Retiree Health Plan Advisory Board
Modernization Subcommittee Meeting Agenda

Date:	Wednesday July 28, 2021
Time:	01:00 pm – 04:00 pm
Location:	Video Tele-Conference
Teleconference:	**Join Meeting** **Audio Only:** (650) 479-3207 Access Code: 177 623 1459 Password: RHPAB (74722 from phones)
Committee Members:	Cammy Taylor, Judy Salo, Joelle Hall, G. Nanette Thompson

OnlinePublicNotices

1:00 pm Call to Order – Cammy Taylor, Modernization Subcommittee Chair
- Roll Call and Introductions
- Approval of Agenda
- Ethics Disclosure

1:05 pm Public Comment

1:15 pm Working Session on Pharmacy Prior Authorizations

2:30 pm Break

2:45 pm Working Session on Preventive Care

4:00 pm Adjourn

Retiree Health Plan Advisory Board

Modernization Committee Meeting Minutes

Date: Friday, June 18, 2021 9:00 a.m. to 12:00 p.m.

Location: Virtual meeting via teleconference and WebEx only

Meeting Attendance

Name of Attendee	Title of Attendee	
Retiree Health Plan Advisory Board (RHPAB), Modernization Committee Members		
Cammy Taylor	Committee Chair	Present
Joelle Hall	Committee Member	Absent
Nanette (Nan) Thompson	Committee Member	Present
Judy Salo	Board Chair	Present
State of Alaska, Department of Administration Staff		
Emily Ricci	Chief Health Administrator, Retirement + Benefits	
Betsy Wood	Deputy Health Official, Retirement + Benefits	
Teri Rasmussen	Program Coordinator, Retirement + Benefits	
Steve Ramos	Vendor Manager, Retirement + Benefits	
Elizabeth Hawkins	Appeals Specialist, Retirement + Benefits	
Christina Vasquez	Appeals Specialist, Retirement + Benefits	
Chris Murray	Member Liaison, Retirement + Benefits	
Others Present + Members of the Public		
Dr. Lydia Bartholomew	Aetna (medical third party administrator)	
David Broome	Aetna (medical third party administrator)	
Hali Duran	Aetna (medical third party administrator)	
Daniel Dudley	Aetna (medical third party administrator)	
Blythe Keller	Aetna (medical third party administrator)	
Miranda Roberts	Aetna (medical third party administrator)	
Andrew Robison	Aetna (medical third party administrator)	
Nicole Brown	OptumRx (pharmacy third party administrator)	
Lauren Carney	OptumRx (pharmacy third party administrator)	
Jocelyn Hain	OptumRx (pharmacy third party administrator)	
Carrie Sather	OptumRx (pharmacy third party administrator)	
Sara Guidry	OptumRx (pharmacy third party administrator)	
Sadhna Paralkar	Segal Consulting (contracted actuarial)	
Richard Ward	Segal Consulting (contracted actuarial)	
Anna Brawley	Agnew::Beck Consulting (contracted support)	
Sharon Hoffbeck	Retired Public Employees of Alaska (RPEA)	
Dorne Hawxhurst	Public Member	
Chris Pace	Public Member	
Barbara Potter	Public Member	

Common Acronyms

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

- ACA = Affordable Care Act (formal name: Patient Protection and Affordable Care Act)
- ARMB = Alaska Retirement Management Board
- CMO = Chief Medical Officer
- CMS = Center for Medicare and Medicaid Services
- COB = Coordination of Benefits
- COVID-19 = Novel Coronavirus Disease (identified 2019), also known as SARS-CoV-2
- DB = Defined Benefit plan (for Tier 1, 2, 3 PERS employees and Tier 1, 2 TRS employees)
- DCR = Defined Contribution Retirement plan (Tier 4 PERS employees, Tier 3 TRS employees)
- DOA = State of Alaska Department of Administration
- DRB = Division of Retirement and Benefits, within State of Alaska Department of Administration
- DVA = Dental, Vision, Audio plan available to retirees
- EGWP = Employer Group Waiver Program, a federal program through Medicare Part D that provides reimbursement for retiree pharmacy benefits
- EOB = Explanation of Benefits, provided by the plan administrator detailing claims coverage
- HIPAA = Health Insurance Portability and Accountability Act (1996)
- HRA = Health Reimbursement Arrangement account, a mechanism for the employer to reimburse high-income Medicare enrollees for any premium charge for their plan (IRMAA)
- IRMAA = Income Related Monthly Adjustment Amount, a surcharge from CMS for a Medicare plan for individuals or households earning above certain thresholds
- MA = Medicare Advantage, a type of Medicare plan available in many states
- MAGI = Modified Adjusted Gross Income, based on an individual or household's tax returns and used by CMS to determine what if any premium must be paid for a Medicare plan.
- OPEB = Other Post Employment Benefits; an accounting term used to describe retirement benefits other than pension benefits
- OTC = Over the counter medication, does not require a prescription to purchase
- PBM = Pharmacy Benefit Manager, a third-party vendor that performs claims adjudication and network management services
- PEC = proposal evaluation committee (part of the procurement process to review vendors' bids)
- PHI = protected health information, a term in HIPAA for any identifying health or personal information that would result in disclosure of an individual's medical situation.
- PMPM = Per member per month, a feature of capitated or managed-care plans
- PPO = Preferred Provider Organization, a type of provider network
- RDS = Retiree Drug Subsidy program (a federal pharmacy subsidy program)
- ROI = Return on Investment
- RFP = Request for Proposals (a term for a procurement solicitation)
- RHPAB = Retiree Health Plan Advisory Board
- TPA = Third Party Administrator
- USPSTF: U.S. Preventive Services Task Force

Meeting Minutes

Item 1. Call to Order + Introductory Business

Chair Cammy Taylor called the meeting to order at 9:05 a.m.

Emily Ricci introduced the Division of Retirement and Benefits team, including new staff member Chris Murray, who will serve as Member Liaison. He previously worked in the Division of Insurance.

Approval of Meeting Agenda

Materials: Agenda packet for 6/18/21 RHPAB Modernization Committee Meeting

- **Motion** by Judy Salo to approve the agenda as presented. **Second** by Nan Thompson.
    - **Result**: No objection to approval of agenda as presented. Agenda is approved.

Ethics Disclosure

Cammy Taylor requested that Committee members state any ethics disclosures in the meeting.
No members made ethics disclosures.

Item 2. Working Session: Preventive Care

Materials: Presentation beginning on page 2 of the 6/18/21 agenda packet

Cammy invited Emily Ricci to speak. As a preface, she shared that the meeting today will review the proposed structure for preventive care benefits, as well as a proposal regarding prior authorizations for specialty medications. She noted that the plan's pharmacy costs went up 24% in one year (2019 to 2020), and that there is great interest in addressing this rise in cost and ensuring utilization of high cost, complex specialty medications is appropriate and medically necessary. The pharmacy presentation will be given by OptumRx regarding specialty medications.

Emily introduced Dr. Lydia Bartholomew, Blythe Keller and other members of the Aetna team, and asked them to present.

Aetna Presentation about Preventive Care

Dr. Bartholomew is Aetna's chief medical officer for the Western region and has worked with the Division for several years. As a primary care doctor by training, she is excited about the possibility of covering these services. The presentation will include an overview of Aetna's clinical policies, the policies in the Affordable Care Act about preventive care, and considerations for preventive care services.

Aetna uses a team of experts to develop clinical policies, developed by committee and internal review before being approved. Policy bulletins are shared with providers regularly, including changes in policy. Separately, there is a committee to determine whether Aetna will recommend adding a change or policy to the national pre-certification list. In addition to regular changes, there is a process for ad hoc review of a particular policy. These policies are the basis for coverage decisions, from the overall policy about coverage, to coverage of individual policies.

The Affordable Care Act (ACA) has several required preventive services (see slide on page 5). These rules apply to non-grandfathered plans. The AlaskaCare retiree plan is not subject to these requirements,

because it is a retiree-only plan and exempt. The employee plan does follow ACA requirements, it is not grandfathered. The ACA requirements: evidence based preventive services with an "A" or "B" rating by the United States Preventive Services Task Force (USPSTF), standard vaccines recommended by the Advisory Committee on Immunization Practices (ACIP), preventive care for children recommended under the Bright Futures guidelines, developed by the American Academy of Pediatrics, and women-specific preventive care as outlined by the USPSTF and other evidence-based guidelines.

The USPSTF regularly reviews their recommendations, such as which cancer screenings are effective and for which populations. Several other organizations have their own recommendations, from professional medical associations to groups like the American Cancer Society, other insurers, to states' laws or regulations.

Aetna develops its own clinical policies and reviews these many other guidelines. The slide on page 8 outlines the review process. Part of the policy may include determinations regarding whether the service should be covered under the medical plan, a pharmacy plan, or another type of plan.

Emily summarized by noting that the USPSTF guidelines are relatively conservative on their own, and many plans expand what they will cover beyond these guidelines based on other clinical, evidence-based recommendations. She also reiterated why the retiree plan is exempt from the ACA's provisions regarding coverage of preventive services.

Dr. Bartholomew continued: the slide on page 9 illustrates the different recommendations for breast cancer screenings. As an example, while the USPSTF has a relatively narrow recommendation for screening, and this has changed over time. But providers still make a broader recommendation (mammograms for women age 40 and older), so Aetna has chosen to cover this more broadly.

- Emily asked why this is controversial?
    - Dr. Bartholomew noted that part of the issue is cost, whether the additional benefit of wider screening justifies the additional cost; as well as the increased radiation risk and development of other cancers for undergoing an X-ray. There are different ways to weigh the relative benefits and risks, so other clinicians or plans may come to a different conclusion from the same evidence. This is an example of why developing clinical policies is complex.
- Emily also asked for clarification about Digital Breast Tomosynthesis/MRI/Ultrasonography?
    - Dr. Bartholomew explained that these other imaging methods can be useful for diagnostic if there is concern, but can be less useful for broad screening. Additionally, there is a significant false-positive risk, which can result in unnecessary procedures and stress for the patient, so that also is a factor in whether it should be covered.
- Judy Salo asked whether ultrasound is effective, why it isn't used more often, since it is lower cost?
    - Ultrasound is used as a supplemental in diagnostic procedures, but on its own is not considered an effective screening method in most cases.
- Nan asked what the procedure tomosynthesis involves?
    - Dr. Bartholomew answered this is a form of "3D mammogram" that gives a clearer image—but it is considered less effective and does not consistently identify an issue.
    - Emily noted that it is covered in the employee plan when required, for women with dense breast tissue for whom it may be necessary.

- Dr. Bartholomew confirmed that this is not a USPSTF recommendation, but Aetna does cover this.
- Emily also noted the difference between preventive (screening) and diagnostic care.
- Dr. Bartholomew described the difference as whether the patient is presenting symptoms (pain or other issues); a diagnostic mammogram also includes more views, versus a preventive screening.

Dr. Bartholomew continued: the slide on page 10 illustrates the guidelines for cervical cancer screenings. There is a combination of screenings for detection of cervical cancer, including Pap smears and other HPV tests. There are also guidelines for adolescent women (under age 21) who are considered high risk. USPSTF does not recommend screenings for young women, but Aetna covers this in high-risk situations.

The slide on page 11 gives an overview of prostate cancer screening, another guideline that has changed over time. While the USPSTF does not recommend prostate-specific antigen screening (PSA), as it often results in false positives and potentially unnecessary treatment. However, Aetna covers screenings for men over 40 annually— Dr. Bartholomew noted that many states still require coverage of PSA testing, and the American Cancer Society recommends a patient-centered approach: meaning, the patient learns the benefits and risks of the service, and their individual risk factors, to decide whether to proceed with the screening.

The slide on page 12 outlines the recommendation for colorectal cancer screenings, which has multiple options and different guidelines depending on the person's age and risk factors.

- Emily asked why Aetna's coverage is more broad for this screening, for any adult over 40 years?
  - Dr. Bartholomew explained they cover the full age range that the USPSTF recommends, but also does not stop coverage past age 70, with the rationale that it should be in the healthiest older adults. Aetna covers screenings for adults over 70 as well, depending on the member's health circumstances.
- Emily asked how this has changed over time? She saw updates regarding USPSTF policy changes about colorectal cancer screenings and colonoscopies.
  - Dr. Bartholomew will follow up on this: she is referring to Aetna's coverage policy, which is scheduled to be reviewed this month.

Questions and comments from members:

- Judy asked, given these coverage recommendations presented, what would this cover for the members who are not Medicare eligible, versus what is covered under Medicare already?
  - Emily noted there is a table in the preventive services proposal (page 18) comparing the current plan's coverage of these services, the proposed changes to the retiree plan to cover these services, and what the equivalent coverage is under Medicare. She gave an overview:

Emily noted that the specific coverage may change as the group discusses the proposal further. Some of the coverage under the current plan is outdated, for example there is some coverage for mammograms but not consistent with current guidelines. Many vaccines would also be covered, consistent with current guidelines. The plan also currently does not cover annual routine physical exams, women's preventive visits (except for Pap smears), or child preventive visits. The proposal would cover these services. She also pointed out that the table current combines several cancer screenings under one line

in the table: staff will split these out to illustrate individual screening coverage. She described that the items in the table are the major gaps that would be covered by preventive services.

- Judy asked, if the Division does decide to cover these services beyond the USPSTF, would the guidelines from the American Cancer Society be utilized?
    - Emily noted that there are several different sources for recommended guidelines, so she would not recommend tying the policies to one specific entity's guidelines. Instead, staff propose following what is covered in the employee plan already, it is a relatively standard set of covered services, and it would be easier for the third party administrator (TPA) to process claims for both populations, instead of having to manually review claims. Furthermore, by following Aetna's clinical guidelines as a policy, they can be updated over time as the science or evidence base changes.
- Judy commented that having a change in their health plan can be difficult, such as someone moving from the employee plan to the retiree plan and losing that coverage. Additionally, she is concerned about whether there is a similar step-down of coverage from what's proposed for the retiree plan, versus what is covered under Medicare.
    - Emily responded that adopting the same coverage policies under the employee plan and the retiree plan would address this issue: what's being covered in the employee plan is standard, and is mostly aligned with many other employee plans the person may be covered under (University, etc.). She acknowledged Medicare coverage has a different set of covered services, but reiterated that while Medicare is the primary payer, the retiree's coverage would also still apply if a service isn't covered by Medicare itself, because of coordination of benefits. This should again provide a consistent set of coverage, and not result in a reduction of coverage for people who are enrolled in Medicare.
    - Judy requested the group review a few examples of how coverage would differ under Medicare versus the proposed changes in the retiree plan, and which areas would be different. She understands the biggest issue is the gap in coverage now, so it would not change the proposal, but would help anticipate what is confusing for retirees, or the concerns they have about how enrolling in Medicare might negatively affect them.
    - Andrew Robison responded that the only issue he could see would be if someone goes to a provider who does not accept Medicare, so the service would only be covered by the retiree plan and not by Medicare.
- Cammy asked for clarification: the proposal is essentially to cover the same services as in the employee plan, and in addition to what Medicare covers. Is this accurate? And it looks like the USPSTF's recommendations are not necessarily what is covered under Medicare, either. She agreed with Judy's suggestion to look at examples to illustrate the differences in coverage across the retiree plan, employee plan and Medicare.
    - Emily responded yes, this would make the retiree mirror the employee plan. What Medicare covers is also not subject to ACA requirements, so there are likely differences in what is covered. The USPSTF is a general baseline of coverage for many plans, if not most plans, but is not a universal required standard.
- Emily asked the Aetna team what the implications of mirroring Medicare guidelines would have for the plan? She noted a concern that manually adjudicating claims takes additional time and cost, as well as introducing higher risk of errors when the TPA has to make those adjustments.

- Judy stated she has concerns about limited Medicare providers in Alaska, and retirees having trouble finding a provider. She wants to ensure there are not coverage issues for retirees who go to a provider who does not accept Medicare, and are receiving services that aren't covered.
- Judy also asked what the process is for changing or updating Aetna's recommendations, such as when new evidence or guidelines come out?
    - Dr. Bartholomew commented that it's difficult to anticipate when recommendations will change. There is a team of researchers who review new publications, monitoring USPSTF's updates about changes in recommendation, and stay abreast of updates. Additionally, providers will share studies with Aetna's committee (not just preventive, but for any type of service or condition) and the committee will review and discuss whether a change is warranted. The team also does an annual review of the literature on each policy, to review what has been published in the last year and whether updates are needed.
      She noted that there is a separate process for pharmacy guidelines—they do get notice from the FDA when a new medication is being approved, and what guidelines. In this case, they will do a review in advance and ensure they are ready with a coverage policy for that drug.
- Emily asked why Aetna's team reviews different studies?
    - Dr. Bartholomew responded each study can have biases or limitations in what conclusions can be drawn—what is the size of the study, is there a control group that matches the study group, is it an open label (versus double blind) study, where there might be a placebo effect or other bias. And there are many other forms of bias that can impact the study's effectiveness. Evaluating the evidence needs to be comprehensive. Additionally, when there is a review of evidence, the researchers could still come to a problematic conclusion or misinterpret, so it requires careful review. And, there may be several studies that can provide a broader picture, versus a single study with limited applicability.
- Emily also noted that it can be complicated with new information, such as bone marrow transplants.
    - Dr. Bartholomew agreed, lack of evidence is challenging because it doesn't mean it doesn't work, but that there isn't enough information to draw a conclusion. Recommendations do change over time with new evidence; sometimes the evidence does build up and shows something is not effective after all. This can be confusing to track.
- Judy noted another example, which is a pharmacy plan issue specifically of interest to retirees, is the new drug for Alzheimer's, which has been controversial.
    - Dr. Bartholomew noted she could not comment on coverage of this specifically, but is another good example of how the process for developing good recommendations can be challenging.

Emily redirected the group to the preventive care coverage proposal. She noted that the group should discuss what if any recommendations for coverage to consider beyond what the employee plan's policies are, as well as whether and how to mirror Medicare's coverage. She also pointed out that the group needs to discuss coverage of services for routine services, such as wellness visits: one option is coverage with a deductible like other health care services; the other is to cover the services at 100% for a network provider, more like the employee plan, and a lower level of coverage out of network. There would need to be a waiver or exception allowed, as happens in the employee plan, when a member does not have in-network options in their community. (This would mainly be an issue in Alaska).

- Cammy commented that there are a lot of details to consider, and that the committee would like to have more time to review and discuss. They have discussed a committee meeting in July.
- Judy commented that she supports Option B (100% coverage for in-network providers), and matching to the extent possible the employee plan. She does want to ensure that the members who do not have in-network options are addressed in the policy.
- Nan supported the general idea of matching the employee plan's terms, as this would help the third party administrator efficiently manage the plan, and Judy's point about minimizing the pain of transition from employees moving into the retiree plan.

Emily noted that when this proposal was first developed in 2018, Option A was the operating proposal. Additionally, the Division anticipates there is some additional cost to the plan for this coverage of about $3.0 to $3.5 million, but this is a benefit to members and will hopefully result in better health outcomes. In order to move forward, it is helpful to remove provisions that aren't being considered—staff can update this with Option B (coverage at 100% for in-network) and continue refining the proposal. She also described that most of the additional estimated cost in the proposal is from colonoscopies for members not enrolled in Medicare, as this could be considered diagnostic versus preventive screening. The group would need to discuss how this is paid and in what circumstances—diagnostic services would cost more to the member.

- Judy also asked for the discussion to include a baseline colonoscopy: does a member need a baseline screening at a certain age? This needs to be clarified, and how it would be covered.
    - The Aetna team noted these questions, and will follow up with Division staff.
- Nan also would like discussion of the home-based test, and when it would be appropriate for screening or diagnostic purposes, versus a colonoscopy. What are the effective tests for colorectal cancer? When would one or the other be recommended?
    - Andrew Robison noted Aetna has a process for reviewing colonoscopy claims, and determine whether it would be considered preventive versus diagnostic. If no prior colonoscopies have been done for that member, then it can be considered preventive and covered differently.
    - Emily agreed it would be useful to talk through this further: it is a point of confusion for members, and would be helpful to better clarify.

The Board took a 15-minute break at 10:35 a.m., and returned to the meeting at 10:45 a.m.

Item 3. Working Session: Pharmacy Prior Authorizations

Materials: Presentation beginning on page 30 of the 6/18/21 agenda packet

Emily provided context before the presentation: specialty drugs consisted of about $110 million spend in the 2020, about 1% of prescriptions for 3% of the member population, compared with $89 million in 2019—a $21 million growth in one calendar year. While specialty medications are continuing to be a trend and increasingly used, there are no cost and utilization controls in the plan to review how these are used before the prescriptions are filled. For example, is a drug designed for cancer treatment being used for migraines?

The Division is proposing a review and prior authorization process for use of specialty medications, working with OptumRx to design this proposed policy. She invited OptumRx to present.

OptumRx Presentation about Retiree Plan Specialty Prior Authorizations

Nicole Brown and Jocelyn Hain presented:

The slides beginning on page 30 illustrate how specialty medications have been significantly increasing, both in utilization and in cost. There has been across the health care market a rapidly increasing share of specialty drugs (slide on page 32): about 8% annual growth in cost; 10% increase in utilization over the past 4 years. Specialty drugs each cost approximately $52,000 per year on average. A patient utilizing specialty drugs is often taking up to 10 medications per year, with average of 7 conditions managed.

The slide on page 33 illustrates costs specifically to the AlaskaCare retiree pharmacy plan: it is a small number of members utilizing these drugs, but five common medications each cost about $10,000 for a 30 day supply per patient, with an annual cost of over $100,000 for each per person.

Emily clarified that the information on this slide is to point out that some of these medications are being utilized, but with no checks or prior review through the prior authorization process, like there would be in the medical plan. Therefore, the plan has no way to review whether the drug is being used for the diagnosis it is indicated for, before the claim is paid. There should be better review of when and how medications are appropriate for use. Page 34 further illustrates the increase trends in the plan: this represents at 24% increase in one year.[1] This is also a larger rate of and dollar increase compared with traditional medications, which was a 10% increase over the same year period. This is notable because while specialty drugs are 1% of all prescriptions, they represent a huge portion of total spending (37%).

- Judy Salo noted that the retiree member population will continue to have chronic conditions needing treatment or management, and that specialty drugs will be utilized. She understands that there will continue to be an increase in use of these drugs. Is this because they are more widely available, or more are available? Or is it reflecting a trend in health outcomes? Will this increase likely continue over the longer term?
    - Nicole responded yes, this area will continue to grow. However, OptumRx has seen an increase in these treatments being used, including for several different conditions. The issue is whether this drug should be used for the member's specific diagnosis, and how that would interact with other medications the patient is on.
- Cammy Taylor asked for clarification what the prior authorization process would be used for? How does this work? What situations are drugs potentially not being used effectively?
    - Jocelyn noted that the information presented about the five medications listed are being prescribed to members, but there is no information about whether this is appropriate for their diagnosis, what they are being used for, and there is no mechanism to consider whether this was clinically appropriate for that member. She also noted that more specialty drugs are being used, they are being approved for more indications, and may be used without consideration for the member's other prescriptions or treatments.

Emily reiterated that the Division does strongly support maintaining access for members to the medications they need, for the health conditions they have. The proposal is about prior authorizations

[1] Emily clarified that the slide on page 34 has a typo, should read 24.1%, not 34.1%.

and additional review for only these specialty medications, 1% of all prescriptions, and not for generic or brand name drugs that are not considered in this category. She also noted that this is different from the concept of step therapy, where a patient is required to utilize one or more drugs—either a generic or other common medication for that condition—before they can access other brand-name or less common drugs for their treatment. This is a feature of many other plans, but not being proposed as part of this policy change. The proposed change is to add prior authorization for certain specialty medications, which does not include requiring use of a less expensive drug first.

- Cammy asked for clarification: what percent of members would be impacted?
    - Emily responded this is also a small portion of members, about 2,300 used one of these medications in 2020, 3.7% out of about 66,000 members in the retiree plan overall. This will be covered later in the presentation.

Jocelyn continued: pages 35-36 illustrate OptumRx's prior authorization process, which is a pre-approval process to ensure the prescription is appropriate, safe for the patient, and will result in better health outcomes. Typically about 75% of prior authorizations for specialty medications are approved. OptumRx develops prior authorization guidelines with a national review process with physicians across the U.S., who review new specialty medications to provide oversight and develop guidelines, and determine whether the benefits will outweigh the risks. She stressed that the decision process is clinical in nature, and does not take cost into account, to avoid medical decisions being made based on cost.

Pages 37 and 38 illustrate more specific data related to the retiree plan's utilization of specialty medications. The table on page 38 shows the top 5 classes of specialty classes used in the plan today, the number of people using each medication class, and the associated costs. Page 39 provides more detail about the prior authorization rate for these drug classes, and an example of when certain drugs are approved or not: the drug Actiq (brand name) is indicated as effective for managing pain related to cancer, but not for pain related to migraines. Because this is an opioid medication, with risks and a contra-indication for migraines (not considered effective), it is not approved for that use and presents other risks to the patient. Each class of drug may have different approval rates (percent of pre-authorizations approved) because of each drug's situation and approved uses.

- Cammy asked for, as an example, the difference between the two drugs' approval rate—Revlimid is 94%, while Stelara is 65%?
    - Jocelyn clarified this is across Aetna's book of business, so it depends on the drug class, the providers utilizing the drug (which can also vary by region), and whether the drug has other "off-label" uses that may or may not be effective. In these two examples, former (Revlimid) is used primarily for cancer, while the other (Stelara) is more likely to be prescribed for arthritis pain, but is not considered the first or most effective choice, and has other potential risks and side effects.
        - Emily asked for clarification: why would this be considered less effective? Is OptumRx is using external recommendations or guidelines?
            - Jocelyn responded that the particular drug class is not considered first-line therapy compared to more traditional oral therapies, and also has significant downsides for use, which make it a less desirable choice. OptumRx does review the current evidence and how the drugs are recommended to be utilized, and weighs these against the risks.

Nicole continued: OptumRx uses digital tools to support the member throughout the process, including providing information about the clinical rationale if a prior authorization is denied. This is provided to the provider as well as the patient. There is also an online tool for providers called PreCheck My Script, which they can use to start the authorization process and review what is recommended. In 2020, about 12,600 physicians treated AlaskaCare patients using this tool.

Page 41 outlines tools for providers to use the prior authorization (PA) process: providers can get real-time electronic PA, or use PreCheck My Script to review plan benefits. When the member is at the pharmacy, the tool is being developed for reviewing the member's coverage at the point of sale. A prior authorization can also expire, so OptumRx has an automated process for reviewing and notifying providers of expiring PAs, to ensure a provider can update the information for prescriptions like maintenance medications.

Page 42 includes a process chart for how the member interacts with the PA system. If this process is put in place, a member with a current prescription would be notified that they will be subject to a prior authorization. The member and provider are given information how to complete the PA process, so the member and provider can determine whether to pursue this and how. If the PA is submitted and approved, the prescription will continue to be filled as normal. If the PA is not approved, the provider and member receive information about the decision, and allows for a reconsideration process. OptumRx can conduct an expedited review and make a decision within 24 hours if it is time sensitive; otherwise it is typically 24 to 72 hours if it's a standard request. PAs are typically valid for 24 to 36 months. A soon to expire PA would trigger a notification 30 days in advance.

- Nan Thompson asked about the 60-day notice? She is thinking of prescriptions that are issued at short notice or on an emergency basis. How would this work for a new prescription?
    - Nicole responded: the 60-day period is referring to if the policy is put in place and for existing medications, that are already being used by members today. The 30-day notice is for any expiring PAs, and the notice goes directly to the provider, so the member does not need to be directly involved in that process. The review process (24 to 72 hours, or under 24 hours expedited) reflects the turnaround between a PA submittal and OptumRx decision.

Pages 43 and 44 provide two examples for members using this process for a specialty medication after a diagnosis is made, and prescription written by a provider. The first shows a process in which the specialty medication is submitted, and is approved automatically; the second shows a process where the prescription is written first, triggering a notification by the plan that it needs prior authorization, and requires a coverage determination via clinical review. In that example, clinical determination takes 24-72 hours and reviews the provider's rationale and other factors; the PA is approved, the provider is notified that they need to resubmit the prescription, and it is covered when the member fills the prescription.

- Cammy Taylor asked whether the clinical PA criteria is available to members?
    - Jocelyn responded this information is not available directly to the public. It is not typical for the public to have access to the criteria, but they follow FDA approved labeling and national clinical guidelines for those drugs. These are available to the public, but not directly OptumRx's criteria itself.
- Cammy asked, as an example, on page 47 there are two drugs listed for pulmonary fibrosis. If there are only two, why would either drug be denied?

    - Jocelyn responded for those specific medications, it would likely be approved, but there are several factors including correct diagnosis and whether it is indicated or contra-indicated for that specific condition. And, there may be other medications or therapies recommended to try first, before this is utilized.
- Cammy also asked about multiple sclerosis (MS) medications—would this require having to use other therapies first, before any of these?
    - Jocelyn responded there are clinical guidelines for each of these conditions, and many of the drugs on the list are indicated only for certain circumstances—could depend on the results of other tests, that it's specifically indicated for that patient's condition, and for example whether the patient is able to increase ability to walk based on taking this medication. Many drugs are recommended only for a narrow set of conditions or circumstances.
    - Emily clarified that this is not the same policy as step therapy. The decision about whether these drugs would be approved for use would depend on the clinical implications, including consideration of serious side effects or other health risks. Many drugs are not appropriate for all patients, and the decision would be based on the therapeutic impact and not directly the cost savings. She stated that the purpose is to ensure it's being used appropriately according to the clinical indications, and not speaking to the cost. Cost considerations would be secondary.
- Cammy commented that for progressive diseases like MS, she is concerned whether the determination would be available to the member and is appropriate for their needs.
    - Emily agreed, and noted for the OptumRx team that communicating back to members is important, and informing them of the decision. And, it is important that there is the appropriate diagnosis on file.
- Cammy clarified: she is concerned about members, particularly those who are already on a medication now and would be subject to the PA process going forward, having a decision made that they have to switch to a different medication because their current one wasn't approved, and is not receiving the information about how this decision was made.
    - Steve Ramos confirmed that members do receive a letter explaining what criteria need to be met, when this happens in the Aetna medical plan. The letter gives reasons for why this wasn't appropriate, and which criteria were used—it does not provide all of the clinical policy bulletins directly, but does provide an explanation to the member.
- Judy asked about how the prior authorization process begins? Does it begin at the point of the prescription being covered or denied, or more proactively? How will providers be engaged?
    - Jocelyn responded the process proposed would notify members with these medications currently, with the 60-day notice period. The providers using the PreCheck My Script app can see for each member whether they have a medication requiring a PA, and can initiate that process on the app to get a PA submitted and approved. Most prescribing physicians for these drugs are specialists, so they are used to using PA processes for medical plan coverage as well as pharmacy coverage, so this is standard practice and how to use this approval process.
    - Lauren Carney, who oversees OptumRx's other public sector group plans, noted that having a PA process for specialty medications is standard in their plans.
    - Emily reiterated that it is important for members to have access to the information about the PA denial, so staff would work with OptumRx closely on this point.

- Judy commented that she believes members will understand why this policy is important, for clinical and cost reasons, but also that members will want to trust the process as well as the result. They will assume that their provider has made a good decision, and need to be well informed. She is also concerned about minimizing stress and concern from the member, since the population we are discussing has significant health issues, may be in serious pain, and already managing a lot of complex medical and claims information in the process.
    - Emily responded the transition from CVS to OptumRx also required changing over prior authorizations, and there was a process for notifying members.
- Judy also commented that she is surprised to hear that the company (OptumRx) is not better informed about what is being prescribed.
    - Jocelyn responded there is no mechanism in the plan, since the pharmacy benefit manager is not receiving the relevant medical information (diagnosis codes, etc.)
- Cammy requested additional information, either at a future committee meeting or the quarterly meeting. She acknowledged that this needs attention, there will be an increase in retirees utilizing these drugs, and more drugs entering the market. She would like to know if there is an increase in the incidence of these conditions within the retiree population, for example? Also, she would like to see a (year to date) trend for spending in 2021—will this increase trend continue? She noted that 2019's first quarter may have been low because of the transition from CVS, when people pre-filled medications in 2018 under the old plan. Does this make a significant difference?
    - Jocelyn noted that this represents many of the sickest members in the population, and they do expect this number to grow in general.
    - To the second question, she noted that they can look at this data: there will likely only be one quarter of data to review, but this can also illustrate what the trend looks like.
    - Emily noted that staff plan to format this as a proposal like other prior discussions, so they will be able to present this to the group at a future meeting.
- Judy requested that the proposal should include a clear plan for the transition period, and how members and providers would be notified and brought through the process, as well as how members will receive information about the decisions made through the PA process. She also requested a definition of "specialty drug" even if it is defined on a financial basis.
    - Emily agreed staff will include the transition process in the proposal. She agreed it will be important to ensure members and their providers receive clear information about the decision, particularly if they wish to appeal or pursue a new decision.
    - Lauren confirmed that there is a list of these drugs, and will provide a definition, based on the language in their contract as well. They can provide a definition, sometimes it is based on cost, but also the patient coordination required, programs associated with the product, and other ways they are utilized.
    - Jocelyn confirmed they do have a standard definition, what's in the contract, and the list of drugs they consider. There is also characteristics such as storage and handling, administration, etc. OptumRx will provide this to Division staff.

Item 4. Public Comment

Teri Rasmussen confirmed that no one requested to provide comments in advance, but that some comments were received in writing and these will be provided to board members. The public is

encouraged to provide written comments via e-mail to AlaskaRHPAB@alaska.gov. Comments received are distributed to all Board members.

Item 5. Closing Thoughts + Meeting Adjournment

Staff proposed that the next meeting be held on July 16, 2021. This did not work for some members, so staff will coordinate with committee members.

The Retiree Health Plan Advisory Board will meet on Thursday, August 5, 2021.

- **Motion** by Judy Salo to adjourn the meeting. **Second** by Nan Thompson.
    - **Result**: No objection to adjournment. The meeting was adjourned at 12:05 p.m.

Specialty Prior Authorization

July 28, 2021

OPTUMRx®

AlaskaCare Health Plans

Prior Authorization vs. Step Therapy

Prior-Authorization

- A review by OptumRx on behalf of your plan to ensure a prescription drug is medically necessary.
- Ensures therapy meets FDA guidelines for the condition being treated.
- Ensures providers follow nationally recognized care criteria when prescribing medication.
- Requires the prescriber to provide documentation in support of the PA criteria prior to medication being dispensed.

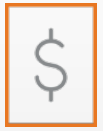
Step Therapy

- Requires a patient try one or more lower cost, preferred medications to treat a health condition.
- Ensures therapy follows cost and clinical guidelines.

OPTUMRx®

Why Prior Authorization for Specialty Medications?

- Achieves improved quality of member care by using evidence-based criteria to promote appropriate use of certain specialty medications
  - Reduces inappropriate use of high-cost specialty medications



FIDUCIARY RESPONSIBILITY

Health plans have a responsibility to ensure services provided align with the terms of the plan and are medically necessary.

SAFETY

Adverse drug events are the most common cause of medicinal harm for patients.

STANDARD PLAN MANAGEMENT

OptumRx administers Prior Authorization for 55 million members.*

*Includes 221K EGWP retirees from the State of New Jersey.
*98.4% (60 out of 61) Public Sector clients with coverage for specialty medications have Prior Authorization review.

OPTUMRx®

Accessibility to the OptumRx Specialty PA Criteria

- ✓ Specialty Prior Authorization criteria will be located on the OptumRx member portal.
- ✓ Retirees will have the ability to access the criteria specific to their specialty medication directly from the member portal at www.optumrx.com or by calling OptumRx Customer Service.

OPTUMRx®

Visibility to your Prior Authorization

Conveniently monitor PAs

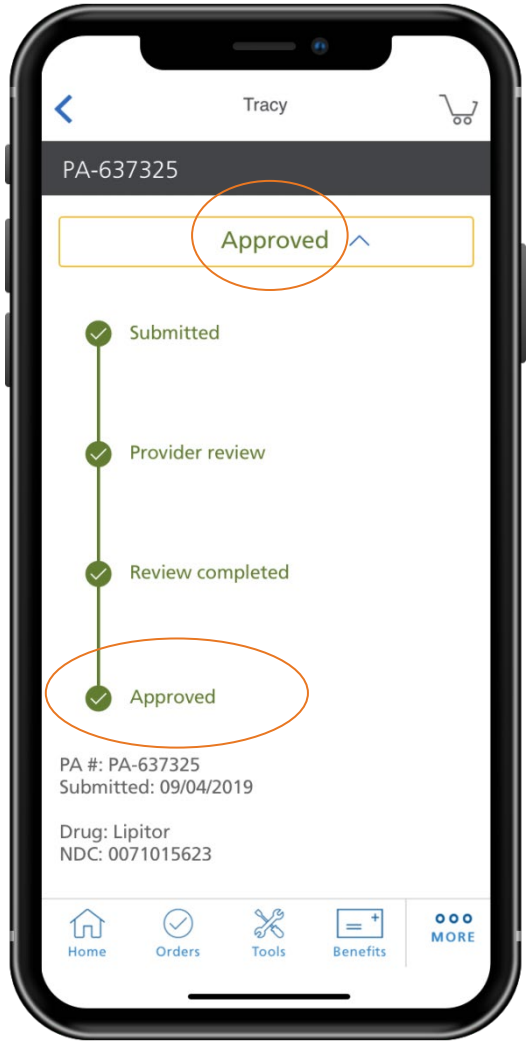
Track a PA status at anytime

PA alerts eliminate surprises

Members know before they arrive at the pharmacy or need to call their doctor's office and can take immediate action

Proactive notification

Messages member with immediate actions they can take without having to call customer service



Prior Authorization

Promoting appropriate and effective medication use

Some medications should be reviewed for coverage because

- They're only approved for, and effective in, treating specific illnesses
- They're high cost and may be prescribed for conditions for which appropriateness and effectiveness have not been well-established

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

Example: Xyrem® Annual Cost $159.6K

COVERED
for narcolepsy

FDA-approved for treating narcolepsy with or without cataplexy

NOT COVERED
for chronic fatigue syndrome or fibromyalgia

Not FDA-approved or sufficient clinical and safety evidence to support use in these conditions

OPTUMRx®

Prior Authorization Criteria: Xyrem

Product Name: Xyrem	
Diagnosis	Narcolepsy with Cataplexy (Narcolepsy Type 1) [2, 3, A, C, D]
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of narcolepsy as confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible)

AND

2 - Symptoms of cataplexy are present

AND

3 - Symptoms of excessive daytime sleepiness (e.g., irrepressible need to sleep or daytime lapses into sleep) are present

AND

4 - Prescribed by or in consultation with one of the following:

- Neurologist
- Psychiatrist
- Sleep Medicine Specialist

References:

1.Xyrem Prescribing Information. Jazz Pharmaceuticals, Inc. Palo Alto, CA. October 2018.

2.Morgenthaler TI, Kapur VK, Brown T, et al. Practice parameters for the treatment of narcolepsy and other hypersomnias of central origin: An American Academy of Sleep Medicine report. Sleep. 2007 Dec;30(12):1705-11.

3.Wise MS, Arand DL, Auger RR, et al. Treatment of narcolepsy and other hypersomnias of central origin: An American Academy of Sleep Medicine review. Sleep. 2007 Dec;30(12):1712-27.

4.International classification of sleep disorders. 3rd ed. Darien, IL: American Academy of Sleep Medicine; 2014.

5.Sateia MJ. International classification of sleep disorders - third edition: highlights and modifications. CHEST. 2014 Nov;146(5):1387-1394.

6.Scammell TE. Clinical features and diagnosis of narcolepsy. UpToDate Website. March 2017. www.uptodate.com. Accessed October 24, 2018.

7.Per clinical consult with neurologist/sleep specialist, October 9, 2012 (confirmed on March 20, 2015).

Prior Authorization

Promoting appropriate and effective medication use

Example: Humira®

Annual Cost $114.8K

COVERED
for RA, PJIA, PsA, AS, CD, UC, Plaque Psoriasis, Hydradenitis Suppurativa, UV

FDA-approved for treating rheumatoid arthritis, polyarticular juvenile idiopathic arthritis, psoriatic arthritis, ankylosing spondylitis, crohn's disease, ulcerative colitis, plaque psoriasis, hidradenitis suppurativa, and uveitis

NOT COVERED
for Behcet's Disease, Sarcoidosis

Not FDA-approved or sufficient clinical and safety evidence to support use in these conditions

Prior Authorization Criteria: Humira

Product Name: Humira	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active RA

AND

2 - Prescribed by or in consultation with a rheumatologist

AND

3 - Trial and failure, contraindication, or intolerance to one non-biologic disease-modifying antirheumatic drug (DMARD) [e.g., methotrexate (Rheumatrex/Trexall), Arava (leflunomide), Azulfidine (sulfasalazine)] [2]

Trial & Failure:
This criteria is for a patient with a moderately to severely active disease state. Based on nationally accepted treatment guidelines, patients with this diagnosis are started on a conventional treatment regimen until the disease progresses or the conventional treatment is unsuccessful for the patient. The patient then progresses to a biologic as a last line of therapy. Biologics are more aggressive therapies with greater side-effects. This approach is in accordance with the patient selection for clinical trials by the manufacturer and submitted to the FDA for approval of the drug.

Prior Authorization Criteria: Humira

Product Name: Humira	
Diagnosis	Crohn's disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active Crohn's disease [7, 8, B]

AND

2 - Trial and failure, contraindication, or intolerance to one of the following conventional therapies: [7]

- 6-mercaptopurine (Purinethol)
- azathioprine (Imuran)
- corticosteroids (e.g., prednisone, methylprednisolone)
- methotrexate (Rheumatrex, Trexall)

AND

3 - Prescribed by or in consultation with a gastroenterologist

References:

1.Humira Prescribing Information. Abbvie Inc. North Chicago, IL. February 2021.
2.Singh JA, Saag KG, Bridges SL Jr, et al. 2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. Arthritis Care Res. 2015;68(1):1-25.
3.Ringold S, Angeles-Han ST, Beukelman T, et al. 2019 American College of Rheumatology/Arthritis Foundation guideline for the treatment of juvenile idiopathic arthritis: therapeutic approaches for non-systemic polyarthritis, sacroiliitis, and enthesitis. Arthritis Rheumatol. 2019;71(6):846-863.
4.Singh JA, Guyatt G, Ogdie A, et al. 2018 American College of Rheumatology/National Psoriasis Foundation guideline for the treatment of psoriatic arthritis. Arthritis Rheumatol. 2019;71(1):5-32.
5.Menter A, Strober BE, Kaplan DH, et al. Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with biologics. J Am Acad Dermatol 2019;80:1029-72.
6.Ward MM, Deodhar A, Gensler LS, et al. 2019 Update of the American College of Rheumatology/Spondylitis Association of America/spondyloarthritis research and treatment network recommendations for the treatment of ankylosing spondylitis and nonradiographic axial spondyloarthritis. Arthritis Rheumatol. 2019;71(10):1599-1613.
7.Lichtenstein GR, Loftus EV, Isaacs KL, et al. ACG clinical guideline: management of Crohn's disease in adults. Am J Gastroenterol. 2018;113:481-517.
8.Hanauer SB, Sandborn WJ, Rugeerts P, et al. Human anti-tumor necrosis factor monoclonal antibody (adalimumab) in Crohn's disease: the CLASSIC-I trial. Gastroenterol. 2006;130:323-333.
9.Rubin DT, Ananthakrishnan AN, Siegel CA, et al. ACG clinical guideline: ulcerative colitis in adults. Am J Gastroenterol. 2019;114:384-413.
10.Feuerstein JD, Isaacs KL, Schneider Y, et al. AGA clinical practice guidelines on the management of moderate to severe ulcerative colitis. Gastroenterol. 2020;158:1450-1461.

Specialty pharmacy drug list

July 1, 2021

Optum® Specialty Pharmacy provides specialty medication support through your pharmacy benefits with OptumRx. Optum Specialty Pharmacy provides comprehensive support services, including access to pharmacists around the clock, for high-cost oral and injectable medications used to treat rare and complex conditions. In addition, your medications will be shipped to you at no extra cost.

Characteristics of specialty medications

Specialty medications are often drugs you take by mouth or inject. For a medication to be filled through Optum Specialty Pharmacy, it must be at least one of the following:

High-priced

- Can cost more than $1,000/30 day supply.

Complex

- Drug imitates compounds found in the body.
- Part of a specialty drug class.

High-touch

- Special shipping or handling like refrigeration.
- Needs a doctor or pharmacist to measure how well it works for you.
- Special steps to follow as you take.

Specialty pharmacy drug list

Adult incontinence

Solesta

Ammonia detoxicants

Ravicti PA

Anemia

Aranesp PA
Epogen PA
Mircera PA
Procrit PA
Reblozyl PA
Retacrit PA

Antibacterials

Arikayce PA

Anticoagulation

Arixtra
Fragmin
Lovenox

Anticovulsants

Diacomit PA
Epidiolex PA
Fintepla PA

Anti-gout agent

Krystexxa PA

Antihyperlipidemic

Evkeeza
Juxtapid PA

Anti-infective

Daraprim PA
Prevymis

Asthma

Cinqair PA
Fasenra PA
Nucala PA
Xolair PA

Cardiovascular

Northera PA
Vyndamax PA
Vyndaqel PA

Central nervous system agents

Austedo PA
Brineura PA
Enspryng PA
Firdapse PA
Hetlioz PA
Ingrezza PA
Radicava PA
Ruzurgi PA
Sabril PA
Tiglutik PA
Uplizna PA
Xenazine PA

Chemotherapy protectant

Elitek

Cystic fibrosis

Bethkis
Cayston PA
Kalydeco PA
Kitabis pak
Orkambi PA
Pulmozyme PA
Symdeko PA
Tobi
Tobi Podhalr
Tobramycin
Trikafta PA

Dermatologic

Scenesse PA

Diagnostic

Acthrel

Duchenne muscular dystrophy

Amondys 45
Emflaza PA

Endocrine

Bynfezia Pen PA
Chenodal PA
Crysvita PA
Cuprimine PA
Cystadane
Depen Titra
Egrifta PA
Firmagon PA
Imcivree
Isturisa PA
Jynarque
Korlym PA
Kuvan PA
Lupaneta PA
Lupron Depot PA
Makena PA
Myalept PA
Mycapssa PA
Natpara PA
Nityr PA
Parsabiv
Procysbi PA
Samsca
Sandostatin PA
Signifor PA
Somatuline PA
Somavert PA
Supprelin LA PA
Syprine PA
Tepezza PA
Thiola
Thyrogen PA
Triptodur PA
Xuriden PA

Enzyme therapy

Aldurazyme PA
Aralast NP PA
Buphenyl
Carbaglu
Cerdelga PA
Cerezyme PA
Cholbam PA
Cystagon
Elaprase PA
Elelyso PA
Fabrazyme PA
Galafold PA
Givlaari PA
Glassia PA
Kanuma PA
Lumizyme PA
Mepsevii PA
Naglazyme PA
Onpattro PA
Orfadin PA
Palynziq PA
Prolastin-C PA
Revcovi PA

PA – Prior authorization required

Specialty pharmacy drug list

Strensiq PA
Sucraid
Tegsedi PA
Vimizim PA
Vpriv PA
Zavesca PA
Zemaira PA

Gastrointestinal agents

Gattex PA
Ocaliva PA
Xermelo PA

Gene therapy

Zolgensma PA

Growth hormone deficiency

Genotropin PA
Humatrope PA
Increlex PA
Norditropin PA
Nutropin AQ PA
Omnitrope PA
Saizen PA
Serostim PA
Zomacton PA
Zorbtive PA

Hematological agents

Adakveo PA
Cablivi PA
Doptelet PA
Fibryga
Mozobil PA
Mulpleta PA
Nplate PA
Oxbryta PA
Panhematin
Promacta PA
Riastap
Soliris PA
Tavalisse PA
Thrombat III
Ultomiris PA

Hemophilia

Advate
Adynovate
Afstyla
Alphanate
Alphanine SD
Alprolix
Benefix
Ceprotin
Coagadex
Corifact
Eloctate
Esperoct
Feiba
Helixate FS
Hemlibra
Hemofil M
Humate-P
Idelvion
Ixinity
Jivi
Koate
Koate-DVI
Kogenate FS
Kovaltry
Mononine
Novoeight
Novoseven RT
Nuwiq
Obizur
Profilnine
Rebinyn
Recombinate
Rixubis
Sevenfact
Tretten
Vonvendi
Wilate
Xyntha

Hepatitis B

Baraclude
Epivir HBV
Hepsera
Vemlidy

Hepatitis C

Epclusa PA
Harvoni PA
Ledip-Sofosb PA
Mavyret PA
Pegasys PA
Peg-Intron PA
Ribavirin
Sofos/Velpat PA
Sovaldi PA
Technivie
Viekira PA
Vosevi PA
Zepatier PA

Hereditary angioedema

Berinert PA
Cinryze PA
Firazyr PA
Haegarda PA
Kalbitor PA
Orladeyo
Ruconest PA
Takhzyro PA

Immune globulin

Asceniv PA
Bivigam PA
Carimune NF PA
Cutaquig PA
Cuvitru PA
Cytogam PA
Flebogamma PA
Gamastan S/D PA
Gammagard PA
Gammaked PA
Gammaplex PA
Gamunex-C PA
Hizentra PA
Hyperrho S/D
Hyqvia PA
Micrhogam
Octagam PA
Panzyga PA
Privigen PA
Rhogam
Winrho SDF
Xembify PA

Immunological agents

Actimmune PA
Arcalyst PA
Benlysta PA
Gamifant PA
Ilaris PA
Lemtrada PA
Lupkynis

Palforzia PA

Infertility

Cetrotide PA
Follistim AQ PA
Ganirelix PA
Gonal-F PA
HCG PA
Menopur PA
Novarel PA
Ovidrel
Pregnyl PA

Inflammatory conditions

Actemra PA
Avsola PA
Cimzia PA
Cosentyx PA
Dupixent PA
Enbrel PA
Entyvio PA
H.P.Acthar PA
Humira PA
Ilumya PA
Inflectra PA
Kevzara PA
Kineret PA
Olumiant PA
Orencia PA
Otezla PA
Remicade PA
Renflexis PA
Ridaura
Rinvoq PA
Siliq PA
Simponi PA
Skyrizi
Stelara PA
Taltz PA
Tremfya PA
Xeljanz PA

Metabolic agents

Nulibry

Metabolic bone disease

Reclast

Mood disorder

Spavato PA
Zulresso PA

Multiple sclerosis

Ampyra PA
Aubagio PA
Avonex PA
Bafiertam PA
Betaseron PA
Copaxone PA
Extavia PA
Gilenya PA
Kesimpta PA
Mavenclad PA
Mayzent PA
Ocrevus PA
Plegridy PA
Ponvory
Rebif PA
Tecfidera PA
Tysabri PA
Vumerity PA
Zeposia PA

Musculoskeletal agents

Botox Cosmet PA
Evrysdi PA
Exondys 51 PA
Spinraza PA
Viltepso
Vyondys 53
Xiaflex PA

Narcolepsy

Wakix PA
Xyrem PA
Xywav PA

Neurological agents

Botox PA
Dysport PA
Myobloc PA
Xeomin PA

Neutropenia

Fulphila PA
Granix PA
Leukine PA
Neulasta PA
Neupogen PA
Nivestym PA
Nyvepria
Udenyca PA
Zarxio PA
Ziextenzo PA

Oncology - injectable

Abecma
Abraxane
Adcetris PA
Adriamycin
Adrucil
Alferon N
Alimta
Aliqopa PA
Alkeran
Arranon
Arzerra PA
Asparlas
Avastin PA
Bavencio PA
Beleodaq PA
Belrapzo PA
Bendamustine PA
Bendeka PA
Besponsa PA
Bicnu
Blenrep PA
Bleomycin
Blincyto PA
Bortezomib PA
Busulfex
Breyanzi
Campath
Camptosar
Carboplatin
Cisplatin Injectable
Cladribine
Clolar
Cosela
Cosmegen
Cyclophosphamide
Cyramza PA
Cytarabine
Dacogen PA
Danyelza
Darzalex PA
Daunorubicin
Docetaxel
Doxil
Doxorubicin
Eligard PA
Ellence
Elzonris PA

Specialty pharmacy drug list

Empliciti PA
Enhertu PA
Erbitux PA
Erwinaze
Etopophos
Etoposide Injectable
Evomela
Faslodex
Fensolvi PA
Fludarabine
Fluorouracil Injectable
Folotyn PA
Fusilev
Gazyva PA
Halaven PA
Herceptin PA
Herzuma PA
Hycamtin
Idamycin PFS
Ifex
Ifosfamide
Imfinzi PA
Imlygic
Infugem
Intron A PA
Istodax OVR PA
Ixempra kit
Jelmyto
Jevtana PA
Kadcyla PA
Kanjinti PA
Kepivance
Keytruda PA
Khapzory PA
Kymriah PA
Kyprolis PA
Lartruvo PA
Leuprolide Injectable PA
Levoleucovor
Libtayo PA
Lumoxiti PA
Lupron Depot PA
Margenza
Marqibo
Mesnex
Mitomycin Injectable
Monjuvi PA
Mvasi PA
Mylotarg PA
Navelbine
Nipent
Ogivri PA
Oncaspar
Onivyde
Ontruzant PA
Opdivo PA
Padcev PA
Pamidronate
Paraplatin
Pepaxto
Perjeta PA
Phesgo PA
Photofrin
Polivy PA
Portrazza PA
Poteligeo PA
Proleukin
Provenge PA
Riabni
Rituxan PA
Romidepsin PA
Ruxience PA
Sarclisa PA
Sylatron PA
Sylvant PA
Synribo PA
Taxotere
Tecartus PA
Tecentriq PA
Temodar PA
Tepadina
Thiotepa
Tice BCG
Torisel
Totect
Trazimera PA
Treanda
Trelstar mix PA
Trisenox
Trodelvy PA
Truxima PA
Unituxin PA
Valstar
Vantas PA
Vectibix
Velcade PA
Vidaza
Vinblastine Injectable
Vyxeos PA
Xgeva PA
Yervoy PA
Yescarta PA
Yondelis
Zaltrap PA
Zanosar
Zepzelca PA
Zevalin
Zinecard
Zirabev PA
Zoladex

Oncology - oral

Afinitor PA
Alecensa PA
Alkeran
Alunbrig PA
Ayvakit PA
Balversa PA
Bosulif PA
Braftovi PA
Brukinsa PA
Cabometyx PA
Calquence PA
Caprelsa PA
Cometriq PA
Copiktra PA
Cotellic PA
Daurismo PA
Erivedge PA
Erleada PA
Etoposide Capsule
Farydak PA
Fotivda
Gavreto PA
Gilotrif PA
Gleevec PA
Gleostine
Hycamtin
Ibrance PA
Iclusig PA
Idhifa PA
Imbruvica PA
Inlyta PA
Inqovi PA
Inrebic PA
Iressa PA
Jakafi PA
Kisqali PA
Koselugo PA
Lenvima PA
Lonsurf PA
Lorbrena PA
Lynparza PA
Matulane
Mekinist PA
Mektovi PA

Mesnex
Nerlynx PA
Nexavar PA
Nilandron
Ninlaro PA
Nubeqa PA
Odomzo PA
Onureg PA
Orgovyx
Pemazyre PA
Piqray PA
Pomalyst PA
Purixan
Qinlock PA
Retevmo PA
Revlimid PA
Rozlytrek PA
Rubraca PA
Rydapt PA
Sprycel PA
Stivarga PA
Sutent PA
Tabloid
Tabrecta PA
Tafinlar PA
Tagrisso PA
Talzenna PA
Tarceva PA
Targretin PA
Tasigna PA
Tazverik PA
Temodar PA
Tepmetko
Thalomid PA
Tibsovo PA
Tukysa PA
Turalio PA
Tykerb PA
Ukoniq
Venclexta PA
Verzenio PA
Vitrakvi PA
Vizimpro PA
Votrient PA
Xalkori PA
Xeloda PA
Xospata PA
Xpovio PA
Xtandi PA
Yonsa PA
Zejula PA
Zelboraf PA
Zolinza PA
Zydelig PA
Zykadia PA
Zytiga PA

Oncology - topical

Targretin Gel PA
Valchlor PA

Ophthalmic agents

Beovu PA
Bevacizumab
Cystadrops PA
Cystaran PA
Dextenza
Eylea PA
Iluvien
Jetrea
Keveyis PA
Lucentis PA
Luxturna PA
Macugen PA
Oxervate PA
Ozurdex
Retisert
Visudyne
Yutiq

Opioid antagonists

Sublocade

Osteoarthritis

Durolane PA
Euflexxa PA
Gel-one PA
Gelsyn-3 PA
Genvisc 850 PA
Hymovis PA
Monovisc PA
Orthovisc PA
Sodium Hyalu PA
Supartz PA
Synvisc PA
Triluron PA
Trivisc PA
Visco-3 PA

Osteoporosis

Evenity PA
Forteo PA
Prolia PA
Teriparatide PA
Tymlos PA

Pain management

Prialt

Parkinson's disease

Apokyn PA
Inbrija PA
Kynmobi PA

Pulmonary fibrosis

Esbriet PA
Ofev PA

Pulmonary hypertension

Adcirca PA
Adempas PA
Flolan PA
Letairis PA
Opsumit PA
Orenitram PA
Remodulin PA
Revatio PA
Tracleer PA
Tyvaso PA
Uptravi PA
Veletri PA
Ventavis PA

RSV

Synagis PA

Substance abuse treatment

Vivitrol

Transplant

Astagraf XL
Atgam
Cellcept
Cellcept IV
Envarsus XR
Myfortic
Neoral
Nulojix PA
Prograf
Rapamune
Sandimmune
Zortress PA

PA – Prior authorization required

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DRAFT

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
Review Date	July 28, 2021

Contents

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.

[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 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#

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.

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	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	$150	80%	No out-of-pocket maximum for preventive services

[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-mandated coverage, Medicare coverage, and Aetna's policies regarding those services. The ACA-mandated 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.	USPSTF Grade B: Biennial screening mammography for women aged 50 to 74.[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] As of May 4, 2021, an update for this topic is in progress by the USPSTF. USPSTF, Breast Cancer: Screening. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/breast-cancer-screening

[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.	One every 3 years for women aged 21 to 65 for cervical cytology alone. One every 5 years for women aged 30 to 65 for HPV testing alone, or when cervical cytology is combined with HPV testing.[20]	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.[21]
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 recommended against.[22]	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. [23]

[20] USPSTF, Cervical Cancer: Screening. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/cervical-cancer-screening
[21] Aetna Clinical Policy Bulletin 0443, https://www.aetna.com/cpb/medical/data/400_499/0443.html
[22] https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/prostate-cancer-screening1
[23] 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.[24] 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.[25]	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.[26]	"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.

[24] 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

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

[26] 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. [27] Commonly covered services include vaccinations, screening tests, and education & health counseling.[28]	Screening Pap tests, pelvic exams, and HPV screening once every 24 months. More frequently for those at high risk.[29]	Well Woman visits covered once annually.
Well Child Preventive Visits	Not Covered	Covered as outlined by the USPSTF and other evidence-based guidelines.[30] 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.

[27] Preventive Care Benefits for Women. HealthCare.gov. https://www.healthcare.gov/preventive-care-women/
[28] 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
[29] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Screening-papPelvic-Examinations.pdf
[30] 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.[31]	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.[32] • 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).

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

[32] 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.[33]

**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 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:

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.

[33] 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.[34]

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

[34] 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.[35]

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.[36] 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.[37]

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 as reflected in AlaskaCare claims data from May of 2019 through April of 2021.

[35] Colorectal (Colon) Cancer. US Centers for Disease Control and Prevention. https://www.cdc.gov/cancer/colorectal/basic_info/screening/index.htm

[36] Healthy People 2030. US DHSS. https://health.gov/healthypeople/objectives-and-data/browse-objectives/preventive-care

[37] 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

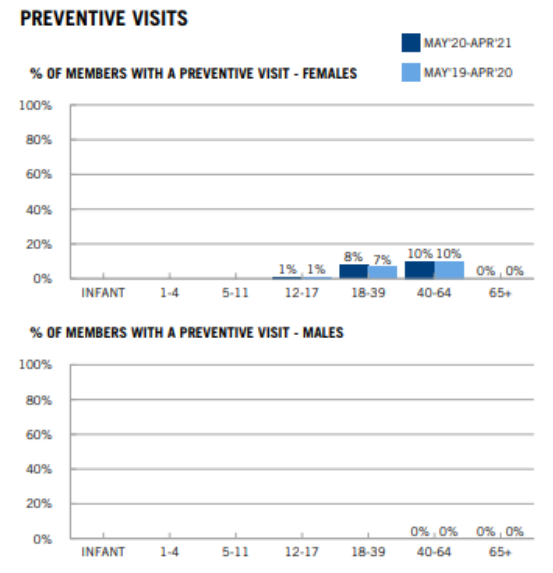
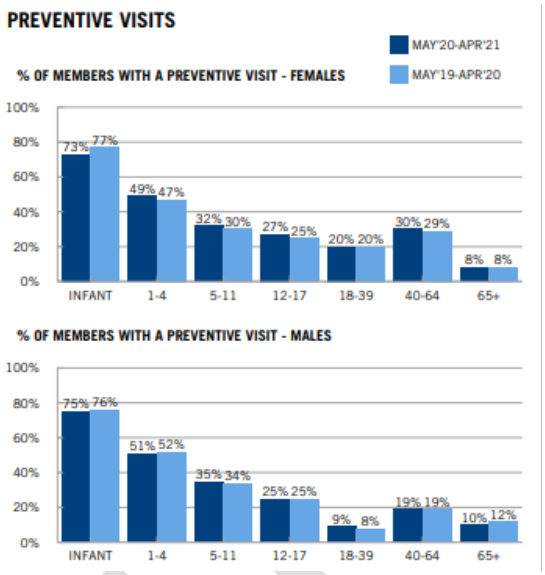


Figure 2. AlaskaCare Active Employee Plan Preventive Visit Claims



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[38]

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.[39] They found high-risk groups often stay away from

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

[39] 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,[40] 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."[41]

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.[42]

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)[43] and to the Additional State Contributions (ASC)[44] 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. [45]

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[40] 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.

[41] Ibid.

[42] Ibid.

[43] 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.

[44] 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.

[45] *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"[46] 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[47] 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.[48]

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.

[46] 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.

[47] 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%.

[48] *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

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, 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

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