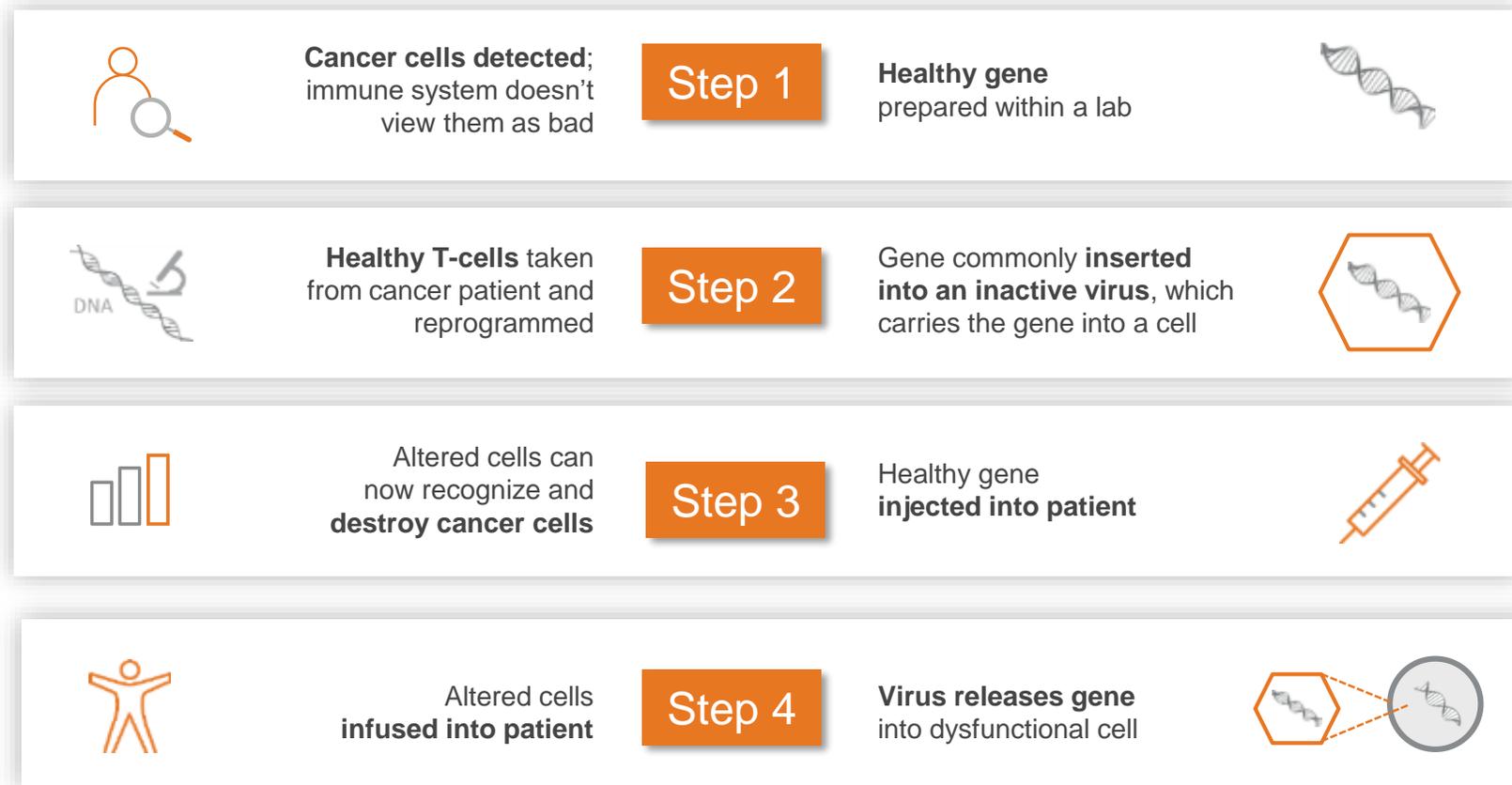
May 7, 2018

The Rise of **Orphan Drugs** for Rare Diseases

Cellular and gene therapy

Cellular therapy

Gene therapy



Zolgensma (onasemnogene abeparvovec)

Novartis/AveXis

Indication	<ul style="list-style-type: none">• Treatment of pediatric patients less than 2 years of age with spinal muscular atrophy with bi-allelic mutations in the survival motor neuron 1 (SMN1) gene• Approved: 5/24/2019• Launched: 5/29/2019
Efficacy	<ul style="list-style-type: none">• Ongoing late-stage trial: 19 of 21 patients were alive without permanent ventilation and were continuing in the study as of March 2019 data cutoff• Early stage trial: at 24 months following Zolgensma infusion, 12/12 patients in a high-dose cohort were alive without permanent ventilation
Clinical Profile	<ul style="list-style-type: none">• Gene therapy (delivers a copy of the gene encoding the human SMN protein)• IV• Boxed warning: acute serious liver injury• Dose: 1.1×10^{14} vector genomes per kilogram of body weight
Competitive Environment	<ul style="list-style-type: none">• Advantages: novel mechanism of action, one-time infusion (vs. chronic administration of Spinraza), strong short-term/early stage data• Disadvantages: long-term data lacking, boxed warning for acute serious liver injury• WAC = \$2.125 million for a one-time dose.



Zolgensma Cost Comparison



Zolgensma Members = All cholesterol lowering agents spend for 1Q19 for AlaskaCare retirees



Zolgensma Members = All asthma/COPD spend for 1Q19 for AlaskaCare retirees

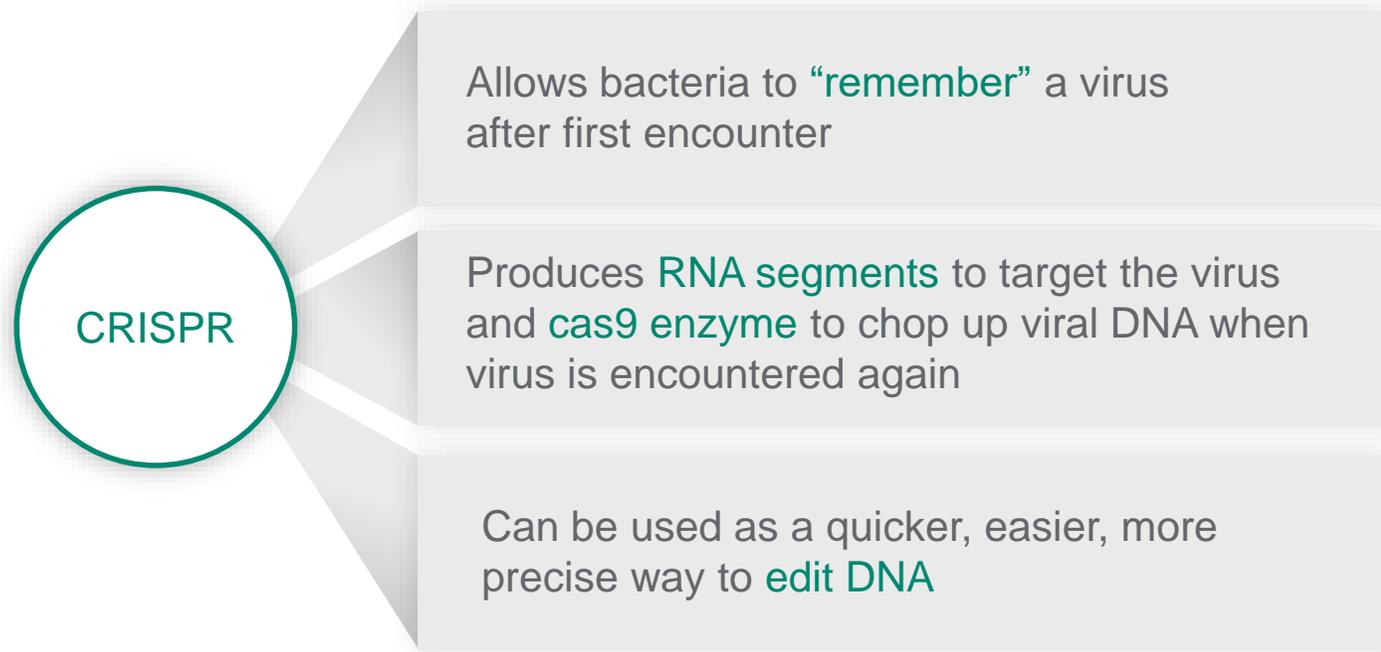


Zolgensma Members = All Retiree oncology spend for 1Q19

What is CRISPR?

Clustered regularly interspaced short palindromic repeats

A naturally-occurring genetic sequence native to the immune systems of certain bacteria.



Makes it possible to reliably alter genes in almost any organism

Biosimilars overview

Biosimilars will provide less expensive versions of branded biologic drugs in the same way generic drugs do for branded traditional drugs.



51 biosimilar clinical trials underway in the U.S.³



737 medications moving through various pipelines⁴

TRADITIONAL MEDICATIONS

- Easily replicated and mass-produced
- FDA approval process ~50 simple tests²
- Chemicals can be copied quickly and inexpensively

2-3 years
Development time

\$2-5 million
Development costs

BIOLOGIC MEDICATIONS

- Made in living cells = identical copies impossible
- FDA approval requires ~250 complex tests²
- Complex: Take longer and cost more to duplicate

>5 years
Development time

\$100 million
Development costs

15% expected average savings¹ with biosimilars vs. **80%** with typical generics.

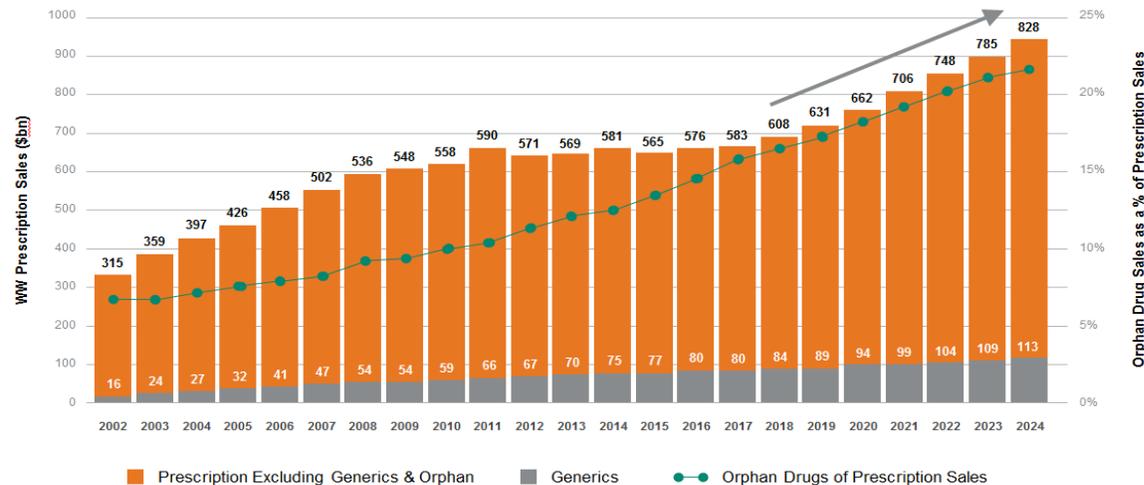
Sources: 1.Ventola CL. Evaluation of Biosimilars for Formulary Inclusion: Factors for Consideration by P&T Committees. P T. 2015 Oct; 2. Buildingciologics.com. Manufacturing Matters with Biological Medicines: How Are Biological Medicines Different from Other Medications? 2013 3. Thomson Reuters: Cortellis online database. 2016; 4. Biosimilarspipeline.com. Biosimilars/Biobetters Pipeline Database – Top Level Data (3/8/2016).

Orphan drugs: Market challenge

Orphan drugs are costly and treat rare conditions

Approximately 7,000 rare conditions **impact one in ten Americans**,¹ with therapy as high as \$750K per year.²

Worldwide Orphan Drug Sales & Share of Prescription Drug Market (2002-2024)



Orphan Drugs Impact

- ✓ Make up 17% of total worldwide Rx sales today.
- ✓ Expected to reach **22%** by 2024.³
- ✓ Payers often lack tools to manage and control spend.

Most expensive drugs

Average annual cost per member **~\$147K** and rising³

Growing number

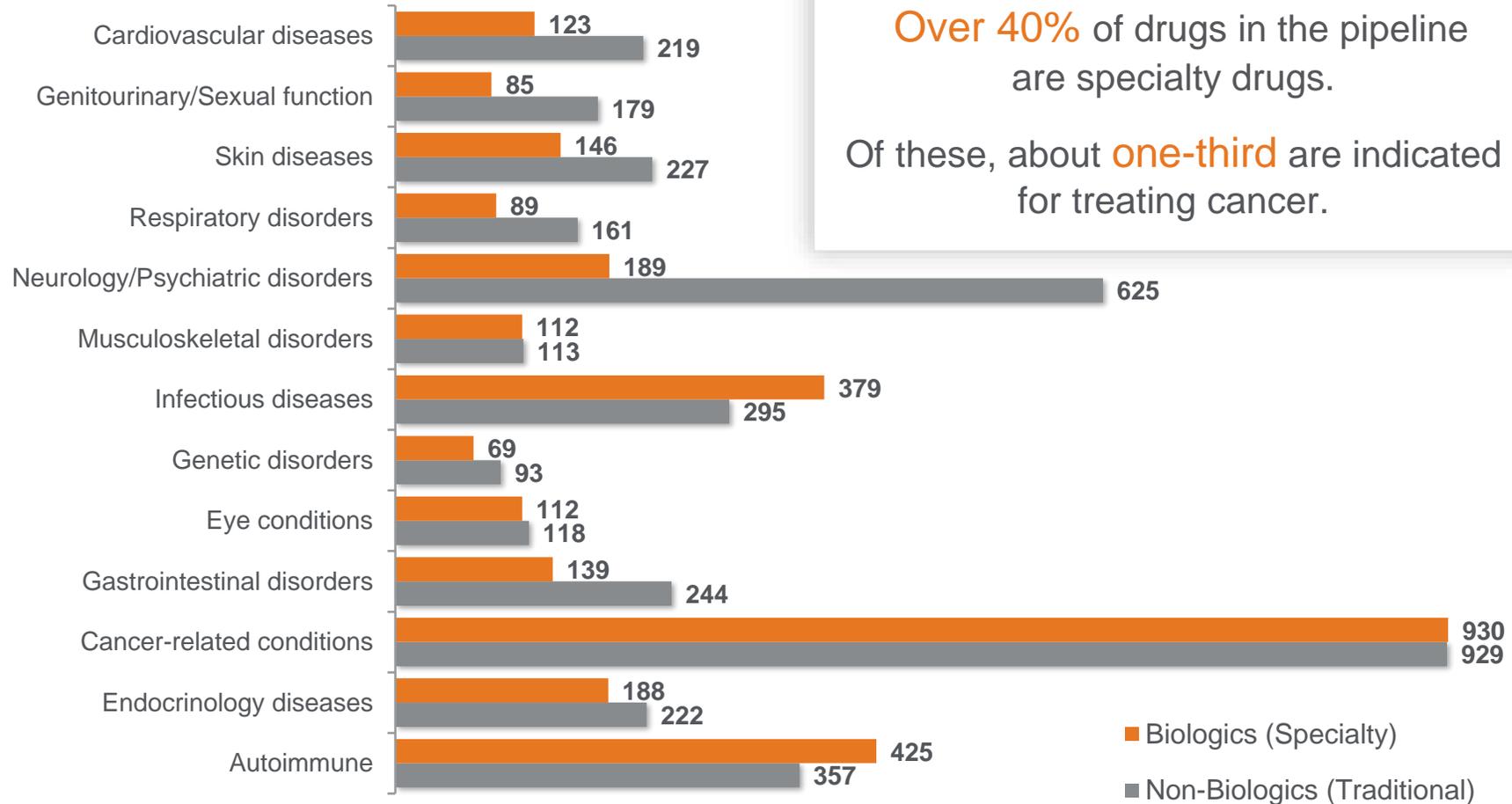
Annual rate of FDA orphan drug approvals **doubled** since 2012⁴

Safety and efficacy concerns

48% more safety concerns for drugs with expedited FDA review⁵

1. Global Genes. Rare Diseases Facts and Statistics. 2015. 2. Managed Care. Orphan drugs: Way too many, way too expensive. June 4, 2017. 3. EvaluatePharma® Orphan Drug Report 2018. 4. U.S. Food and Drug Administration. Lanthier, M. Insights into Rare Disease Drug Approval: Trends and Recent Developments. October 17, 2017. 5. BMJ. Mostaghim, SR, Gagne, JJ, Kesselheim, AS. Safety related label changes for new drugs after approval in the U.S. through expedited regulatory pathways: Retrospective cohort study. September 7, 2017.

Specialty drugs in development



High Dollar Drug Strategy



Tackling specialty medications

Defining the category



1-2%

members with specialty conditions



\$4.1K

average monthly cost



1/2

new drug approvals

These members suffer from **complex, rare, or life-debilitating conditions** and often need intensive, ongoing care coordination, support and intervention

Many specialty drugs are called **biologics**, meaning they are derived from living cells and difficult to manufacture, making them much more expensive than traditional drugs

Specialty drugs now account for **one-half of all new drug approvals**, and these drugs come in many forms, including:



Injectable

Medical & Pharmacy Benefit



Oral

Pharmacy Benefit



Infused

Medical Benefit
(Physician / Nurse)

Dynamics impacting specialty trends



New therapy innovations

- Higher costs from breakthrough treatments: **Zolgensma® for SMA, est. \$2M for a one-time treatment.**¹
- New and expensive **gene** therapies: **SPK-8011 for Hemophilia @ ~\$1.5M per patient**² and **cellular** therapies of **~\$500K per treatment.**³
- Total cost for **cancer medications**, including new immunotherapies and targeted agents in the **U.S. jumped from \$26.8 billion in 2011 to \$42.1 billion in 2016.**⁴



Robust medication pipeline

- Majority of the pipeline is specialty medications with **over 250 medications.**⁵
- Pipeline dominated by cancer treatments with over **1,500 clinical trials for checkpoint inhibitors.**⁶
- Biosimilar blockbuster equivalents pending launch: **Hyrimoz®, Truxima®, Cyltezo®.**⁷



Chronic treatment

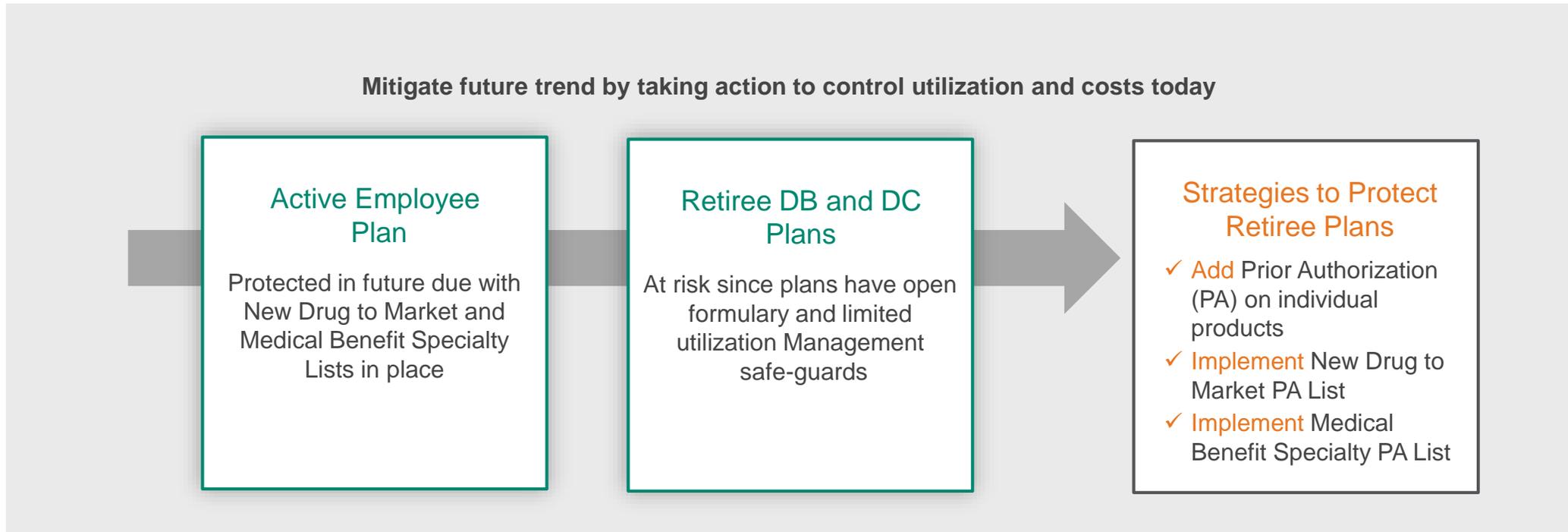
- Increased prevalence, diagnosis and treatment rates for **cancer.**
- Short-term evolving into long-term treatments: **Gleevec® for leukemia.**
- **1.7M Americans** expected to be diagnosed with cancer in 2018.⁸

1. Taylor, Phil. "Novartis Says \$4m Price Is Reasonable for SMA Gene Therapy." Pharmaphorum, 6 Nov. 2018, pharmaphorum.com/news/novartis-says-4m-price-is-reasonable-for-sma-gene-therapy/. 2. <https://www.investors.com/news/technology/biomarin-spark-hemophilia-gene-therapies/>. 3. <https://endpts.com/fda-ushers-in-a-new-era-in-cancer-treatment-with-game-changing-car-t-approval-for-novartis/>. 4. Journal of Oncology Practice, "Big Jump in US Spending on Cancer Drugs From 2011 to 2016", Sept. 20, 2018. 5. <http://www.specialtypharmacytimes.com/news/specialty-pharmacy-drugs-2016-approvals-and-2017-forecasts#sthash.q5wlxG03.dpuf>. 6. <https://endpts.com/an-explosion-of-pd-111-checkpoint-studies-is-crowding-the-industry-pipeline-and-thats-a-problem/>. 7. BioMedTracker (internet database). Updated periodically. Sagient Research Systems, Inc. Available by subscription at: <http://www.biomedtracker.com/>. 8. American Cancer Society Facts and Figures. 2018.

AlaskaCare New to Market High Dollar Drug Assessment

Rapidly changing market, creating uncertainty about direction of pharmacy benefits

OptumRx **manages** new drug pipeline trend before it happens



First Mover Process
minimizes client financial impact and protect patient safety



Pharmacy & Therapeutics Committee
ensures optimal clinical depth, integrity and transparency



Prior Authorizations
certifies clinically appropriate use of medications

'First Mover' process

Minimizing client financial impact and protect patient safety



Comprehensive Pipeline Monitoring

Early detection and prioritization of pipeline drugs 12-18 months prior to FDA approval

Proactive Pharmacy & Therapeutics (P&T) Committee Review Pre-FDA Approval

Expedited P&T clinical review and implementation of sound clinical / financial management strategies

Trend Modeling and Forecasting

Robust analytics before and after drug launch to project and then monitor key clinical and financial metrics

OptumRx National Pharmacy & Therapeutics Committee

Ensuring optimal clinical depth, integrity and transparency

Independent, multi-specialty and nationally represented group of physicians and pharmacists that provides evidence-based review and appraisal of new and existing medications and their place in therapy.



Transparency

- Established P&T observation for clients and consultants
- Consistently high satisfaction and positive feedback
- Opportunity to submit questions
- Summary clinical evidence and decisions available



Clinical Rigor

- Comprehensive presentations and deliberations
- Scientific proof including real world evidence
- Evidence-based grading using accepted best practice clinical standards
- P&T member engagement
- Consultation with external, practicing specialists



Independence & Integrity

- Compliance with national quality standards
- Voting members are practicing physicians or pharmacists not employed by Optum/UnitedHealth
- Annual conflict of interest disclosures; monthly calls for changes/updates of disclosure
- Routine monitoring of Office of Inspector General and public reporting sites
- Clinical Quality team oversight

Prior Authorization Creation

Development process helps ensure quality



OptumRx P&T Committee Review and Approval

How PA guidelines are developed

- Peer-reviewed medical literature
- Nationally-recognized treatment guidelines
- FDA information
- Consultations
 - Healthcare providers
 - Key opinion leaders
 - Clinical specialists
- Pharmaceutical, device and/or biotech information

Benefits

Prior Authorizations create potential for plans to achieve the following benefits:

- **Increased formulary awareness and positioning** through clinical criteria that promote safe and effective medication use
- **Improved quality of member care** by using evidence-based criteria to promote appropriate use of certain medications
- **Reduced inappropriate use** of these medications which generates cost savings

Prior Authorization Example

Promoting safe and effective medication use

Some medications must be authorized for coverage because

- They're only approved or effective in treating specific illnesses
- They cost more or they may be prescribed for conditions for which safety and effectiveness have not been well-established

If left unmanaged without requiring prior authorization, these medications can significantly increase plan costs.

Example: Actiq®



COVERED
for cancer pain

FDA-approved for treating cancer-related pain in members already taking opioid medication around-the-clock



NOT COVERED
for migraines

Contraindicated in the management of acute or post-operative pain including migraines

High Dollar Drug Strategies for AlaskaCare

Balances flexibility and member disruption

Prior Authorizations

Comprehensive

A la Carte

Individual Selections

Vigilant Drug List

New Drug to Market

Medical Benefit Specialty

Prior Authorization Edits

Ensuring clinically appropriate use of medications



~400

Prior authorization edits

Comprehensive PAs

Adopting full suite of UM strategies to increase client savings

Incorporates full utilization management suite of PA



Designed for clients to manage their pharmacy benefit to ensure: **appropriate medication use, ingredient cost savings, rebate potential**

Guides members to **therapeutically comparable, affordable** medication options

A la Carte PAs

Delivering defined flexibility

Clients choose PA across multiple medication classes



Designed to meet individual client needs based on **unique drug trending and marketing dynamics**

Additional **flexibility and ingredient cost savings**
Medication lists **vetted by our P&T committee**
Ensures compliance with formulary strategies

OptumRx Vigilant Drug List

Protect your pharmacy benefit with the highest level of vigilance

New Drug to Market

Clinical Quality Strategy

- New drug products have temporary prior authorizations implemented for up to six months after launch
- Temporarily placed on new unique chemical entities while overall health care value is evaluated to provide appropriate access and clinical program support
- Helps to ensure safety and efficacy through OptumRx Pharmacy & Therapeutic Committee review.
- *Medications on list are not customizable*

Medical Benefit Specialty

Benefit Preservation Strategy

- Prior Authorizations implemented on specific specialty medications where the course of therapy exceeds \$500,000 and should typically be administered in an inpatient setting (at least for the first dose)
- Medications placed in program following OptumRx Pharmacy & Therapeutic Committee review
- *Medications on list are not customizable*

High Dollar Drugs Retiree Plan Preservation Strategies

Claims Submitted Jan 2019-March 2019

	Plan	Total Gross Savings	Total Net Savings (Annualized)	Total Net Savings Per Member Per Month	Utilizing Members
Comprehensive Prior Authorization	EGWP	\$2,717,531	\$2,604,558	\$5.28	5,496
	Commercial Retiree	\$1,213,677	\$1,161,257	\$3.90	2,819

	Plan	Plan Paid	Member Paid	Rxs	Utilizing Members
New Drug to Market <i>No current utilization for Medical Benefit Specialty</i>	EGWP	\$74,482	\$10,046	769	709
	Commercial Retiree	\$28,761	\$1,792	327	296



AlaskaCare EGWP

Centers for Medicare & Medicaid Services (CMS) Part D EGWP Subsidies Update January through June 2019

CMS Direct Subsidy	Coverage Gap Discounts	Catastrophic Reinsurance	Low Income Premium Subsidy (LIPS)	Low Income Cost Sharing Subsidy (LICS)
A Per Member Per Month (PMPM) subsidy paid by CMS to subsidize drug costs in the Part D Initial Coverage Period	A quarterly payment from pharmaceutical manufacturers to subsidize brand name drug costs in the Part D standard Coverage Gap	A monthly CMS subsidy paid to subsidize 80% of drug costs above the TrOOP (True Out of Pocket) threshold	A subsidy paid by CMS to provide premium assistance to certain lower income retirees	A subsidy paid by CMS to provide drug cost sharing assistance to certain lower income retirees
\$687,371	*\$14,503,862	\$8,885,943	\$86,826	*\$503,098

*LICS numbers for Q1 and Q2, and Coverage Gap Discount numbers for Q2 are estimates based on CMS accepted Prescription Drug Event (PDE) data

TOTAL CMS Subsidies through Q2 2019 - \$24,667,100



Employer Group Waiver Program (EGWP)

2019 Updated Analysis

August 7, 2019

AlaskaCare

 **Segal Consulting**

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Summary Comparison—RDS vs. EGWP

	RDS	EGWP
OPEB Reduction	No	Yes
Annual Application	Yes	No
Plan Year	Any	Should be Calendar Year
Network	Commercial	CMS Requirements, but can be customized – separate contract/terms
Benefits	No requirements, with Actuarial Attestation	CMS Requirements, but can replicate current benefits
Formulary	Commercial	Minimum CMS Requirements; can replicate current
Prior Authorizations	No Requirement	Part B/D and Part D/not covered, but can utilize wrap to replicate current
Subsidies	Claims dependent; capped for catastrophic	Base subsidy for all members; Subsidies increase with costs
IRMAA	No	Yes
Out of Country/other MA/EGWP coverage	Yes	No, but can cover in RDS plan that replicates benefits
Plan Fiduciary	State	State
Federal Subsidies - Initial	\$18M	\$48M (\$30M net of RDS)
Federal Subsidies - Updated	\$18M	\$48M (\$30M net of RDS)

Financial Analysis

	Updated (2019)	Initial (2019)
EGWP		
Base Subsidy	\$3.5M	\$4.0M
Coverage Gap Discount	+ \$28.5M	+ \$28.0M
Catastrophic Reinsurance	+ \$21.0M	+ \$22.0M
Low Income Subsidy	+1.0M	-
= Total Subsidies	= \$54.0M	= \$54.0M
Additional Admin Fees	- \$5.2M	- \$5.2M
IRMAA	- \$0.8M	- \$0.8M
= Net EGWP	= \$48.0M	= \$48.0M
RDS Subsidy	\$18.0M	\$18.0M
Estimated Savings	\$30.0M	\$30.0M

Updated 2019 projection consistent with prior projection.

Thank You! Questions?



DRAFT/DELIBERATIVE

Retiree Health Plan Modernization Topics: Status in Employee Standard Plan

#	Modernization Topic	Status in the AlaskaCare Employee Plan						
1a.	Enhance travel benefits	<ul style="list-style-type: none"> • Standard SurgeryPlus benefits currently available to AlaskaCare Employee Members. • After members meet their deductible, 100% of coinsurance is waived • Covered expenses include: <ul style="list-style-type: none"> ○ Episode of Care received through SurgeryPlus benefits ○ Airfare for eligible patient and companion ○ Hotel or other approved accommodations ○ Transportation to/from airports ○ Pre-loaded debit card with \$25 per diem per patient per day (or \$50 per patient and companion per day) • Plan Language Reference: AlaskaCare Employee Health Plan Booklet; 3.5.24 <i>SurgeryPlus Benefits</i> 						
1b.	Enhance travel benefits, add health concierge	<ul style="list-style-type: none"> • The Division of Retirement and Benefits is currently evaluating enhancing travel benefits and coverage available to members and providing members with access to a healthcare concierge services beginning 1/1/2020 						
2.	Network steerage: 70% out-of-network and 90% in-network	<ul style="list-style-type: none"> • The AlaskaCare Employee Plan has steerage provisions that reward members who receive facility services from in-network or preferred facilities in Anchorage and the other 49 states. <table border="1" style="margin-left: 20px; margin-top: 10px;"> <thead> <tr> <th style="text-align: center;">Services</th> <th style="text-align: center;">Coinsurance</th> </tr> </thead> <tbody> <tr> <td>Facility services with a network provider</td> <td style="text-align: center;">80%</td> </tr> <tr> <td>Facility services with an out of network hospital, surgery center, rehabilitative facility, or freestanding imaging center in other 49 states or non-preferred provider hospital, surgery center, rehabilitative facility, or free-standing imaging center in Anchorage</td> <td style="text-align: center;">60%</td> </tr> </tbody> </table> • Plan Language Reference: AlaskaCare Employee Health Plan Booklet; 2.1.1 <i>Medical Benefit Schedule</i> 	Services	Coinsurance	Facility services with a network provider	80%	Facility services with an out of network hospital, surgery center, rehabilitative facility, or freestanding imaging center in other 49 states or non-preferred provider hospital, surgery center, rehabilitative facility, or free-standing imaging center in Anchorage	60%
Services	Coinsurance							
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Retiree Health Plan Modernization Topics: Status in Employee Standard Plan

3.	Increase deductible and out-of-pocket maximum	<ul style="list-style-type: none"> The AlaskaCare Standard Employee Plan has higher deductibles and out-of-pocket maximums than the Retiree Defined Benefit Plan <table border="1" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th style="text-align: center;">Provision</th> <th style="text-align: center;">AlaskaCare Defined Benefit Retiree Plan</th> <th style="text-align: center;">AlaskaCare Employee Standard Plan</th> </tr> </thead> <tbody> <tr> <td>Annual individual deductible</td> <td style="text-align: center;">\$150</td> <td style="text-align: center;">\$300</td> </tr> <tr> <td>Annual family deductible</td> <td style="text-align: center;">3 per family: \$450</td> <td style="text-align: center;">\$600</td> </tr> <tr> <td>Annual individual out-of-pocket limit</td> <td style="text-align: center;">\$800</td> <td style="text-align: center;">\$1,750 <i>\$3,500 if use out of network/non-preferred facility services in Anchorage or other 49 states</i></td> </tr> <tr> <td>Annual family out-of-pocket limit</td> <td style="text-align: center;">---</td> <td style="text-align: center;">\$3,500 <i>\$7,000 if use out of network/non-preferred facility services in Anchorage or other 49 states</i></td> </tr> </tbody> </table> <ul style="list-style-type: none"> Plan Language Reference: AlaskaCare Employee Health Plan Booklet; <i>2.1.1 Medical Benefit Schedule</i> 	Provision	AlaskaCare Defined Benefit Retiree Plan	AlaskaCare Employee Standard Plan	Annual individual deductible	\$150	\$300	Annual family deductible	3 per family: \$450	\$600	Annual individual out-of-pocket limit	\$800	\$1,750 <i>\$3,500 if use out of network/non-preferred facility services in Anchorage or other 49 states</i>	Annual family out-of-pocket limit	---	\$3,500 <i>\$7,000 if use out of network/non-preferred facility services in Anchorage or other 49 states</i>
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Annual individual out-of-pocket limit	\$800	\$1,750 <i>\$3,500 if use out of network/non-preferred facility services in Anchorage or other 49 states</i>															
Annual family out-of-pocket limit	---	\$3,500 <i>\$7,000 if use out of network/non-preferred facility services in Anchorage or other 49 states</i>															
4.	In-network enhanced clinical review of high-tech imaging and testing	<ul style="list-style-type: none"> Aetna’s enhanced clinical review program has been considered for the AlaskaCare Employee Plan, but it has not yet been implemented. 															
5.	Out-of-network reimbursement as a percentage of Medicare	<ul style="list-style-type: none"> Out-of-network reimbursement as a percentage of Medicare has been implemented for facility services received in Anchorage or outside of Alaska. Plan Language Reference: AlaskaCare Employee Health Plan Booklet; <i>3.3.4 Cost Sharing for Out-of-Network Benefits</i> 															
6.	Expanded telehealth services	<ul style="list-style-type: none"> Plan participants have access to Teladoc. Copays for general medical consultations and dermatology consultations are \$0. 															

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Retiree Health Plan Modernization Topics: Status in Employee Standard Plan

		<ul style="list-style-type: none"> Plan Language Reference: AlaskaCare Employee Health Plan Booklet; 3.5.4 <i>Teladoc Services</i>
7.	Expand preventive coverage to add full suite of preventive services	<ul style="list-style-type: none"> Preventive services received from a network provider are covered at 100%. Normal cost share provisions (deductible, coinsurance) apply to preventive services received from an out-of-network provider. If no network provider is available, members may seek a waiver and the cost share provisions would not apply. Plan Language Reference: AlaskaCare Employee Health Plan Booklet; 3.5.5. <i>Preventive Care and Screening Services</i>
8.	Remove or increase lifetime limit (currently \$2M)	<ul style="list-style-type: none"> There is no lifetime maximum that applies to covered expenses Plan Language Reference: AlaskaCare Employee Health Plan Booklet; 3.3.10. <i>Lifetime Maximum</i>
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>	<ul style="list-style-type: none"> Rehabilitative care is covered for non-chronic conditions and acute illnesses and injuries, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute illness, injury or surgical procedure. The Medical Benefit Exclusion list includes rolfing, acupuncture, acupressure and acupuncture therapy. Plan Language Reference: AlaskaCare Employee Health Plan Booklet; 3.5.15 <i>Cognitive Therapy, Physical Therapy, Occupational Therapy, and Speech Therapy Rehabilitation Benefits</i> and 3.7 <i>Medical Benefit Exclusions</i>
10.	Exclude coverage for drugs with over-the-counter (OTC) equivalents	<ul style="list-style-type: none"> OTC drugs and drugs with an OTC equivalent are not covered Plan Language Reference: AlaskaCare Employee Health Plan Booklet; 3.6.15. <i>Pharmacy Benefit Exclusions</i>
11.	Implement high-value pharmacy network with lower copays for chronic meds, medical synchronization, counseling, and packaging options for participating members.	<ul style="list-style-type: none"> Efforts to implement a high-value pharmacy network in the employee plan are ongoing.
12.	Add wellness benefits such as gym membership or program like Silver Sneakers - <i>public comment proposal</i>	<ul style="list-style-type: none"> AlaskaCare Employee members have access to a discounted Weight Watchers at work program: http://doa.alaska.gov/drb/alaskaCare/employee/wellness/weightWatchers.html

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Retiree Health Plan Modernization Topics: Status in Employee Standard Plan

Upcoming topics																																										
13.	Clarify coverage of implants related to periodontal disease under the medical plan and/or under the dental plan	<ul style="list-style-type: none"> • Efforts to clarify coverage of implants related to periodontal disease under the Employee medical plan and/or under the Employee dental plan are ongoing. • Plan Language Reference: AlaskaCare Employee Health Plan Booklet; 3.5.29 																																								
14.	Implement 3-tier pharmacy benefit; change out-of-network pharmacy benefits	<ul style="list-style-type: none"> • The AlaskaCare Employee Plan has a 3-tier pharmacy benefit. The cost share levels are currently under review and may be changed in 2020. <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th style="width: 30%;">Prescription Tier</th> <th style="width: 20%;">Coinsurance</th> <th style="width: 20%;">Minimum Covered Person Payment</th> <th style="width: 30%;">Maximum Covered Person Payment</th> </tr> </thead> <tbody> <tr> <td colspan="4">Retail 30 Day at Network Pharmacy</td> </tr> <tr> <td>Generic prescription drug</td> <td>80%</td> <td>\$10</td> <td>\$50</td> </tr> <tr> <td>Preferred brand-name prescription drug</td> <td>75%</td> <td>\$25</td> <td>\$75</td> </tr> <tr> <td>Non-preferred brand-name prescription drug</td> <td>65%</td> <td>\$80</td> <td>\$150</td> </tr> <tr> <td colspan="4">Mail Order 31-90 at Network Pharmacy</td> </tr> <tr> <td colspan="2">Prescription Tier</td> <td colspan="2">Copayment</td> </tr> <tr> <td colspan="2">Generic prescription drug</td> <td colspan="2">\$20</td> </tr> <tr> <td colspan="2">Preferred brand-name prescription drug</td> <td colspan="2">\$50</td> </tr> <tr> <td colspan="2">Non-preferred brand-name prescription drug</td> <td colspan="2">\$100</td> </tr> </tbody> </table> <ul style="list-style-type: none"> • Plan Language Reference: AlaskaCare Employee Health Plan Booklet; 2.1.2. <i>Prescription Drug Schedule</i> 	Prescription Tier	Coinsurance	Minimum Covered Person Payment	Maximum Covered Person Payment	Retail 30 Day at Network Pharmacy				Generic prescription drug	80%	\$10	\$50	Preferred brand-name prescription drug	75%	\$25	\$75	Non-preferred brand-name prescription drug	65%	\$80	\$150	Mail Order 31-90 at Network Pharmacy				Prescription Tier		Copayment		Generic prescription drug		\$20		Preferred brand-name prescription drug		\$50		Non-preferred brand-name prescription drug		\$100	
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15.	Limit compound coverage to high-quality, narrow network of pharmacies	<ul style="list-style-type: none"> • Compounded medications that do not contain at least one prescription ingredient that is FDA approved for medical use in the United States are not covered. This includes compounded medications formulated from any drug coded as over-the-counter, and any drugs coded as a pharmaceutical aid, such as bulk chemical. 																																								

DRAFT/DELIBERATIVE

Retiree Health Plan Modernization Topics: Status in Employee Standard Plan

		<ul style="list-style-type: none"> Plan Language Reference: AlaskaCare Employee Health Plan Booklet; 3.6.15. <i>Pharmacy Benefit Exclusions</i>
16.	Add medically necessary treatment of gender dysphoria including surgery – <i>public comment proposal</i>	<ul style="list-style-type: none"> Any treatment, drug, service or supply related to changing sex or sexual characteristics is excluded from coverage, including: <ul style="list-style-type: none"> Surgical procedures to alter the appearance or function of the body. Prosthetic devices. Plan Language Reference: AlaskaCare Employee Health Plan Booklet; 3.7. <i>Medical Benefit Exclusions</i>
17.	Copayment for primary care	<ul style="list-style-type: none"> The Division of Retirement and Benefits is currently evaluating implementing a copayment for primary care cost share structure beginning 1/1/2020
Plan Housekeeping Items		
18.	Clarify reimbursement policies for surgical assistants in the plan booklet	<ul style="list-style-type: none"> Efforts to clarify reimbursement policies for surgical assistants in the plan booklet are ongoing. Plan Language Reference: AlaskaCare Employee Health Plan Booklet; 16 <i>Definitions</i>

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

Retiree Health Plan Modernization Overview

The goal of the Retiree health plan modernization effort is to provide value to the members through incorporating common benefits not currently available while preserving the overall benefit of the plan and implementing standard cost saving mechanisms. The Division and the Board are committed to communicating and collaborating with retirees to protect, improve, and sustain Alaska’s retiree health benefits for current and future generations of retirees. The plan was first developed in 1975 and provides extensive and valuable benefits for retirees and their dependents necessary for the diagnosis and treatment of an injury or disease. Due to its age, the plan design lacks some key benefit provisions now common in most health plans. It also lacks common cost control mechanisms.

The Retiree Plan Health Advisory Board is evaluating a set of proposed initiatives that could be implemented in the future to modernize the AlaskaCare retiree health plan.

INITIATIVE	Page	05/2018	08/2018	11/2018	02/2019	05/2019	08/2019
 1. 3-Tier Pharmacy	2	X	X	X	X	X	X
 2. Deductible Out of Pocket Maximum	3	X	X	X	X	X	X
 3. Enhanced Clinical Review	4	X	X	X	X	X	X
 4. Enhanced Travel with Health Concierge	5	X	X	X	X	X	X
 5. Lifetime Maximum	6	X	X	X	X	X	X
 6. Network Incentives	7		X	X	X	X	X
 7. Out of Network Reimbursement	8		X	X	X	X	X
 8. Over-the-Counter Equivalent Drugs	9	X	X	X	X	X	X
 9. Preventive Services	10	X	X	X	X	X	X
 10. Rehabilitative Care	11	X	X	X	X	X	X
 11. Telehealth Services	12			X	X	X	X

Proposal Title	Three-Tier Pharmacy Benefit	
Health Plan Affected	Defined Benefit Retiree Plan	
Proposed Effective Date	January 1 st , 2020	
Reviewed By	Retiree Health Plan Advisory Board	
Proposal Drafted	April 2019	
Status of Proposal	Under Consideration	

Summary of Current State

The AlaskaCare defined benefit retiree pharmacy plan has an open formulary, meaning that the plan will cover drugs prescribed by a provider, acting within the scope of his or her license, for the treatment of an illness, disease, or injury. The AlaskaCare employee plan, the defined contribution retiree plan, and for those defined benefit retirees who elect to opt out of the enhanced Employer Group Waiver Program (EGWP) and instead participate in the opt-out pharmacy benefit, have a three-tier pharmacy benefit cost structure in place. With a three-tiered benefit, prescription drugs fall into one of three categories or “tiers.” Each tier has a different copay or out-of-pocket cost. The first tier is for generics, the second is for preferred brand-name drugs, and the third is for nonpreferred brand-name drugs.

Objectives

- a) Maintain choice for members while promoting greater use of therapeutically comparable and affordable drugs.
- b) Provide savings to the members and to the health trust and balance other modernization proposals.

Summary of Proposed Change

This proposal would establish a three-tier pharmacy benefit cost structure in the AlaskaCare defined benefit retiree prescription drug plan to promote utilization of generic and preferred brand-name medications. The tiered formulary design can incentivize cost effective drugs that are therapeutically equivalent when there are multiple drugs available. The plan would be amended to establish different copayments for medications based on drug type:

Tier 1: Generic Drugs – lowest cost tier

Generic medications are therapeutically, and often chemically, identical to brand medications and are widely available at competitive prices.

Tier 2: Preferred Brand-Name Drugs – slightly higher cost tier

Preferred brand-name drugs are brand-name medications for which a generic option is not available.

Tier 3: Non-Preferred Brand-Name Drugs – highest cost tier

Non-preferred brand-name drugs are brand-name medications that are available in an equivalent generic form, or as a preferred brand-name drug. These drugs typically cost more than their generic or preferred brand-name equivalent. While many individuals can use generic, preferred brand-name, and non-preferred brand-name medications interchangeably, some individuals may have a medical need to utilize a non-preferred brand-name medication. In these instances, the member or his or her doctor may seek a medical exception. If the exception is granted, the drug will be available at the preferred brand-name drug copay.

This proposed change would only impact medications obtained at a retail pharmacy. Medications obtained via mail order would remain available for a \$0 copay. Members who have coverage under multiple AlaskaCare plans, or who have other drug coverage that coordinates with AlaskaCare would continue to experience a reduction in their copays.

Proposal Title	Deductible & Out of Pocket Maximum	
Health Plan Affected	Defined Benefit Retiree Plan	
Proposed Effective Date	January 1 st , 2020	
Reviewed By	Retiree Health Plan Advisory Board	
Proposal Drafted	December 2018	
Status of Proposal	Under Consideration	

Summary of Current State

Compared to other commercial health plans in the United States, the Alaska Care defined benefit health plan features significantly lower cost share provisions, i.e. deductible and out-of-pocket limits much lower than the average health plan. The concern with lower cost share provisions, such as those in the retiree plan is that it reduces member's sensitivity to price, making them less likely to distinguish between high value and low value services, and less likely to distinguish between provider type, such as network or non-network providers. Lower cost share provisions are often associated with higher utilization of medical services. Higher utilization of services in and of itself should not be viewed negatively; the purpose of health insurance is to assist members in affording necessary medical services in the most appropriate setting at the appropriate time. However, utilization of low value services, those which provide little benefit, are not proven to be efficacious, or which could be avoided without any impact to a member's overall health outcome, add cost to the member and the plan without providing substantial benefit.

Objectives

- a) Incentivize member use of network providers through benefit design.
- b) Strengthen the health plan's purchasing power with providers.
- c) Provide savings to the members and to the health trust and balance other modernization proposals.

Summary of Proposed Change

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

- Option 1 – Increase deductible by \$50 per individual and the OOP limit by \$100
- Option 2 – Increase deductible by \$150 per individual and the OOP limit by \$300
- Option 3 – Increase deductible by \$500 per individual and the OOP by \$1,000

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

	Current	Option 1	Option 2
Deductible Individual	\$150	\$200	\$300
Deductible Family (up to 3x individual)	\$450	\$600	\$900
OOP Individual	\$800	\$900	\$1,100
OOP Family	Unlimited	\$2,700	\$3,300
Plan Savings¹	None	\$2.9 million	\$9.3 million

¹ Segal Memorandum dated December 10, 2018

Proposal Title	Enhanced Clinical Review	
Health Plan Affected	Defined Benefit Retiree Plan	
Proposed Effective Date	January 1 st , 2020	
Reviewed By	Retiree Health Plan Advisory Board	
Proposal Drafted	December 2018	
Status of Proposal	Set Aside	

Summary of Current State

The plan currently covers diagnostic high-tech imaging and testing including radiology, cardiology services, musculoskeletal imaging, sleep management studies, and cardiac rhythm implant devices if a member has specific symptoms. Generally, these tests and services are not covered if performed as part of a routine physical examination. Even so, utilization and the per member per month cost associated with high-cost, high-tech imaging and testing services has risen over time, and is currently significantly higher in AlaskaCare plans than across Aetna “book of business” comparisons.

Not only does increased usage affect the plan financially, but this growth in utilization of enhanced imaging techniques can create other unintended impacts and consequences. Unnecessary imaging applications bring additional costs to the member and the plan and can result in members receiving needless exposure to radiation during the imaging process, without measurable contribution to positive health outcomes or more accurate diagnoses.

Objectives

- a) Ensure that the high-tech imaging and diagnostic testing members receive from network providers is medically necessary and follows appropriate evidence-based guidelines.
- b) Provide savings to the members and to the health trust and balance other modernization proposals.

Summary of Proposed Change

The proposed change would require in-network providers to seek prior authorization of certain outpatient radiology and cardiology services, sleep studies, interventional pain management programs, and musculoskeletal procedures (hip/knee replacements) for non-Medicare eligible members. This proposed change would not apply to services obtained through a non-network provider. Precertification would not apply in emergency situations.

This initiative would largely operate behind the scenes; network providers (not patients) would be responsible for obtaining preauthorization in advance of administering services and seeking reimbursement. The extra scrutiny assists in ensuring that evidence-based guidelines of appropriate care are being followed prior to the administration of high-cost imaging and/or testing.

The AlaskaCare retiree health plan could choose to adopt ECR for the full suite of services offered through the program, or ECR could be adopted for some services, and forgone for others.

Proposal Title	Enhanced Travel & Health Concierge	
Health Plan Affected	Defined Benefit Retiree Plan	
Proposed Effective Date	January 1 st , 2020	
Reviewed By	Retiree Health Plan Advisory Board	
Proposal Drafted	October 2018	
Status of Proposal	Under Consideration	

Summary of Current State

The current plan language regarding travel costs is confusing and covered expenses are narrow in most circumstances. The portions of covered travel costs vary depending on the qualified circumstance but are typically limited to airfare costs only; lodging, per diem expenses, and travel for a companion are rarely eligible for coverage.

Accessing the travel benefit can be confusing and many expenses are not covered. All travel, excluding emergency travel and surgery less expensive in other locations, requires pre-authorization. If travel is not-preauthorized members are not eligible for reimbursement. In addition, the plan does not pay for travel costs up front, the member is required to front those costs and submit them for reimbursement following completion of the trip which can place a financial burden on the member at a vulnerable time.

Objectives

- a) Increased access to specialists that may not be available locally for members requiring care.
- b) Increase covered travel costs.
- c) Enhance patient outcomes through reduced complication rates based on the quality of providers in the SurgeryPlus network. Surgery Plus reports complication rates of 0.82% among members using their network compared to the 14.1% average for AlaskaCare retirees living in Alaska but seeking care outside of the state in 2017.

Summary of Proposed Change

This benefit was implemented on August 1, 2018 for the AlaskaCare Active employee plan. The addition of the SurgeryPlus network will provide members with access to surgeons who demonstrate they meet and maintain a combination of objective and subjective quality metrics. The expansion of travel benefits for diagnostic services will address an unmet need among the membership as will the expansion of lodging and per diem expenses for the member and companion. The addition of a care coordinator for members seeking care from providers outside of the SurgeryPlus network, including those available locally, will benefit members in finding a provider, transferring records, and scheduling procedures.

- a) Add the SurgeryPlus travel program which arranges and coordinates travel for a member and their companion to a network of surgeons and facilities that meet rigorous quality metrics for deeply discounted prices.
- b) Cover travel for diagnostic procedures not covered by the SurgeryPlus travel program and either not available locally or less expensive in other locations.
- c) Cover travel for a companion when a member receives treatment or a diagnostic procedure that requires general anesthesia.
- d) Provide lodging and per diem benefits for the length of stay for second opinions, or when treatment or diagnostic procedures are not available locally or less expensive in other.
- e) Expand travel coordination services to include prospective travel arrangement paid and coordinated by SurgeryPlus for services that are not part of their network but meet the expanded criteria outlined in points 3 to 5 above.
- f) Provide members access to the SurgeryPlus credentialing and physician recommendations, records transfer, scheduling assistance, and follow-up and adherence support for services received locally.

Proposal Title	Lifetime Maximum	
Health Plan Affected	Defined Benefit Retiree Plan	
Proposed Effective Date	January 1 st , 2020	
Reviewed By	Retiree Health Plan Advisory Board	
Proposal Drafted	July 2018	
Status of Proposal	Under Consideration	

Summary of Current State

The AlaskaCare retiree defined benefit health plan currently contains a \$2 million lifetime maximum. In 1985, the lifetime max was increased from \$250,000 to \$1 million, and in 1999 it was increased again to the present limit of \$2 million.

The Patient Protection and Affordable Care Act (ACA) required most health plans to remove any lifetime maximum, and as a result these provisions are becoming increasingly uncommon in health plans.² At the same time, the cost of health care has grown significantly over the past decade due to a variety of factors including access to new advancements.

While the number of individuals impacted by the existing lifetime maximum is small, those who are impacted find themselves without an avenue for affordable health insurance at an extremely vulnerable time. Without a change to this plan provision, it is likely that an increasing number of individuals will reach the lifetime maximum given the growing cost of health care and new technologic innovations.

Objectives

- a) Ensure members will retain access to health insurance during a catastrophic health event.
- b) Prospectively reinstate full coverage for all members who have hit the lifetime maximum.

Summary of Proposed Change

The proposed change would eliminate the lifetime maximum limit. The lifetime maximum does not apply to costs associated with claims under the pharmacy plan, but it would apply to any injections or other medications covered by the medical plan. The proposal would also reinstate coverage for members who have already hit the lifetime maximum.

² As a retiree plan, the AlaskaCare retiree plan is exempt from this ACA provision.

Proposal Title	Network Incentive	
Health Plan Affected	Defined Benefit Retiree Plan	
Proposed Effective Date	January 1 st , 2020	
Reviewed By	Retiree Health Plan Advisory Board	
Proposal Drafted	October 2018	
Status of Proposal	Under Consideration	

Summary of Current State

Most health plans include provisions in their benefit design to promote use of network providers. This incentive encourages use of the network providers which creates both cost savings for the plan and the member while further increasing the negotiating leverage of the plan. Plans with stronger incentives for network use and disincentives for non-network use can steer members towards network providers and away from non-network providers more effectively which in turn can create pressure for providers to come into network in order to increase patient volume.

Network providers have a contractual relationship with an insurance company in which both parties agree to a certain reimbursement schedules and other policies. These policies may include credentialing requirements for participating providers, an agreed upon fee schedule, and an agreement from the provider to write off the difference between the fee schedule and their billed charges rather than seeking the difference from the member; a practice commonly referred to as balance billing. When members use a non-network provider, the plan must determine what to pay for services since there is not an agreed upon fee schedule with the provider. In the AlaskaCare retiree health plan, this is called the recognized charge.

The recognized charge is, with very few exceptions, higher than the negotiated charge, meaning both the plan and the member are paying more for the same service than they would if the service was received through a network provider. Uniquely, the retiree health plan does not differentiate between care received from 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).

Objectives

- a) Achieve discounted provider charges in order to reduce the members cost share and reduce balance billing.
- b) Increase providers willingness to participate in the network, particularly in the Anchorage area where there is competition amongst providers.

Summary of Proposed Change

The proposed change would increase the coinsurance from 80% to 90% for services received from a network provider and decrease the plan coinsurance from 80% to 70% for services received from a non-network provider.

Using a network provider brings benefits both to the member and the plan. Benefits to the member include: no balance bills, provider responsible for prior authorization not the member, and discounted charges which reduce member's cost share.

Benefits to the plan include discounted charges, providers agree to certain billing practices, and providers agree to follow pre-authorization requirements.

Benefits to the provider include , increased volume, member satisfaction preferential treatment in terms of plan design incentives.

Proposal Title	Out-Of-Network Reimbursement	
Health Plan Affected	Defined Benefit Retiree Plan	
Proposed Effective Date	January 1 st , 2020	
Reviewed By	Retiree Health Plan Advisory Board	
Proposal Drafted	March 2019	
Status of Proposal	Under Consideration	

Summary of Current State

The AlaskaCare retiree health plan utilizes a network of providers contracted with the plan’s claims administrator 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 to write off the difference between the fee schedule and their billed charges rather than seeking the difference from the member - a practice commonly referred to as balance billing. When members use a non-network provider, the plan 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 out-of-network services is called the recognized charge, and “is the lesser of what the provider bills for that services or supply; or the 90th percentile of the prevailing charge rate for the geographic area where the service is furnished as determined by Aetna in accordance with Aetna reimbursement policies.” 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. Because the recognized charge is determined based on the amount providers bill, over time, as providers bill higher amounts, the FAIR Health benchmark can increase, resulting in a higher prevailing charge rate, and greater compensation for out-of-network providers. With very few exceptions, the recognized charge is usually higher than the negotiated charge. When out-of-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.

Objectives

- a) Strengthen the health plan’s purchasing power with providers.
- b) Incentivize member use of network providers through benefit design.
- c) Provide savings to the members and to the health trust and balance other modernization proposals.

Summary of Proposed Change

The proposed change would alter the methodology used to determine payments to out-of-network providers by changing from the 90th percentile of the prevailing charge rate for the geographic area to a percentage of the Medicare Physician Fee Schedule. This proposal offers three different reimbursement rates for out-of-network providers:

- 185% of Medicare’s Fee Schedule,
- 195% of Medicare’s Fee Schedule, or
- 205% of Medicare’s Fee Schedule.

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 out-of-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.

Proposal Title	Over the Counter Equivalent Drugs	
Health Plan Affected	Defined Benefit Retiree Plan	
Proposed Effective Date	January 1 st , 2020	
Reviewed By	Retiree Health Plan Advisory Board	
Proposal Drafted	July 2018	
Status of Proposal	Set Aside	

Summary of Current State

The AlaskaCare defined benefit retiree health plan provides coverage for prescription drugs prescribed by a provider that may have an over-the-counter (OTC) equivalent.³ Some medications in this category were initially only available with a prescription, but since their initial entry onto the market now have a generic and/or an OTC equivalent available (e.g. Prilosec).

In 2018, the retiree plans spent nearly \$5.8 million on generic and brand prescription drugs known to have over-the-counter equivalents. Over 25%, or \$1.5 million, was spent on brand drugs, two-thirds of which (\$1.1 million) had generic therapeutic equivalents in addition to their OTC counterparts. Over the same year, beneficiaries of the retiree plan paid nearly \$80,000 in copays for all drugs with an OTC equivalent: roughly \$0.04/unit, or \$3.60 for a 90-day supply.

\$4.1 million of the total was spent on omeprazole and esomeprazole (commonly known as Prilosec and Nexium respectively). Typical prices for brand-name, generic, and OTC versions of esomeprazole are:

- Brand-Name Prescription (40mg): \$500 for a 90-day supply
- Generic Prescription (40 mg): \$287 for a 90-day supply
- OTC Equivalent (20mg, can be taken twice): \$19.80 for 90ct⁴, \$39.60 for 40mg, 90-day equivalent.

The dispense-as-written notation on these drug claims reveal that the choice of brand over generic among drugs with OTC options was in most cases indicated by the member themselves, not their physician.

Objectives

- Provide savings to the members and to the health trust and balance other modernization proposals.

Summary of Proposed Change

Discontinue coverage of prescription medication when an over the counter (OTC) equivalent of the drug is available. There are two options.

- **Option A** - Coverage for brand-name and generic prescription medication would be discontinued if an OTC equivalent of the drug is available.
- **Option B** - Coverage for brand-name prescription medication would be discontinued if both a generic AND an OTC equivalent of the drug are available.

³ p. 70, <http://doa.alaska.gov/drb/pdf/ghlb/retiree/DBRetireeInsuranceBooklet-01012019.pdf>

⁴ Safeway, Kroger, Carrs, Walmart) with manufacturer coupon

Proposal Title	Preventive Services	
Health Plan Affected	Retiree Defined Benefit Health Plan	
Proposed Effective Date	January 1, 2020	
Reviewed By	Retiree Health Plan Advisory Board	
Proposal Drafted	August 29, 2018	
Status of Proposal	Under Consideration	

Summary of Current State

The plan was first developed in 1975 and provides extensive and valuable benefits for retirees and their dependents necessary for the diagnosis and treatment of an injury or disease. The plan was not established as a preventive or ‘wellness’ plan. Preventive services that are used to screen individuals prior to symptoms being exhibited are limited to mammograms, Pap smears and Prostate Specific Antigen tests (to detect prostate cancer in males).

One of the main reoccurring complaints the Division of Retirement and Benefits (Division) receives is related to the retiree plan’s lack of preventive care coverage. This is a complex topic since the plan serves two very distinct populations: those retirees and their dependents who are eligible for Medicare, and the retirees under the age of 65 (U65) who do not yet qualify for Medicare coverage. As Medicare already offers many preventive services at no cost to the beneficiary, adding preventive coverage is not as high a priority for those eligible for Medicare benefits.

Around 2010, in conjunction with certain requirements in the Patient Protection and Affordable Care Act (ACA), insurance coverage for age-specific guidelines indicating the utilization of screening and preventive services for older adults grew increasingly common. Despite these industry changes, the omission of most preventive benefits in the plan may cause retirees to forego getting recommended age-specific vaccinations, screenings, and other preventive services. The goal of preventive services is to increase early detection and treatment of health conditions in order to improve clinical outcomes, arrest disease at an earlier stage when it is easier and more effectively treated, and to promote health-conscious behavior.

Objectives

- a) Support the members in early detection of health problems, increase overall health, and in maintaining their health.

Summary of Proposed Change

The Division proposes adding the full suite of evidence based preventive services to the plan that mirror those provided in most employee plans in accordance with the Affordable Care Act. These expanded services include those with an “A” or “B” rating by the United States Preventive Task Force.⁵ The specific services will change as the USPTF updates their recommendations to reflect the most current research and evidence.

The Division proposes that preventive services would be subject to normal cost-share provisions (annual deductibles, coinsurance, copay and annual maximum out-of-pocket limits, etc.), with the exception that the coinsurance paid by the plan will be reduced by 20% when the preventive care services are provided by an out-of-network provider. Further, those out-of-network expenses will not count towards the annual out-of-pocket maximum.

⁵ A list of services is available at: <https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/>

Proposal Title	Rehabilitative Care	
Health Plan Affected	Defined Benefit Retiree Plan	
Proposed Effective Date	January 1 st , 2020	
Reviewed By	Retiree Health Plan Advisory Board	
Proposal Drafted	July 2018	
Status of Proposal	Under Consideration	

Summary of Current State

The AlaskaCare Defined Benefit retiree plan does not cover rehabilitative maintenance care, that is, care to maintain or prevent deterioration of a chronic condition. The plan currently covers outpatient rehabilitative care designed to restore and improve bodily functions lost due to injury or illness. This care is considered medically necessary only if significant improvement in body function is occurring and is expected to continue. Starting at the 26th visit all claims for the member are pended for review of chart notes. The provider must submit clinical records that document a member continues to experience significant improvement. If the records are not returned within 45 days or fail to demonstrate significant improvement in accordance with the established clinical criteria, the services are denied. The existing plan coverage of rehabilitative services is highly problematic and is the most frequently appealed plan provision. It accounts for approximately one third of all retiree appeals received by the Division in 2017, 2018 and 2019.

Objectives

- a) Provide the ability for retirees to receive rehabilitative care that may include maintenance and preventive therapies of chronic conditions.
- b) Decrease the volume of claims that are pended and require providers to send chart notes.
- c) Decrease the volume of rehabilitative care appeals.

Summary of Proposed Change

The proposed amended change would update the plan language to allow for maintenance or preventive therapies of chronic conditions. It would increase and clearly define the plan's coverage of rehabilitative care, alleviating confusion amongst members and providers.

The proposed benefit change will cover rehabilitative care received from an in-network provider without a visit limit, and cover chiropractic care received from an in-network provider without a visit limit. Removing the limit will reduce the requirement for claim chart note review and allow for maintenance and preventive therapies of chronic conditions. The proposed benefit will continue to have a visit limit on rehabilitative and chiropractic care received from an out-of-network provider. However, the limit amount will be increased and an option to reset the visit count at the start of each benefit year will be added. If care is received from an out-of-network provider, the member would be provided up to 45 visits per benefit year for outpatient rehabilitative care, and up to 20 visits for chiropractic care. 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.

Proposal Title	Telehealth Services	
Health Plan Affected	Defined Benefit Retiree Plan	
Proposed Effective Date	January 1 st , 2020	
Reviewed By	Retiree Health Plan Advisory Board	
Proposal Drafted	July 2018	
Status of Proposal	Under Consideration	

Summary of Current State

Telehealth is the use of technology that enables remote healthcare for low-severity care. It makes it possible for physicians to treat patients whenever needed and wherever the patient is, by using a computer or smartphone. Telemedicine can overcome geographic barriers to healthcare, especially for specialized providers. Telemedicine can be particularly beneficial for patients in medically underserved communities and those in rural geographical locations where clinician shortages exist.

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 Medicare and non-Medicare eligible members and could provide an additional access point to care. Telehealth services are a benefit for AlaskaCare active employees since 2018.

In 2017, low severity care⁶ 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. Many Alaska communities do not have an after-hours or Urgent Care option, often necessitating a trip to the Emergency Room. Knowing that telemedicine is becoming an increasing need, convenience and cost-saver, this proposal would incorporate this service in order to increase patient care options for the AlaskaCare members.

Objective

- a) Increase accessibility to patient care for non-emergency health episodes.
- b) Increase access and provide choices to members for behavioral health services.

Summary of Proposed Change

This proposal would expand access to telehealth services for members covered under the AlaskaCare defined benefit retiree health plan. Access would be expanded by providing retirees and their dependents access to a vendor, or vendors that connect members with a medical provider over the phone, via mobile devices or the internet, and/or by video for non-emergency medical episodes, dermatology consultations, and caregiver consultations.

Telehealth services allow members to speak remotely to a licensed health care provider and receive a 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.

This proposal currently contemplates two different approaches for expanding telehealth services in the AlaskaCare retiree health plan for consideration: Teladoc and CirrusMD.

⁶ 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 Optum Insight's severity index. More information is provided in the accompanying document titled "Episode Treatment Groups: Analyzing Health Care Data from Episodes of Care."

AlaskaCare Retiree Health Plan Modernization Project



Division of Retirement and Benefits
Department of Administration

AlaskaCare Retiree Plan Overview

AlaskaCare Retiree Plans

- Defined Benefit Health Plan
 - 73,000+ covered lives
- Defined Contribution Health Plan
 - 22 covered lives
- Dental, Vision & Audio Plan
 - 54,600+ covered lives
- Long-Term Care Plan
 - 27,000 covered lives

- \$641.5 million annual spend in FY 18:*
- \$579.8 million Health Plan
- \$44.6 million Dental, Vision & Audio Plan
- \$17.1 million Long-Term Care Plan

* Based on audited financial statements

AlaskaCare Retiree Defined Benefit Health Plan

Defined Benefit Plan	Medical
Deductible	\$150 individual / \$450 family
Coinsurance	80%
Annual Out-of-Pocket Maximum	\$800 individual
Preventive Care	Limited: mammogram, PSA, pap smear
Dependents	Covered up to age 19, 23 if full-time student
Lifetime Maximum	\$2,000,000
	Pharmacy
Generic	\$4 copay retail / \$0 copay mail order Up to 90 day supply
Preferred Brand Name	\$8 copay retail / \$0 copay mail order Up to 90 day supply
Non-preferred Brand Name	\$8 copay retail / \$0 copay mail order Up to 90 day supply

Retiree Health Plan Challenges

- Older plan design; lacks many common plan provisions.
 - No preventive coverage
 - Dependents only until age 23 if in school
 - \$2 million lifetime max
- Lack of meaningful cost saving measures
- Changes subject to stringent legal evaluation:
 - Benefits protected by constitutional diminishment clause
Alaska Constitution, Article XII, section 7
 - Changes must be evaluated within that context
- Limited communication with retiree community

Efforts to Enhance Member Communication

- Established Retiree Health Plan Advisory Board
 - Hear concerns, address issues, and collaborate
 - Provide a meaningful way for the Department to evaluate and discuss possible benefit changes to modernize the plan
- Innovative communications
 - Monthly Telephonic Town Hall
 - E-newsletters
- Evaluate coverage changes
 - Develop plan modernization process with advisory board

Modernization Efforts

- Many retirees have expressed a desire for updates to benefits, such as removal of the lifetime maximum and adding preventative care
- Modernization efforts through the RHPAB have been ongoing since 2018
- The goal of the modernization project is to:
 - 1) provide value to the member through incorporating common benefits not currently available while
 - 2) preserve the overall benefit of the plan; and
 - 3) implement standard cost saving mechanisms.

Modernization Challenges

- Though enhancements and offsets have been analyzed and discussed at length, few have been implemented
- Difficult to implement proposals on a stand-alone basis, as impacts of one proposal may be offset or enhanced by a different proposal
- Proposals should be balanced against one another while maintaining actuarial neutrality, and caring for diminishment concerns
- One size may not fit all – some proposals may benefit certain members, but not others
- Sweeping plan changes do not provide members with choices

Conceptual Alternative Modernization Approach

Idea: Offer retirees a voluntary choice to participate in an alternative retiree health plan

- The defined benefit retiree legacy plan would remain available to all eligible retirees
- Retirees could voluntarily participate in an alternative plan with plan provisions modeled on the AlaskaCare Employee Standard Plan
- Retirees could participate in an Open Enrollment period annually if they wish to change plans for the following benefit year. (Members could also change plans if they experience a qualifying status change throughout the year or experience substantial hardship)

Conceptual Alternative Modernization Approach

- Many of the modernization proposals under consideration are present in the AlaskaCare Employee Standard Plan, or are slated for implementation soon including:
 - Preventative care
 - No lifetime max
 - Coverage for dependents up to age 26
 - Access to Teladoc
 - Network steerage and out-of-network reimbursement differential
 - Enhanced Travel Benefits with SurgeryPlus
 - Copayment for primary care services (coming soon)
 - Enhanced CarePlus benefit with Surgery Plus (coming soon)
 - Wellness benefits (anticipated for 2021)

Conceptual Alternative Modernization Approach

- Participants in the alternative retiree plan would have higher cost sharing provisions (deductible, out-of-pocket maximum, pharmacy copayments) than legacy plan.
- Members in both plans who currently receive premium-free coverage could continue to receive premium-free coverage.
- The alternative retiree plan would change and evolve over time along with the employee standard plan as new plan provisions are implemented, and coverage is updated.

What Happens to the Current Plan?

- Current benefits would remain unchanged
- Today's defined benefit retiree health plan would continue to exist as it does today and could be called the AlaskaCare Retiree Legacy Plan
- Members in the legacy plan would continue to have access to the same benefit provisions
- Members who elect to participate in the alternative retiree plan could have an annual opportunity to elect the AlaskaCare Retiree Legacy Plan during a fall open enrollment.

Pros and Cons

Pros

- Would provide flexibility and increased choice to members.
- Would allow the Division to offer a plan that is flexible and can be changed and updated with mainstream practices.
- Would preserve the existing defined benefit plan.
- Would allow retirees to select the plan that meets their needs at that point in their life (e.g. Medicare eligible vs Non-Medicare eligible).

Cons

- Would require additional education and communication for retirees to ensure they are making an educated choice.
- Would require additional administrative complexity and operational burden to the Division and the claims administrator.
- Risk that the alternative plan could experience the same challenges as the legacy plan.
- Members in the legacy plan would not see any benefit changes or improvements.

Next Steps

- Board reaction and response
- Need to answer:
 - Can the Division offer a voluntary alternative plan to retirees that can evolve and be updated over time?
- Develop formal proposal
- Outline/map out logistics
- Communicate with retirees

