

**Retiree Health Plan Advisory Board (RHPAB)
Modernization Committee
Meeting Agenda**

Meeting: Modernization Committee
Date: Tuesday April 23rd, 2019
Time: 9:00am -3:00pm
Location: **Anchorage:** Atwood Building, 550 W 7th, 19th Floor Conf. Room
Juneau: State Office Building, 6th Floor Conf. Room
Teleconference: 1-650-479-3207 / 803 564 027
Committee Members: Cammy Taylor (chair), Joelle Hall, Judy Salo, Mauri Long

- 9:00am** **Call to Order**
- **Approve Agenda**
 - **Approve previous Meeting Minutes**
 - **Introductions**
- 9:10am** **Public Comment**
- **Read the Oral Public Comment Script**
- 9:30am** **Discuss Modernization Topics Analysis – DRB Presentations**
- **Enhanced Clinical Review**
 - **Teladoc**
 - **Out of Network Reimbursement**
 - **Pharmacy**
- 11:45am** **Break**
- 01:15 pm** **SecureCare Presentation – Bharon Hoag**
- 01:40 pm** **Continue discussion of Modernization Topics**
- 03:00pm** **Meeting End**

Common Acronyms

The following acronyms are commonly used during board meetings and when discussing the retiree health plan generally:

- ACA = Affordable Care Act (formal name: Patient Protection and Affordable Care Act)
- ARMB = Alaska Retirement Management Board
- CMS = Center for Medicare and Medicaid Services
- COB = Coordination of Benefits
- DB = Defined Benefit plan (for Tier 1, 2, 3 PERS employees and Tier 1, 2 TRS employees)
- DCR = Defined Contribution Retirement plan (for Tier 4 PERS employees and Tier 3 TRS employees)
- DOA = State of Alaska Department of Administration
- DRB = Division of Retirement and Benefits, within State of Alaska Department of Administration
- DVA = Dental, Vision, Audio plan available to retirees
- EGWP = Employer Group Waiver Program, a federal program through Medicare Part D that provides reimbursement for retiree pharmacy benefits
- EOB = Explanation of Benefits, provided by the plan administrator detailing claims coverage
- HIPAA = Health Insurance Portability and Accountability Act (1996)
- HRA = Health Reimbursement Arrangement account, a mechanism for the employer to reimburse high-income Medicare enrollees for any premium charge for their plan (IRMAA)
- IRMAA = Income Related Monthly Adjustment Amount, a surcharge from CMS for a Medicare plan for individuals or households earning above certain thresholds
- MAGI = Modified Adjusted Gross Income, based on an individual or household's tax returns and used by CMS to determine what if any premium must be paid for a Medicare plan.
- OPEB = Other Post Employment Benefits; an accounting term used to describe retirement benefits other than pension benefits
- OTC = Over the counter medication, does not require a prescription to purchase
- PBM = Pharmacy Benefit Manager, a third-party vendor that performs claims adjudication and network management services
- PEC = proposal evaluation committee (part of the procurement process to review vendors' bids)
- PHI = protected health information, a term in HIPAA for any identifying health or personal information that would result in disclosure of an individual's medical situation.
- RDS = Retiree Drug Subsidy program (a federal pharmacy subsidy program)
- RFP = Request for Proposals (a term for a procurement solicitation)
- RHPAB = Retiree Health Plan Advisory Board
- TPA = Third Party Administrator

Meeting Minutes

Item 1. Call to Order + Introductions

Committee Chair Cammy Taylor called the meeting to order at 9:32 a.m. The committee conducted roll call for members present.

- **Motion** by Joelle Hall to approve the meeting agenda. **Second** by Cammy Taylor.
 - Joelle noted that she needs to leave the meeting before noon for another commitment, and suggested moving the discussion of the next meeting date earlier on the agenda.
- **Result:** No objection. Meeting agenda approved, with discussion of next meeting before noon.

The committee briefly reviewed the minutes from the October 30 committee meeting.

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

Committee members and staff welcomed Mauri Long as the third modernization committee member, confirmed at the November 28, 2018 quarterly RHPAB meeting.

Item 2. Public Comment

Before beginning public comment, Cammy Taylor established who was present in Anchorage and Juneau, on the phone or online, and who intended to provide public comments. Individuals were asked to state their full name for the record, and were reminded of the following:

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

Public Comments

- **Wendy Wolf, RPEA.** Wendy thanked Emily Ricci and Michele Michaud for their informative presentation at the Southcentral chapter of RPEA on Tuesday, December 11. She noted that there were 210 attendees. Unfortunately, flight cancellations in Juneau prevented Emily and Michele from presenting in person, but were available via teleconference and WebEx to present remotely from Juneau. Wendy looks forward to welcoming them back to a future meeting, hopefully in person!
 - Cammy Taylor had also attended this meeting, and thanked DRB staff for their presentation. She was impressed by the great attendance, and heard from people in the room that they appreciated having the information shared. She supports doing this again!

Item 3. Modernization Topics Analysis: Presentations of DRB Staff Research

Materials: DRB Analysis in 12/12/18 meeting packet, "Enhanced Travel Benefits w/ Wrap"

Cammy Taylor invited staff to present additional information about the travel benefit proposal with SurgeryPlus for certain qualifying procedures, previously discussed in the 10/30/18 meeting.

Presentation: Enhanced Travel Benefits with Wrap

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

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

(Page 22 of packet) There are some additional changes to the proposal, noted in Track Changes in the document. Changes include coverage of travel for diagnostic procedures, not currently covered; only some surgeries and procedures not available locally are covered under the current plan. Coverage of travel for diagnostic services would give members more flexibility in seeking these services, and less uncertainty about what is covered. Additionally, the plan would cover lodging and per diem benefits for travel to seek a second opinion, if not available locally, or significantly less expensive in another place. The new proposal would also include travel coordination services for services not in the SurgeryPlus network, but would work similar to travel coordination for surgeries. The new proposal would also include access to physician recommendations, scheduling assistance, etc. for local services as well as services used as travel benefits.

- Cammy Taylor asked how this would impact Medicare eligible members, would they be able to access service at a lower cost?
 - Michele Michaud responded that travel benefits would most likely be available for Medicare eligible members if a service is not available locally, but since Medicare rates are set nationally, it is less likely that they would qualify for a service based on price differential. Medicare eligible members could still use the travel coordination services as well.
 - Richard Ward noted that there is a differential in Medicare rates in Alaska (and other geographies, based on cost) but that the difference may not be enough to produce significant savings by traveling for a procedure, and therefore make this option infeasible for some procedures.

The proposal has also been updated by setting travel benefit limits based on standard lodging and per diem rates: rather than giving a specific dollar amount that would lose value in the future, the rates would be set by current Alaska per diem rates. Outside of Alaska, the rates would be set at the level of federal rate, which are determined at the county level to recognize the costs of different markets (for example, cities with higher average hotel rates would have a higher allowance). The proposal allows for travel with a companion when medically necessary, such as a minor traveling for a procedure.

For defining “less expensive,” the proposed threshold is that the locally-available service would need to be at least \$2,000 more than the cost of that service in the proposed travel location, measured using EDH data and a floor of 200% of Anchorage Medicare rates to determine the benchmark service cost.

- Cammy Taylor asked for clarification about the formula to determine this threshold? For example, if a service is available for \$2,500 locally, it would be difficult to find the service for \$2,000 less.
 - Richard Ward commented that there would be multiple components: for the cost of the local service, if the \$2,500 is the lowest charge, this would be treated differently than if there was a provider locally who also offers the service for less. The determination would take into account the cost of the service locally from all providers, as well as the cost for that service at the travel destination.
 - The group also clarified that if a procedure is available for less than \$2,000 locally, the person would not be eligible for the travel benefit for this service.
- Mauri Long asked for the rationale of \$2,000 as the threshold, as the travel costs alone would be at least \$1,000 for a person traveling out of Alaska, and more if there is an extended stay or multiple travelers. She commented that this may not generate enough savings as intended, depending on the cost of the service and the travel costs.
 - Richard Ward commented that the threshold is intended to be the first step in determining eligibility: this initial calculation would be followed by other criteria such as cost of travel, cost of service in other places, and the benefits of expanding access to that service. Some services, in some circumstances, will generate more savings than others. Consideration of all these factors would determine if the travel option is feasible.

Regarding long term stays, the threshold would be a stay of more than 30 days, with a different rate for lodging (an extended stay arrangement) and meals. There is a State of Alaska per diem threshold defined for long term stays, this would be used as the rate for long term stays in the plan.

The plan also proposes a maximum reimbursement amount of \$10,000 per diagnosis. This is consistent with the existing limits for some services, such as transplants.

- Mauri Long commented that the phrase “per diagnosis” is challenging to implement, people are likely to have multiple diagnoses depending on their condition(s) and the provider would use several CPT codes. She understands the purpose of setting a limit for travel to address one specific health care need or episode, suggested that the language should better reflect the intent, for example “per trip” or “per episode.” She pointed out that a person could say that, because they have 5 co-occurring diagnoses, they would be eligible for up to \$50,000 of travel benefits.
 - Michele Michaud commented that this is a good suggestion, staff will consider this further and bring a recommendation. She noted that “per trip” would also be challenging for people who require quarterly treatment, for example, as it would all be related to the same diagnosis. She agreed that there needs to be a good definition for “episode of care.”
 - Cammy Taylor added that she had these concerns as well, “per diagnosis” does not seem sufficient, but she agrees with the overall intent and supports better language to define this.

The two added paragraphs on page 28 outline the travel coordination services available for treatments that are not covered by SurgeryPlus, including booking travel and providing a prepaid card with the total per diem allowance loaded to it. The new section also outlines services that SurgeryPlus would offer, such as conducting research on providers in order to find qualified options for the member to consider, even if not in the SurgeryPlus network.

Additional information on page 29 discusses Medicare eligible members: they can still access the travel benefits and receive assistance finding a good provider for their service, locally or out of the community, but because they must use a Medicare provider, they would be limited to the providers within the SurgeryPlus network who accept Medicare.

Staff discussed the possibility of waiving co-insurance on these services; if not, the member would be required to pay their deductible and co-insurance amount.

- Mauri Long requested a copy of the contract between the State and SurgeryPlus (currently providing services for the active employee plan), and would like to review this contract prior to providing her opinion on this item.

(Page 63 in packet) There are two charts indicating the origin of travel requests by AlaskaCare retirees in April-August 2018, and the top diagnoses of services requested.

- Cammy Taylor asked whether the additional services offered in these revisions would change the actuarial impact, which was stated as “neutral” in the previous version?
 - Richard Ward responded that the actuarial value is still determined to be neutral, noted on page 30. This is because the services covered are the same, but may have lower cost in another place; actuarial value is different than financial value.
- Mauri Long asked for clarification about why it is neutral: is it because the services are still offered, but the cost may change depending on where they are located?
 - Richard responded that this is correct—because the services themselves are covered at the same level of cost-sharing between the member and the plan, there may be financial impacts for providing more access to services and/or savings from lower-cost services.
- Cammy Taylor invited the committee members to comment if there are changes they would like to see to these proposals, as Segal will be conducting financial analysis on the changes to determine what if any impacts there will be.
 - Mauri Long plans to review the SurgeryPlus contract to better understand the current arrangement, and interested in the financial impacts.
 - Joelle Hall believes the proposal as described matches what committee members have asked for staff to consider, and is interested in seeing the financial analysis on the proposal as written. She is interested to know whether the plan would incur additional cost by offering the “wrap” of concierge services, and potentially more people utilizing this travel benefit, but also noted that there may be savings from people utilizing providers who have low rates of complications and therefore less follow-up costs.
 - Mauri will review the contract she requested as soon as possible after receiving it, she does not necessarily plan to suggest changes but will send staff any comments after reading the contract. If Mauri raises additional questions that may impact the parameters of the proposal, staff will forward the questions to Segal for consideration in their analysis.

Presentation: Increase Deductible / Out of Pocket Maximum

Materials: *Modernization Topics in 12/12/18 packet, “Increase Deductible / Out of Pocket Maximum”*

This proposal has been brought up from time to time, and would be a potential offset to the enhanced benefits proposed for the plan under other modernization topics. Staff considered multiple deductible and out of pocket maximum amounts in their initial analysis, summarized in the table on page 67. This

would increase the amount members would need to pay out of pocket each year, if they utilize services at a higher level than the current deductible and out of pocket maximum. For each option, the family maximums are defined as a family of 3; Michele noted that their analysis shows that most retiree households have no more than 3 members.

- Joelle Hall noted that there a typo in Option 1, it should read that the family deductible is \$600, not \$800, since it is shown as three times the individual deductible of \$200.
 - Michele agreed this is a typo, and will correct the document.
 - Richard Ward added that the assumptions in his analysis are correct, based on \$600.

Michele continued: approximately 78% of members incurred at least \$150 in expenses, and 30% met their out of pocket maximum amount. Staff anticipate that if this is implemented, members would need to cover more of the cost of care, and would be more likely to seek in-network care because they would have lower rates, better coverage and would not be balance billed. This incentive to use in-network providers would generate savings to the plan as well as the member.

- Cammy Taylor noted that 70% of retirees are Medicare eligible, and AlaskaCare is paying only a portion of their total medical costs already. How would this impact those members?
 - Michele responded that this is correct, Medicare eligible members need to meet their deductible either way before the plan begins covering services, but the benefits are coordinated so the plan also covers some services not covered by Medicare.
 - Richard Ward noted that of the 30% of members who meet their out of pocket maximum each year, about 80% of total plan costs are attributed to this group.
- Cammy Taylor noted that this would increase costs for members, as they will be responsible for more of the cost of care.
 - Michele Michaud agreed, but noted that this may also steer members toward seeking lower-cost in-network care where possible, as they would not be balance billed and would potentially get services at a lower rate. Currently there is little incentive to stay in-network.

Staff researched other comparable retiree plans to see what the standard practice is. They found that in many other places, the same benefits are offered to retirees as to active employees, so they used active employee plans for comparison as well. Segal Consulting utilized 50 states' worth of plan data, including plans for local governments, school districts and other groups, as generally comparable groups to the AlaskaCare plan. In general, deductible and out of pocket limits are lower for state plans than commercial plans or private employer plans, but also found that AlaskaCare's limits are significantly lower (meaning, more generous to the member) than other plans. Additionally, the high cost of care in Alaska means that a person or household may meet their deductible after a single primary care visit, and after that point the plan pays 80% for care, up to the out of pocket limit for the member, at which point the plan pays 100%. This creates limited financial incentive for members to make economic choices, and limited benefit for remaining in-network for care since the plan covers most of the cost either way. This proposal would increase members' financial responsibility for their medical costs.

Additionally, Richard shared that industry studies have shown approximately 30% of health services received are not medically necessary, and in some cases can be harmful or counterproductive; having a stronger financial incentive will tend to reduce unnecessary utilization.

- Cammy Taylor commented that in a health care speakers’ panel series in 2017, she recalled learning that some of the market or financial mechanisms that influence behavior nationally, were not necessarily at play in Alaska, where the high cost of care and differences in the system create different incentives and utilization. She encouraged following up with those speakers for more information, as well as talking with Mark Foster, who did some of the analysis in that series.
- Judy Salo commented that the assumption in this analysis is that retiree members would have a high ability to make these sophisticated financial decisions about their care, and she is concerned about this assumption, as well as the shift of costs to individuals. She noted that she would not necessarily feel comfortable making that level of decision, as a retiree herself.
 - Richard Ward responded that the team has not done all of the necessary analysis at this point, but agreed that this would be a cost shift to members to some degree. He anticipates seeing a broad impact after conducting more analysis.
 - Michele Michaud asked Richard if his team has reviewed the Alaska studies (by the UAA Institute of Social and Economic Research, ISER) and whether they would be willing to do so, to understand more about Alaska’s local market?
 - Richard responded that yes, his team can review this research.
 - Betsy Wood commented that it is important to consider this proposal in the context of all the modernization proposals. Some would enhance benefits; others, like this one, would be offsets. The intent of considering these as a package is to determine how to sustainably pay for additional benefits, so this should be considered in the context of the other proposals that would add benefits for members as well.
 - Richard Ward commented that another proposal, changing co-insurance rates to incentivize in-network care, did not have the intended financial impacts in their analysis; it would not have generated as much savings as anticipated, as most people meet their deductible each year. This is another option to consider a change to plan design.
- Cammy Taylor commented that she anticipates this being a focus of public comment and concern from retirees, and several commented to her on this specific item at the RPEA meeting yesterday. She thanked Betsy for reminding the committee about the overall discussion in this project about changes to the plan and how to accommodate the additional benefits requested by retiree members. She also reminded that group that in terms of direct costs to members, Medicare eligible retirees have additional out of pocket expenses associated with enrolling in Medicare, which they are required to do. Medicare rates are controlled, but Medicare Part B has a premium surcharge for members above a certain income level, and there is member cost sharing for Parts A and B. These rates, including the monthly premiums, have increased over time.
 - Joelle Hall asked for a rough estimate of Medicare-related cost increases over time?
 - The group discussed the fact that premiums are set by income level and would impact retirees differently depending on their annual income and what share of income is medical related expenses, like Medicare premiums. Regardless, rates generally increase over time.
- Judy Salo speculated that this will most impact single individuals, without coordinated benefits. Does staff have information about the number of single versus multi-person households?
 - Michele Michaud responded that staff does not have this specific number available, but commented that most households are 3 people or less. There are a large number of people with internal coordinated benefits (two people who both have AlaskaCare coverage), potentially up to 1/3 of the 67,000 members have internal coordinated benefits. Staff do not

- know how many have external (another plan, not AlaskaCare) coordinated benefits, this would take some time to research the specifics.
- Richard Ward added that the data they use for analysis has a total number of coordinated benefits, but they do not have detailed information about which plans are coordinated.
 - Joelle Hall asked for clarification, what if the group considered separately whether to change the deductible amount, versus changing the out of pocket maximum? Which would have more financial impact to the plan, in terms of savings?
 - Richard Ward commented that generally, increasing the deductible would generate the most savings to the plan, as this represents the member's responsibility to pay before the co-insurance in the plan kicks in. He noted that changing out of pocket maximums also has a financial impacts, the proposals put forward are approximately balanced between the two, but one could be changed and have a higher impact individually than the combinations proposed here. The relative impacts are not 50% / 50% necessarily, but are also not 90% / 10%, they are roughly proportional in the options presented.
 - Mauri Long commented that given that most people meet their deductible and fewer meet the out of pocket maximum, it would follow that there is more impact by changing the deductible. She asked for clarification about the relative impacts.
 - Richard Ward responded that the number of people impacted would be higher, but because the out of pocket maximum is only met by 30% of people but who incur 80% of the plan costs, changing this would also have a larger impact to the plan in terms of total costs, for a smaller number of members. He still noted that these factors balance out to generate roughly proportional impacts for implementing both of these changes.

Richard Ward presented Table 3 (page 70 in the packet), illustrating the anticipated impacts on members for the three options. He noted that all members, or at least those who utilize services up to the deductible amount, would be impacted to some degree because they would pay more. However, the second row in the table shows the number of members who would be fully impacted by the changes, meaning that they utilize services up to this level of deductible/out of pocket maximum, and would therefore be paying 100% of the increased member responsibility.

He clarified the information in the table: of the 61,000 members who meet the deductible today, all would be impacted to some degree, equal to the amount the deductible was increased. For example, increasing the deductible by \$150 means all those members would be impacted by that amount, if they utilize services up to that amount. However, the more the deductible is increased, the smaller number of members who utilize those services up to that amount, so they would be most impacted by a larger change in the deductible or out of pocket maximum, while others would have a relatively smaller impact unless they also fully utilize services. For example, if the deductible or out of pocket maximum increased by \$1,000, hypothetically, a small number of members utilize plan services up to that amount, so those members would be responsible for significantly more cost (the full \$1,000). Other members who do not utilize as many services would only be impacted up to the additional cost they incur. The analysis did incorporate assumptions about coordination of benefits, for which the plan pays relatively more.

- Cammy Taylor and Joelle Hall commented that they are both surprised by the relatively low number of retirees utilizing services at higher levels. Joelle noted that this may be due in part to Medicare eligible retirees, whose medical costs are partially paid by Medicare.

- Richard Ward explained that with the large number of coordinated benefits and other factors, this may include \$4,000 or more of utilized services, factoring in the 80% co-insurance by the plan.
- Richard also commented that with Medicare coverage, there are other factors such as 0% co-insurance, while others may have 20% co-insurance under Medicare. There is a wide range of actual co-insurance rates depending on the member's actual utilization. It made the result more complex and resulted in fewer fully-impacted members than expected.
- Mauri Long pointed out that despite these relatively low number of impacted members, there is a significant financial impact to the plan (Table 5). She asked for clarification of how to generate the level of savings (\$27.3 million) given that only 5,100 people would be fully impacted.
 - Richard Ward responded that the various new thresholds being considered do not scale in a linear way, but the higher the member's responsibility for costs, the more savings to the plan, not necessarily proportional to the dollar increase. He also noted that the 5,100 fully impacted members is a smaller group than total number of members impacted in some way—many people would pay more than the deductible and at least a portion of care via co-insurance, but may not need to pay up to the out of pocket maximum.
 - Cammy responded that, for example, if the deductible is changed from \$150 to \$300 or \$500, if many people utilize at least \$300 or \$500 in services each year, all of those savings would be generated back to the plan as members would pay more out of pocket.

The committee took a 15-minute break at 11:10 a.m., returning at 11:25 a.m.

Continued Discussion: Increase Deductible / Out of Pocket Maximum

Cammy Taylor re-convened the meeting, and shared that committee members have some questions:

- Cammy Taylor stated that for a Medicare eligible retiree who has Medicare and AlaskaCare, with the exception of services that are not covered under either plan, the deductible is concurrently met and the plans coordinate. She asked how many people who do not have coordinated benefits and are not Medicare eligible, and would therefore only be covered by AlaskaCare alone?
 - Richard Ward commented that he can pull information about the number of members who do not have coordination of benefits identified, as a proxy for this information. He will share this in the next meeting.
- Judy Salo commented that this is one of the more difficult policy decisions, and that of the options presented, she believes Option 3 (the largest increase) would be the focus of the most anxiety on the part of retirees. She recommended that this should be removed from consideration at this time, and to focus on the smaller-amount increases.
 - Joelle Hall agreed with this recommendation and the rationale.
- Mauri Long commented that according to the actuarial impact of the plan, it appears that this would have between 0.5% and 4.6% of actuarial impact to the plan, corresponding with the magnitude of financial impact as well. She agreed with removing Option 3 as well.
- Cammy Taylor requested that staff remove Option 3, and move forward with additional analysis of Options 1 and 2. She would also like to continue discussion of this proposal at the next committee meeting, and give the committee members as well as the public time to review this and submit comments. She encouraged the public to submit comments on the proposal.

- Joelle Hall recommended to the committee that there should be a discussion about process, and the most practical approach for continued consideration of all the proposals. She would like the process well defined, including the points at which public comment will be solicited and engagement with retirees on these options would occur, and how. She recommends moving forward with the set of benefit changes discussed to date, including the imaging proposal to be discussed in today's meeting, be considered the "official" package for moving forward in discussion. She noted that the February 2019 meeting is very soon, and believes the full package should be brought forward at that meeting. She would like clarification about the advisory board's role in the process, and the official and unofficial mechanisms for getting review and comments on this package. She noted that the range of changes would be none of the proposals, some proposals, and all the proposals: she anticipates that a significant number of retirees would opt for none of the proposals. She asked staff to provide guidance on whether "none" is an option, or whether the State intends to move forward with at least one of the changes. If the intent is to implement at least one of these, this should be stated upfront when framing the discussion and what will be on the table. She recommends that the full package should be developed, and sent out in an official communication to share these proposals for consideration, and use as many channels as possible to disseminate the information. She asked staff to define the overall decision process, including the role of the Board (RHPAB) in that decision process. She notes that transparency and regular communication will be very important, particularly during legislative session.
- Cammy Taylor noted there are also proposals related to coverage of pharmacy benefits, DRB staff have reported these are still being worked on. Should these be included on the list, and the timeline needs to include time for completing those proposals? She asked staff whether the pharmacy proposals could be brought to the January committee meeting?
 - Michele Michaud noted that Emily is still working with the pharmacists' group to develop the related proposals (#3 and #14), Emily should speak to whether the proposals would be done by the January committee meeting. She will connect with Emily after the meeting.
- Cammy Taylor commented that the January committee meeting should include review of the remaining information about the proposals, and discussion of process. She reminded staff to include discussion of item #17, gender dysphoria and gender reassignment surgery.
 - Betsy Wood agreed that reviewing an updated process document in the January committee meeting would be helpful, staff will develop an outline for this process.
- Mauri Long commented that she is interested in further discussion of #17. She is also interested in one item not yet discussed, coverage of dental implants under the medical plan (#15).
- Cammy Taylor proposed that the committee discuss the pharmacy proposals, continue discussion of the increased deductible/out of pocket as well as clinical review for high-tech imaging, and discuss the gender dysphoria proposal.
- Judy Salo commented that she has heard from several retirees about dental implants, and would be interested in more discussion of this item. If it is not done through the modernization committee, perhaps this could be discussed by the proposal evaluation committee (PEC) when looking at responses to the RFP for medical and dental plans.
 - Michele Michaud clarified that the issue at hand is the overlapping benefits in the dental and medical plans, which is confusing for members, it is not an issue related to the third party administrator and would be better served by discussion with this group. Both plan

types cover the service in some situations, so members are often unclear which plan covers this service and at what amount.

- Judy agreed that regardless of who discusses this, it is an important benefit issue to clarify, she has personal experience with this problem and also noted that it leaves members in “purgatory” if neither plan states whether it was covered. For example, could it be removed from one of the plans to clarify the overlap?
- Richard Ward commented that they would need to do further analysis to characterize the magnitude of the issue, but he agrees that this is a confusing provision.
- Mauri Long commented that changes to dental implants could have considerable financial impact to the member, since the dental plan has a low maximum coverage amount. She recommends that the committee discuss this.
- Cammy asked for clarification: the medical exclusion is proposed to be for periodontal disease, not injury or other circumstances?
- Michele Michaud noted the request for clarification, and stated that this item would not be difficult to research and prepare an analysis. Staff will do this for the January meeting.

Setting Next Committee Meeting Date: January 2019

The committee proposed a meeting the week of January 14, 2019, with the intent to review additional proposals to be included in the package, as well as review of the draft process document from DRB staff.

- Next meeting: Thursday, January 17, 2019. The meeting will be slightly longer, 9 a.m. to 1 p.m. *[Additional update after the meeting: this date conflicts with the scheduled date of the next Tele Town Hall, so the committee meeting will instead be held on Wednesday, January 16, 2019.]*

Item 4. Modernization Topics Analysis: Presentations of DRB Staff Research

Materials: Modernization Topics Table in 12/12/18 meeting packet, “Enhanced Clinical Review for High-Tech Imaging”

Cammy Taylor invited Hali Duran with Aetna to present this item.

Presentation: Enhanced Clinical Review for High-Tech Imaging

Hali Duran presented an overview of the issue: there is increased utilization under the AlaskaCare plan of high-cost services for some imaging services, such as radiology and cardiac imaging. Utilization of these services has been increasing over time, and is significantly higher in AlaskaCare than comparable plans: the AlaskaCare per member per month spend for these services is \$82, compared with \$53 across all Aetna plans (book of business). In addition to the financial impacts, this trend also may result in unnecessary care or exposure of the member to harmful radiation during the imaging process, without necessarily better outcomes or accurate diagnosis if this imaging was not medically necessary. Implementing enhanced clinical review could generate an estimated \$458,663 in annual net savings.

- Cammy Taylor commented that comparing with the national average is challenging because of Alaska’s higher costs, is this an appropriate measure? She also agreed that there is a marked increase in utilization of these services, this has been documented over several years.
 - Hali responded that the book of business does incorporate some geographic differential across the U.S., but that this does not fully reflect Alaska’s disproportionate costs.

- Cammy requested a comparable analysis of other services to understand the differential between Alaska and other places, and a list of services included in this category. She posed the question: is there a greater need for diagnostic services due to increased illness or injuries? Or is this an increased utilization of unnecessary services for whatever reason, such as more technology available and therefore providers want to utilize it to recoup the cost of purchasing the equipment, even if a lower cost service is equally effective?
- Daniel Dudley noted that the services include cardiac imaging, diagnostic radiology, hip and knee replacements, sleep management studies, etc. Aetna can provide a list of these services. The intent is to ensure that the services utilized are medically necessary. He also clarified that pre-certification would be required for in network providers, and the coordination would be primarily through the administrator and the provider, and not impact the member much directly unless the service is not recommended after this review.
- Cammy Taylor asked Aetna about the rate of appeals in other plans related to these services, and when prior authorization is required and the claim/authorization is denied?
 - Hali responded that the first step in the process for a denied claim for this service would be a peer review of the provider and another physician to discuss the necessity of that service. Many issues are resolved this way. If the providers still disagree, the appeal can proceed. She will research this issue in Aetna's other plans, including how many items go through peer review, and how many are appealed after that point if the service is not recommended.
- Mauri Long is also interested in the number of appeals, and noted that these processes can be lengthy to access complex imaging services, which may be problematic if they relate to a serious or potentially serious and time-sensitive health issue. She wants to understand whether this review would result in delays in people getting needed services.
 - Hali responded that the general policy is to respond to a prior authorization request within 2 days. Approximately 90% are done within 2 days, and 95% were done within 5 days. There is an emergency/expedited process as well, approximately 99% of these reviews were completed within the required time. The peer to peer discussion may take more time, but will be dependent on providers' schedules rather than Aetna's processes. If an appeal proceeds, it would be subject to the same timeframes as other appeals.
 - Daniel Dudley added that the peer to peer conversation is intended to help providers follow evidence-based medicine and utilize services appropriately.

(Page 80 in packet) Slide 3 includes a list of services that would require prior authorization. Hali clarified that these services currently represent about 11% of all AlaskaCare medical costs. This proposal would not impact other services related to an inpatient stay, such as observation and other tests.

- Cammy Taylor asked for clarification: this applies only to in-network providers, and for people who are not Medicare eligible? Does this apply for inpatient services, or outpatient only?
 - Hali responded that this is correct, it would only apply for outpatient services, not for Medicare eligible retirees, and in-network providers only.
 - Michele Michaud added that generally, members will not directly interact with this policy change, their provider would be required to submit paperwork for prior authorization and would consult with a peer if there is a question about the necessity of this. If a service is denied, this would impact the member and require an alternative, but they do not anticipate this to be an issue for all imaging orders.

- Hali shared her personal experience with this, as her health coverage is through Aetna and her imaging services needed review. She asked about the process when it happened, since she is aware of the policy, but would not otherwise have been involved in that process.
- Cammy Taylor asked whether there is an anticipated actuarial impact?
 - Richard Ward anticipated that there would not be an actuarial impact since it does not change coverage, but he would need to research further to verify this.
- Mauri Long asked for clarification about the role of this committee: is the committee asked to provide a recommendation about this proposed change, and how would it impact the other proposals being considered? Is action by the Board (RHPAB) necessary on this item?
 - Michele Michaud clarified that this is a change, but not to the fundamentals of the plan (co-insurance, network, etc.) She confirmed that the State could change this without additional review, but staff want to provide transparency on any significant changes to the plan, even if it does not have actuarial impact. They will look to RHPAB for a recommendation on this item, as well as the others before the group.
- Cammy Taylor thanked Hali and Daniel for presenting, and asked Aetna to provide more information about providers' experience in other plans, and whether doctors have found this process to be easy to use and believe that it results in appropriate utilization of care. She noted that, given the lack of impacts to the member and the potential for savings and getting appropriate care, this seems like a promising recommendation, but will withhold an opinion until she learns more about how this rule is working now in other plans.
- Mauri Long commented that for outpatient imaging, the wait can be several weeks for non-emergency imaging services. She is concerned about the impact on timing, it is emotionally difficult for members to wait a long period of time for testing and the results of those tests, especially for a potentially serious condition. She would like to ensure there is minimal delay in accessing imaging services, so members can get results in a timely manner, and know what treatments they need.
- Cammy Taylor asked whether the in-network providers, in Alaska or elsewhere, are already required to do this, or if this would require additional agreements with providers?
 - Hali responded that this is part of network contracts already, so providers would be required to do this because it is part of their overall agreement with Aetna.
- Cammy also asked whether other plans in Alaska include this review requirement?
 - Hali responded that it depends, some plans focus on some services and not others. She would need to research which plans require this review, and for which services.
 - Cammy responded that it seems some services that are not time sensitive, such as sleep studies, could be considered as different from imaging services such as cardiology, which as Mauri pointed out may be more important to access quickly. She would like to know which provider types participate in the program, and the time-sensitive services versus less time-sensitive services.
 - Michele Michaud noted that Aetna has had this policy for several years, but it was not included in the AlaskaCare plans initially because the provider network was so small in state. Now that there are significantly more providers participating in the network, the Division would like to revisit the discussion about utilization of these services. She proposed that Aetna share information about which plans include this in Alaska and for which services, and include analysis of a carveout of cardiac services from this policy as an example.
- Judy Salo asked for a list of in-network providers in Alaska.

- Michele responded that on the website (AlaskaCare.gov), you can use the “find a doctor” tool for searching for in-network providers in the Aetna network.
- Judy asked whether staff track the number of people who use this search function? In her previous experience living in small communities in Alaska, there are very limited options and it is not common for people to even think to research whether they are in network. She also noted that for Medicare eligible retirees, they will be looking for Medicare providers only. She supports the general intent of promoting in-network care, but would like to know how this is practical particularly for retirees in Alaska, rural Alaska and other rural areas.
- Michele will check with the communications team if this information about utilization of the website’s search function is available. She noted that the numbers may not be useful even if they are available, as she and other DRB staff regularly use that feature for their research and the data would include their searches.
- Judy commented that she would like to understand the implications for in-network versus out-of-network providers, particularly for members living in areas with limited options.
- The group will continue discussion of this item after receiving the requested information.

Item 5. Final Thoughts + Meeting Adjournment

- No final comments.
- Committee members thanked staff and the contractors in the meeting for their work!
- **Motion** by Mauri Long to adjourn the meeting. **Second** by Cammy Taylor.
- **Result:** The meeting was adjourned at 12:20 p.m.

Retiree Health Plan Advisory Board Public Comment Guideline

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

Retiree Health Plan Advisory Board Public Comment Guideline

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

DRAFT-Summary of Responses to Proposed Plan Design Change

Proposed change: Enhanced Clinical Review for High-Tech Imaging

Plans affected: DB Retiree Plan

Reviewed by: Retiree Health Plan Advisory Board Modernization Subcommittee

Proposed implementation date: TBD

Review Date: April 23, 2019

Table 1. Plan Design Changes

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

Description of proposed change:

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

Background

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

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

DRAFT-Summary of Responses to Proposed Plan Design Change

Under this proposal, the AlaskaCare retiree health plan would adopt Aetna’s Enhanced Clinical Review (ECR) program. Under this program, network providers submit precertification requests to a vendor contracted by Aetna to review such requests in advance of administering services or conducting tests. After review, the precertification determination would be sent in a letter to the member and by fax to both the provider who ordered the service and the provider who would perform the service (if different from the ordering provider).

If a precertification request is denied, providers have the option to request a peer-to-peer review within 14 days from the date of denial. Another physician will review and discuss the necessity of the service with the provider at a mutually agreed-upon time. Most disputes are resolved at this level, but if a disagreement about the necessity of the service persists, the provider can appeal directly to Aetna through the standard Provider Appeal process.

When providers agree to join Aetna’s network, they agree to conform to Aetna’s published clinical policy bulletins regarding the medical necessity of services, including high-tech imaging and testing. Aetna has implemented enhanced clinical review programs with other clients, so network providers are already familiar with the process. This initiative would largely operate behind the scenes; network providers (not patients) would be responsible for obtaining preauthorization in advance of administering services and seeking reimbursement. The extra scrutiny assists in ensuring that evidence-based guidelines of appropriate care are being followed prior to the administration of high-cost imaging and/or testing.

[This program has been adopted by 18,149 of Aetna’s self-funded customers, covering 5.4 million members nationally.¹](#)

Table 2: Comparison of Current to Proposed Change

CURRENT: 2019 Retiree Insurance Information Booklet	
Current (Page 44-45 of 2019 Retiree Insurance Information Booklet)	<p>Radiation, X-rays, and Laboratory Tests</p> <p>The Medical Plan pays normal benefits for X-rays, radium treatments, and radioactive isotope treatments if you have specific symptoms. This includes diagnostic X-rays, lab tests, TENS therapy, and analyses performed while you are an inpatient. Charges for these services are not paid if related to a routine physical examination except as noted below.</p> <p>The plan provides coverage for the following routine lab tests:</p> <ul style="list-style-type: none"> • One pap smear per year for all women age 18 and older.

¹ [Enhanced Clinical Review Program \(Follow-up Q&A for March 20, 2019 RHPAB meeting\), Aetna Presentation dated March 20, 2019.](#)

DRAFT-Summary of Responses to Proposed Plan Design Change

	<ul style="list-style-type: none">• Charges for a limited office visit to collect the pap smear are also covered.• Prostate specific antigen (PSA) tests as follows:<ul style="list-style-type: none">○ One annual screening PSA test for men between ages 35 and 50 with a personal or family history of prostate cancer, and○ One annual screening PSA test for men 50 years and older.• Mammograms as follows:<ul style="list-style-type: none">○ One baseline mammogram between age 35 and 40,○ One mammogram every two years between age 40 and 50, and○ An annual mammogram at age 50 and above and for those with a personal or family history of breast cancer. <p>These tests will be paid at normal plan benefits following the deductible. Other incidental lab procedures in connection with pap smears, PSA tests, and mammograms are not covered.</p>
<p>Current (Page 44-45 of 2019 Retiree Insurance Information Booklet)</p>	<p>Services Requiring Pre-certification</p> <p>The following list identifies those services and supplies requiring precertification under the medical plan. Language set forth in parenthesis in the precertification list is provided for descriptive purposes only and does not serve as a limitation on when precertification is required.</p> <p>Precertification is required for the following types of medical expenses:</p> <ul style="list-style-type: none">• Stays in a hospital• Stays in a skilled nursing facility• Stays in a rehabilitation facility• Stays in a hospice facility• Outpatient hospice care• Stays in a residential treatment facility for treatment of mental disorders and substance abuse• Partial confinement treatment for treatment of mental disorders and substance abuse• Home health care• Private duty nursing care• Transportation (non-emergent) by fixed wing aircraft (plane)• Transportation (non-emergent) by ground ambulance• Applied Behavioral Analysis (early intensive behavioral intervention for children with pervasive developmental delays)• Autologous chondrocyte implantation, Carticel (injection into the knee of cartilage cells grown from tissue cultures)• Cochlear implant (surgical implant of a device into the ear to try to improve hearing)• Cognitive skills development

DRAFT-Summary of Responses to Proposed Plan Design Change

	<ul style="list-style-type: none"> • Customized braces (physical – i.e., non-orthodontic braces) • Dental implants and oral appliances • Dialysis visits • Dorsal column (lumbar) neurostimulators: trial or implantation (for relief of severe pain) • Electric or motorized wheelchairs and scooters • Gastrointestinal tract imaging through capsule endoscopy • Hyperbaric oxygen therapy • Limb prosthetics • Oncotype DX (a method for testing for genes that are in cancer cells) • Orthognathic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint (reconstructive surgeries to attempt to correct structural abnormalities of the jaw bones) • Organ transplants • Osseointegrated implant • Osteochondral allograft/knee (grafting of cartilage and bone from a cadaver to the knee joint) • Proton beam radiotherapy • Reconstruction or other procedures that may be considered cosmetic • Surgical spinal procedures • Uvulopalatopharyngoplasty, including laser-assisted procedures (surgery to reconfigure the soft palate to try to help with sleep apnea) • Ventricular assist devices • MRI-knee • MRI-spine • Intensive outpatient programs for treatment of mental disorders and substance abuse, including: <ul style="list-style-type: none"> ○ Psychological testing ○ Neuropsychological testing ○ Outpatient detoxification ○ Psychiatric home care services • Travel
Proposed Change	<p>When receiving services from a network provider, precertification must be obtained by the provider from the Third Party Administrator for the following types of medical expenses:</p> <ul style="list-style-type: none"> • High-tech radiology (MRI/CT Scans) • Diagnostic cardiology • Sleep management studies • Cardiac rhythm implant devices • Interventional pain management

DRAFT-Summary of Responses to Proposed Plan Design Change

- Hip and Knee replacements (arthroplasties)

Member Impact:

Under the current benefits, some patients may be undergoing costly and potentially duplicative procedures that expose them unnecessarily to elevated levels of radiation. The proposed change would help ensure that the high-tech imaging and diagnostic testing member receive from network providers is medically necessary and follows appropriate evidence-based guidelines.

This proposed initiative would provide members with an additional measure of confidence that the care they are receiving is medically necessary and essential to their course of care. Furthermore, enhanced clinical review will help protect members against unnecessary medical expenses.

Because the precertification process would occur between the network provider and the Third Party Administrator, if the precertification is granted members should anticipate minimal, if any, interaction with this policy. If a service is denied, the provider may consult with a peer to discuss the need for the procedure, but the member will be informed of the denial and will need to consider next steps or other options with their provider.

Actuarial Impact

Neutral / Enhancement / Diminishment

Table 3: Actuarial Impact

	Actuarial Impact	Notes
Current	N/A	N/A

This initiative is not anticipated to have an actuarial impact on the plan.² The plan will continue to cover high-tech imaging and diagnostic testing when medically necessary.

DRB operational impacts:

The Division will work to educate members and increase familiarity with the enhanced clinical review process. The Division will also work to educate staff members about the initiative to ensure members are provided with accurate information regarding the process and staff are prepared to assist members.

² Segal Memo Implementation of Enhanced Clinical Review (ECR) Program for High Tech Radiology Services dated March 15, 2019.

DRAFT-Summary of Responses to Proposed Plan Design Change

Financial Impact to the plan:

Table 4, Estimated Savings

Proposed Change	Estimated Annual Financial Impact
Enhanced clinical review for high-tech imaging and diagnostic testing	\$250,000 net savings to the plan

The current per non-Medicare eligible member per month plan spend on radiology is approximately \$82, compared with the per member per month average spend of \$53 for the same services across Aetna's book of business.³ It is anticipated that 2-3% of services and procedures covered by this proposal would be denied or redirected to an alternate form of care. Savings to the plan are projected to be \$350,000 annually, but the total cost of the program is projected to be \$100,000 annually, resulting in \$250,000 annual net savings.⁴

Clinical considerations:

The proposed changes would require additional clinical review for some high-tech imaging and diagnostic testing. These services are currently available to members when medically necessary, and under the proposed initiative would continue to be available to members. This initiative would provide an extra degree of certainty that the services rendered are, in fact, medically necessary.

Third Party Administrator (TPA) operational impacts:

The proposed program is already part of existing network contracts between Aetna and participating providers, and has already been put into practice with other accounts. Because the administrative framework for review, determinations, and appeals already exists and has been implemented, the impact to the TPA of applying an enhanced clinical review program to the plan would be minimal.

The addition of this policy may result in additional appeals processing by the TPA, but typically the volume of appeals in this program is relatively small. In the month of October 2018, across the Aetna's book of business, there were 170,000 total enhanced

³ *Enhanced Clinical Review Program*, Aetna Presentation dated December 12, 2018.

⁴ *Segal Memo Implementation of Enhanced Clinical Review (ECR) Program for High Tech Radiology Services* dated March 15, 2019.

DRAFT-Summary of Responses to Proposed Plan Design Change

clinical review requests submitted, 667 of which were appealed (.39%). 2% of appeals arose from denials. During that time frame, 261 appeals (39.1%) were overturned.⁵

Provider considerations:

As network providers are already familiar with this policy because it is part of their network agreement with Aetna, the anticipated impact to those providers is minimal. They are already familiar with the policy and with the process because they are required to conform to these procedures for other Aetna-covered patients.

Documents attached include:

Document Name	Notes
<i>Enhanced Clinical Review Program, Aetna Presentation dated December 12, 2018.</i>	 Enhanced Clinical Review Program 12.12
<i><u>Enhanced Clinical Review Program (Follow-up Q&A for March 20, 2019 RHPAB meeting), Aetna Presentation dated March 20, 2019</u></i> <i><u>Enhanced Clinical Review Program (Follow-up Q&A for Feb 6, 2019 RHPAB Meeting), Aetna Presentation dated December 12, 2018.</u></i>	 ECR Follow-up for RHPAB Modernization
Financial Analysis – Segal Memo	 Segal ECR Memo 20190315.pdf

⁵ ~~*Enhanced Clinical Review Program (Follow-up Q&A for March 20, 2019 RHPAB meeting), Aetna Presentation dated March 20, 2019*~~
~~*Enhanced Clinical Review Program (Follow-up Q&A for Feb. 6, 2019 RHPAB meeting), Aetna Presentation dated February 6, 2019.*~~



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MEMORANDUM

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

From: Richard Ward, FSA, FCA, MAAA

Date: March 15, 2019

Re: Implementation of Enhanced Clinical Review (ECR) Program for High Tech Radiology Services

The AlaskaCare Retiree Plan currently provides coverage for medical treatments and applies the general plan provisions, such as deductible, coinsurance and out-of-pocket limitations, to determine any portion of the costs that are the member’s responsibility. If the member has additional coverage, such as Medicare or other employer provided coverage, any portion of the costs covered by that plan is also considered. Below is a table outlining the current benefits offered under the Plan:

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

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

Some of the benefit coverages provided by the plan require precertification to ensure proper medical protocols and guidelines are followed. These precertification requirements currently include some high tech imaging such as MRIs for the spine and knee.

The change under consideration would add an enhanced level of precertification (or preauthorization) for all high tech imaging, including, MRI/MRA, CT/CCTA, PET, and Nuclear Cardiology. This program will require network providers to follow evidenced based guidelines for these imaging services, and it will also encourage members to seek treatment from network facilities and providers. This program would only apply to services and procedures not covered by Medicare.

Actuarial Value

These changes promote efficient utilization of medical services, which helps manage program costs. However, there are no changes to how the cost share is determined and therefore, the ECR program does not affect the actuarial value of the Plan.

Financial Impact

While the Actuarial Value of the Plan would not be impacted by the implementation of this program, there would be a financial impact to plan costs. Our analysis leverages the analysis conducted by Aetna. Segal has reviewed Aetna's analysis to determine that all assumptions are appropriate and reasonable.

Radiology costs are about \$80 per member per month (pmpm) for non-Medicare retirees. It is estimated that approximately 2-3% of network procedures and services covered by the ECR program would be denied or redirected to more efficient care. The cost of affected procedures is anticipated to be higher than average. Savings to the plan are estimated to be \$350,000 annually.

Based on a \$0.70 per retiree per month (prpm) fee for the program, and approximately 11,600 non-Medicare retirees, the total annual cost of the program is approximately \$100,000, resulting in \$250,000 in annual net savings.

It is worth noting that the ECR program currently coordinates exclusively with network providers. Since the Retiree Plan does not have a benefit differential for network and non-network providers and services, there is the possibility that some retirees may “shop” between network and non-network providers if the initial review results in a denial. These instances may be isolated and the overall impact minimal, but we believe it is worth noting now in order to proactively monitor the Plan for this potential behavior once the ECR program is implemented.

This analysis is based on 2016 and 2017 medical and pharmacy claims data, projected to 2019 at 3.0% and 6.0% annual trends, respectively. The data was reviewed, but not audited, and found to be sufficient and credible for this analysis.

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

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

Quality health plans & benefits
Healthier living
Financial well-being
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Enhanced Clinical Review program

(Follow-up Q&A for
March 20, 2019 RHPAB meeting)



Program Details

- **Program Summary:**
 - Program inception – 2007
 - Adopted by 18,149 self-funded Aetna customers nationally, all segments
 - 5.4 million members
 - Add preauthorization for participating providers for high tech radiology services –
 - MRI/MRA, CT/CCTA, PET, Nuclear Cardiology
 - Providers need to follow evidence-based guidelines of appropriate care
 - Steerage for members to in-network facilities/physician
 - Aetna Vendor: MedSolutions DBA eviCore Healthcare
- **Approval Process:**
 - Requesting provider completes precertification
 - Determination is sent in a letter to the member, and by fax to both rendering and ordering provider.
- **Denial Process:**
 - Providers may request a peer-to-peer review within 14 days from the date of the denial.
 - Providers may choose a convenient time for the peer-to-peer review. It may take 1-2 days to complete the peer-to-peer where a discussion and determination is made.
 - If Precertification denial is upheld after a peer-to-peer review, the provider can appeal directly to Aetna through the standard Provider Appeal process.
- **Precertification Statistics (October 2018 -- Aetna BOB):**
 - 170,000 total requests
 - 667 appealed (.39%)
 - 261 were overturned, an overturn rate of 39.1%
 - 2% of appeals from denials

Savings and Fees

- **Savings Opportunity: \$1.50 to \$1.90 PRPM**
 - Based on Aetna national book of business results, since 2007
 - Not adjusted for customer geography and demographics
 - ROI of 2.14 to 2.71
 - Annual net savings estimate-- **\$201,341 to \$302,011**
- **Program Fee: \$0.70 PRPM**
 - High tech radiology (MRI/CT Scans) \$0.35
 - Diagnostic Cardio \$0.10
 - Sleep Study \$0.05
 - Cardiac Implantable \$0.05
 - Interventional Pain Management \$0.10
 - Hip/Knee Replacements \$0.05
 - Choose a custom bundle or all programs
 - Variable cost via Claim Wire, no fixed cost
- **Implementation:**
 - Required 60-day notice

Savings Projection

- **Mitigating inappropriate utilization due to a multitude of factors including:**
 - New technologies intensify the application of imaging studies for new diagnostic means
 - Greater consumer demand
 - Aging population
 - Increased capacity through self-referrals by physicians
 - New standards of care
 - Defensive medicine
- **Savings Model:**
 - Based on a BOB percentage of services redirected/not authorized due to Medical Necessity Review
 - BOB Average Cost Per Denied Service
 - Customer-specific data
 - Savings reflect the avoided cost of services not authorized

Sample Program Reporting



Enhanced Clinical Review Program Claim Report

Prior Incurred Period : 01/01/2016 - 12/31/2016
 Current Incurred Period : 01/01/2017 - 12/31/2017
 Prior Paid Period : 01/01/2016 - 12/31/2016
 Current Paid Period : 01/01/2017 - 12/31/2017
 Total Current & Paid Claims : \$96,265,026

Group Number : XXXXXXXXX - XXXXXXXXX
 Product Category : All
 Prior Member Months : 259,635
 Current Member Months : 268,846

	Radiology Claims					
	Current Incurred & Paid Claims	% of Total Medical Claims	% of Total Radiology Claims	Prior Claims Per Member	Current Claims Per Member	Trend
Total Radiology	\$7,875,436	8.2%		\$336	\$352	4.5%
*Inpt Radiology	\$75,712	0.1%	1.0%	\$2	\$3	40.8%
*Ambulatory Radiology	\$7,799,724	8.1%	99.0%	\$334	\$348	4.2%
High Tech Radiology (ambulatory)	\$3,919,456	4.1%	49.8%	\$152	\$175	15.0%
*Hospital Ambulatory	\$2,915,094	3.0%	37.0%	\$107	\$130	21.5%
*Freestanding Centers	\$1,004,361	1.0%	12.8%	\$45	\$45	-0.6%

Modality	Precertification Decisions Per 1,000 Members Per Month								
	Services/1,000			Hospital Ambulatory Services/1,000			Freestanding Centers Services/1,000		
	Prior	Current	Trend	Prior	Current	Trend	Prior	Current	Trend
Hi-Tech Radiology	9.36	9.72	3.8%	4.70	5.25	11.6%	4.96	4.76	-4.0%
Diagnostic Cardiology	2.08	2.39	15.0%	1.54	1.82	18.4%	0.59	0.61	3.5%
Cardiac Implantable Device	0.02	0.01	-61.5%	0.02	0.01	-61.5%	0.00	0.00	0.0%
Sleep Studies	0.60	0.48	-19.0%	0.45	0.36	-19.9%	0.15	0.13	-15.8%
Hip & Knee Replacement	0.02	0.02	-3.5%	0.02	0.02	-3.5%	0.00	0.00	0.0%
Pain Management	0.80	1.10	37.4%	0.54	0.74	38.3%	0.27	0.36	35.8%
Grand Total All Procedures	12.88	13.73	6.6%	7.27	8.20	12.8%	5.97	5.86	-1.8%

Performance Guarantees

- Contractual performance guarantees are based upon a two day turnaround time response
- Performance Guarantee Results:
 - 2nd Quarter of 2018 – BOB PG was 95% met
 - 98% within 5 business days
 - 99% of urgent request completed within 8 hours
 - Real-time peer-to-peer review goal to reach a conclusion
- Alaska Heart Institute feedback (Jan. 2019):
 - Our network team surveyed Alaska Heart Institute about their experience with Aetna ECR regarding member disruption and they did not report any incidences of disruption.

Thank you

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

aetna[®]

Enhanced Clinical Review program



Enhanced Clinical Review – U65 Retiree Plan

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

Network providers only.
- **RESULTS**— Estimated Net Annual Savings:
 - U65 Retiree Plan - TBD
- **REPORTING**-- AetInfo

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

Critical touch points of care

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

Testing and diagnosis

High-tech radiology
Diagnostic cardiology
Sleep management studies

Treatment

Cardiac rhythm implant
devices
Interventional pain
management*
Hip and Knee replacements
(arthroplasties)*

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

Evidence-Based standards

Determine appropriate level of care



Aetna-preferred providers

Deliver more cost-effective care



Result:

Improved health outcomes and maximized savings

Alaska Care

Confidence that their health care dollars are supporting beneficial care

Members

Peace of mind that they are getting the right care, at the **highest benefit level**

Thank you

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Policy forms issued in OK include: HMO OK COC-5 09/07, HMO/OK GA-3 11/01, HMO OK POS RIDER 08/07, GR-23 and/or GR-29/GR-29N.

DRAFT-Summary of Responses to Proposed Plan Design Change

Proposed change: Expanding Telehealth Services to AlaskaCare Retirees

Plans affected: DB Retiree Plan, DC Retiree Plan

Reviewed by: Retiree Health Plan Advisory Board

Proposed implementation date: TBD

Review Date: April 23, 2019

Table 1: Plan Design Changes

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

Description of proposed change:

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

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

Background:

In 2017, low severity care¹ accounted for 31% (\$237 million) of health care spend across both the AlaskaCare employee and retiree health plans. Low severity care encompasses non-emergency and minimally-invasive services. \$178 million (or 75%) of low-severity care costs were incurred by the retiree health plan, including \$25.7 million in out-of-

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

DRAFT-Summary of Responses to Proposed Plan Design Change

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

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

Teladoc providers have limited prescribing privileges and comply with state statutory and regulatory requirements.

To use Teladoc’s services, members must first set up an account through the Teladoc website. Then, members can request a consult through the website, or by phone. A doctor will reach out by phone within minutes. If a member misses the call, the doctor will try two more times to reach them. There is no time limit on consultations.

Member impact:

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

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

Actuarial impact: UNDER DEVELOPMENT

Neutral / Enhancement / Diminishment

Table 2: Actuarial Impact²

Actuarial Impact	
Current	N/A
Proposed	N/A—Under developmentNo Impact

DRB operational impacts:

² Segal Memorandum dated April 19, 2018

DRAFT-Summary of Responses to Proposed Plan Design Change

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

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

Financial impact to the plan:

The cost of implementing Teladoc in the AlaskaCare retiree plan ~~would~~ could vary between \$653,000 and \$852,900 a year, depending on member-usage. Savings would potentially arise through the avoidance of traditional high-cost services for low-severity episodes, and will therefore also vary depending on actual utilization and member experience. - Assuming 5% of members utilize Teladoc, the projected annual savings to the plan is approximately \$250,000.³

~~The savings estimates are under development.~~

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

~~Table 1 below estimates plan costs given PY 2018's Retiree Plan enrollment and current Teladoc terms.~~⁴ ~~Cost estimates assume a low-end utilization of 7% (5040 calls/yr) and a high-end of 15% (10,800 calls/yr).~~

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

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

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

³ Segal Memorandum dated April 19, 2018

⁴ The per member per month (PEPM) cost is \$0.93, and each call is \$40. Utilization is calculated as # of calls divided by covered lives.

DRAFT-Summary of Responses to Proposed Plan Design Change

Table 4: Evaluation of Avoidable, Low-Severity Care⁵

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

Clinical considerations:

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

Third Party Administrator (TPA) operational impacts:

This may require manual adjudication of claims.

Provider considerations:

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

Documents attached include:

Document Name	Attachment	Notes
Segal Memorandum	A	 Segal Telemedicine Memo 20190419 UPD

⁵ These estimates are intentionally conservative as to not overestimate substitutable care. The following are expenditures for the least-intensive care episodes in 2017 for the Retiree Plan as determined through OptumInsights.

MEMORANDUM

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

From: Richard Ward, FSA, FCA, MAAA

Date: April 19, 2019

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

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

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

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

A change to the benefits under consideration would provide access to Teledoc’s services at a \$5 member copay per consultation. Caregiver consultations have a \$45 copay and dermatology consultations have a \$75 copay, which includes one follow-up consultation. The benefit would provide an additional access point for members who are experiencing acute medical conditions.

Actuarial Value

Since the the Plan currently covers telemedicine consultations, the changes under consideration would enhance access and therefore, there would not be an impact on the Plan’s actuarial value.

Financial Impact

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

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

For this analysis, we are assuming that the total cost of a Teladoc consultation is \$40 with a \$5 member copay for most services. Based on the member copay and considerations discussed previously, it is assumed that 5.0% of the members will utilize Teladoc, resulting in approximately 5,000 calls annually. Additionally, it is to be expected that a portion of those calls will not lead to a resolution, and necessitate a follow-up visit to either a primary care physician or specialist, resulting in additional cost to the plan. The plan will also be charged a per member per month administration fee of \$0.93.

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

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

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

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

DRAFT-Summary of Responses to Proposed Plan Design Change

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

Plans affected: DB Retiree Plan

Reviewed by: Retiree Health Plan Advisory Board

Proposed implementation date: TBD

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

Table 1: Plan Design Changes

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

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

Description of proposed change:

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

Background:

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

DRAFT-Summary of Responses to Proposed Plan Design Change

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

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

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

Because the recognized charge is determined based on the amount providers bill, over time the FAIR Health benchmark increases based on billing amounts resulting in both higher prevailing charge rates and greater compensation for non-network providers. In some cases, the recognized charge may be higher than the negotiated charge, meaning both the plan and the member are paying more for the same service than they would if the service was received through a network provider.

When non-network providers and facilities are reimbursed at substantially higher rates than in-network providers, it can be difficult to incentivize providers and facilities to join the network.

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

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

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

DRAFT-Summary of Responses to Proposed Plan Design Change

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

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

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

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

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

Member impact:

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

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

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

DRAFT-Summary of Responses to Proposed Plan Design Change

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

Table 2. AlaskaCare Non-Medicare Eligible Retiree Medical Claims Incurred Calendar Year 2018³

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

Amongst non-Medicare eligible retirees:

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

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

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

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

⁴ Ibid.

DRAFT-Summary of Responses to Proposed Plan Design Change

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

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

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

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

Actuarial impact:

Neutral / Enhancement / Diminishment

Table 2: Actuarial Impact

Actuarial Impact	
Current	N/A
Proposed	N/A

Actuarial analysis forthcoming.

DRB operational impacts:

The Division anticipates minimal operational impacts as follows:

- Staff will need to review and distribute communications to educate members about the potential impacts and increase awareness of the new reimbursement approach.
- A plan amendment will need to be developed, put forward for public comment, and published before the benefit takes effect.
- Staff will need to coordinate and oversee implementation of the new benefit to ensure it is accurately administered by the TPA.
- Staff will need to coordinate with the TPA to ensure that providers are made aware of the new reimbursement approach.

DRAFT-Summary of Responses to Proposed Plan Design Change

Financial impact to the plan:

The financial analysis is forthcoming.

Clinical considerations:

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

Third Party Administrator (TPA) operational impacts:

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

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

Provider considerations:

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

The proposed change could increase providers' willingness to participate in the network, particularly in the Anchorage area where there is competition amongst providers.

Documents attached include:

<u>Document Name</u>	<u>Attachment</u>	<u>Notes</u>
Segal Memorandum	A	Forthcoming

DRAFT-Summary of Responses to Proposed Plan Design Change

Proposed change: Removing Coverage of OTC-Equivalent Drugs

Plans affected: DB Retiree Plan

Reviewed by: Retiree Health Plan Advisory Board

Proposed implementation date: TBD

Review Date: April 23, 2019

Table 1: Plan Design Changes

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

* The financial impact varies between the two proposed options

Description of proposed change:

This proposal offers for consideration two options to discontinue coverage of prescription medication when an over-the-counter (OTC) equivalent of the drug is available. Under both scenarios, a prescribing provider could override the exclusion with a medical indication on the prescription in instances where the prescription-grade medication is medically preferable.

Option A

Coverage for brand-name and generic prescription medication would be discontinued if an OTC equivalent of the drug is available.

Option B

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

Both Options:

An OTC drug would be considered equivalent to a prescription drug if:

- The OTC drug has the same active pharmaceutical ingredient(s) (API) as the prescription drug product, AND
- The API(s) have the same, similar or easily substitutable dosage strength, AND

DRAFT-Summary of Responses to Proposed Plan Design Change

- The OTC drug can be used in the same route of administration as the prescription drug.¹

Background:

The AlaskaCare defined benefit retiree health plan provides coverage for prescription drugs prescribed by a provider that may have an OTC equivalent.² Some medications in this category were initially only available with a prescription, but since their initial entry onto the market now have a generic and/or an OTC equivalent available.

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

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

- Brand-Name Prescription (40mg): \$500 for a 90-day supply
- Generic Prescription (40 mg): \$287 for a 90-day supply
- OTC Equivalent (20mg, can be taken twice): \$19.80 for 90ct³, \$39.60 for 40mg, 90-day equivalent.

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

Member impact:

Option A

About 15,800 unique members received and filled a prescription for a drug that had an over-the-counter equivalent in 2018. 54% of these members, or 8,500 received two or fewer OTC-equivalent prescriptions over the benefit year.

¹ The means of drug comparison in both proposals are lifted from the FDA

² p. 70, <http://doa.alaska.gov/drb/pdf/ghlb/retiree/DBRetireeInsuranceBooklet-01012019.pdf>

³ Safeway, Kroger, Carrs, Walmart) with manufacturer coupon

DRAFT-Summary of Responses to Proposed Plan Design Change

Members who are prescribed a drug with an OTC equivalent would be responsible for paying out of pocket for the entire cost of the drug, rather than paying only an \$8, \$4, or \$0 copay.

Option B

About 1,300 claimants received and filled a prescription for a brand-name drug that had both a generic and an OTC equivalent in 2018. About 75% of these members (900) received a brand drug over generic or OTC options without an indication of physician or personal preference (the drug claims did not have a dispense-as-written code). About 250 of these claimants, or under 20% of the total, expressed a personal preference for brand over other options, without a physician's indication. This accounted for roughly 60% of the total plan's costs for brand drugs with generic and OTC options.

Due to the copay structure of brand and generic medication outside of mail-order pharmacy drugs (which have \$0 in copays for both brand and generic), this change is anticipated to reduce total copayments from AlaskaCare retirees and their dependents by eliminating the \$8 brand-name copay for this set of medications while also maintaining a set of therapeutically-equivalent options in the form of prescription generic drugs or over-the-counter drugs.

Actuarial impact:

Neutral / Enhancement / Diminishment - Forthcoming

Table 2: Actuarial Impact

Actuarial Impact	
Current	
Proposed	

DRB operational impacts:

Options A & B

To exclude coverage of OTC-equivalent drugs, the Division would need to amend the Defined Benefit Retiree Insurance Information Booklet to reflect the change, coordinate with the pharmacy benefit manager to ensure the change is properly implemented, and communicate the change to retirees and their dependents.

DRAFT-Summary of Responses to Proposed Plan Design Change

Financial impact to the plan:

Option A

The savings impact to the plan may be difficult to estimate under Proposal A. If applied to 2018, the plan may have forgone \$5.8 million in expenditures at the high-end.

However, there are some factors which may impact this savings estimate:

- Physicians may override the exclusion in instances where the prescription-grade drug is medically-preferable.
- The plan receives federal subsidies and manufacturer rebates on certain drugs, and the sum of these subsidies and rebates may decrease with less upfront expenditure.
- Certain prescription drugs with over-the-counter equivalents may be protected under the Medicare formulary, which may restrict the plan's ability to exclude these drugs due to the AlaskaCare enhanced Employer Group Waiver Program – a group Medicare Part D plan.

A full financial analysis is forthcoming

Option B

This change is preliminarily estimated to save the plan \$300,000-\$400,000 a year.

It should be anticipated that patients who do not currently have a physician's medical indication for a brand drug, but currently receive one, will seek to obtain one from their provider.

On net, the average requested brand name with a therapeutic-equivalent in the form of a generic medication or an OTC drug is \$760 per prescription, compared to the \$81 per generic prescription with an OTC equivalent. Transferring 80% of members with a brand prescription and without a physician's indication onto its generic equivalent would increase generic spend by approximately \$50,000 and reduce brand spend by approximately \$463,000, resulting in a \$413,000 overall decrease in plan spend.

If only 60% of those members convert to generic from brand, generic expenditure would increase by approximately \$38,000 and brand expenditure would decrease by approximately \$347,000, resulting in a \$309,000 overall decrease in plan spend.

A full financial analysis is forthcoming.

DRAFT-Summary of Responses to Proposed Plan Design Change

Clinical considerations:

Options A & B

Prescribing providers would be more like to prescribe generic medications and/or steer members towards OTC equivalent medications. While therapeutically equivalent drugs can be expected to have the same effect as their brand-name counterparts, some individuals respond differently to different medications and may require brand-name drugs. These members will be able to seek a medical indication on their prescription from their provider to override these exclusions.

Third Party Administrator (TPA) operational impacts:

Options A & B

The TPA will need to reconfigure their system to reflect the change. The TPA will also need to communicate the change to members and to network pharmacies.

Provider considerations:

Members should ask their physician about whether their prescriptions would be impacted by this change, and if the OTC equivalent is right for their therapeutic needs. Providers will need to learn about the change and be prepared to provide a medical indication on prescriptions when necessary.



aetna®

Agenda

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



Leadership



Louis M. Andersen

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



Medical Directors



Mark Knoll, DC

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



Erick Alvarez, PT

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



Operations



Ann E. Bruns

Vice President, Operations: SecureCare, Inc.

Provider Contracting: Aetna / Coventry Health Care

Marketing & Provider Relations Manager: Midlands Choice Regional PPO

Nebraska Group Services: BCBSNE Independent Broker Services

Education: MCC; HIA



Company Overview

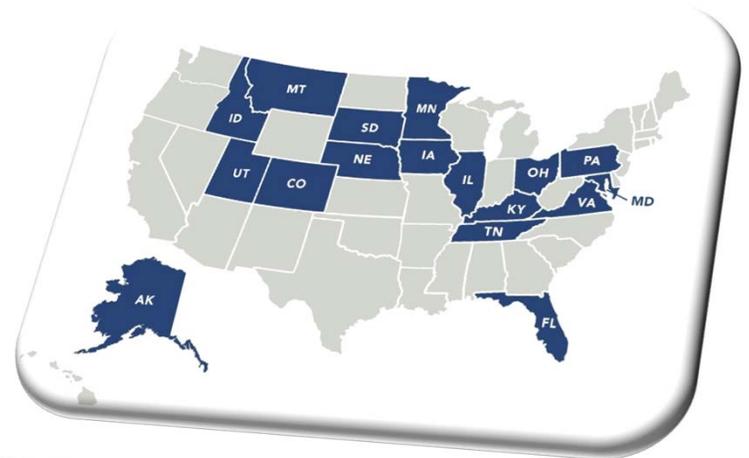
SecureCare, Inc. was founded in 1994 in Omaha, Nebraska.

Our Mission:

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

Operational Footprint:

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



Current Payer Partners

Commercial Health Plans



Government Programs



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



Our Services



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



Why SecureCare?

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

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



Changing Industry Dynamics

We eliminate Prospective Medical Necessity Review. Why?

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

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



Utilization Management (UM) Services

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

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

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

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



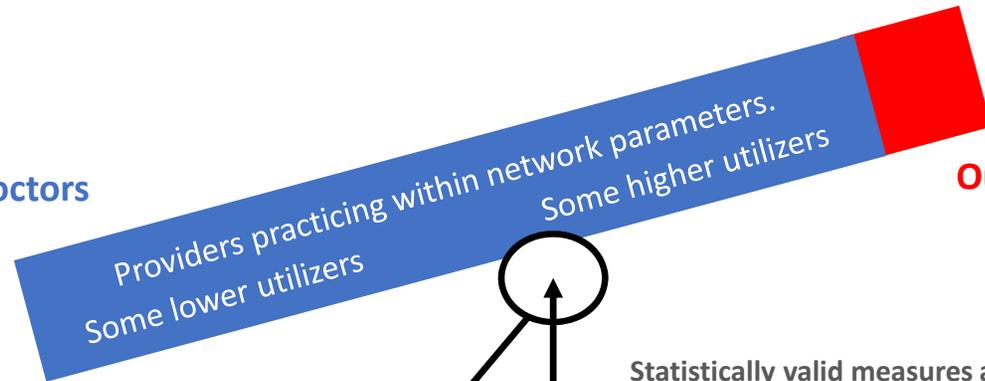
Utilization Management (UM) Services

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



Statistically Valid Network Management

Majority of Doctors



Insurance company macro level
financial measures achieved

- Actuarial – product pricing
- Underwriting
- Finance
- PMPM expectations

Statistically valid measures across a
statistically valid data set

- Macro-level targets
- Not individual provider averages
- “Average patient” – does not exist
- “Average clinic” – does exist



Credentialing

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



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

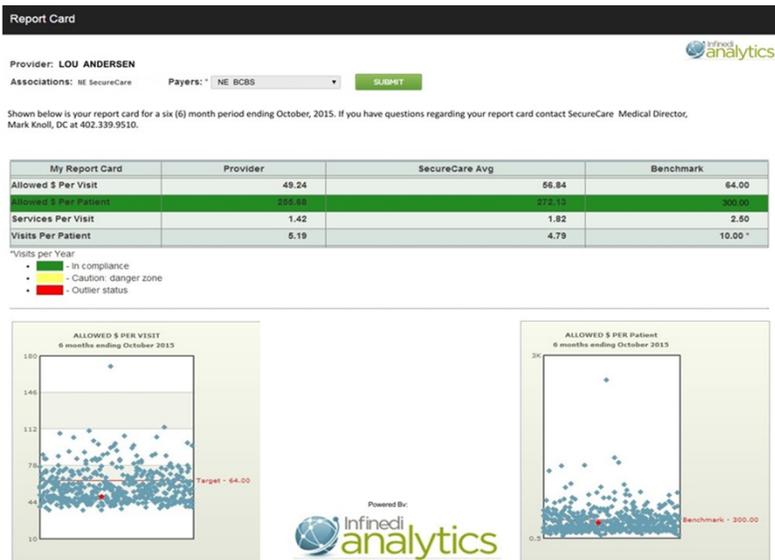
- Credentialing Committee
- Quality Management Committee
- Clinical Review Committee

Credentialing performance metrics include:

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



Information Technology



SecureCare is primarily a paperless company.

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

SecureCare Online Portal

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

Company Communications

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



Choosing the Right Partner

SecureCare

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



Choosing the Right Partner

SecureCare

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



Connectivity

SecureCare makes it easy and flexible for Aetna to connect:

Contracting Options:

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

Credentialing Options:

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



Questions?

