Proposal Title	Expanded Preventive Coverage (R007)
Health Plan Affected	Defined Benefit Retiree Plan
Proposed Effective Date	January 1st, 2022
Reviewed By	Retiree Health Plan Advisory Board
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1) Summary of Current State

The AlaskaCare Defined Benefit Retiree Health Plan (Plan) was first developed in 1975 and provides extensive and valuable benefits for retirees and their dependents necessary for *the diagnosis and treatment* of an injury or disease.[1] The Plan was not established as a preventive or 'wellness' plan. Plan coverage for preventive services that are used to screen individuals prior to symptoms being exhibited is limited to mammograms, Pap smears and Prostate Specific Antigen tests (to detect prostate cancer in males).[2]

One of the most common reoccurring complaints the Division of Retirement and Benefits (Division) receives is related to the retiree Plan's lack of preventive care coverage. This lack of coverage impacts retirees and their dependents differently, depending on whether the member is eligible for Medicare.

Members who are under the age of 65 (U65) are particularly impacted by the lack of preventive coverage. U65 members generally do not qualify for Medicare coverage and the Plan is their primacy insurance coverage. Because the Plan excludes most preventive services, U65 members typically must pay out of pocket for the entire cost of those services.

Members who are over the age of 65 (O65) are generally eligible for Medicare, which becomes their primary coverage. Their AlaskaCare coverage becomes secondary to Medicare. Because Medicare offers many preventive services at little or no cost to the beneficiary,[3] members covered by Medicare have coverage for many of these services.

In conjunction with the effective date of certain requirements in the Patient Protection and Affordable Care Act (ACA), insurance coverage for preventive care following age-specific guidelines indicating the utilization of screening and preventive services for older adults became required coverage in most health plans. Preventive services are intended to increase early detection and treatment of health conditions in order to improve clinical outcomes, arrest disease at an earlier stage when it is easier and more effectively treated, and to promote health-conscious behavior. As a retiree-only plan, the Plan is exempt from the ACA provisions mandating coverage for preventive care.

The lack of Plan coverage for most preventive benefits may result in U65 retirees foregoing recommended age-specific vaccinations, screenings, and other preventive services. It is also a source of significant dissatisfaction for new retirees who are used to having these services covered (typically with no member cost share) by their pre-retirement health care plan(s).

2) Objectives

a) Support members in maintaining their health.
b) Promote high-value care.

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[1] AlaskaCare Retiree Insurance Information Booklet, January 2021, Sec. 3.3.1(d) *Medically Necessary Services and Supplies;* and Sec. 5.1, *Limitations and Exclusions*.
[2] AlaskaCare Retiree Insurance Information Booklet, January 2021, Sec. 3.3.11(a)-(d), *Radiation, X-rays, and Laboratory Tests.*
[3] Details regarding Medicare coverage and cost-sharing for preventive and screening services can be found here: https://www.medicare.gov/coverage/preventive-screening-services.

c) Increase accessibility to patient care for non-emergency health episodes.

3) Summary of Proposed Change

The Division proposes adding the full suite of evidence-based preventive services to the Plan that mirror those provided in most employee plans in accordance with the Affordable Care Act.[4] These preventive services include, but are not limited to:

1. evidence based preventive services with an "A" or "B" rating by the United States Preventive Services Task Force (USPSTF),[5]
2. standard vaccines recommended by the Advisory Committee on Immunization Practices (ACIP),[6]
3. preventive care for children recommended under the *Bright Futures* guidelines, developed by the American Academy of Pediatrics,[7]
4. women-specific preventive care as outlined by the USPSTF, the Health Resources & Services Guidelines (HRSA) and other evidence-based guidelines.[8]

The specific services covered by the Plan will change over time as the recommendations are updated to reflect the most current research and evidence.

In alignment with the Plan booklet, *Section 3.3.1 Medically Necessary Services and Supplies*,[9] and mainstream commercial health insurance practices, the Plan will utilize the current Third-Party Administrator's (TPA) clinical coverage standards for purposes of determining coverage of preventive services under the Plan. Clinical coverage standards regarding preventive care are subject to change and are updated periodically. The current TPA (Aetna) follows the ACA requirements for coverage of preventive care services, though in some cases, at the recommendation of expert groups outside those defined by the ACA, Aetna's coverage may be broader than the ACA requirements. If the Plan transitions to a different TPA in the future, that TPA's ACA-compliant clinical standards will be utilized to determine coverage of preventive services under the Plan. This aligns with coverage offered under the AlaskaCare employee plan.

Aetna describes its clinical coverage standards in clinical policy bulletins (CPBs), which are all available online for public review.[10] Aetna's CPBs are based on objective, creditable sources, such as relevant scientific literature, guidelines, consensus statements, and expert opinions. Aetna's CPBs are reviewed at least once annually, or on an ad hoc basis as needed.

Cost Sharing

Based on consensus from the Retiree Health Plan Advisory Board (RHPAB) Modernization Subcommittee, the following member cost sharing structure for preventive services is proposed. The proposed cost share structure was labeled as "Option B" in earlier iterations of this proposal.

[4] https://www.healthcare.gov/coverage/preventive-care-benefits/
[5] https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/
[6] https://www.cdc.gov/vaccines/hcp/acip-recs/index.html
[7] https://brightfutures.aap.org/Pages/default.aspx
[8] https://www.healthcare.gov/preventive-care-women/
[9] http://doa.alaska.gov/drb/pdf/ghlb/retiree/AlaskaCareDBRetireeBooklet2021.pdf
[10] Aetna's clinical policy bulletins are available online: https://www.aetna.com/health-care-professionals/clinical-policy-bulletins/medical-clinical-policy-bulletins.html#

Table 1. Proposed Cost Sharing Provisions

	Covered Preventive Services	Deductible	Coinsurance	Out-Of-Pocket Maximum
Current	Limited coverage for specific preventive services	$150	80%	$800; applies after the deductible is satisfied
Proposed In Network	Coverage for preventive services in alignment with the ACA and the TPA's CPBs	N/A; deductible doesn't apply	100%	N/A; in-network preventive services covered at 100%
Proposed Out-of-Network	Coverage for preventive services in alignment with the ACA the TPA's CPBs	$150	80%	No out-of-pocket maximum for preventive services

The proposed cost share structure would implement richer cost share provisions for preventive care received from network providers. The AlaskaCare deductible would not apply, and the plan would pay 100% coinsurance for covered services. [11]

For preventive care received from out-of-network providers, members would first have to meet the $150 deductible, and then the plan would pay 80% coinsurance for covered services. Out-of-network preventive services would not be subject to the out-of-pocket maximum; the plan would continue to pay 80% coinsurance for any out-of-network preventive services received.

If there are no network provider options in a member's area, the member may contact Aetna and request precertification of use of an out-of-network provider for preventive services. If this precertification is approved, the in-network cost sharing provisions (subject to recognized charge)[12] would apply and the plan would pay 100% of the cost for the preventive services (subject to recognized charge). If the out-of-network provider's charge for the service is more than the recognized charge, the provider may bill the member for the "balance," or amount above the recognized charge. If a provider issues a balance bill to the member, the member is responsible for paying that amount to the provider. Amounts above recognized charge are excluded as outlined under the AlaskaCare Retiree Insurance Information Booklet Section 5.1 *Limitations and Exclusions*.

This cost share structure is similar to most commercial plan standards including the AlaskaCare employee plan.

[11] In-network providers have agreed to a set of discounted negotiated rates for services provided. In-network providers have agreed not to bill members for any amount over these agreed-upon rates.

[12] For out-of-network providers, the recognized charge for medical services and supplies are the lesser of a) what the provider bills or submits for that service or supply; or b) 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. See Retiree Insurance Information Booklet, section *3.1.4 Recognized Charge*. http://doa.alaska.gov/drb/pdf/ghlb/retiree/AlaskaCareDBRetireeBooklet2021.pdf

Coordination with Medicare

The Plan would continue to coordinate with Medicare in accordance with the 2021 AlaskaCare Retiree Insurance Information Booklet, *Section 3.1.7, Effect of Medicare*.[13] In accordance with state statute, when a member reaches age 65, their AlaskaCare retiree plan benefits become supplemental to Medicare.

Coverage Provisions

Table 2 highlights key preventive services and compares current Plan coverage, ACA-specified coverage, Medicare coverage, and Aetna's policies regarding those services. The ACA-specified column represents current guidelines from the USPSTF, ACIP, and other relevant sources which are subject to change as those guidelines are updated. The Aetna Policy column is reflective of coverage for "preventive" care. Depending on a member's specific condition, some services may be considered medically necessary under other circumstances or at different frequencies if provided under diagnostic circumstances or as treatment. Please note that some of the services included in Table 2 may be currently covered by the Plan if they are performed to aid in a diagnosis, rather than performed as a screening.

Table 2. Key Preventive Services Coverage Comparison

Service	Current Plan Coverage	ACA-Specified Guidelines[14]	Medicare Coverage[15]	Aetna Policy[16,17]
Mammograms	One baseline between age 35-40. One every two years between age 40-50. Annually at age 50 and above and for those with a personal or family history of breast cancer.	HRSA: Annual screening for average-risk women 40 and older.[18]	One baseline between age 35-39. Screening mammograms once every 12 months age 40 or older. Diagnostic mammograms more frequently than once a year, if medically necessary.	Screening for women 40 years of age and older, once annually.[19] *Annual mammography is also considered medically necessary for younger women who are judged to be high risk and meet certain criteria (may be considered diagnostic, not preventive).*

[13] http://doa.alaska.gov/drb/pdf/ghlb/retiree/AlaskaCareDBRetireeBooklet2021.pdf
[14] These represent ACA-specified guidelines from the USPSTF, ACIP, and other relevant sources and are subject to change as those guidelines are updated.
[15] Unless otherwise noted, Medicare coverage in this table aligns with coverage descriptions provided at www.Medicare.gov, accessed May 4, 2021.
[16] Aetna's clinical policy bulletins outline medical necessity for all care, regardless of whether or not it is considered preventive. For services to be considered preventive, they must be billed with preventive-specific codes.
[17] Unless otherwise noted, Aetna standard policy for Preventive care aligns with coverage descriptions provided at https://www.aetna.com/health-guide/preventive-care-by-age.html, accessed July 12, 2021. Coverage descriptions assume appropriate diagnosis and procedure codes are submitted on the claim(s).
[18] Health Resources & Services Administration. Women's Preventive Services Initiative. https://www.hrsa.gov/womens-guidelines-2019
[19] Aetna Clinical Policy Bulletin 0584, https://www.aetna.com/cpb/medical/data/500_599/0584.html

Service	Current Plan Coverage	ACA-Specified Guidelines[14]	Medicare Coverage[15]	Aetna Policy[16,17]
Pap Smear	One per year for women 18 years of age and older. Also includes limited office visit to collect the pap smear.	HRSA/USPSTF Grade A: One every 3 years for women aged 21 to 65 for cervical cytology alone.[20] One every 5 years for women aged 30 to 65 for HPV testing alone, or when cervical cytology is combined with HPV testing.[21]	One every 24 months. One every 12 months for those at high risk. HPV testing once every five years for women aged 30 to 65 without HPV symptoms.	For women 21 years of age and older, once annually. HPV screening for women 30 years of age or older, once annually.[22]
Prostate specific antigen (PSA)	One annual screening test for men between ages 35 and 50 with a personal or family history of prostate cancer. One annual screening test for men 50 years and older.	USPSTF Grade C: Men ages 55 to 69, are encouraged to make an individual decision about prostate-specific antigen (PSA)-based cancer screening with their clinician. USPSTF Grade D: Routine PSA screening for men age 70 and older is not recommended.[23]	Digital rectal exams and prostate specific antigen (PSA) blood tests once every 12 months for men over 50 (starting the day after your 50th birthday).	For men 40 years of age and older, once annually. Prostate cancer screening via digital rectal exam is considered preventive for males 40 years of age and older, once annually. [24]

[20] Health Resources & Services Administration. Women's Preventive Services Initiative. https://www.hrsa.gov/womens-guidelines-2019
[21] USPSTF, Cervical Cancer: Screening. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/cervical-cancer-screening
[22] Aetna Clinical Policy Bulletin 0443, https://www.aetna.com/cpb/medical/data/400_499/0443.html
[23] https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/prostate-cancer-screening1
[24] Aetna Clinical Policy Bulletin 0521, https://www.aetna.com/cpb/medical/data/500_599/0521.html.

Service	Current Plan Coverage	ACA-Specified Guidelines[14]	Medicare Coverage[15]	Aetna Policy[16,17]
Vaccines	Limited coverage for all members for vaccines covered by Medicare Part D through the pharmacy plan. Common vaccines include shingles, diphtheria, tetanus, measles-mumps-rubella (MMR), polio, hepatitis, and HPV.	Coverage for those recommended by ACIP. Recommended vaccine schedules are released for children 0-18 years and for adults age 19 and older.[25] Common vaccines include hepatitis A & B, HPV, flu, measles-mumps-rubella (MMR), meningitis, pneumonia, tetanus, diphtheria, pertussis, polio, chickenpox, rabies.	Flu, pneumonia, hepatitis B for persons at increased risk of hepatitis, COVID-19, vaccines directly related to the treatment of an injury or direct exposure to a disease or condition, such as rabies and tetanus.[26]	Coverage for those recommended by ACIP. Recommended vaccine schedules are released for children 0-18 years and for adults age 19 and older. Common vaccines include hepatitis A & B, HPV, flu, measles-mumps-rubella (MMR), meningitis, pneumonia, tetanus, diphtheria, pertussis, polio, chickenpox, rabies.
Annual Wellness Visit	Not Covered	Covered in conjunction with preventive services.[27]	"Welcome to Medicare" visit covered once within first 12 months of Medicare Part B coverage. Yearly wellness visits once every 12 months.	Covered once annually for adults over 18.

[25] See attachment E: https://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf and attachment F: https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf

[26] How to pay for Vaccines: Medicare https://www.cdc.gov/vaccines/adults/pay-for-vaccines.html

[27] Preventive Care Benefits for Adults. HealthCare.gov. https://www.healthcare.gov/preventive-care-adults/

Service	Current Plan Coverage	ACA-Specified Guidelines[14]	Medicare Coverage[15]	Aetna Policy[16,17]
Well Woman Preventive Visits	Not Covered (exception of limited exam to collect the pap smear)	Covered as outlined by the USPSTF and other evidence-based guidelines. [28] Commonly covered services include vaccinations, screening tests, and education & health counseling.[29]	Screening Pap tests, pelvic exams, and HPV screening once every 24 months. More frequently for those at high risk.[30]	Well Woman visits covered once annually.
Well Child Preventive Visits	Not Covered	Covered as outlined by the USPSTF and other evidence-based guidelines.[31] Commonly covered services include developmental screenings, physical examinations, behavioral assessments, blood screenings, hearing screenings, immunization vaccines.	Children under the age of 20 may only be eligible for Medicare in very limited circumstances. However, "Welcome to Medicare" visits are covered once within first 12 months of Medicare Part B coverage. Yearly wellness visits once every 12 months.	Children ages 0-12 months, seven preventive exams annually. Children ages 1-3 years, three preventive exams annually. Children 3 years of age and older, one preventive exam annually.

[28] Preventive Care Benefits for Women. HealthCare.gov. https://www.healthcare.gov/preventive-care-women/
[29] Get Your Well-Woman Visit Every Year. U.S. Department of Health and Human Services. https://health.gov/myhealthfinder/topics/everyday-healthy-living/sexual-health/get-your-well-woman-visit-every-year
[30] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Screening-papPelvic-Examinations.pdf
[31] https://www.healthcare.gov/preventive-care-children/

Service	Current Plan Coverage	ACA-Specified Guidelines[14]	Medicare Coverage[15]	Aetna Policy[16,17]
Colorectal Cancer Screening	Not Covered	USPSTF Grade A: Colorectal cancer screening recommended for all adults age 50-75. Frequency varies by type of screening. USPSTF Grade B: Colorectal cancer screening recommended for all adults age 45-49. Frequency varies by type of screening. USPSTF Grade C: Clinicians should selectively offer colorectal cancer screening for adults age 76-85, as appropriate based on an individual's specific circumstances.[32]	Screening colonoscopies covered once every 24 months if at high risk; or once every 120 months, or 48 months after a previous flexible sigmoidoscopy.	Covered for adults 45 years of age and older. Frequency depends on colorectal cancer screening type.[33] • Annual immunohistochemical or guaiac-based FOBT; or • Colonoscopy (every 10 years for persons at average risk); or • CT Colonography (virtual colonoscopy) (every 5 years); or • Double contrast barium enema (DCBE) (every 5 years for persons at average risk); or • Sigmoidoscopy (every 5 years for persons at average risk) • Sigmoidoscopy (every five years) with annual immunohistochemical or guaiac-based fecal occult blood testing (FOBT); or • Stool DNA (FIT-DNA, Cologuard) (every 3 years).

[32] USPSTPF, Colorectal Cancer: Screening: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/colorectal-cancer-screening

[33] Aetna Clinical Policy Bulletin 0516, https://www.aetna.com/cpb/medical/data/500_599/0516.html

Service	Current Plan Coverage	ACA-Specified Guidelines[14]	Medicare Coverage[15]	Aetna Policy[16,17]
Lung Cancer Screening	Not Covered	USPSTF Grade B: Annual screening recommended in adults aged 50 to 80 who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years.	Covered once annually for asymptomatic adults age 55-77 who have a 30 pack-year smoking history and are current smokers or have quit within the last 15 years.	For current or former smokers ages 50 to 80 with a 20 pack-year smoking history (if a former smoker, has quit within the past 15 years), once annually.[34]

**Table 2 highlights coverage provisions for key services. This table is not a complete and exhaustive list of ACA preventive service coverage mandates, or preventive service coverage provisions. Please refer to relevant guidelines for complete and exhaustive coverage provisions.*

Screening vs. Diagnostic Services

Services are considered preventive care when the person receiving care:

a) does not have any symptoms, or tests or studies indicating an abnormality at the time the service is provided;
b) has had a screening done in accordance with the relevant clinical guidelines and the results were considered normal;
c) has had a diagnostic service with normal results, after which the physician recommends future preventive care screenings using the appropriate normal age and gender recommendations contained in the relevant clinical guidelines; or
d) has a preventive service done that results in a diagnostic service being done at the same time, because it is an integral part of the preventive service (*e.g.*, polyp removal during a preventive colonoscopy).

If a health condition is diagnosed during a preventive care exam or screening, the provider may use a specific billing code to indicate that the exam or screening was preventive, and though it resulted in a diagnosis it should still qualify as preventive care and the claim will be paid according to the relevant preventive care cost-share provisions.

Services are considered diagnostic care (not preventive care) when:

a) abnormal results on a previous preventive or diagnostic screening test requires further diagnostic testing or services;
b) abnormal test results found on a previous preventive or diagnostic service requires the same test be repeated sooner than the appropriate normal age and gender recommendations contained in the relevant clinical guidelines;
c) services are ordered due to current symptom(s) that require further diagnosis.

[34] Aetna Clinical Policy Bulletin 0380, http://www.aetna.com/cpb/medical/data/300_399/0380.html

Example:

Colorectal cancer screenings may be covered as preventive or diagnostic depending on individual circumstances reflected in the information provided with the claim. A colorectal cancer screening provided to an asymptomatic person who meets guidelines for screening will typically be considered a preventive service. A follow-up to an abnormal screening, or a screening administered because a member is having symptoms (e.g., rectal bleeding, unintentional weight loss, or anemia) will typically be considered diagnostic. Both preventive and diagnostic screenings can produce "baseline" results. The term "baseline" typically refers to initial results, rather than follow-up action.[35]

Colorectal cancer screenings include different types of tests (e.g., stool-based tests such as stool DNA tests, or direct visualization tests such as colonoscopies). There is no hard evidence to support any one of the colon cancer screening methodologies over another when screening individuals of average risk.

If preventive coverage is added, Aetna will process colorectal cancer screening claims according to how the claim is billed and coded. For example:

1. **What happens if a polyp is found?** Preventive screenings that identify a condition or abnormality (e.g., a colonoscopy that finds a polyp) are still billed as preventive screenings. Typically, providers will add a procedure code modifier to the claim to indicate that the preventive service became diagnostic based on their findings. For instance, modifier 'PT' identifies a colorectal cancer screening test that converted to a diagnostic test or other procedure. If modifier PT is present on the claim, then the associated codes are considered (and billed as) preventive screenings, even though a diagnosis resulted from the test.
2. **What happens if the claim is submitted with a non-preventive diagnosis code?** The claim would be considered as a diagnostic service and would be subject to normal deductible, coinsurance, and out-of-pocket maximums. If the service was truly preventive (*e.g.*, the member received a colonoscopy and had never had a previous preventive colonoscopy), members can contact the Aetna concierge to request the claim be reprocessed as preventive.
3. **What if a person has a family history of colorectal cancer?** This would typically be reflected in the diagnosis code submitted with the claim. When this occurs, associated claims are typically considered diagnostic services, not preventive. However, if no previous preventive claims were paid, the claim in question may be eligible for coverage as a preventive service.
4. **What about follow-up colorectal cancer screenings?** Any additional tests would be considered based on the diagnosis code that is billed. If the diagnosis code indicates the service is diagnostic, the claim will be subject to normal deductible, coinsurance, and out-of-pocket maximums.

Actuarial Impact | Increase 0.50%
Financial Impact | Annual Cost Increase $3.35m
Member Impact | Enhancement
Operational Impact (DRB)| Neutral
Operational Impact (TPA) | Minimal

[35] Baseline results could refer to either well or ill results.

4) Analysis

Screening tests look for a disease before a person exhibits symptoms, while preventive care services are meant to prevent diseases or conditions from developing or progressing. Adding coverage for preventive care services and screenings to the AlaskaCare defined benefit retiree health plan is anticipated to increase the use of preventive services and to support members in maintaining their health.

Screenings and preventive services can help prevent or detect diseases early, when the disease is easier to treat. For example, colorectal cancer nearly always develops from abnormal, precancerous growths. Screening tests can identify these growths before they become cancerous or before they progress to later stages of the disease, and they can be removed before they progress. Approximately 90% of new cases of colorectal cancer occur in people over the age of 50, making colorectal cancer screenings an important and valuable benefit for a retiree population.[36]

The United States Department of Health and Human Services (DHHS) outlines increasing the use of various preventive care services as key objectives in their Healthy People 2030 framework.[37] These objectives include increasing the proportion of the population who receive preventive services and who are screened for cancer including lung, breast, cervical and colon cancer. A 2009 joint report by the Centers for Disease Control and Prevention, the AARP, and the American Medical Association specifically highlights the importance of preventive care for individuals age 50 to 64 years of age and the difference in screenings provided to individuals who have insurance coverage versus those who do not have insurance coverage.[38]

Currently, data regarding retiree member's use of preventive visits outside of those currently covered by the plan (e.g. mammograms or PSA testing) is limited as retirees may be receiving these services and paying for them out of pocket. O65 members are likely receiving more preventive visits due to Medicare's coverage, but those visits are typically not captured in AlaskaCare's claims data. However, when comparing the prevalence of preventive visits based on the AlaskaCare active employee plan and the AlaskaCare retiree plan claims data there are striking differences between the plans. Figures 1 and 2 reflect prevalence of preventive visits for males and females between the AlaskaCare retiree and active employee plans as reflected in AlaskaCare claims data from May of 2019 through April of 2021.

[36] Colorectal (Colon) Cancer. US Centers for Disease Control and Prevention. https://www.cdc.gov/cancer/colorectal/basic_info/screening/index.htm
[37] Healthy People 2030. US DHSS. https://health.gov/healthypeople/objectives-and-data/browse-objectives/preventive-care
[38] Promoting Preventive Services for Adults 50-64: Community and Clinical Partnerships. CDC, AARP, AMA, https://www.cdc.gov/aging/pdf/promoting-preventive-services.pdf

Figure 1. AlaskaCare Retiree Plan (U65 and O65) Preventive Visit Claims

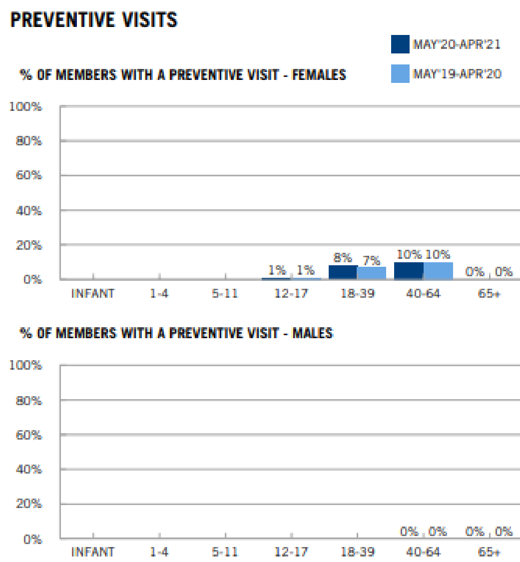
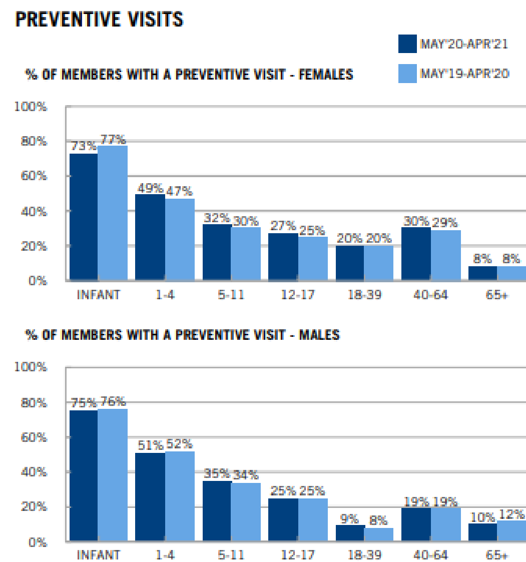


Figure 2. AlaskaCare Active Employee Plan Preventive Visit Claims



Expanding preventive care coverage to the AlaskaCare retiree plan is anticipated to increase member's use of these important services, support early detection of disease, and prevent disease progression.

5) Impacts

Actuarial Impact | Increase 0.50%

Expanding the scope of covered preventive services to align with the benefit coverage mandated by the ACA would increase the actuarial value of the plan by 0.50%. See Table 3 for details.

Table 3. Actuarial Impact

	Actuarial Impact
Current	N/A
Proposed Expanded Preventive Care Coverage In-Network: -100% coinsurance; -deductible does not apply; -out-of-pocket limit N/A Out-of-Network: -80% coinsurance; -deductible applies; -out-of-pocket limit N/A	0.50% increase[39]

Financial Impact | Annual Cost Increase ~$3.35m

Potential Future Claims Impact

Coverage for preventive screenings does not necessarily result in plan savings as articulated by the Robert Woods Johnson Foundation in their 2009 study.[40] They found high-risk groups often stay away from

[39] *Preventive Care Benefits – Focus on Actuarial and Financial Impact for the Retiree Plan* (Updated)*,* Segal Consulting memo dated April 19, 2021.

[40] Goodell, S., Cohen, J., & Neumann, P. (2009, Sep 1). Cost Savings and Cost-Effectiveness of Clinical Preventive Care. Retrieved from https://www.rwjf.org/en/library/research/2009/09/cost-savings-and-cost-effectiveness-of-clinical-preventive-care.html.

screenings,[41] and health-conscious members may use the screenings in excess. The result is higher procedure volume and total costs without the net savings associated with early detection or treatment.

> "It is unlikely that substantial cost savings can be achieved by increasing the level of investment in clinical preventive care measures. On the other hand, research suggests that many preventive measures deliver substantial health benefits given their costs.
>
> Moreover, while the achievement of cost savings is beneficial, it is important to keep in mind that the goal of prevention, like that of other health initiatives, is to improve health. Even those interventions that cost more than they save can still be desirable. Because health care resources are finite, however, it is useful to identify those interventions that deliver the greatest health benefits relative to their incremental costs."[42]

Annual Cost Impact

Based on Segal Consulting's preliminary retiree claims projection of $633,000,000 for 2021 and trended forward at 6% for 2022, the annual anticipated fiscal impact of this change is estimated to be approximately $3,350,000 in additional costs.[43]

Medicare covers many preventive and screening services at 100%. For Medicare-eligible members, no change in utilization is assumed and the impact on the Plan is anticipated to be negligible. The analysis considers the financial impacts associated with the approximately 21,000 members under the age of 65 and not yet eligible for Medicare.

Projected Long-Term Financial Impacts

The annual cost increase associated with the proposed benefit additions may have long-term impacts to the healthcare Actuarial Accrued Liability (AAL)[44] and to the Additional State Contributions (ASC)[45] associated with the Plan. These impacts are somewhat tempered because the additional costs are primarily associated with the U65 retiree population, and because the total number of potential future participants is finite.

In an illustrative example, if the proposed changes had been reflected in the June 30, 2020 valuations, the AAL would have increased by approximately $28.6 million, and the ASC for Fiscal Year (FY) 2023 would have increased by approximately $400,000. [46]

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[41] Benson WF and Aldrich N, CDC Focuses on Need for Older Adults to Receive Clinical Preventive Services, Critical Issue Brief, Centers for Disease Control and Prevention, 2012, http://www.chronicdisease.org/nacdd-initiatives/healthy-aging/meeting-records.
[42] Ibid.
[43] Ibid.
[44] AAL: The excess of the present value of a pension fund's total liability for future benefits and fund expenses over the present value of future normal costs for those benefits.
[45] Employer contributions to retirement payments were capped in FY08. Since then, the state makes additional assistance contributions to help cover the accrued unfunded liability associated with participating employers.
[46] *Impact of Potential Change in Preventive Care Benefits for AlaskaCare Retiree Health Plan,* Buck Consulting, May 7, 2021.

The ASC provides payment assistance to participating employers' Actuarially Determined Contribution (ADC). The ADC is determined by adding the "Normal Cost"[47] to the amount needed to offset the amortization of any existing unfunded accrued liability over a period of 25 years.

The illustrative increase to the FY23 ASC is associated with the Normal Cost only. The current overfunded status[48] of the retiree health care liabilities has eliminated the immediate need for amortization payments to offset any health care unfunded liability. It is important to note the that long-term funded status of the trusts is subject to change in response to market volatility and many other factors.

If the retiree health care liabilities were not overfunded, in accordance with the Alaska Retirement Management Board's (ARMB) current funding policy, the total illustrative increase in the FY23 ASC would be approximately $2.3 million.[49]

Member Impact | Enhancement

Neutral / Enhancement / Diminishment

Studies suggest that increasing coverage for preventive care may increase the use of preventive services by members. As noted above, most members over the age of 65 receive coverage for preventive services through Medicare, but many of those members have dependents covered by the plan who are not yet Medicare-eligible. This proposed change will be an added benefit for all members, providing access to preventive care previously excluded under the retiree health plan which members may be currently paying for in full.

As an example, colorectal cancer screenings can be some of the more expensive preventive services. The USPSTF guidelines recommend colorectal cancer screenings for adults starting at age 45. The AlaskaCare retiree plan has approximately 18,000 members between the ages of 45-64 who would benefit from expanded coverage for colorectal cancer screenings. Colorectal cancer screenings are a covered benefit under Medicare for which most retirees aged 65 and above are eligible.

The Division regularly receives feedback from members about the lack of preventive coverage in the plan, and the addition of these services is something the Division believes members will find both valuable and beneficial.

Operational Impact (DRB) | Neutral

To implement this change, the Division will need to make updates to the AlaskaCare Retiree Insurance Information Booklet. These booklet changes will be provided to the public to review and to comment on prior to the 2022 plan year. Sample plan language outlining coverage for preventive services is attached.

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[47] The normal cost represents the present value of benefits earned by active employees during the current year. The employer normal cost equals the total normal cost of the plan reduced by employee contributions.

[48] Due in part to the savings realized as a result of the 2019 implementation of the enhanced Employer Group Waiver Program (EGWP) group Medicare Part D prescription drug program, the retiree health care liabilities are currently overfunded. The Division's 2020 draft Actuarial Valuation Reports for the Public Employees' Retirement System (PERS) and the Teachers' Retirement System (TRS) indicate that the PERS actuarial funded ratio is 113.5% and the TRS actuarial funded ratio is 121.4%.

[49] *Impact of Potential Change in Preventive Care Benefits for AlaskaCare Retiree Health Plan,* Buck Consulting, May 7, 2021.

**Note: this language is not the final proposed language for inclusion in the AlaskaCare retiree health plan; it is meant to only serve as an example. **

The Division anticipates the expansion of preventive benefits in the retiree health plan will reduce calls, complaints and appeals to the Division related to lack of preventive coverage.

The retiree health plan is an antiquated plan design and is unusual in its lack of coverage for most preventive services. For this reason, there is a substantial communication and education need for the Division to notice members regarding the lack of preventive services. That need would no longer exist if the benefits were expanded.

Operational Impact (TPA) | Minimal

Using the TPA's CPBs to determine what services are covered, the impact to the TPA is minimal. The TPA would need to update and test the coding in their claims adjudication system to ensure that the claims are processed correctly. This is often an "yes/no" indicator switch in a TPA's claims adjudication system. The change would simplify the administration of the AlaskaCare retiree health plan, which currently requires customization to provide the limited preventive services covered by the plan today.

Similarly, it is industry standard to have a separate network/out-of-network coinsurance for preventive services and therefore will not require any customization. The TPA's customer service staff will need to be trained to address requests from retiree members who do not have access to a network provider in their area. However, similar network access provisions currently exist in the AlaskaCare employee plan, so the staff are already familiar with the process.

Last, offering the full suite of preventive services allows greater flexibility in disease management and broader communication options when there is not a concern about recommending a service not covered under the health plan.

6) Considerations

Clinical Considerations

It is largely agreed that the recommended preventive services can help detect disease, delay their onset, or identify them early on when the disease is most easy to manage or treat. Adding these services could have a positive clinical impact.

An example is colorectal cancer screenings. Excluding skin cancers, colorectal cancer is the third most common cancer diagnosed in both men and women. Screening can prevent colorectal cancer by finding and removing precancerous polyps before they develop into cancer. The cost of treatment is often lowest, and the survivor rates are better, when the tumor is found in the earlier stages.

Provider Considerations

The Division expects that expanding preventive coverage will have a positive impact on providers. They may gain customers in members who previously would have forgone the non-covered services, and they should see ease in administration in that they will not need to bill the member directly for the non-covered services.

The coinsurance differential may incentivize some doctors to join the network, as many members may look for a network provider to maximize their health plan benefits.

7) Proposal Recommendations

Summary

Add the full suite of evidence-based preventive services in alignment with the Affordable Care Act and the AlaskaCare TPA's clinical coverage standards; implement the following cost sharing provisions:

In-Network	Out-of-Network
Deductible does not apply. 100% coinsurance.	$150 deductible applies. 80% coinsurance. Not subject to the individual out-of-pocket maximum. *If use of out-of-network provider is pre-certified, in-network cost sharing provisions apply.*

DRB Recommendation

The Division of Retirement and Benefits recommends implementation of this proposal, effective January 1, 2022.

RHPAB Board Recommendation

Insert the RHPAB recommendation here when final along with any appropriate comments.

Description	Date
Proposal Drafted	07/20/2018
Reviewed by Modernization Subcommittee	08/10/2018, 09/28/2018, 10/30/2018, 04/23/2019, 06/12/2019, 06/18/2021, 07/28/2021
Reviewed by RHPAB	08/29/2018, 11/28/2018, 02/06/2019, 05/08/2019, 08/07/2019, 05/13/2021, 08/05/2021, 09/09/2021

Documents attached include:

Attachment	Document Name
A	*Preventive Care Benefits – Focus on Actuarial and Financial Impact for the Retiree Plan (Updated),* Segal Consulting memo dated April 19, 2021
B	*Impact of Potential Change in Preventive Care Benefits for AlaskaCare Retiree Health Plan,* Buck Consulting, May 7, 2021.
C	Sample Preventive Care Plan Language: Aetna Fully Insured Preventive Service Booklet Language 2021
D	A and B Recommendations | United States Preventive Services Taskforce | 2021
E	Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, 2021

F	Recommended Adult Immunization Schedule for Ages 19 Years or Older, 2021
G	Aetna Presentation, *Preventive Care*, June 18, 2021