

**Retiree Health Plan Advisory Board  
Modernization Subcommittee Meeting Agenda**

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**Date:** Friday June 18, 2021  
**Time:** 09:00 am – 12:00 pm  
**Location:** Video Tele-Conference  
**Teleconference:** [Join meeting](#)  
Audio Only: (650) 479-3207 Access Code:177 296 0282# Password:  
8286 5483#  
**Committee Members:** Cammy Taylor, Judy Salo, Joelle Hall, G. Nanette Thompson

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[OnlinePublicNotices](#)

- 09:00 am Call to Order – Cammy Taylor, Modernization Subcommittee Chair**
- Roll Call and Introductions
  - Approval of Agenda
  - Ethics Disclosure
- 09:10 am Working Session on Preventive Care**
- Aetna Presentation: Preventive Care
- 10:30 am Break**
- 10:40 am Working Session on Pharmacy Prior Authorizations**
- OptumRx Presentation: Retiree Plan Specialty Prior Authorization
- 11:50 am Public Comment**
- 12:00 pm Adjourn**

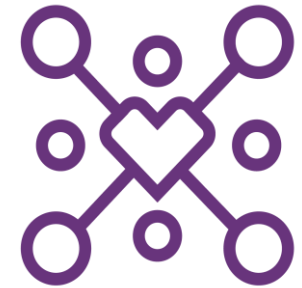
# Preventive Care

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# Overview

We will discuss the following issues:

- Developing clinical policies
- Affordable Care Act defined Preventive Care
- Evaluating & implementing changes to recommended Preventive Care services
- Review Aetna's Preventive Care Services



# Developing Clinical Policy Bulletins (CPBs)

- Designated teams of individuals review emerging evidence and recommendations
- Emerging evidence and recommendations are reviewed against established criteria
- Policies are reviewed at least once annually or on an ad hoc basis with emerging evidence and recommendations



# ACA defined Preventive Care

- Non-grandfathered plans are required to cover a set of preventive services at no cost to covered members.
- Services required based on recommendations from:
  - United States Preventive Services Task Force (USPSTF) services with an A or B grade
  - Standard vaccines recommended by Advisory Committee on Immunization Practices
  - Preventive care recommended for children by the Bright Futures guidelines

Source: <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/preventive-care-background>

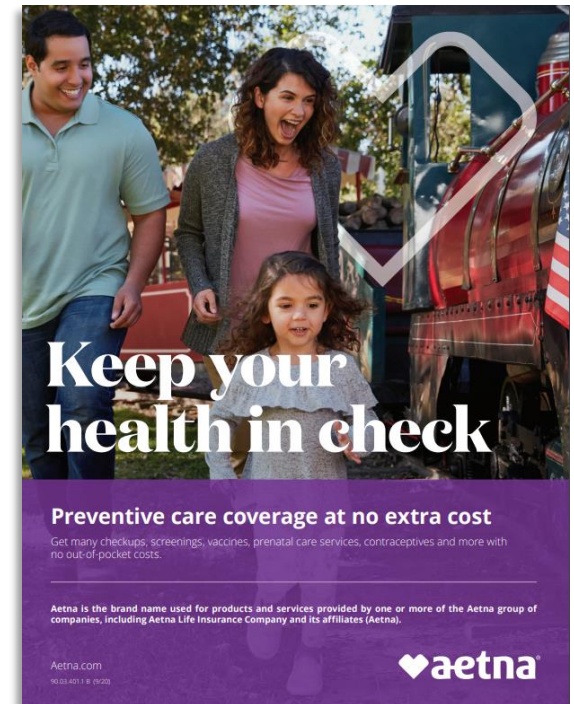
# USPSTF Grades

Grade	Definition	Suggestions for Practice
<b>A</b>	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer or provide this service.
<b>B</b>	The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.	Offer or provide this service.
<b>C</b>	The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small.	Offer or provide this service for selected patients depending on individual circumstances.
<b>D</b>	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
<b>I Statement</b>	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.	Read the clinical considerations section of USPSTF Recommendation Statement. If the service is offered, patients should understand the uncertainty about the balance of benefits and harms.

Source: <https://www.uspreventiveservicestaskforce.org/uspstf/about-uspstf/methods-and-processes/grade-definitions>

# Aetna Preventive Care

- In general, Aetna follows ACA requirements to define a set of Preventive Care services that are covered at no cost to members of a non-grandfathered plan
- In some cases, Aetna may include a broader set of services or service definitions under its Preventive Care benefit at the recommendation of expert groups outside of those defined by the Affordable Care Act
- All of the services under Aetna's Preventive Care benefit are defined here: [LINK](#)



# Evaluating new requirements

- As new USPSTF A&B rated services are, the clinical policy team convenes to review.
- Standard clinical review process convenes with input from Aetna's Legal & Compliance Departments.
- Decisions/changes approved by Aetna's Chief Medical Officer or designee.
- Members of the Clinical Policy Unit work with persons from coding and reimbursement areas (Medical Policy and Operations) regarding implementation of clinical polices in Aetna systems
- Additionally all policies on drugs and biologics covered under medical are also evaluated in the National Pharmacy and Therapeutics (P&T) process, so those treatments are evaluated by two separate groups and harmonized.



# Aetna policy: breast cancer screening

<p><b>USPSTF Grade(s)</b>  <b>*Update in Progress*</b></p>	<p><b>Mammogram</b>            C Grade – Women 40-49 years            B Grade – Women 50-74 Years every other year            I Grade – Women 75+</p> <p><b>Digital Breast Tomosynthesis/MRI/Ultrasonography, other</b>            I Grade – Women all ages &amp; Women with dense breasts</p>
<p><b>USPSTF Link</b></p>	<p><a href="#">LINK</a></p>
<p><b>Aetna Preventive</b></p>	<p>Women 40+            One per year</p>
<p><b>Aetna Medical</b></p>	<p>Medical necessity outlined in CPB.</p>
<p><b>Aetna CPB Link</b></p>	<p><a href="#">LINK</a></p>
<p><b>CPB Last &amp; Next Review</b></p>	<p>11/20/20, 06/24/21</p>
<p><b>Difference</b></p>	<p>Aetna covers annual mammogram as a preventive benefit for women aged 40+ regardless of indication.</p>

# Aetna policy: cervical cancer screening

<b>USPSTF Grade(s)</b>	<b>A Grade - Cervical Cytology</b> Women 21-65 Years every 3 years Women 30-65 Years every 5 years with high-risk HPV testing  <b>A Grade - High-risk human papillomavirus testing (hrHPV)</b> Women 30-65 Years every 5 years
<b>USPSTF Link</b>	<a href="#">LINK</a>
<b>Aetna Preventive</b>	<b>Cervical Cytology</b> Women 21+ once a year  <b>HPV</b> Women 30+ once a year
<b>Aetna Medical</b>	Medical necessity outlined in CPB.
<b>Aetna CPB Link</b>	<a href="#">LINK</a>
<b>CPB Last Review</b>	10/19/20
<b>CPB Next Review</b>	05/31/21
<b>Difference</b>	Aetna allows more frequent testing than officially recommended

# Aetna policy: prostate cancer screening

<b>USPSTF Grade(s)</b>	<b>Prostate-Specific Antigen (PSA)</b> C Grade – Men 55-69 Years D Grade – Men 70+ Years
<b>USPSTF Link</b>	<a href="#">LINK</a>
<b>Aetna Preventive</b>	<b>Prostate Specific Antigen (PSA)</b> Men 40+ once annually
<b>Aetna Medical</b>	Medical necessity outlined in CPB.
<b>Aetna CPB Link</b>	<a href="#">LINK</a>
<b>CPB Last Review</b>	11/25/20
<b>CPB Next Review</b>	06/10/21
<b>Difference</b>	Aetna covers as preventive under certain conditions whereas it is not a USPSTF Grade A or B service

# Aetna policy: colorectal cancer screening

<b>USPSTF Grade(s)</b>	B Grade – Adults aged 45-49 A Grade – Adults aged 50-70  Frequency depends on colorectal cancer screening type
<b>USPSTF Link</b>	<a href="#">LINK</a>
<b>Aetna Preventive</b>	Any Adult 45+  Frequency depends on colorectal cancer screening type
<b>Aetna Medical</b>	Medical Necessity outlined in CPB
<b>Aetna CPB Link</b>	<a href="#">LINK</a>
<b>CPB Last Review</b>	6/8/20
<b>CPB Next Review</b>	6/10/21
<b>Difference</b>	None

# Questions & Discussion



Proposal Title	Expanded Preventive Coverage (R007)
Health Plan Affected	Defined Benefit Retiree Plan
Proposed Effective Date	January 1 <sup>st</sup> , 2022
Reviewed By	Retiree Health Plan Advisory Board
Review Date	June 18, 2021

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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. 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).

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 more impacted by the lack of preventive coverage. U65 members generally do not qualify for Medicare coverage and have AlaskaCare as their primary 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 less impacted by the lack of preventive coverage. O65 members 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<sup>1</sup>, adding preventive coverage to the AlaskaCare retiree plan is less impactful to those eligible for Medicare benefits.

Around 2014, 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.

## 2) Objectives

- a) Support members in maintaining their health.
- b) Promote high-value care.
- c) Increase accessibility to patient care for non-emergency health episodes.

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<sup>1</sup> Details regarding Medicare coverage and cost-sharing for preventive and screening services can be found here: <https://www.medicare.gov/coverage/preventive-screening-services>.

### 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.<sup>2</sup> These preventive services include:

1. evidence based preventive services with an “A” or “B” rating by the United States Preventive Services Task Force (USPSTF),<sup>3</sup>
2. standard vaccines recommended by the Advisory Committee on Immunization Practices (ACIP),<sup>4</sup>
3. preventive care for children recommended under the *Bright Futures* guidelines, developed by the American Academy of Pediatrics,<sup>5</sup>
4. women-specific preventive care as outlined by the USPSTF and other evidence-based guidelines.<sup>6</sup>

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

#### Cost Sharing Options

The Division proposes two different member cost sharing options for preventive services, as outlined below in Table 1.

**Option A** would apply the current retiree plan cost share provisions to preventive care received from network providers. Members would first have to meet the \$150 deductible, and then the plan would pay 80% coinsurance for covered services, until the member meets their \$800 out-of-pocket maximum. At that point, the plan would pay 100% of covered services<sup>7</sup>.

For preventive care received from out-of-network providers, members would first have to meet the \$150 deductible, and then the plan would pay 60% 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 60% coinsurance.

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<sup>8</sup>) would apply. In this instance, any cost sharing amount paid by the member under the terms of the plan (e.g. deductible or coinsurance) would apply to the member’s out-of-pocket maximum. However, if the out-of-network provider’s charge for the service is more than the recognized charge, the provider may bill the member

<sup>2</sup> <https://www.healthcare.gov/coverage/preventive-care-benefits/>

<sup>3</sup> <https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/>

<sup>4</sup> <https://www.cdc.gov/vaccines/hcp/acip-recs/index.html>

<sup>5</sup> <https://brightfutures.aap.org/Pages/default.aspx>

<sup>6</sup> <https://www.healthcare.gov/preventive-care-women/>

<sup>7</sup> 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.

<sup>8</sup> 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 90<sup>th</sup> percentile of the prevailing charge rate for the geographic area where the service is furnished as determined by Aetna in accordance with Aetna reimbursement policies. See Retiree Insurance Information Booklet, section 3.1.4 Recognized Charge.

<http://doa.alaska.gov/drb/pdf/ghlb/retiree/AlaskaCareDBRetireeBooklet2021.pdf>



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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 Limitation and Exclusions.

**Option B** would implement richer cost share provisions for preventive care received from network providers. The deductible would not apply, and the plan would pay 100% coinsurance for covered services.

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.

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) would apply. In this instance, any cost sharing amount paid by the member under the terms of the plan (e.g. deductible or coinsurance) would apply to the member’s out-of-pocket maximum. However, 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 Section 5.1 Limitation and Exclusions.

Option B is more similar to most commercial plan standards including the AlaskaCare employee plan.

*Table 1. Proposed Cost Sharing Provisions*

	Covered Preventive Services	Deductible	Coinsurance	Out-Of-Pocket Maximum
<b>Current</b>	Limited coverage for specific preventive services	\$150	80%	\$800; applies after the deductible is satisfied
<b>Option A In Network</b>	Coverage for preventive services in alignment with the ACA	\$150	80%	\$800; applies after the deductible is satisfied
<b>Option A Out-of-Network</b>	Coverage for preventive services in alignment with the ACA	\$150	60%	No out-of-pocket maximum for preventive services
<b>Option B In Network</b>	Coverage for preventive services in alignment with the ACA	N/A; deductible doesn’t apply	100%	N/A; in-network preventive services covered at 100%
<b>Option B Out-of-Network</b>	Coverage for preventive services in alignment with the ACA	\$150	80%	No out-of-pocket maximum for preventive services

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## Coordination with Medicare

Under both Option A and Option B, 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.<sup>9</sup> In accordance with state statute, when a member reaches age 65, their AlaskaCare retiree plan benefits become supplemental to Medicare.

## Coverage Provisions

Table 2 provides an overview of current ACA-compliant coverage provisions. These represent the current guidelines from the USPSTF, ACIP, and other relevant sources, and are subject to change as those guidelines are updated. 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. Comparison of Current to Proposed Change: Service Coverage

Benefit	Current	Proposed <sup>10</sup>	Medicare Coverage <sup>11</sup>
<b>Mammograms</b>	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.	Screening every 1 to 2 years for women over 40. Earlier or additional screenings for those at high risk. <sup>12,13</sup>	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.
<b>Pap Smear</b>	One per year for women 18 years of age and older. Also includes limited office visit to collect the pap smear.	One every 3 years for women aged 21 to 65. One every 5 years for women aged 30 to 65 when combined with HPV testing for women who do not want a Pap smear every 3 years.	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.

<sup>9</sup> <http://doa.alaska.gov/dr/p/ghlb/retiree/AlaskaCareDBRetireeBooklet2021.pdf>

<sup>10</sup> These represent the current guidelines from the USPSTF, ACIP, and other relevant sources and are subject to change as those guidelines are updated.

<sup>11</sup> Unless otherwise noted, Medicare coverage in this table aligns with coverage descriptions provided at [www.Medicare.gov](http://www.Medicare.gov), accessed May 4, 2021.

<sup>12</sup> Frequency of covered mammograms is dependent on the patient's individual medical condition and history. See Aetna Clinical Policy Bulletin 0584 for medical necessity information as of 3/11/2021: [https://www.aetna.com/cpb/medical/data/500\\_599/0584.html](https://www.aetna.com/cpb/medical/data/500_599/0584.html)

<sup>13</sup> As of May 4, 2021, an update for this topic is in progress by the USPSTF.

Benefit	Current	Proposed <sup>10</sup>	Medicare Coverage <sup>11</sup>
<p><b>Prostate specific antigen (PSA)</b></p>	<p>One annual screening test for men between ages 35 and 50 with a personal or family history of prostate cancer.</p> <p>One annual screening test for men 50 years and older.</p>	<p>The USPSTF gave a “C” grade to PSA screening for men ages 55 to 69, encouraging them to make an individual decision about prostate cancer screening with their clinician. The USPSTF provided a “D” grade recommendation against routine PSA screening for men age 70 and older.<sup>14</sup></p> <p>However, Aetna considers PSA screening a medically necessary preventive service for men age 45 and older who are at average risk, and for men age 40 and older who are at high risk.<sup>15</sup></p>	<p>One annual screening every 12 months for men over 50.</p>
<p><b>Vaccines</b></p>	<p>Limited coverage for all members for vaccines covered by Medicare Part D through the pharmacy plan.</p> <p>Common vaccines include shingles, diphtheria, tetanus, measles-mumps-rubella (MMR), polio, hepatitis, and HPV.</p>	<p>Coverage for those recommended by ACIP. Recommended vaccine schedules are released for children 0-18 years and for adults age 19 and older.<sup>16</sup></p> <p>Common vaccines include hepatitis A &amp; B, HPV, flu, measles-mumps-rubella (MMR), meningitis, pneumonia, tetanus, diphtheria, pertussis, polio, chickenpox, rabies.</p>	<p>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.<sup>17</sup></p>

<sup>14</sup> <https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/prostate-cancer-screening1>

<sup>15</sup> Aetna Clinical Policy Bulletin 0521, [https://www.aetna.com/cpb/medical/data/500\\_599/0521.html](https://www.aetna.com/cpb/medical/data/500_599/0521.html).

<sup>16</sup> 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>

<sup>17</sup> How to pay for Vaccines: Medicare <https://www.cdc.gov/vaccines/adults/pay-for-vaccines.html>

Benefit	Current	Proposed <sup>10</sup>	Medicare Coverage <sup>11</sup>
Annual Routine Physical	Not Covered	Covered.	“Welcome to Medicare” visit covered once within first 12 months of Medicare Part B coverage. Yearly wellness visits once every 12 months.
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. Commonly covered services include cervical cancer screenings (Pap smear every 3 years for women age 21-65, HPV screening), well-woman visits to get recommended services for women under 65.	Screening Pap tests, pelvic exams, and HPV screening once every 24 months. More frequently for those at high risk. <sup>18</sup>
Well Child Preventive Visits	Not Covered	Covered as outlined by the USPSTF and other evidence-based guidelines. <sup>19</sup> 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.

<sup>18</sup> <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Screening-papPelvic-Examinations.pdf>

<sup>19</sup> <https://www.healthcare.gov/preventive-care-children/>

Benefit	Current	Proposed <sup>10</sup>	Medicare Coverage <sup>11</sup>
<p><b>Routine Cancer Screening</b></p>	<p>Not Covered (except Mammograms, PSA and Pap Smear as outlined above)</p>	<p>Subject to any age, family history and frequency guidelines that are evidence-based items or services that have in effect a rating of A or B<sup>20</sup> in the recommendation so the United States Preventive Services Task Force and Evidence informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration.<sup>21</sup></p> <p>Includes breast cancer, cervical cancer, colorectal cancer, lung cancer, prostate cancer, and skin cancer screenings.</p>	<p>Subject to specific age, family history and frequency guidelines.</p> <p>Includes breast cancer, cervical cancer, colorectal cancer, lung cancer, prostate cancer, and skin cancer screenings.</p>

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 preventive exam or screening still qualifies for preventive care coverage, and for the relevant preventive care cost-share provisions.

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

<sup>20</sup> <https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/>

<sup>21</sup> <https://www.hrsa.gov/womens-guidelines/index.html>

- 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.

Actuarial Impact | Increase 0.45% - 0.50%  
Financial Impact | Annual Cost Increase \$3m - \$3.35m  
Member Impact | Enhancement  
Operational Impact (DRB) | Neutral  
Operational Impact (TPA) | Moderate

#### 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 ward off 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.<sup>22</sup>

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.<sup>23</sup> 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.<sup>24</sup>

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

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<sup>22</sup> Colorectal (Colon) Cancer. US Centers for Disease Control and Prevention. [https://www.cdc.gov/cancer/colorectal/basic\\_info/screening/index.htm](https://www.cdc.gov/cancer/colorectal/basic_info/screening/index.htm)

<sup>23</sup> Healthy People 2030. US DHSS. <https://health.gov/healthypeople/objectives-and-data/browse-objectives/preventive-care>

<sup>24</sup> Promoting Preventive Services for Adults 50-64: Community and Clinical Partnerships. CDC, AARP, AMA, <https://www.cdc.gov/aging/pdf/promoting-preventive-services.pdf>

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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 as reflected in AlaskaCare claims data from February of 2019 and January of 2021.

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

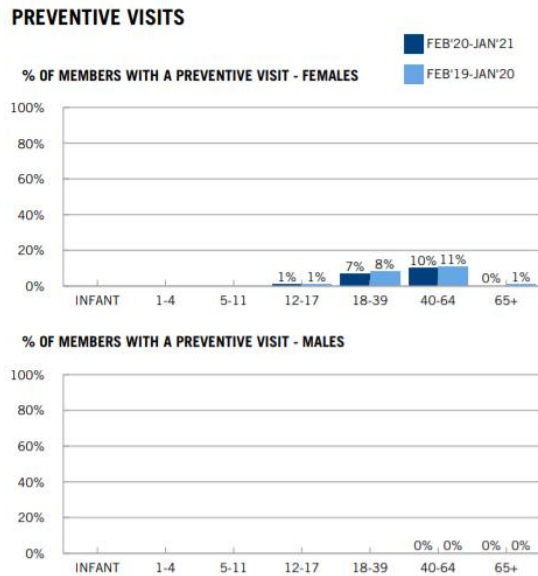
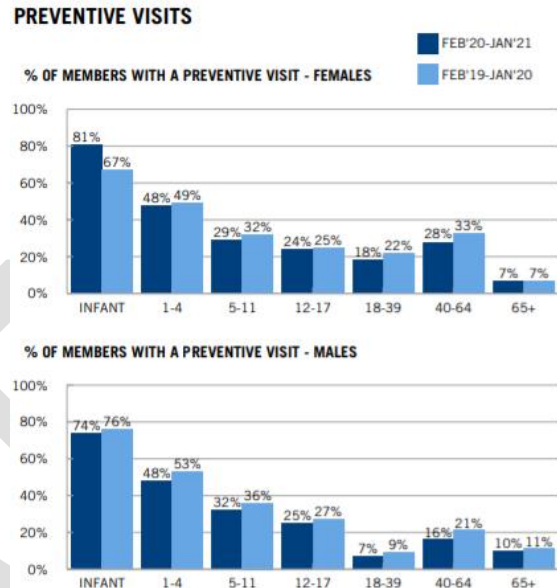


Figure 2. AlaskaCare Active Employee Plan  
Preventive Visit Claims



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 0.45% - 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 0.45% - 0.50%, depending on the member cost share structure elected. See Table 3 for details.

Table 3. Actuarial Impact

	Actuarial Impact
<b>Current</b>	N/A
<b>Expanded Preventive Care Coverage: Option A</b> <u>In-Network:</u> <ul style="list-style-type: none"> <li>• \$150 deductible applies</li> <li>• 80% coinsurance</li> <li>• out-of-pocket limit applies</li> </ul> <u>Out-of-Network:</u> <ul style="list-style-type: none"> <li>• 60% coinsurance</li> <li>• deductible applies</li> <li>• out-of-pocket limit does not apply</li> </ul>	0.45% increase <sup>25</sup>
<b>Expanded Preventive Care Coverage: Option B</b> <u>In-Network:</u> <ul style="list-style-type: none"> <li>• 100% coinsurance</li> <li>• deductible does not apply</li> <li>• out-of-pocket limit not applicable</li> </ul> <u>Out-of-Network:</u> <ul style="list-style-type: none"> <li>• 80% coinsurance</li> <li>• deductible applies</li> <li>• out-of-pocket limit does not apply</li> </ul>	0.50% increase <sup>26</sup>

**Financial Impact | Annual Cost Increase \$3m - \$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.<sup>27</sup> They found high-risk groups often stay away from screenings,<sup>28</sup> 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

<sup>25</sup> *Preventive Care Benefits – Focus on Actuarial and Financial Impact for the Retiree Plan* (Updated), Segal Consulting memo dated April 19, 2021.

<sup>26</sup> Ibid.

<sup>27</sup> 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>.

<sup>28</sup> 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>.



## DRAFT

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.”<sup>29</sup>

### Annual Cost Impact

Based on a 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 changes is estimated to be approximately \$3,000,000 (for Option A) and \$3,350,000 (for Option B) in additional costs depending on the cost share structure elected.<sup>30</sup>

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 details 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 will have long-term impacts to the healthcare Actuarial Accrued Liability (AAL)<sup>31</sup> and to the Additional State Contributions (ASC)<sup>32</sup> associated with the Plan. These impacts are somewhat tempered because the additional costs are primarily associated with the U65 retiree population, and also because the defined benefit retirement system is a closed system, meaning it is closed to brand new entrants and 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 \$25.6 million (for Option A) or \$28.6 million (for Option B), and the ASC for Fiscal Year (FY) 2023 would have increased by approximately \$400,000, regardless of which cost share option was implemented.<sup>33, 34</sup>

The ASC provides payment assistance to participating employers’ Actuarially Determined Contribution (ADC). The ADC is determined by adding the “Normal Cost”<sup>35</sup> to the amount needed to offset the amortization of any existing unfunded accrued liability over a period of 25 years.

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<sup>29</sup> Ibid.

<sup>30</sup> Ibid.

<sup>31</sup> 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.

<sup>32</sup> 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.

<sup>33</sup> Each cost share option produced a different estimated illustrative increase to the FY23 ASC, however when those estimates are rounded, the impact of both options is \$400K.

<sup>34</sup> *Impact of Potential Change in Preventive Care Benefits for AlaskaCare Retiree Health Plan*, Buck Consulting, May 7, 2021.

<sup>35</sup> 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.

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The illustrative increase to the FY23 ASC is associated with the Normal Cost only. The current overfunded status<sup>36</sup> of the retiree health care liabilities has eliminated the immediate need for amortization payments to offset any unfunded liability. It is important to note that the 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 increases in the FY23 ASC would be approximately \$2.0 million (for Option A) or \$2.3 million (for Option B).<sup>37</sup>

### 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.

As an example, one of the more expensive preventive services is a screening colonoscopy. The USPSTF guidelines recommend screening colonoscopies once every 10 years for non-high-risk adults starting at age 50. The AlaskaCare retiree plan has approximately 17,000 members between the ages of 50-64 who would benefit from expanded coverage for screening colonoscopies. Colonoscopies 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. \*\*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

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<sup>36</sup> 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%.

<sup>37</sup> *Impact of Potential Change in Preventive Care Benefits for AlaskaCare Retiree Health Plan*, Buck Consulting, May 7, 2021.

## DRAFT

Division to notice members regarding the lack of preventive services. That need would no longer exist if the benefits were expanded.

### Operational Impact (TPA) | Moderate

Using the industry standard set by the Affordable Care Act 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 a “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.

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 colonoscopies. 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) Implementation Options

### Implementation Options:

**Option A:** Add the full suite of evidence-based preventive services in alignment with the Affordable Care Act, implement the following cost sharing provisions:

<u>Option A</u> In-Network	<u>Option A</u> Out-of-Network
\$150 deductible applies. 80% coinsurance up to \$800 annual out-of-pocket maximum. 100% coinsurance after annual out-of-pocket reached.	\$150 deductible applies. 60% coinsurance. Not subject to the individual out-of-pocket maximum.  <i>If use of out-of-network provider is pre-certified, in-network cost share and out-of-pocket maximums apply.</i>

**Option B:** Add the full suite of evidence-based preventive services in alignment with the Affordable Care Act, implement the following cost sharing provisions:

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

## 8) Proposal Recommendations

### DRB Recommendation

Insert the Division recommendation here when final.

### 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, <a href="#">06/18/2021</a>
Reviewed by RHPAB	08/29/2018, 11/28/2018, 02/06/2019, 05/08/2019, 08/07/2019, 05/13/2021

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**Documents attached include:**

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

DRAFT

# Retiree Plan Specialty Prior Authorization Opportunity



# Addressing rising costs and improving outcomes

## RISING PRESCRIPTION COSTS



**Up to \$600B**  
projected drug spend in the  
U.S by 2023<sup>1</sup>

**AFFORDABILITY**

## ADVERSE DRUG EVENTS



Risk of an adverse drug event  
increases by  
**7-10%**  
with each additional medication<sup>2</sup>

**SAFETY**

## SPECIALTY DRUG INCREASE



**More than 2x**  
specialty medication growth  
rate vs. other drugs<sup>3</sup>

**ACCESS**

# Specialty medications dominate spend

## COST

8% year over year growth **\$505B** in spend by 2023<sup>1</sup>

>10% increase in utilization in past four years<sup>1</sup>

~\$52K/year per medication<sup>2</sup>

## COMPLEXITY

### Specialty patients

Take ~10 different medications over the course of a year<sup>3</sup>

Manage ~7 conditions at a time<sup>3</sup>



# Retiree Plan Specialty Drug Costs Per Rx

Specialty medications for chronic conditions

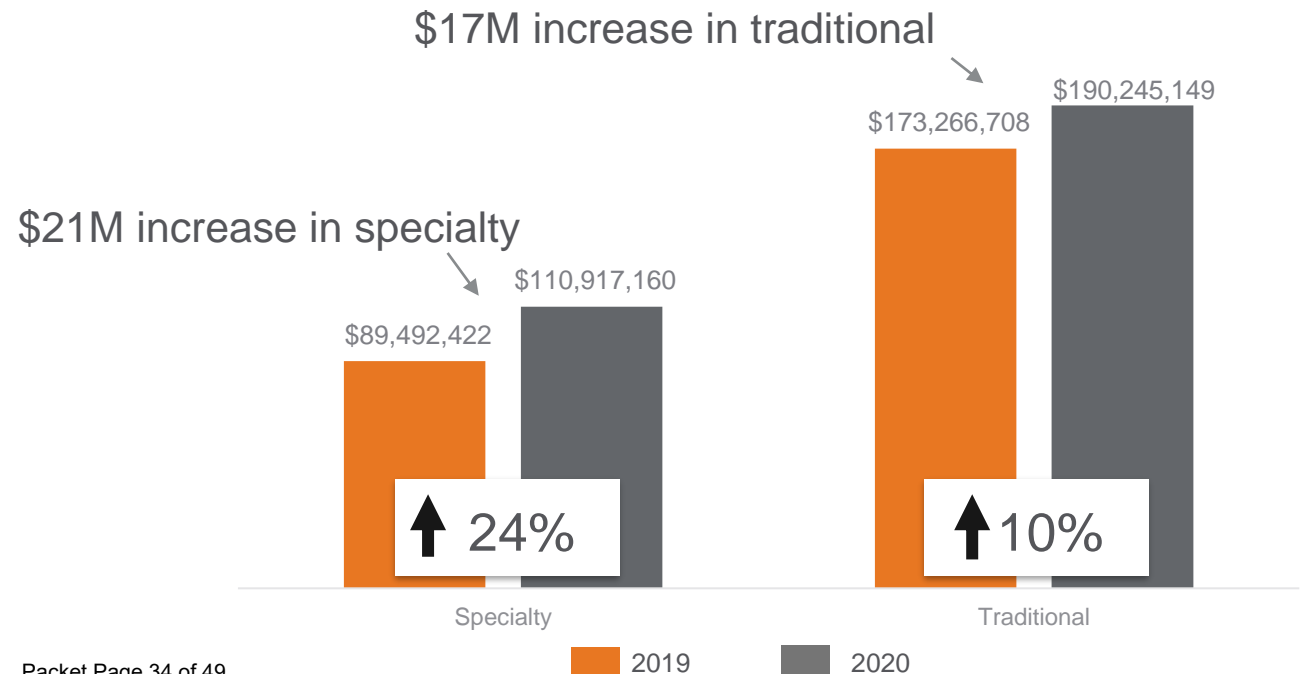
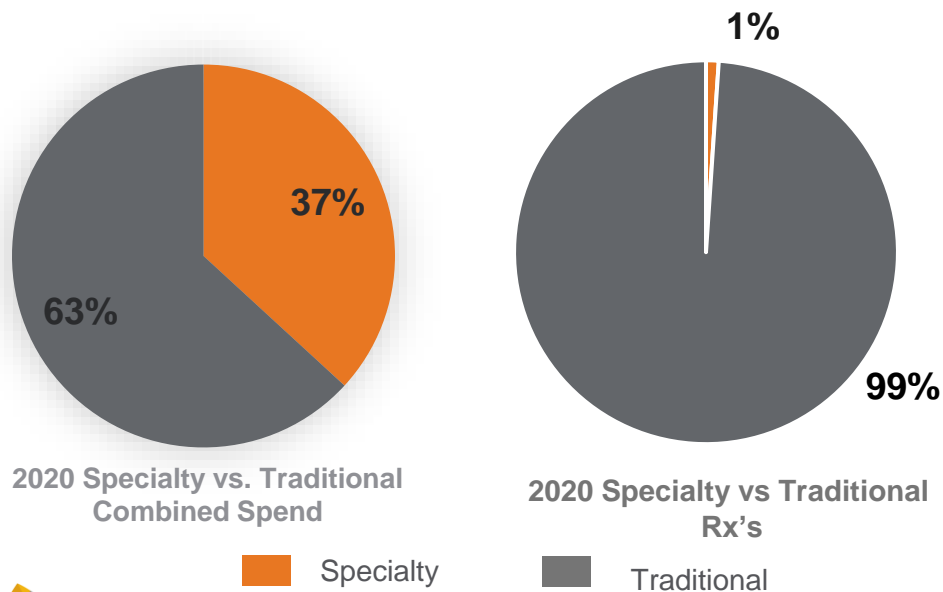
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Specialty Drug	Average Cost Per 30 Day Supply <u>Per Utilizer</u>	Average Cost Annually <u>Per Utilizer</u>	Total Number of Utilizers in 2020
Humira Pen	\$9,570	\$114,841	166
Xeljanz XR	\$9,476	\$113,715	74
Enbrel Sureclick	\$10,017	\$120,213	59
Jakafi	\$13,369	\$160,439	16
Revlimid	\$16,061	\$192,743	60

# Retiree Specialty Medication Increases

2019 to 2020

- Specialty medication represented 37% of combined retiree total pharmacy spend, or **\$110 M in 2020**
- This was an increase from **\$89M, or 34.1%, in 2019**. This was driven by an increase in specialty Rx's and more costly specialty medications.
- Specialty Rx's represent 1% of the total Rx's.



# What is prior authorization?

A pre-approval process guided by rigorous clinical standards similar to AlaskaCare medical review process for intensive, high-cost medical procedures.



## THE RIGHT DRUG AT THE RIGHT TIME

Your physician provides specific information to OptumRx clinicians to review and compare to evidence-based criteria and clinical standards for the drug



## SAFETY

The process promotes safe and effective use of high-cost medications  
Better health outcomes along with prudent plan management preserves health trust funds



## RETIREE EXPERIENCE

Prior Authorization decisions are communicated to you and your physician  
OptumRx Specialty prior authorization approval rate is 72-77%

# How does OptumRx develop prior authorization?

OptumRx National Pharmacy & Therapeutics Committee

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

## Multi Specialty



- Internal Medicine
- Epidemiology
- Cardiovascular
- Geriatrics
- Pediatrics
- Endocrinology
- Rheumatology
- Pain Medicine
- Hematology/Oncology

## Nationally Represented



- Northeast
- Southeast
- Midwest
- West
- Southwest

## Responsibilities



- Appraisal of new and existing drugs and drug classes
- Utilization management (prior authorization) program review
- Oversight of clinical programs

## Determinations



- Unique therapeutic benefit
- Comparable safety and efficacy
- Risk of harm outweighs the benefit

# Retiree Plan – Specialty Prior Authorization Savings Opportunity

Estimated annual savings (based on Jan 2020 – Dec 2020 data)

- A total of 60,677 retirees utilized the prescription drug plan in 2020. **2,272 retirees, 3.7% of all utilizers, utilized a specialty medication**
- Specialty Rx's totaled 10,923, less than 1%, of the overall 1,380,472 prescriptions
- In 2020 **specialty costs increased \$21M, or 24%**

	Total Annual Estimated Savings	Estimated Annual PMPM Savings
Over 65 Retiree	\$8,996,142	\$17.85
Under 65 Retiree	\$4,015,741	\$12.87
<b>Combined Retiree</b>	<b>\$ 13,011,883</b>	<b>\$ 15.95</b>

# Retiree Plan

## A look at the top 5 specialty classes prior authorization opportunity

	Anti-Inflammatory Biologic Agents	Multiple Sclerosis	Pulmonary Hypertension	Pulmonary Fibrosis	Oncology – Oral Agents
Commonly Used Medications (full drug listing in appendix)	Stelara,, Humira, Taltz, Cosentyx, Xeljanz, Cimzia, Enbrel, Otezla	Tecfidera, Ocrevus, Gilenya, Aubagio, Copaxone, Avonex	Uptravi, Adempas, Orenitram, Letairis, Opsumit	Ofev, Esbriet	Revlimid, Jakafi, Zejula, Calquence, Alecensa, Ninlaro, Idhifa
Utilizers	787	169	83	40	561
Actual Plan Paid	\$35,548,336	\$8,863,490	\$4,135,856	\$2,996,883	\$36,967,233
Average Cost Per Rx in Class	\$8,745	\$10,862	\$9,070	\$11,395	\$12,510
Estimated Plan Reduction	\$3,520,828	\$688,392	\$574,123	\$519,530	\$3,876,799

# Prior Authorization Savings

## What's considered in the savings calculation?

- Some prior authorization requests are not approved because use of the medication is not appropriate and does not meet evidence-based criteria. Actiq prescribed for migraines demonstrates a medication that may not be approved based on criteria. Commonly used drugs and approval rates\*:
  - Humira PA approval rate 86%
  - Revlimid PA approval rate 94%
  - Tecfidera PA approval rate 85%
  - Stelara PA approval rate 65%
- Some prior authorization requests result in the physician writing a prescription for an alternative drug. The difference between the cost of the original medication and the alternative is considered savings.
- Some prior authorization requests are abandoned by the physician or patient. The cost of the drug associated with the abandoned prior authorization is considered savings.

## Example: Actiq®



**COVERED**  
for cancer pain

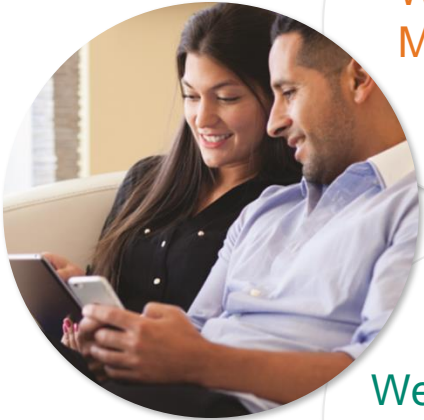
FDA-approved for treating cancer-related pain in members already taking opioid medication around-the-clock



**NOT COVERED**  
for migraines

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

# Enhance the member and provider experience with sophisticated digital tools



We support  
Members by:

- Giving them **control** to **initiate or check the status** of a PA request through our **website** and **mobile app**
- Offering **MyScript Finder** to look up **details, costs** and **formulary-driven lower-cost alternatives**
- **Providing clinical rationale** and next steps if they experience a denial

We support  
Physicians by:

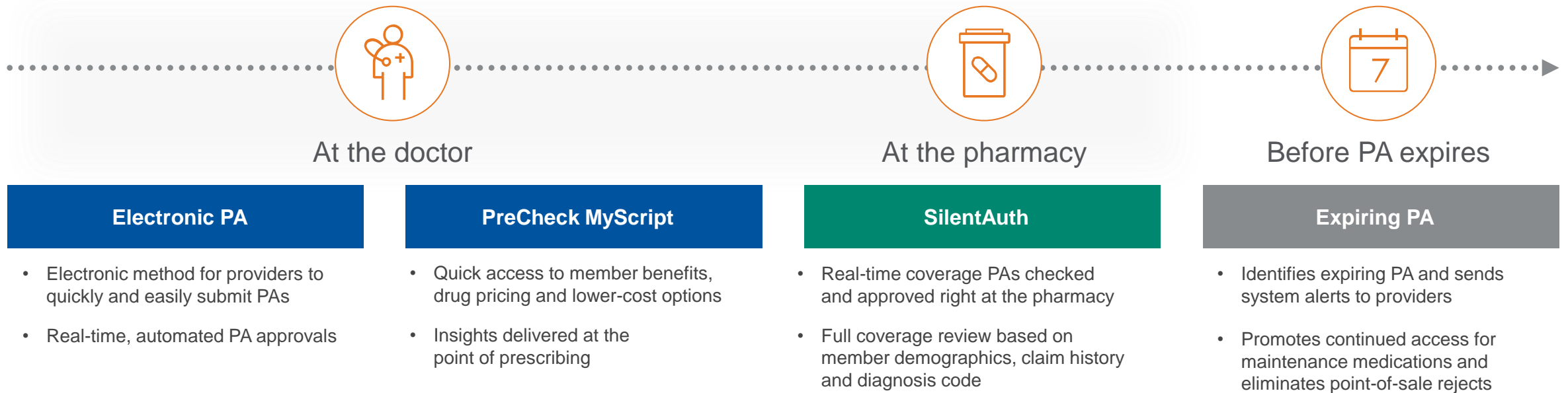
- The use of our **provider portal** allows providers to **check PA status**
- Offering the **PreCheck MyScript®** tool to **initiate authorizations** and give **formulary-driven alternatives** in **real-time**. In 2020, 12,597 physicians treating AlaskaCare retirees utilized **PreCheck MyScript®** .



# Prescriber experience and tools

Faster prescribing, better communication, continued access

Prior authorization (PA) capabilities work together to improve the provider and member experience



# Member experience

Prior authorization review is needed to ensure appropriate and effective medication use for the member's specific condition

Member receives notification letter 60 days in advance advising their medication will be subject to prior authorization



Member discusses the medication subject to prior authorization with their prescriber



Prescriber initiates prior authorization with OptumRx in one of three methods: electronic, phone or mail submission



Coverage is approved\* and member can fill at their preferred pharmacy



## Coverage Determinations

OptumRx will provide notice of the coverage decision within 24 hours after receiving an expedited request or 72 hours after receiving a standard request. The initial notice may be provided verbally so long as a written follow-up notice is mailed to the enrollee within 3 calendar days of the verbal notification.

## Expiring Prior Authorizations

OptumRx identifies approved prior authorizations for prescriptions expiring within 30 days and initiates outreach to prescriber to extend prior authorization proactively, taking the member out the middle.

Clinical criteria is not met for coverage approval and member and prescriber are notified in writing with decision rationale and next steps for reconsideration

Provider writes new prescription for alternative medication or proceeds with next steps for reconsideration through OptumRx

\*Approvals are valid for 3-36 months depending on medication



# Retiree Journey: Barbara's story

## Prior authorization promotes safe and effective medication use



Barbara, age 61 diagnosed with multiple sclerosis



Electronic Prior Authorization (ePA) saves time and avoids unnecessary delays.



Barbara can check real-time status through our website and mobile app.

1

Barbara is prescribed **Gilenya** by her physician and the pharmacy receives her electronic prescription.

2

The pharmacy processes the prescription and **receives a utilization management message indicating "prior authorization (PA) required."**

3

The pharmacy notifies Barbara's physician that a PA is required and the **physician submits an ePA to OptumRx.**

4

The PA request **meets clinical criteria and is auto-approved** with no additional information required.

5

**Barbara's physician is notified of the PA approval.**

The **pharmacy re-submits the claim to OptumRx and the claim is approved.**

Barbara receives PA approval notification via letter from OptumRx.

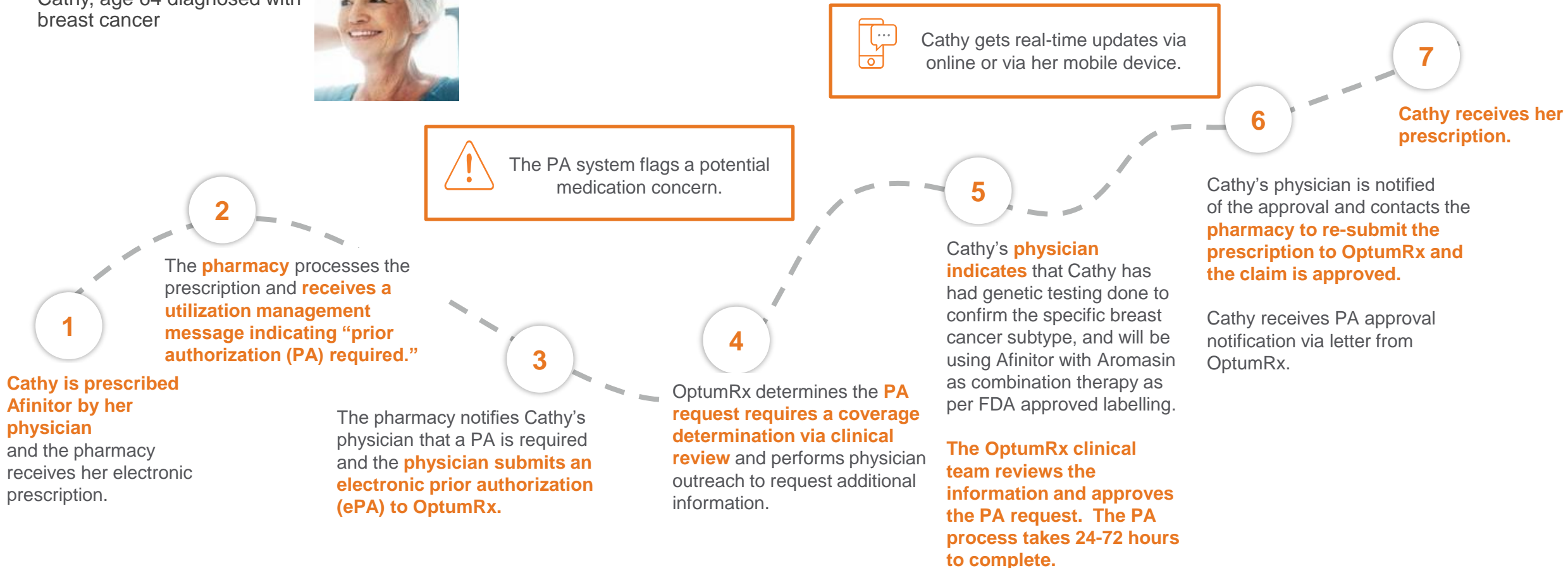
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**Barbara receives her prescription.**

# Retiree Journey: Cathy's story

## Clinical rigor helps to ensure members receive the right medications

Cathy, age 64 diagnosed with breast cancer



# Specialty Management Savings Opportunity Summary

- ✓ A total of 60,677 retirees utilized the prescription drug plan in 2020. Retirees who filled for a specialty medication represented 2,272, or 3.7%, of that total.
- ✓ Specialty Rx's totaled 10,923, or less than 1%, of the overall 1,380,472 prescriptions
- ✓ Specialty represented 37% of the total retiree pharmacy spend
- ✓ Retiree plan specialty costs increased \$21M in 2020, or 24%, based on increased Rx's and higher cost specialty medications being utilized
- ✓ Implementing specialty prior authorization would save an estimated **\$13M**

# Appendix



# Top 5 Specialty Class Prior Authorization Opportunities

## Medication list

	Anti-Inflammatory Biologic Agents	Multiple Sclerosis	Pulmonary Hypertension	Pulmonary Fibrosis	Oncology – Oral Agents
Medications	Actemra, Avsola, Cimzia, Cosentyx, Enbrel, Enbrel Mini, Entyvio, Humira, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Renflexis, Remicade, Rinvoq, Siliq, Simponi, Simponi Aria, Skyrizi, Stelara, Taltz, Tremfya, Xeljanz, Xeljanz XR	Ampyra, Avonex, Aubagio, Bafiertam, Betaseron, Extavia, Copaxone, Gilenya, Glatopa, Lemtrada, Mavenclad, Mayzent, Novantrone, Ocrevus, Plegridy, Rebif, Tecfidera, Tysabri, Vumerity, Zeposia	Adcirca, Adempas, Alyq, Flolan, Letairis, Opsumit, Orenitram, Remodulin, Revatio, Tracleer, Tyvaso, Uptravi, Veletri, Ventavis	Esbriet, Ofev	Afinitor, Afinitor Disperz, Alecensa, Alunbrig, Ayvakit, Balversa, Bosulif, Braftovi, Brukinsa, Cabometyx, Calquence, Caprelsa, Cometriq, Copiktra, Cotellic, Daurismo, Erivedge, Erleada, Farydak, Gilotrif, Gleevec, Ibrance, Iclusig, IDHIFA, Imbruvica, Inlyta, Inrebic, Iressa, Jakafi, Kisqali, Kisqali Femara, Koselugo, Lenvima, Lonsurf, Lorbrina, Lynparza, Mekinist, Mektovi, Nerlynx, Nexavar, Ninlara, Nubeqa, Odomzo, Pemazyre, Piqray, Pomalyst, Qinlock, Retevmo, Revlimid, Rozlytrek, Rubraca, Rydapt, Sprycel, Stivarga, Sutent, Tabrecta, Tafinlar, Tagrisso, Talzenna, Tarceva, Targretin, Tassigna, Tazverik, Temodar, Thalomid, Tibsovo, Tukysa, Turalio, Tykerb, Venclexta, Verzenio, Vitakvi, Vizimpro, Votrient, Xalkori, Xeloda, Xospata, Xpovio, Xtandi, Yonsa, Zejula, Zelboraf, Zolanza, Zydelig, Zykadia, Zytiga

# Non-EGWP (Under 65) Retiree Plan

A look at the top 5 specialty classes with prior authorization opportunity (Jan 2020 – Dec 2020)

	Anti-Inflammatory Biologic Agents	Multiple Sclerosis	Pulmonary Hypertension	Osteoporosis	Oncology – Oral Agents
Example Medications (full drug listing in appendix)	Stelara,, Humira, Taltz, Cosentyx, Xeljanz, Cimzia, Enbrel, Otezla	Tecfidera, Ocrevus, Gilenya, Aubagio, Copaxone, Avonex	Uptravi, Adempas, Orenitram, Letairis, Opsumit	Forteo, Prolia, Xgeva, Tymlos, Evenity	Revlimid, Jakafi, Zejula, Calquence, Alecensa, Ninlaro, Idhifa
Utilizers	307	79	5	75	121
Actual Plan Paid	\$13,405,897	\$3,954,684	\$1,290,256	\$634,985	\$5,948,179
Actual Plan Paid per Rx	\$8,004	\$10,894	\$26,332	\$3,097	\$10,273
Estimated Plan Reduction	\$1,147,215	\$302,200	\$123,803	\$202,747	\$725,076



# EGWP (Over 65) Retiree Plan

A look at the top 5 specialty classes with prior authorization opportunity (Jan 2020 – Dec 2020)

	Anti-Inflammatory Biologic Agents	Multiple Sclerosis	Pulmonary Hypertension	Pulmonary Fibrosis	Oncology – Oral Agents
Example Medications (full drug listing in appendix)	Cimzia, Cosentyx, Enbrel, Humira, Skyrizi, Stelara, Taltz, Tremfya, Xeljanz	Copaxone, Gilenya, Ocrevus, Rebif, Tecfidera, Tysabri	Letairis, Revatio, Tracleer, Tyvaso, Upravi	Ofev, Esbriet	Bosulif, Gleevec, Ibrance, Imbruvica, Jakafi, Mekinist, Revlimid, Sprycel, Tagrisso, Tassigna, Verzenio, Xospata
Utilizers	480	90	78	34	440
Actual Plan Paid	\$22,142,439	\$4,908,806	\$2,845,600	\$2,661,737	\$31,019,054
Actual Plan Paid per Rx	\$9,135	\$10,836	\$6,992	\$11,137	\$13,050
Estimated Plan Reduction	\$2,373,613	\$386,192	\$450,320	\$455,586	\$3,151,723