Retiree Health Plan Advisory Board
Meeting Agenda

Date:	Thursday September 3, 2020
Time:	9:00am – 2:30pm
Location:	**Video Teleconference Only**
Teleconference:	Conf #: 855-244-8681 ID#: 133 525 6583 Password: 792 92 343
	Join meeting
Committee Members:	Judy Salo (chair), Lorne Bretz, Joelle Hall, Dallas Hargrave, Paula Harrison, Cammy Taylor, and G. Nanette Thompson

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9:00 am **Call to Order – Judy Salo, Board Chair**

- Roll Call and Introductions
  - Welcome New Board Members
- Approval of Agenda
- Approve Previous Meeting Minutes
- Ethics Disclosure

9:15 am **Public Comment**

9:30 am **Department & Division Update**

10:00 am **Plan Year 2021 Open Enrollment**

- DVA Regulations Proposed Changes
- DVA Open Enrollment

10:30 am **Break**

10:45 am **Plan Year 2021 Open Enrollment, Continued**

- Rates for 2021

12:00 pm **Lunch**

1:00 pm **Education Session**

- COVID-19 Overview: Vaccines, Treatments, and the Future

2:00 pm **Public Comment**

2:15 pm **Final Thoughts**

- Next meeting: November 5, 2020
- 2021 Meeting Calendar

2:30 pm **Adjourn**

https://aws.state.ak.us/OnlinePublicNotices/Notices/View.aspx?id=197013

Retiree Health Plan Advisory Board

Board Meeting Minutes

Date: Wednesday, May 27, 2020 8:30 a.m. to 12:30 p.m.

Location: Virtual meeting via teleconference and WebEx only

Meeting Attendance

Name of Attendee	Title of Attendee	
Retiree Health Plan Advisory Board (RHPAB) Members		
Judy Salo	Chair	Present
Cammy Taylor	Vice Chair	Present
Joelle Hall	Member	Present
Gayle Harbo	Member	Present
Dallas Hargrave	Member	Present
Mauri Long	Member	Present
Nan Thompson	Member	Present
State of Alaska, Department of Administration Staff		
Ajay Desai	Director, Division of Retirement + Benefits	
Emily Ricci	Chief Health Administrator, Retirement + Benefits	
Betsy Wood	Deputy Health Official, Retirement + Benefits	
Teri Rasmussen	Program Coordinator, Retirement + Benefits	
Andrea Mueca	Health Operations Manager, Retirement + Benefits	
Steve Ramos	Vendor Manager, Retirement + Benefits	
Erika Burkhouse	Assistant Vendor Manager, Retirement + Benefits	
Mike Gamble	Member Liaison, Retirement + Benefits	
Others Present + Members of the Public		
Hali Duran	Aetna (third party administrator of medical plan)	
Richard Ward	Segal Consulting (health plan actuary)	
Noel Cruse	Segal Consulting (health plan actuary)	
Anna Brawley	Agnew::Beck Consulting (contracted support)	
Brad Owens	Retired Public Employees of Alaska (RPEA)	
Wendy Woolf	Retired Public Employees of Alaska (RPEA)	
Lorne Bretz	Alaska Retirement Management Board	
Lawrence Yerich	Retiree / public member	
	Others present who did not identify by name	

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
- CMO = Chief Medical Officer
- CMS = Center for Medicare and Medicaid Services
- COB = Coordination of Benefits
- COVID-19 = Novel Coronavirus Disease (identified 2019), also known as SARS-CoV-2
- DB = Defined Benefit plan (for Tier 1, 2, 3 PERS employees and Tier 1, 2 TRS employees)
- DCR = Defined Contribution Retirement plan (Tier 4 PERS employees, 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
- MA = Medicare Advantage, a type of Medicare plan available in most states
- 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.
- PMPM = Per member per month, a feature of capitated or managed-care plans
- PPO = Preferred Provider Organization, a type of provider network
- RDS = Retiree Drug Subsidy program (a federal pharmacy subsidy program)
- ROI = Return on Investment
- RFP = Request for Proposals (a term for a procurement solicitation)
- RHPAB = Retiree Health Plan Advisory Board
- TPA = Third Party Administrator
- USPSTF: U.S. Preventive Services Task Force

Meeting Minutes

Item 1. Call to Order + Introductory Business

Chair Judy Salo called the meeting to order at 8:30 a.m. A quorum was present.

Approval of Meeting Agenda

Materials: Agenda packet for 5/27/20 RHPAB Meeting

- **Motion** by Mauri Long 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 Meetings' Minutes

Materials: Draft minutes from the previous (2/6/20) RHPAB Meeting.

- **Motion** by Mauri Long to approve February 6, 2020 meeting minutes. **Second** by Cammy Taylor.
  - **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.

- Mauri Long reiterated her previous disclosure, that she owns a small number of shares in Teladoc.

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

- **Brad Owens, RPEA**. Brad shared that there is a pending lawsuit related to medical plan changes in 2014 and 2016 and wanted to provide a status update to the board. The lawsuit is about process: what is owed by the State to retirees by the state regarding changes to the medical

plan which is protected by the Alaska constitution. The court has found that there is a high standard for the State to undergo a good faith process when making changes, and that the State owes good faith and fair dealing when considering the benefits. The State must also provide adequate public notice prior to making changes, to give retirees an opportunity to provide input. This should include a written statement to retirees outlining the changes, and what if any offsets were made to address potential diminishments.
Brad also reiterated his request shared in the February meeting, that retirees (members of the public) have an opportunity to ask questions and participate in the meeting.

- **Lawrence (Larry) Yerich, retiree in Anchorage**. Larry also provided comments in writing, which will be shared with the board. He commented that retirees should have access or coverage of a gym or physical fitness benefit, as this benefits not just physical health but also mental and emotional well-being. He recently enrolled in Medicare and was surprised this benefit is not included in Medicare either, as it is increasingly common in other plans. The monthly fees of local gyms would be a financial burden without some form of subsidy. He requested the board and the Department of Administration commissioner re-consider this issue as soon as possible.

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

Materials: Presentation beginning page 25 in 5/27/20 meeting packet

Emily Ricci and other staff provided several updates:

COVID-19 Response

Emily shared that as the board is aware, the world experienced significant changes since the February 6 meeting. Staff have been working at home for the last 2 months and have made several temporary changes to the plan in response to the COVID-19 pandemic. During this time, almost 100% of the staff's capacity was focused on these changes and communicating them out to retirees. Now that these changes are in place and the immediate urgency has subsided, Division staff have been able to focus up to 50% of their capacity on other ongoing projects, including the modernization project. Staff intend to continue working through the analyses to prepare for a larger discussion at the August meeting. Today's meeting will focus on the "How," possible avenues to implement these changes.

Overview

Ajay Desai shared that as early as February, Division staff were coordinating with Department of Health and Social Services (DHSS) and considering how to protect the health and safety of retirees in the face of this new disease. Staff approached the commissioner about temporarily expanding benefits in the retiree plan to allow retirees access needed benefits and receive treatment if they contracted the disease. This proactive effort allowed them to quickly implement these new temporary benefits in response. He also emphasized that the Division's first priority is protecting the lives covered in the AlaskaCare plans and working to minimize the human cost of the pandemic for this population. The primary focus is serving beneficiaries of the plan and protecting lives; this is the intent of all their work. He and staff will continue to focus on this and find ways to best protect and provide for care of retirees.

Emily added, prior to sharing information about what is known currently, that many of the impacts will still be unknown for some time: for example, billing typically occurs between 30 to 90 days after the actual service is rendered, so a visit that occurred in early March may not show up in the system as a completed claim until as late as June. Therefore, many new temporary benefits and overall utilization

data will not be available for some time. There is some preliminary information on spending and utilization, as well as some other metrics available.

Division Actions + Preliminary Impacts

Betsy Wood provided updates on available data: she noted that the data does not separate retiree and employee plans, so some of the numbers are combined data points.

- In the pharmacy plan, "refill too soon" notifications have been temporarily lifted. This means that a person can refill a prescription earlier than normal, rather than needing to wait until they are closer to the end of their current fill. This is intended to allow members to access medications as needed, particularly if they need to be self-quarantining for a long period of time, as well as ensuring they can get needed medications.
- The pharmacy plan also covers flu and pneumonia vaccines on a temporary basis for retirees. In March, 79 retirees received flu vaccines and in April, only 2. This has not been heavily utilized to date, but they will continue offering this benefit for the time being. For the pneumonia vaccine, 69 retirees utilized that benefit in March and 20 in April.
- In the medical plan, staff are tracking claims volume and number of contacts to customer service centers. For both metrics, numbers are down: fewer people are utilizing benefits and generating claims, and fewer people contacted the concierge center. In March and April, contacts were down 46% compared with the same period in 2019. Additionally, there is a 13% decrease in claims during this same period, with April being down 26% from the previous year. They anticipate that these numbers do not include all claims for this period that will be submitted, and that there will be an uptick in claims as states open up again and people move toward returning to normal utilization.
- The medical plan also includes a temporary benefit for retirees to utilize Teladoc: to date, since early March, about 917 retirees have enrolled in the benefit, with about 132 actually utilizing the service. A letter was sent to retirees informing them of this temporary benefit and how to enroll. This is a similar pattern to the employee plan, when this benefit was added: there was a slow trend in increased enrollment and utilization.
- In the dental plan, Delta Dental noted a much lower call volume in March and April; there was also a very high call volume in January due to questions about the dental plans, from both employees and retirees. Retirees had questions about the DVA plan changes. There is also lower utilization of services, due in part to shutdowns in most states and the current recommendation to avoid non-emergency dental procedures to avoid risk of exposure and infection. It is likely that this will remain low in the first quarter as the data continues to come in; the plan has seen an increase in utilization this quarter so far, and anticipating an increase as states open up and allow dental offices to operate.

Betsy also shared that the Division continues to hold regular tele town halls with retirees, in addition to the regular monthly schedule, they added extra events to share information to retirees and answer questions. The events are very helpful and allow for anticipating what questions retirees want answered, and what communications or information to provide. More frequent events allowed them to quickly get information to retirees, check in on what retirees are concerned about, and communicate about the temporary plan changes. Staff also introduced a new format, a guest speaker in the first 30 minutes of the event, who can provide valuable information as an expert. They have hosted Dr. Joe McLaughlin, Alaska DHSS epidemiologist; Dr. Michelle Rothoff, Alaska DHSS epidemiologist; and Dr. Keri

Gardner, chief medical officer at Alaska Regional Hospital. Attendance has been especially high over the last two months, including over 1,000 people remaining on the line for the entire hour-long event.

Staff will continue hosting townhall events and feature other topics that retirees are interested in: Medicare questions, long term care benefits, and others. Please share ideas for topics or questions that retirees would be interested in!

Questions from the board:

- Judy asked whether there is a different process for Medicare enrollees versus not Medicare?
    - Betsy responded no, telemedicine is not reimbursable under Medicare, so the benefit is the same for all retiree populations regardless of age.
- Gayle asked whether the Division has made a decision about whether and how the Health Fairs will occur this fall?
    - Betsy noted that they have not made a decision yet but are working to figure out how and if these events could be held safely. The health fairs important way to retirees and employees but pose several challenges in the face of limiting spread of the disease and not putting people at risk.
- Judy commented there will likely be a surge in demand for medical procedures and other care, such as hip surgeries and other deferred services that people were not seeking out during the shutdown period. What do staff anticipate in how demand for services will change over time?
    - Emily noted that this is unknown and remains to be seen how much there is a delay in demand, versus less demand if people forego procedures. There are also significant unknowns for providers: will they increase prices to offset loss in revenue for less procedures? Will the lower utilization offset any price increases, with a net zero result to the plan? And how long will reduced demand continue?
    - Richard Ward added that Segal is closely tracking trends in the health care field, this is a relevant question that remains to be seen. It is still unclear how much care will be deferred (and still occur), versus simply not utilized. This will continue to be unknown.

Temporary Plan Changes

Emily presented the slides beginning on page 25 of the packet, reviewing temporary benefits added or changed in the retiree plan. She noted that, per the language on page 27, changes are temporary and are dependent on the termination of the state or federal public emergency. Slide 28 provides an overview of the timeline of the pandemic, including early indicators in January 2020 that this is a serious disease with significant risk of worldwide spread.

The first plan changes were made on March 4, as well as several state and federal actions declaring a state of emergency following the WHO designation of this situation as a pandemic. While Alaska did not see a high number of cases compared with other states, there were 232 cases and 4 deaths in the state in March, with the numbers increasing to 363 cases and 9 deaths in April, and to 402 cases and 10 deaths as of May (with more continuing to be identified and reported). Currently the state is under the Reopen Responsibly plan and working to anticipate what the "new normal" looks like for the rest of 2020. Additionally, many retirees live in other states, including higher risk areas. The Division continues to anticipate and plan for possible scenarios and ongoing impacts to the AlaskaCare member population.

Emily also noted several challenges specific to the health care system related to the pandemic:

- *Prevention*: there were many challenges in responding to and preventing spread of the disease, including stay at home orders and supply chain issues for personal protective equipment (PPE).
- *Testing*: sufficient supplies and access was a challenge particularly in the beginning.
- *Treatment*: this is a new disease and our clinical understanding is evolving; outbreaks can phonetically overwhelm the capacity of the health system and effective treatments are being developed and discovered.
- *Access to Care*: many people are delaying or avoiding the health care system altogether, which will have other impacts on population health over time. Many retirees are vulnerable, due to age and preexisting conditions and other factors, so this population is particularly at risk.

Early in the situation, Division staff coordinated with DHSS, the Chief Medical Officer (CMO), Medicaid and the Division of Insurance to identify priorities and strategies for protecting the population. The five priorities are: supporting the public health response, assisting members to access needed care, reduce strain on the health care system, protect members from losing coverage, and ensure continued high-quality service to members.

Slides 31-35 outline specific temporary plan changes made in response to the pandemic, summarized in this table:

Temporary Plan Change or Division Action	**Effective Date**
Allow early refills for up to 90-days supply (excluding opioids)	March 3, 2020
Increase email communications to AlaskaCare members	March 4, 2020
Expand telemedicine billing codes eligible for coverage to align with new Medicare coverage for the same services	March 4, 2020
Maintain benefits for COBRA participants and extend enrollment period	March 4, 2020
Waive member cost-share for telemedicine visits	March 4, 2020
Expand Aetna crisis support line to retirees	March 6, 2020
Provide temporary coverage for influenza and pneumococcal vaccines	March 6, 2020 (flu) March 13, 2020 (pneumonia)
Expand Teladoc services to AlaskaCare retirees	March 9, 2020
Waive member cost share for COVID-19 testing and office visits. *This includes services not specifically related to COVID-19 but other respiratory illnesses, given that testing was unreliable, and the disease might initially present as another type of respiratory illness. Coverage of other respiratory illnesses will end sooner, as COVID-19 testing is more available.*	March 9, 2020
Expand townhall to include state epidemiologist/medical directors	March 13, 2020
DRB offices closed to the public	March 16, 2020
CHCS Long-Term Care assessments transitioned to remote evaluations	March 17, 2020
12 out of 13 health team members working remotely	March 20, 2020
Waive applicable cost sharing provisions for COVID-19 inpatient care	March 26, 2020
Suspend precertification and utilization management requirements	March 29, 2020

Temporary Plan Change or Division Action	Effective Date
Extend precertification periods for prescriptions and medical services	March 29, 2020
Aetna, Delta Dental and OptumRx member teams transitioned to working remotely	Late March 2020
Extend IRMAA deadline for 2019 claim forms from March 31 to June 30	Late March 2020
Maintain benefits for Direct Bill participants who miss payments	April 1, 2020
Suspend full-time student review *The Division anticipates reinstating this in fall 2020, tentatively.*	April 6, 2020
Suspend incapacitated dependent verification review	April 14, 2020

Emily noted it is remarkable how quickly telemedicine benefits were adopted, and procedures adjusted, at a speed unthinkable under normal circumstances, given the previous pace of change to adopt and utilize these types of services. They continue to review utilization and the need for each change, as the situation develops, so each temporary change will depend on specific need. They are also keeping up with current federal requirements and guidelines and attempting to stay consistent with those rules, which are also changing rapidly, according to ongoing federal guidance.

The pandemic and all related impacts, including health impacts as well as financial impacts to the health industry and the economy overall, will continue to be an issue for the foreseeable future. Division staff continue to monitor each of the temporary changes, communicate with retirees and stay abreast of all relevant updates.

Slide 37 includes several resources related to COVID-19.

Questions and comments from the board:

- Cammy Taylor thanked staff for their quick response to this emergency and ongoing care for retirees and all AlaskaCare members in this difficult situation. She provided several comments summarizing what she's heard from other retirees recently:
    - Interest in extending or making permanent the ability to fill prescriptions early: retirees are concerned about other emergencies, such as an earthquake, and this policy allows for greater access to prescriptions and ability to have a longer-term supply of needed medications if a supply chain is interrupted.
    - More access to the high-dose flu vaccine for older people: in 2019, there was limited supply of this vaccine at least in Alaska, but this is effective.
    - General interest in coverage of vaccines generally, including a future COVID-19 vaccine but also other vaccines for infectious diseases.
    - General concern about whether a vaccine, when it is available, has been thoroughly tested and is safe, particularly for older and vulnerable populations like retirees.

Emily thanked Cammy, and all retirees they have been in contact with, for being understanding and flexible during this difficult situation. She noted that the Division is actively reviewing these changes and balancing the need to responsibly manage the plan with the need to provide coverage for retirees. For example, early refills would not be feasible to expand permanently, this is not a common practice with other plans; however, they could expand the "vacation override" option to include other situations like

emergencies, when there would be concern about accessing medications or having shortages. The goal would be to maintain responsible utilization of medications, while not encouraging personal stockpiling.

Regarding vaccines: AlaskaCare does not purchase or manage vaccines, but this is a service provided at health fairs and other venues. The plan covers FDA-approved treatments and vaccines, including emergency authorizations. This means that for both testing and a future vaccine, the plan can accommodate coverage of this. However, the Division will follow clinical guidelines, and only covering approved and recommended tests and treatments. When a vaccine is available, the Division will use the same approach and ensure that coverage is for safe and effective treatment.

Testing Update

There are several tests available and being approved by the FDA, including both antibody (active or previous infection) and viral testing (active infection). These will continue to develop over time, including new options such as home test kits. Emily stressed that there are also ineffective or fake tests circulating in the market, so it is important to seek out an effective and approved test to ensure an accurate result. She encouraged people to coordinate first with their physician to access a test that is FDA approved, and to not simply order a test online or from an unknown source.

EGWP and IRMAA Update

Andrea Mueca shared that the 2019 deadline for submitting request for reimbursement for the IRMAA surcharge was March 31, 2020. This includes submitting paperwork showing that they are income-eligible for the surcharge and to establish an HRA account for reimbursement. Division staff provided several reminders in town halls, e-newsletters, print mailing and other methods. The March deadline has been extended to June 30, 2020 due to the pandemic. Approximately 100 members who should be eligible for this reimbursement have not responded or provided the necessary information for reimbursement. Staff will continue to contact these members through June to encourage them to submit the needed paperwork.

Additionally, the Division now sends reminder letters to all retirees a few months prior to them turning 65, to remind them to enroll in Medicare as required, to submit their paperwork to the Division noting this is done, and to help them transition to the EGWP pharmacy plan. Andrea is excited that this is now happening for the first time, it has long been a priority project for her. This will help retirees understand their options and what actions they should take to have a smooth transition to Medicare.

Dental, Vision and Audio (DVA) Plan Update

Andrea shared that the State issued an RFP for vendors to provide two services: first, to administer the COBRA and direct-bill services; second, to host the member enrollment platform for the DVA plan. Currently PayFlex provides the first service, and Segal Consulting built the website and platform for the first year of the DVA plan enrollment process. The Division hopes that one vendor can provide both services. Interviews of potential candidates will be conducted June 9 and 10; board members are invited to participate in the interviews as subject matter experts. The RFP closes on June 1, 2020.

Betsy Wood added that the Division understands members have had frustrations with the current vendor regarding payments and is seeking a vendor who prioritizes excellent customer service and working with members to make the process smooth. She encouraged board members to participate in this process, retirees' feedback is valuable.

- Judy Salo agreed that participating in the procurement process is very helpful and encouraged fellow board members to participate if available. Division staff will send an update to the board when they know how many responses they've received, which will allow them to plan timing.
- Nan Thompson shared that she is not available in June, but very much appreciated participating in a previous procurement process. She encouraged board members to be involved, even if they are only available for part of the time, it is a great learning process.

The Board took a 15-minute break at 10:18 a.m., and returned to the meeting at 10:33 a.m.

Item 4. Education Session: Medicare Advantage

Materials: Presentation beginning page 39 in 5/27/20 meeting packet

Chair Judy Salo invited Emily Ricci and Richard Ward to present.

Emily introduced the context for this presentation: to date, many changes to the Defined Benefit retiree plan have been discussed, and previous changes made to the plan have been primarily to the actual plan. There are, however, other options for implementation: one of these is Medicare Advantage (MA), a type of private sector plan available in many other states, but not currently offered in Alaska. She noted that it is likely that a large proportion of Medicare eligible retirees in Alaska are likely already members in the AlaskaCare plan: this means that decisions made about this plan would have a significant impact on the market overall. This could also address benefits that retirees have requested, such as wellness and gym membership, but these are very preliminary discussions and would take significant additional vetting and considerations before any decisions are made.

Richard Ward provided an overview of Medicare generally. There are 4 parts:

- Part A: hospital services (required to enroll if eligible)
- Part B: outpatient/physician services (required to enroll to enroll if eligible)
- Part C: Medicare Advantage plans with additional services (optional additional services)
- Part D: Prescription drugs, including group plans like EGWP (optional)

Part C allows insurers to combine multiple plans (Parts A and B) as well as supplemental services not offered under the core plans. Medicare Advantage plans integrate multiple insurers' coverage into one plan as well, rather than having to coordinate two plans for services not covered by Medicare. CMS contracts with various other providers to administer benefits under these plans.

The Medicare Modernization Act (2003) made several changes including financial support for employers offering prescription drug benefits; created EGWPs for employer-sponsored plans; revamped an existing program to become Medicare Advantage; and created the Retiree Drug Subsidy (RDS) program, which AlaskaCare utilized before implementing EGWP in 2018, and continues to utilize for non-EGWP retirees.

Medicare Advantage are fully insured plans offered by private insurers, with costs covered by premiums as well as other federal subsidies to the insurer. The plans are typically capitated (meaning, a set per member per month cost) and include built-in incentives for managing population health such as wellness and prevention, chronic disease management and other features. Plans are typically offered and priced by a service area, such as a county, and pricing of each plan is based on the aggregate risk level of that population, the performance of the insurance carrier, and other factors. Availability of plans

varies by county in other states. This allows for higher economy of scale and a focus on cost management, which also allows for coverage of additional benefits.

Page 43 compares features of traditional Medicare plans versus Medicare Advantage plans: traditional Medicare is directly paid by the federal government (CMS), while Medicare Advantage is all managed by a private insurer who gets reimbursed or subsidized by the federal government. Traditional Medicare reimburses on a fee for service basis, while Medicare Advantage plans are managed care plans. Plans and provider participations vary by location: private insurers establish their own networks of providers who accept Medicare and also contract with the insurer under Medicare Advantage plans.

There are individual and group plans, similar to how there are individual Medicare Part D pharmacy plans, versus EGWPs which are Part D group plans. For regional plans that cover a majority ("51% rule") of Medicare eligible members in their service area in a group plan, that plan may also provide coverage on a "passive PPO" basis, meaning that the plan members can receive the same level of care whether the provider is in or out of network. This is relevant because people living in an area with no Medicare Advantage plans could receive the same benefits as others in locations with Medicare Advantage plans, if they are covered under a group plan under this passive PPO rule.

- Joelle asked for clarification, would provider rates under a Medicare Advantage plan utilized in Alaska be the same rates for another county or other location?
    - Richard clarified no, provider rates are still set locally; the 51% rule allows members not otherwise living in an Medicare Advantage area to access the same network of providers who accept Medicare. This is already in place today, and not dissimilar from the current AlaskaCare plan, which has the same set of benefits regardless of where the member lives.
    - In order to meet the 51% requirement, it may be easier in Alaska because much of the state is concentrated in a few populous counties: Anchorage, Kenai Peninsula, Mat-Su, Fairbanks, Juneau. The member numbers do not need to be statewide to access this benefit, and people can be counted twice if they live in one area but are covered or eligible for a plan in another. Double-covered individuals are not counted twice.
- Cammy asked how coverage works if someone lives in another state or county, or travels: would they be limited to the network / Medicare providers in that area, even if there is a broader network under their plan?
    - Richard clarified no, a person could see any Medicare provider because of this rule, and wouldn't be limited to the plan(s) offered in the area they are currently located in. This is similar to AlaskaCare benefits now, for a member experience perspective; a person would pay a co-pay at the pharmacy, for example, and not have a different experience to what they do today. The plan provisions apply no matter where the person lives.
- Cammy followed up: currently, a Medicare-enrolled AlaskaCare retiree is double covered (Medicare primary, AlaskaCare secondary). Does a provider get reimbursed the same amount regardless of which plan, given that Medicare rates are typically lower?
    - Richard responded yes, provider reimbursements can be set by the Medicare Advantage plan, which can be more generous than the underlying Medicare reimbursement rates. Similar to EGWP: AlaskaCare provides wraparound coverage of prescriptions not covered by Medicare and can set higher than the base rates. Therefore, the same benefits or same level of benefits can be provided, at higher rates than Medicare alone,

but are offset by more federal subsidies for this type of plan, so there is not necessarily an increased cost.

- Emily added the advantage of this type of plan is they can reimburse providers at rates different than the normal fee for service rates, which may allow opportunities to pay for primary care at higher rates to incentivize more providers to accept Medicare. This would address an existing gap, that Alaska retirees have difficulty finding providers who accept Medicare because it is not financially advantageous to them.
- Richard agreed: typically, Medicare is described as a reduction in fees or network discount, but the reverse can also be true, by increasing provider reimbursement of Medicare to be more comparable to other (commercial) insurance plans.

Richard concluded: Medicare Advantage plans have steadily increased enrollment over the last 20 years, with most states having one or more plans and have Medicare eligible individuals covered by Medicare Advantage plans. The average enrollment in 2019 was 34% (one third) of Medicare enrollees, with larger numbers tending to be in places where retirees move or relocate: West and Southwest, Florida, upper Midwest and Hawaii. The Plains states and East Coast states have somewhat lower enrollment. Alaska has 1% enrollment, up from 0% in previous years, but no plans are offered in Alaska; existing enrollment represents people living in Alaska but covered under a plan issued in another state.

There are insurers offering both PPO and HMO plans across the U.S., with the main PPO providers being Aetna, Blue Cross Blue Shield, Humana and United Health Care. HMOs include CIGNA, Kaiser and several local or regional carriers.

Other features of Medicare Advantage: enhanced care management and coordination, opportunity for higher subsidy amounts depending on an enhanced EGWP risk score, additional access to federal funds and a greater economy of scale. Medicare Advantage plans cover a more comprehensive set of services, such as preventive care and wellness options like Silver Sneakers programs. Also provides for more health management tools, to encourage health management within the population (such as chronic disease management). The ability to set different rates may offer other savings opportunities compared with Medicare. The fact that many retirees are located in states outside Alaska may help Alaska Care meet the 51% threshold to allow for the group PPO features.

- Judy asked what steps need to occur to implement Medicare Advantage in Alaska: does this require regulatory change?
    - Richard responded that the following steps would need to happen: an insurer would need to establish a network of providers to create a Medicare Advantage network, following CMS's minimum access requirements for a network. This includes hospitals, labs, imaging, outpatient care and others. When this network is established, the insurer can offer this type of plan in Alaska, or one or more boroughs/geographic areas in Alaska. The barriers are not regulatory per se, but insurers not seeing a viable market in Alaska yet.
    - Emily added that she understands that this requires insurers to see a viable market, and that it hasn't happened yet. Staff are interested in gauging retirees' interest in considering this option, given that it would require a private sector entity to create this plan. Even if AlaskaCare was interested in pursuing this, it would require participation of an insurer. The Division typically issues an RFI (request for information) when

considering a new service or option such as this, to gauge interest from the private sector and understand what the barriers would be from their perspective.

- Gayle asked whether the Division has previously considered a Medicare Advantage plan, or is this new? She noted that about 70% of retirees are now Medicare eligible, so this seems like a promising option to manage costs and expand benefits for retirees. She would like to continue discussion of this option if it is advantageous to the State and to retirees.
    - Emily confirmed that she is not aware of any discussion about Medicare Advantage plans to date since she joined the Division in 2016, so this is new as far as she is aware. However, it is a valuable opportunity to consider, so they are in early stages of vetting this idea.
- Judy asked whether the concept of a "wrap" is similar to a Medicare Advantage plan? Is this more or less complex than a wrap like EGWP, since that involves two plans?
    - Richard confirmed that it is similar, but rather than having two plans that coordinate, this is one plan that combines benefits. In some ways it is simpler because it is one plan versus coordination of multiple plans. Many of the regulatory and other issues related to Medicare plans were already addressed in the work that went into implementing the EGWP, since it is also a group Medicare plan. There isn't a separate set of requirements for this type of plan, it has to do more with Medicare overall.
- Gayle commented that this does appear to offer some advantages to members, if it expands access to more benefits and incentivizes providers to participate in Medicare.
    - Emily noted that this could also expand access to primary care, such as addressing providers who are only taking a certain number of Medicare patients by providing incentive to take more patients, by increasing the reimbursement amount for some services. It would take time to implement this type of program but could help increase access to care for members where it is challenging today.
- Cammy asked how premiums would be determined, given that retirees enrolled in Medicare already pay Medicare Part B premiums?
    - Richard responded that members would need to still pay Part B premiums, this is not built into Medicare Advantage premiums. Insurers set Medicare Advantage premium rates, negotiated by the plan sponsor and the carrier, determined by the net costs beyond estimated federal subsidies. So, this would still have a premium cost, which would need to be figured out. Estimated full-cost premiums would be determined by the differential between total claims costs minus Medicare reimbursement and subsidy amounts, for the supplemental benefits.
- Gayle asked whether high-income retirees would still be subject to an IRMAA for this plan?
    - Richard responded yes, this would also be a factor. These and other details need to be lined out and evaluated.
    - Emily added that one option would be to consider additional benefits paid for by premiums, which would allow people to opt into these additional benefits by enrolling in a Medicare Advantage plan, but all of this needs to be considered further.
- Cammy asked whether savings would primarily accrue to the plan?
    - Richard responded yes, cost savings would be primarily to the plan.
- Judy commented that the board is interested in reviewing this further and looks forward to considering whether this is a net benefit for Alaska and retirees. She noted that the country will

face significant fiscal challenges and impacts to the economy, so she anticipates potentially many large changes to the status quo moving forward.

Item 5. Modernization Project: 2020 Next Steps

Materials: Documents beginning page 50 in 5/27/20 meeting packet

Emily reiterated that staff have been completely focused on the COVID-19 response and had to set aside other projects such as this one. However, they are now able to focus more fully on the modernization project and anticipate moving forward as planned with the board's discussion in August of the proposals they selected in the February meeting.

She also noted there are important questions regarding the "What" (what changes if any should be made to the plan, and the details of those changes) as well as the "How" (how any changes would be implemented). Emily noted that there is a lot of information to absorb, including this new concept of Medicare Advantage plans as an option to implement changes, but staff will look to the board for direction on what the process looks like for making decisions and over what period they would be implemented in the future.

- Judy and Cammy responded that they are interested in considering what Medicare Advantage could look like, given that it relates to several provisions being discussed, but that there is a lot of work involved with delineating what this could look like.
    - Emily suggested that staff work with Segal Consulting to outline a potential Medicare Advantage proposal, and to consider issuing an RFI to gauge interest in and potential challenges with implementing MA plans in Alaska.
- Gayle asked whether it's possible to model the financial / cost impacts at this early stage?
    - Emily noted that the margins of error would be large, but there are basic parameters that could be modeled with available data.
    - Richard added that his firm has assisted other plans with considering Medicare Advantage plans, so they could utilize previous assumptions and adjust for AlaskaCare specifically. They could model expected subsidies and overall costs and would need to make some assumptions about Alaska retirees given that there is no plan now and this constitutes a majority of retirees in the plan.
    - Emily added that there could be multiple options modeled, and it would be iterative discussion with insurers. She noted that issuing an RFI would be a significant step and would get attention of major insurers and would allow for learning from insurers without needing to commit to a direction.
- Joelle noted that many of the proposals being considered are common in other plans and in other states, but not common features in Alaska. What proposals being considered could be rolled into a Medicare Advantage plan, potentially?
    - Richard responded this analysis has not been done yet, but it is very likely that several of the items on the list (such as wellness benefits) could be addressed by implementing a Medicare Advantage plan. However, more analysis would be needed, including whether how this would impact existing analysis of actuarial impacts and other factors. He did note that for other plans adopting Medicare Advantage plans, they are typically adopted only

if they provide the same or better care at lower overall cost, particularly for public sector plans.

- Emily asked Richard, what are the incentives for providers if a Medicare Advantage plan (with the larger PPO if they have 51% coverage) to participate in a network, if they would get reimbursed the same?
    - Richard responded that there are still steerage provisions and potentially better reimbursement, so they would benefit by contracting and receiving more patients through this network. There could still be a preferential network for providers, and non-network providers would be paid a standard Medicare rate. The network dynamics still apply for providers, but the member would not experience a difference because they can choose to go to any provider who accepts Medicare.
    - Emily noted that there may be other benefits to this approach, including addressing existing confusion with having two payers, multiple EOBs and other points of frustration with the current system. However, more analysis is needed, this is only preliminary.
    - Richard agreed, but cautioned that EOBs are likely to still be complex.
- Cammy asked how often members and the State would need to deal with enrollment and contracting? Is this an annual issue?
    - Richard responded contracts can be multi-year, he noted that in the past Medicare Advantage plans would not extend out many years because of the uncertainty with the new type of plan. Now that plans are more mature and it is an established program, insurers are more willing to engage in multi-year contracts as there is more certainty. He noted that working with another state's retirement plan, they have been able to engage in a renewal process over multiple years. There would be annual paperwork for members, but not a full enrollment process year over year necessarily.

Emily concluded the discussion: the Division is committed to still discussing these proposals as they have been, including changes to the plan as it exists today. This is how plan options have been presented to date. However, given the potential benefits of Medicare Advantage plans and that it could address the interests of members and the State, if the board is interested in further pursuing discussion of Medicare Advantage plans, staff can begin a parallel analysis process and outline what an Medicare Advantage plan could look like. The State could also issue an RFI to gauge interest in Alaska Medicare Advantage plans, but this requires first identifying parameters about what would be offered. Staff could work to outline these parameters, present to the board for feedback and guidance, and then use that framework in the RFI for potential vendors to respond to. In the meantime, staff will move forward with the "what," the proposals for discussion that were selected from the larger list in February.

- Gayle and Judy agreed this would be a valuable approach; no objection. Could this be discussed at the August meeting as well?
- Staff confirmed that the August 2020 meeting is tentatively scheduled for Thursday, August 6, but this has not been formally confirmed. The date will be finalized later in the summer.
- Judy asked when staff would likely return to the office in person? She is interested to understand whether the meeting could be held in person, or if the meeting would be virtual only. She understands this is uncertain.
    - Emily noted that their leadership have been supportive of staff working from home, and so they will continue to work on a plan to allow staff to work safely, in the office or at

home as needed. However, it is uncertain—every in-person interaction currently carries risk, so this will be difficult to manage until the situation changes (e.g., there is a viable vaccine or cases dwindle to nothing in the future). Until that time, there is additional risk so staff would anticipate continuing with virtual meetings rather than opening in person.
    - Judy commented that while this format has limitations, the meeting went pretty well, especially allowing screen sharing to focus on the content being shared.
- Judy invited all board members to provide feedback on how the meeting went and how to improve this format, given that with the current situation they will need to likely continue meeting virtually. She noted it is challenging to stay focused in a computer-based meeting, so she wants to make sure the meeting can be run effectively, and that people feel that they can meaningfully participate. She asked board members to share suggestions. She also noted that when they meet to continue the modernization work, the discussion should be well facilitated, including questions sent in advance to think ahead of time; using a roll call method or formal management of the discussion to allow everyone to speak; and other methods.
- Cammy asked whether staff would like to have a modernization committee meeting in advance of the August meeting? This could allow the group to collect questions and discuss how to run the August discussion.
    - Judy noted there is limited time and may be difficult to find time for a meeting, but also that this summer will not be a "normal" Alaska summer either way. But she supports the idea if it works with the timeline.
    - Emily requested that staff have time to develop a timeline and determine whether it is feasible to have that meeting, including time to prepare materials in advance. She noted that if they organize a meeting, they want to make sure they have time to prepare and make the best use of the board's time. Staff will confer on this as soon as possible and respond to the board.

Item 6. Public Comment, Continued

Chair Judy Salo reminded the public of the comment guidelines, and invited members of the public to provide additional comment.

- **Brad Owens, RPEA**. Brad thanked Division staff for their quick and thorough response to the COVID-19 pandemic, and for protecting the health of retirees. He also commented that both the Division and RPEA have common ground in wanting to protect the health of retirees.

Item 7. Closing Thoughts + Meeting Adjournment

Closing Thoughts

- Mauri suggested the board consider a delay in the board's quarterly meeting, and instead hold a modernization committee meeting in August before discussing the proposals as a full board. Given that Medicare Advantage plans offer potential to address many of the proposals being discussed, especially additional benefits, but also could make the needed offsets to offer new benefits more palatable and feasible for retirees. She speculated that it may be a better use of time, rather than moving forward with analysis without taking this into consideration. Additionally, having to do an online meeting would be difficult at the intensity that they anticipated for the August meeting, which was intended to be a work session on all these issues. She suggested a half-day committee meeting

would be more workable in this format and would allow for more time and analysis of this new option for implementing these changes.
    - Staff will discuss this option when looking at the timeline.
- Dallas noted that staff time is the critical consideration for the overall timeline and suggested that staff provide realistic guidance on what they can prepare in the next few months. He recognized the amount of work involved and limited capacity and is comfortable with a timeline they propose.
- Judy thanked the board for attending today, and staff for great preparation and presentations!

- **Motion** by Gayle Harbo to adjourn the meeting. **Second** by Joelle Hall.
    - **Result**: No objection to adjournment. The meeting was adjourned at 12:22. p.m.

The next Retiree Health Plan Advisory Board meeting is planned for August 2020 (specific date TBD).

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.

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.

NOTICE OF PROPOSED CHANGES IN THE REGULATIONS OF THE DEPARTMENT OF ADMINISTRATION, DIVISION OF RETIREMENT AND BENEFITS

The Division of Retirement and Benefits proposes to amend and adopt regulation changes in Title 2 of the Alaska Administrative Code dealing with eligibility, coverage, and enrollment rules for the AlaskaCare retiree Dental-Vision-Audio (DVA) insurance plan, including the following:

1) 2 AAC 39.210 will be amended to include a new section that includes provisions for benefit recipients with multiple retirement accounts to elect DVA coverage under each account. Benefit recipients must select the same plan option for all accounts, though they may elect different coverage tiers for each account.

2) 2 AAC 39.240 will be amended to remove redundant language.

3) 2 AAC 39.260 will be amended to include new sections regarding coverage changes, new language further defining family structure changes and dependent eligibility, and a new section regarding reduction in coverage and premiums by the Division. The intended effect of these amendments and new sections is to allow members to increase coverage upon change in a dependent's eligibility status, and to allow members to make changes in initial coverage upon enrollment for new coverage.

4) 2 AAC 39.265 will be amended regarding open enrollment and will include a new section further detailing enrollment and coverage elections.

5) 2 AAC 39.290 will be amended to further define the definition of administrator.

You may comment on the proposed regulation changes by submitting written comments to the Division of Retirement and Benefits at P.O. Box 110203, Juneau, AK 99811-0203, by fax at (907) 465-3086, and by electronic mail at *doa.drb.alaskacare.retiree.plan@alaska.gov*. Comments may also be submitted through the Alaska Online Public Notice System by accessing this notice on the system and using the comment link. The comments must be received not later than 4:30 p.m. Alaska Daylight Time on September 20, 2020.

Oral comments may be submitted at a hearing to be held via WebEx on September 9, 2020 at 2:00 p.m. Alaska Daylight Time. To participate, join the conference call at
Conference # (855) 244-8681
Access code: 133 394 8639
Password: 45337357

If you are a person with a disability who needs a special accommodation to participate in this process, please contact Trudy Champagne at *Trudy.Champagne@alaska.gov* and (907) 465-4460 not later than September 1, 2020, to ensure that any necessary accommodation can be provided.

A copy of the proposed regulation changes is available on the Alaska Online Public Notice System and by contacting AlaskaCare, Division of Retirement and Benefits at P.O. Box 110203, Juneau, Alaska 99811-0203, or by visiting AlaskaCare.gov.

After the public comment period ends, the Division of Retirement and Benefits will either adopt the proposed regulation changes or other provisions dealing with the same subject, without further notice, or decide to take no action. The language of the final regulation may be different from that of the proposed regulation. You should comment during the time allowed if your interests could be affected. Written comments received are public records and are subject to public inspection.

Statutory authority: AS 14.25.004; AS 14.25.005; AS 22.25.027; AS 39.35.004; AS 39.35.005.

Statutes being implemented, interpreted, or made specific: AS 39.30.090.

Fiscal information: The proposed regulation changes are not expected to require an increased appropriation.

The Division of Retirement and Benefits keeps a list of individuals and organizations interested in its regulations. Those on the list will automatically be sent a copy of all of the Division of Retirement and Benefits notices of proposed regulation changes. To be added to or removed from the list, send a request to the Division of Retirement and Benefits at P.O. Box 110203, Juneau, AK 99811-0203, giving your name, and either your email address or mailing address, as you prefer, for receiving notices.

Date: August 20, 2020

Paula Vrana

Paula Vrana
Deputy Commissioner
Department of Administration

2 AAC 39.210 is amended by adding a new subsection to read:

(b) A benefit recipient with multiple retirement accounts may elect dental-vision-audio insurance under each retirement account. If a benefit recipient elects coverage under multiple retirement accounts, different coverage tiers as outlined in (a) of this section may be elected for each separate account so long as the same plan option is elected for all accounts.

2 AAC 39.240(a) is amended to read:

(a) A benefit recipient who elects dental-vision-audio insurance coverage must pay for that coverage by paying the premium established by the administrator. Premium payments are deducted from the monthly benefit warrant unless the benefit is insufficient to permit the deduction of the full monthly premium. If at any time the benefit amount is insufficient to cover the full monthly premium, the administrator will notify the benefit recipient, and all premium payments due after the notice must be made by the [BENEFIT] recipient directly to the insurance carrier. Retroactive premiums, to the date coverage would have lapsed due to an insufficient benefit warrant, must be paid directly to the insurance carrier by the benefit recipient.

2 AAC 39.260(a) is amended to read:

(a) A benefit recipient may discontinue dental-vision-audio insurance coverage for a recipient's covered dependent at any time. Once coverage has been discontinued it may be reelected only in accordance with (b)**,** [OR] (d)**, or (f)** of this section.

2 AAC 39.260(b) is amended to read:

(b) A benefit recipient may add coverage for the recipient's eligible dependents [ONLY] when a change has occurred in the recipient's family structure **or in a dependent's eligibility as defined in AS 39.35.680(12) or AS 14.25.220(13)**. A change in family structure occurs at the marriage of a recipient or at the birth**,** [OR] adoption**, or assumption of legal custody or legal guardianship** of a **dependent** [FIRST] child. Application for the additional coverage must be made within 120 days after the change in the recipient's family structure **or the dependent's eligibility status** occurs.

2 AAC 39.260(c) is amended to read:

(c) An application for a change in coverage must be submitted in writing and is subject to verification by the administrator. A change in coverage based on an application that is postmarked or received on or before the 15th of a month, will be effective on the first day of the next calendar month. A change in coverage based on an application that is postmarked or received after the 15th of a month, will be effective no later than the first day of the second month after the date of postmark or receipt of the application. **The division will make retroactive adjustments to premiums if necessary** [RETROACTIVE ADJUSTMENTS OF PREMIUMS WILL BE MADE IF NECESSARY].

2 AAC 39.260 is amended by adding new subsections to read:

(e) A benefit recipient may increase or change dental-vision-audio insurance coverage during an annual open enrollment period under 2 AAC 39.265.

(f) A benefit recipient already enrolled in dental-vision-audio insurance coverage may change his or her coverage if the recipient subsequently becomes eligible under 2 AAC 39.220.

(g) If the division becomes aware that a benefit recipient's dependent is not eligible for coverage, the division will automatically decrease the recipient's coverage tier and corresponding premiums to appropriately reflect the recipient's family structure.

2 AAC 39.265 is amended to read:

2 AAC 39.265. Open enrollment period. An open enrollment period will be held once a year [DURING THE MONTHS OF OCTOBER AND NOVEMBER] for new law benefit recipients who elect major medical insurance coverage under AS 14.25.168(d) or AS 39.35.535(c). Only during this open enrollment period may a new law benefit recipient **increase** [ADD] or change dental-vision-audio insurance coverage and only if the recipient selects the same or greater level of major medical insurance coverage under 2 AAC 39.300.

2 AAC 36.265 is amended by adding a new subsection to read:

(b) During the open enrollment period of each benefit year, benefit recipients already enrolled in a dental-vision-audio plan may elect an offered dental-vision-audio plan option and increase or decrease their coverage tier level. Coverage premiums for elected benefits are subject to change under 2 AAC 39.280.

2 AAC 39.290(1) is amended to read:

(1) "administrator" means the director of the division of retirement and benefits of the department of administration **or their designee**;

AlaskaCare Retiree Dental, Vision, and Audio Open Enrollment for Plan Year 2021

During the open enrollment period, AlaskaCare Dental, Vision, and Audio (DVA) plan members will be able to choose between the standard dental plan and the legacy dental plan, and will be able to select the appropriate coverage tier for their individual situation: retiree only; retiree and spouse; retiree and children; or retiree, spouse, and children.

Open Enrollment Process

- Open enrollment begins Tuesday, October 20 and closes Wednesday, November 25, 2020.
- The plan year 2021 open enrollment will be passive: if members do not participate in open enrollment, their plan selections for 2021 will remain the same as they are today.
- Members will use the same online enrollment form that was used during the plan year 2020 open enrollment period.
- The DVA plan comparison document will be available to members on the AlaskaCare website.
- The DVA enrollment guide will be available to members on the AlaskaCare website.
- Members will only receive new ID cards from Delta Dental of Alaska if they make changes to their elections.

Member Outreach

- **Mid September 2020** Retiree e-newsletter DVA highlight –open enrollment will begin October 20, 2020
- **Early October 2020** DVA open enrollment reminder postcard #1
- **Mid October 2020** Special DVA Townhall Event
- **Mid October 2020** DVA open enrollment reminder email #1
- **Mid October 2020** Retiree e-newsletter DVA highlight
- **Late October 2020** Open enrollment reminder postcard #2
- **Late October 2020** DVA open enrollment reminder email #2
- **Early November 2020** DVA open enrollment reminder email #3
- **Mid November 2020** Retiree e-newsletter DVA highlight
- **Late November 2020** DVA open enrollment reminder email #4

AlaskaCare
2020 Premium Rate Development

Medical and Pharmacy
Dental, Vision, Audio
Long-Term Care

Retiree Health Plan Advisory Board

September 3, 2020 / Richard Ward, FSA, FCA, MAAA

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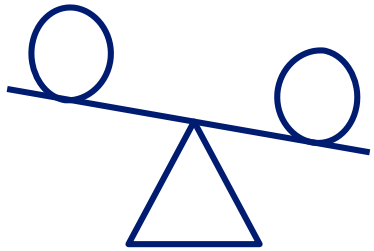
Segal

Premium Rate Development

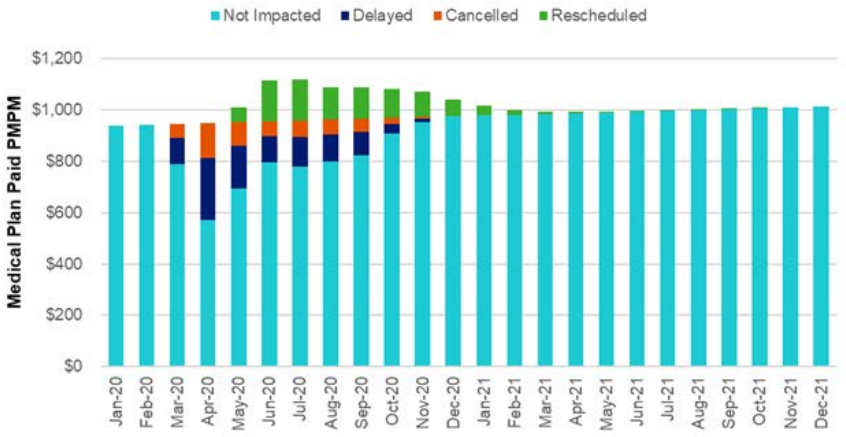
- At its most basic level, premium rates are developed to cover claims costs as well as administrative and operational expenses
- In many plans, this is considered over a multi-year period and balances other considerations, such as:
  - Annual premium rate stability/volatility
  - Premium rate competitiveness
  - Managing risk and selection
  - Equity between plan and coverage options
  - Timing difference between premium revenue and expenses



Primary objective is the overall financial health and viability of the entire plan over the long term

COVID-19

- Due to the emergency conditions associated with the pandemic, AlaskaCare enacted some temporary measures (in part due to federal mandates), such as:
  - Covering COVID19 testing
  - Waiving cost share for COVID19 related inpatient hospital services
  - Expanding telemedicine coverage
  - Enabling early medication refills
  - Suspension of disenrollment for non-payment (ie direct billed retirees)
  - Coverage of flu and pneumonia vaccines
  - Temporarily waived cost share for inpatient services at out-of-network hospitals (ended June 1)
  - Temporarily suspended management tools for inpatient care including precertification, retrospective review and other requirements (ended June 1)
  - Temporarily waived cost share for non-COVID-19 testing, including respiratory syncytial virus (RSV) and influenza A & B tests (ended June 1)
- Effective March 19, 2020, Governor Dunleavy issued COVID-19 Health Mandate 005, which called for postponing or canceling non-urgent or elective procedures until June 15, 2020.
- COVID-19 Health Mandate 015 enables Routine Health Services to resume on April 20 and Non-Urgent/Non-Emergent Elective Surgeries and Procedures to resume on May 4, 2020
- Utilization and costs for medical, dental and vision care were significantly affected and much lower than anticipated.
- Pharmacy costs and utilization were largely unaffected, and may have increased due to early refill provisions
- Some care will be deferred and will provided in late 2020 and into 2021



Premium Rate Development – Med/Rx

1. For the Medical/Rx plan, recent claims experience is trended forward to the next plan year to get projected claims
   - Claims are adjusted for upcoming changes
   - There are generally little/no changes to consider
   - Rates are by coverage tier, but do not differ by Medicare status
   - Net of Rx rebates, EGWP and RDS subsidies
2. Add administrative and operational costs to projected claims to get initial full premium
3. Rates are used to determine contributions for a small number of retirees
4. Long-term (employer and State) funding is determined by the Retiree Health/OPEB valuation as part of the overall pension/retirement actuarial valuation

Medical and Pharmacy Projection

- Segal projects the following financial results for Calendar Year (CY) 2021:

	2021
Total Projected Claims	$633,211,578
Administration and Operational Expenses	$28,964,200
Pharmacy Contract Renegotiation/RFP	($5,100,000)
Rx Rebates	($59,200,000)
EGWP/RDS Subsidy	($57,360,000)
Total Projected Cost	$540,515,778
Premium Based Revenue*	$590,708,520
$$ Funding Overage/(Gap)	$50,192,742
% Funding Overage/(Gap)	9.3%
Est. IBNR Liability As Of Dec 31, 2021	$53,349,000

* Medical/Rx revenue is based on all participants at the Retiree composite rate (as counts by Tier II/Tier III rate tiers were not available) x 12. Retirees that pay premiums pay these rates. State and Employer contributions are payroll based.

- Experience continues to be favorable for the Medical/Rx plan with a $50.2 M projected overage.
- 2021 premium rates for Medical and Prescription Drugs are sufficient at current levels. Results reflect a dampening of medical trend mostly due to the growth in the number of Medicare primary participants outpacing the number of non-Medicare participants coming on the plan. A Medicare primary participant costs some 50% less than a non-Medicare primary participant.
- There was a 10% decrease in premium rates effective Jan 1, 2020 to align rates with expenses.
- This analysis includes the anticipated savings for the pharmacy pricing market check and negotiations.
- Modest increase projected for EGWP subsidies.

The above projection is an estimate of future cost and is based on information available to The Segal at the time the projection was made. The Segal has not audited the information provided. A projection is not a guarantee of future results. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, change in demographics, overall inflation rates and claims volatility. Projection of retiree costs takes into account only the dollar value of providing benefits for current retirees during the period referred to in the projection. It does not reflect the present value of any future retiree benefits for active, disabled, or terminated employees during a period other than that which is referred to in the projection, nor does it reflect any anticipated increase in the number of those eligible for retiree benefits, or any changes that may occur in the nature of benefits over time.

The Coronavirus (COVID-19) pandemic is rapidly evolving and will likely impact the 2020 US economy and health plan claims projections for most Health Plan Sponsors. As a result, projections could be significantly altered by emerging events. At this point, it is unclear what the impact will be for Health Plan Sponsors. Segal is working to develop plan cost adjustment factors and reports to apply to both short-term and long-term financial projections. Additionally, the potential for federal or state fiscal relief is also not contemplated in these budget projections. Given the high level of uncertainty and fluidity of the current events, some plans may seek periodic updated estimates throughout the year to closely monitor health plan budget projections this year. Additional projections may be out of scope.

CY2021 Medical and Pharmacy Funding Rates

- There was a 10% decrease in contributions effective CY2020 based on the continuing strong performance of the Retiree Medical and Pharmacy plan.
- A 5.0% decrease would still maintain a projected overage while providing additional premium relief to Retirees that pay rates.
  - The overage at current rates is projected to be 9.3%. A 5% reduction would result in a projected 3.8% overage.

Baseline	2020	2021	$$ Change	% Change
Medical - Composite	$1,101.00	$1,101.00	$0.00	0.0%
Medical - Tier II/III Retiree Only	$741.00	$741.00	$0.00	0.0%
Medical - Tier II/III Retiree & Spouse	$1,482.00	$1,482.00	$0.00	0.0%
Medical - Tier II/III Retiree & Child	$1,047.00	$1,047.00	$0.00	0.0%
Medical - Tier II/III Retiree & Family	$1,788.00	$1,788.00	$0.00	0.0%
Baseline Annual	**$590,708,520**	**$590,708,520**	**$0**	**0.00%**
5.0% Decrease in Contribution Rates				
Medical - Composite	$1,101.00	$1,046.00	($55.00)	(5.3%)
Medical - Tier II/III Retiree Only	$741.00	$704.00	($37.00)	(5.3%)
Medical - Tier II/III Retiree & Spouse	$1,482.00	$1,408.00	($74.00)	(5.3%)
Medical - Tier II/III Retiree & Child	$1,047.00	$995.00	($52.00)	(5.2%)
Medical - Tier II/III Retiree & Family	$1,788.00	$1,699.00	($89.00)	(5.2%)
5.0% Decrease Annual	**$590,708,520**	**$561,199,920**	**($29,508,600)**	**(5.0%)**

* Rates are rounded to the nearest dollar and may not be exactly 5% different than current rates.

- The projected overage for each set of rates:

	Baseline	5% Decr
Funding Overage	$50,192,742	$20,684,142

Medical and Pharmacy

- Actual Medical/Rx plan experience for FY17 – FY19:

	Period 1	Period 2	Period 3	P1=> P2	P2=> P3
	Jul '17-Jun '18	Jul '18-Jun '19	Jul '19-Jun '20		
Members <65 PMPM	$1,035.03	$1,113.62	$1,075.40	8%	-3%
Members 65+ PMPM	$473.85	$512.82	$476.20	8%	-7%
Composite PMPM	$644.92	$681.23	$629.99	6%	-8%
Total Medical/Rx Claims	$555,389,845	$595,672,310	$559,657,200	7%	-6%

Note: Subscribers plan is used to determine dependent's age for determine of over/ under age 65 status. PMPM rates are not net of Rx rebates nor EGWP/RDS subsidies.

- The projected claims reflect a dampening of medical trend year over year mostly due to the growth in the number of Medicare primary participants outpacing the number of non-Medicare participants coming on the plan.
- A Medicare primary participant costs approximately 50-65% less than a non-Medicare primary participant.
- The transition to the Employer Group Wavier Plan (EGWP) from the Retiree Drug Subsidy (RDS) is providing additional drug subsidies and rebates from the federal government and will continue to mitigate trend.
- The impact of COVID-19 contributes to the overall decrease from period 2 to period 3.

Premium Rate Development - DVA

1. For the DVA plan, recent claims experience is trended forward to the next plan year to get projected claims
   - Claims are adjusted for upcoming changes
   - Until 2020, there were little/no changes to consider
   - For 2020, the Legacy Plan was introduced, with changes for:
     - Plan design
     - Provider payments (network and non-network)
     - The Legacy and Standard Plan costs will also likely vary for differences in utilization and selection, but those are not factored into the two plans' premiums, resulting in an anticipated subsidy between the plans (but costs are accounted for in the aggregate)
     - Court ruling changed default plan (from Standard to Legacy) after pricing was finalized
2. Add administrative and operational costs to projected claims to get initial full premium
3. Factor in long-term considerations to determine final rates

DVA Plan is very well reserved, resulting in final rates determined so that lower premiums in the near-term do not result in long-term solvency issues nor large premium increases when "excess" reserves are spent

Dental, Vision and Audio Projection

- Segal projects the following financial results for Calendar Year 2021 compared to 2020:

	2021	2020	Difference
Total Projected Claims	$49,771,132	$47,470,788	4.8%
Administration and Operational Expenses*	$2,142,713	$2,159,694	-0.8%
Total Projected Cost	$51,913,845	$49,630,482	4.6%
Premium Based Revenue (no increase for 2021)	$47,813,184	$47,549,664	0.6%
$$ Funding Overage/(Gap)	($4,100,661)	($2,080,818)	
% Funding Overage/(Gap)	(7.9%)	(4.2%)	
Est. IBNR Liability As Of Dec 31, 2021	$3,961,000	$3,724,000	6.4%

* Net of Interest

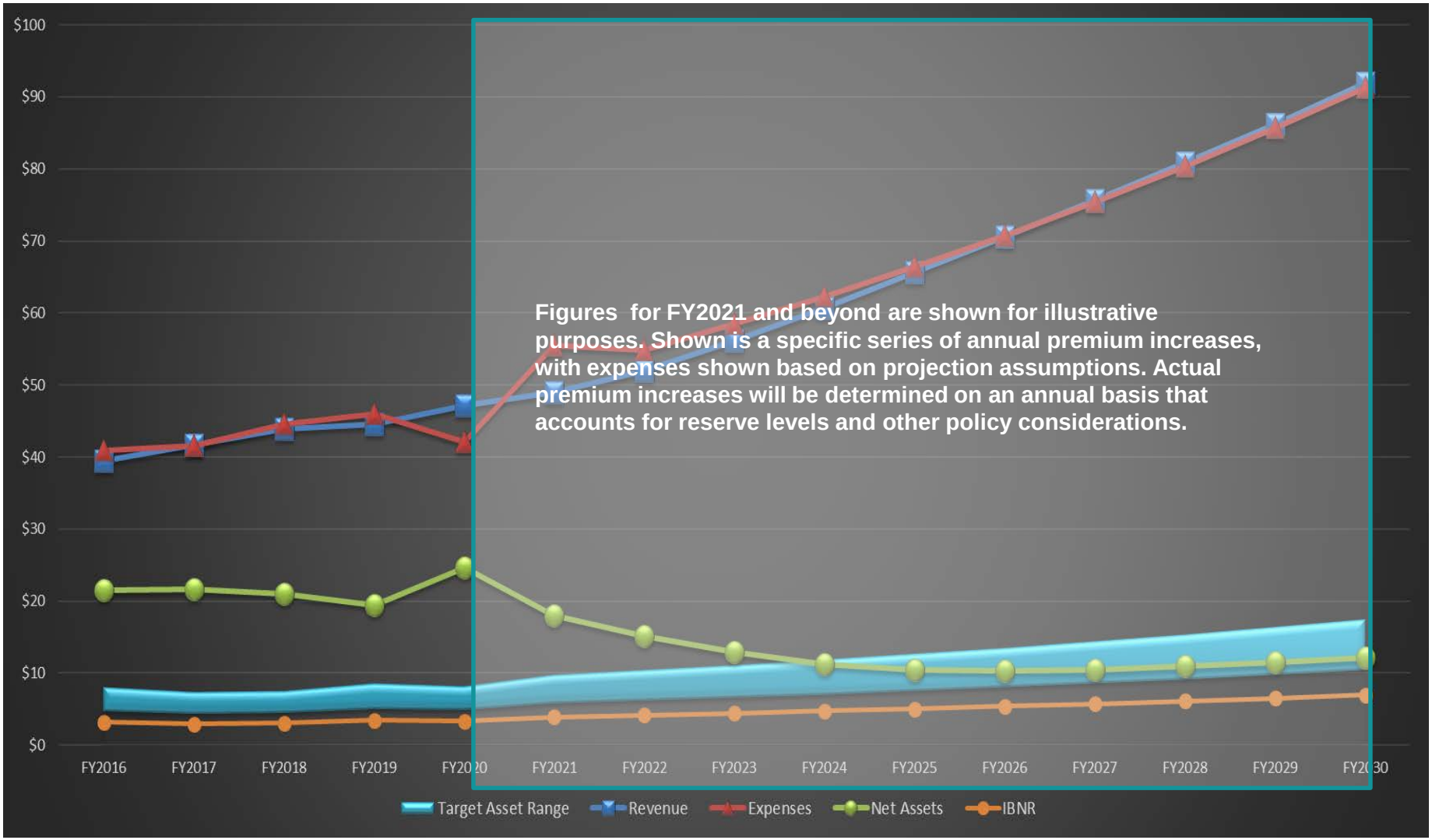
- 2021 funding in the projection includes both the voluntary Legacy and Standard DVA (Dental/Vision/Audio) plans.
- If there are no changes to the current funding levels, there is a projected gap of approximately $4.1M. This is an increase of about $2M from the current 2020 expectations and is primarily due to normal trend increases.
- The DVA assets are expected to continue to be above the minimum reserve target of 150% of IBNR even with no funding increase. However, the funding gap is anticipated to grow to about 8%, which will increase the rate assets are used to cover costs as well as increasing future funding needs.
- We have included both the Legacy and Standard plans in the model and show a possible combination of rate increases to manage a controlled spend-down to target asset levels (150%-250% of IBNR) and maintain premium stability.

CY2020 Dental, Vision, and Audio Funding Rates

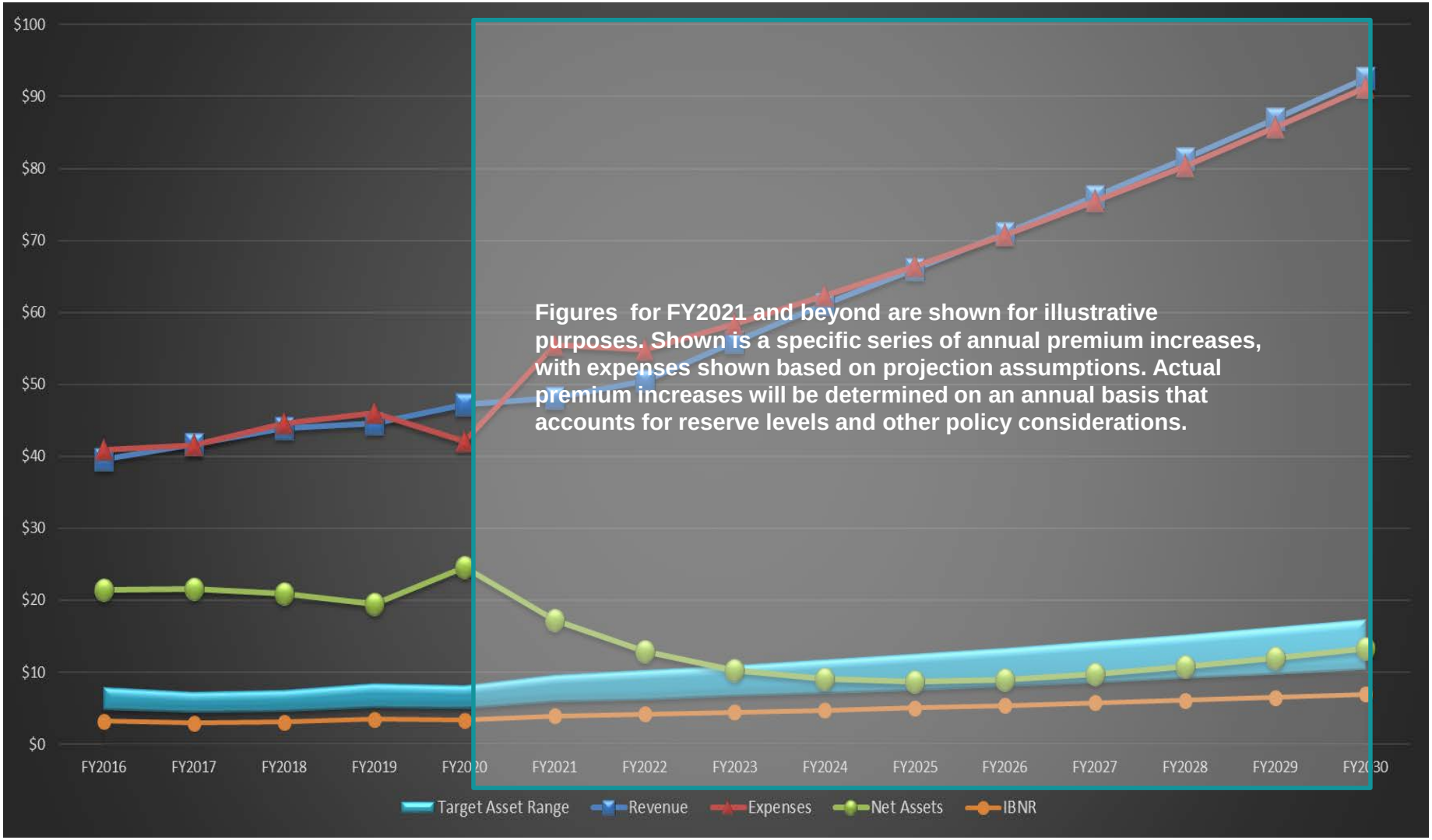
- The Standard plan rates have remained level since 2017.
- While the need for an increase is not immediate, a wider funding gap will result in higher future increases. The following table shows how a "trend increase" of 3.5% would affect the rates.
  - Please note actual increases may not equal exactly 3.5% due to rate rounding.

Illustrative 3.5% Increase			
Standard Plan Rates	**2020**	**2021**	**$$ Change**
Retiree	$66.00	$68.00	$2.00
Retiree & Spouse	$131.00	$136.00	$5.00
Retiree & Child	$119.00	$123.00	$4.00
Retiree & Family	$187.00	$194.00	$7.00
Legacy Plan Rates			
Retiree	$73.00	$76.00	$3.00
Retiree & Spouse	$145.00	$150.00	$5.00
Retiree & Child	$132.00	$137.00	$5.00
Retiree & Family	$207.00	$214.00	$7.00

Projected DVA Revenues, Expenses, Net Assets ($millions)
3.5% Increase for CY2021 and Moderate Subsequent Increases



Projected DVA Revenues, Expenses, Net Assets ($millions)
0% Increase for CY2021 and Higher Subsequent Increases



CY2021 Increase Impact on Future Rate Increases

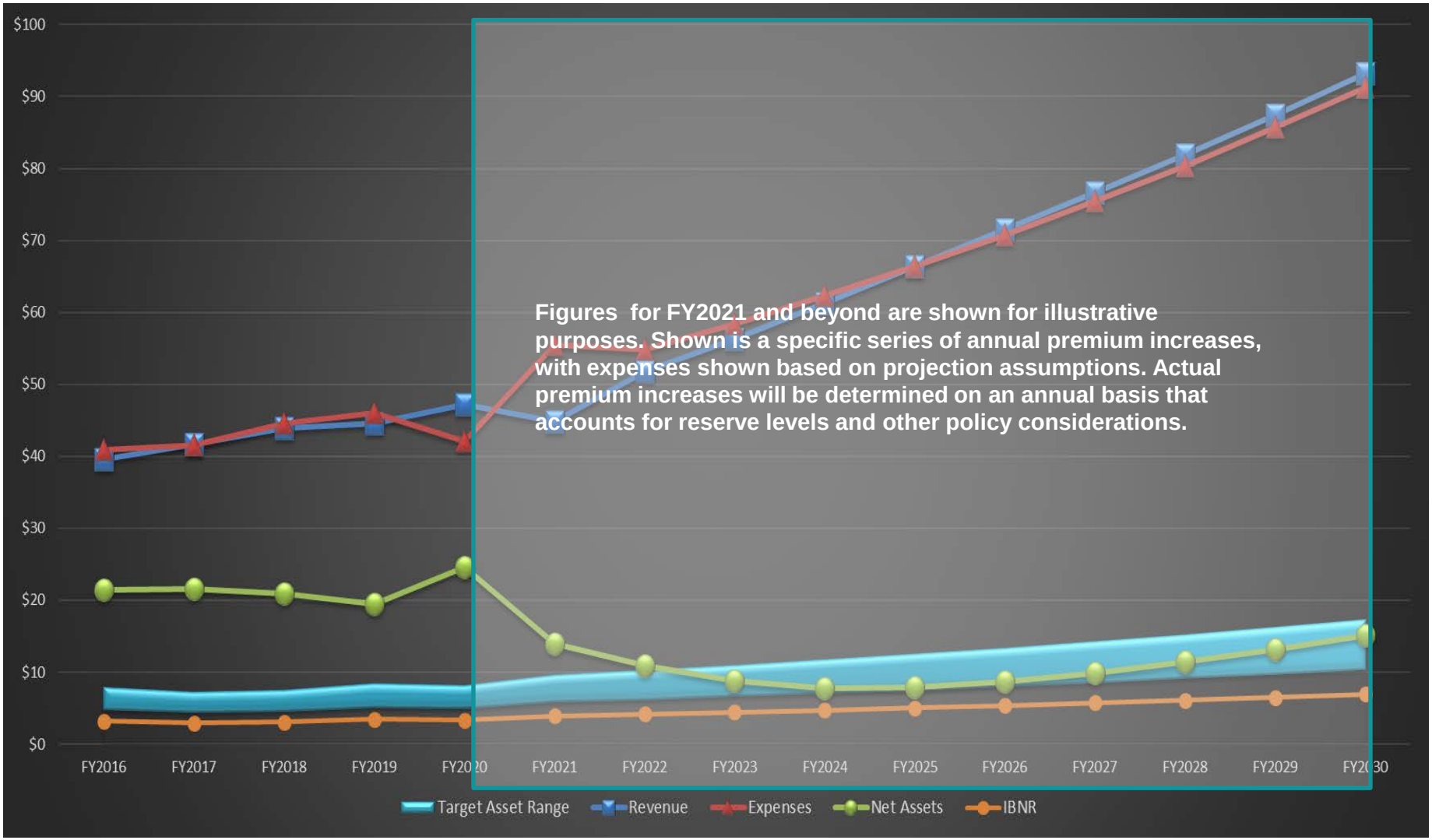
- Premiums will need to be increased in the future
- The real decision point is the timing of those increases
- In general, near-term increases lead to lower future increases and increased flexibility with the timing of future increases
- A trend increase for 2021 (3.5%) leads to lower increases and improved premium stability in the future
- The following table shows the relative difference that could occur with future increases. Variations in experience and the timing of when rate changes are adopted could lead to different increases that shown below, but the relative differences shown below are indicative of the relative difference in the two paths.

Premium Holiday

- Given that the DVA trust continues to maintain a surplus of assets above the target level of 150-250% of IBNR, Segal has been asked to review the impact of a premium holiday.
- A premium holiday will offer financial relief to the retirees and help to spend down assets without impacting the contribution rates.
- The following chart shows the financial impact of a one-month premium holiday occurring after December 31, 2020 and before June 30, 2021 on the FY21 projected end-of-year assets. Each month of premium holiday is equivalent to about $4.1M.

# of Months of Premium Holiday	Impact to Revenue	2021 FYE Assets	Assets to IBNR* (2021 FYE)
0	$0	$18,052,886	4.6
1	-$4,129,474	$13,882,117	3.6

Projected DVA Revenues, Expenses, Net Assets ($millions)
1 Month Premium Holiday 2020 and Moderate Subsequent Increases



Premium Rate Development - LTC

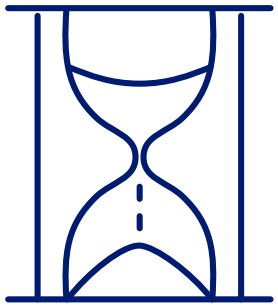
For the LTC plan, the benefits are paid well after the premiums are paid. Therefore, a long-term view is necessary

1. Project forward all anticipated benefits (and expenses), accounting for assumed mortality, morbidity, lapses, etc
2. Project forward all anticipated premium revenue (at current rates), accounting for assumed mortality, morbidity, lapses, etc
3. Add net difference between projected benefits and premiums and factor in assumed investment returns
4. If present value of net assets is greater than $0, then current premiums are anticipated to be sufficient.

Segal recommends maintaining current premium rates through the next actuarial valuation. The 2019 valuation identified investment gains having resulted in an improved net present value funded position. However, care should be exercised before modifying premiums rates based on short term gains (or losses).

LTC Valuation Results (June 30, 2019)

Component	($000)
1. PV of Future Benefits	$740,263
2. PV of Future Expenses	$7,108
3. PV of Future Premiums (PVFP)	$315,648
4. Valuation Liabilities (=3 – 1- 2)	($431,723)
5. Valuation Assets	$526,287
6. Valuation Margin (= 5 + 4)	$94,564
7. Margin as a % of PVFP (= 6/3)	30.0%
8. Funded Status (= 5/4)	121.9%



Questions?

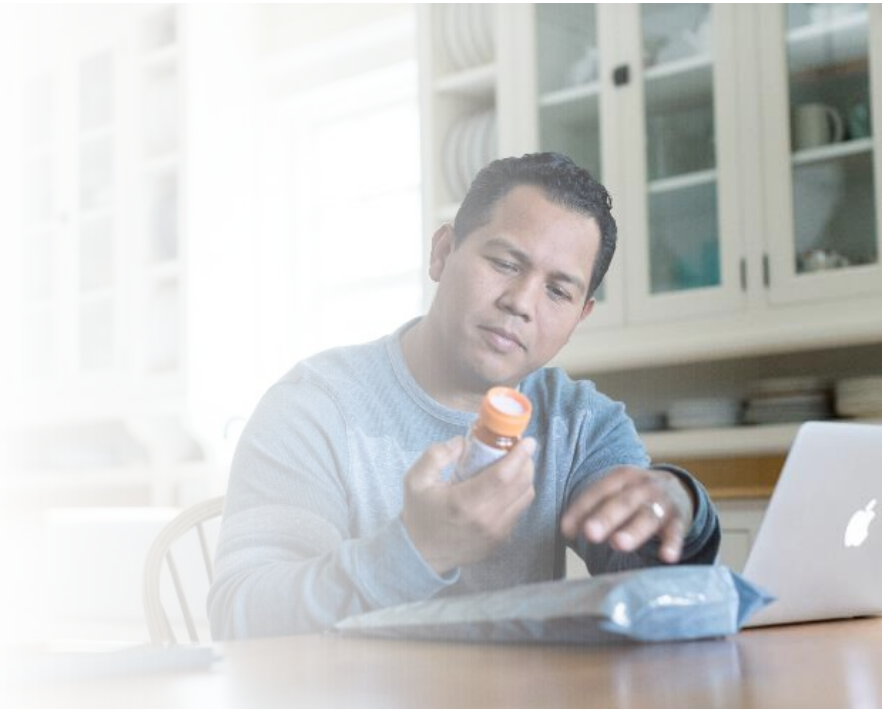
COVID-19 Overview

Vaccines, Treatments & the Future

OPTUMRx®

Our Response to COVID-19

We're in this together. The health of our members, clients, and OptumRx staff is our top priority – today and in the weeks and months ahead. We are following guidance from the Centers for Disease Control and Prevention, as well as state and local public health departments, in supporting your needs.



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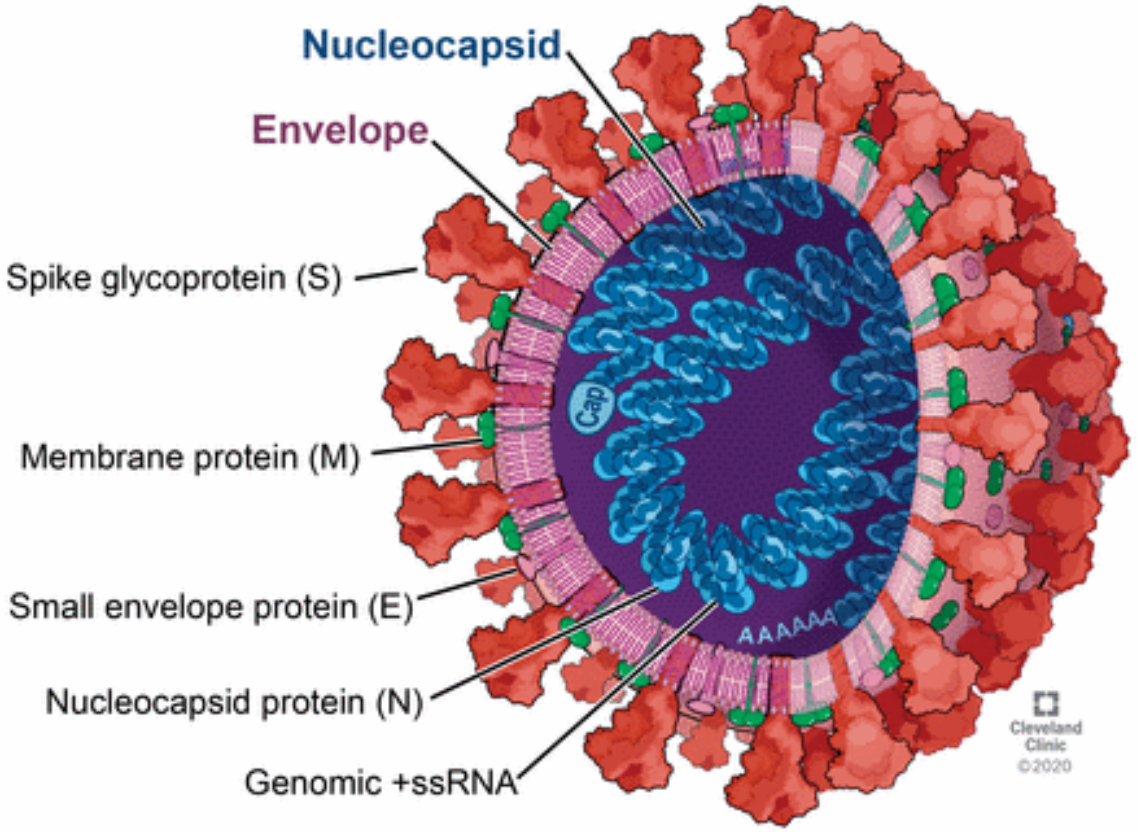
Meet the Coronavirus



https://www.ccjm.org/content/early/2020/05/12/ccjm.87a.20047

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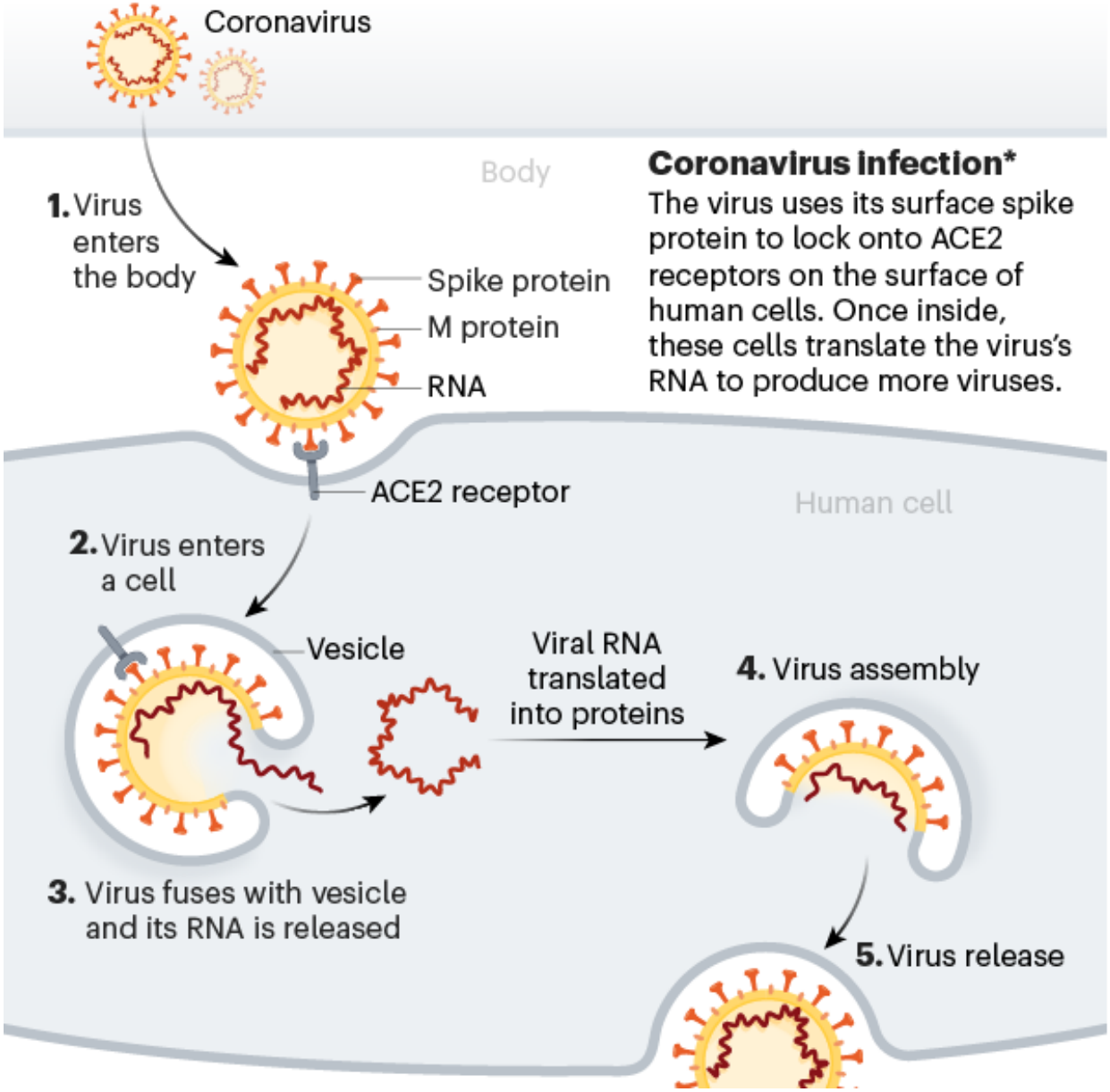

*Simplified
https://www.nature.com/articles/d41586-020-01221-y

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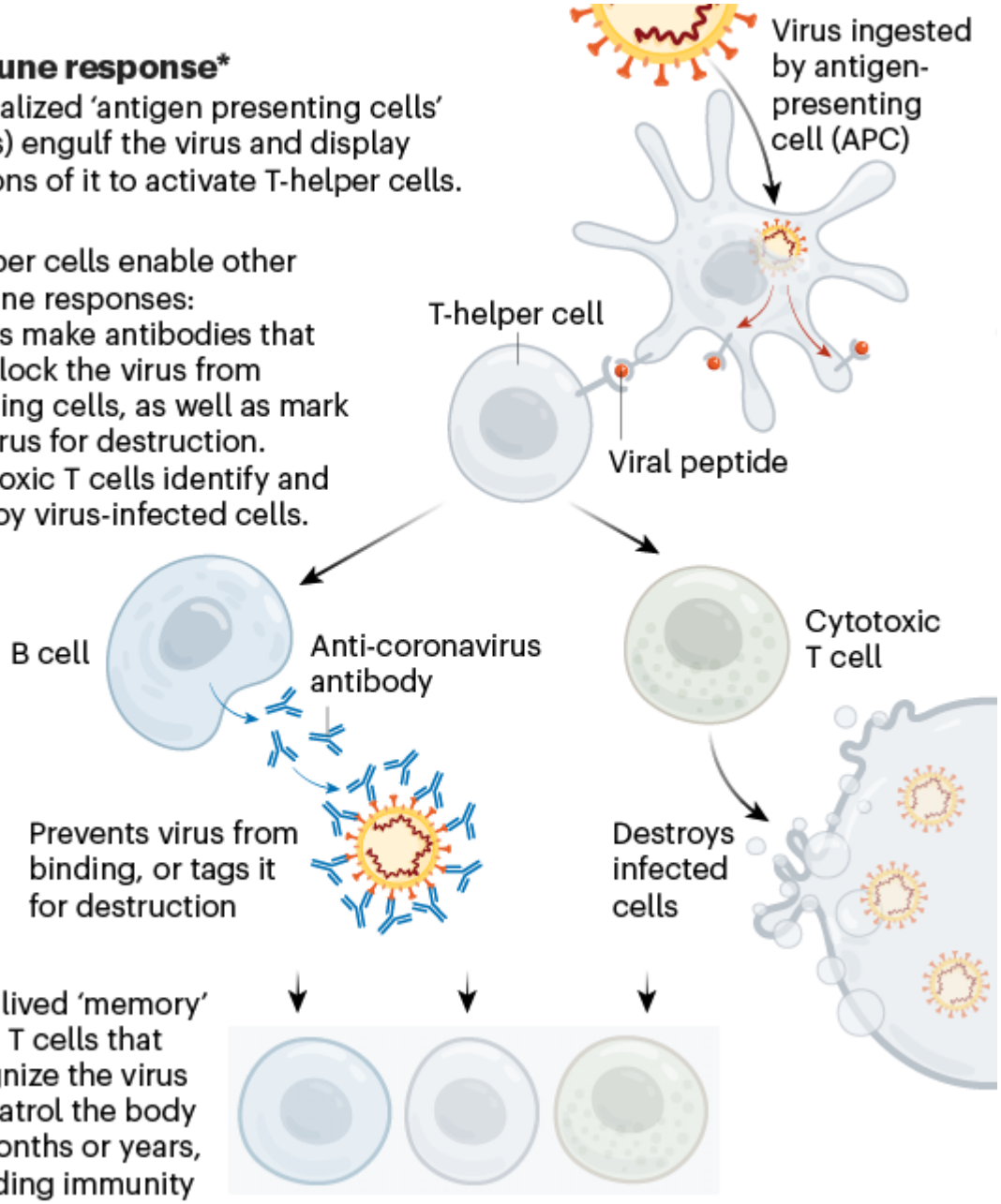
Immune response*

Specialized 'antigen presenting cells' (APCs) engulf the virus and display portions of it to activate T-helper cells.

T-helper cells enable other immune responses:
B cells make antibodies that can block the virus from infecting cells, as well as mark the virus for destruction.
Cytotoxic T cells identify and destroy virus-infected cells.



Long-lived 'memory' B and T cells that recognize the virus can patrol the body for months or years, providing immunity

*Simplified
https://www.nature.com/articles/d41586-020-01221-y

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Vaccinations in the Works

There are at least eight types of vaccines being explored to combat the coronavirus:

- **Virus:** inactivated or weakened (~7)
  - Targets the virus itself
- **Viral Vector:** replicating or non-replicating (~25)
  - Genetically engineer an existing virus (i.e. measles, adenovirus) to produce coronavirus proteins in the body
- **Nucleic Acid:** DNA or RNA (~20)
  - Using the coronavirus protein that prompts immune response by inserting nucleic acid into the cell to produce copies of the viral protein
- **Protein-Based:** protein subunit or virus-like particles (~33)
  - Inject coronavirus proteins directly into the body

https://www.nature.com/articles/d41586-020-01221-y

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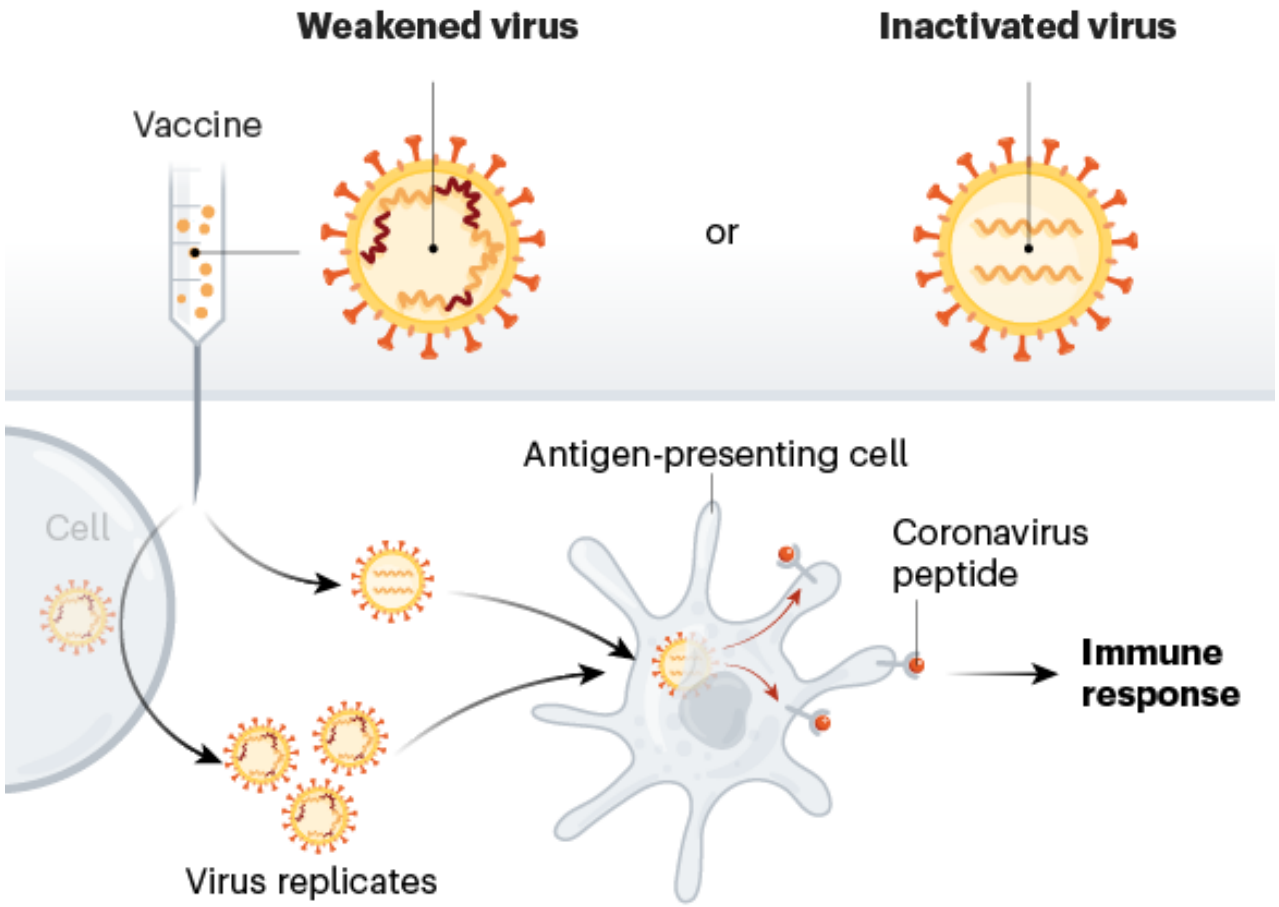
Virus Vaccines



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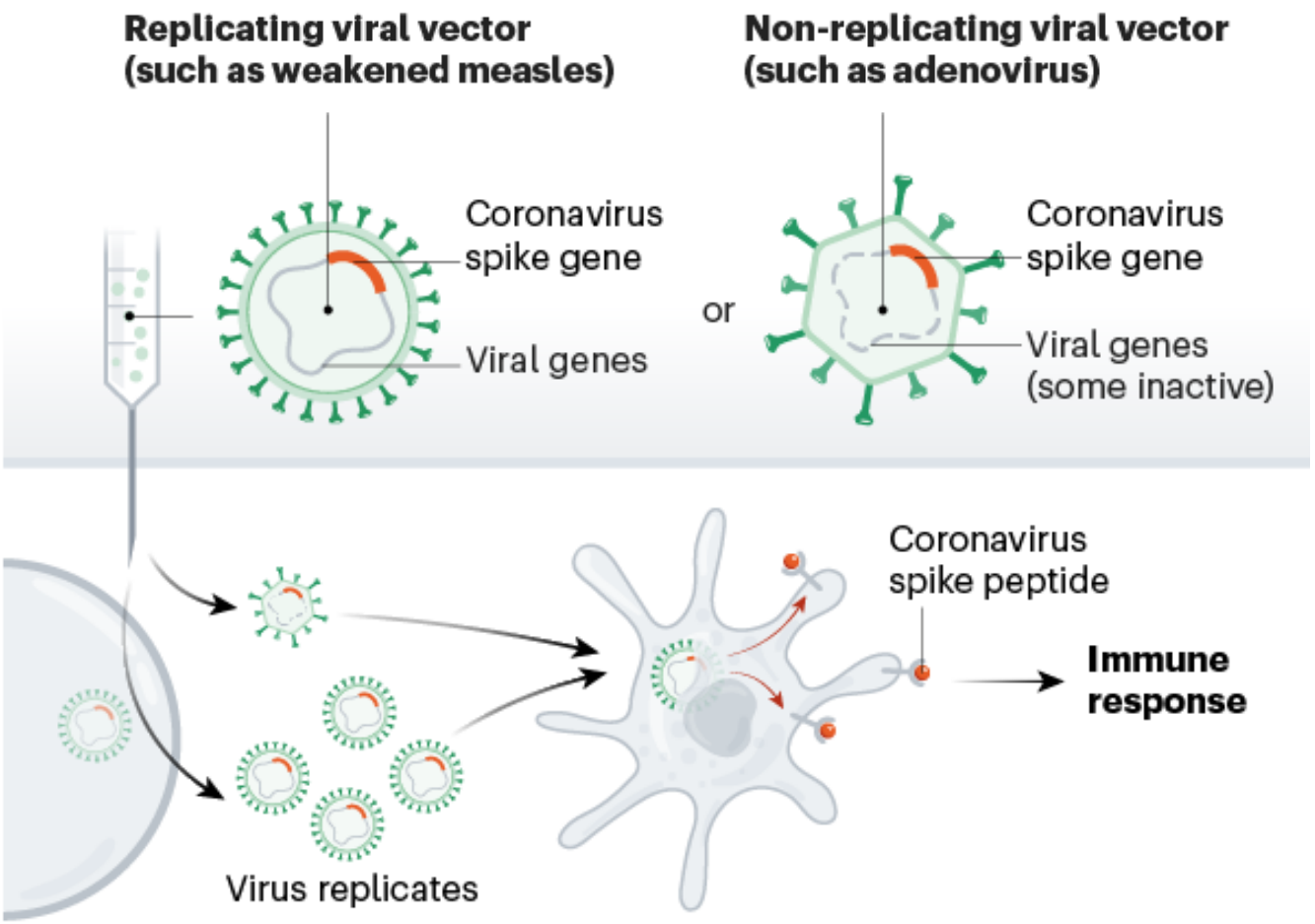
Viral-Vector Vaccines



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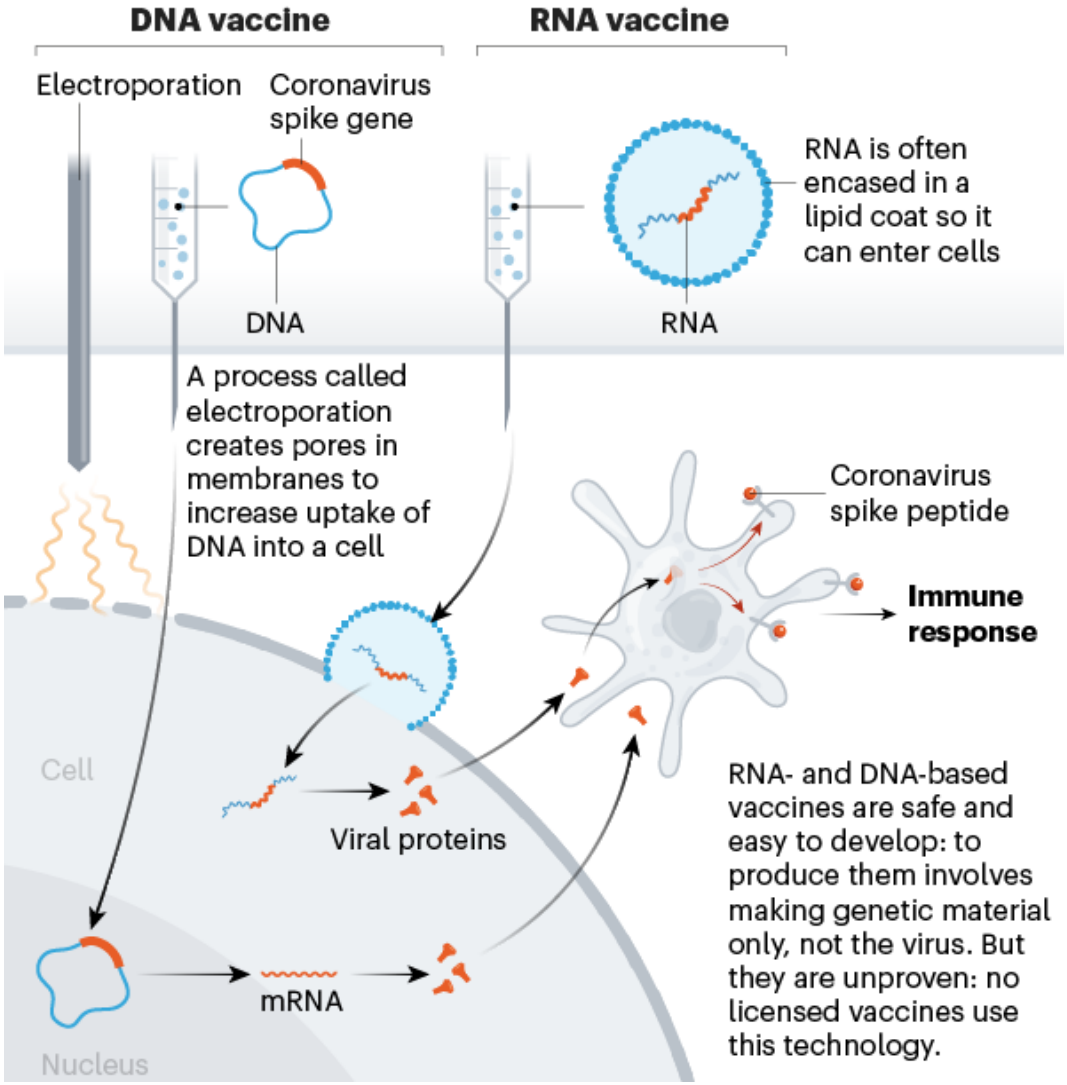
Nucleic Acid Vaccines



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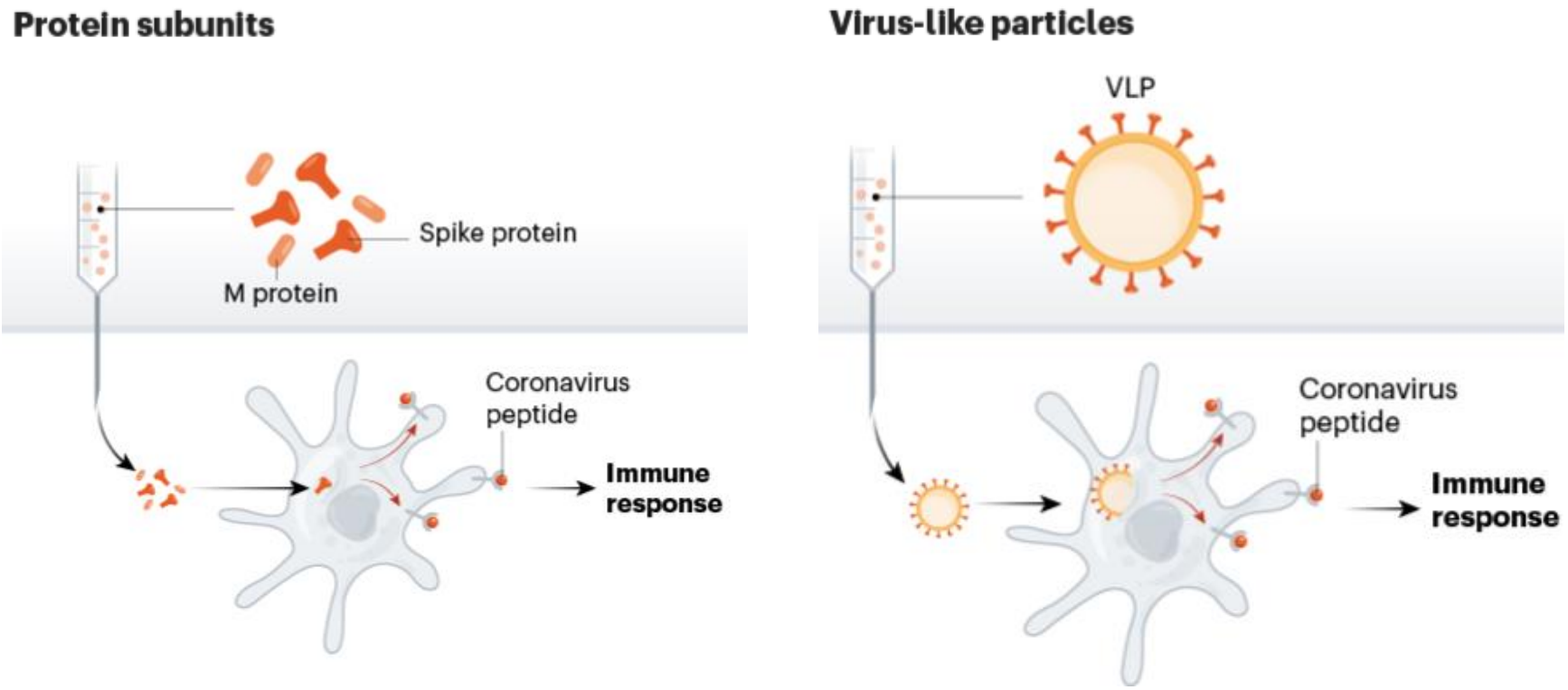
Protein-Based Vaccines



VLP – virus-like particle
https://www.nature.com/articles/d41586-020-01221-y

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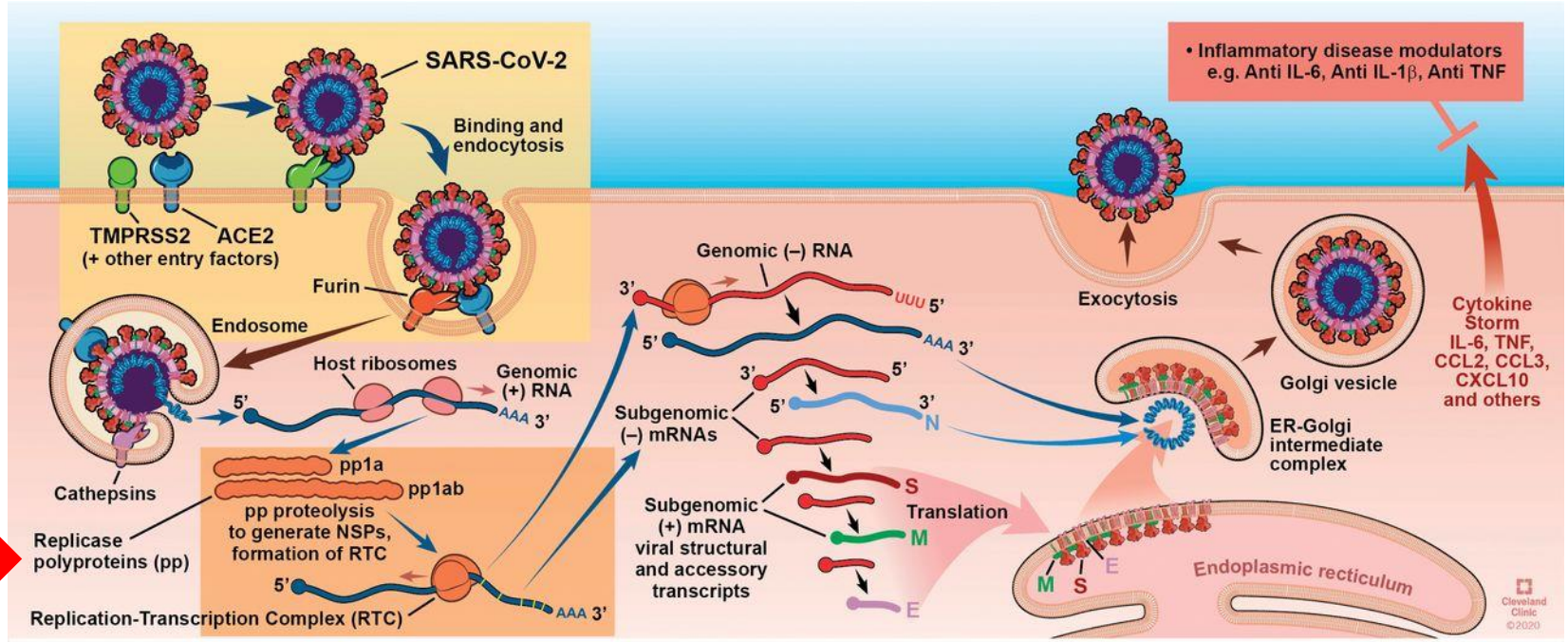
Combatting Coronavirus: Treatment Targets



https://www.ccjm.org/content/early/2020/05/12/ccjm.87a.20047

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COVID-19 Investigational Drug Update

Vaccine development is progressing rapidly

Operation Warp Speed

- Public/Private partnership to facilitate and accelerate the development, manufacturing, and distribution of vaccines; includes HHS, CDC, FDA, NIH, BARDA, private firms
- NIAID has established the Covid-19 Prevention Trials Network (COVPN) to facilitate enrollment into vaccine and prevention clinical trials

FDA guidance

- A vaccine will have to be at least 50% more effective than placebo against COVID-19 in order to be approved
- EUA guidance is vague

There are 22 vaccines in human trials and ~155 in early preclinical stages

- **mRNA-1273** by Moderna: 8 patients in phase 1 exhibited neutralizing antibodies; phase 2 trial fully enrolled (300 younger adults and 300 older adults); Fast track status granted; phase 3 trials to start in July
- **INO-4800** by Inovio: Phase 1 enrollment complete; 34 out of 36 demonstrated overall immunological response rates
- **BNT-162b1** by Pfizer/BioNTech: Phase 1/2 data: At day 28, 24 subjects who received 10 µg or 30 µg had SARS-CoV-2 neutralizing antibodies
- **AZD1222** by AstraZeneca (UK): Phase 1 enrollment is complete; phase 2/3 trial begun in UK; phase 3 trial begun in Brazil; U.S. is funding
- 5 vaccines (China): All in phase 1 or 2 trials
- Others (Australia, Germany, Russia): All in phase 1 or early phase 2 trials

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COVID-19 Investigational Drug Update

Recent data releases bring some focus, but the picture is still unclear

Remdesivir

- Emergency Use Authorization (EUA) approved May 1, 2020
- Manufacturer filed for FDA approval in the U.S. on August 10, 2020
- Published data:
  - Compassionate use (NEJM): 68% benefited, 13% died
  - Randomized controlled trial (Lancet): No better than placebo
  - Gilead severe patients (NEJM): 5 day regimen as good as 10 day*; no new safety signals
- Recent top-line data announcements:
  - NIH trial: Time to recovery 11 vs 15 days (placebo); Mortality 7.1% vs. 11.9% (placebo)*
  - Gilead (moderate): 5 day regimen 65% more likely to have clinical improvement at day 11 vs. SOC group
  - Compassionate use: 83% of pediatric patients and 92% of pregnant/postpartum women recovered by day 28
  - Severe vs. retrospective cohort SOC: 62% risk reduction in mortality (7.6% vs. 12.5% at day 14)*
- Inhaled remdesivir has entered phase 1 trials and IV formulation being studied in children

Dexamethasone

- RECOVERY trial: mechanically ventilated patients mortality decreased by 35%* and patients requiring oxygen, by 20%*

Hydroxychloroquine/chloroquine (HCQ/CQ)

- EUA revoked on 6/15/2020 because HCQ/CQ likely ineffective
- RECOVERY and SOLIDARITY trial arms for HCQ/CQ stopped; other large trials stopped

* Statistically significant

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Focused on the Needs of Our Customers

Operational resiliency

OptumRx is currently not experiencing delays in dispensing prescriptions.

Even when faced with these extraordinary circumstances, we have years of experience managing challenging situations and have invested heavily in data and supply chains to help mitigate delays in calls to member services and dispensing prescriptions.

We are constantly evaluating drug supplies and disaster recovery plans to respond to circumstances, even those beyond our control.

Ongoing support

Our client management teams are equipped with the technology necessary to remain dedicated to serving your needs.

We have robust business continuity practices and at this time remain operational across our organization. Our customer service and support teams continue to be available online and by phone.

We have detailed and frequently updated FAQs on COVID-19 for members and clients. And support materials that can be shared with anyone.

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What Can You Do?

Wash your hands

Wear a mask in public

Stay home if you feel sick

Practice social distancing

Be mindful of where information is coming from

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AlaskaCare Meeting Dates for 2021

Quarterly Meeting Retiree Health Plan

- ☑ Wednesday, February 3, 2021
- ☑ Wednesday, May 5, 2021
- ☑ Wednesday, August 4, 2021
- ☑ Wednesday, November 3, 2021

Retiree Health Plan Advisory Board (RHPAB) Meetings

- ☑ Thursday, February 4, 2021
- ☑ Thursday, May 6, 2021
- ☑ Thursday, August 5, 2021
- ☑ Thursday, November 4, 2021